INTERNATIONAL ACTIVITY REPORT 2018

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MEDECINS SANS FRONTIERES

THE MÉDECINS SANS FRONTIÈRES CHARTER

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

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

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

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

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

The country texts in this report provide descriptive overviews of MSF's operational activities throughout the world between January and December 2018. Staffing figures represent the total full-time equivalent employees per country across the 12 months, for the purposes of comparisons.

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

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

This activity report serves as a performance report and was produced in accordance with the recommendations of Swiss GAAP FER/RPC 21 on accounting for charitable non-profit organisations.

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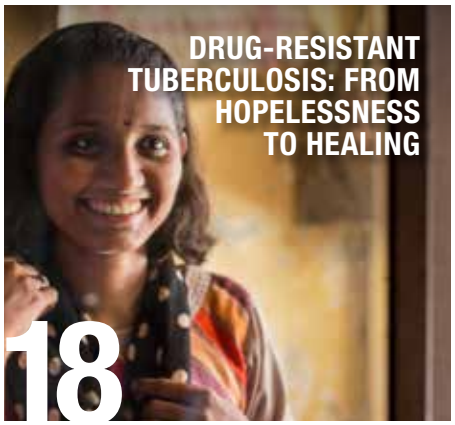
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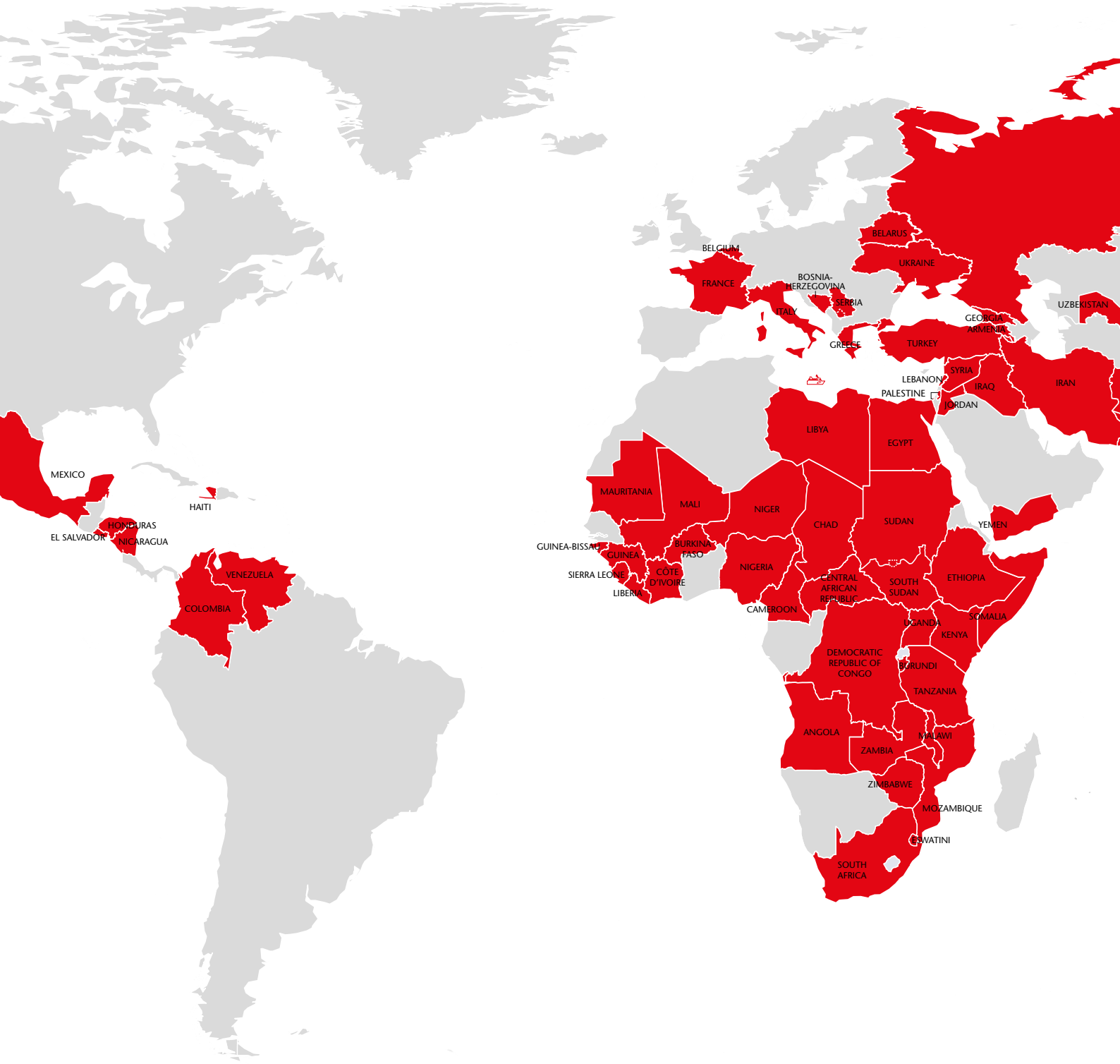
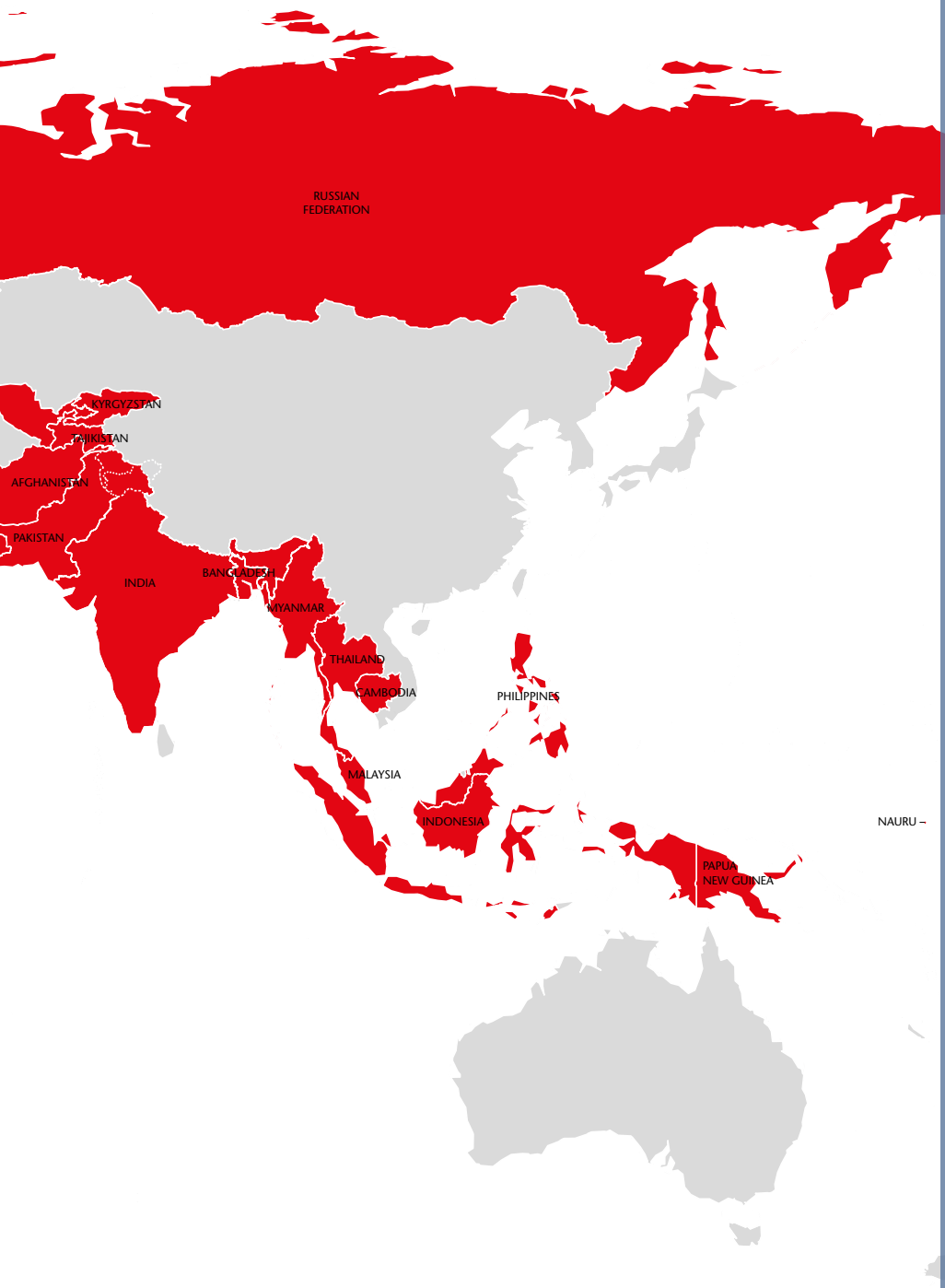
MSF PROGRAMMES AROUND THE WORLD





Countries in which MSF only carried out assessments or small-scale cross-border activities in 2018 do not feature on this map.

21 ANGOLA
21 ARMENIA
22 AFGHANISTAN
24 BALKANS
25 BANGLADESH
26 BELARUS
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27 BURKINA FASO
27 BURUNDI
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30 CENTRAL AFRICAN REPUBLIC
32 CHAD
33 COLOMBIA
34 DEMOCRATIC REPUBLIC OF CONGO
38 EGYPT
38 EL SALVADOR
39 ESWATINI[1]
39 FRANCE
40 ETHIOPIA
42 GREECE
43 GEORGIA
43 GUINEA
44 GUINEA-BISSAU
44 HONDURAS
45 HAITI
46 INDIA
48 INDONESIA
48 IRAN
49 ITALY
49 KYRGYZSTAN
50 IRAQ
52 JORDAN
53 LEBANON
54 KENYA
56 LIBYA
57 LIBERIA
57 MAURITANIA
58 MALAWI
59 MALAYSIA
60 MEXICO
62 MALI
63 MOZAMBIQUE
64 MYANMAR
65 NAURU
65 NICARAGUA
66 NIGER
68 NIGERIA
70 PAKISTAN
71 PAPUA NEW GUINEA
72 PALESTINE
74 PHILIPPINES
74 RUSSIAN FEDERATION
75 SEARCH AND RESCUE OPERATIONS
76 SIERRA LEONE
77 SOMALIA
78 SOUTH AFRICA
79 SUDAN
80 SOUTH SUDAN
82 SYRIA
84 TAJIKISTAN
84 TANZANIA
85 THAILAND
85 TURKEY
86 UGANDA
87 UKRAINE
87 UZBEKISTAN
88 YEMEN
90 VENEZUELA
90 ZAMBIA
91 ZIMBABWE

[1]Formerly Swaziland

FOREWORD

With tens of millions of people on the move around the world and millions more trapped in conflict, amid political forces that – deliberately or otherwise – block access to lifesaving aid, the scale of violence and suffering inflicted on civilians in 2018 remained appalling.

In 2018, Médecins Sans Frontières (MSF) was confronted with a barrage of cynical attacks and toxic narratives aimed at criminalising migrants and those showing solidarity towards them, undermining humanitarian action, international law and the very principles of humanity and solidarity. The most emblematic and brazen of these attacks put an end to the *Aquarius'* search and rescue operations on the Mediterranean Sea, condemning ever more men, women and children to drown along the world's deadliest migration route. Whatever the reasons for leaving their countries of origin – whether they are fleeing violence, poverty, insecurity or the effects of climate change – people on the move have a right to protection and access to medical care, just as do those who choose to stay or are unable to leave.

Whether it fits the political agenda or not, we will continue to offer all people in distress the most appropriate, effective medical assistance we can. Our teams conduct independent evaluations to determine medical needs and what relief we can bring, in consultation first and foremost with the people we seek to assist. As you will see in this report on our activities, community engagement and patient-centred models of care are already integral to many of our projects, but understanding how we can better work with our patients and their communities to define the most suitable models of care remains a priority for us all. This is the only way we will become truly accountable to the people we assist and remain fit for purpose in years to come.

We cannot talk about being accountable and 'people-centred' without also mentioning our efforts to tackle abuse and inappropriate behaviour within MSF and provide support to the victims. Grievance channels have been improved and we have seen an increase in the number of cases reported as a result, but given the size and scope of our organisation, we know there must be more. We must therefore do more – to improve our systems, to make them more widely accessible, and to ensure they are trusted and used by all our staff and patients, their caregivers and their communities.

Our social mission determines that our teams work in difficult, stressful situations, often in horrific circumstances, to provide lifesaving medical assistance to people who would otherwise be without. We are immensely grateful to our tens of thousands of staff in the field who spend their day-to-day lives assisting others. None of this work would be possible without the support of our 6.3 million donors. Thank you for your ongoing belief in our work.

Dr Joanne Liu

INTERNATIONAL PRESIDENT

Christopher Lockyear

SECRETARY GENERAL

A health worker waits to receive a new unconfirmed Ebola patient at the MSF-supported Ebola treatment centre in Bunia, Democratic Republic of Congo, November 2018.

© John Wessels

THE YEAR IN REVIEW

By Dr Marc Biot, Dr Isabelle Defourny, Marcel Langenbach, Kenneth Lavelle, Bertrand Perrochet and Teresa Sancristoval, Directors of Operations

In 2018, Médecins Sans Frontières (MSF) teams provided medical and humanitarian assistance to people facing extreme hardship in over 70 countries. From treating war-wounded ever closer to frontlines in Yemen, to responding to epidemic outbreaks such as cholera in Niger, or providing assistance to people fleeing violence in the Central African Republic, emergency response continued to be a core part of our work.

As 2018 drew to a close, the Democratic Republic of Congo (DRC) was in the midst of its second Ebola outbreak of the year, and its biggest ever. MSF was part of the response, led by the Ministry of Health. Although rapid and well-resourced, with teams having access to a promising new vaccine and several new drugs with the potential to better protect and treat people, the response, and those managing it, failed to adapt to people's priorities, and to gain the trust of the community. This lack of trust in the health services meant people delayed or avoided seeking treatment. By the end of the year, the epidemic in North Kivu and Ituri provinces had claimed more than 360 lives and in some areas was still not under control.

Seeking care in war zones

Early in the year, Syrian civilians and medical staff were caught in the violence in Idlib, in the northwest, and in East Ghouta, near the capital Damascus. In East Ghouta, the barrage was relentless in February and March, with waves of dead and injured arriving at MSF-supported hospitals and health posts. As the siege blocked incoming aid, medical staff had few medical supplies to work with. By the end of the offensive, 19 of the 20 hospitals and clinics we supported were destroyed or abandoned, leaving civilians with few options to seek medical help.

The war in Yemen, which has left the country and its healthcare system in ruins, entered its fourth year. The Saudi- and Emirati-led coalition continued to target civilian areas with airstrikes and bombings, including our new cholera treatment centre in Abs. The war is taking a heavy toll on people, who often must

continued overleaf ›

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Displaced families in Pulka town queue for relief items after having been driven from their homes by the conflict between non-state armed groups and the army in northeast Nigeria, May 2018.

negotiate constantly changing frontlines to find care for their war-wounds or their general medical needs. Yemen was the country where our teams treated the highest number of war-wounded in 2018, over 16,000 people. After a major offensive was launched in Hodeidah in June, doctors in our Aden hospital treated Hodeidah residents who had been driven for six hours, the majority of them in a critical condition. Conflict intensified on several frontlines at the end of the year, leading to an influx of people with war-related injuries. We also treated more than 150 people wounded by mines planted by Houthi-led Ansar Allah troops around Mocha. Constant attacks on our staff and patients at facilities in Ad Dhale forced us to withdraw from the town in November.

The consequences of deterrence and detainment migration policies

The number of MSF projects working with displaced people has more than doubled since 2012. Record numbers of people have left their homes in search of safety, but many only encounter more violence, abuse and exploitation along the way.

In trying to escape extreme levels of violence at home, people from the Northern Triangle of Central America – Guatemala, Honduras and El Salvador – are exposed to shocking brutality on their routes north through Mexico to the United States. This takes its toll, and we treat the mental, as well as the physical, injuries of people who are kidnapped, raped, tortured and exploited.

In the Mediterranean, those attempting to make the dangerous crossing from Libya are frequently intercepted by the Libyan coastguard. Funded by European governments, the coastguard is implementing the EU's policy of push-backs and deterrence. People who are picked up by the coastguard are returned to awful conditions in detention centres, where our access to them is severely restricted.

Across the world in 2018, countries reinforced borders in a bid to keep out migrants and refugees. Governments attempted to cover up the human cost of their harmful policies by demonising, threatening and ultimately blocking some of our efforts to bear witness and provide assistance. We were forced to end our search and rescue operations in the Central Mediterranean in early December after increasingly obstructive actions by European governments, particularly Italy, which shut its ports to migrant rescue boats, despite an estimated 2,297 people having drowned while attempting to flee Libya during the year. In October, the Nauruan government expelled our team with just 24 hours' notice, with no more explanation than that 'our services were no longer required'. Until then, we had been providing desperately needed mental healthcare to local people and asylum seekers held on Nauru as part of Australia's offshore detention policy.

Treating visible and invisible wounds

From March, the Israeli army responded with brute force to the 'March of Return' protests in Gaza, firing on people and leaving thousands with horrific gunshot injuries, mostly to the legs. Our surgical teams were overwhelmed by the number of patients with severe and complex wounds; in 2018, teams in Palestine performed over 3,000 major surgical interventions, compared with 400 in 2017. Patients and medical staff now face the challenge of long-term rehabilitation and multiple surgical procedures, while trying to avoid the high risk of infection, in an enclave with limited resources due to the 11-year blockade.

In the Central African Republic, a cycle of revenge and retaliatory violence escalated, particularly in Bangui and Bambari in April and May, and in Batangafo in November. Our teams provided surgical care to war-wounded patients and were twice forced to activate mass casualty plans in Bangui. However, fighting prevented us from reaching many of the injured people who had fled into the bush.

We also addressed people's invisible wounds, running mental health services in 54 countries. In 2018, MSF released a number of reports that highlighted the grave mental health situation of refugees and

displaced people in particular, including alarming rates of mental illness and thoughts of suicide among people stuck on Lesbos in Greece and on Nauru, and in camps in South Sudan. We ran group and individual counselling sessions for refugees in these countries, as well as in Mexico, Bangladesh and Liberia.

Displaced people out of the spotlight

In Ethiopia, ethnic violence, high insecurity, and a lack of support in their places of origin forced at least 1.4 million people to become internally displaced in multiple, simultaneous and massive displacement crises. Most people left their houses with close to nothing and needed food, shelter, water and psychosocial support. Our teams worked in camps in the country's south and west, where overcrowding and poor sanitation facilitated the spread of conditions such as diarrhoea and skin infections. The forced relocation of displaced people and the barriers to the impartial delivery of aid were constant dilemmas faced by humanitarian organisations. Ethiopia is also now host to the second-largest refugee population in Africa, mainly Eritreans, Somalis and South Sudanese.

In northeast Nigeria, nearly two million people have been displaced across Borno and Yobe states by the ongoing conflict. Rann town in Borno came under attack on 1 March – for the second time in just over a year – forcing us to temporarily suspend activities. We worked in 17 locations across the two states in 2018, where hundreds of thousands of people remain heavily dependent on aid for their survival, with hundreds of thousands more in areas inaccessible to humanitarian organisations.

Medical achievements improve patient care

In November, MSF's partner organisation Drugs for Neglected Diseases *initiative* (DND*i*) received approval for fexinidazole, a sleeping sickness drug that is safer, easier to administer and more effective than previous treatments. MSF projects trialled fexinidazole, which is the first new chemical entity to be developed by DNDi.

Ninety-seven per cent of unsafe abortions and related deaths occur in Africa, Latin America and southern and western Asia, and over the last two years, a significant effort has been made to increase access to safe abortion care in MSF projects in these regions. In 2018, around 70 projects in 25 countries reported providing safe termination of pregnancy to over 11,000 women and girls who requested it.

Our continuous drive to improve the quality of diagnostics led us to expand our investment in point-of-care ultrasound. We also developed eCARE, an algorithm to support paediatric diagnostic capacity, which substantially increases health workers' compliance with guidelines and decreases the use of unnecessary antibiotics.

MSF's Access Campaign continues to advocate better access to key sofosbuvir-based drug combinations, used to treat hepatitis C. This enabled our teams to scale up and simplify treatment in a number of countries in 2018, including Cambodia, where we also introduced a simplified diagnostic process that has significantly reduced the time between screening and the start of treatment.

Our work is not without its risks. Our teams provide care under the threat of detention, abduction and attack; our thoughts remain with Romy, Richard and Philippe, our colleagues abducted in DRC in July 2013, who remain missing.

MSF nurse Aoife Ni Mhurchu gives anti-seasickness pills to one of the 27 people transferred to the *Aquarius* on 7 January 2018, having been rescued from a small wooden boat by a supply vessel 100 kilometres from the Libyan coast.

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OVERVIEW OF ACTIVITIES

Largest country programmes

By expenditure

1. Democratic Republic of Congo	€109.9 million
2. South Sudan	€83.3 million
3. Yemen	€57 million
4. Central African Republic	€51.2 million
5. Syria	€47 million
6. Iraq	€45.5 million
7. Nigeria	€44.9 million
8. Bangladesh	€39.9 million
9. Afghanistan	€32 million
10. Niger	€31.6 million

The total budget for our programmes in these 10 countries was €542.3 million, **52 per cent of MSF's operational expenses in 2018** (see Facts and Figures for more details).

By number of field staff[1]

1. South Sudan	3,682
2. Democratic Republic of Congo	2,848
3. Central African Republic	2,829
4. Afghanistan	2,514
5. Bangladesh	2,380
6. Nigeria	2,365
7. Niger	2,157
8. Yemen	2,058
9. Ethiopia	1,760
10. Haiti	1,746

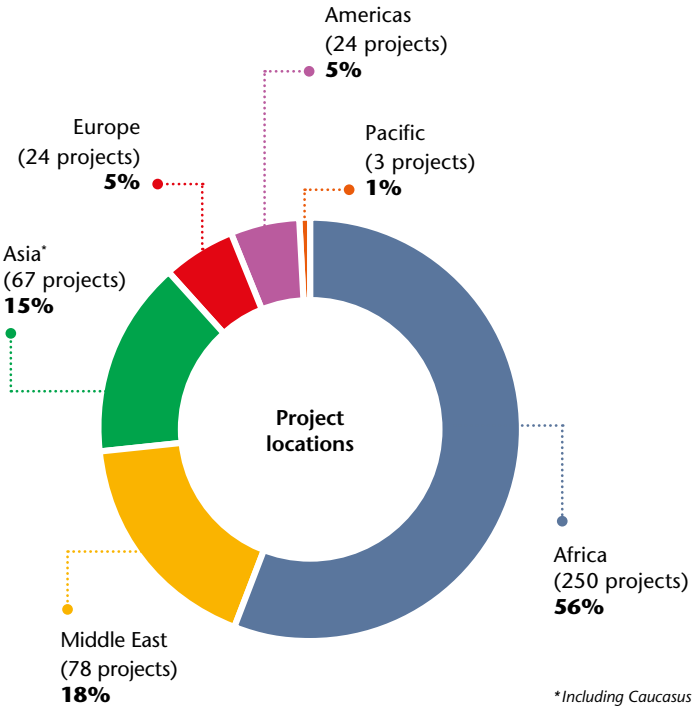
By number of outpatient consultations[2]

1. Democratic Republic of Congo	1,826,300
2. South Sudan	1,157,900
3. Bangladesh	954,300
4. Central African Republic	852,600
5. Niger	589,100
6. Syria	569,300
7. Yemen	535,600
8. Ethiopia	500,800
9. Sudan	467,400
10. Afghanistan	411,700

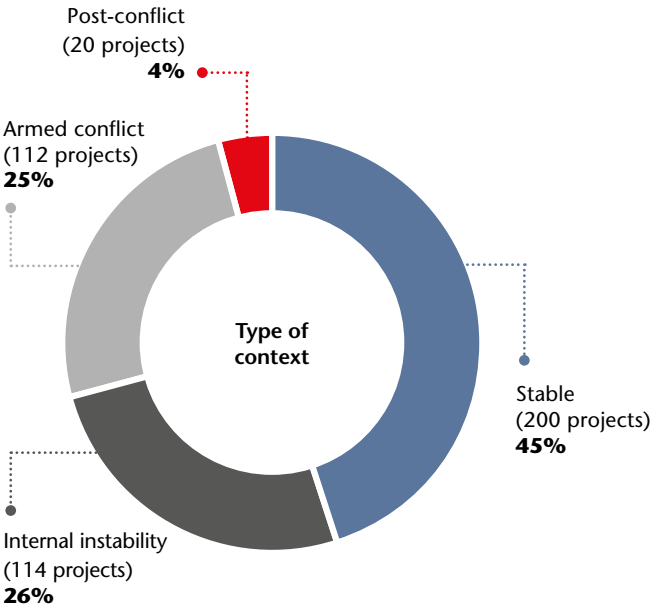
[1] ***Staff numbers*** *represent full-time equivalent positions (locally hired and international) averaged out across the year.*

[2] ***Outpatient consultations*** *exclude specialist consultations.*

Project locations



Context of intervention



2018 ACTIVITY HIGHLIGHTS

11,218,700
outpatient consultations

758,200
patients admitted

2,396,200
cases of malaria treated

74,200
severely malnourished children admitted to inpatient feeding programmes

159,100
people on first-line HIV antiretroviral treatment at the end of 2018

17,100
people on second-line HIV antiretroviral treatment at the end of 2018 (first-line treatment failure)

309,500
births assisted, including caesarean sections

104,700
major surgical interventions involving the incision, excision, manipulation or suturing of tissue, requiring anaesthesia

24,900
people medically treated for sexual violence

16,500
people started on first-line tuberculosis treatment

2,840
people started on drug-resistant tuberculosis treatment

404,700
individual mental health consultations

63,700
people treated for cholera

1,479,800
people vaccinated against measles in response to an outbreak

33,900
people vaccinated against meningitis in response to an outbreak

2,800
people admitted to Ebola treatment centres, of whom **450** were confirmed as having Ebola

14,400
people on hepatitis C treatment

3,184
migrants and refugees assisted at sea

The above data groups together direct, remote support, and coordination activities. These highlights give an overview of most MSF activities but cannot be considered exhaustive. Any additions or amendments will be included in the digital version of this report, available at msf.org.

GAZA: OVERWHELMED BY GUNSHOT WOUNDS

© Heidi Levine/Sipa Press

Voice from the field: Marie-Elisabeth Ingres, Head of Mission for Palestine

The Palestinian enclave of Gaza has been blockaded by Israel for more than a decade, during which time its people have witnessed three wars and other frequent outbreaks of violence. The economy is in freefall and the humanitarian situation continues to deteriorate. Israel only permits a small number of people to leave, and since the border with Egypt is also frequently closed, people feel – and in effect often are – trapped.

'The Great March of Return' protests held at the border almost every Friday since 30 March 2018 have been met with hails of gunfire from the Israeli army. By the end of 2018, 180 people had been shot dead and 6,239 injured by live fire – the vast majority sustaining wounds to the legs. It is these complex and severe injuries that our teams have been struggling to respond to.

How do you treat thousands of similar injuries, all needing multi-stage treatment, potentially lasting for years? Marie-Elisabeth Ingres describes what she saw in Gaza in 2018.

"We were not prepared for what happened. We had been watching every rocket launched from Gaza, every assassination and bombardment, wondering if it would trigger a new war, one even more violent than that of 2014. However, we had not envisaged the number of people who would be shot during the March of Return protests. These protests have turned into bloodbaths, occurring with such relentless regularity, month after month, that we have become almost used to them.

30 March 2018: we were stupefied when we learned that more than 700 people had been injured and 20 killed by live fire from Israeli soldiers stationed at the fence that separates Israel from Gaza. From that moment, a machine was set in motion to respond to the huge needs and since then it has not stopped. Friday after Friday, hundreds of patients with bullet injuries have been treated in Ministry of Health hospitals. Half of those injured have ended up in our clinics for post-operative care. Our teams in the field have worked tirelessly to increase our capacities, rapidly scaling up recruitment and training. We brought in surgeons, anaesthetists and other specialists to treat the mass influxes of wounded patients; nevertheless, our facilities struggled to cope and were quickly overwhelmed by the number and the severity of the injuries.

» ABOVE PHOTO: On 6 June 2018, Palestinians wounded by Israeli live ammunition arrive for post-operative care at an MSF clinic in Gaza.

Along with the other humanitarian organisations in Gaza, we had to quickly prepare for 14 May, because of the numerous calls to protest against the inauguration of the American embassy that day in Jerusalem. It was a black Monday, a day of war. It reminded our traumatised Palestinian colleagues of the 2014 war. For me, it brought back memories of 5 December 2013 in Bangui, Central African Republic, when the anti-Balaka attacked the city: the bodies that arrived in the space of a few short hours; the overwhelmed teams; the horror in the face of tragedy.

In Gaza, from that Monday on, the machine went into overdrive, and except for a few lulls, there has been no let-up. Every week there are new patients, many with open fractures, at risk of infection, that will require months, if not years, of medical care, surgical procedures and rehabilitation. Some will be disabled for life. All of this has occurred in a blockaded territory where the health system was already unable to provide adequate care for everyone. The injured of Gaza have largely been abandoned simply because of where they were born.

The young Palestinians that we see in our clinics feel hopeless, as though they have no future. Of course, some may have been manipulated by the authorities into protesting along the fence. Or they may have been simply protesting against an unjust life and a lack of liberty. Laws, personal freedoms and human rights are disregarded by all sides. Millions of people have become mere pawns in political games in which they have little say.

Today, our teams continue to do all they can to treat these young men's wounds and prevent the loss of their limbs, although we know that we will be able to heal only a small proportion of them because of the constraints imposed by the Israeli blockade and the various Palestinian authorities. We feel a sense of dread at each moment of tension, as we wait to see if Gaza will erupt once again into war, as it did in 2014. If it doesn't, perhaps we will be able to envision addressing the complex medical needs – including treatment of bone infections, reconstructive surgery and physiotherapy – of some of those who have been crippled by their injuries before it is too late. Expert surgeons, antibiotic specialists and a new laboratory able to analyse bone samples are required to deal with severe wounds such as open fractures. We are doing all we can to find these people and resources, both in Gaza and abroad.

The situation in Gaza poses many human, technical, logistical and financial challenges for us, but we are committed to providing the best response possible. We will not give up, even if we do not have the resources to manage right now and the political context is not in our favour, with people's medical needs falling to the bottom of the authorities' agendas. We are struggling, but if we save even a few young people, we will have succeeded."

Patients with gunshot wounds to the lower limbs wait to have their dressings changed at MSF's post-operative clinic in Gaza City, May 2018.

A wounded demonstrator is evacuated from the throng as tens of thousands gather at the border between Gaza and Israel on 14 May 2018, in the seventh week of protests. More than 1,300 Palestinians were shot and 60 killed at the fence that day, which marked the 70th anniversary of the declaration of the State of Israel and the day the US embassy in Jerusalem was inaugurated.

In May 2018, medical teams operate on patients with bullet wounds at Al Aqsa hospital, where MSF surgeons were sent to support the Ministry of Health.

© Alva Simpson White/MSF

Mohammed, 28, waits to find out whether he can travel to Jordan to have the surgery he needs to regain the use of his leg. Gaza, September 2018.

MOHAMMED'S STORY

"I was injured during the 'Great March of Return' protest on Friday 6 April. I knew it was dangerous, but I went anyway – everybody did. I was just standing there when I got shot. I felt the bullet shattering my bone.

I've had six operations so far, including debridement operations [cleaning the wound of damaged tissue and foreign objects] and an operation to close the wound. Then I was told I might need to undergo an amputation after closing the wound.

At the start, I was coming to the MSF clinic daily to receive treatment. Now I go three times a week for physiotherapy and to have the dressings changed on my leg. After receiving physiotherapy, I feel better. The spasms decrease and moving my muscles is easier.

Why was I protesting? I am like every Palestinian – we have been through a lot of conflicts with Israel, and it is never-ending. I went to protest at the border because it is our right and this is our land. I went there only for this purpose.

I haven't been back. I can't move. I stay at home. I sleep for a few hours and then I'm woken by the pain. If I can have my leg back as it used to be, then maybe I can go back to work and have a future."

© Alva Simpson White/MSF

ABU HASHIM

MSF physiotherapist in Gaza

"Fractures like Mohammed's occur after high-impact trauma and considerable force. The soft tissue has been destroyed and the bone shattered. He has also had a skin graft. But the most complicated thing about Mohammed's injury is that his common peroneal nerve is completely cut, making his foot drop – meaning he is not be able to walk properly and could be disabled for life. The physiotherapy is very painful for him, but vital to avoid joint stiffness and to move the muscles."

An X-ray of Mohammed's right leg, held together by an external fixator. Injured five months previously, the loss of bone is too great for the fracture to heal by itself. It will require multiple surgical interventions, including reconstructive surgery, a type of care available only to a tiny number of people in Gaza.

THE BROKEN AMERICAN DREAM: VIOLENCE ON THE CENTRAL AMERICAN MIGRATION ROUTE

By Lali Cambra and Elias Primoff

In the so-called Northern Triangle of Central America – and along the treacherous migration route north through Mexico to the United States – two powerful opposing forces have trapped thousands of people in a seemingly endless cycle of violence and displacement. Every year, deep social inequality, political instability and brutal conflict in Guatemala, Honduras and El Salvador drive some 500,000 people to flee northwards in search of safety, while in the US, the government is stepping up deportations and dismantling legal protections for refugees and asylum seekers in an effort to force them back.

Mexico is caught in the middle. Although the US government has repeatedly attempted to declare Mexico a safe place for refugees to seek asylum, evidence – including testimonies collected by Médecins Sans Frontières (MSF) teams working with people on the move across the country – prove that it is anything but. Stranded at waypoints and towns along the border, migrants, refugees and asylum seekers from both Mexico and Northern Triangle countries are exposed to kidnapping, extortion and horrific abuse.

In 2018, we scaled up our response to the physical and psychological consequences of this unfolding disaster, expanding our mental health and psychosocial activities in health facilities as well as migrant shelters along the routes north. We are also working to adapt our response to better serve the growing numbers of people on the move.

No choice but to flee

People treated by MSF teams across the region share stories of the violence and criminality that forced them to leave their homes. In particular, they describe the stranglehold that *maras*, or gangs, have on people in their home countries. Many see no choice but to flee.

Lucila, a 56-year-old fruit seller from San Salvador, El Salvador's capital and most populous city, now works in a migrant shelter. She told an MSF psychologist there that her eldest son had been murdered by a gang. When the same gang tried to recruit another one of her children, the two of them left their home for good.

Mother-of-five Guadalupe fled her home in Honduras when one of the *maras* began to "take an interest" in her 14-year-old son. "The gang wanted him to keep watch for them," she says. "That's why we left." Guadalupe was later attacked and sexually abused at the border between Guatemala and Mexico by two men. She came to the MSF clinic in Tenosique, where we tended her physical and psychological wounds.

» ABOVE PHOTO: Migrants at Shelter 72 in Tenosique trace their journey through Mexico, where they are very vulnerable to physical violence by criminal gangs, petty criminals and authorities. Mexico, February 2018.

MSF teams are running a number of projects in Northern Triangle countries to assist vulnerable and displaced people. In Honduras, our *servicio prioritario*, or priority service, offers comprehensive emergency medical and psychosocial care to victims of violence, including sexual violence. And in El Salvador, we send mobile clinics to provide primary, mental, and sexual and reproductive health services in regions where insecurity prevents people from accessing medical assistance.

Caring for people on the move

Those who make the heart-wrenching decision to leave their homes encounter more danger on the road. Throughout Mexico, migrants, refugees and asylum seekers face robbery, kidnapping, violence and death. "We see what can be expected in people on the move: sores, dehydration, fever," says Candy Hernández, an MSF doctor working at Shelter 72 in Tenosique, a Mexican town in Tabasco state on the border with Guatemala. "But we also see the terrible effects of the violence of the gangs that attack [people] on their journeys and then rob them: machete wounds, beatings, abuse and sexual violence."

Those who push on and make their way through Mexico find that violence and criminality are rife on the US border as well. Kidnapping is a lucrative business here: exhausted and disoriented, many migrants, refugees and asylum seekers are seized by criminal groups at bus stations and then held for ransom.

This is what happened to Alberto, from Guatemala. He ended up in a shelter in Nuevo Laredo, Mexico, where he was seen by our team. "They interrogate you, they take away your mobile phone and they force you to give them your family's phone number," he told them. "They call your family and ask for money. It might be US$2,500 or US$3,000." If a hostage can't come up with the money, they face torture or death.

From the southern border with Guatemala to the Rio Grande and at key locations in between, we have teams working in fixed and mobile clinics, and in migrant shelters, providing medical and psychosocial support to migrants and refugees, as well as local communities affected by violence. We also offer specialised mental healthcare to victims of extreme violence at a therapeutic centre in Mexico City. "We see similar situations here for people on the move as we do for people who have lived through war," explains MSF psychologist Diego Falcón Manzano, who works at the Mexico City facility. Criminals along the migration route often use psychological torture when seeking to extort victims or forcibly recruit new gang members. "Before, on the journey, you were either beaten or raped. Now, they don't just beat you, they make you see how it's done to other people. Or they make you kill someone or handle human body parts."

Forced return

Even if people make it across the border into the US, their problems do not end there: they face the prospect of deportation and being sent back to square one – or worse. And it's not only the people caught trying to make the crossing who are returned to Mexico or their countries of origin; many others who have spent years or even decades building lives in the US can be suddenly deported to countries they've long since stopped calling home.

Deportees find themselves thrust back into the same climate of brutality and fear they tried so desperately to escape. Often, they discover that the gangs they fled have been waiting for their return. Many see no choice but to immediately begin the dangerous journey north once more, re-entering the cycle of violence and displacement, driven by forces outside their control.

© Juan Carlos Tomasi/MSF

A man rests at a shelter after having his sore and wounded feet tended to. Tenosique, Mexico, February 2018.

© Robin Hammond/NOOR

THE ROHINGYA: NO COUNTRY TO CALL HOME

By Dalila Mahdawi

More than a year after their mass exodus from Myanmar, the future looks more uncertain than ever for the Rohingya. Following a campaign of violence by the Myanmar military in August 2017 – ostensibly in response to attacks by the Arakan Rohingya Salvation Army – Rohingya refugees have continued to cross the border into Bangladesh. Over 908,000 had fled there by the end of 2018.

While the scale and speed of the exodus were unprecedented, for those familiar with Rohingya history it would not have come as a surprise. After all, their persecution stretches back decades. A marginalised ethnic minority, they have long been subject to appalling discrimination and segregation within Myanmar. In 1982, a citizenship law rendered them effectively stateless, and they face many other egregious restrictions, for example on marriage, family planning, education and freedom of movement.

Almost 130,000 Rohingya and other Muslims remain in de facto detention camps in central Rakhine state, unable to access basic services or earn a living, while hundreds of thousands more in the north are almost completely cut off from international humanitarian aid. Since 1978, time and again discrimination and targeted violence have caused them to flee in their thousands into neighbouring countries or embark on dangerous boat journeys across the sea to Malaysia. Today, the Rohingya are a stateless people scattered across Asia and beyond, with very few allies or options.

Médecins Sans Frontières (MSF) has been working with the Rohingya for decades – in Myanmar since 1994, in Bangladesh on and off since 1985, and in Malaysia starting in 2004. In August 2017, when the targeted attacks by the Myanmar military forced the biggest-ever number of Rohingya into neighbouring Bangladesh, we were able to swiftly increase our activities in Cox's Bazar district and provide emergency care to patients with violence-related injuries, including rape and gunshot wounds, as well as severe trauma. We carried out massive vaccination campaigns and by December 2018 had conducted around one million consultations for medical conditions, such as diarrhoeal diseases, skin diseases and respiratory infections, that were directly related to the lack of healthcare available to the Rohingya in Myanmar or their abysmal living conditions in Bangladesh.

The Rohingya continue to be confined to overcrowded, unsanitary camps, unable to work, receive a formal education or access basic services. They are almost entirely dependent on humanitarian aid and the

» ABOVE PHOTO: A Rohingya man carries wood through Kutupalong-Balukhali mega camp, which in 2018 became the largest refugee camp in the world. Cox's Bazar district, Bangladesh, August 2018.

generosity of their Bangladeshi hosts. Their experiences of unspeakable violence in Rakhine and anxiety about what the future holds exacerbate their health problems, yet the availability of specialised services, such as mental health support or free, high-quality secondary healthcare, is extremely limited. News of imminent repatriations in November, which were shelved after no refugees were willing to return, highlighted how precarious the Rohingya's situation remains.

By the end of 2018, some aid organisations had started to close or scale down their operations in Bangladesh as the situation was no longer considered an emergency. The response has been largely short-term in scope, treating the symptoms of Rohingya disenfranchisement without sufficiently addressing the causes of it. Donor countries have lost interest and at the time of writing, funding for the humanitarian response remains grossly inadequate, with key questions yet to be answered: what will happen to the over one million Rohingya in Bangladesh, living in dangerously cramped and squalid camps, with no prospects of integration or resettlement? Denied refugee status in Bangladesh, will they ever be able to return home? If they do, to what will they be returning? Will the Rohingya be forced back to Myanmar, as they were in 1978-79 and again in 1993-97?

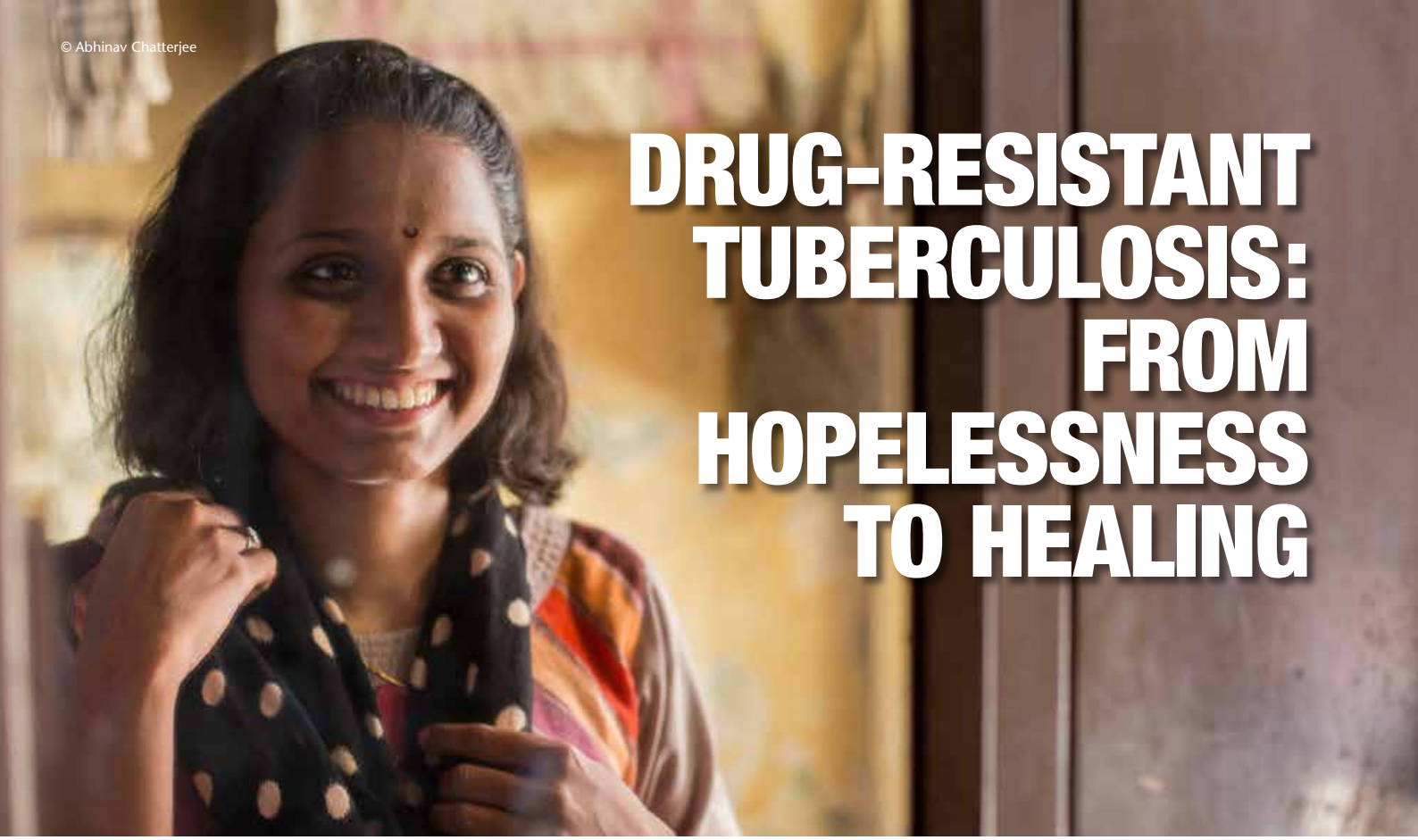
These questions hang over Rohingya refugees in Malaysia too. As in Bangladesh, our teams there witness daily the consequences of the Rohingya's marginalisation; deprived of legal status, they are highly susceptible to extortion, abuse and detention. Their plight in these countries exposes a global collective failure to protect an already vulnerable people from further violations. As such, it requires not only regional but international leadership and solutions.

Of course, the root of the problem lies in Myanmar, where 550,000-600,000 Rohingya still live. Very little is known about the health and humanitarian status of those in northern Rakhine. Our repeated requests for access to this region continue to be ignored or denied by the authorities. Despite international outrage at the violence committed by Myanmar security forces against the Rohingya in 2017, external pressure has produced little to no change on the ground. Discrimination and segregation persist, and small numbers of Rohingya continued to flee to Bangladesh in 2018.

For more than two decades, we have witnessed a steadily deteriorating human rights and humanitarian situation in Rakhine. The continued restrictions on access to the north, and the de facto detention of Rohingya in camps in the central region pose serious operational and ethical dilemmas for MSF. Bearing witness, or *témoignage*, remains a central reason for our continued presence, even as our ability to respond to the health needs has reduced considerably.

As the world's gaze shifts from the Rohingya to the next humanitarian emergency, the challenge for 2019 and beyond will be to keep the plight of one of the most vulnerable groups of people in the world visible. We will continue to provide much-needed medical and humanitarian services and speak out about the scale of the Rohingya's needs in Myanmar, Bangladesh and Malaysia, but the international community's moral outrage must be translated into meaningful actions to end discrimination and denial of citizenship, a pre-condition for the voluntary, safe and dignified return of Rohingya to Myanmar. Governments need to move beyond subsistence support in Bangladesh and redouble their diplomatic efforts so that the Rohingya have a genuine chance of a better life.

Rozia and her two-month-old son Zubair are seen by a doctor in the MSF hospital in Goyalmara, Cox's Bazar district, Bangladesh, April 2018.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DRUG-RESISTANT TUBERCULOSIS: FROM HOPELESSNESS TO HEALING

By Jason Maddix

Although believed by many to be a disease of the past, tuberculosis (TB) kills more people today than any other infectious disease and is one of the top 10 causes of mortality worldwide. An estimated 1.6 million people die from TB each year, equivalent to a staggering 4,400 lives lost every day. World leaders have set ambitious goals to combat the disease, but the international response to this global crisis is shamefully off track.

Drug-resistant TB (DR-TB) – caused by bacteria that do not respond to standard TB treatment – is a particularly worrying and growing problem in many of the places Médecins Sans Frontières (MSF) works. Until very recently, globally recommended treatment options available to people with DR-TB took up to two years to complete and included up to 14,600 pills and painful daily injections that caused devastating side effects, such as deafness and psychosis. On top of that, the cure rates were very poor for multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB), strains of the disease that fail to respond to even greater numbers of drugs. Today, newer treatment options exist that could stop senseless deaths from these forms of TB, but far too few people are receiving them.

After losing her mother to MDR-TB five years ago, Ankita Parab learned that she too was infected with the disease. Following two years of arduous treatment, she was declared cured. Later, her brother also fell ill with MDR-TB. In 2016, when her brother's condition worsened, his doctor referred him to MSF's TB clinic in Mumbai, India, where he was quickly started on a treatment regimen that included the newer TB drugs. Ankita was also tested for TB through contact tracing, one of the preventive services MSF offers to all family members living with people with TB. The results were a terrible shock for her. Despite her earlier treatment, Ankita had developed XDR-TB – the most severe form of the disease.

Although our team in Mumbai started both siblings on the newer treatment at the same time, tragically, Ankita's brother's illness was too advanced and he died soon after. Her brother's death and her new diagnosis were a double blow for Ankita. She remembers thinking, "He started his treatment at the same place, so if this can happen to him, it can happen to me as well – I'm not special. He took care of himself better than I ever did."

It can be extremely difficult for people to complete long, toxic DR-TB treatment regimens without consistent encouragement and support, particularly when faced with personal hardships like the loss of a family member, unemployment or social exclusion due to other people's fear of the disease. Comprehensive psychosocial support – including help to address mental health issues such as anxiety and depression – is a cornerstone of MSF TB treatment programmes worldwide.

With support from her family, friends and MSF medical staff and counsellors, Ankita completed her two years of XDR-TB treatment with MSF in May 2018 and was declared cured. Follow-up testing in November confirmed there was no relapse or recurrence of TB.

Key to Ankita's successful treatment was the use of one of the newer drugs that significantly improve DR-TB cure rates and cause far fewer side effects. However, these medicines – bedaquiline and delamanid –

» ABOVE PHOTO: Ankita Parab at her home in Mumbai, India, April 2019.

remain inaccessible to the vast majority of people eligible to receive them. In 2018, MSF medical teams and the MSF Access Campaign intensified work to overcome this deadly access impasse through both clinical research and targeted advocacy.

One barrier to improving care is rooted in the fact that a combination of medicines is required to form effective DR-TB treatment regimens. But pharmaceutical corporations developed bedaquiline and delamanid in isolation and did not study the safety and efficacy of the drugs in combination with existing medicines. This prevailing model of research and development causes missed opportunities and undue delays in getting better treatment options to people.

To improve the chances of survival for people in our care, MSF is conducting crucial research together with partner organisations to develop the evidence base for the therapeutic value of newer DR-TB treatments. These trials will not conclude until 2022; however, based on data from drug safety monitoring and operational research in clinical settings, the World Health Organization announced new DR-TB treatment recommendations in 2018 that include the use of the newer drug bedaquiline.

While the pharmaceutical corporation Johnson & Johnson (J&J) holds patents on bedaquiline, it is only one contributor to the broad, collective effort that has enabled development of the drug and demonstration of its therapeutic value. Support has also come from public and philanthropic funding and a TB community desperate to provide improved treatment options for people with DR-TB. When bedaquiline was first authorised for use in 2012, it was the first DR-TB drug to be developed in more than 40 years. But by late 2018, only 28,700 people had received it worldwide – less than 20 per cent of those who could have benefited from it.

Based on this alarming unmet medical need and J&J's unwarranted monopoly control over bedaquiline access and pricing, MSF spoke out unapologetically in 2018 to urge the company to take swift action to ensure affordable access to the drug for everyone who needs it to survive. Highlighting the joint effort that has established bedaquiline's clinical value, and analysis that shows it can be manufactured and sold profitably for as little as 25 US cents per day, we called on J&J to allow the production of more affordable generic versions of the drug and drop its price for bedaquiline to no more than US$1 per day. In October, MSF joined with other civil society organisations to interrupt the opening ceremony of the 49th Union World Conference on Lung Health in The Hague in order to reiterate these calls. And ahead of the first-ever United Nations High-Level Meeting on Tuberculosis in September, we called on world leaders to translate their ambitious commitments to address TB into bold, genuine action to save lives, including scaling up existing medicines and diagnostic tests, and developing and delivering faster, safer, simpler tools for tomorrow.

As we continue to strive to provide the best possible TB treatment for people in our care, we will also maintain our pressure on governments and pharmaceutical companies to live up to their commitments to reduce suffering and death from this terrible disease.

MSF provided TB treatment to 19,400 patients in 2018, including 2,840 patients with DR-TB. The MSF Access Campaign was launched in 1999 to push for access to, and the development of, lifesaving medicines, diagnostic tests and vaccines for people in MSF's care and beyond.

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At the 49th Union World Conference on Lung Health in October 2018, MSF joins with other civil society organisations to call on drug company Johnson & Johnson to ensure affordable access to the critical TB drug bedaquiline.

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MSF teams on their way back from Numbi, a small town 2,000 metres above sea level in one of the most remote parts of the Democratic Republic of Congo's South Kivu province, April 2018. © Marta Soszynska/MSF

ANGOLA

No. staff in 2018: 65 | Expenditure in 2018: €1.7 million | Year MSF first worked in the country: 1983 | msf.org/angola

Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURE:

5,870 people treated for malaria

In 2018, Médecins Sans Frontières supported the Angolan health authorities to respond to outbreaks of malaria and cholera, and to improve the country's monitoring of these and other endemic diseases.

Our emergency team started working in Huambo province in January, to assist the health authorities in response to an outbreak of malaria, which affected mainly children, typically the most vulnerable to the disease.

The team was based in Huambo provincial hospital, where the most severe cases were transferred. We rehabilitated an unused area within the facility to increase the number of beds available from 65 to 150. As rains and rising temperatures exacerbated the outbreak, we extended our support to nine municipal hospitals during an intervention that lasted until April.

The emergency team also responded to a cholera outbreak in Uige, reinforcing case management and isolation procedures in the city's cholera treatment centre, and strengthening community surveillance systems for early case detection. In addition, we provided training and donated material to help control the outbreak.

Meanwhile, we worked with the Ministry of Health to improve the systematic collection and dissemination of epidemiological data. A 10-year epidemiological analysis of the 13 main endemic diseases in Angola was produced, and the ministry now uses the findings to prioritise the alerts it generates for specific diseases.

We left Angola at the end of the year but will continue to monitor the situation, ready to respond in case of new emergencies.

ARMENIA

No. staff in 2018: 42 | Expenditure in 2018: €1.7 million | Year MSF first worked in the country: 1988 | msf.org/armenia

Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

21 people treated for hepatitis C

13 people started on treatment for DR-TB

Médecins Sans Frontières has been helping to tackle resistant forms of tuberculosis (TB) in Armenia since 2005. In 2018, we started to hand over activities to the national health authorities.

Over the last 14 years, we have progressively expanded our programme so that the latest treatment for drug-resistant TB (DR-TB) is now available throughout the country. Since 2015, we have been participating in the endTB project, an international initiative aimed at finding shorter, less toxic and more effective treatments for DR-TB. Enrolments in the observational study were completed in Armenia in June 2017, with a total of 106 patients participating. Follow-up continued throughout 2018 and the project is scheduled for completion in March 2019.

We have also been offering hepatitis C treatment to patients with DR-TB and chronic active hepatitis C since 2016: 20 per cent of DR-TB patients followed by our teams at that time were co-infected with hepatitis C, which can affect liver function and exacerbate the side effects of DR-TB treatment. In 2018, we started an epidemiological study aimed at documenting the safety and efficacy of combining the newest treatments for DR-TB with direct-acting antivirals for hepatitis C.

In April, we also sent a team to perform thoracic surgery on six TB patients in Armenia, where such treatment is not otherwise available.

On completion of the endTB project and our epidemiological study in March 2019, we will hand over our remaining activities in Armenia to the national health authorities. In preparation, in 2018 our teams started providing theoretical and on-the-job training to doctors and nurses working in TB clinics across the country, with case management already handed over in many areas by the end of 2018.

AFGHANISTAN

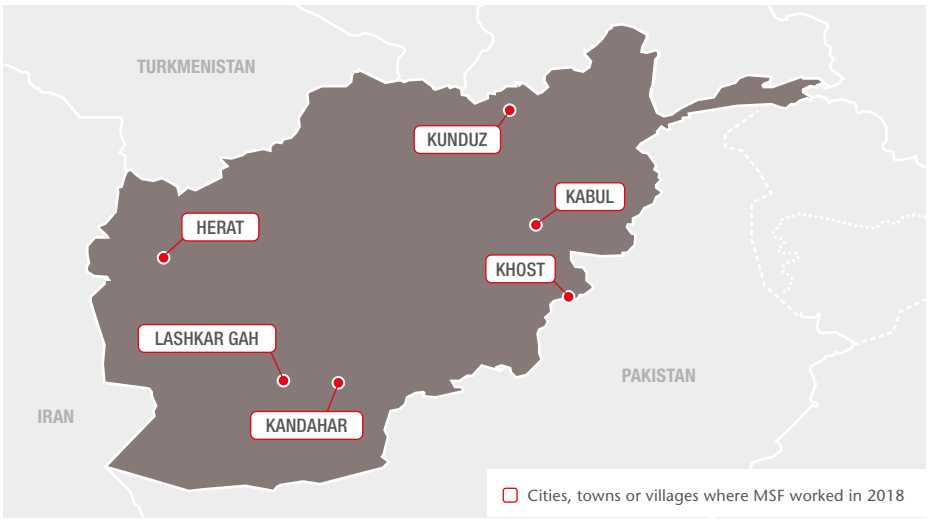
No. staff in 2018: 2,514 | Expenditure in 2018: €32 million | Year MSF first worked in the country: 1980 | msf.org/afghanistan

KEY MEDICAL FIGURES:

411,700 outpatient consultations

74,600 births assisted

6,890 major surgical interventions



As the conflict in Afghanistan intensified in 2018, Médecins Sans Frontières (MSF) reinforced activities in several programmes across the country, in particular emergency, paediatric and maternal healthcare.

We saw a steady increase in the number of people seeking medical assistance in our facilities in 2018, as the population contended with insecurity, a dysfunctional healthcare system, and internal displacement resulting from violence or natural disasters such as drought. While the conflict severely impedes people's access to healthcare in Afghanistan, so too do economic issues. Over 50 per cent of Afghans currently live below the poverty line and around 10 million have limited or no access to essential healthcare services.[1]

Activities in Kabul

The capital has experienced massive population growth over the last decade, as people continue to arrive from other parts of the country, fleeing insecurity or looking for economic opportunities. Returnees from Pakistan and Iran have also contributed to the population increase.

We have supported the Ministry of Public Health in Ahmad Shah Baba district hospital in eastern Kabul since 2009, running outpatient and inpatient services, with a focus on maternal health and emergency care. We started to hand over activities in 2018, transferring outpatient services to the ministry at the end of December. Between 2009 and 2018, our teams conducted over one million outpatient consultations and over 460,000 emergency room consultations. In 2018, we also supported neonatal, paediatric, ante- and postnatal care, surgery, treatment for malnutrition, family planning, health promotion and vaccinations. The remaining maternity activities will be handed over at the end of March 2019.

At Dasht-e-Barchi hospital, we continued to support the Ministry of Public Health to provide 24-hour maternal care. The hospital is the only facility for emergency and complicated deliveries in a neighbourhood with a population of over one million. We run the labour and delivery rooms, an operating theatre, a recovery room, a 30-bed maternity unit and a 20-bed neonatal unit. In 2018, our teams assisted over 15,000 births, and more than 1,300 newborns in serious condition were hospitalised in the neonatal unit. We support maternity care in another

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An illustration from *Hila: Born in Afghanistan*, a comic that tells the stories of patients and staff at MSF's Khost maternity hospital, where taking photographs and videos is extremely restricted for cultural reasons.

An antenatal consultation at MSF's clinic in Herat, Afghanistan, in December 2018. Jamala, who is expecting her sixth child, left her home village in Badghis province in August because of drought.

hospital in the area with staff, training and essential drugs.

Khost maternity hospital

We have been running a dedicated maternity hospital in Khost, eastern Afghanistan, since 2012, providing a safe environment for women to deliver around the clock. The number of deliveries continues to grow, with the team assisting almost 23,500 births in 2018. It is estimated that MSF assists close to half of the total deliveries in Khost province.

We also support five health centres in outlying districts, increasing their capacity to manage normal deliveries so the MSF hospital can focus on patients with complications. This includes strengthening the referral system to the MSF hospital, providing medical supplies, staff training and financial assistance to recruit more midwives, and constructing new maternity buildings for two of the facilities. We also provide staff and financial and logistical resources to support the maternity department at Khost provincial hospital.

Boost hospital, Lashkar Gah

We have supported Boost provincial hospital, one of only three referral facilities in southern Afghanistan, since 2009. The hospital is located in the capital of southern Helmand province, one of the areas most affected by active conflict, where there is a scarcity of fully functional medical facilities. Checkpoints and insecurity on the roads also make it hard for people to seek care, so patients often arrive at the hospital in a critical state. In 2018, we continued to see significant increases in patient numbers, stretching the hospital to capacity. Our teams assisted over 14,000 births, performed more than 133,500 emergency room consultations and treated almost 5,000 children for malnutrition.

Emergency support in Herat

In April, we started working in the emergency department of Herat regional hospital, one of the largest health facilities in western Afghanistan, and gave staff training on improving patient flow in the hospital, triage and managing mass casualty situations. It is estimated that around 150,000 internally displaced people arrived in the city during the year, from conflict- and drought-affected areas of Herat, Badghis and Ghor provinces. In December, we set up a winter clinic for internally displaced people on the outskirts of the city, with a focus on care for women and children under five.

Drug-resistant tuberculosis (DR-TB) in Kandahar

We have been supporting the health ministry in the diagnosis and treatment of DR-TB patients in Kandahar province since 2016. In that time, 102 DR-TB patients have been enrolled in the programme, and over half have been started on an innovative regimen that reduces treatment time down from at least 20 months. In September, the foundation stone was laid for a new 24-bed TB centre, due to open in the second half of 2019. We also supported the Ministry of Public Health in providing care for drug-sensitive TB patients in Mirwais regional hospital and at the provincial TB centre. Nearly 1,100 cases of drug-sensitive TB cases were diagnosed in 2018 alone.

Trauma care in Kunduz

In July 2017, we opened an outpatient clinic to treat stable patients with wounds from minor burns or trauma, previous surgery, or diseases such as diabetes that cause chronic skin lesions. Our teams treated almost 2,400 patients and conducted more than 14,000 follow-up appointments in 2018. We also continued to run a small stabilisation clinic in Chardara district, west of Kunduz city, and started the construction of a new MSF trauma facility in the city.

After the US airstrike that destroyed the trauma centre in 2015, killing 24 patients, 14 staff and four patient caretakers, we engaged in discussions with all parties to the conflict to formalise commitments that MSF's staff, patients and hospitals will not be attacked. We have explicit commitments that MSF can treat every person who needs medical care, no matter their ethnicity, political affiliations or which side of the conflict they are on.

[1] *United Nations Office for the Coordination of Humanitarian Affairs, and Central Statistics Organization's Afghanistan Living Conditions Survey 2016-17*

BALKANS

No. staff in 2018: 61 | Expenditure in 2018: €2.4 million | Year MSF first worked in the Balkans: 1991 | msf.org/serbia | msf.org/bosnia-herzegovina

☐ Cities, towns or villages where MSF worked in 2018

The maps and place names used do not reflect any position by MSF on their legal status.

Thousands of migrants and refugees attempted to cross the Balkans in 2018 en route to other destinations in Europe.

In the Serbian capital, Belgrade, Médecins Sans Frontières continued to run a clinic providing mental healthcare to migrants. Our teams, which included a psychologist, also conducted outreach activities in several informal settlements around the border towns of Šid and Subotica, for those who remained outside the Serbian reception centres.

In the first months of the year, we saw an increase in the number of people reaching Bosnia-Herzegovina with the hope of entering Croatia and continuing further west. Thousands tried to cross the Croatian border during the summer, and at times there were up to 5,000 people living in informal settlements and abandoned buildings around the border towns of Velika Kladuša and Bihać.

We offered medical assistance in collaboration with Bosnian medical authorities and supported civil society groups to improve living conditions with additional services such as showers, clothing and laundry facilities.

During our seven months of activities in Bosnia-Herzegovina in 2018, we conducted almost 5,000 medical consultations. Most of the health problems we treated – such as respiratory tract infections, skin diseases and musculoskeletal pain – were related to unsanitary living conditions.

Many of our patients reported having been subjected to violence or pushed back with unnecessary force by border guards. We continued to denounce the use of violence against migrants and to support civil society and volunteer organisations monitoring and reporting such incidents.

KEY MEDICAL FIGURES:

21,700 outpatient consultations

1,200 individual mental health consultations

People shelter in woods around Bihać, Bosnia-Herzegovina, July 2018.

BANGLADESH

No. staff in 2018: 2,380 | Expenditure in 2018: €39.9 million
Year MSF first worked in the country: 1985 | msf.org/bangladesh

Médecins Sans Frontières (MSF) continues to respond to the medical and humanitarian needs of Rohingya refugees and vulnerable Bangladeshi communities, and to address gaps in healthcare in Dhaka's Kamrangirchar slum.

We rapidly scaled up our operations in Cox's Bazar in response to the massive influx of Rohingya in the second half of 2017 and the first three months of 2018, following a renewed wave of targeted violence by the Myanmar military that started in August 2017. At the end of 2018, we remained one of the main providers of humanitarian assistance to stateless Rohingya, approximately one million of whom have sought refuge in Bangladesh.

Most live in precarious shelters in overcrowded settlements prone to mudslides and flooding, where the quality of hygiene and sanitation services is dire, and there is a shortage of clean drinking water. The main diseases we treat, such as upper and lower respiratory tract infections and skin diseases, are directly related to the poor living conditions.

By the end of 2018, we had teams working in four hospitals, five primary health centres, five health posts and one outbreak response centre, which together provide a range of inpatient and outpatient services, including emergency and intensive care, paediatrics, obstetrics, sexual and reproductive healthcare, treatment for victims of sexual violence and for patients with non-communicable diseases, such as diabetes and hypertension, and laboratory tests.

Mental health and psychiatric services were also available at most MSF facilities by the end of the year. Health promotion and outreach teams visited the refugee settlements, including the Kutupalong-Balukhali mega camp, which in 2018 became the largest refugee camp in the world, to monitor health indicators, respond to disease outbreaks, deliver health and hygiene education, and raise awareness about sexual violence.

We responded to outbreaks of diphtheria, measles and chicken pox in 2018, which reflected the Rohingya's lack of access to routine vaccinations and basic healthcare in Myanmar. Working with the Bangladeshi Ministry of Health, we carried out mass cholera, diphtheria and measles vaccinations, as well as routine vaccinations at most health facilities. By the end of the year, the outbreaks had been contained, although there were still some cases of diphtheria. We also treated several hundred cases of chicken pox, a disease that can cause complications for pregnant women and people with weakened immune systems.

In addition, we mounted a massive water and sanitation intervention in the camps, setting up two water distribution systems benefiting hundreds of thousands of people. We drilled boreholes and tube wells, rehabilitated old latrines and constructed new sustainable ones, built showers and distributed domestic water filters.

In the second half of the year, we turned to addressing gaps in secondary healthcare and boosting the capacity of hospitals in Cox's Bazar. We began working with the Sadar Hospital Authorities and the Directorate General of Health Services to improve infection control, hygiene protocols and waste management in Sadar district hospital to reduce hospital-acquired infections. We supported the development of a waste zone that will be the first of its kind in a public hospital in Bangladesh, ensuring medical waste is properly separated and disposed of.

Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

360 million litres of water distributed

954,300 outpatient consultations

26,600 individual mental health consultations

2,540 births assisted

Kamrangirchar slum

Our teams in Kamrangirchar, a slum area in Dhaka, continued to run reproductive healthcare services for girls and women in 2018, carrying out almost 12,000 antenatal consultations and assisting 760 deliveries. We offered medical and psychological support to 885 victims of sexual violence and intimate partner violence, conducted 9,300 family planning consultations, and carried out 2,000 individual mental health consultations with people of all ages. As part of our occupational health programme, we provided over 9,500 medical consultations and tetanus vaccinations to 550 people working in dangerous conditions in Kamrangirchar's numerous small-scale factories.

© Elena Di Natale

MSF midwife Laura checks on a pregnant woman in Jamtoli camp, Bangladesh, November 2018.

BELARUS

No. staff in 2018: 31 | Expenditure in 2018: €1.9 million | Year MSF first worked in the country: 2015 | msf.org/belarus

Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURE:

41 people started on treatment for MDR-TB

Médecins Sans Frontières supports the Belarusian Ministry of Health to treat patients with multidrug-resistant tuberculosis (MDR-TB).

Belarus is listed as a high-burden country for MDR-TB in the World Health Organization's 2018 Global Tuberculosis Report.

In 2018, we supported the Ministry of Health in three TB facilities: in Minsk; in City TB hospital in Volkovichi, Minsk region; and in Orsha, where we had a team providing drug-resistant TB (DR-TB) treatment for 22 inmates of a penal colony. Six of these patients were co-infected with hepatitis C and were given new drugs that have a 95 per cent cure rate.

The focus of our programme in Minsk is on supporting adherence to treatment for patients with alcohol-use problems and marginalised groups. Using a patient-centred approach, our multidisciplinary team provided psychosocial assistance to support adherence to the entire course of treatment, conducting 2,225 consultations in 2018.

By the end of the year, 59 patients with DR-TB were on treatment with new regimens containing bedaquiline and/or delamanid as part of an endTB observational study.[1] With 41 new patients enrolled in 2018, the project reached the national target of 122 patients recruited since August 2015.

In 2018, we also started recruiting Belarusian patients for the TB PRACTECAL trial, which explores short, innovative MDR-TB treatment regimens; 20 people had been recruited by the end of the year.

[1] *Conducted in partnership with Partners In Health and Interactive Research and Development in more than 17 countries, the endTB partnership aims to find shorter, less toxic and more effective treatments for MDR-TB.*

BELGIUM

No. staff in 2018: 23 | Expenditure in 2018: €1 million | Year MSF first worked in the country: 1987 | msf.org/belgium

Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

2,900 individual mental health consultations

150 group mental health sessions

Médecins Sans Frontières continued to provide psychological care and psychosocial support to migrants and refugees living in or transiting through Belgium in 2018.

Many migrants and refugees arriving in Europe have suffered traumatic experiences in their countries of origin and during their journeys, which have taken a toll on their mental health. Inadequate asylum, reception and integration policies in destination countries exacerbate these psychological vulnerabilities and often cause further trauma and deterioration of their mental health.

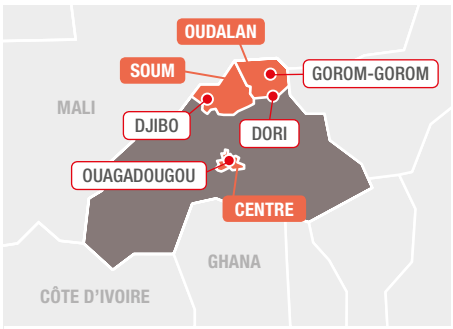
In 2018, we provided psychosocial support in collective and individual housing projects for asylum seekers in the Belgian municipalities of Charleroi, Morlanwelz and Roeselare. Activities included mental health screening, in-depth assessments, psychoeducation, follow-up sessions, and recreational activities to promote general well-being.

Our teams also assisted migrants living outside the formal reception system, many of whom were transiting through Belgium trying to reach other destinations. These people have an uncertain legal status and often end up living in dire conditions, increasing the risk of new mental health issues on top of existing trauma.

In September 2017, we teamed up with six other organisations to offer a complete package of services in a 'humanitarian hub' in Brussels. These services include medical and mental healthcare, family tracing, socio-legal advice and the distribution of clothes. Our team actively participates in the management of the project and provides mental healthcare. We conducted more than 1,800 individual consultations in the hub with 448 patients in 2018. The majority of these people were men from Sudan, Ethiopia and Eritrea.

BURKINA FASO

No. staff in 2018: 104 | Expenditure in 2018: €4.3 million | Year MSF first worked in the country: 1995 | msf.org/burkina-faso



Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

Médecins Sans Frontières opened new projects in Burkina Faso's northernmost provinces in 2018, but our efforts to meet the needs of communities near the border with Mali were hampered by violence.

Civilians were caught up in clashes between armed groups and the security forces, particularly in the Sahel region bordering Mali, where thousands were forced to flee their homes. In the capital, Ouagadougou, coordinated attacks were launched on the French embassy and Burkina Faso's military headquarters, leaving 30 people dead.

We opened projects in the northern provinces of Soum and Oudalan midway through the year, to increase the provision of emergency healthcare services and assist local and displaced communities in deserted health districts.

We supported three hospitals in Dori, Gorom-Gorom and Djibo, reinforcing their emergency room capacity by training staff, rehabilitating buildings and operating theatres, and donating medical equipment and medicines. We fully equipped Gorom-Gorom hospital's emergency room, and sent a team of surgeons and anaesthetists to increase the capacity of Djibo hospital's surgical unit.

In addition, we started supporting several rural health centres in Soum and Oudalan, providing free medical care for children with malaria and diarrhoea. However, these activities were repeatedly interrupted due to growing insecurity.

Further south, we continued to support the Ministry of Health in its response to the dengue epidemic that had been declared in Centre region in September 2017. We established a network of facilities to assist with surveillance and diagnose suspected cases, as well as training healthcare staff and helping to set up a contingency plan in the event of a new outbreak.

KEY MEDICAL FIGURES:

8,140 outpatient consultations

2,150 people treated for malaria

380 major surgical interventions

BURUNDI

No. staff in 2018: 385 | Expenditure in 2018: €6.6 million | Year MSF first worked in the country: 1992 | msf.org/burundi

Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

In 2018, Médecins Sans Frontières (MSF) continued to treat victims of trauma in the Burundian capital and to assist in preventing and responding to disease outbreaks across the country.

In Bujumbura, we provided care for victims of trauma and burns in the 68-bed l'Arche Kigobe hospital. Our medical teams carried out 22,400 consultations in the emergency room and over 4,000 surgical interventions during the year. Over six per cent of the patients admitted were victims of violence. In the outpatient department, our teams performed almost 9,500 medical consultations, 20,000 wound dressings and 14,300 physiotherapy sessions.

After responding to a significant increase in malaria cases in Ryansoro district (Gitega province) in 2017, we followed up in 2018 with indoor residual spraying, a technique that consists of spraying individual houses with insecticide to kill off mosquitoes. In two waves over a six-month period, 322 Burundian Ministry of Health staff and locally recruited volunteers supported by MSF sprayed more than 35,000 houses in rural areas, offering protection to a total of 160,000 people. We also provided malaria treatment at 14 health centres and Ntita district hospital, and supported the local blood bank in Gitega.

We maintain the ability to respond to emergencies in Burundi, and were therefore able to support the Ministry of Health during a cholera outbreak that hit the town of Rumonge at the end of the year. The outbreak was announced on 28 December and we had a team on site that same day. We provided medical and logistical supplies, an ambulance and training to the ministry, as well as clean water for the community.

KEY MEDICAL FIGURES:

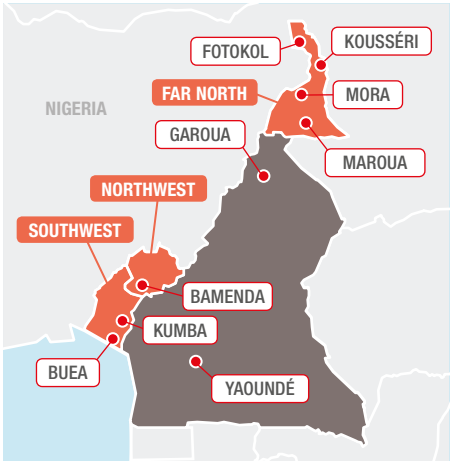
55,200 people treated for malaria

4,160 major surgical interventions

3,870 people admitted to hospital

CAMEROON

No. staff in 2018: 709 | Expenditure in 2018: €12.7 million | Year MSF first worked in the country: 1984 | msf.org/cameroon



Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

83,200 outpatient consultations

3,800 major surgical interventions

3,530 children admitted to inpatient feeding programmes

© Sylvain Cherkaoui/COSMOS

Falta Mohammad from Nigeria, with her two children at Mora hospital, Cameroon, January 2018. She travelled from a camp for internally displaced people in Banki, Nigeria, to get nutritional treatment for her four-year-old daughter.

The number of displaced people in Cameroon surged in 2018, as fighting broke out between the military and armed separatist groups in the west.

While insecurity and violence in the Far North region and in neighbouring Nigeria continued to push thousands of Nigerian refugees and local communities south, sociopolitical tensions in the English-speaking Northwest and Southwest regions escalated into armed conflict that displaced over 435,000 people by the end of the year.[1] Most fled to the bush, where they lacked shelter, food, water and basic health services.

Emergency assistance in Northwest and Southwest regions

In June, Médecins Sans Frontières opened temporary mobile clinics in Kumba town, Southwest region, to provide primary healthcare consultations for the displaced. Our teams conducted 366 outpatient consultations in the first week alone, mainly for malaria, respiratory tract infections and diarrhoea.

We then extended our activities into Buea, also in Southwest region, and Bamenda, Northwest region, remote areas where large numbers of people were caught up in fighting. Supporting seven facilities across the two regions, our teams treated patients with medical emergencies, focusing on pregnant women and children under five; put mass casualty plans in place; and trained staff to deal with large influxes of wounded patients. We set up ambulance referral services, supported community health workers, donated medical supplies and provided psychosocial support.

Displaced people and refugees in Far North region

Our teams in the north continued to offer medical care, including surgery and psychological support, to displaced people, Nigerian refugees and host communities. We also conducted paediatric activities.

Our teams in Maroua hospital performed 3,250 major surgical interventions and 1,500 individual psychological consultations in 2018, while the teams in Mora expanded activities closer to the border with Nigeria. This included supplying water to the displaced people's camp in Kolofata and reactivating primary healthcare services in Amchidé.

Although there was a lull in armed violence along the border for most of 2018, a rise in attacks and clashes towards the end of the year increased the likelihood of fresh waves of displacement.

In Kousséri, on the border with Chad, we were able to hand over activities to the Ministry of Health, thanks to the improved security situation, increased capacity of local healthcare services, and the presence of other NGOs. Between 2015 and October 2018, we provided nutritional and paediatric care at the hospital, and supported three health centres with outpatient consultations.

Cholera outbreak

Cholera broke out in northern Cameroon in 2018, with a total of 995 suspected cases and 58 deaths between the end of June and the end of November. We supported the Ministry of Health's response with donations of medicine and logistical equipment, built a cholera treatment centre in Fotokol, and helped to refurbish existing centres in Yaoundé's Djoungolo district and at Garoua regional hospital. Our teams provided training on hygiene and sanitation measures and community health promotion and helped vaccinate almost 105,000 people in Makary health district to prevent the outbreak from spreading further north.

[1] *Cameroon: North-West and South-West Situation Report No. 2, as of 31 December 2018, OCHA*

CAMBODIA

No. staff in 2018: 143 | Expenditure in 2018: €4.8 million | Year MSF first worked in the country: 1979 | msf.org/cambodia

Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

8,290 people treated for hepatitis C

3,890 people treated for malaria

Médecins Sans Frontières continued to develop more effective diagnosis and treatment strategies for hepatitis C and malaria in Cambodia in 2018.

Once considered a lifelong and deadly disease, hepatitis C can now be cured using direct-acting antivirals (DAAs) – new drugs that are both simpler to take and better tolerated, but also more expensive. Hepatitis C is endemic in Cambodia and access to diagnosis and treatment is virtually non-existent. The goal of our project in Preah Kossamak hospital in Phnom Penh is to simplify the diagnosis and treatment of hepatitis C, to prove its cost-effectiveness, and to make it replicable in other countries.

In 2018, the time between screening and the start of the treatment was reduced from 140 to 9 days thanks to a simplified diagnostic process, and the use of the new DAAs cut the number of appointments each patient needed while on treatment from 16 to 5, including just one with a medical doctor.

In March, we launched a project in the district of Mong Russey to adapt this simplified model of care to a rural context. In addition to screening at nurse-led health centres, active case finding was carried out in villages in the district from October. The team tested more than 12,700 villagers in the last three months of the year.

Since 2015, we have also been developing models of intervention to contribute to the elimination of malaria in Preah Vihear and Stun Treng, two areas of multidrug resistance in northern Cambodia. In 2018, we conducted the first-ever pilot of a new highly sensitive rapid diagnostic test. We also increased the number of districts in which we worked, and the health authorities replicated one of our models of intervention.

CÔTE D'IVOIRE

No. staff in 2018: 216 | Expenditure in 2018: €5.4 million | Year MSF first worked in the country: 1990 | msf.org/cote-divoire

Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

6,440 births assisted, including
620 caesarean sections

Improving mother and child health remained the key focus for Médecins Sans Frontières in Côte d'Ivoire in 2018.

After decades of instability, the Ivorian health system is still recovering from the political and military crisis that engulfed the country from 2002 to 2010. The maternal mortality rate is particularly high, with about 645 deaths for every 100,000 live births.[1] The Ministry of Health has made maternal healthcare a priority, offering it free of charge to all pregnant women, but budget restrictions, drug stockouts and a lack of trained staff continue to hamper access to good-quality services for women and their newborns.

Needs are especially acute in rural areas such as Hambol, where we have been supporting the Ministry of Health since 2014. We have teams working in the maternity, neonatology ward and operating theatre at Katiola referral hospital, where we admitted 793 newborns for care in 2018. We also provide medical supplies, staff, coaching and training to Dabakala hospital, Niakara hospital and six health centres, and support a referral system for obstetric and neonatal emergencies.

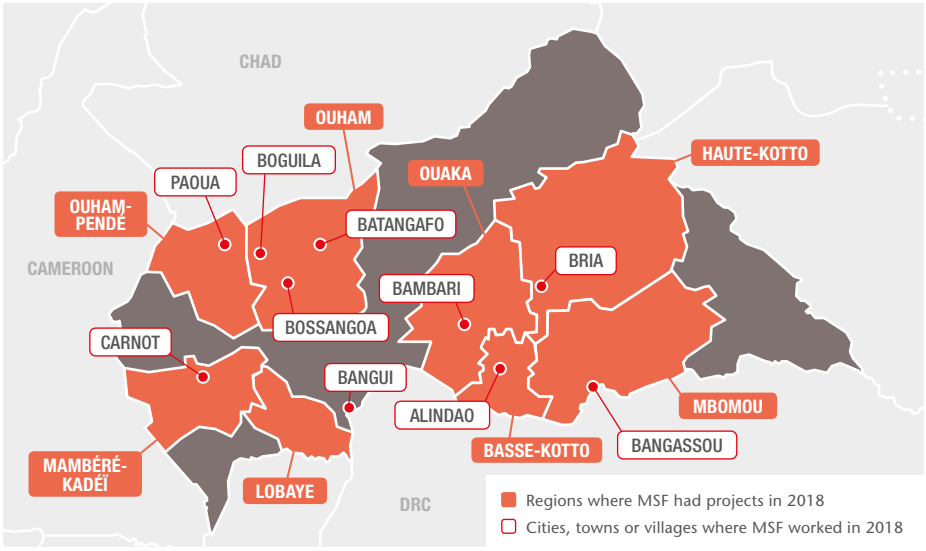
In order to reduce mother-to-child transmission of hepatitis B, we started working with the Ministry of Health to introduce systematic vaccination immediately after birth in all MSF-supported facilities. Over 11,000 newborns were vaccinated against hepatitis B in 2018.

We also respond to emergencies as required. In September, we distributed plastic sheets, cooking tools and blankets to some 100 families who had lost their homes in Attienhaka, 15 kilometres from Katiola, when parts of the village were burned down in an act of revenge following a crime.

[1] *World Health Organization*

CENTRAL AFRICAN REPUBLIC

No. staff in 2018: 2,829 | Expenditure in 2018: €51.2 million | Year MSF first worked in the country: 1997 | msf.org/car



KEY MEDICAL FIGURES:

852,600 outpatient consultations

546,800 people treated for malaria

54,500 people admitted to hospital

17,800 births assisted

9,970 major surgical interventions

5,290 people treated for HIV

4,010 people treated after incidents of sexual violence

Renewed, full-blown conflict across much of the Central African Republic (CAR) produced scenes of extreme violence in 2018, directed at people still suffering the trauma of the civil war that tore the country apart.

Médecins Sans Frontières (MSF) continued to provide lifesaving care amid brutal attacks against civilians, including killings and sexual violence. Whole villages and displacement sites were burned down, exacerbating the already immense humanitarian needs.

By the end of 2018, almost 650,000 people were internally displaced, while the number of refugees from CAR in neighbouring countries had risen to 575,000 (from 540,000 at the beginning of 2018).[1]

Access to medical care, food, water and shelter was severely restricted by the conflict, and our ability to respond was repeatedly hampered by insecurity and attacks on our facilities. Nevertheless, we continued to run projects for local and displaced communities in eight provinces and in the capital, Bangui, providing primary and emergency care, maternal and paediatric services, trauma surgery and treatment for malaria, HIV and tuberculosis (TB).

Responding to the spiralling violence

At the beginning of the year, we expanded our programme in Paoua as violent clashes between two armed groups turned into large and indiscriminate attacks against civilians, causing 90,000 people to flee their homes. Our team in Paoua town, where over 75 per cent of the displaced sought refuge, distributed safe water, offered primary healthcare and ran mass vaccination campaigns and health surveillance activities.

The situation also deteriorated in Bangui. In April and May, our teams worked around the clock to offer first aid to the wounded in Gbaya Dombia maternity facility in PK5 district, referring those requiring surgery to the MSF-run SICA hospital. On 1 April, the hospital received over 70 casualties within just a few hours.

In April, we returned to Bangassou, where we had been forced to suspend activities for five months following several security incidents.

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A surgeon at the MSF hospital in Bangui, Central African Republic, extracts a bullet lodged deep in a patient's shoulder, April 2018.

The remains of Batangafo village, Central African Republic, in November 2018, just over a week after violent clashes between armed groups.

With a smaller team at the regional hospital, we focused on lifesaving care, including support to the critical care unit, emergency room and neonatology ward. In the departments where we no longer had staff, we continued to supply drugs and provide financial and material support, and training. We also had teams working at displacement sites, including one in Ndu, a village over the border in the Democratic Republic of Congo (DRC), where many people took refuge following violence in 2017.

In Bambari, we had to temporarily scale down our operations in April after the violent looting of our facility. Once lauded as an example of successful and lasting disarmament, the town again became a battlefield, and the hospital where we work was stormed by armed groups. Full capacity was restored at the end of June, allowing us to continue our comprehensive medical programmes serving war-wounded patients, sick and malnourished children, and pregnant women requiring emergency surgery.

In November, 10,000 people took shelter in the compound of the MSF-supported Batangafo hospital, as combatants torched three sites hosting displaced communities. The hospital was then threatened and accused of sheltering "enemies", while roadblocks and the presence of combatants around or within its premises hampered access to all those in need.

A few days later, an armed group attacked a displacement site in Alindao, leaving at least 100 people dead and causing over 20,000 to flee into nearby villages. In response, we sent a team to address their most urgent medical needs. In addition to running mobile clinics and conducting vaccinations, we supported Alindao health centre and the emergency room at the hospital, and organised referrals to Bambari for the most severe cases.

Tackling the silent killers: malaria and HIV

By creating additional barriers to healthcare, the conflict is compounding the chronic medical emergency that has been unfolding in CAR for decades. Malaria remains the main killer of children under five, and HIV/AIDS is a leading cause of death among adults. We focus on providing treatment for these diseases, and making it as accessible as possible.

Almost 547,000 patients were treated for malaria in 2018, including more than 163,000 in Bossangoa and Boguila alone.

To mitigate the daily challenges of living with HIV, MSF supports patients in Bossangoa, Boguila, Kabo and Batangafo to form community-based groups so they can take turns to pick up each other's antiretroviral medication at health facilities. In Carnot, where we provided care to 1,775 people living with HIV in 2018, we continue to work on decentralising HIV/AIDS treatment.

Protecting the health of women and children

We assisted almost 9,600 births in Bangui, and offered sexual and reproductive healthcare to reduce sickness and mortality from obstetric complications and the consequences of unsafe terminations of pregnancy, the main cause of death among women arriving at MSF-supported maternity facilities in the city. We are supporting family planning services in a number of ways to address the issue of unwanted pregnancies, for example with the provision of condoms, contraceptive implants and pills, tubal ligation and termination of pregnancy if required.

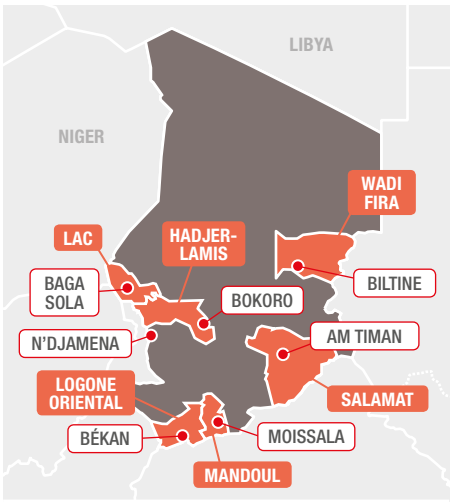
Our teams also support routine vaccinations and conducted several mass campaigns in 2018. In such a volatile context, we took advantage of every opportunity to vaccinate children and carry out other preventive measures such as deworming treatments and the distribution of vitamins and mosquito nets.

In October, we sent a team to Mbaïki, in Lobaye province, in response to an outbreak of monkey pox. We set up a surveillance system and treated a dozen patients. A month later, we tackled an outbreak of hepatitis E in Bocaranga, in Ouham-Pendé province.

[1] *OCHA Humanitarian Bulletin, December 2018*

CHAD

No. staff in 2018: 589 | Expenditure in 2018: €15.2 million | Year MSF first worked in the country: 1981 | msf.org/chad



Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

© Abdoulaye Barry/MSF

MSF nurse Khalil Moussa talks to two-year-old Madjrié and his mother, Mariam, during a mobile malaria consultation in Am Timan, Chad, August 2018.

KEY MEDICAL FIGURES:

142,400 outpatient consultations

82,100 people treated for malaria

9,800 children treated in outpatient feeding programmes

1,860 births assisted

The few facilities in the Chadian capital offering treatment for severe malnutrition were overwhelmed by large numbers of patients in 2018.

Malnutrition is endemic in the Sahel strip, which runs across the middle of Chad, and in 2018 it was exacerbated by a number of factors, including particularly severe seasonal food insecurity, a general lack of purchasing power, and a deepening economic crisis. Access to care was further reduced by a public health workers' strike.

Médecins Sans Frontières (MSF) launched an emergency response in the capital, N'Djamena. In July, in partnership with the Ministry of Health, we opened an inpatient feeding centre, where our teams treated over 1,000 children aged under five for severe acute malnutrition and associated medical complications. We set up an additional six outpatient feeding centres in health centres around the city.

We also treated severely malnourished children in Wadi Fira, a rural region in eastern Chad, where the 'lean season' – when food stocks are depleted and the risk of malnutrition mounts – was particularly harsh in 2018.

Responding to other emergencies

In May, in response to an outbreak of measles around Bokoro, in Hadjer Lamis, we supported the health authorities to set up disease surveillance and provide medical care to children.

We also sent an emergency team to Logone Oriental, where 29,000 people sought refuge from attacks in the Central African Republic. Hospital access was hampered during the rainy season, which brings a seasonal peak in malaria and malnutrition, so our teams focused on running mobile clinics and supporting health centres near the border, in Békan and Bégoné. We provided paediatric care for both refugees and local communities, and set up a stabilisation unit and referral system for children in need of secondary care. The team conducted over 16,500 consultations, admitted 430 children to the stabilisation unit and referred 300 to the hospital in Goré. They also ensured a supply of safe drinking water.

Fighting malaria in Moissala

Since 2010, our work in Moissala, southern Chad, has focused on the prevention and treatment of malaria in young children and pregnant women. In 2018, we treated over 5,600 patients in Moissala hospital, 57 per cent of whom presented with malaria. We also treated 45,000 patients across 23 health centres, while initiating an assessment of the broader health needs among women and children in the area, with a view to expanding activities. Preventive treatment campaigns (seasonal malaria chemoprevention) reached over 120,000 children.

Project handovers in Lac and Salamat regions

The humanitarian emergency caused by the mass displacement of civilians in Lac region in 2015 has subsided, with people starting to return home. This, combined with the presence of other organisations on the ground, enabled us to complete the handover of our activities to the local health authorities in 2018.

We also completed the handover of our activities in Am Timan, Salamat region, where we had been running nutrition programmes, supporting the regional hospital's maternal and paediatric services, and providing treatment for malaria, HIV and tuberculosis since 2010. In these eight years, our teams treated more than 40,000 children for acute malnutrition, admitted 20,500 patients to hospital and assisted 17,500 births.

COLOMBIA

No. staff in 2018: 104 | Expenditure in 2018: €2.7 million | Year MSF first worked in the country: 1985 | msf.org/colombia

Regions where MSF intervened in emergencies in 2018
Cities, towns or villages where MSF worked in 2018

Médecins Sans Frontières (MSF) supported migrants, relatives of victims of forced disappearances, displaced people and victims of violence in Colombia throughout 2018.

In spite of the peace process between the government and the FARC rebel group, there are still frequent outbreaks of violence in some areas of the country. Thousands of civilians are subjected to forced confinement or displacement due to clashes between armed groups and criminal organisations over territory, and many community leaders have been assassinated. In 2018, our emergency team travelled to Chocó, Norte de Santander and Arauca to assist people displaced by the conflict and called for more aid to be delivered to the affected communities.

We also had teams working at crossing points on the border with Venezuela to assist Venezuelan migrants. We provided emergency medical care in locations such as La Gabarra, Hacarí, El Tarra and Puerto Santander. We later set up a team in the Regional Hospital of the North in Tibú, in Norte de Santander, to support Venezuelans living in the area without access to medical services due to their administrative situation in Colombia. Healthcare for children under five and pregnant women were the main focus of the team's activities.

In Cali and Puerto Asís, our teams offered psychological care and support from social workers to people whose family members had been forcibly disappeared during the years of conflict in Colombia. More than 11,600 relatives of victims of forced disappearances participated in group activities run by MSF psychologists in 2018, and 443 benefited from individual and family interventions.

In Buenaventura, we provide psychological support for victims of violence, comprehensive care for victims of sexual violence, and termination of pregnancy for women who request it. MSF was one of the organisations that spoke out against a legislative initiative that sought (unsuccessfully) to restrict access to voluntary termination of pregnancy in Colombia. We warned of the barriers – geographical, economic and cultural – that exist for women seeking safe abortions, even with liberal legislation in place that is protective of women's rights. All of our projects in Colombia offer treatment for victims of sexual violence and termination of pregnancy on request.

In 2018, the teams in Buenaventura also offered emergency medical assistance and relief kits to indigenous and Afro-Colombian people who had been displaced from their communities in rural areas by conflicts between armed or criminal groups. In addition, they ran a telephone helpline and mental health consultations in the neighbourhoods on the outskirts of the city affected by territorial disputes between criminal groups.

We completed our project in Tumaco, where we had been treating victims of violence, including victims of sexual violence, but we will retain a presence in the city as it will become the base for our emergency response team for Nariño and the surrounding area.

KEY MEDICAL FIGURES:

9,160 individual mental health consultations

7,880 outpatient consultations

290 people treated after incidents of sexual violence

An exhibition on enforced disappearances at the University of Santiago in Cali, Colombia, August 2018.

DEMOCRATIC REPUBLIC OF CONGO

No. staff in 2018: 2,848 | Expenditure in 2018: €109.9 million | Year MSF first worked in the country: 1977 | msf.org/drc

The Democratic Republic of Congo (DRC) has endured decades of multiple overlapping crises and severe limitations in medical capacity. 2018 was marked by further upsurges of extreme violence and frequent, far-reaching disease outbreaks.

Médecins Sans Frontières (MSF) ran 54 medical projects in 17 of the country's 26 provinces in 2018. With services ranging from basic healthcare to nutrition, paediatrics, treatment for victims of sexual violence and care for people living with HIV/AIDS, we provide comprehensive medical assistance where it is needed most. We responded to nine measles outbreaks and two successive outbreaks of Ebola in 2018, including the country's largest ever, which was still ongoing at the end of the year.

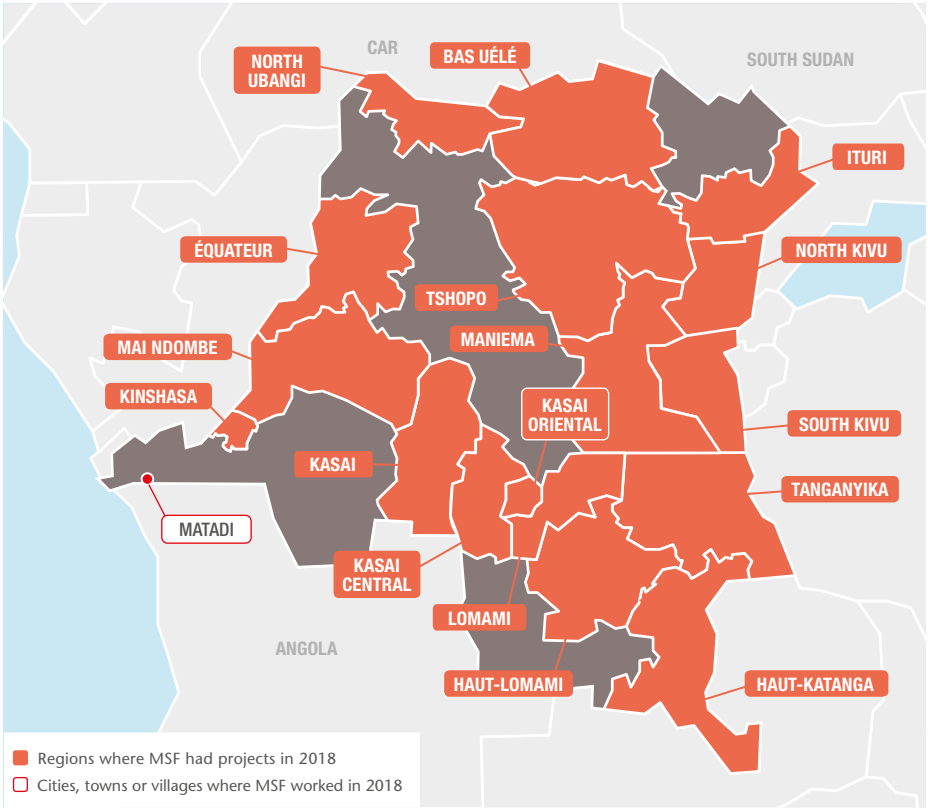
Assisting displaced and host communities

Since 2016, approximately 1.4 million people have been displaced by violence in Greater Kasai region. In 2018, our teams in the region supported referral hospitals in Kakenge, Kananga, Tshikapa and Tshikula, as well as 35 health centres in the surrounding areas, with nutritional, paediatric and maternal healthcare, surgery for violent trauma, treatment for victims of sexual violence, and referrals. In Kamonia health zone, southern Kasai province, we also provided medical assistance to Congolese people forced out of neighbouring Angola.

We conducted more than 80,000 medical consultations in Bunia city and in Djugu territory, Ituri province, where intercommunal clashes and fighting between armed groups caused further largescale displacement. We also built latrines and showers, responded to outbreaks of measles and cholera, and treated victims of sexual violence.

We continued to assist people displaced by violence in 2017 in Kalémie, Tanganyika

An MSF nurse checks on cholera patients in an MSF-supported cholera centre in Tchomia, Democratic Republic of Congo, March 2018.



KEY MEDICAL FIGURES:

1,826,300 outpatient consultations

776,600 people treated for malaria

102,600 people admitted to hospital

38,200 individual mental health consultations

34,300 births assisted

24,500 children treated in outpatient feeding programmes

9,100 people treated for HIV

7,760 major surgical interventions

6,950 people treated after incidents of sexual violence

6,910 people treated for cholera

province, providing relief items and water together with community-based healthcare and psychological support. We also set up new primary and secondary healthcare services for victims of violence and displacement in Salamabila, Maniema province, and Kalongwe, in South Kivu.

At the end of the year, we sent an emergency team to assist many thousands of people fleeing extreme violence in the region around Yumbi, in Mai-Ndombe province in the west of the country.

To assist refugees from the Central African Republic who had crossed into northern DRC, we supported hospitals and health centres in Gbadolite and Mobayi-Mbongo, North Ubangi province, and ran mobile clinics that also served the local community. In Bili, in the same province, we supported emergency, paediatric and neonatal services in the referral hospital and in 50 health centres and health posts with an integrated community approach.

Over to the east, along the border with South Sudan, we treated more than 48,000 refugees in the informal sites of Karagba and Ulendere.

Comprehensive care in the Kivu provinces

In the Kivu provinces, in eastern DRC, which have been plagued by conflict for over 25 years, we maintain a number of long-term projects that ensure continuity of care while also launching emergency responses to violence-related trauma and displacement.

In North Kivu, our teams run comprehensive medical programmes in Lubero, Masisi, Mweso, Rutshuru and Walikale, supporting the main reference hospitals and peripheral health centres to deliver both basic and secondary care. Services include emergency and intensive care, surgery, nutrition and maternal and paediatric healthcare, community-based healthcare, and outreach activities such as mass vaccination in hard-to-reach areas.

In South Kivu, we offer treatment for malaria, HIV, tuberculosis, malnutrition, acute respiratory infections and diarrhoeal diseases to refugees, displaced people and local communities. We had teams working in more than a dozen facilities across the

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An MSF motorbike driver in the Democratic Republic of Congo's South Kivu province negotiates a muddy road to get provisions to the hospital in Numbi, April 2018.

continued overleaf ›

province, including a new health centre in Kusisa. Constructed in 2018, it offers maternity, paediatric and emergency wards and an operating theatre.

Treating victims of sexual violence

In Kananga, in Kasai Central province, we treated between 200 and 250 victims of sexual violence each month in 2018, mostly women but also men and young children.

We also set up psychological and medical services for victims of sexual violence in a hospital and four health centres in Salamabila, in Maniema province, and increased services in another six health centres around Mambasa, in Ituri province, piloting mobile apps to help improve the provision of treatment for 5,500 patients suffering from sexually transmitted infections and victims of sexual violence.

We also run a clinic for victims of sexual violence in Walikale, North Kivu, where we provide medical and mental healthcare and family planning services.

Responding to epidemics

Responding to epidemics is a core activity for MSF in DRC, and in 2018 our emergency teams conducted surveillance and initial diagnosis from 10 sites across the country, resulting in multiple emergency interventions.

We responded to nine measles outbreaks affecting Haut-Uélé, Ituri, former Katanga, Kasai, Maniema, and Tshopo provinces throughout the year, providing care and supporting the Ministry of Health to contain the spread.

We also supported the ministry's response to large cholera outbreaks affecting many areas, including cities such as Kinshasa, Lubumbashi, Ngandajika and Mbuji-Mayi.

In Maniema, we continue to support the Ministry of Health with the management, active case finding and treatment of sleeping sickness (human African trypanosomiasis).

HIV/AIDS remains another deadly threat in the country, with alarming numbers of people presenting in such an advanced stage of the disease that they need immediate hospital care or are too late for treatment.

We run a major HIV/AIDS programme at the Centre Hospitalier de Kabinda in Kinshasa, where we provided care for more than 2,000 people in 2018, including patients with advanced HIV. Our teams support the HIV/AIDS activities of two other hospitals in Kinshasa, and run HIV-mentoring programmes in three of the city's health centres. We also provide technical and financial support to five health facilities in Goma, including Virunga general hospital, to improve the provision of HIV care and increase access to antiretroviral treatment.

Our missing colleagues

On 11 July 2013, four MSF staff were abducted in Kamango, in the east of DRC, where they were carrying out a health assessment. One of them, Chantal, managed to escape in August 2014, but we are still without news of Philippe, Richard and Romy. We remain committed to obtaining their release.

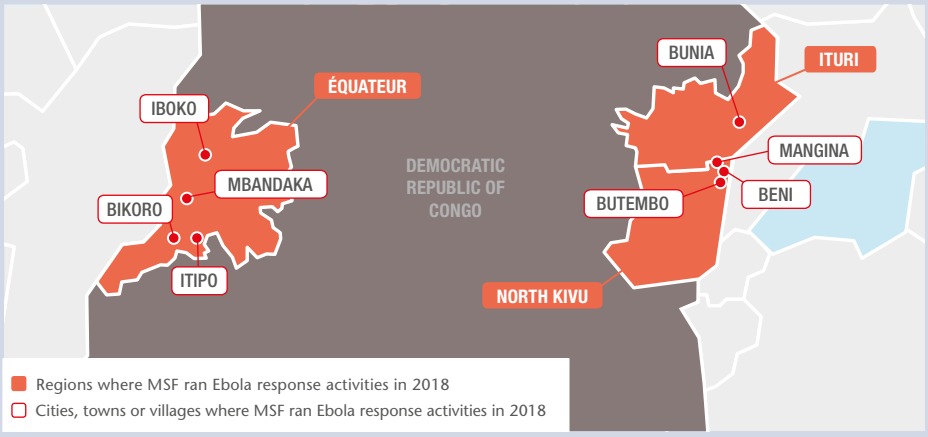
A health promoter uses songs to educate young mothers and pregnant women in a primary health centre in Tshonka, in the Democratic Republic of Congo's South Kivu province, April 2018.

An 11-year-old girl recovers in a hospital room in Bunia, Democratic Republic of Congo, March 2018. She was injured, and her mother and three siblings killed, in an attack on her village in Ituri province.

EBOLA OUTBREAKS

KEY MEDICAL FIGURES:

2,800 people admitted to Ebola treatment centres, of whom **450** were confirmed as having Ebola



As 2018 drew to a close, DRC was in the midst of its second Ebola outbreak of the year and the country's biggest ever.

The epidemic has proven extremely hard to control, despite a massive mobilisation of resources. Serious doubts have been cast over the approach taken and its failure to meet people's expectations and needs. The infection rate has been steadily picking up and the responders have struggled to earn the population's trust, prompting a re-thinking of the response strategy as we entered 2019.

The first Ebola outbreak was declared on 8 May in Équateur province, in northwestern DRC. MSF supported the Congolese Ministry of Health in Bikoro, Itipo, Mbandaka and Iboko, providing care to 38 confirmed patients, 24 of whom survived and returned to their homes. Sadly, 14 died. More than 120 other patients showing symptoms consistent with Ebola were isolated and tested but found not to have the virus.

Teams from MSF, the World Health Organization (WHO) and the Congolese Ministry of Health vaccinated a total of 3,199 people using an investigational vaccine approved by the WHO under the framework for expanded access/compassionate use. Around Bikoro and Itipo, our teams alone vaccinated 1,673 people considered to be most at risk of contracting the virus, including first- and second-line contacts of confirmed Ebola patients and frontline workers (health workers, burial workers, traditional healers and motorbike taxi drivers).

On 24 July, the Ministry of Health declared the end of the outbreak. The following week, on 1 August, a second one was declared, this time in the northeastern province of North Kivu.[1]

We participated in the response immediately, investigating the first alert and setting up an Ebola treatment centre in Mangina, the small town where the outbreak was declared. We then opened a second treatment centre in Butembo, a city of one million people which became a hotspot later in the year. We progressively increased the level of care provided, and from the early stages of the outbreak were able to offer the first-ever potential therapeutic treatments, under an emergency WHO protocol.

As in Équateur, we contributed to the intervention by vaccinating frontline workers, while the WHO and Ministry of Health vaccinated first- and second-line contacts. We also helped local health centres to prevent and control infections, by setting up triage zones and decontaminating facilities where a positive case had been reported. An MSF rapid response team was sent to investigate alerts.

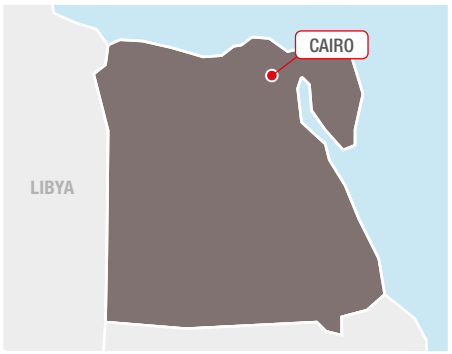
By the end of the year, over 600 confirmed and suspected cases had been reported and more than 360 people had died. The outbreak was not yet under control and the struggle continued in the face of numerous challenges. With new cases appearing in scattered clusters, the epicentre has moved multiple times. The high mobility of people in the region, and the fact that some new cases are not linked to any previously known chains of transmission make it even harder to trace contacts and control the evolution of the outbreak. As does the fact that this is all happening in a conflict zone: insecurity prevents full access to certain areas and episodes of violence have interrupted activities, potentially causing precious ground to be lost.

Flora, an Ebola health worker, prepares to enter the high-risk zone of the Ebola treatment centre in Butembo, Democratic Republic of Congo, November 2018.

[1] *Laboratory tests found that both outbreaks were caused by the Zaire species of the virus, but by two different strains of it – meaning the outbreaks were unrelated.*

EGYPT

No. staff in 2018: 142 | Expenditure in 2018: €2.5 million | Year MSF first worked in the country: 2010 | msf.org/egypt



Cities, towns or villages where MSF worked in 2018

In 2018, Médecins Sans Frontières continued to provide integrated healthcare tailored to the needs of migrants and refugees in the Egyptian capital.

Egypt is a key transit and destination country for migrants and refugees coming from countries such as Syria, Eritrea, Sudan and Yemen. According to the United Nations refugee agency, UNHCR, there were 244,910 refugees and asylum seekers in Egypt at the end of 2018, mostly living in Cairo, Alexandria and other cities.[1] Many of these men, women and children arrived in Egypt after fleeing war and have experienced violence in their countries of origin or on their journey.

Since 2012, we have been running a project offering integrated healthcare to migrants and refugees living in Cairo. Our clinic provides patients with treatment adapted to their specific needs, including medical and mental healthcare, sexual and reproductive healthcare, physiotherapy and social support.

In 2018, we registered over 2,000 new patients and conducted some 22,000 consultations, including 11,800 individual mental health consultations and 20 group sessions, almost 2,200 medical consultations, 3,800 physiotherapy sessions, and 4,200 social support sessions led by social workers.

KEY MEDICAL FIGURES:

11,800 individual mental health consultations

2,190 outpatient consultations

[1] *UNHCR Operational Update, Egypt, October-December 2018*

EL SALVADOR

No. staff in 2018: 58 | Expenditure in 2018: €1.7 million | Year MSF first worked in the country: 1983 | msf.org/el-salvador

Cities, towns or villages where MSF worked in 2018

Médecins Sans Frontières returned to El Salvador in 2018 to improve access to medical and psychological healthcare in communities affected by violence.

Since 2015, El Salvador has been ranked among the countries with the highest homicide rates in the world,[1] and an average of 13 women a day are victims of sexual violence.[2] Fights between rival gangs and their clashes with security forces create invisible borders that limit people's mobility, and the ability of health services to reach them.

We set up mobile clinics in areas where access to healthcare is particularly affected by violence and insecurity. As well as primary healthcare and mental health support, the teams provided sexual and reproductive healthcare services and ran community activities including local support groups and health promotion.

We worked with the Comandos de Salvamento in Soyapango, using medically equipped MSF vehicles to provide urgent care and carry out an average of 100 hospital referrals a month in places that are considered no-go zones by other ambulance services.

We also worked alongside national institutions and other NGOs in shelters for migrants and displaced or returned Salvadorans who had attempted to flee violence, poverty or a combination of the two.

By the end of the year, our activities had reached 11 neighbourhoods in San Salvador and Soyapango, and enabled Ministry of Health medical teams to resume services in other areas.

Over 9,300 people participated in our community activities and almost 600 patients benefited from our sexual and reproductive healthcare services in 2018. We advocate treating sexual violence as a medical emergency and providing comprehensive care to protect victims from further suffering.

KEY MEDICAL FIGURES:

7,030 outpatient consultations

1,550 individual mental health consultations

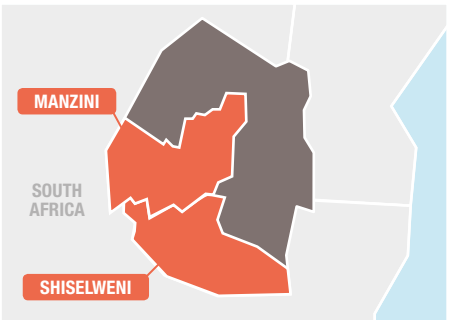
380 group mental health sessions

[1] *World Economic Forum, 2017*

[2] *UNDP, Salvadoran Security Ministry and National Direction of Statistics and USAID, 2018*

ESWATINI

No. staff in 2018: 231 | Expenditure in 2018: €6.1 million | Year MSF first worked in the country: 2007 | msf.org/eswatini



Regions where MSF had projects in 2018

KEY MEDICAL FIGURES:

6,230 people on first-line ARV treatment, and **610** on second- and third-line ARV treatment

580 people started on treatment for TB, including **100** for DR-TB

Despite a decrease in the number of new infections and deaths from HIV and tuberculosis (TB) in Eswatini (formerly Swaziland), controlling the spread remains a challenge.

Almost one-third of adults in Eswatini are HIV positive,[1] which also increases their vulnerability to TB and other infections. In this context, Médecins Sans Frontières continued to assist the Ministry of Health with prevention and care in Shiselweni region in 2018, while handing over some long-term activities to the ministry and partner organisations, such as our project in Manzini region, which began as an emergency intervention in 2010.

Our emphasis in Eswatini is on community-based, patient-centred models of care and what is known as a 'test and start' strategy, which involves initiating antiretroviral (ARV) treatment at the time of diagnosis, irrespective of clinical criteria.

We offer community-based testing for HIV and TB, oral HIV self-testing for hard-to-reach groups such as sex workers and men who have sex with men, and pre-exposure prophylaxis (PrEP) for people at increased risk of HIV infection. A total of 5,296 people accessed HIV self-testing and 468 were initiated on PrEP in 2018.

Our teams provide specialised, integrated care for people living with HIV, including second- and third-line ARV therapy for those whose previous treatment has failed to work, and point-of-care screening and treatment for other diseases, such as cervical cancer, drug-resistant TB and cryptococcal meningitis, which commonly occur in people living with HIV.

In 2018, 1,610 women were screened for cervical cancer, of whom 8 per cent tested positive. Of these, 67 per cent were treated. We provided prophylactic treatment for cryptococcal meningitis to 26 patients.

[1] *Swaziland HIV Incidence Survey 2 (SHIMS-2), 2016/2017; Mbabane, Eswatini*

FRANCE

No. staff in 2018: 4 | Expenditure in 2018: €2.2 million | Year MSF first worked in the country: 1987 | msf.org/france

Regions where MSF had projects in 2018

Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURE:

1,400 individual mental health consultations

Unaccompanied minors who arrive in France are often traumatised by violence and abuse suffered on their journey and end up in inadequate reception facilities, facing a maze of obstructionist bureaucracy.

In 2018, Médecins Sans Frontières (MSF) focused on assisting young, unaccompanied migrants, especially those whose applications for child protection had been turned down as they were not recognised as minors, often for disputable reasons.

We offer respite and care, and facilitate access to legal support and medical, social, psychological and administrative services in partnership with other organisations in an MSF-run centre in Pantin, a suburb of Paris. A total of 787 minors benefited from these services in 2018. More than 430 legal appeals were filed; while most were still pending at the end of the year, 94 were successful and the minors concerned were eventually placed under the care of child protection services.

In partnership with Utopia 56, an association that helps migrants, we developed a network of volunteer families in southern France to host minors throughout the course of their appeal, during which time they are excluded from any protection or assistance from the state.

We also run mobile clinics in Paris, through which almost 1,000 medical consultations were carried out in 2018.

Our teams continued to monitor the situation across the country throughout the year, especially along the borders with Italy and Spain. In 2018, French border police continued to forcibly return people to Italy and Spain, preventing them from applying for asylum, in violation of the law.

We also made donations, including 10,000 blankets, to support other organisations and volunteers in Calais, Bayonne, Nantes and Paris.

ETHIOPIA

No. staff in 2018: 1,760 | Expenditure in 2018: €31.2 million | Year MSF first worked in the country: 1984 | msf.org/ethiopia

KEY MEDICAL FIGURES:

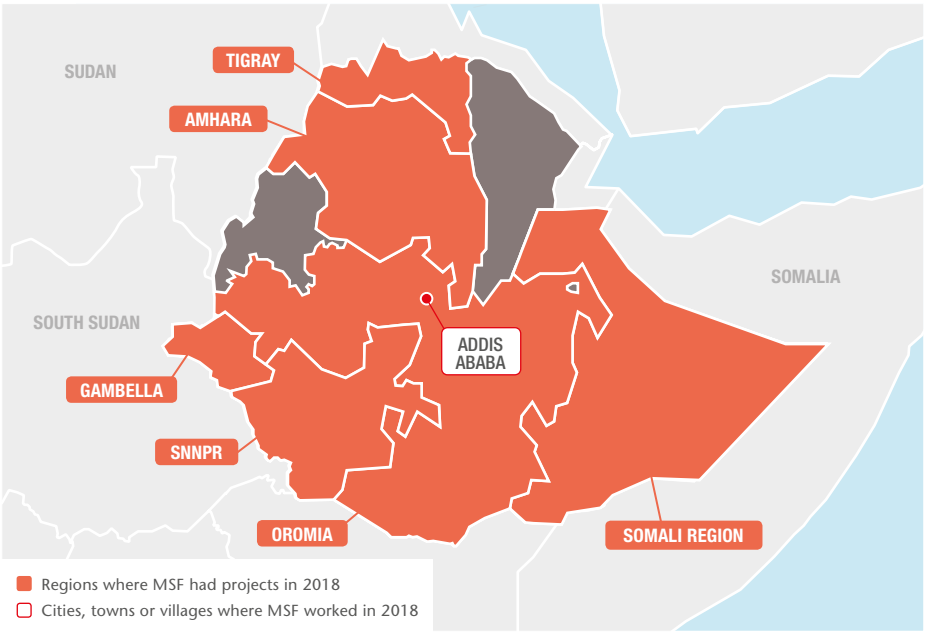
500,800 outpatient consultations

47,100 people treated for malaria

19,100 people admitted to hospital

11,600 individual mental health consultations

3,010 children treated in outpatient feeding programmes



At least 1.4 million people were displaced in Ethiopia in 2018[1] as ethnic violence broke out in several parts of the country simultaneously.

In addition to growing numbers of internally displaced people, Ethiopia hosts the second-highest number of refugees in Africa – more than 900,000 at the end of 2018, mostly from South Sudan, Somalia and Eritrea.

Médecins Sans Frontières (MSF) continues to fill gaps in healthcare and respond to emergencies affecting local communities, internally displaced people and refugees.

Emergency responses

In July, we launched one of our biggest emergency interventions of 2018 worldwide around Gedeo, SNNP region (SNNPR), and Guji, Oromia region, after an escalation in ethnic violence that left hundreds of thousands of displaced people without basic services. When our teams arrived, people were living in cramped conditions, sleeping on the ground in vacant buildings, and suffering from diarrhoea, intestinal parasites and respiratory tract infections. We supported several hospitals, health centres, health posts and mobile clinics until the end of the year, when the crisis eased and we handed activities over to the local authorities.

Between July and December, we conducted nearly 91,000 outpatient consultations, treated around 3,000 children for severe acute malnutrition, and vaccinated 103,800 under-15-year-olds against measles in a preventive vaccination campaign organised in collaboration with the Regional Health Bureau in Gedeo. MSF staff also provided mental health support, treated victims of sexual violence, distributed essential relief items and trucked in 69 million litres of clean water.

In October, we launched another emergency intervention to respond to the needs of people displaced by violence in East Wellega on the border between Benishangul-Gumuz and Oromia regions. Our teams focused on emergency healthcare, water and sanitation, and at the end of the year, expanded these operations to neighbouring West Wellega.

Gambella region

In 2018, we increased our support to Gambella hospital, the only facility in the region offering specialised medical care for a population of 800,000, half of them refugees from South Sudan. Our teams worked in the emergency room, operating theatre and surgical inpatient unit and assisted 2,280 births. We maintained our focus on neonatology and maternity services to reduce the high maternal and child mortality rates.

© Gabriele François Casini/MSF

Three-year-old Samuel is helped to drink by his grandmother at Gedeb hospital, where he is being treated for acute malnutrition. Ethiopia, August 2018.

Medical team leader Dr Ernest Nshimiyimana and clinical officer Leya Haileyesus check on patients in the kala azar ward at Abdurafi health centre in Ethiopia, November 2018.

We also worked with the Ethiopian authorities in Kule, Nguenyyiel and Tierkidi refugee camps, which together provide shelter for around 200,000 South Sudanese refugees,[2] as well as in Pamdong reception centre. Teams worked in a health centre, a 24-hour maternity unit and six health posts, offering most medical services including support to victims of sexual violence, and referrals for surgery to Gambella hospital.

Tigray region

The signing of the Ethiopia–Eritrea peace deal in July and the opening of the border on 11 September led to an influx of Eritreans claiming asylum, mainly women and children. We provide both inpatient and outpatient psychiatric and mental health services to Eritrean refugees in two camps and to the local communities. Many of our Eritrean patients reported traumatising experiences at home, on their journeys to Ethiopia, and in the camps.

Amhara region

Our focus in and around the town of Abdurafi is the treatment, diagnosis and prevention of kala azar (visceral leishmaniasis) and snakebites, two deadly but neglected tropical diseases. In 2018, the teams in our clinic treated 647 patients for snakebites, and 369 for kala azar. We have been carrying out research on kala azar in Abdurafi since 2002, in conjunction with the Institute of Tropical Medicine Antwerp, the University of Gondar and the Ethiopian Public Health Institute, seeking to develop better treatment methods for complicated cases and better prevention methods. The team is also trying to find a more effective snakebite treatment.

Somali region

We have had teams working in Dolo town, Liben zone, on the border with Somalia, since 1995. The health centre in Dolo Ado offers basic healthcare to the local community and people who have fled violence and food insecurity in Somalia and settled in five camps in the zone. We also treat many Somali nationals who cross the border in search of medical care. At the end of the year, we handed over all our activities at the health centre to the health authorities, except for maternity and obstetric care.

We also handed over our medical activities at Wardher hospital and the district health centres in Danod and Lahel-Yucub in Doolo zone to the Regional Health Bureau at the end of the year. Since 2007, we had been supporting outpatient and inpatient services, water and sanitation activities and emergency referrals. We maintained and ran isolation wards during disease outbreaks, assisted deliveries and provided antenatal care, treatment for tuberculosis and for severe acute malnutrition in children under five.

We have also been offering comprehensive primary healthcare through mobile clinics in more than 10 locations in Doolo zone for children under the age of 15 and pregnant and lactating women. Our plan is to expand these mobile activities to provide care for all ages, as well as surveillance of emerging disease outbreaks, community engagement and health promotion, covering a wider area to reach more people, including the nomadic pastoralist communities.

Deported migrants

Since November 2017, the Kingdom of Saudi Arabia has been forcibly expelling migrants living irregularly on its territory. An average of 10,000 Ethiopians are deported each month, with chartered planes arriving weekly in Addis Ababa, according to the International Organization for Migration. We started providing medical and mental health screening and support in the airport and at a centre in the city in March. Despite the trauma most of our patients had experienced, many tried to make the perilous Red Sea crossing back to Saudi Arabia.

[1] *Ethiopia: Humanitarian Response Situation Report No.19 (November 2018)*

[2] *United Nations refugee agency, UNHCR*

GREECE

No. staff in 2018: 223 | Expenditure in 2018: €9.5 million | Year MSF first worked in the country: 1991 | msf.org/greece

Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

A woman brings her child to be vaccinated against the most common childhood diseases during a vaccination campaign on the Greek island of Lesbos, November 2018.

KEY MEDICAL FIGURES:

26,500 outpatient consultations

7,440 individual mental health consultations

4,480 routine vaccinations

320 victims of torture treated

280 people treated after incidents of sexual violence

More than 50,000 migrants and refugees from countries such as Syria, Afghanistan and Iraq arrived in Greece in 2018.[1]

Médecins Sans Frontières (MSF) continued to provide medical and mental healthcare to migrants on the Greek islands and the mainland. Between January and December 2018, our teams conducted around 26,500 outpatient consultations across Greece and vaccinated around 4,500 children against the most common childhood diseases.

Greek islands

Since the so-called EU-Turkey deal in March 2016, migrants and refugees who were in transit through the Greek islands have been trapped, waiting for their status to be determined. Consequently, they spend long periods in inadequate reception centres, with poor access to healthcare and the fear of being sent back to Turkey, which exacerbates their medical and mental health problems. We continued to denounce this deal and its dramatic impact on the health of men, women and children trapped on the islands in 2018.

Since 2016, we have been running a clinic on Lesbos offering primary healthcare, sexual and reproductive health services and mental health support. In late 2017, we set up an additional clinic outside Moria reception centre, providing the same services for children under 16, pregnant women and victims of sexual violence. We also have a team in Mytilene town treating patients with severe mental health conditions caused by trauma and violence in their country of origin or on their journey to Greece. Many of our patients, including minors, reported that the insecure and inhumane conditions in Moria itself played a major part in pushing them towards despair, self-harm or suicidal thoughts.

On Chios, we provide primary healthcare, sexual and reproductive healthcare, mental health support and social care for refugees and migrants. We have cultural mediators and social workers in the hospital on the island, and in April started running travel medicine services to guarantee healthcare continuity for patients in transit, including health advice, vaccinations, medication and referrals to MSF services in Athens.

Until April, we also provided mental healthcare, health promotion and temporary shelter for people in the town of Vathy, on the island of Samos, which hosts mostly women, children and patients requiring urgent medical treatment on the mainland.

Athens

We run two clinics in Athens to respond to the specific needs of migrants and refugees.

At our 'day care centre', teams provide sexual and reproductive healthcare, mental health support, social care and treatment for chronic diseases.

In our second centre, run in collaboration with Day Centre Babel and the Greek Council for Refugees, we offer comprehensive care to victims of torture, ill-treatment and other forms of degrading treatment. The clinic's multidisciplinary approach comprises medical and mental healthcare, physiotherapy, social assistance and legal support.

Northern Greece

In response to the huge increase in arrivals (more than 18,000 in 2018 compared with around 6,500 in 2017), and the absolute lack of healthcare provision by the Ministry of Health, in July we sent a team to work in the reception and identification centre in Fylakio, in Evros region, on the border with Turkey, until the end of the year. We provided general healthcare consultations, sexual and reproductive health and travel medicine consultations.

[1] *UNHCR Operational Portal, Mediterranean Situation*

GEORGIA

No. staff in 2018: 51 | Expenditure in 2018: €1.7 million | Year MSF first worked in the country: 1993 | msf.org/georgia

Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURE:

16 people started on treatment for MDR-TB

Treatment for multidrug-resistant tuberculosis (MDR-TB) remained the focus of Médecins Sans Frontières activities in Georgia in 2018.

Although the incidence of TB is falling in Georgia, drug resistance is found in over 10 per cent of new patients and 30 per cent of those already receiving treatment for the disease.[1]

We implement endTB in Georgia, a UNITAID-funded partnership covering 17 countries, launched in 2015 with the aim of finding shorter, less toxic and more effective treatments for drug-resistant TB. A key part of this initiative is an observational study of the safety and efficacy of bedaquiline and delamanid; we have enrolled 297 MDR-TB patients in the study in Georgia. The last patients will finish their treatment in January 2019 and receive follow-up visits for six months, allowing for completion of the study in July 2019.

Georgia is also participating in an endTB clinical trial that uses bedaquiline and/or delamanid to find radically shorter, more tolerable, injection-free treatments for MDR-TB. Enrolment in the trial ended in February 2018, with 10 patients to be monitored until February 2020.

In addition, we continued to support the local health authorities in Abkhazia, supervising the care of patients being treated for MDR-TB, extensively drug-resistant TB (XDR-TB) and co-infections such as hepatitis C. Ensuring access to quality-assured drugs and ongoing patient monitoring are the most urgent challenges here. We supported the enrolment of 14 patients on newer TB drug regimens and provided hepatitis C treatment to five co-infected patients in 2018, with 76 patients screened for treatment to begin in 2019.

[1] *World Health Organization, Tuberculosis surveillance and monitoring in Europe, 2018*

GUINEA

No. staff in 2018: 302 | Expenditure in 2018: €8.4 million | Year MSF first worked in the country: 1984 | msf.org/guinea

Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

24,100 people treated for malaria

11,500 people on first-line ARV treatment, and **1,030** on second-line ARV treatment

In 2018, Médecins Sans Frontières (MSF) continued to support the Guinean Ministry of Health to provide care for 12,500 patients on lifelong antiretroviral (ARV) treatment for HIV.

In the capital, Conakry, we run testing, treatment and follow-up services for stable HIV patients through eight health centres, and provide specialised care for AIDS patients in a 31-bed unit in Donka hospital.

In 2018, we started a programme whereby stable patients get drug refills and check-ups every six months rather than monthly, helping to reduce the impact of stigma and improve adherence to treatment. We also helped stock the national pharmacy with ARV drugs when interruptions to the supply put patients in our care in jeopardy.

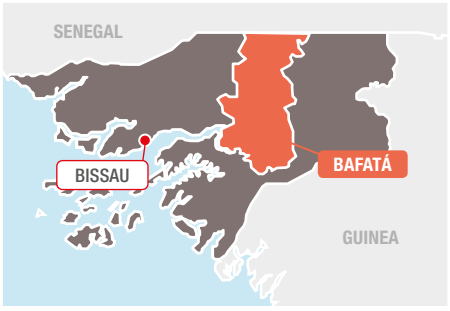
In Kouroussa, in the northeast, we continued the rollout of a child health programme initiated in 2017, providing staff and logistical support to the provincial hospital, which serves a population of 315,000. In 2018, over 3,000 under-fives were admitted, more than half of them with severe malaria.

As part of an ongoing strategy to prevent children from developing complicated diseases and reduce child mortality, in 2018 we focused on the early provision of care at community level. Thanks to 120 specially trained community volunteers, 8,819 children were diagnosed with malaria using rapid tests, and more than 90 per cent were treated directly in the community. The volunteers also measure children's arms for signs of malnutrition and identify those who need to be referred to the closest health centre – nine of which are supported by MSF.

We vaccinated more than 18,000 children in Kouroussa in response to an outbreak of measles in May, and launched a large-scale preventive vaccination campaign in collaboration with the Guinean health authorities in November following another increase in the number of cases. By 23 December, more than 74,000 children between six months and seven years old had been vaccinated.

GUINEA-BISSAU

No. staff in 2018: 289 | Expenditure in 2018: €4.5 million | Year MSF first worked in the country: 1998 | msf.org/guinea-bissau



Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

Guinea-Bissau is one of the poorest and least developed countries in the world. Access to healthcare is severely limited due to a lack of facilities, resources and qualified staff.

Médecins Sans Frontières runs a project in the country's only tertiary facility, Simão Mendes national hospital, in the capital, Bissau, focusing on child health. Our teams manage paediatric emergencies and inpatient therapeutic feeding, as well as paediatric and neonatal intensive care.

Respiratory infections, malaria, diarrhoea and meningitis are the main diseases affecting children in Guinea-Bissau; for newborns, asphyxia and neonatal sepsis are the principal causes of death. We have established a functioning triage system in the paediatric emergency unit to guarantee faster and more efficient treatment and have worked closely with the Ministry of Health to ensure that the correct protocols and treatment procedures are implemented to reduce child mortality. We are now working towards introducing more technical or sophisticated treatments, which require better trained medical staff and more specialised equipment, to treat more complex and critical patients.

In April, we closed our project in the central region of Bafatá, having successfully reinforced the local health services in the area. Since 2014, we had been managing the paediatric services and nutrition programme for children under the age of five at the regional hospital, supporting health centres in rural areas and training community health workers to diagnose and treat malaria, diarrhoea and acute respiratory infections. We had also set up a referral system for patients requiring hospital treatment.

KEY MEDICAL FIGURES:

17,400 outpatient consultations, including **13,200** for children under five

3,300 people admitted to hospital

1,140 people treated for malaria

HONDURAS

No. staff in 2018: 96 | Expenditure in 2018: €2.3 million | Year MSF first worked in the country: 1974 | msf.org/honduras

Cities, towns or villages where MSF worked in 2018

With its long history of political, economic and social instability, Honduras is among the countries in Central America most affected by poverty and insecurity.

In 2018, Médecins Sans Frontières continued to offer comprehensive care to victims of violence, including sexual violence, in various clinics in the capital, Tegucigalpa. Our teams provide medical treatment for rape, including post-exposure prophylaxis to prevent HIV and hepatitis B infection, and treatment for other sexually transmitted infections such as syphilis and gonorrhoea. In addition, counselling, group therapy and psychological first aid are available.

In June, we opened a health centre in Nueva Capital, a neighbourhood on the outskirts of Tegucigalpa where many internally displaced people have settled. Our services include primary healthcare, mental health consultations for victims of violence, social support and health promotion. With our community approach, we aim to help people overcome the barriers they face in accessing our service in the city centre.

In Choloma, in the north of the country, we have a team working at a mother and child clinic, offering family planning, ante- and postnatal consultations, psychosocial support to victims of violence, including victims of sexual violence, as well as assisting deliveries. Health promotion teams visit different sites in this industrial city, such as factories and schools, to raise awareness of the services available in the clinic and to provide information about sexual and reproductive health for adolescents.

In accordance with international protocols, we continue to advocate access to comprehensive medical care for victims of sexual violence in Honduras, where emergency contraception is still banned.

KEY MEDICAL FIGURES:

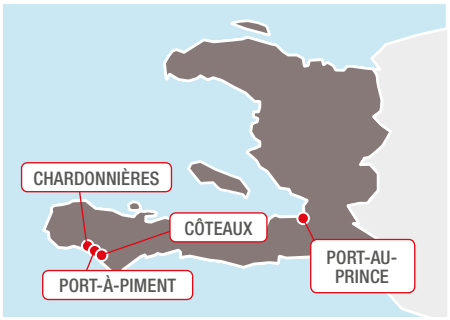
11,000 outpatient consultations

4,390 individual mental health consultations

300 people treated after incidents of sexual violence

HAITI

No. staff in 2018: 1,746 | Expenditure in 2018: €25.2 million | Year MSF first worked in the country: 1991 | msf.org/haiti



Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

7,950 major surgical interventions

1,870 births assisted

Dr Jerry Dely, left, and the MSF team operate on a patient at Drouillard hopsital, Haiti, March 2018.

In 2018, Médecins Sans Frontières (MSF) continued to provide a range of specialist medical services in Haiti, from treatment for victims of sexual violence to advanced surgery and trauma care.

Our teams in the capital, Port-au-Prince, and in the southwest are filling critical gaps in health services and helping to boost the capacity of the local health system.

Trauma care

Nap Kenbé hospital, located in the Port-au-Prince neighbourhood of Tabarre, provides specialist surgical care for victims of trauma. In 2018, our team admitted 1,370 patients and performed 3,240 major surgical procedures. As planned, the number of admissions was stabilised in 2018 in order to prepare for our withdrawal by June 2019. In December, we started discussions with the Ministry of Health regarding the handover of our activities to the Haitian authorities.

Mother and child care

In 2011, we started running the Centre de Référence des Urgences Obstétricales, a 176-bed hospital in Port-au-Prince for women with obstetric complications and newborns requiring specialist treatment. It closed in July, after offering care to a total of approximately 120,000 women and assisting 37,000 births. We gradually decreased admissions leading up to our departure, while urging the Ministry of Health to fulfil its responsibilities towards women with pregnancy complications.

Burns treatment

MSF's 40-bed Drouillard hospital, near the Cité Soleil slum, is the only facility in Port-au-Prince where specialised care is available for patients with severe burns, a widespread problem linked to poor housing conditions. More than a quarter of our patients are children under five, and 90 per cent come straight to us without going to a non-specialist facility first. Services include surgery, wound dressing, physiotherapy and mental health support. In 2018, we completed the construction of a new hospital, with better facilities that will improve infection control, a major issue in burns treatment. We also started running training sessions on burns treatment for medical personnel in other Haitian health facilities.

Victims of sexual and gender-based violence

Sexual violence is an under-reported medical emergency and care for victims in Haiti remains inadequate. In Pran Men'm clinic, in Port-au-Prince's Delmas 33 neighbourhood, we offer emergency care to victims of sexual and gender-based violence.

Emergency care in Martissant slum

In Martissant (Port-au-Prince), the MSF emergency and stabilisation centre provided first-line emergency care to 27,800 sick and injured people in 2018. Some were admitted for observation for a few days, but the majority were referred to more specialist facilities after stabilisation.

Primary healthcare in Sud department

In the southwest, we support the Ministry of Health in the delivery of primary healthcare, focusing on mother and child healthcare and water-borne diseases.
We have worked in Port-à-Piment since October 2016, and in 2018 rehabilitated and started supporting two more health centres, in Côteaux and Chardonnières. In Port-à-Piment alone, our teams conducted more than 25,500 outpatient consultations, treated 2,180 emergency patients and assisted 624 births during the year, as well as running community health promotion and water and sanitation activities in the surrounding areas in order to prevent cholera outbreaks in this zone.

INDIA

No. staff in 2018: 611 | Expenditure in 2018: €13.4 million | Year MSF first worked in the country: 1999 | msf.org/india

KEY MEDICAL FIGURES:

56,000 outpatient consultations

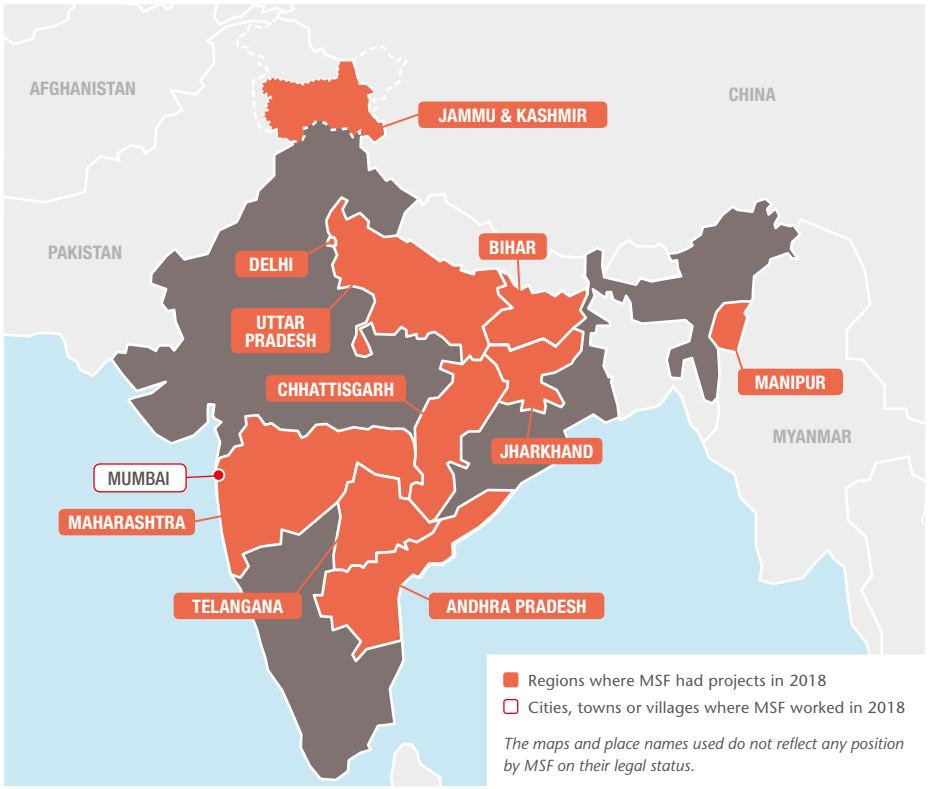
4,330 individual mental health consultations

2,300 people treated for hepatitis C

2,100 people on first-line ARV treatment

1,360 people started on treatment for TB, including **970** for MDR-TB

560 children treated in outpatient feeding programmes



Healthcare remains a challenge for millions of people in India, due to a combination of poverty, social exclusion and an over-burdened public health system.

Médecins Sans Frontières (MSF) continues to work with vulnerable communities, providing medical care linked to infectious diseases, mental health, sexual violence and malnutrition.

© Nikhil Roshan

In Jharkhand, India, 16-month-old Somai Soya is checked for malnutrition using a mid-upper arm circumference measuring tape, October 2017.

Treating drug-resistant tuberculosis (DR-TB) and HIV in Mumbai

Mumbai's M East ward is one of the areas with the highest rates of TB in India's most populous city. For the last 10 years, MSF has worked in an independent clinic that offers comprehensive care for HIV and DR-TB patients – including those with very complex drug resistance patterns that require treatments not available elsewhere in the public or private sector.

In collaboration with the national TB programme and the local government, we also run an outpatient TB department at Shatabdi hospital in M East ward. Many of our TB patients have developed resistance because they have been receiving ineffective treatment for years; others are directly infected by extensively resistant strains. Our model of care provides less toxic and more effective treatments for DR-TB, using newer drugs and offering psychosocial assistance to improve adherence to treatment.

Our teams work in the community to strengthen case finding and adherence to treatment. In 2018, we launched an initiative to ensure systematic clinical and psychosocial follow-up of DR-TB patients at seven health posts, with the objective of demonstrating a replicable model of community-based care.

Specialised care for TB, HIV and hepatitis C in Manipur

Manipur has a high prevalence of HIV, hepatitis C and both drug-sensitive and

Zoya, who has been treated for kala azar-HIV co-infection and tuberculosis in Bihar, India talks to MSF health promoter Chavvi Kumar, August 2018.

drug-resistant TB. Due to a lack of healthcare resources, it also has a high incidence of co-infection, which means each disease speeds up the progress of the other, making patients more vulnerable and treatment more difficult.

Through clinics in Churachandpur, Chakpikarong and Moreh, near the Myanmar border, our teams offer screening, diagnosis and treatment, as well as counselling and health education about how to get tested and treated.

In 2018, we increased our support to Churachandpur district hospital, to improve treatment for HIV patients co-infected with hepatitis C. We also started using bedaquiline to treat patients with extensively drug-resistant TB.

Hepatitis C project in Meerut, Uttar Pradesh

Western Uttar Pradesh has a very high prevalence of hepatitis C, a potentially fatal disease that can lead to liver failure and liver cancer if left untreated. We have been running a pilot hepatitis C project in Meerut since January 2017, in collaboration with the National Health Mission. The aim is to demonstrate the effectiveness of decentralised and simplified hepatitis C treatment and care, and to share best practices for replicating the model in other high-prevalence areas. We provide testing, treatment, health education and counselling at a district hospital.

Fighting kala azar and advanced HIV in Bihar

Kala azar (visceral leishmaniasis) is a neglected tropical disease that is prevalent in Bihar, and co-infection with HIV is a growing public health concern. More than 80 per cent of co-infected patients present with late-stage HIV, often suffering from TB in addition. Together with the Indian Council of Medical Research and the National Vector Borne Disease Control Programme, we have been developing and implementing more tailored, safe and effective treatments for co-infected patients, and looking for better detection methods to improve their prospects.

Additionally, together with state authorities, we have agreed to set up an integrated centre that will offer holistic care and treatment to patients with advanced HIV, including diagnosis and management of opportunistic infections. The centre, which is due to open in February 2019, will provide a wide range of services, including psychological, nutritional, medical and, where necessary, palliative care.

Mental healthcare in Jammu and Kashmir

Years of conflict have taken a psychological toll on the residents of Jammu and Kashmir, the effects of which are compounded by the stigma associated with mental health issues. We have been offering counselling services there since 2001, and in 2018 had teams working in hospitals in four districts – Srinagar, Baramulla, Pulwama and Bandipora. In Bandipora, we are helping the government to implement a mental health programme with a strong community awareness-raising component.

Sexual and gender-based violence in Delhi

In 2015, we opened a 24-hour clinic in North Delhi's Jahangirpuri district for victims of sexual and domestic violence. Services include post-exposure prophylaxis to prevent HIV/AIDS, the prevention and management of unwanted pregnancies and sexually transmitted diseases, and psychosocial support. We also run counselling services at the local district hospital.

Throughout 2018, we continued to work with community-based organisations, police, government protection agencies and the health ministry to raise awareness of the clinic's services and develop an efficient referral system.

Reaching remote communities in Andhra Pradesh, Chhattisgarh and Telangana

A low-intensity but longstanding conflict has left large sections of the population of Andhra Pradesh, Chhattisgarh and Telangana states without access to healthcare. Medical facilities are few and far between, meaning that even preventable, treatable conditions can become life-threatening. We run mobile clinics to take primary healthcare to remote communities in these states. As well as treatment for malaria, respiratory infections, pneumonia and skin diseases, we conduct health education sessions on topics such as hygiene, care of newborns, family planning and prevention of sexually transmitted diseases.

Treating severe acute malnutrition in Jharkhand

We have been working with the health authorities in Jharkhand to identify and treat children with severe acute malnutrition since 2017. In 2018, we continued to focus on preventive and therapeutic measures, including screening and community engagement. Together with the Rajendra Institute of Medical Sciences, we launched a study in November to investigate how childhood malnutrition evolves into severe forms, and how it can be addressed most effectively. The results will be shared with policy makers in India, to ensure that in a country with the highest worldwide burden of severe acute malnutrition, children receive the best possible treatment.

INDONESIA

No. staff in 2018: 35 | Expenditure in 2018: €0.9 million | Year MSF first worked in the country: 1995 | msf.org/indonesia

Médecins Sans Frontières (MSF) launched a new programme focusing on the health needs of adolescents in Indonesia and responded to multiple emergencies throughout 2018.

We opened a new programme to improve access to healthcare services for adolescents in Pandeglang, Banten province, in February. Our team worked with community health practitioners, trained and supported health centre staff, provided specialised maternity services, and followed up on individual cases. We also developed activities to disseminate information on adolescent health services through schools, at public events and at an MSF youth education centre.

In Jakarta, we supported the Ministry of Health's health screening programme and the development of adolescent reproductive health guidelines for the Thousand Islands archipelago, which lies off the north coast.

In April, we ran a series of training sessions, workshops and hospital visits to address methanol poisoning, a nationwide issue in Indonesia. We also supported local doctors with specific guidelines on managing treatment.

Emergency response

Indonesia was hit by a series of natural disasters in 2018: earthquakes in Lombok island in July and August; an earthquake, followed by a tsunami and liquefaction in Palu, Sulawesi, in September; and the eruption of Krakatoa, which caused a tsunami along the Sunda Strait, in December.

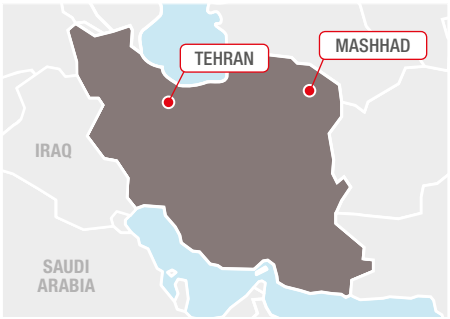
In Lombok and Palu, we sent emergency teams comprising medical, mental healthcare and water and sanitation experts to support the national response. Pandeglang was the area of Sunda Strait most affected by the tsunami. As this was the site of our new adolescent healthcare project, the team there was able to provide immediate and sustained support to the local response, focusing on primary healthcare, mental health support and hygiene for displaced people.

KEY MEDICAL FIGURE:

2,520 outpatient consultations

IRAN

No. staff in 2018: 58 | Expenditure in 2018: €2.1 million | Year MSF first worked in the country: 1990 | msf.org/iran



In Iran, Médecins Sans Frontières runs programmes to assist drug users, sex workers, refugees, homeless people and other vulnerable groups who face barriers when seeking healthcare.

Drug addiction is a particular public health concern in Iran, with the number of drug users having doubled over the last six years to nearly three million (3.5 per cent of the population).[1] They, and other vulnerable groups such as sex workers, homeless people and the Ghorbati ethnic minority, suffer from stigma and exclusion in Iran, which limits their access to medical care. In 2018, this was further restricted by a financial crisis that crippled the health system.

Our teams worked in South Tehran throughout the year, providing treatment for a range of communicable diseases to which marginalised communities are particularly exposed, including hepatitis B and C, HIV, tuberculosis (TB) and syphilis. We saw a large increase in the number of patients enrolling for hepatitis C treatment, an 82 per cent increase on 2017.

We also ran sexual and reproductive healthcare services, comprising gynaecology and obstetrics, ante- and postnatal care, and consultations for victims of sexual violence, as well as psychosocial support and counselling. A mobile clinic specifically for women was set up in the city.

In addition, we opened a new programme for refugees and the local community in Mashhad, near the Afghan border, where a significant number of the estimated two million Afghans in Iran live. Our teams there offer a similar range of services as in South Tehran: through fixed and mobile clinics, we treat hepatitis C and operate a referral system for patients needing treatment for HIV and/or TB.

[1] *Middle East Institute*

KEY MEDICAL FIGURES:

29,900 outpatient consultations

3,750 individual mental health consultations

82 people treated for hepatitis C

ITALY

No. staff in 2018: 79 | Expenditure in 2018: €4.9 million | Year MSF first worked in the country: 1999 | msf.org/italy

- Regions where MSF had projects in 2018
- Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

2,760 individual mental health consultations and **54** group sessions

1,490 outpatient consultations

Although numbers were significantly down on previous years, still more than 20,000 people arrived on Italian shores in 2018, many of them traumatised by the sea crossing and prior detention in Libya.

Amid increasingly hostile manoeuvres by Italian authorities to shut down search and rescue operations, Médecins Sans Frontières (MSF) continued to provide psychological and medical assistance to migrants and refugees in Italy, including specialised care for victims of torture.

Our teams offered psychological first aid to those disembarking in southern ports, and ran a clinic in Catania for patients requiring care after discharge from hospitals in Sicily. The clinic closed at the end of the year due to the drop in new arrivals. MSF psychologists also supported asylum seekers in reception centres in the province of Trapani, handing over activities at the end of the year as planned.

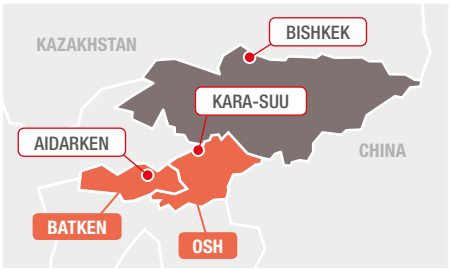
We sent mobile teams to work in informal settlements around Rome, where migrants often languish in poor living conditions. Alongside a network of civil society organisations and volunteers, our teams carried out around 1,500 medical consultations and psychological interventions in 2018, as well as offering psychosocial assistance to unaccompanied minors in reception centres in Rome.

For the third consecutive year, we ran a centre in Rome for the rehabilitation of victims of torture, ill-treatment and other forms of degrading treatment. Victims of torture can access psychological, medical, legal and social support at the centre, which we run in collaboration with local partners Medici Contro la Tortura and ASGI.

In Turin and Palermo, we provided support and orientation to more than 800 people to access national health services. We also distributed relief items such as blankets and tents to migrants and refugees living in informal settlements, in particular in Rome and around Italy's northern borders.

KYRGYZSTAN

No. staff in 2018: 105 | Expenditure in 2018: €2.6 million | Year MSF first worked in the country: 2005 | msf.org/kyrgyzstan



- Regions where MSF had projects in 2018
- Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

5,640 outpatient consultations

1,870 antenatal consultations

79 people started on treatment for DR-TB

In 2018, Médecins Sans Frontières (MSF) explored innovative ways of supporting patients with drug-resistant tuberculosis (DR-TB) in Kara-Suu district, where TB rates are among the highest in the country.

Kyrgyzstan is one of the countries with the world's highest rates of multidrug-resistant TB (MDR-TB). We are helping to bring care closer to patients' homes, reducing or eliminating the time they have to spend in hospital.

In 2018, we introduced video-observed treatment to support medication adherence for DR-TB patients. We also supported 103 primary healthcare facilities in Kara-Suu to start collecting sputum samples, to enable decentralised TB screening. By the end of the year, over 70 per cent of DR-TB patients in the district were on outpatient treatment; only a small number were still admitted to ensure close follow-up and management of side effects.

In March, the seventh regional MSF TB symposium was hosted in Bishkek, bringing together more than 160 Eurasian experts to discuss new approaches to treatment and how to increase the use of newer drugs and diagnostic tools.

We continued preparations to launch the endTB clinical trial to find radically shorter, more tolerable, injection-free treatments for MDR-TB. Unfortunately, after three years of preparatory work, the difficult decision was taken at the end of the year not to run the trial in Kyrgyzstan due to the delay in obtaining regulatory approval.

In Aidarken, Batken province, where the prevalence of non-communicable diseases (NCDs) is the highest in Kyrgyzstan, we continued to diagnose and treat NCDs and provide healthcare to pregnant women and children.

With the support of technical experts and in collaboration with the Ministry of Emergency Situations, we also conducted a seismic survey examining the risks of an earthquake to the residents of Batken, including the potential for heavy metal pollution due to the presence of mercury and antimony mines.

IRAQ

No. staff in 2018: 1,513 | Expenditure in 2018: €45.5 million | Year MSF first worked in the country: 2003 | msf.org/iraq

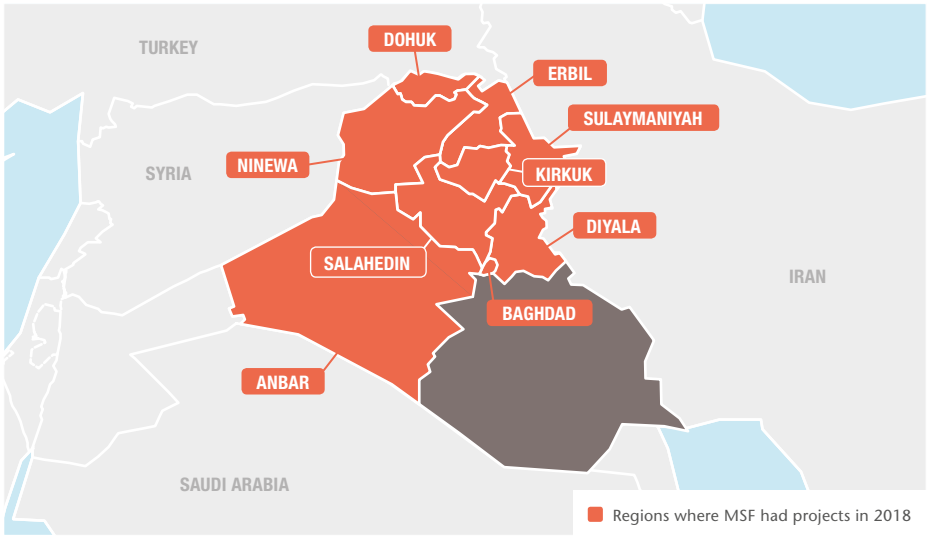
KEY MEDICAL FIGURES:

197,600 outpatient consultations

38,500 individual mental health consultations

11,100 births assisted

3,780 major surgical interventions



With almost two million people[1] still displaced and many health facilities damaged or destroyed, medical needs remain extremely high in Iraq.

Although the conflict subsided in late 2017 and increasing numbers of displaced people returned to their areas of origin in 2018, significant barriers to returning remain. Many displaced families lack the necessary documentation, properties and livelihoods have been damaged if not destroyed, and security concerns persist in some areas. The context remains complex and unpredictable, due to ongoing political disputes, tribal conflicts and attacks by armed groups.

In 2018, Médecins Sans Frontières (MSF) continued to offer services ranging from basic healthcare and treatment for non-communicable diseases (NCDs), to maternity, paediatric and emergency care, surgery and mental health support for displaced people, returnees and communities most affected by violence. We also rehabilitated and equipped hospitals and clinics in some of the most war-affected regions to help get the Iraqi health system back on its feet.

Anbar governorate

We continued to provide primary healthcare, treatment for NCDs and mental health services, including psychiatric care, in two camps for internally displaced people (IDPs), handing over activities in the second half of the year as the camp populations gradually decreased and other organisations started providing medical services.

In April, we opened an outpatient clinic at Ramadi teaching hospital to treat patients with moderate and severe mental health disorders.

Baghdad governorate

Our teams in Baghdad Medical Rehabilitation Centre provided post-operative rehabilitation to 261 severely injured patients in 2018, including physiotherapy, pain management and mental healthcare.

We also completed the rehabilitation of Imam Ali hospital's emergency department, in Sadr city, with the installation of high-quality medical equipment and a new triage system, supplied 60,000 tablets of first-line medication to Iraq's national tuberculosis (TB) programme, and donated a GeneXpert machine to Rusafa chest and respiratory clinic to improve the detection of drug-resistant TB.

Diyala governorate

MSF teams offered treatment for NCDs, mental health support and sexual and reproductive healthcare in Jalawla and Sadiya primary health centres for families returning to the area, and in camps for displaced people in Khanaqin. We also ran health education sessions on chronic

Haussian, a 13-year-old boy from Fallujah, Iraq plays with an old bicycle, October 2018. Haussian and his family have lived in a tent in Amriyat Al-Fallujah camp for the past three years.

Dr Mohammed Salih and his colleague treat a young patient in the emergency room at Nablus hospital in west Mosul, Iraq, March 2018.

and endemic diseases, sexual and reproductive health, and psychological first aid.

Erbil governorate

We provide psychological, psychiatric and psychosocial care in four different camps around Erbil, and to displaced people and host communities in Kalak. We reduced our activities in October as the camp populations declined, concentrating on moderate to severe mental health cases and treatment for NCDs.

Kirkuk governorate

As displaced people continued returning to Hawija, one of the areas most affected by conflict, our teams conducted some 14,500 outpatient consultations, as well as treatment for NCDs and health education sessions in Al-Abassi and Hawija city. We also provided mental healthcare in Al-Abassi, and rehabilitated the water stations in Al-Shazera and Al-Abassi to ensure clean drinking water and to prevent outbreaks of water-borne diseases.

We continued to run basic medical and mental healthcare in Daquq camp until it closed in September, and offered technical support and training at Hawija hospital in the emergency room, laboratory and maternity department and in infection prevention and control.

Ninewa governorate

Several neighbourhoods in Mosul still lie under piles of rubble, and thousands of people struggle to access basic services such as healthcare, water and electricity. In 2018, we scaled up our medical activities in both east and west Mosul in response.

In Nablus, west Mosul, we ran a comprehensive maternity unit with surgical capacity for caesarean sections, paediatric healthcare (including for newborns), stabilisation and referrals for emergencies and mental health services. Our teams assisted more than 5,300 normal deliveries, performed 1,120 caesarean sections and treated 34,500 patients in the emergency room.

In April, we opened a comprehensive post-operative care facility in east Mosul for patients with violent or accidental trauma injuries. The facility has a mobile operating theatre, a 20-bed inpatient ward, 11 recovery rooms, a mental health department and a rehabilitation unit.

In July, we launched a programme specifically aimed at increasing access to mental healthcare and psychosocial aid. Working in three health centres, our teams provide counselling, psychosocial first aid, psychosocial support and referrals for psychiatric care.

At the end of the year, we also completed the rehabilitation of Al-Salam hospital's 24-hour emergency department, which now has two wards, a trauma room, a pharmacy, two consultation rooms and a triage area.

South of Mosul, we provide emergency consultations, intensive care, treatment for burns and mental healthcare for the resident and displaced population of Qayyarah sub-district and the surrounding area. Our 62-bed hospital has an inpatient department, a paediatric ward and an inpatient therapeutic feeding centre. As the healthcare needs of displaced people and those returning to the area continued to grow in 2018, we expanded our burns and neonatal activities and set up a second operating theatre. Our teams performed more than 18,000 emergency room consultations and almost 2,500 surgical interventions during the year.

We also started providing primary healthcare in Qayyarah Airstrip camp at the beginning of 2018, including outpatient treatment for malnutrition, mental healthcare, sexual and reproductive health services, and referrals. In July, we added a 24-hour emergency room.

In August, we completed the rehabilitation of Sinuni hospital, in Sinjar district, where medical activities were significantly limited during the conflict. It reopened with a fully equipped emergency room, maternity unit, inpatient paediatric ward and mental health services.

We also continued to provide emergency maternity and neonatal care, basic paediatrics, emergency stabilisation services and mental health support in Tal Maraq health facility, Zummar sub-district.

Salahedin governorate

For the first six months of the year, we conducted outpatient and mental health consultations for returnees and displaced people through our mobile clinics in Tikrit and managed a primary healthcare centre in Al-Allam camp. Following a reduction in the number of displaced people and an increase in activities by other organisations, we handed over these activities to the Iraqi Department of Health in June.

Emergency response activities

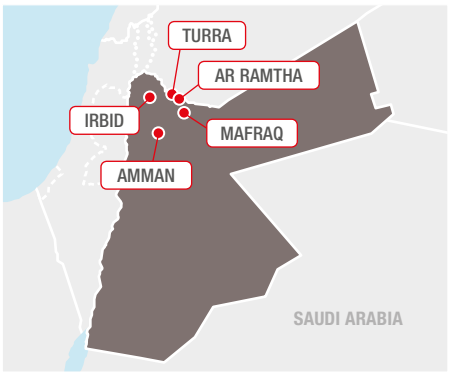
After several cases of Crimean-Congo haemorrhagic fever were reported in different regions of Iraq, we rapidly deployed a team of experts to support hospitals. In July, 228 Iraqi doctors, nurses and cleaners were trained in five public hospitals in Diwaniyah, Najaf, Babel and Baghdad governorates.

We also supported the Department of Health to vaccinate more than 111,000 children aged six months to 15 years old in response to a measles outbreak in Ninewa governorate in July.

[1] *IOM Iraq Displacement Tracking Matrix*

JORDAN

No. staff in 2018: 417 | Expenditure in 2018: €25.5 million | Year MSF first worked in the country: 2006 | msf.org/jordan



Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

69,000 outpatient consultations

11,200 individual mental health consultations

2,690 births assisted

1,410 major surgical interventions

© Hussein Amri/MSF

MSF project manager Samar Ismail evaluates the first prototype of a partial prosthetic hand in October 2018 – a landmark for the team in Amman, Jordan. The prosthetic was designed for Basil, who lost three fingers when injured by shrapnel in Syria in 2013.

In Jordan, Médecins Sans Frontières (MSF) runs healthcare programmes to assist Syrian refugees and vulnerable host communities.

Following the closure of the border between southern Syria and Jordan and the announcement of a 'de-escalation zone' in southwestern Syria in July 2017, the number of refugees and war-wounded entering the country decreased. However, there are still almost 671,000 registered and an unknown number of unregistered Syrian refugees in Jordan, most of whom rely on humanitarian assistance to meet their basic needs. In February 2018, the Jordanian government announced the cancellation of subsidised healthcare for Syrian refugees, making it even more difficult for them to access medical services.

Non-communicable diseases (NCDs)

Our three clinics in Irbid governorate provide Syrians and vulnerable Jordanians with treatment for NCDs, a leading cause of death in the region. The teams offer medical and mental healthcare, including home visits, psychosocial support, physiotherapy and health promotion, to patients with diseases such as diabetes and hypertension. In 2018, we carried out more than 21,000 outpatient consultations and over 4,000 individual mental health consultations.

In 2018, we also supported a primary healthcare centre in Turra, in Ar Ramtha's Sahel Houran district, where we conducted outpatient consultations for Syrian refugees and the local community, before handing over to the Ministry of Health.

Maternal and child health

We have been running a maternity department and a 16-bed neonatal intensive care unit in Irbid since late 2013, assisting a total of around 16,000 deliveries. In the nine months to September, when we handed over the maternity department to another NGO, our teams carried out 11,000 antenatal consultations, assisted almost 2,700 births and admitted 664 newborns.

In 2018, we increased our focus on mental healthcare, offering support to Syrian children and their parents in Mafraq governorate.

Reconstructive surgery for victims of violence in the Middle East

Our reconstructive surgery hospital in Amman continued providing comprehensive care to a monthly average of 200 patients with conflict-related injuries from neighbouring countries, mainly Iraq, Syria, Yemen and Palestine. This includes orthopaedic, plastic and maxillofacial surgery, physiotherapy, mental health support and fitting prosthetics. Since 2016, we have been 3D-printing upper-limb prosthetic devices that are essential for patients to regain their physical integrity and autonomy. In 2018, our teams performed 1,160 surgical interventions.

Emergency surgery in Ar Ramtha

In early 2018, we took the difficult decision to close our 41-bed surgical facility in Ar Ramtha, due to the sharp decrease in the number of wounded patients referred from southern Syria following the closure of the border in June 2016.

Since September 2013, the project had helped thousands of patients recover from physical injuries, as well as psychological trauma. In just over four years, our teams tended at least 2,700 war-wounded patients in the emergency room, carried out over 3,700 major surgical interventions, performed more than 8,500 physiotherapy sessions and conducted around 5,900 psychosocial support sessions.

LEBANON

No. staff in 2018: 649 | Expenditure in 2018: €29.8 million | Year MSF first worked in the country: 1976 | msf.org/lebanon

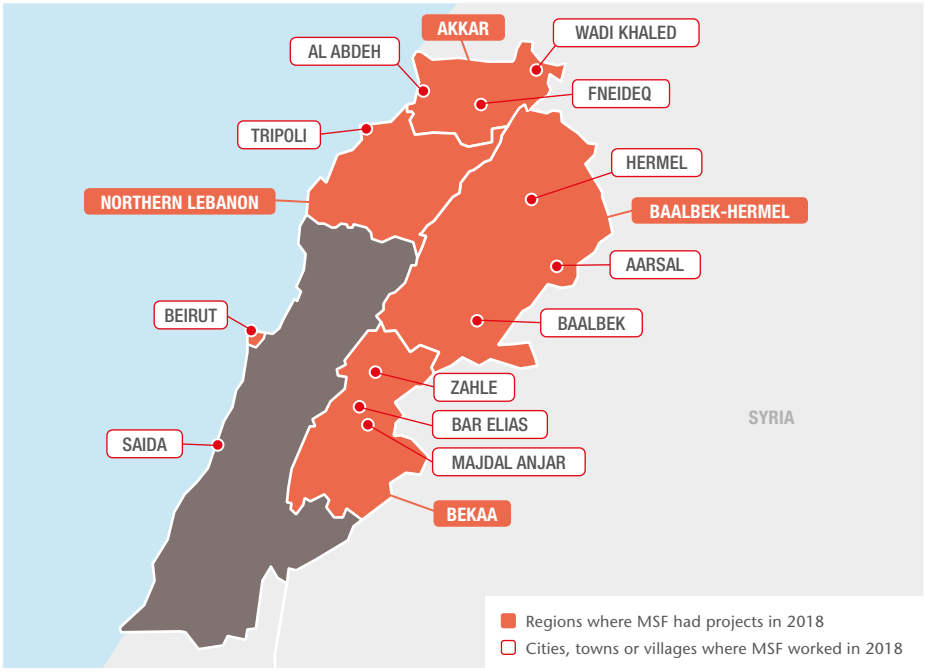
KEY MEDICAL FIGURES:

125,400 outpatient consultations

11,700 individual mental health consultations

4,660 births assisted

3,660 people admitted to hospital



More than a million people have fled into Lebanon since the conflict in neighbouring Syria began in 2011, making it the country with the largest number of refugees per capita in the world.

Many refugees are living in deplorable conditions with their most basic needs unmet. The huge number of extra people in the country has put a severe strain on services, including the health sector. Even where healthcare is available, the cost of consultations, laboratory tests and medication is a barrier for refugees, as well as for migrants and economically and socially vulnerable Lebanese.

Médecins Sans Frontières continues to work across Lebanon to provide these communities with free, quality medical assistance such as treatment for non-communicable diseases, sexual and reproductive healthcare, mental healthcare and maternity services. In 2018, we expanded our projects to offer specialist services, such as paediatric intensive care, treatment for thalassemia and general elective surgery.

Bekaa Valley

In Bekaa and Baalbek-Hermel, where the majority of Syrian refugees have settled, we offer primary healthcare in Hermel, Aarsal, Baalbek and Majdal Anjar.

We have teams working in two mother and child health centres in Aarsal and Majdal Anjar, and run a specialised paediatrics programme in Zahle, which includes emergency consultations, paediatric intensive care and treatment for thalassemia.

We completed the rehabilitation of a hospital in Bar Elias in July, and towards the end of the year started providing chronic wound care and general elective surgery.

In addition, we supported the Ministry of Public Health to vaccinate 22,000 children against measles and polio in Zahle, Baalbek and Hermel.

Northern Lebanon and Akkar

We offer essential primary healthcare in Wadi Khaled, as well as mental health support in a clinic in Fneideq, for both Syrian refugees and the local community.

In Tripoli and Al Abdeh, we continued to offer chronic diseases care and family planning services. In 2018 we implemented the WHO Mental Health Gap Action Programme[1] adopted by the Lebanese Ministry of Public Health, training general practitioners so that they can prescribe medication when necessary, under the supervision of an external psychiatrist.

South Beirut

Since September 2013, we have been managing a primary healthcare centre and a women's centre in Shatila refugee camp, where Palestinians, Syrians, Lebanese and people of various other nationalities live in poor, overcrowded conditions with limited services.

We launched a vaccination campaign around Sabra and Shatila in March in collaboration with the Ministry of Public Health, vaccinating around 10,000 children against measles and polio, and opened a birthing centre at Rafik Hariri University Hospital in July. Our teams here assist deliveries and treat neonatal referrals from our Shatila clinic.

In Burj-al-Barajneh refugee camp, we run family planning and mental healthcare services, and operate a home-based care programme for patients with chronic diseases who have mobility problems.

South Lebanon

We also operate a home-based care programme in Ein-al-Hilweh refugee camp, in Saida, for patients with mobility problems, and continue to support medical personnel in the camp to improve their emergency preparedness and response plan so they can stabilise any injured people caught up in violence.

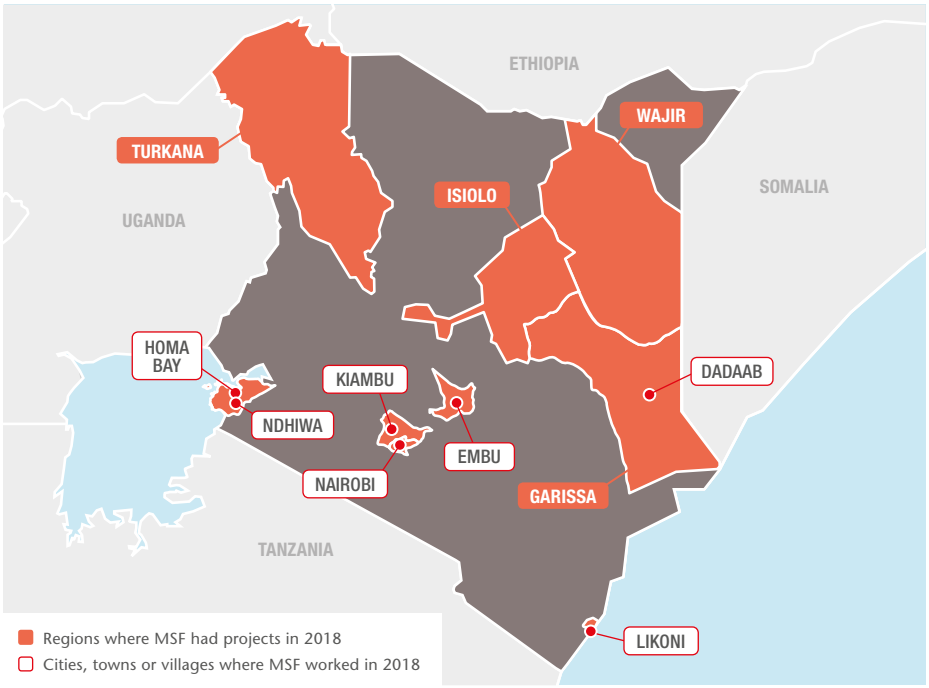
[1] *WHO Mental Health Gap Action Programme (mhGAP)*

© Mario Fawaz/MSF

An MSF nurse gives a young girl a polio vaccination as part of a vaccination campaign around Shatila and Sabra refugee camps in Lebanon, March 2018.

KENYA

No. staff in 2018: 839 | Expenditure in 2018: €24.4 million | Year MSF first worked in the country: 1987 | msf.org/kenya



KEY MEDICAL FIGURES:

226,000 outpatient consultations

15,700 people on first-line ARV treatment, and **990** on second-line ARV treatment

9,510 births assisted, including **860** caesarean sections

3,320 people treated after incidents of sexual violence

210 people started on treatment for TB

Médecins Sans Frontières (MSF) responded to multiple emergencies and public health challenges in Kenya in 2018, including disease outbreaks, urban violence and treatment failure affecting people living with HIV, while continuing our decades-long support for refugees in Dadaab.

Life expectancy is steadily increasing in Kenya, with improvements in mortality rates for both HIV and tuberculosis (TB). However, infectious diseases and maternal mortality remain serious concerns.

HIV care in Homa Bay

Despite a generally good coverage of antiretroviral (ARV) therapy, many people living with HIV in Homa Bay county continue to experience treatment failure, and many present at our facilities with advanced HIV co-infections such as Kaposi's sarcoma. In 2018, we focused on treatment failure, advanced HIV and programmes for adolescents.

More than half the patients admitted to Homa Bay county referral hospital – where MSF supports two adult wards and a tuberculosis (TB) ward – are HIV positive. An average of 18 HIV positive patients died each month in 2018, almost 30 per cent of them within the first 24 hours of admission. In response, we have implemented various innovative systems, including a dedicated laboratory and point-of-care testing for inpatients, which have facilitated faster treatment. We also run a follow-up clinic at the hospital that liaises with patients' local health facilities to create a continuum of care as close to home as possible.

Providing vital obstetric care in Mombasa

After more than two years of running sexual and reproductive health services from a

An MSF emergency team immobilise a man injured in a road traffic accident in Eastleigh, a suburb of Nairobi, Kenya, October 2017.

temporary shipping-container facility in Likoni, Mombasa county, we completed the rehabilitation of Mrima health centre, which opened in May. The new 36-bed facility has more spacious consultation rooms and upgraded medical equipment, enabling us to provide better care for a higher number of expectant mothers in a densely populated area with no other emergency obstetric or neonatal care facilities. In 2018, our teams assisted almost 7,000 deliveries, over half of them in the new facility. We also offered antenatal services, medical assistance for victims of sexual violence and health promotion in the community.

A mother introduces a visitor to her newborn baby in the newly extended Mrima health centre in Likoni, Kenya, May 2018.

Treating non-communicable diseases (NCDs) in Embu

We mentor Ministry of Health staff in Embu county to improve the management of NCDs in primary healthcare facilities. The first cohort of four clinical officers, five nurses and six community health volunteers graduated from the programme in November, having successfully completed modules on asthma, diabetes, hypertension and epilepsy.

Medical care for people who use drugs in Kiambu

Following an assessment in 2018, we noted a significant need for integrated medical care for people who use drugs in Kiambu county. In collaboration with local partners, we carried out an awareness-raising campaign to help the community understand the problem and will open a specialised clinic in Karuri in 2019. Our aim is to reduce the rates of illness and mortality associated with illicit opioid drug use by increasing access to appropriate health services, including different models of opioid substitution therapy and patient support.

Assisting victims of violence in Nairobi

We run an ambulance referral service, a toll-free call centre and a trauma room in Nairobi's Eastlands area, to improve access to emergency care for victims of urban violence. In 2018, our teams received over 7,600 calls, resulting in 6,230 ambulance interventions and 4,340 referrals to health facilities. The team in the trauma room conducted 9,250 consultations, receiving mostly walk-in patients.

We also run a specialised clinic for victims of sexual and gender-based violence in Eastlands, and support four other facilities run by the Ministry of Health. In 2018, we treated an average of 269 patients a month, representing an 18 per cent increase on the previous year. Our outreach teams increased their community awareness-raising activities, explaining what sexual and gender-based violence is and what assistance is available.

In addition, we continued to support the Ministry of Health in the management of drug-resistant TB (DR-TB), by providing equipment and training. Our ground-breaking DR-TB programme, which we handed over in 2017, introduced the use of GeneXpert machines for diagnosis and oral drugs bedaquiline and delamanid for treatment. We also achieved the country's first successful treatment of a patient with extensively drug-resistant TB. In 2018, we piloted a nine-month treatment regimen which the Ministry of Health adopted.

Medical care in Dadaab refugee complex

We continue to offer comprehensive healthcare to over 70,000 refugees living in Dagahaley camp in Dadaab and the local community through a 100-bed hospital and two decentralised health posts. In 2018, we conducted more than 175,000 outpatient consultations and admitted over 10,000 patients for care. Our teams provide a wide range of services, including nutrition support, sexual and reproductive healthcare, emergency surgery, medical and psychological assistance to victims of sexual violence, vaccinations, mental health services, treatment for HIV and TB, palliative care for patients with chronic illnesses and home-based insulin management for people with diabetes.

Emergency responses

Our emergency teams responded to several disease outbreaks and other emergencies in 2018, including ambulance support, medical care and the distribution of relief kits to communities whose homes were ravaged by fires around the country.

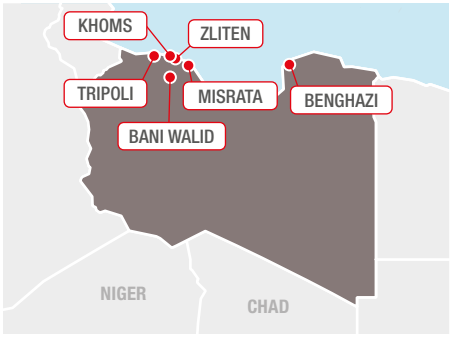
Heavy rains early in the year resulted in a five-month cholera outbreak in Nairobi, Embu, Isiolo, Garissa and Turkana counties. We assisted in the treatment of patients and provided logistical and medical supplies to support the wider response.

In March, we sent staff and medical supplies to support the response to an influenza outbreak in Nanyuki, Laikipia county, and in June, we assisted the Ministry of Health to respond to an outbreak of Rift Valley fever in Wajir county. Caused by a virus transmitted by mosquitoes and blood-feeding flies, Rift Valley fever can lead to potentially lethal haemorrhagic fever. We helped to treat 82 patients and contain the outbreak within a couple of weeks.

At the end of the year, we responded to an influx of wounded patients arriving from the Ethiopian county of Moyale, where violence had erupted. The team supported Takaba district hospital in Mandera county, which received more than 100 wounded within three days.

LIBYA

No. staff in 2018: 101 | Expenditure in 2018: €9.5 million | Year MSF first worked in the country: 2011 | msf.org/libya



Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

46,900 outpatient consultations

1,160 antenatal consultations

180 people started on treatment for TB

© Sara Creta/MSF

A woman stands in a detention centre in Libya, in September 2018, after being intercepted at sea.

Despite ongoing instability, Libya remained a destination for migrant workers from across Africa and a transit country for migrants, asylum seekers and refugees attempting to cross the Mediterranean and reach Europe.

In 2018, Médecins Sans Frontières (MSF) provided medical assistance to migrants and refugees arbitrarily held in detention centres nominally under the control of the Ministry of the Interior.

Many of our patients in the centres were extremely vulnerable people, for example unaccompanied children, lactating mothers and their newborns, and survivors of human trafficking who had been held captive for prolonged periods, deprived of food, tortured and exposed to extreme violence, including the killing of family members.

Most of the medical issues we treated were related to or aggravated by the dire conditions inside the centres, with overcrowding, inadequate food and drinking water, and insufficient latrines facilitating the spread of acute respiratory tract infections, tuberculosis, diarrhoeal diseases and skin diseases such as scabies. Mental health disorders and trauma were frequently exacerbated by the ordeal of indefinite detention.

MSF repeatedly denounced this unacceptable situation deliberately reinforced by European policy makers, but we saw little positive progress. On the contrary, the campaign to effectively criminalise search and rescue vessels on the Mediterranean and the EU's handover of responsibility to the Libyan coastguard for these operations, further sealed off the Libyan coast, trapping vulnerable people in a country where their lives are endangered and where serious human rights violations occur, as documented by the United Nations and other organisations.

In 2018, our teams conducted over 31,500 medical consultations in detention centres in Tripoli, Misrata, Khoms and Zliten and referred over 1,000 patients to secondary healthcare facilities. On dozens of occasions in Misrata and Khoms, we gained access to people who had been brought back from the sea by the Libyan coastguard or commercial ships in violation of international refugee law and maritime conventions. We carried out about 140 first aid consultations at disembarkation points in 2018.

We continued to work in Bani Walid, reportedly a major hub for smugglers and traffickers, in order to assist people who had been held captive by criminal networks in the area but had managed to escape or been released. We conducted 810 medical consultations with survivors and referred a dozen people for secondary healthcare in Misrata or Tripoli.

The majority of migrants and refugees live outside detention centres or are held in clandestine places of captivity, and like the local communities in Libya they are affected by the deterioration in public health facilities, which face severe shortages of medicines and staff. In 2018, our teams provided 2,500 outpatient consultations in Tawergha and Misrata to both local people and migrants. We also started offering antenatal and postnatal care to women living in Bani Walid. Conversely, we closed our project in Benghazi, in the east of the country, where our presence had become less relevant.

LIBERIA

No. staff in 2018: 323 | Expenditure in 2018: €5.7 million | Year MSF first worked in the country: 1990 | msf.org/liberia

Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

Médecins Sans Frontières runs a paediatric hospital in the Liberian capital, offering specialised care, including surgery, and supports health centres to make psychiatric treatment more accessible at community level.

We opened Bardnesville Junction Hospital in Monrovia in 2015 to provide specialised care for children as the Liberian health system came under severe strain during the West African Ebola outbreak.

Serving children aged between one month and 15 years old, the hospital receives some of the most critical paediatric cases from a large urban area of approximately one million people. In 2018, we admitted around 100 patients a week with conditions such as malaria, severe acute malnutrition, non-bloody diarrhoea and respiratory tract infections. The hospital has an emergency room, an intensive care unit, a paediatric ward and a nutrition ward, and is a certified clinical teaching site for Liberian nursing students.

We opened a paediatric surgery programme at Bardnesville in January and performed 735 procedures during the year, including emergency interventions and common operations such as paediatric hernia repairs. Towards the end of the year, we built a second operating theatre to perform additional, subspecialised procedures not widely available in Liberia, such as reconstructive plastic surgery.

We also expanded our innovative mental health and epilepsy care programme around Monrovia, in Montserrado county. Building on a model established by the World Health Organization to make psychiatric care available at community level, we worked with the county health authorities to provide training, supervision and medication for staff in four primary health centres to treat conditions such as bipolar disorder, severe depression, post-traumatic stress disorder and schizophrenia, as well as epilepsy. Teams of health volunteers and counsellors identified patients in their communities, supported their treatment at home and raised awareness about mental illness.

KEY MEDICAL FIGURES:

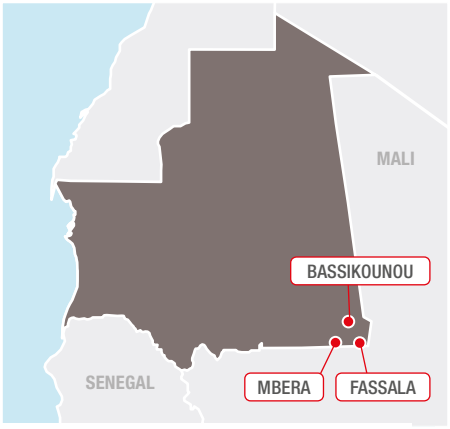
5,360 people admitted to hospital, including **1,430** children in inpatient feeding programmes

3,500 people treated for malaria

740 major surgical interventions

MAURITANIA

No. staff in 2018: 273 | Expenditure in 2018: €4.5 million | Year MSF first worked in the country: 1994 | msf.org/mauritania



Cities, towns or villages where MSF worked in 2018

Médecins Sans Frontières (MSF) continued to provide emergency medical care to Malian refugees and host communities in Mauritania until December 2018.

MSF returned to Mauritania in 2012, when thousands of people fled the conflict in northern Mali and settled in Mbera camp on the border between the two countries. The camp still hosts more than 50,000 refugees.[1] Although a peace agreement was signed in 2015, the situation remains unstable in Mali, and many people are therefore reluctant to return.

Our teams provided medical assistance in Mbera camp, including ante- and postnatal care, family planning, obstetrics and neonatology, treatment for chronic and infectious diseases, and nutritional support. We also provided care to local communities neighbouring the refugee camp, in the towns of Bassikounou and Fassala, and surrounding villages.

In 2018, our teams performed 190 major surgical interventions, such as caesarean sections and orthopaedic procedures, and conducted a multi-antigen vaccination campaign throughout the district, to protect children under five and women against the most common childhood diseases.

Although the context remains volatile, the situation in Mbera and the neighbouring districts of Bassikounou and Fassala has become chronic, requiring a long-term response that focuses on the development of a sustainable public health system. For this reason, after six years of emergency and post-emergency medical interventions, we decided to hand over our activities in Mauritania to the Alliance for International Medical Action (ALIMA) in December 2018. We will continue to monitor the needs in the region and our emergency teams remain ready to intervene if required.

[1] *UNHCR Operational Update, December 2018*

KEY MEDICAL FIGURES:

47,300 outpatient consultations

1,170 births assisted, including **85** caesarean sections

MALAWI

No. staff in 2018: 348 | Expenditure in 2018: €9 million | Year MSF first worked in the country: 1986 | msf.org/malawi

Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

© Luca Sola

Alfred Nema, aged 18, collects his ARV medication in Chiradzulu, Malawi, July 2017.

KEY MEDICAL FIGURES:

23,700 people on first-line ARV treatment, and **4,120** on second-line ARV treatment

1,100 people started on treatment for TB

In Malawi, Médecins Sans Frontières is working to reduce mortality from HIV by facilitating earlier treatment and more advanced care, particularly for women, adolescents and other vulnerable groups.

HIV prevalence is over 10 per cent among people aged 15 to 64, one of the highest in the world. The country's HIV programme has achieved significant success, with over 80 per cent of the one million people who have tested positive being started on treatment. However, more robust strategies are required to prevent infection and reduce mortality among more at-risk patients.

HIV care in Chiradzulu and Nsanje

In rural Chiradzulu district, we focus our HIV activities on complex cases such as patients on second- or third-line antiretroviral (ARV) therapy and those with opportunistic infections or facing treatment failure. In 2018, our teams provided care to almost 5,500 patients, of whom 2,500 were children and adolescents.

Our services include decentralised outpatient clinics, 'teen clubs' for adolescents, point-of-care tests, counselling and inpatient care.

In Nsanje, where we have teams in 10 health facilities, we are supporting the health ministry to increase early access to treatment and decentralised models of care involving the community. Around 25 to 30 per cent of HIV patients seek medical care only when they are already in advanced stages of the disease, increasing the risk of opportunistic infections or even death. The majority are already on ARV treatment yet struggle with daily treatment or have developed resistance to their medication.

Cervical cancer

Cervical cancer accounts for 40 per cent of all cancers among women in Malawi and kills an estimated 2,314 a year. We are developing a comprehensive cervical cancer programme, comprising screening, diagnosis, vaccination, treatment, surgery, chemotherapy, radiotherapy and palliative care.

In 2018, we screened more than 11,000 women in Blantyre and Chiradzulu districts and started building a cervical cancer clinic in Queen Elizabeth hospital, the main university teaching hospital in Malawi. It will open in 2019, with an operating theatre, an 18-bed inpatient ward and a day clinic; services such as vaccinations, chemotherapy and radiotherapy will be added progressively.

Healthcare for prisoners and sex workers

We handed over our HIV, tuberculosis (TB) and primary healthcare services in Maula, Chichiri, Dedza and Kachere prisons to the prison authorities and partner organisations, with an 'operational toolkit' documenting the key components of healthcare provision in a prison setting, so that the model can be implemented elsewhere. Over 400 inmates benefited from our HIV and TB services in 2018.

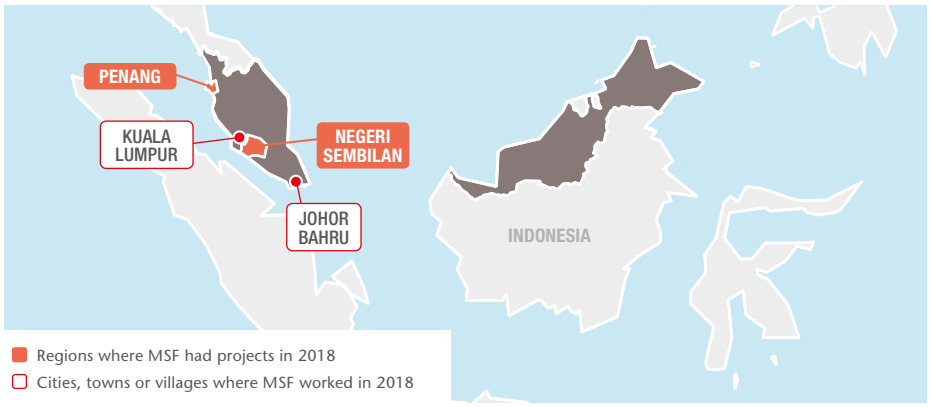
Since 2014, we have also been working to increase access to HIV, TB and sexual and reproductive healthcare services for women engaged in sex work around trade centres and along transport routes in Dedza, Mwanza, Zalewa and Nsanje districts. Our project data has shown that female sex workers are almost six times more likely to contract HIV than other women but face greater challenges in accessing health services. By the end of 2018, 4,784 sex workers had been enrolled in the project, including 850 women living with HIV, of whom 80 per cent are receiving ARV treatment.

MALAYSIA

No. staff in 2018: 44 | Expenditure in 2018: €1.4 million | Year MSF first worked in the country: 2004 | msf.org/malaysia

KEY MEDICAL FIGURE:

6,020 outpatient consultations



Médecins Sans Frontières (MSF) has been providing healthcare to stateless Rohingya and other refugee communities in the Malaysian state of Penang since 2015.

Malaysia is not a signatory to the 1951 UN Refugee Convention, and asylum seekers and refugees are criminalised by domestic law. The constant threat of arrest and detention is a major source of stress for an already vulnerable population; it discourages health-seeking behaviour and can cause patients to abscond from hospital, interrupting treatment.

In 2018, we ran 45 mobile clinics, which together performed a total of 3,500 medical consultations. Our teams also conducted health education sessions in learning centres for refugee children, raising awareness about health issues such as dengue and general personal hygiene, and distributing hygiene kits.

In October we inaugurated a fixed primary healthcare clinic in a Penang neighbourhood where many undocumented migrants and refugees reside. By the end of December, the clinic had already carried out 1,800 consultations and made 113 referrals. In addition, 780 patients received mental health education, psychosocial support and/or counselling.

We also extended our provision of healthcare to at-risk groups such as survivors of human trafficking. Our teams work in five of the government protection shelters for survivors of trafficking in Kuala Lumpur, Negeri Sembilan and Johor Bahru. We run mobile clinics, make referrals to government health services and donate medicines. Having identified a particular gap in mental healthcare, primarily due to the language barriers faced by survivors of trafficking of more than 10 different nationalities, in 2018 we started providing psychosocial and counselling services to survivors in their native languages.

In collaboration with MERCY Malaysia, we conduct regular mobile clinics and carry out water and sanitation improvements in Belantik detention centre in Kedah, northwest of Penang. In December, we jointly organised a symposium on improving access to healthcare for refugees and asylum seekers in Malaysia. The symposium's recommendations were presented to the government and a steering committee will be set up by the Ministry of Health to look into how they can be implemented.

We also continued to address the lack of protection caused by barriers to asylum claims. The UN refugee agency, UNHCR, continues to restrict asylum seekers from Myanmar, including Rohingya, from making direct claims. This applies to approximately 87 per cent of asylum seekers in Malaysia, and prevents them from receiving the documentation they need to reduce the risk of arrest and allow limited access to essential services. For many stateless Rohingya, UNHCR-issued papers will be the only identity documents they possess. A limited number of NGOs can refer asylum claims to the refugee agency based on a set of additional vulnerability criteria; in 2018 we made 612 such referrals.

© Arnaud Finistre

A Rohingya man is examined at the MSF clinic in Penang, Malaysia, in April 2019, following a fall from the second floor while he was working on a construction site.

MEXICO

No. staff in 2018: 188 | Expenditure in 2018: €5.2 million | Year MSF first worked in the country: 1985 | msf.org/mexico

KEY MEDICAL FIGURES:

23,500 outpatient consultations

8,710 individual mental health consultations

In Mexico, Médecins Sans Frontières provides medical and mental healthcare to migrants and refugees on their way north, and to victims of violence in some of the country's most dangerous cities.

We have teams working on Mexico's southern and northern borders, and at various key locations in between, offering medical, psychological and social support to migrants and refugees along the perilous migration route from Central America to the United States. Our projects also assist vulnerable local communities and victims of violence, including sexual violence, in Guerrero state and in the border city of Reynosa.

The perilous journey north

Thousands of people from the Northern Triangle of Central America – El Salvador, Guatemala and Honduras – cross Mexico each year, the vast majority fleeing violence and poverty in their countries of origin. Far from finding security and protection once in Mexico, people on the move face high levels of violence, including kidnappings, extortion, inhumane treatment, abuse, sexual assault and torture at the hands of criminal groups acting with total impunity, especially in cities on the borders. The US government's zero tolerance policies and restrictions on granting asylum, coupled with an increase in 'security' at the border, have only aggravated the crisis.

Although the migratory flows were similar to previous years, in 2018 our teams saw an increase in the number of women, children and families attempting a route traditionally undertaken mostly by men.

In Tenosique, known to be one of the main points of departure for journeys through Mexico, we provided medical, psychological and social assistance to increasing numbers of vulnerable migrants and refugees at Shelter 72.

We have a team offering similar services in La Casa del Migrante in Coatzacoalcos, Veracruz, where each day hundreds of people stop off before continuing north. Most of the health issues we treat are a result of people's arduous journeys, such as respiratory problems, skin infections, foot injuries and trauma from falls. Many of them have also suffered some kind of physical or psychological violence, including sexual violence. In 2018, we installed an additional mobile clinic beside the railway tracks in Coatzacoalcos to cater for migrants waiting to board trains.

In Mexico City, we run a specialised therapeutic centre for migrants and asylum seekers who have been victims of extreme violence or cruel, inhumane or degrading treatment in their country of origin or on their journey. The centre offers patients a safe shelter while they receive medical and mental healthcare. In 2018, we provided 52 patients with a combination of medical and psychiatric or psychological care, as well as accommodation, food and occupational therapy. In addition, we supplied referrals to other organisations for social assistance, legal advice and employment.

© Juan Carlos Tomasi/MSF

A man's feet are examined during a medical consultation at Shelter 72 in Tenosique, Mexico, February 2018.

A patient is treated by one of MSF's mobile clinic teams in a village in Guerrero state, Mexico, February 2018.

In February, we handed over to the local authorities the medical, psychological and social support activities we had been running in a migrant shelter in Guadalajara for the past year.

Tamaulipas borderlands

In Reynosa, a city that has been racked by violence for more than a decade, we continue to offer medical, psychological and social care to victims. We run a fixed clinic and send mobile teams to several parts of the city, including two migrant shelters. In 2018, our teams also began assisting people recently deported from the United States in a reception centre on the border with Texas.

In September, an additional team consisting of a health promoter, a psychologist and a social worker started working at the reception centre for deported people and two migrant shelters in Matamoros, an industrial city on the border with the United States.

At the end of October, we started providing psychosocial support at La Casa Amar and La Casa Nazareth, two shelters for migrants and refugees in Nuevo Laredo, another of Mexico's most dangerous cities. Medical care is also available at La Casa Nazareth.

Guerrero state

We scaled up our activities in the Tierra Caliente, Norte and Centro regions of Guerrero, where violent turf wars between rival opium and marijuana producers affect entire communities, leaving them isolated and unable to access medical care. In collaboration with the Ministry of Health, we run mobile clinics in 26 communities affected by the territorial conflict between criminal groups that produce poppies and marijuana. Our teams offer medical, psychological and humanitarian assistance to victims of violence, as well as treatment for chronic diseases and sexual and reproductive healthcare.

We have also been providing mental health support and psychosocial care for victims of violence in Ciudad Renacimiento, Progreso, Zapata and Colonia Jardín, the most violent neighbourhoods of Acapulco, since 2016. In December, we reduced our activities to focus on treating victims of sexual violence at Renacimiento hospital, in collaboration with the Ministry of Health. However, our team continues to monitor the health situation and is ready to respond to emergencies.

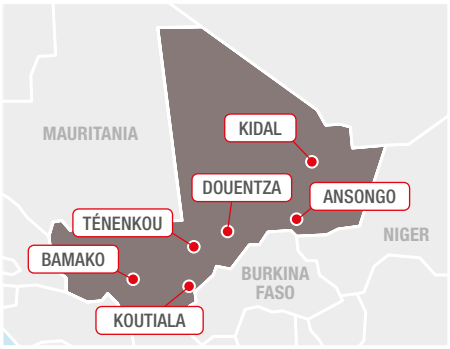
Emergency response

In January, a territorial conflict forced thousands of people from the communities of Chenalhó municipality, Chiapas, to flee to neighbouring Chalchihuitán. We sent a team of eight doctors and psychologists to provide medical care, individual and group mental health consultations and psychosocial support to about 1,000 people.

We also sent an emergency team to assist thousands of migrants and refugees stranded in the border city of Tijuana in December. As well as medical and psychological consultations, our teams carried out water and sanitation activities to improve hygiene conditions in the shelters.

MALI

No. staff in 2018: 794 | Expenditure in 2018: €14.8 million | Year MSF first worked in the country: 1992 | msf.org/mali



Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

261,200 outpatient consultations

116,100 people treated for malaria

19,600 routine vaccinations

4,240 children admitted to inpatient feeding programmes

© Lamine Keita/MSF

Patients and caregivers wait to see MSF doctors during a mobile clinic in Diafarabé, west of Ténenkou, Mali, December 2018.

Insecurity in north and central Mali continued to disrupt healthcare and other public services in 2018, especially in rural areas.

Médecins Sans Frontières is working around the country to improve access to healthcare in both rural communities and urban areas.

Mopti

Central Mali's Mopti region has become increasingly unstable, with frequent outbreaks of violence, both intercommunal and between the military and non-state armed groups. Many aid organisations have stopped working in the region, meaning access to medical assistance is further curtailed.

We have teams working in Douentza and Ténenkou hospitals, and organising referrals from surrounding areas often affected by fighting. In August, we expanded our activities to three health centres in remote areas of Douentza district, and sent 'malaria agents'[1] to hard-to-reach communities in Ténenkou district to support our mobile clinics during the malaria peak, between July and December.

Ansongo

In Ansongo town, Gao region, we support the local hospital with emergency care, surgery, maternal and child healthcare and neonatology. We provide medical and psychological care for victims of violence, including sexual violence, and organise emergency referrals to Gao hospital as required. We also provide care for pregnant women and children under five at a health centre in town.

We run a community-based healthcare programme in several nomadic sites in the surrounding district, to ensure that nomadic communities also have access to healthcare. The focus is on preventing, diagnosing and treating the most common diseases affecting pregnant women and children. We also support the referral of cases from the community to primary health centres.

In April, when more than 700 sub-Saharan migrants expelled from Algeria passed through Gao city, we distributed around 500 hygiene kits and provided psychological assistance to 260 people.

Kidal

North of Gao, we have been supporting the delivery of medical and mental healthcare in Kidal district since 2015, through two health centres in the town and four in the periphery. We also assist with epidemiological surveillance and referrals to Kidal hospital, and run a programme similar to the one in Ansongo to address common diseases affecting pregnant women and under-fives in 30 nomadic camps.

In 2018, we carried out a multi-antigen campaign in partnership with the Ministry of Health and local authorities to vaccinate more than 10,000 children under five throughout the region.

Koutiala

In the south, we support nutrition and paediatric services at Koutiala hospital, where we completed the construction of a new 185-bed paediatric care unit in 2018. In addition, we have teams conducting a range of preventive and curative activities in health centres and communities, especially during the seasonal malaria and malnutrition peaks. By June, we were supporting 37 out of the 42 district health centres, with extra community workers engaged during the malaria peak. Our teams in Koutiala conducted over 160,000 outpatient consultations during the year.

Bamako

In October, we started working with the Ministry of Health on the diagnosis and treatment of cervical and breast cancer. We are supporting the haemato-oncology unit at University Hospital of Point G, including the provision of hospital and home-based palliative care.

[1] *Community health workers trained to test and treat simple malaria, and to refer more severe cases*

MOZAMBIQUE

No. staff in 2018: 430 | Expenditure in 2018: €10.1 million | Year MSF first worked in the country: 1984 | msf.org/mozambique

Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

14,500 people on first-line ARV treatment

240 people started on treatment for TB, including **160** for DR-TB

33 people treated for hepatitis C

© Sanna Gustafsson/MSF

Filipe, a former sex worker recruited as a peer educator, spreads the word about MSF's services in Beira, Mozambique, July 2018.

Over 13 per cent of people aged 15-49 in Mozambique are living with HIV – an estimated 2.1 million individuals – and 34,000 of them are co-infected with tuberculosis (TB).[1]

Mozambique is one of the countries with the highest rates of HIV and TB worldwide. In 2018, Médecins Sans Frontières teams in Maputo and Beira focused on improving the detection and rapid treatment of opportunistic infections among people with advanced HIV, by implementing a specialised package of care and support for people facing the challenge of staying on lifelong treatment or those developing drug resistance.

In Maputo, an MSF feasibility study into the use of liposomal doxorubicin to treat Kaposi's sarcoma, the most frequent cancer affecting people with advanced HIV, showed better outcomes than other available treatments. We treated over 240 patients with this newer drug in 2018 and started advocating to push down the price and get the national treatment guidelines updated.

We started 160 people on treatment for drug-resistant TB (DR-TB) in six health centres in Maputo in 2018; 70 per cent of those patients received less toxic, injection-free treatments. Preliminary positive results from an MSF feasibility study into DR-TB short regimens enabled the Ministry of Health to adopt them as national policy in June.

We partnered with a local organisation to open a drop-in centre for people who use drugs in Maputo. The centre, which offers testing and treatment for HIV, TB and hepatitis C, and comprehensive harm reduction services, including a needles and syringes distribution programme, received around 100 visitors a day.

We also launched a pilot project to prevent mother-to-child transmission of hepatitis B in one of the biggest hospitals in Maputo.

In Beira, as part of our project for key populations, teams offered sexual and reproductive healthcare, including HIV testing and treatment, to vulnerable and stigmatised groups such as sex workers and men who have sex with men. Around 300 people were enrolled in a pre-exposure prophylaxis study to prevent them from contracting HIV.

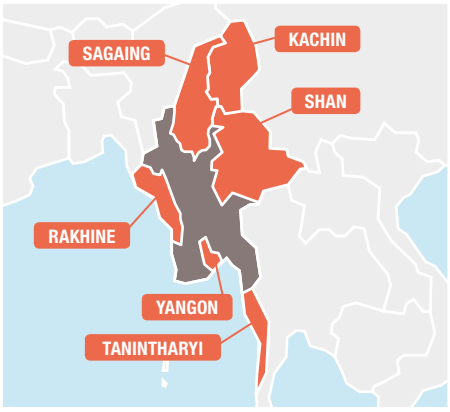
We also ran sexual and reproductive health services for girls and women at a local health centre, where we offer safe abortion care to reduce high mortality rates and suffering seen among women and girls without access to such services.

In 2018, we handed over our HIV project in Tete to the Ministry of Health. For 16 years, our teams in Tete had been working on innovative approaches to scale up HIV care, including community antiretroviral (ARV) treatment groups and a community initiative to monitor and address supply issues around HIV and TB drugs.

[1] *WHO Global Tuberculosis Report 2018*

MYANMAR

No. staff in 2018: 1,115 | Expenditure in 2018: €15.1 million | Year MSF first worked in the country: 1992 | msf.org/myanmar



Regions where MSF had projects in 2018

KEY MEDICAL FIGURES:

55,500 outpatient consultations

20,500 people on first-line ARV treatment

770 people started on treatment for TB

110 people treated for hepatitis C

© Scott Hamilton/MSF

MSF's mobile medical unit take a break on their way back to Lahe town, in Naga, Myanmar, February 2019.

In 2018, the Myanmar government continued to refuse humanitarian access to conflict-affected areas and forcibly displaced people, thus limiting where Médecins Sans Frontières (MSF) could deliver medical assistance.

Very few humanitarian organisations were permitted access to northern Rakhine in 2018, and fewer still received authorisation to provide aid. Despite repeated requests, our team in Maungdaw was not allowed to resume medical activities, apart from some HIV counselling support in two government hospitals from July.

Our mobile teams based in Sittwe, central Rakhine, continued to offer primary healthcare and arrange emergency referrals for patients from all communities. In 2018, we established a new mental health programme, in which MSF staff made weekly visits to camps in Pauktaw township, where Kaman and Rohingya Muslims have been effectively detained since 2012, when they were displaced by violence. These services were also provided in Aung Mingalar, a closed Muslim ghetto in Sittwe town, and ethnic Rakhine villages in Sittwe and Ponnagyun townships.

Plans to repatriate Rohingya refugees from Bangladesh in November did not proceed as none were willing to return to Myanmar. We remain concerned about the medical status and living conditions of those still in Rakhine, and in August reiterated our calls for the authorities to allow international aid organisations unfettered access and the freedom to conduct an independent needs assessment.

HIV care

Once the largest provider of HIV treatment in Myanmar, MSF continues to work closely with the Ministry of Health and Sports to transfer patients to the decentralised National AIDS Programme so they can receive care closer to home. This includes patients on treatment for co-infections such as hepatitis C, tuberculosis (TB) and multidrug-resistant TB (MDR-TB).

Patients were transferred from our projects in Yangon, Shan, Kachin and Dawei (Tanintharyi). In Yangon alone, we managed the transfer of 6,000 patients in 2018, enabling our teams to provide comprehensive care to our remaining patients and focus on health outreach, education and peer-to-peer counselling in an effort to prevent the spread of HIV. We targeted groups vulnerable to infection, such as the fishing community and migrant workers in Dawei, and sex workers, drug users and migrants in Shan and Kachin. In these two states, protracted conflict and mass displacement create additional barriers to obtaining medical care.

By December, we were still providing treatment to a total of 2,270 patients living with HIV in Dawei, where we have also been screening and treating hepatitis C since 2017. Almost 90 per cent of our patients co-infected with hepatitis C received treatment with highly effective direct-acting antivirals in 2018.

Basic healthcare in Naga

We have mobile teams in Naga, Sagaing, a remote, mountainous region in northern Myanmar, where communities have limited access to basic healthcare, especially during the rainy season, when some may be completely inaccessible for months. Travelling up to eight hours by motorcycle to reach the most distant villages, often on hazardous muddy paths, our teams conducted almost 8,500 medical consultations in 2018, and supported the Ministry of Health with vaccination campaigns and TB detection and screening.

NAURU

No. staff in 2018: 16 | Expenditure in 2018: €1.2 million | Year MSF first worked in the country: 2017 | msf.org/nauru

KEY MEDICAL FIGURE:

2,280 individual mental health consultations

Médecins Sans Frontières (MSF) was forced to abruptly abandon hundreds of vulnerable patients when informed by the Nauruan government that our services were "no longer required".

In November 2017, under a formal agreement with the Nauruan Ministry of Health, we started providing free psychological and psychiatric care to Nauruan nationals, as well as asylum seekers and refugees sent to the island as a result of the Australian policy of offshore processing.

Under this policy, asylum seekers who attempt to reach Australia by boat are sent to remote Pacific islands to have their asylum application processed. When we started our activities, many of them had spent more than five years on Nauru and had lost any hope of being resettled elsewhere.

After 11 months of intervention and without warning, the Nauruan government informed us in October that our services were no longer required and must cease within 24 hours, suddenly leaving hundreds of patients in desperate need of care.

In December, we published the first independent report demonstrating the scale of the mental health emergency. Almost half of our Nauruan patients required treatment for psychosis. Of the refugees and asylum seekers we treated, 30 per cent had attempted suicide and 60 per cent had considered it. Strikingly, while most Nauruan patients improved under MSF's care, only 11 per cent of refugee and asylum seeker patients did, demonstrating a link between their indefinite containment and the deterioration of their mental health. These findings pushed MSF to publicly call for an end to Australia's offshore processing policy and for the immediate evacuation of all refugees and asylum seekers to a place of safety where they can have fast access to permanent resettlement.

NICARAGUA

No. staff in 2018: 10 | Expenditure in 2018: €0.6 million
Year MSF first worked in the country: 1972 | msf.org/nicaragua

In 2018, Médecins Sans Frontières returned to Nicaragua to offer psychosocial support to people affected by violence resulting from civil and political unrest.

Starting in June, our teams provided mental healthcare to 698 patients, most of them suffering from conditions such as anxiety, adjustment disorder and post-traumatic stress as a result of having witnessed or experienced violent events.

We conducted initial consultations and follow-up sessions with individuals and families in the capital, Managua, as well as in Masaya, Jinotepe, León, Jinotega, and Matagalpa.

In addition, we provided basic training in mental healthcare, psychological first aid and self-care to community leaders and educators, to enable them to give psychological support to others in crisis situations, and to manage the physical and psychological impact on themselves.

We also trained 559 psychologists and health professionals to identify trauma and to detect the signs and symptoms of violence and traumatic grief, including in minors. The training better equipped them not only to diagnose but also to intervene and care for victims of violence.

According to figures from the UN refugee agency, UNHCR, by the end of 2018, 18,632 Nicaraguans had registered asylum claims in Costa Rica.[1] We therefore extended our training to clinical psychologists and organisations in Costa Rica, to support their provision of mental healthcare to Nicaraguans who have crossed the border.

[1] *UNHCR, Nicaragua Situation Fact Sheet, November 2018*

☐ Cities, towns or villages where MSF worked in 2018

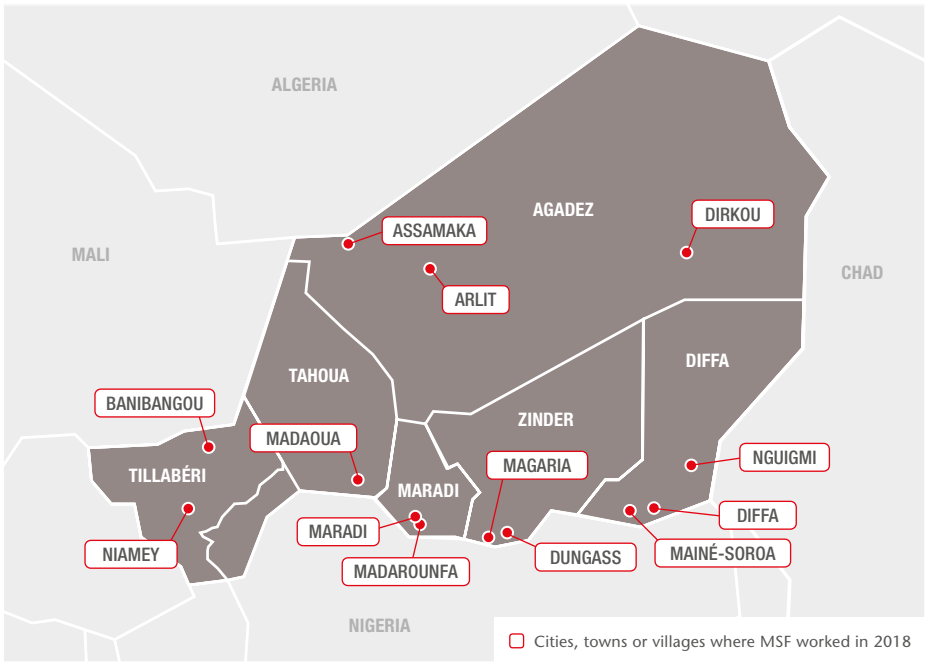
KEY MEDICAL FIGURES:

1,080 individual mental health consultations

76 group mental health sessions

NIGER

No. staff in 2018: 2,157 | Expenditure in 2018: €31.6 million | Year MSF first worked in the country: 1985 | msf.org/niger



KEY MEDICAL FIGURES:

589,100 outpatient consultations

173,200 people treated for malaria

86,300 people admitted to hospital, including **59,500** children aged under five

22,200 children admitted to inpatient feeding programmes, and **42,300** treated in outpatient programmes

10,500 births assisted

Médecins Sans Frontières focuses on improving paediatric care and reducing child mortality in Niger, particularly during the annual malnutrition and malaria peaks.

In 2018, we also responded to disease outbreaks and helped improve vaccination coverage, while increasing the assistance we provide to victims of violence and displacement, migrants and host communities.

Responding to emergencies

We continued to support the health services with vaccinations, epidemiological surveillance and emergency interventions to tackle disease outbreaks across Niger. To curb meningitis and measles epidemics in Tahoua and Agadez regions, we vaccinated almost 262,000 people. Between July and October, we treated over 2,500 patients during a cholera epidemic in Maradi and Tahoua regions. When the outbreak began to ebb, we supported the preventive vaccination of 167,000 people in high-risk areas.

In addition, our emergency teams distributed relief kits to over 5,000 people displaced by flooding or violence in Niamey, Tillabéri, Agadez, Tahoua and Diffa. They also provided mental health support to 423 individuals, to help them overcome the trauma they experienced.

Diffa region

After four years of armed conflict, 250,000 refugees and internally displaced people are still living in dire conditions in Diffa's informal camps. Insecurity and a lack of resources have also had a devastating impact on local communities.

In 2018, our teams worked in the main maternal and paediatric hospital in Diffa town, the district hospitals in Nguigmi, Chetimari and Mainé-Soroa, and several health centres and health posts across the region. In Mainé-Soroa, we developed cross-border activities to provide access to healthcare for local people and nomadic communities living between Niger and

MSF paediatrician Dr Nicolas Peyraud examines a patient in the intensive care unit in Magaria district hospital, Niger, September 2018.

the northernmost fringes of Nigeria's Yobe state. Our teams also ran numerous mobile clinics and one-off interventions in areas where the presence of armed groups restricts people's movements and the delivery of humanitarian assistance.

The mental health needs of children and adolescents traumatised by conflict are often overlooked. We run a mental health and psychosocial programme, through which we have trained 100 community workers to identify symptoms of psychological problems, particularly in young people. This has vastly increased the number of children we have been able to assist: our teams conducted almost 13,000 individual consultations in 2018, and by the end of the year over 30 per cent of patients were children aged under 14.

Zinder region

Our teams in Zinder region focus on treating children under five for severe acute malnutrition and common childhood diseases. In 2018, we supported the paediatric unit in Magaria district hospital and 11 health centres, as well as 14 health posts across the region during the seasonal malaria and malnutrition peaks. We also developed community outreach activities, including awareness raising sessions, active case finding and an initiative training parents to use mid-upper arm circumference (MUAC) measuring tapes to screen their children for malnutrition.

In 2018, we admitted more than 22,000 under-fives to the paediatric unit in Magaria – twice as many as in previous years. We also conducted 127,500 outpatient consultations for children under five and treated 20,900 children in our outpatient feeding programme, almost half of them between August and October. We reached a point when we admitted more than 1,000 children to hospital in one day, including over 250 children requiring intensive care.

We also assisted the Ministry of Public Health with seasonal malaria chemoprevention activities, carrying out more than 18,000 rapid tests and providing treatment to the 12,200 children who tested positive.

Maradi region

We run another paediatric programme aimed at reducing child mortality in Madarounfa. It comprises inpatient care for severe malnutrition, malaria and other diseases affecting children under five in the district hospital, and outpatient treatment for uncomplicated malnutrition in the surrounding health zones.

© Elise Mertens/MSF

Samira, a community volunteer, explains to mothers how to use mid-upper arm circumference measuring tape to screen their children for malnutrition in Magaria health zone, Niger, May 2018.

From September, we improved active case finding of children with malnutrition by using community health workers to show mothers how to use MUAC tapes. Through this activity, 253 new cases were identified by the end of the year. MSF-supported community health workers also screened more than 29,800 people for malaria, over 80 per cent of whom tested positive and received treatment.

Due to its proximity to the border, the project receives many patients from Nigeria – they account for up to 30 per cent of malnutrition cases. In early 2018, we started actively searching on both sides of the border for children who had abandoned nutrition treatment prematurely.

Tahoua region

We have been running the inpatient therapeutic feeding centre and paediatric and neonatal units in Madaoua district hospital since 2006. In May 2018, we started supporting outpatient feeding centres and paediatric services in Madaoua and Sabon-Guida health centres. To reduce maternal mortality, we also had teams working in the maternity ward in Madaoua, and on a sexual and reproductive healthcare programme in Sabon-Guida.

The results of a nutritional and retrospective mortality study we conducted indicated that the situation had stabilised in Madaoua and Sabon-Guida. Based on this and the Ministry of Public Health's increased capacity, in December we announced our gradual withdrawal from both locations.

Migrants, refugees and host communities

Niger is a major transit country for migrants, asylum seekers and refugees, including people expelled from Algeria, returned from Libya or travelling north towards Europe. These people often face abuse and exclusion.

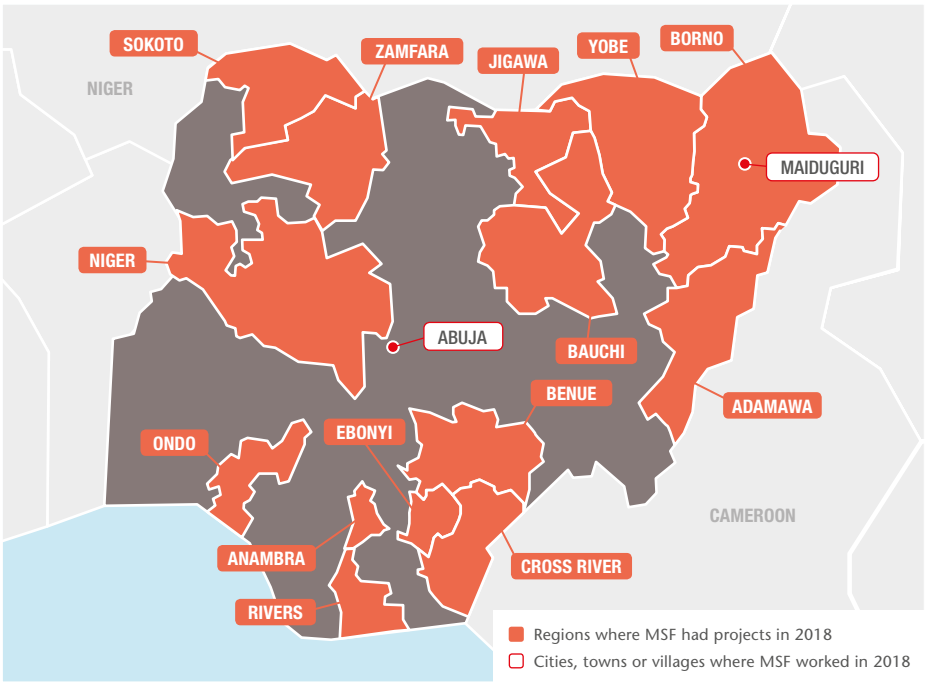
In 2018, we offered medical care in Niamey and in the region of Agadez, both of which are at the crossroads of migration routes. Our team in Niamey carried out over 5,000 consultations in fixed and mobile clinics. Across Agadez – in Tabelot, Séguédine, Anaye and Dirkou – we supported primary, reproductive and emergency healthcare and referrals for migrants and local communities. In Arlit health centre, we provided mental healthcare and organised referrals to Arlit hospital.

In the border village of Assamaka, we provided 1,960 people expelled from Algeria with medical and mental health consultations and distributed relief kits.

In Tillabéri, we reopened inactive primary health centres and ran mobile clinics for local communities and people displaced by interethnic tensions and conflicts in neighbouring Mali and Burkina Faso. We distributed relief kits to 225 families and offered essential medical assistance such as vaccinations, malnutrition screening and reproductive healthcare services.

NIGERIA

No. staff in 2018: 2,365 | Expenditure in 2018: €44.9 million | Year MSF first worked in the country: 1996 | msf.org/nigeria



KEY MEDICAL FIGURES:

334,300 outpatient consultations

60,200 people admitted to hospital

41,300 people treated for malaria

26,900 people treated for cholera

15,400 births assisted

12,800 individual mental health consultations

The conflict in northeast Nigeria showed no signs of abating in 2018, while insecurity and violence escalated across the middle of the country and in the northwest too.

By the end of the year, 1.9 million people were internally displaced and 7.7 million were in need of humanitarian assistance in northeast Nigeria.[1] Médecins Sans Frontières (MSF) continued to assist people affected by the violence in Borno and Yobe states throughout 2018, while maintaining a range of basic and specialist healthcare programmes and responding to other emergencies across the country.

Vital medical assistance in the northeast

Almost a decade of conflict between the military and non-state armed groups have taken a heavy toll on people in northeast Nigeria. Many thousands have been killed or have died of malnutrition and easily treatable diseases such as malaria due to a lack of healthcare. MSF and other NGOs have been working to fill gaps in services, but their access is frequently hampered by insecurity. According to the United Nations refugee agency, UNHCR, there were up to 230,000 people newly displaced in the last quarter of 2018 alone, and 800,000 remained out of the reach of aid organisations.

Assistance is mostly concentrated in Maiduguri, the capital of Borno state, which hosts one million displaced people, but even here, services remain inadequate. Outside Maiduguri, people living in towns or enclaves controlled by the military are unable to farm or fish, due to restrictions on their movements. And humanitarian assistance cannot be delivered to people living in areas controlled by non-state armed groups.

© Albert Masias

MSF water and sanitation experts install a hand-operated water pump at Abgokim clinic in Cross River state, Nigeria, November 2018.

Internally displaced people find shelter in Monguno, northeast Nigeria, January 2018.

We have teams in various locations around Borno and Yobe states, supporting emergency rooms, operating theatres, maternity and paediatric wards and other inpatient departments, carrying out nutrition programmes and vaccination campaigns, and offering mental healthcare, reproductive health services, support to victims of violence, including sexual violence, and HIV testing and treatment. We also support emergency referrals to Maiduguri, and monitor food, water and shelter needs among the displaced.

In 2018, we ran fixed primary healthcare facilities in Maiduguri, Ngala, Rann, Banki and Pulka, secondary healthcare facilities in Pulka and Gwoza, and paediatric hospitals in Maiduguri and Damaturu, as well as in Monguno, until activities were handed over in July, and in Bama as of August. We also ran mobile clinics on an ad hoc basis in Gajigana, Gajiram and Kukawa.

During the year, our teams conducted over 247,400 outpatient consultations, assisted more than 5,000 births, treated 15,700 children for malnutrition and 27,400 people for malaria.

Emergency response to disease outbreaks and displacement

In March, in response to one of Nigeria's largest ever Lassa fever outbreaks, we sent a team to support the 700-bed federal teaching hospital in Abakaliki, Ebonyi state. We improved infection prevention and control measures, strengthened surveillance and case notification systems, and provided clinical management and operational research to help tackle this poorly understood and neglected viral haemorrhagic disease. We also supported Akure general hospital and nine health centres in Ondo state during the epidemic.

We responded to cholera outbreaks in Borno, Yobe, Adamawa, Bauchi and Zamfara states, treating a total of 26,900 people. We supported the Ministry of Health to implement an oral cholera vaccination campaign in Bauchi state, and vaccinated 332,700 people in Borno and Yobe states.

As political violence escalated in Cameroon's Southwest and Northwest regions, more than 30,000 people fled into Nigeria. In June, we launched an emergency intervention in Cross River state to provide medical care and clean water to refugees and host communities. By the end of the year, the teams had conducted over 7,100 medical consultations.

In neighbouring Benue state, hundreds of thousands of people have been displaced by interethnic conflict over natural resources. In February, we responded by setting up healthcare services in Makurdi, Logo and Guma camps, and conducting water and sanitation activities.

Healthcare for women and children

Reducing maternal and neonatal mortality is a priority for MSF throughout the country. As well as running paediatric hospitals in Maiduguri, Damaturu and Monguno, then Bama, in the northeast in 2018, we continued to provide comprehensive emergency obstetric and neonatal care in Jahun general hospital, Jigawa state.

In 2018, 63 per cent of the 16,000 pregnant women admitted to Jahun hospital had complications. A specialised team performed 267 vesico-vaginal surgeries on women with obstetric fistula, a condition resulting from prolonged or obstructed labour. Basic emergency obstetric and neonatal care is also available at three heath centres we support in the area.

We have teams working in two clinics in Port Harcourt, offering medical care and psychosocial support to an increasing number of victims of sexual violence. Over 1,400 people were treated in 2018, 61 per cent of whom were under 18.

In December, we closed our project in Anambra state, where we had been supporting malaria testing and treatment in a primary healthcare centre and seven health posts in Okpoko township since November 2017. In that time, almost 6,000 people were tested for malaria and 3,500 received treatment, including 2,900 in 2018 alone. The majority were pregnant women and children under five.

In Sokoto, we continue to support Noma Children's Hospital, the main facility in the country specialising in noma, a facial gangrene infection that affects children in particular. In 2018, our teams performed 150 surgeries on 117 patients, as well as providing mental healthcare services and community outreach, surveillance, awareness-raising and health promotion.

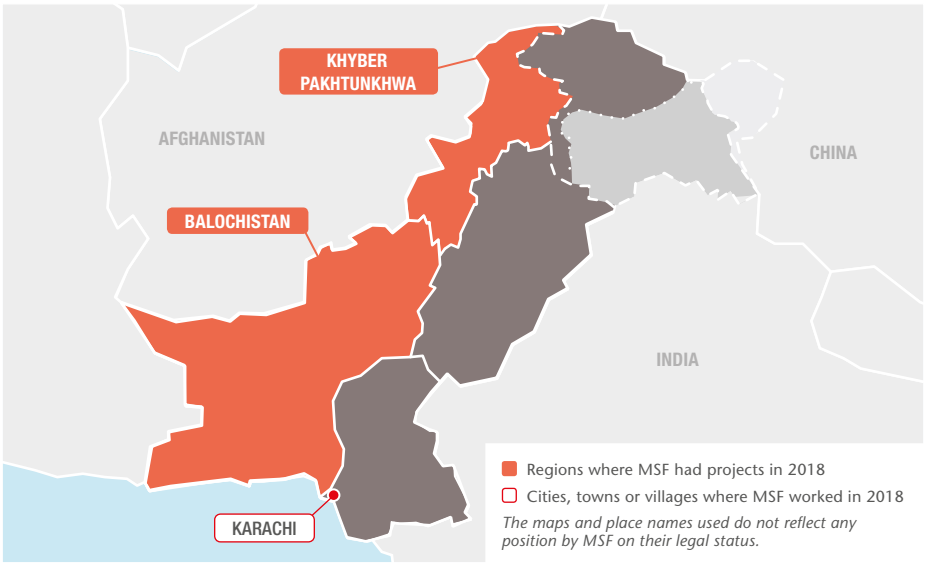
Since 2010, we have also been treating children aged under five for lead poisoning associated with artisanal gold mining in Zamfara state. Our teams work in the 99-bed paediatric ward of Anka general hospital and in five outreach clinics in the surrounding area. In 2018, we treated around 800 patients a month. We set up a similar project for lead-poisoned children in Rafi, Niger state, in 2015. This was handed over to the national health authorities midway through 2018.

MSF and the Ministry of Health organised two medical conferences in 2018, one on noma, the other on lead poisoning, in both cases to raise awareness and increase government attention, with a particular focus on prevention.

[1] *UN Office for the Coordination of Humanitarian Affairs and UNHCR*

PAKISTAN

No. staff in 2018: 1,423 | Expenditure in 2018: €17.5 million | Year MSF first worked in the country: 1986 | msf.org/pakistan



KEY MEDICAL FIGURES:

269,200 outpatient consultations

29,600 births assisted, including **2,910** caesarean sections

10,900 children treated in outpatient feeding programmes

1,150 people treated for hepatitis C

Mother and child health remains a focus for Médecins Sans Frontières in Pakistan, where access to healthcare is challenging, especially in isolated rural communities and urban slums.

Pregnant women die from preventable complications during pregnancy and delivery, and newborn care is unavailable in many parts of the country; even where it is available, many cannot afford it.

Mother and child health in Balochistan

In Chaman district headquarters hospital, near the border with Afghanistan, our teams work with the Ministry of Health to provide reproductive, neonatal and paediatric healthcare. We also manage trauma cases in the emergency room and offer inpatient and outpatient nutritional support for malnourished children under the age of five. These services are available to local residents, Afghan refugees and people who cross the border seeking medical assistance.

In Kuchlak, a town in Quetta district that is home to a large number of Afghan refugees, we manage a health centre offering outpatient treatment for children, including nutritional support for children under the age of five, wound dressing services for children under 12, 24-hour basic emergency obstetric care and psychosocial counselling. Patients with emergency obstetric complications are referred to Quetta.

We also support an inpatient therapeutic feeding programme for severely malnourished children, the general paediatric and neonatal wards, and reproductive healthcare in Dera Murad Jamali district headquarters hospital. We set up a water treatment plant at the hospital to ensure availability of clean water for patients, their caregivers and medical staff. In the eastern districts of Jaffarabad and Naseerabad, our teams treated over 9,000 malnourished children through a network of outreach sites and mobile clinics.

Emergency, maternal and neonatal care in Khyber Pakhtunkhwa

Around 75 per cent of the patients at the women's hospital in Peshawar come from rural areas of the district and what were previously known as the Federally Administered Tribal Areas. Neonatal mortality rates are high, and we focus on high-risk pregnancies and people with reduced access to care. We also provide comprehensive 24-hour emergency obstetric care. In 2018, our team assisted almost 4,900 births and admitted 600 newborns to the neonatal unit.

In Timergara, around 200 kilometres north of Peshawar, we support the district headquarters hospital's emergency department and offer comprehensive emergency obstetric and neonatal care. Our team assisted 13,750 births and treated 178,980 patients in the emergency room in 2018. The 'kangaroo mother care' unit, where the mother's body acts as a natural incubator, was expanded from eight to 14 beds. In response to a large outbreak of diarrhoeal disease early in the year, we set up a treatment centre at the hospital. By July, we had treated over 4,100 people. Since May, MSF international staff have had only intermittent access to the project in Timergara. At the end of the year, the teams were still awaiting permission from the authorities to be present permanently.

Cutaneous leishmaniasis

In May, we opened our fourth cutaneous leishmaniasis treatment centre in Pakistan. Cutaneous leishmaniasis is a neglected tropical disease that is endemic in Pakistan. Transmitted by the bite of a sandfly, it is characterised by disfiguring and painful skin lesions. Although not fatal, it often results in stigma and discrimination, affecting patients' daily life and mental health. The new centre, in Peshawar, was soon working at full capacity, showing the growing need for cutaneous leishmaniasis treatment in the region. By the end of the year, we had treated 1,380 patients. As well as safe and effective medication, we offered mental health support and raised awareness about treatment and prevention. Our teams also treated 3,770 patients for the disease in three locations in Quetta district,

Balochistan: Kuchlak maternal and child health centre; Bolan medical complex; and Benazir Bhutto hospital.

Hepatitis C

Since 2012, we have been running a clinic in Machar Colony, a densely populated slum in Karachi, where around 150,000 people live in unsanitary conditions with little access to clean drinking water. In 2018, we decided to close our outpatient department and birthing unit as these services are available at another facility nearby, and focus on diagnosing and treating hepatitis C, a major health concern in Pakistan: it has the second-highest prevalence of the disease in the world. In 2018, we started 1,146 patients on treatment; by the end of the year, 878 had completed treatment. Our team also offered patient counselling and ran health education activities. Preparations were made to expand the programme into Balochistan in 2019.

© Khaula Jamil

MSF dermatologist Dr Shakeel Ashraf examines a child for cutaneous leishmaniasis at Benazir Bhutto hospital in Quetta, Pakistan, October 2018.

PAPUA NEW GUINEA

No. staff in 2018: 175 | Expenditure in 2018: €4.6 million | Year MSF first worked in the country: 1992 | msf.org/papua-new-guinea

Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

16,500 outpatient consultations

1,720 people started on treatment for TB, including **62** for MDR-TB

Tuberculosis (TB), the second-highest cause of mortality in Papua New Guinea, remained a key challenge for the country's health services and the focus for Médecins Sans Frontières (MSF) in 2018.

In collaboration with the national TB programme, we are working to improve screening, diagnosis, treatment initiation and follow-up at Gerehu hospital in Port Moresby, the capital, and in the city of Kerema in Gulf province.

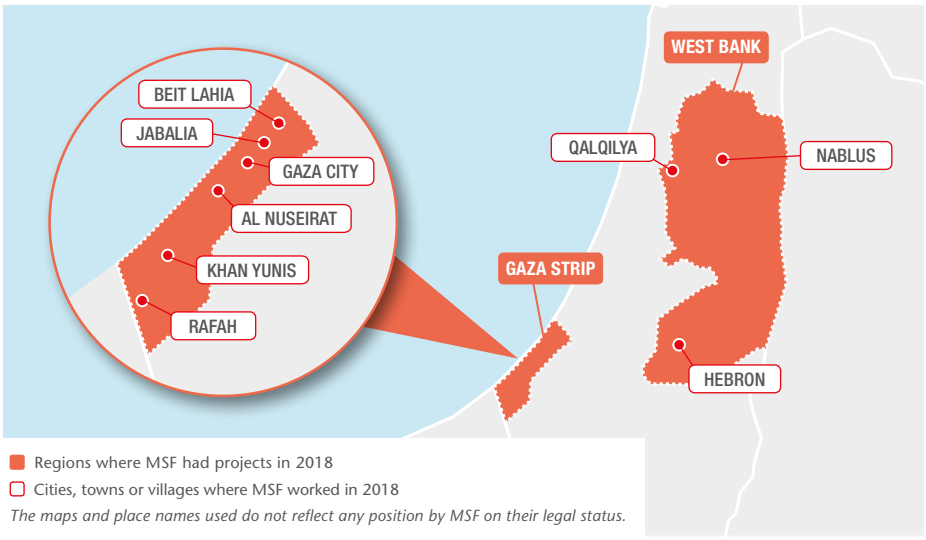
In 2018, our priority was to improve patient care, adherence to treatment and treatment success rates. With this in mind, we started discussions with the Ministry of Health on the implementation of the World Health Organization's new treatment recommendations.

The team in Port Moresby worked on patient follow-up and outreach activities to encourage, facilitate and improve adherence to treatment. Our patient numbers increased over the course of the year, suggesting growing acceptance of MSF, while at the same time revealing the lack of screening and diagnostic services in the capital.

We also scaled up our mobile activities, running clinics in remote areas in Gulf province and providing better access to diagnosis and treatment for patients previously excluded from these services for geographical, economic or cultural reasons. The decentralised model of care means that patients do not need to come to a medical facility so frequently. We also introduced improvements in quality of care, with the integration of HIV testing, greater emphasis on counselling and closer monitoring of patients, their treatments and any side effects.

PALESTINE

No. staff in 2018: 244 | Expenditure in 2018: €11.6 million | Year MSF first worked in the country: 1989 | msf.org/palestine



Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018
The maps and place names used do not reflect any position by MSF on their legal status.

KEY MEDICAL FIGURES:

196,600 outpatient consultations

6,320 individual mental health consultations and **850** group sessions

3,180 major surgical interventions

In 2018, Médecins Sans Frontières (MSF) provided specialist surgical and post-operative care to huge numbers of patients with complex gunshot injuries in Gaza, and responded to growing mental health needs in the West Bank.

Gaza's fragile health system was overwhelmed by the number of people returning from protests with complex gunshot wounds throughout much of 2018. We drastically scaled up our operations in response to the needs of these severely injured patients, while continuing to run clinics for burns patients in the blockaded enclave and provide mental healthcare in the West Bank.

Gaza

According to the World Health Organization, 6,239 people were injured by Israeli army bullets during protests along the fence that separates Gaza from Israel between 30 March and 31 December. Nearly 90 per cent of these injuries were to lower limbs. Half were open fractures, often with serious damage to the bone; many of the others involved severe tissue loss and extensive damage to the nerves and vascular system.

These are complex and severe injuries that require long and careful follow-up. While MSF and other medical organisations provided initial lifesaving surgery for some of the wounded, the Ministry of Health provided the first line of response in most cases, stopping the bleeding and fitting external fixators for patients with more severe or complex fractures. After being discharged, many were admitted to our care for further surgery to clean and close large, open wounds and perform regular dressing changes.

Bone infection is a risk for many of the patients with open fractures: experience from MSF projects in other Middle Eastern conflict areas suggests that between 25 and 40 per cent may be affected. The lack of laboratory capacity in Gaza means it is not possible to adequately test for infections in most patients. And yet it is only once a wound is stabilised and free of infection that the process of rebuilding the bone can begin. Afterwards, these patients will continue to require long periods of care and physiotherapy to return function to badly damaged limbs.

By the end of the year, we were running five clinics, offering wound dressings, physiotherapy and pain management. We also increased our surgical capacity, opening an inpatient department for our surgical patients in Al Awda hospital in Jabalia, and performing plastic and orthopaedic surgery in Al Shifa and Dar Al Salam hospitals.

© Laurie Bonnaud/MSF

A patient with a gunshot injury receives physiotherapy in Gaza, May 2018.

© Alva Simpson White/MSF

A mental health awareness session is held in Qalqilya, in the West Bank, August 2018, where parents, guardians and young people of all ages come to play, chat and have open conversations about mental health.

We made a number of emergency surgical interventions in other hospitals and clinics throughout the year to address the growing demand for care for the wounded. We ran a surgical programme in Yousef al-Najjar hospital from July to December and sent vascular surgeons to Al Aqsa hospital between April and June.

By 31 December, we had received over 8,000 patients in our post-operative clinics, including 3,780 trauma patients. Our teams changed 107,140 dressings, conducted almost 66,000 physiotherapy sessions and operated on over 1,500 trauma patients, performing 2,320 surgical interventions. In December, we were still following up 900 trauma patients.

Despite the huge increase in our activities, the Gazan health system, already crippled by over 10 years of blockade, remains unable to cope with the large number of patients with complex injuries. It is therefore possible that a lack of capacity for reconstructive surgery, and the inability to prevent and treat bone infections, will lead to a wave of delayed amputations.

In addition to our work with trauma patients, we admitted 4,475 burns patients to our post-operative clinics in 2018, carrying out surgical procedures on 129 of them. The number of admissions was stable compared with 2017 but more than twice as many as in 2015.

The West Bank

We continue to run mental healthcare programmes in the West Bank, where the ongoing occupation, violence and socioeconomic insecurity have taken a severe toll on residents.

In 2018, we refocused our mental health support for victims of political violence in Hebron around a strategy of increased engagement with the community in the form of outreach activities. This support was delivered against a backdrop of increasing violence by Israeli settlers towards Palestinians. Hebron is one of the locations in which attacks most frequently occur, and most of our patients there had been directly or indirectly exposed to violence: their house may have been raided by the armed forces, or a family member detained, arrested, injured or killed. They suffered from anxiety, depression and adjustment disorders as a result.

In 2018, our teams in Hebron offered psychotherapy, individual and family counselling, mental health awareness sessions and psychoeducational support. More than 1,400 people received psychological first aid, 370 benefited from psychotherapy or counselling, and 8,800 attended group activities over the year.

We also provide mental healthcare for people with various moderate to severe mental health issues in the cities and villages of Nablus and Qalqilya governorates. The main illness we see here is moderate to severe depression, which accounts for 40 per cent of cases and can in many cases be attributed to the occupation and the tensions and violence it creates. However, in 2018 our teams received an increasing number of cases of dysfunctional family and domestic violence, which also have a serious impact on mental health. We ran a total of 2,520 psychotherapy sessions in Nablus and Qalqilya throughout the year and admitted 284 new patients for care; 40 per cent of our patients were under 18 years old.

PHILIPPINES

No. staff in 2018: 39 | Expenditure in 2018: €2.1 million | Year MSF first worked in the country: 1987 | msf.org/philippines

Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

16,900 outpatient consultations

1,330 antenatal consultations

In the Philippines, Médecins Sans Frontières focused on improving access to sexual and reproductive healthcare for slum dwellers in Manila, and supporting internally displaced people and returnees in post-conflict Mindanao.

In 2018, we continued to work with Likhaan, a local organisation, to provide comprehensive sexual and reproductive healthcare in the slums of San Andres and Tondo. Our services are aimed at young women in particular, as they are among the most vulnerable and have significant healthcare needs.

We offer family planning, ante- and postnatal care, management of sexually transmitted infections and screening and treatment for cervical cancer. Although victims of sexual violence are stigmatised in the Philippines, we have seen a steady increase in the number presenting at our clinic for treatment. In addition, our teams operate a mobile clinic four times a week, mainly in Tondo, the capital's largest and most densely populated slum, to reach patients unable to access the fixed clinic.

Our teams in Manila conducted 12,400 family planning sessions and screened 3,630 women for cervical cancer over the course of the year.

In 2018, we also had a team in Marawi city, in the Autonomous Region in Muslim Mindanao (ARMM), the region with the poorest health indicators in the Philippines, where violent confrontations are frequent. A five-month battle for control of Marawi in 2017 destroyed over 70 per cent of the city's health facilities and left around 200,000 internally displaced people and returnees without access to basic healthcare. In 2018, we ran a measles vaccination campaign, then focused on water and sanitation needs, building latrines and water access points. In October, we started supporting the outpatient department and emergency room of one of the few remaining health centres in Marawi.

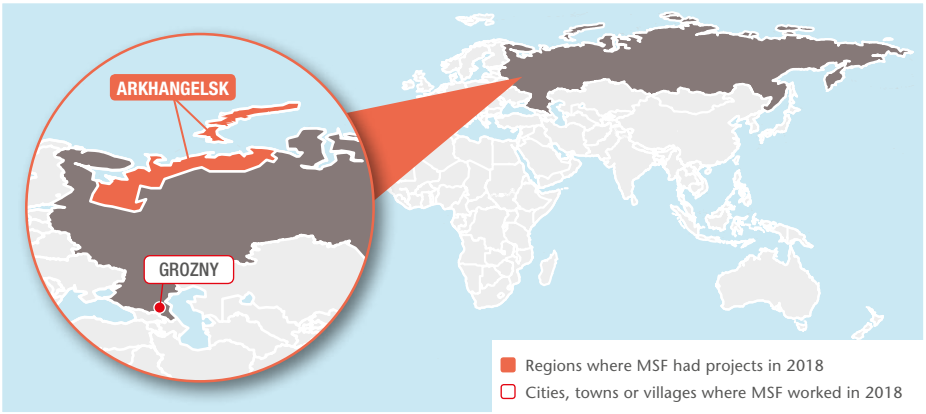
RUSSIAN FEDERATION

No. staff in 2018: 31 | Expenditure in 2018: €2.6 million | Year MSF first worked in the country: 1992 | msf.org/russian-federation

In 2018, Médecins Sans Frontières (MSF) handed over tuberculosis (TB) activities in Chechnya and started a new collaboration in northwest Russia.

In May 2018, MSF signed a memorandum of understanding with the regional Ministry of Health of Arkhangelsk oblast. Our aim is to support the Ministry and the Northern State Medical University in assessing the effectiveness of shorter treatment regimens for patients with multidrug-resistant and extensively drug-resistant TB. The outcomes will provide evidence for future developments in TB policy in Russia and make more effective models of treatment available to more people.

In Chechnya, we successfully completed the handover of our TB programme to the Ministry of Health in May, providing assistance to the laboratory in Grozny to ensure a smooth transition and making a donation of drugs and diagnostic materials to support the ongoing treatment of approximately 70 patients recruited over the previous two years.



Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

We set up the programme in Chechnya in 2004 to treat patients with drug-sensitive TB in close cooperation with the Chechen Ministry of Health. In 2012, the programme changed its focus to drug-resistant TB patients, in response to the evident needs. Our Chechen patients were among the first to have access to the latest TB drugs, bedaquiline and delamanid, in 2014 and 2015 respectively. We treated 5,156 patients for different forms of TB in Chechnya between 2004 and 2018, including 156 who were treated using bedaquiline and/or delamanid.

SEARCH AND RESCUE OPERATIONS

No. staff in 2018: 12 | Expenditure in 2018: €2.7 million | Year MSF started search and rescue operations: 2015
msf.org/mediterranean-migration

KEY MEDICAL FIGURE:

3,240 medical consultations conducted on board

An MSF medic on the *Aquarius* search and rescue vessel changes the dressing of a patient with chemical burns, caused by a toxic mix of seawater and fuel, June 2018.

Italy and other European governments effectively shut down search and rescue operations along the world's deadliest migration route in 2018.

According to the International Organization for Migration, an estimated 2,297 people drowned or went missing in the Mediterranean Sea in 2018. The majority of these deaths occurred in international waters between Libya, Italy and Malta, along what continues to be the world's deadliest migration route. Thousands who managed to survive were intercepted at sea and, with EU support, forcibly returned to Libya in violation of international law. In Libya, refugees and migrants routinely face abuse, torture, exploitation and inhumane conditions of detention, which have a severe impact on their physical and mental health.

The search and rescue vessel *Aquarius*, operated by Médecins Sans Frontières (MSF) and SOS MEDITERRANEE, assisted 3,184 people in 2018. However, in June, the newly elected Italian government took the extraordinary step of effectively closing its ports to all rescued refugees and migrants, leaving the *Aquarius* and 630 vulnerable men, women and children on board stranded at sea for eight days, until they were able to disembark in Valencia, Spain – more than 1,300 kilometres away.

The move sent shockwaves through Europe and set a dangerous precedent that paralysed search and rescue activity in the Central Mediterranean. In the aftermath, governments failed to come up with a sustainable solution to share responsibility for survivors arriving on European shores. For the rest of the year, they and the ships that rescued them were left stranded at sea for days or weeks at a time until ad hoc agreements could be reached.

In August and September, the *Aquarius* came under further political pressure. Despite being in full compliance with maritime regulations and technical specifications, the ship was stripped of its flag and registration, first by Gibraltar, then by Panama, at the instigation of the Italian government. Without a flag, the *Aquarius* was unable to leave port to assist those in distress.

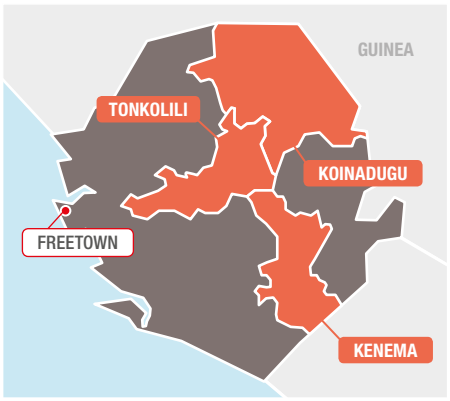
The longstanding campaign to criminalise NGOs who support refugees and migrants intensified in November when the Public Prosecutor's Office of Catania requested the seizure of the *Aquarius* over dubious allegations of illicit waste trafficking at Italian ports. We immediately refuted claims that we had engaged in criminal activity or that the discarded food and clothing of survivors posed a transmission risk for diseases such as HIV, tuberculosis or scabies, but the politically motivated judicial proceedings further undermined our prospects of continuing lifesaving work on the *Aquarius*.

By the end of the year, MSF and SOS MEDITERRANEE were left with no choice but to end rescue operations on the *Aquarius*.

As European governments shirk their responsibilities and curtail the ability of aid organisations to offer assistance, the humanitarian crisis in the Central Mediterranean continues to present long-term challenges. As long as refugees, migrants and asylum seekers are drowning or being forced back to Libya in violation of international law, MSF will seek ways to reach them and provide medical and humanitarian care.

SIERRA LEONE

No. staff in 2018: 837 | Expenditure in 2018: €19.4 million | Year MSF first worked in the country: 1986 | msf.org/sierra-leone



Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

© Giuseppe La Rosa/MSF

Patients wait to be seen at Robarrie clinic in Sierra Leone's Tonkolili district, where MSF provides ante- and postnatal care and malaria treatment, January 2018.

KEY MEDICAL FIGURES:

103,800 outpatient consultations

43,800 people treated for malaria

25,000 antenatal consultations

8,360 people admitted to hospital, including **4,830** children under five

5,890 births assisted

Maternal and child mortality remain high in Sierra Leone, and its health system is still struggling to recover from the 2014-16 Ebola outbreak, which killed approximately 10 per cent of health workers.

Médecins Sans Frontières (MSF) teams work in hospitals, primary health facilities and in the community to increase access to healthcare, fill gaps in the provision of essential medicines, and help develop the country's health workforce. Our focus is on maternal and child healthcare, but we monitor the health situation across the country, ready to respond to emergencies as required.

Tonkolili district

In 2018, we continued to support Magburaka district hospital's maternal and child health services, introducing water and sanitation improvements, a blood bank, and enhanced infection prevention and control measures. Our teams assisted 3,230 births and conducted 16,300 antenatal and 4,370 postnatal consultations during the year, as well as supporting referrals, training staff and conducting community outreach work.

We offer medical and psychological care to victims of sexual violence in Magburaka hospital and the surrounding health facilities, and during the rainy season we supported seven community-based malaria management sites with screening, treatment and referrals.

Koinadugu district

We continued working in the paediatric and maternity wards and the emergency department at Kabala district hospital in Koinadugu throughout 2018, and supported the referral system for the entire district. We also had a team supporting the community health centre, community health workers, traditional birth attendants and the health post.

Having increased the capacity of the hospital and community health facilities, raised the standard of emergency, paediatric and maternity services, and strengthened the referral system, we handed all activities over to the Ministry of Health at the end of the year.

Kenema district

We support 13 primary health facilities in Gorama Mende, Wandor and Nongowa chiefdoms in Kenema district, providing clinical supervision and training, assisting with referrals, filling significant gaps in the supply of essential drugs and medical equipment, and conducting community outreach and health promotion activities.

The foundations of a new hospital were laid in Hangha town in January 2018 and by the end of the year the facility was nearing completion. Scheduled to open in March 2019, the hospital will offer a full range of paediatric services including an emergency room, an intensive care unit, an inpatient therapeutic feeding centre, a general paediatric ward, and an isolation ward, as well as a laboratory and a blood bank. Longer-term expansion plans include the introduction of maternity and radiology services.

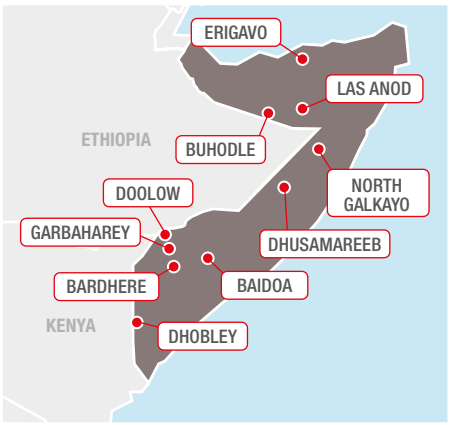
Human resources for health

While laying the physical foundations of the hospital in Kenema, we also set about training staff through the MSF Academy for Healthcare – set up in 2016 to improve the skills of medical and paramedical practitioners in low-resource settings with a shortage of trained professionals.

Training was provided to 160 health workers in Kenema district in 2018. Another 50 (25 nurses and 25 midwives) went to Ghana for a 24-month scholarship programme, and 12 joined nurses from South Sudan on an 18-month anaesthetics diploma course. The nurses and midwives from Sierra Leone will return to work in the new hospital in Kenema, and the project will serve as a pilot to develop the tools and expertise needed to meet training needs in other countries such as the Central African Republic, the Democratic Republic of Congo and South Sudan.

SOMALIA

No. staff in 2018: 120 | Expenditure in 2018: €8.5 million | Year MSF first worked in the country: 1979 | msf.org/somalia



Cities, towns or villages where MSF worked in 2018

Since returning to Somalia in 2017, Médecins Sans Frontières (MSF) has steadily increased support to health facilities in different areas around the country.

After an absence of almost four years due to extreme attacks on staff, our aim is to ensure that people have access to medical care in areas where needs are critical and the security conditions allow us to operate.

We continued to support nutrition, paediatrics and emergency services at Mudug regional hospital in North Galkayo in 2018, and also provided humanitarian assistance in displacement camps in Galkayo.

In May, we started supporting Bay regional hospital in Baidoa, a referral facility for the entire South West state, to address the health needs of women and children. Maternal mortality and the number of stillbirths remain high in the region, in large part due to women presenting late with complications in pregnancy.

By the end of 2018, our team in Baidoa had assisted 690 births, including 110 caesarean sections. Our support will be extended to the hospital's paediatric services, as well as running community health education and awareness-raising sessions, health surveillance activities and hospital referrals.

In addition to these longer-term projects, we carried out numerous ad hoc interventions across Somalia in 2018, sending teams to provide nutritional care in Doolow and Dhusamareeb, and to support paediatric healthcare and prepare for disease outbreaks in Dhobley, Bardhere and Garbaharey, Jubaland state. In collaboration with local agencies, MSF also conducted cataract surgery camps in Erigavo, Las Anod, Buhodle, Galkayo, Baidoa and Bardhere.

KEY MEDICAL FIGURES:

86,600 outpatient consultations

1,540 children treated in outpatient feeding programmes

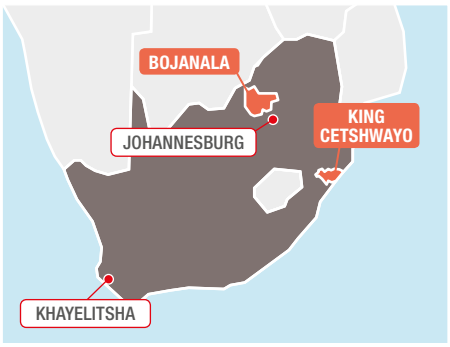
690 births assisted, including **110** caesarean sections

© Adan Said Abdi/MSF

In Baidoa maternity ward, women are looked after in the early stages of labour and again after delivery. Somalia, July 2018.

SOUTH AFRICA

No. staff in 2018: 282 | Expenditure in 2018: €11.6 million | Year MSF first worked in the country: 1986 | msf.org/south-africa



Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

21,000 people treated for HIV

1,430 people started on treatment for TB, including **400** for MDR-TB

550 people treated after incidents of sexual violence

© Melanie Wenger/Cosmos

A patient takes part in a 'body mapping' workshop for adolescent victims of sexual assault in Rustenburg, South Africa, July 2018.

In South Africa, Médecins Sans Frontières (MSF) supports innovations for change in HIV and tuberculosis (TB) treatment, care for victims of sexual violence and access to lifesaving drugs.

In 2018, South Africa became the first country in the world to make the oral drug bedaquiline part of its standard recommended treatment for drug-resistant TB (DR-TB), helping to phase out painful, toxic injections and scale up access to more effective, more tolerable treatments – a long-standing MSF goal.

HIV and TB treatment

We are working to increase access to new and repurposed drugs and community-based care for patients with DR-TB through our HIV and TB projects in Khayelitsha, near Cape Town, and King Cetshwayo district, KwaZulu-Natal, while supporting efforts to reach the UNAIDS 90-90-90 targets for people living with HIV.[1]

In 2018, we conducted a door-to-door HIV survey through our project in King Cetshwayo district. The preliminary results endorsed the innovative community-based strategies we have implemented since 2011 to reduce HIV and TB incidence, sickness and mortality. In 2018, 22,780 people were tested in the community for HIV and 1,280 were started on TB treatment, including 220 on bedaquiline and/or delamanid.

In Khayelitsha, we enrolled 198 mother and baby pairs in postnatal support clubs, designed to improve care for women with HIV and their HIV-exposed infants. The programme was piloted in 2016 and incorporated into the national HIV treatment guidelines a year later.

South Africa also became part of the multi-country endTB clinical trial aiming to find shorter, less toxic and more effective treatment regimens for multidrug-resistant TB (MDR-TB). We launched the trial in Khayelitsha in May and had enrolled 28 patients by the end of the year.

Care for victims of sexual violence

In Bojanala district, in South Africa's platinum mining belt, we are helping to expand access to care for victims of sexual and gender-based violence through four dedicated clinics, known as Kgomotso Care Centres, which offer medical and mental healthcare, and social services. An increasing number of patients are being referred from community-based initiatives, including a school health programme, through which we conducted education sessions reaching 12,670 pupils in 20 schools. Around 27 pupils a month were referred to our care centres in 2018.

We also continue to support termination of pregnancy services for women who request them. Two MSF nurses performed 90 to 100 procedures a month in two community health centres in 2018.

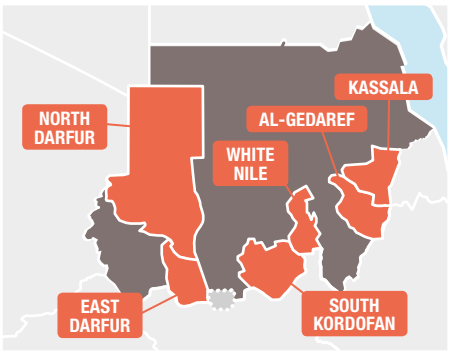
Stop Stockouts Project (SSP)

The SSP is a civil society consortium supported by MSF and five other organisations, which monitors the availability of essential drugs in clinics across the country and pushes for the rapid resolution of stockouts and shortages. In 2018, the SSP helped to identify and raise awareness of stockouts across North West province resulting from health worker strike action.

[1] *The globally agreed 90-90-90 targets require that 90 per cent of people living with HIV know their status, that 90 per cent of people living with HIV initiate and remain on ARV treatment, and that 90 per cent of people on ARV treatment reach and maintain an undetectable viral load by 2020.*

SUDAN

No. staff in 2018: 867 | Expenditure in 2018: €14.8 million | Year MSF first worked in the country: 1979 | msf.org/sudan



Regions where MSF had projects in 2018

The maps and place names used do not reflect any position by MSF on their legal status.

KEY MEDICAL FIGURES:

467,400 outpatient consultations

2,970 births assisted

750 people treated for kala azar

MSF nurse assistant Mou Dut Achuil tests a three-year-old boy for malaria in Kario camp in East Darfur, Sudan, March 2018.

By the end of 2018, there were nearly two million internally displaced people and 851,000 South Sudanese refugees registered in Sudan, as well as many other migrants in transit to Europe.

Médecins Sans Frontières continued to improve and expand health services in Sudan in 2018, particularly for those displaced by violence within the country or across the border in South Sudan, and stepped up efforts to combat kala azar (visceral leishmaniasis), a neglected but potentially fatal tropical disease.

Al-Gedaref

Sudan has the highest rate of kala azar in East Africa, and Al-Gedaref accounts for nearly 70 per cent of cases nationwide. We organise education and awareness-raising in the community, and support diagnosis and case management in two hospitals in the region. In 2018, we started training medical staff in facilities around the country, and prepared to launch a clinical trial set up by the Drugs for Neglected Diseases *initiative* to find a less toxic, less painful and more effective treatment.

Our teams in Al-Gedaref also distributed relief kits in response to heavy rains and flash floods that affected over 220,000 people across much of Sudan, and made a donation of drugs to a local hospital. In neighbouring Kassala, we provided treatment and implemented infection control measures in local health facilities following an outbreak of chikungunya virus.

South Kordofan

South Kordofan is an unstable conflict-affected region in southern Sudan, where approximately 180,000 internally displaced people have been registered and few international organisations are present. We opened a project in 2018, focusing initially on sexual and reproductive healthcare and establishing a level of emergency preparedness in the area.

North Darfur

In the gold-mining area of El Sireaf, where many people have been killed or injured in clashes between nomadic Arab tribes, we run maternity and inpatient services at a hospital for internally displaced people and offer primary healthcare at the nearby Garazawya health centre.

In 2018, we set up two mobile clinics to respond to the needs of displaced people returning to their homes in Tawila. Our teams continued to assist deliveries at the local hospital but handed our outpatient services over to the Ministry of Health.

We responded to a measles outbreak in El Fasher, the capital of North Darfur, treating more than 1,200 cases and vaccinating over 312,000 children aged under 15. The team in El Fasher also treated 15,000 people for malaria.

East and West Darfur

We provide outpatient and inpatient primary healthcare in Kario camp, in East Darfur, which hosts around 23,000 South Sudanese refugees. The facility serves refugees and the local Sudanese community. In 2018, we opened an inpatient therapeutic feeding centre and expanded the maternity ward.

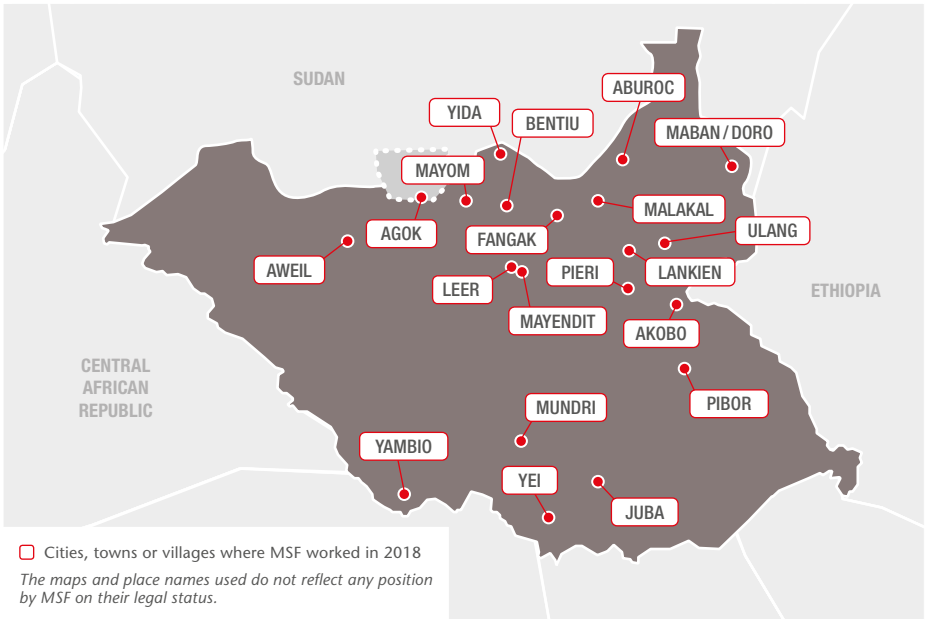
We handed over our paediatric clinic in Krinding, West Darfur, to the Ministry of Health in early 2018, as planned.

White Nile

In Khor Wharal camp, we upgraded our emergency field hospital into a 90-bed secondary healthcare facility and began constructing another 60-bed hospital. In Kashafa camp, we run a 55-bed hospital which is also a referral point for the host community. Together, these projects benefit more than 100,000 South Sudanese refugees and local Sudanese.

SOUTH SUDAN

No. staff in 2018: 3,682 | Expenditure in 2018: €83.3 million | Year MSF first worked in the country: 1983 | msf.org/south-sudan



☐ Cities, towns or villages where MSF worked in 2018

The maps and place names used do not reflect any position by MSF on their legal status.

KEY MEDICAL FIGURES:

1,157,900 outpatient consultations

276,400 people treated for malaria

56,200 people admitted to hospital

14,300 births assisted

7,540 major surgical interventions

3,840 people treated for intentional physical violence

1,370 people treated for kala azar

670 people treated after incidents of sexual violence

Civilians in South Sudan have borne the brunt of over five years of conflict. Two million have fled into neighbouring countries, and another two million are displaced within its borders.

Healthcare is scarce or non-existent in many parts of the country, with less than half the population estimated to have access to adequate medical services. Around 80 per cent of services are delivered by NGOs such as Médecins Sans Frontières (MSF).

In 2018, we responded to the urgent medical needs of people affected by violence while maintaining essential healthcare services through 16 projects across the country, but as in previous years, direct attacks against healthcare staff and facilities repeatedly hampered activities in 2018.

Assisting displaced people and remote communities

In Old Fangak, a remote, swampy region in the north, we run the only secondary healthcare facility serving the many displaced people who have settled there. Our teams also travel by boat into the surrounding communities to run mobile clinics and organise hospital referrals, and we run community health posts in remote locations around Lankien and Pieri.

After an upsurge in intercommunal violence and displacement in Ulang, we started offering emergency and inpatient care in a local health facility, and referred patients with complications to Malakal and Juba.

Further north still, in Aburoc, we continued to support a 12-bed inpatient facility with emergency care, outpatient services and treatment for victims of sexual violence, while also treating common diseases such as diarrhoea and malaria at community level.

In the south, we support primary health centres in Yei and the state hospital's paediatrics unit, which serve local communities and displaced people. We also have teams working in three facilities in Pibor, including a health centre with surgical capacity, we support a primary health centre in Mundri town and run community health posts in remote locations around Mundri.

In December, we handed over our mobile clinics in Akobo and a primary healthcare

© Frederic NOY/COSMOS

Patients attend a mobile medical clinic in the village of Kier, on the banks of the Pibor River, South Sudan, December 2017.

© Sarah Murphy/MSF

An MSF health promoter near Pibor, South Sudan, writes a child's details on a mid-upper arm circumference measuring tape, used to screen children for malnutrition, May 2018.

facility we built in Kier to other organisations. Working in hard-to-reach areas with no other medical services, our teams treated more than 50,000 patients and ensured several hundred referrals for secondary care between late 2017 and the end of 2018.

Protection of Civilians (PoC) sites

Protection of Civilians sites in South Sudan have been in operation for more than five years after people fleeing the conflict sought safety at existing UN bases. These sites afford a level of protection to vulnerable populations who would otherwise be exposed to armed violence outside them. Poor living conditions, ongoing violence and mental trauma have created enormous medical needs in the country's largest PoC site, in Bentiu. Our 160-bed hospital is the only provider of secondary health services inside the PoC, including surgery and specialist care for newborns and complicated deliveries. In 2018, we treated 398 victims of sexual and gender-based violence in the PoC and in a clinic in Bentiu town. Nearly a third of all these cases occurred in a period of just a few weeks following an attack on women and girls in Rubkona county in November 2018. We also set up six malaria treatment points and provided care to over 38,000 patients following a sharp increase in malaria cases in July.

In Malakal PoC site, which hosts about 29,000 people, we run a 40-bed facility offering emergency care, treatment for tuberculosis (TB), kala azar (visceral leishmaniasis) and HIV, as well as mental health services. Our teams there documented an alarming rise in the number of suicide attempts in 2018, evidence of the consequences of long-term displacement, unemployment and limited prospects. We also work in Malakal town, providing the same services as in the PoC, with the addition of neonatal and obstetric care, including for complicated deliveries.

Mother and child healthcare

At Aweil state hospital we run the paediatric, neonatology, maternity and burns wards, the emergency room and intensive care unit, and an inpatient therapeutic feeding centre. The maternity ward was filled to capacity in September; over the year our teams assisted 5,275 deliveries, including 174 by caesarean section.

Our 80-bed hospital in Lankien also provides obstetric and paediatric care, nutritional support and treatment for victims of sexual and gender-based violence, as well as treatment for HIV, TB and kala azar.

Supporting former child soldiers

Children have been used as soldiers all over South Sudan and efforts are now being made to reintegrate them into their communities. In February, we started a pilot programme offering medical and mental healthcare to former child soldiers, 949 of whom were reintegrated into their communities in Yambio in 2018.

Responding to epidemics

We treated over 37,000 people for malaria through our project in Lankien in 2018, and scaled up malaria treatment in Aweil hospital in response to a seasonal peak. Additionally, we supported the Ministry of Health in vaccinating nearly 23,000 children during a measles outbreak in Aweil, and in conducting a preventive cholera vaccination campaign that reached more than 200,000 people in Juba.

Sudanese refugees

In and around Maban, we assist Sudanese refugees and the local community through our activities in Doro refugee camp and support to Bunj state hospital. We also continue to run a 15-bed inpatient department for refugees in Yida, but handed over our HIV/TB treatment programme to another organisation in May 2018.

Abyei Special Administrative Area (ASAA)

In Agok, we finished renovating and extending our hospital, the only secondary health facility in the area of disputed territory between Sudan and South Sudan. We also resumed our community malaria project at the onset of the peak malaria season, treating over 25,000 patients in 23 surrounding villages between June and December, and referring severe cases to the hospital. In response to displacement caused by severe flooding in an usually heavy rainy season, we sent mobile teams to the southern part of the ASAA to provide healthcare and distribute relief items.

Attacks on healthcare

In April, one of our mobile medical teams in Mundri was subjected to a violent armed robbery, which forced us to suspend all activities in the area for several weeks. We also suspended all activities except essential lifesaving treatment in Maban following a violent attack on the MSF office and compound in July, but by mid-September we had returned to full capacity.

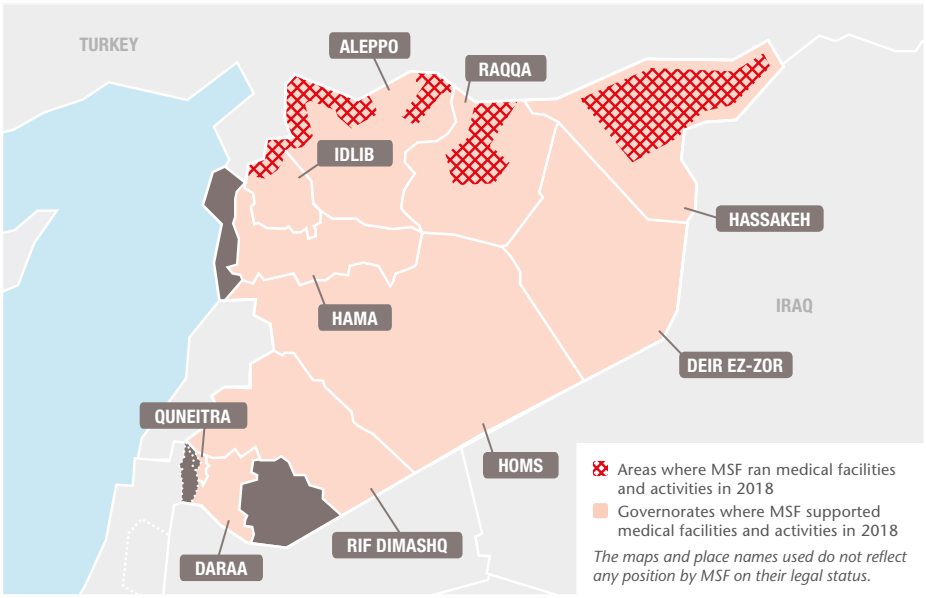
In Mayendit and Leer counties, thousands of civilians fled into the bush and swamplands to escape violent clashes in April and May. Our health facilities were also attacked and looted, but our teams continued to deliver basic medical care to the people they could reach.

© MSF

Ten-year-old Awien Maguor was bitten by a snake while she was sleeping. Her uncle carried her for five hours on his back to reach the hospital in Agok, where she received three doses of antivenom and had more than 19 fasciotomies – a surgical procedure to save the limb. South Sudan, October 2018.

SYRIA

No. staff in 2018: 1,081 | Expenditure in 2018: €47 million | Year MSF first worked in the country: 2009 | msf.org/syria



KEY MEDICAL FIGURES:

569,300 outpatient consultations

22,500 routine vaccinations

17,800 births assisted, including **3,630** caesarean sections

16,900 people admitted to hospital

15,500 individual mental health consultations

9,070 major surgical interventions

War continued to rage in Syria in 2018, leaving millions of people in desperate need of medical and humanitarian assistance.

Civilians, civilian areas and civilian infrastructure, including medical facilities, came under direct fire again in 2018. Thousands of people were killed or wounded, and many more driven from their homes. Médecins Sans Frontières (MSF) continued to operate in Syria but our activities were severely limited by insecurity and access constraints.

Our teams conduct independent evaluations to determine medical needs and what assistance we provide. In areas where access could be negotiated, we ran or supported hospitals and health centres and provided healthcare in displacement camps.

In areas where no direct presence was possible, we maintained our distance support, consisting of donations of medicines, medical equipment and relief items; remote training of medical staff; technical medical advice; and financial assistance to cover facilities' running costs.

Northwest Syria

Thousands of people displaced by the fighting around Damascus, Homs and Daraa settled in the northern governorates of Idlib and Aleppo in 2018. MSF teams delivered maternal healthcare, general primary healthcare and treatment for non-communicable diseases (NCDs) through mobile clinics, distributed relief items and improved water and sanitation systems. We also organised mass vaccination campaigns in and around the camps, and supported vaccination programmes in health facilities.

We supported primary and secondary healthcare in several hospitals and clinics around Idlib and Aleppo with a variety of services such as outpatient and inpatient departments, emergency rooms, intensive care units, operating theatres, blood banks, maternity wards, and treatment for NCDs and thalassemia, all in coordination with local authorities.

In Kobane/Ain Al Arab, in northeast Aleppo governorate, we continued to work with the local health authorities to re-establish basic health facilities, providing outpatient

© Omar Haj Kadour/MSF

A group of children in a camp for internally displaced people in Idlib, Syria, huddle near a fire to keep warm in January 2018.

© Louise Annaud/MSF

A young patient recovers from a critical abdominal injury at the MSF hospital in Hassakeh, Syria, March 2018. He was injured in Kubar, Deir ez-Zor, when a landmine or booby trap exploded.

consultations, vaccinations, psychological support and maternal healthcare. Meanwhile in Atmeh, in Idlib, we continued to run a specialised burns unit that provides surgery, skin grafts, dressings, physiotherapy and psychological support. An average of 150 procedures a month were performed in 2018, and severe or complex cases were referred to Turkey by ambulance. When the Atmeh camps were hit by severe flash floods in December, we distributed tents, blankets and other relief items to the worst affected.

Due to changes on the ground and shifts in needs, some projects in the northwest were handed over to local authorities in 2018, while others were managed remotely. In northern Idlib, however, we were able to establish co-management partnerships with three reference hospitals. This entailed developing medical strategies and protocols with the hospital directors, supporting all services, donating drugs and other medical supplies, and covering the running costs, including staff salaries. MSF also supported lifesaving medication and follow-up for almost 100 patients in Idlib who had received kidney transplants.

Northeast Syria

Fighting continued in parts of Deir ez-Zor governorate, resulting in further displacement and civilian casualties, with many war-wounded arriving at MSF facilities in northeast Syria. Elsewhere in the governorate, and in Hassakeh and Raqqa, the situation was relatively calm and people previously displaced by heavy fighting and offensives in Raqaa and Deir ez-Zor began returning home – to areas where the health infrastructure had been largely destroyed and entire cities and villages were littered with landmines and unexploded remnants of war. Our teams in Hassakeh and Raqqa treated hundreds of patients wounded by landmines, booby traps and explosive ordnance in 2018.

We helped to rehabilitate health facilities in Hassakeh, Raqqa and Deir ez-Zor governorates and supported a wide range of services, including surgery, physiotherapy, maternal, reproductive and mental healthcare, paediatrics, vaccinations, blood banks and treatment for NCDs, in coordination with the local health authorities. In Raqqa and Tabqa, we provided primary healthcare and mental health services, and ran a leishmaniasis treatment programme, handing over our Tabqa clinic to the Tabqa Health Council in October. We also ran a thalassemia programme at Tal Abyad hospital, through which our team performed 2,600 blood transfusions and started 226 patients on chelation therapy.

Teams working in displacement camps offered maternal and mental healthcare, conducted vaccinations, distributed mattresses, blankets and hygiene kits, and set up water and sanitation services. In Ain Issa camp, we also ran a dressings room, treated malnutrition and NCDs, and provided mental healthcare and hospital referrals.

In 2018, MSF was one of the only organisations providing medical assistance inside the city of Raqqa, where we ran a primary healthcare unit and a stabilisation point. We started rehabilitating parts of Raqqa national hospital, continued to support the paediatric, maternity and surgical wards of Tal Abyad hospital to the north, and supported or administered vaccination campaigns across the governorate.

Damascus and central Syria

As the battle for East Ghouta intensified, we struggled to assist communities who had been under siege for more than five years.

In the first two weeks of the offensive, between 18 February and 3 March, the makeshift hospitals and medical centres that MSF was supporting from neighbouring countries reported 4,830 wounded and over 1,000 dead. The influxes of dead and wounded continued, but the situation became too chaotic to collect reliable data after that point.

At the start of the battle, we were supporting 20 medical facilities – some almost entirely, others as one partner alongside other NGOs. By the end, all but one of these facilities had been destroyed or abandoned and our activities in the area came to an end.

North of Homs city, we provided remote support to eight rural hospitals and health centres until May, when the warring parties reached a settlement and the Syrian government took administrative and military control of the area, at which point the medical networks we had been assisting ceased to exist.

Daraa and Quneitra governorates

In June, as the control of Daraa and Quneitra changed hands, we had to end our support to eight health facilities in the region, where we had been offering medical, technical and logistical assistance to improve access to care for displaced people and local communities. We set up a mental health helpline at the end of 2017, and also ran a remote 'telemedicine' service for the first six months of 2018.

TAJIKISTAN

No. staff in 2018: 113 | Expenditure in 2018: €2.4 million
Year MSF first worked in the country: 1997 | msf.org/tajikistan

In Tajikistan, Médecins Sans Frontières (MSF) works with the Ministry of Health to improve access to tuberculosis (TB) and HIV care for children and their families.

We support the implementation of a paediatric and family TB care project in Dushanbe, focusing on drug-resistant TB. Children are particularly vulnerable to TB, and paediatric forms of the disease are especially challenging to diagnose and treat.

MSF and the Ministry of Health of Tajikistan have developed a model of care that is both innovative and patient-centred, and proven to be effective. Our comprehensive approach includes contact tracing and testing, tailored dosing to make medicine easier to take, and monitoring and managing any side effects. Our teams also offer adherence counselling, play therapy, education for inpatients, and psychosocial and nutritional support. We have worked with the Ministry of Health to introduce newer drugs, including bedaquiline and/or delamanid, as well as shorter treatment regimens: 20 people started short course regimens in 2018, and 30 started treatment on newer drug combinations.

By the end of the year, 262 patients – including 206 under the age of 18 – had benefited from treatment as part of this programme. In addition, our teams provided training for 878 doctors, nurses and healthcare staff, and 26 community volunteers.

We also work with the Ministry of Health through the Kulob paediatric and family HIV care project to detect HIV and initiate treatment for children and their family members. The project focuses on diagnosing and treating opportunistic infections, preventing mother-to-child transmission, providing psychosocial support, and implementing infection control to prevent the transmission of blood-borne diseases.

In 2018, we successfully introduced two new screening tools for the detection of paediatric HIV, one of which was adopted nationwide, and trained 1,118 healthcare professionals. Thanks to increased case finding, 26 new paediatric patients started treatment.

Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

220 people started on treatment for TB, including **110** for MDR-TB

190 people treated for HIV

TANZANIA

No. staff in 2018: 311 | Expenditure in 2018: €7.7 million
Year MSF first worked in the country: 1993 | msf.org/tanzania

Médecins Sans Frontières remains the main healthcare provider for almost 100,000 Burundian refugees in Nduta camp in northwestern Tanzania.

By the end of 2018, Tanzania was hosting 326,942 refugees from both Burundi and the Democratic Republic of Congo,[1] the majority in three camps: Nyarugusu, Nduta and Mtendeli.

In Nduta, we run a 151-bed hospital and four health posts, as well as health promotion activities via a network of community health workers. Outpatient services include mother and child care, nutritional support, mental healthcare and treatment for victims of sexual and gender-based violence. In 2018, we also rehabilitated the operating theatre and the sterilisation room at nearby Kibondo district hospital and donated specialist equipment to enable lifesaving surgery for both refugees and the local community.

Malaria remained a major medical problem in Nduta camp, particularly during the rainy season. We have been running comprehensive malaria prevention and control activities since 2016, including biological larviciding and mass distribution of second generation insecticide-treated mosquito nets. These measures have proven effective, reducing the number of cases by more than half in our facilities in 2018.

In March, the governments of Burundi and Tanzania and the United Nations refugee agency, UNHCR, confirmed their commitment to facilitating the voluntary repatriation of more than 70,000 Burundian refugees by the end of the year, adding yet another element of uncertainty for many.

Our teams in Nduta registered a significant increase in the mental health needs among refugees, the main diagnoses being depression and anxiety, but psychiatric disorders as well. In addition to a sense of helplessness about what the future holds, many patients reported having experienced traumatic events and lost family members or friends.

[1] *UNHCR Tanzania Refugee Situation Statistical Report, 31 December 2018*

Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

KEY MEDICAL FIGURES:

332,600 outpatient consultations,

67,500 people treated for malaria

12,700 individual mental health consultations

6,450 births assisted

THAILAND

No. staff in 2018: 31 | Expenditure in 2018: €0.9 million
Year MSF first worked in the country: 1976 | msf.org/thailand

In 2018, Médecins Sans Frontières started mental healthcare services in the southernmost provinces of Thailand, where years of violent unrest have taken a severe toll.

At the beginning of the year, we launched a project to improve access to mental healthcare in the provinces of Pattani, Yala and Narathiwat, near the border with Malaysia. Run in collaboration with the Ministry of Health's Department of Mental Health and other national academic and civil society organisations, the project aims to support the most vulnerable members of communities affected by the ongoing conflict, particularly those who may be hesitant to seek care.

We opened a first counselling centre in Pattani in January. Later in the year, we expanded to another site in the province of Yala and made preparations to open a third counselling centre, in Narathiwat, in January 2019. Initially the project concentrated on women and children, but we are increasing our services to include men affected by the conflict too.

Our teams focus on mental healthcare, facilitating other medical care as necessary. The psychological support includes individual and group therapy, psychosocial education and stress management. In 2018, we conducted regular community-based psychoeducation sessions, and capacity-building training and workshops for community groups, volunteers and local NGOs working with people affected by the unrest.

■ Regions where MSF had projects in 2018

KEY MEDICAL FIGURES:

810 individual mental health consultations

18 group mental health sessions

TURKEY

No. staff in 2018: 114[1] | Expenditure in 2018: €8.1 million
Year MSF first worked in the country: 1999 | msf.org/turkey

Turkey continues to host the highest number of refugees in the world, with more than 3.6 million registered Syrian refugees in addition to over 365,000 people of other nationalities.

Although, according to the Turkish government, around 295,000 Syrians returned home in 2018, the vast majority remain in urban areas in need of medical, psychological and social support.

In 2018, Médecins Sans Frontières (MSF) continued to provide financial and technical support to local NGOs working with migrants and refugees in Turkey.

Sanliurfa

For four years, we have been assisting Support to Life, the Association for Protecting and Improving the Rights of Seasonal Agricultural Workers (Metider) and the International Blue Crescent Foundation to run activities for Syrian refugees. These activities include home-based psychoeducation sessions for people with physical disabilities, a psychosocial support programme, and the provision of translation services in hospitals to help Syrian patients communicate with medical staff. We also supported a government-initiated vaccination campaign in 2018.

Confident that the local NGOs were able to meet the needs in Sanliurfa, we decided to end our support in June.

Kilis and Istanbul

We worked with the Citizens' Assembly (CA) on two other projects for migrants and Syrian refugees in Turkey. CA's mental health and psychosocial support programme in Kilis was handed over to another organisation in April but continued to provide services for Syrian refugees in the city, while the MSF-supported Nefes Centre ran support and advisory services in Istanbul for migrants and refugees who had suffered ill-treatment.

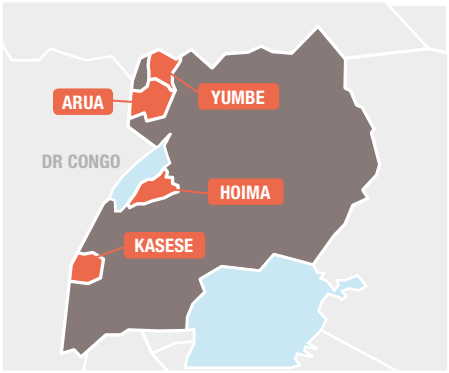
As well as providing technical and financial support to local NGOs, we are engaging in efforts to renew our registration to operate directly.

□ Cities where MSF supported projects in 2018

[1] *Including staff hired by partner organisations*

UGANDA

No. staff in 2018: 559 | Expenditure in 2018: €10 million | Year MSF first worked in the country: 1986 | msf.org/uganda



Regions where MSF had projects in 2018

KEY MEDICAL FIGURES:

151,700 outpatient consultations

8,600 individual mental health consultations

1,010 people on first-line ARV treatment, and **1,170** on second-line ARV treatment

530 people treated after incidents of sexual violence

Uganda is home to 1.1 million refugees, by far the largest number in Africa.[1] The country also has 1.2 million people living with HIV and faces regular outbreaks of communicable diseases.

Focusing our activities on certain vulnerable groups who are disproportionately affected, Médecins Sans Frontières provides screening, treatment and support for people living with HIV, sexual and reproductive healthcare for adolescents, and medical assistance for refugees.

Improving access to treatment for HIV

A reported 1.2 million people in Uganda are living with HIV.[2] Despite efforts to improve access to screening and care, significant gaps remain. Increasingly, resistance to antiretroviral drugs results in failures in first- and second-line treatment, and the availability and supply of third-line drugs, or salvage regimens, can be erratic.

In Arua, we provide advanced HIV care, including various point-of-care tests, treatment of cryptococcal meningitis (which results from low immunity), improvements in the clinical management of patients who have not achieved viral suppression, molecular drug-resistance testing and third-line treatment. Additional activities specifically aimed at children and young people include early HIV detection, peer group support and psychosocial counselling.

In Kasese, we focus on rural fishing communities around lakes Edward and George. We support the formation of community groups to increase access to HIV care and facilitate adherence to treatment, which contributes to improvements in viral load suppression rates.

Sexual and reproductive healthcare for adolescents

Adolescents are particularly vulnerable to sexually transmitted diseases and unwanted pregnancies. There is limited awareness of the risks, aggravating factors and consequences, and insufficient dedicated support available.

We opened a clinic for adolescents in Kasese in 2015 to provide sexual and reproductive healthcare services. Over 32,000 consultations were performed in 2018, with awareness-raising sessions and recreational activities also organised to increase participation.

Assistance for refugees

More than 100,000 people fleeing violence in northeastern Democratic Republic of Congo crossed Lake Albert into Uganda's Hoima district between late 2017 and early 2018. In February, the area was hit by a cholera outbreak, in which more than 2,500 cases were recorded, over 40 per cent of them severe. We launched an emergency response, administering oral cholera vaccines to 47,500 people and ensuring the supply of clean water. Our teams in the refugee settlements also carried out measles and other routine vaccinations, medical consultations, and sexual and reproductive healthcare services.

In Yumbe district, we have been providing inpatient and outpatient care, maternity services and vaccinations to South Sudanese refugees since 2016. We provided clean drinking water and implemented a data collection system to monitor conditions and medical needs in the refugee settlements.

As the number of new arrivals from South Sudan began to decrease early in 2018, we handed over our basic medical consultations to other organisations and focused our efforts on mental healthcare and assistance for victims of sexual violence. Services were rolled out in Imvepi and Rhino settlements, with outreach activities in Bidi Bidi starting in May.

© Stitching Pictures

An elderly man in Kyangwali, Hoima district, receives a cholera vaccination. Uganda, May 2018.

[1] *ReliefWeb*

[2] *Uganda Population-based HIV Impact Assessment (UPHIA), 2016–2017*

UKRAINE

No. staff in 2018: 155 | Expenditure in 2018: €5.5 million | Year MSF first worked in the country: 1999 | msf.org/ukraine

Regions where MSF had projects in 2018

•••'Contact line'

The maps and place names used do not reflect any position by MSF on their legal status.

Access to healthcare remains limited for people living along the frontline of the conflict in eastern Ukraine, which started back in 2014, damaging infrastructure, disrupting services and causing financial distress.

Médecins Sans Frontières operated mobile clinics in a total of 28 locations in or near the conflict zone, delivering much-needed primary healthcare and psychological support to nearly 3,000 people.

The majority of the people treated by our mobile clinics were women over the age of 50 with chronic diseases such as high blood pressure, heart problems and diabetes, and mental health issues such as anxiety and depression. In addition to individual counselling, our teams organised training to help healthcare workers and service providers in the area cope with stress and burnout.

Hepatitis C

We continued to run our hepatitis C project in Mykolaiv region, providing treatment with two direct-acting antivirals – daclatasvir and sofosbuvir – as well as free diagnostic tests, patient support, education and counselling services.

Our hepatitis C patients are all co-infected with HIV and/or on opioid substitution therapy to overcome drug addiction. The first group, who began treatment in 2017, were found to have an impressive cure rate of over 95 per cent.

Drug-resistant tuberculosis

In partnership with the Ministry of Health, we launched a drug-resistant tuberculosis (DR-TB) treatment project at the regional TB hospital in Zhytomyr in 2018. It is one of the first projects in the country to treat patients with the highly effective oral TB drugs bedaquiline and delamanid, and we continue to advocate increased access to these drugs countrywide. The project also provides outpatient care, as well as mental healthcare and social support services, which are often unavailable to TB patients in Ukraine.

KEY MEDICAL FIGURES:

4,770 outpatient consultations

2,660 individual mental health consultations

490 people treated for hepatitis C

100 people started on treatment for DR-TB

UZBEKISTAN

No. staff in 2018: 271 | Expenditure in 2018: €8.6 million | Year MSF first worked in the country: 1997 | msf.org/uzbekistan

Regions where MSF had projects in 2018

Cities, towns or villages where MSF worked in 2018

In Uzbekistan, Médecins Sans Frontières works to improve the quality and availability of treatment for tuberculosis (TB) and HIV.

Our TB project in Nukus, the capital of the Autonomous Republic of Karakalpakstan, has two components: comprehensive patient-centred care and clinical research into shorter, more tolerable and more effective treatments. Our approach includes a shorter, nine-month treatment regimen and home-based outpatient care.

In 2018, we started 2,220 patients on TB treatment. Of these, 660 were drug-resistant in some form, including 450 multidrug-resistant and 70 extensively drug-resistant cases; 199 were treated with new or repurposed drugs. We are supporting the rollout of World Health Organization treatment recommendations throughout Karakalpakstan, where we also manage a state-of-the-art laboratory equipped with some of the most advanced diagnostic instruments.

We launched the multi-site TB PRACTECAL clinical trial in Nukus in 2017 to evaluate the effectiveness of two of the newest TB drugs – bedaquiline and pretomanid – on a much shorter regimen of just six months. By the end of 2018, the Nukus site had recruited 104 patients and an additional site in Tashkent had been approved to start recruitment in early 2019.

We also work with the Ministry of Health to care for people living with HIV. Based in Tashkent since 2013, our project focuses on integrated care for HIV patients co-infected with either hepatitis C, syphilis, or other sexually transmitted infections. In 2018, we began working in clinics that serve at-risk groups such as sex workers, people who inject drugs and men who have sex with men. In 2018, we initiated 750 people on hepatitis C treatment and 810 on antiretroviral (ARV) therapy for HIV.

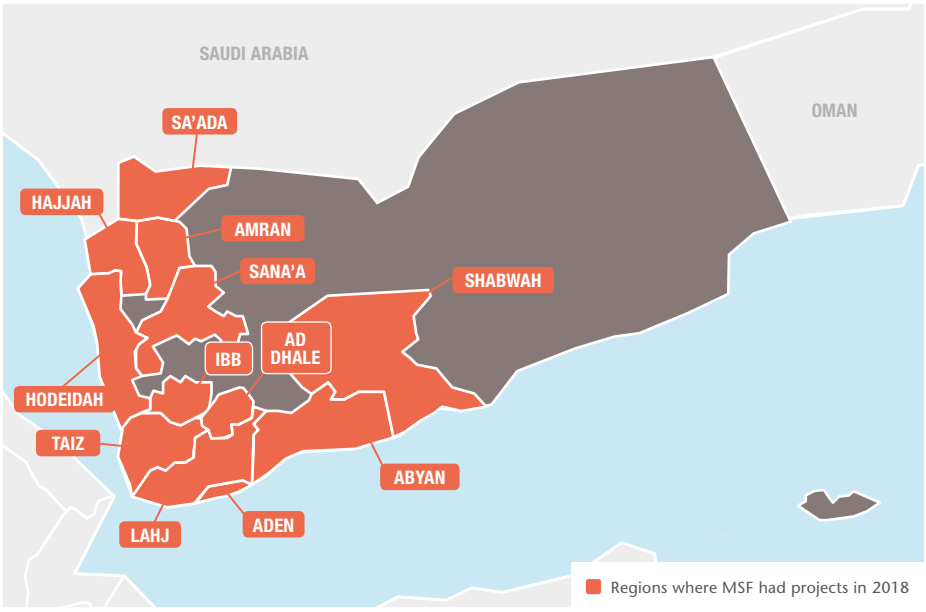
KEY MEDICAL FIGURES:

2,220 people started on treatment for TB, including **660** for DR-TB

810 new patients on first-line ARV treatment, and **55** on second or third-line ARV treatment

YEMEN

No. staff in 2018: 2,058 | Expenditure in 2018: €57 million | Year MSF first worked in the country: 1986 | msf.org/yemen



KEY MEDICAL FIGURES:

535,600 outpatient consultations

63,100 people admitted to hospital, including **21,300** children under five

24,600 major surgical interventions

24,400 births assisted, including **2,450** caesarean sections

16,600 people treated for intentional physical violence, including war wounds

12,700 people treated for cholera

3,150 children admitted to inpatient feeding programmes

After four years of war, the Yemeni health system is in ruins. The conflict escalated throughout 2018, with fast-changing frontlines and attacks against civilians across the country.

Médecins Sans Frontières (MSF) worked in 13 hospitals and health centres and provided support to more than 20 health facilities across 12 governorates in 2018. However, repeated attacks on medical staff and structures during the year forced us to suspend activities in several areas.

Insecurity and access constraints also prevented us – and other organisations – from collecting reliable data on the nutritional and humanitarian needs across the country. Our teams treated over 5,700 children for malnutrition in inpatient and outpatient programmes across Hajjah, Sa'ada, Amran, Ibb and Taiz governorates, but saw no signs of impending famine – contrary to what the UN and others were suggesting.

The number of war-related deaths, and therefore the scale of the war, was also misrepresented in 2018, when the official number of war-related deaths remained 10,000 – unchanged since 2016. This has since been countered with a more realistic, but still conservative, estimate of 60,000.[1]

Over 119,000 people with injuries related to war and violence were treated in MSF and MSF-supported facilities between March 2015 and December 2018.

Medical and surgical care on the Hodeidah frontline

On 13 June 2018, an offensive was launched by the Saudi and Emirati-led coalition (SELC)-backed forces loyal to President Hadi to seize Hodeidah from Ansar Allah troops. In response to the intense fighting along this frontline over the following three months, we opened a surgical hospital in Mocha in August and performed almost 1,300 major surgical interventions by the end of the year. As well as patients with war wounds, we received pregnant women with complications requiring urgent surgery. Referrals are made to our trauma centre in Aden, where MSF teams performed more than 5,400 major surgical interventions, 90 per cent of them violence-related, in 2018.

Following failed peace talks, a new offensive on Hodeidah began in mid-September. Daily clashes partially blocked the main Hodeidah–Sana'a road and raised fears of a siege around the city. In September, we started providing emergency medical and surgical care at Al Salakhana hospital, northeast of the city, after rehabilitating the emergency room and operating theatres. By early November, as fighting intensified further still, Al Salakhana was one of only three operational public hospitals in the area.

A doctor checks on a patient at the MSF hospital in Mocha, Yemen, November 2018.

At the same time, we began rehabilitating and providing donations and technical support to other hospitals in the governorate, at Al Udayn, Far Al Udayn and Ad Dahi, as fighting displaced huge numbers of people and cut off their access to healthcare.

In mid-December, the warring parties agreed to a ceasefire. The Stockholm Agreement included a prisoner swap, the creation of a demilitarised zone around Hodeidah and the withdrawal of Ansar Allah troops. A committee was also set up to discuss the future of the city of Taiz, which, after four

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Inside MSF's trauma hospital in Aden, Yemen, in December 2018.

years, is still divided by frontlines and is a grim example of the urgent need for more medical aid.

Attacks on civilians, medical staff and facilities

According to the independent monitoring group Yemen Data Project, 17,729 civilians were injured or killed in SELC air raids between 2015 and 2018 inclusive, with Sa'ada the worst-affected governorate in 2018: it was targeted by 1,306 air raids – 39 per cent of all recorded air raids and more than in any other year since 2015. Our teams continued to work in Haydan hospital in Sa'ada, which has now been fully rebuilt after being destroyed by an SELC airstrike in 2015.

On 11 June, an MSF cholera treatment centre was bombed in Abs, Hajja governorate – less than two years after Abs hospital was bombed, resulting in 19 deaths and 24 injuries. This was the sixth time an MSF facility has been hit by the warring parties since 2015.

In addition, we were forced to close our projects in Ad Dhale governorate after our staff house was targeted with explosives twice in less than a week in November. Our teams had been working in Ad Dhale since 2012, supporting the health facilities in Ad Dhale, Qataba, Al Azariq and Damt districts to treat more than 400,000 patients. In late December, we also ended our support for Razeh hospital, in Sa'ada governorate, due to its proximity to the frontline and the high level of risk to patients and staff.

The most critical gaps in medical care

The Yemeni health system is in ruins across the whole country, but most evidently in the northern governorates, where SELC airstrikes intensified at the end of 2017 and into 2018.

Many medical staff have left because their salaries have not been paid since August 2016, and few hospitals are still functional. Yemenis struggle to access and afford basic commodities such as fuel, food and medicine because of a deteriorated economy, and the commercial closure of Sana'a airport has prevented people from seeking treatment abroad.

In response to the vast gap in services for women and children in particular, MSF teams provided maternal and paediatric healthcare in Ad Dhale, Amran, Hajjah, Ibb and Taiz governorates in 2018.

On the western coast, one of the biggest medical issues in 2018 remained the lack of surgical capacity. In the 450-kilometre stretch between Hodeidah and Aden, a six to eight-hour drive, the MSF hospital in Mocha is the only facility with an operating theatre serving the local population. Between August and December 2018, our teams in Mocha treated more than 150 people wounded by landmines, improvised explosive devices and unexploded ordnance. A third of them were children who had been playing in fields. In September, a Conflict Armament Research report pointed to Ansar Allah's large-scale mass production of mines and improvised explosive devices, as well as its use of anti-personnel, vehicle and naval mines.

Outbreaks of disease

We treated much fewer cholera cases than in 2017, but with conditions ripe for new waves of the disease, the threat remained. We opened a new cholera treatment centre to deal with an increase in confirmed and suspected cases in Ibb in late 2018.

In 2018, MSF teams continued to see cases of diphtheria across Yemen, and treated 570 patients in Abs, Ad Dhale, Ibb and Taiz. Measles is also a concern, especially in Sa'ada, Hajjah and Amran governorates. In 2018, MSF teams treated 1,981 cases. Immunisation remains a huge challenge: mass vaccination campaigns were delayed on numerous occasions and hampered by access constraints, especially in remote regions, and by a lack of authorisation in some areas.

[1] *According to the Armed Conflict Location & Event Data Project (ACLED).*

VENEZUELA

No. staff in 2018: 138 | Expenditure in 2018: €4.2 million | Year MSF first worked in the country: 2015 | msf.org/venezuela

Regions where MSF had projects in 2018
Cities, towns or villages where MSF worked in 2018

Venezuela's political and economic crisis deteriorated in 2018, causing a steep decline in living standards and prompting hundreds of thousands to leave for other countries in South America, particularly Colombia.

Médecins Sans Frontières (MSF) expanded its activities in the capital, Caracas, which was once again rated one of the most violent cities in the world.[1] We worked with local organisations and public institutions to provide medical and mental healthcare to victims of urban and sexual violence in the municipalities of Libertador and Sucre, making referrals for further treatment, legal assistance and social support as necessary.

MSF advocates considering sexual violence a medical emergency and treating it in a comprehensive way. To this end, we trained hospital and health centre staff on how to receive and attend to victims of sexual violence, and conducted awareness-raising campaigns in several neighbourhoods throughout the year.

We offered medical and psychological care to people affected by floods in Caicara del Orinoco and Churuguara, and supported emergency preparedness in hospitals around the country. We helped to equip emergency rooms, trained staff to deal with mass casualties and provided psychological first aid to civil defence and voluntary rescue groups.

Our medical and psychological care project for young people in Maracaibo ended in March due to difficulties renegotiating the agreement with Zulia state, but we continued to support the national malaria programme in Sifontes, a mining area with the highest number of reported cases in the country. Our activities include diagnosis and treatment, health promotion and vector control.

In 2018, we also started activities across the border, in the Brazilian city of Boa Vista, providing mental healthcare, supporting water and sanitation improvements in shelters, and looking at ways to increase access to medical care overall, as the local health facilities struggle to cope with the number of additional patients arriving from Venezuela.

[1] *BBC, 7 September 2018*

KEY MEDICAL FIGURES:

2,670 individual mental health consultations

490 group mental health sessions

190 people treated after incidents of sexual violence

ZAMBIA

No. staff in 2018: 18 | Expenditure in 2018: €1 million | Year MSF first worked in the country: 1999 | msf.org/zambia

Cities, towns or villages where MSF worked in 2018

In 2018, Médecins Sans Frontières returned to Zambia to respond to a cholera outbreak and assist refugees living in overcrowded camps.

Cholera is a major public health issue in Zambia. Epidemics typically occur during the rainy season in the informal settlements in the capital, Lusaka, where poor hygiene conditions facilitate the spread of the disease.

In January, we supported the Ministry of Health to manage an unusually large number of cases during a cholera outbreak in south Lusaka. We provided 24-hour support at the cholera treatment centre (CTC) at Chawama hospital and increased its capacity to 41 beds. In addition, we trained staff on cholera protocols and preventive measures, including sanitation and hygiene, donated medical and logistical equipment to the hospital and surrounding health facilities, and established surveillance and referral systems to improve the detection of cases and ensure all patients received adequate levels of care.

[1] *UNHCR Inter-Agency Operational Update*

According to the United Nations refugee agency, UNHCR, Zambia was hosting 40,917 refugees by February 2018,[1] mostly from southeastern Democratic Republic of Congo. Many had sought shelter in overcrowded camps in Kenani and Mantapala. We set up nutrition programmes and conducted outpatient consultations in both sites.

With the health ministry, we vaccinated over 5,600 children against measles in a two-round vaccination campaign, and distributed mosquito nets and soap.

To prepare for a possible outbreak of cholera, we set up a 30-bed CTC in each camp and provided medical and logistical training on cholera and nutrition surveillance to 11 health facilities, donated medical and logistical supplies and conducted health promotion activities and training.

KEY MEDICAL FIGURES:

6,740 outpatient consultations

490 people treated for cholera

ZIMBABWE

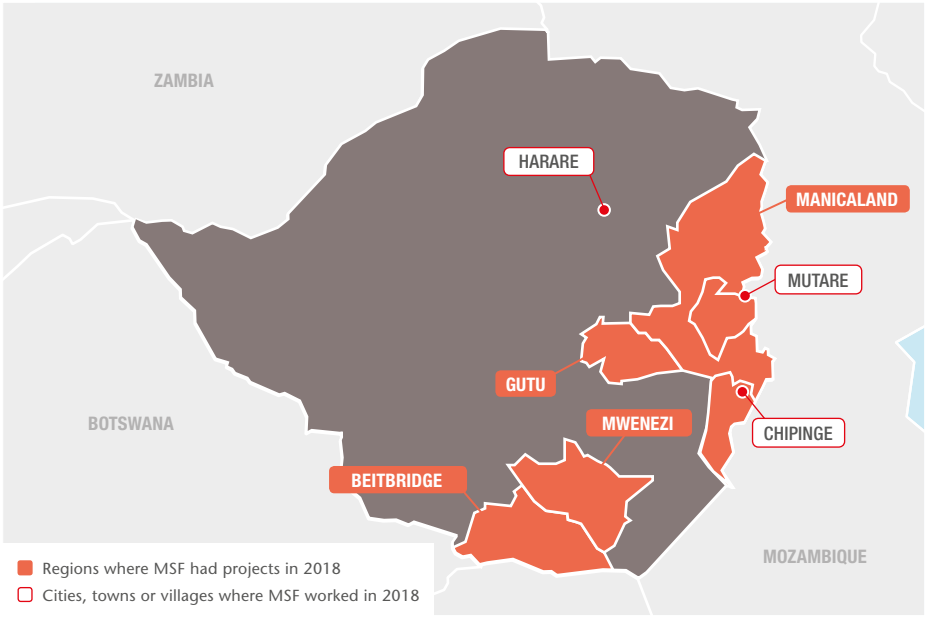
No. staff in 2018: 158 | Expenditure in 2018: €7 million | Year MSF first worked in the country: 2000 | msf.org/zimbabwe

KEY MEDICAL FIGURES:

30,800 people on first-line ARV treatment

9,970 people treated for cholera

370 people treated after incidents of sexual violence



Amid the continuing economic crisis, the Zimbabwean health sector faces many challenges, including shortages of medical supplies and essential medicines and insufficient funding to maintain water and sanitation services.

In 2018, Médecins Sans Frontières (MSF) supported the health ministry to respond to numerous outbreaks of water-borne diseases across the country, including the second-biggest cholera epidemic in its history, which started in the capital, Harare. In all, there were four cholera outbreaks and another four typhoid outbreaks, during which our teams supported the Ministry of Health and Child Care to treat over 13,000 suspected cases. Working alongside the ministry and the World Health Organization, we also participated in a cholera vaccination campaign that reached 1,297,890 people. In addition, MSF teams treated 10,000 patients for suspected typhoid in Harare and two other provinces.

To curb the spread of water-borne diseases in the densely populated capital, we have been working with partner organisations to rehabilitate contaminated boreholes and drill and seal new ones. A crucial element has been engaging people to manage and maintain these water points through community health clubs. Between 2015 and 2018, we rehabilitated 50 boreholes, drilled 9 new ones, and trained 72 community health clubs in 13 suburbs.

Sexual and reproductive healthcare

In 2018, we handed over our project offering medical treatment and psychosocial support to victims of sexual violence in Harare to the city health authorities. Having assisted more than 8,000 patients since the start of the project, we turned our focus to sexual and reproductive health services for adolescents aged 10 to 19, including vulnerable young people living with disabilities. At our new clinic in Mbare suburb, we provided consultations to over 4,300 adolescents in 2018.

© Marion Mossing/MSF

Juliet, a resident of Glenview, Harare, takes an oral cholera vaccine. Zimbabwe, October 2018.

Treatment for non-communicable diseases (NCDs), HIV and tuberculosis (TB)

We worked with the health ministry to implement a nurse-led, doctor-supported programme to scale up the treatment and management of patients with hypertension and diabetes in rural clinics in Chipinge and in Mutare hospital. Over 1,000 patients were enrolled in the programme in 2018 and more than 4,730 consultations conducted.

In rural Mwenezi, we conduct outreach programmes for around 1,400 people living with HIV and TB in remote communities with poor access to health services. In 2018, our teams started 500 patients on antiretroviral (ARV) therapy and implemented a new model of treatment distribution to make it easier for patients to get their refills. Now, trained community health workers receive and distribute ARV deliveries in hard-to-reach areas every three months.

In Gutu, we supported the health ministry's cervical cancer programme, screening 6,470 women for the disease in six health centres and providing treatment for 240 patients. We also administered human papillomavirus vaccinations to 15,650 girls in 246 schools in Gutu as part of a nationwide campaign.

Assistance for returning migrants

In Beitbridge, we run primary healthcare services for migrants deported from South Africa or returning through informal crossing points along the Limpopo River, as well as the large population of informal traders living along one of the busiest borders in Zimbabwe. Over 2,280 migrants and people on the move accessed care in one of the MSF-supported clinics in Beitbridge in 2018.

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, Hong Kong, Italy, Japan, Luxembourg, the Netherlands, Norway, South Africa, Spain, Sweden, Switzerland, the United Kingdom and the United States. There are also branch offices in Argentina, China, the Czech Republic, India, Ireland, Kenya, Lebanon, Mexico, the Russian Federation, South Korea, and the United Arab Emirates. MSF International is based in Geneva.

The search for efficiency has led MSF to create 10 specialised organisations, called 'satellites', which take charge of specific activities such as humanitarian relief supplies, epidemiological and medical research, and research on humanitarian and social action. These satellites, considered as related parties to the national offices, include MSF Supply, MSF Logistique and Epicentre, among others. As these organisations are controlled by MSF, they are included in the scope of the MSF International Financial Report and the figures presented here.

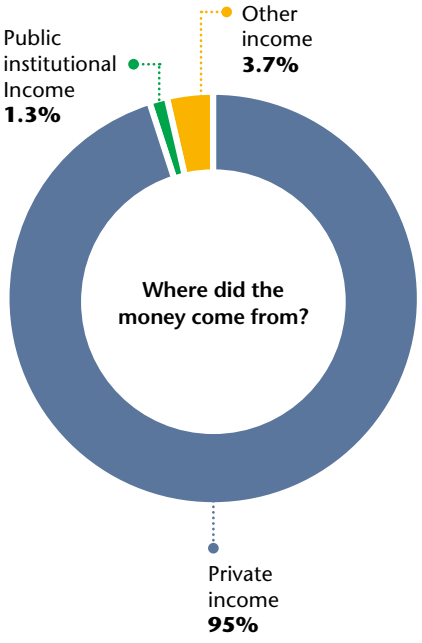
These figures describe MSF's finances on a combined international level. The 2018 combined international figures have been prepared in accordance with Swiss GAAP FER/RPC. The figures have been jointly audited by the accounting firms of KPMG and Ernst & Young.

The full 2018 International Financial Report can be found on www.msf.org. In addition, each national office 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 2018 calendar year. All amounts are presented in millions of euros. **Rounding may result in apparent inconsistencies in totals.**

WHERE DID THE MONEY COME FROM?

	2018		2017	
	in millions of €	*percentage*	*in millions of €*	*percentage*
Private income	1,459.9	95%	1,471.1	96%
Public institutional income	20.7	1.3%	29.9	2%
Other income	55.8	3.7%	30.8	2%
Total income	**1,536.4**	**100%**	**1,531.8**	**100%**

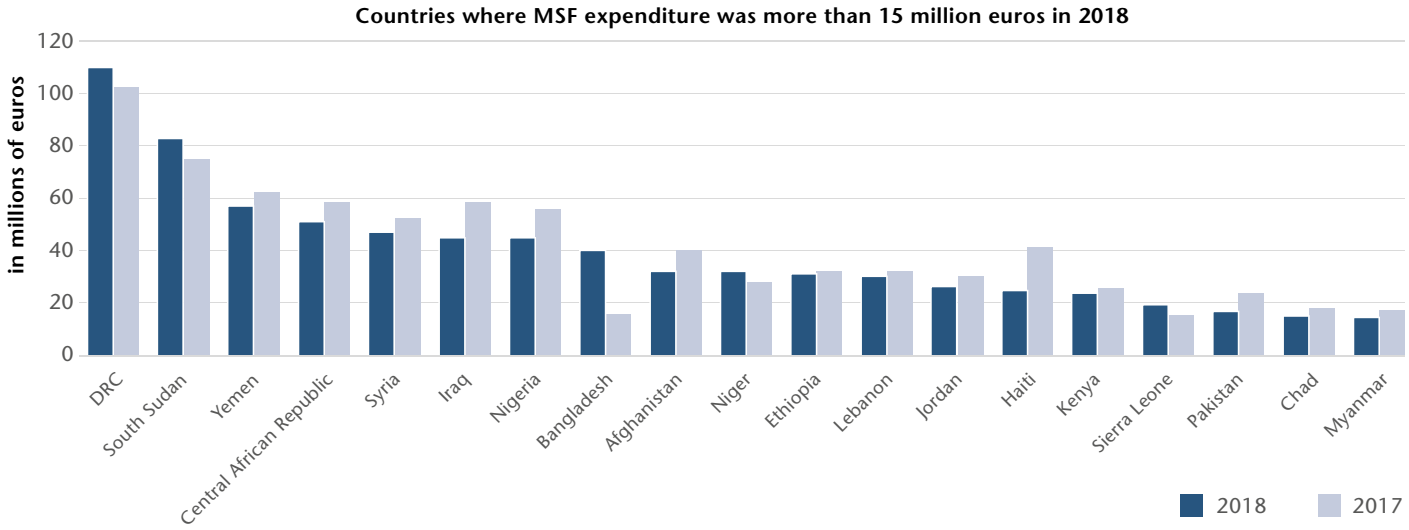


6.3 million private donors

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 2018, 95 per cent of MSF's income came from private sources.

More than 6.3 million individual donors and private foundations worldwide made this possible. Public institutional agencies providing funding to MSF included, among others, the governments of Canada, Japan and Switzerland, the Global Fund and the International Drug Purchase Facility (UNITAID).

WHERE DID THE MONEY GO?



AFRICA

	in millions of €
Democratic Republic of Congo	109.9
South Sudan	83.3
Central African Republic	51.2
Nigeria	44.9
Niger	31.6
Ethiopia	31.2
Kenya	24.4
Sierra Leone	19.4
Chad	15.2
Sudan	14.8
Mali	14.8
Cameroon	12.7
South Africa	11.6
Mozambique	10.1
Uganda	10.0
Libya	9.5
Malawi	9.0
Somalia	8.5
Guinea	8.4
Tanzania	7.7
Zimbabwe	7.0
Burundi	6.6
Eswatini	6.1
Liberia	5.7
Côte d'Ivoire	5.4
Guinea-Bissau	4.5
Mauritania	4.5
Burkina Faso	4.3
Egypt	2.5
Angola	1.7
Zambia	1.0
Other countries*	0.1
Total	**577.6 (55%)**

ASIA AND THE MIDDLE EAST

	in millions of €
Yemen	57.0
Syria	47.0
Iraq	45.5
Bangladesh	39.9
Afghanistan	32.0
Lebanon	29.8
Jordan	25.5
Pakistan	17.5
Myanmar	15.1
India	13.4
Palestine	11.6
Uzbekistan	8.6
Turkey	8.1
Cambodia	4.8
Kyrgyzstan	2.6
Tajikistan	2.4
Philippines	2.1
Iran	2.1
Georgia	1.7
Armenia	1.7
Malaysia	1.4
Other countries*	2.0
Total	**371.8 (35%)**

THE AMERICAS

	in millions of €
Haiti	25.2
Mexico	5.2
Venezuela	4.2
Colombia	2.7
Honduras	2.3
El Salvador	1.7
Other countries*	1.4
Total	**42.8 (4%)**

EUROPE

	in millions of €
Greece	9.5
Ukraine	5.5
Italy	4.9
Russian Federation	2.2
France	2.2
Belarus	1.9
Belgium	1.0
Migration Support East Europe	2.4
Other countries*	0.8
Total	**30.4 (3%)**

OCEANIA

	in millions of €
Papua New Guinea	4.6
Nauru	1.2
Other countries*	0.0
Total	**5.8 (1%)**

UNALLOCATED

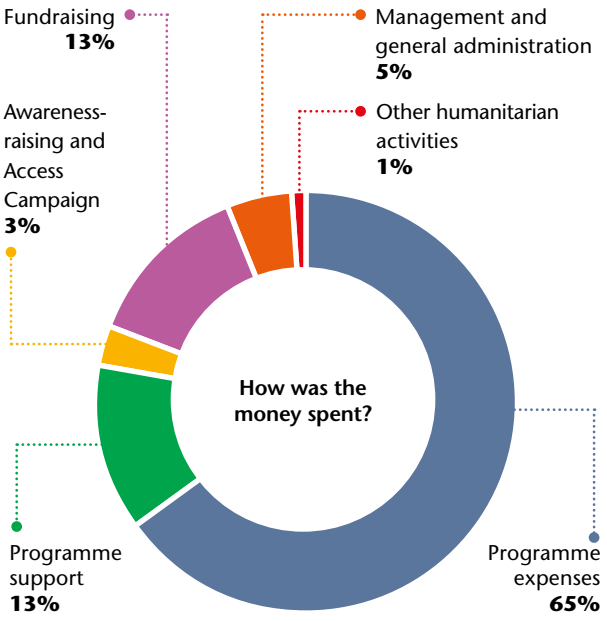
	in millions of €
Transversal activities	7.5
Mediterranean Sea Operations	2.7
Others	8.9
Total	**19.1 (2%)**

Overall programme expenses	**1,047.4 (100%)**

* 'Other countries' combines all the countries for which programme expenses were below one million euros.

HOW WAS THE MONEY SPENT?

	2018		2017	
	in millions of €	*percentage*	*in millions of €*	*percentage*
Social mission				
Programme expenses[1]	1,047.4	65%	1,084.5	67%
Programme support	209.8	13%	190.3	12%
Awareness-raising and Access Campaign	46.5	3%	46.3	3%
Other humanitarian activities	15.5	1%	13.7	1%
Total social mission	**1,319.2**	**82%**	**1,334.8**	**83%**
Other expenses				
Fundraising	208.1	13%	203.2	13%
Management and general administration	80.9	5%	78.4	5%
Total other expenses	**289.0**	**18%**	**281.6**	**17%**
TOTAL OPERATING EXPENSES	**1,608.3**	**100%**	**1,616.4**	**100%**

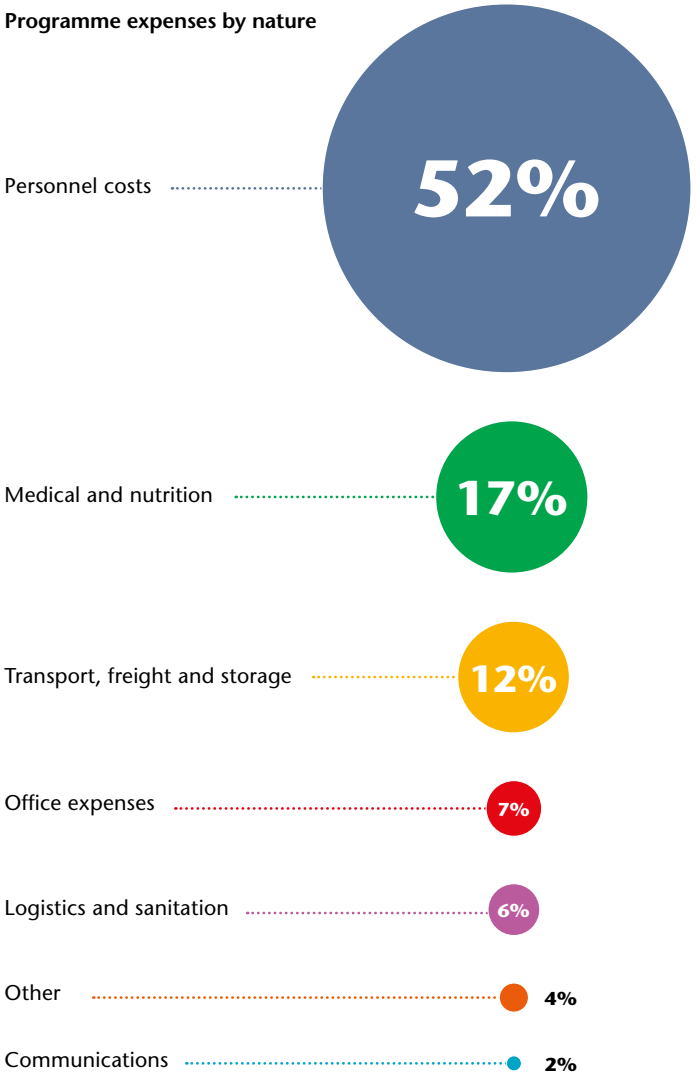


The biggest category of expenses is dedicated to personnel costs: 52 per cent of expenditure comprises all costs related to locally hired and international staff (including plane tickets, insurance, accommodation, etc).

The medical and nutrition category includes drugs and medical equipment, vaccines, hospitalisation fees and therapeutic food. The delivery of these supplies is included in the category of transport, freight and storage.

Logistics and sanitation comprise building materials and equipment for health centres, water and sanitation and logistical supplies. Other includes grants to external partners and taxes, for example.

Programme expenses by nature



[1] **Programme expenses** represent expenses incurred in the field or by headquarters on behalf of the field. All expenses are allocated in line with the main activities performed by MSF according to the full cost method. Therefore, all expense categories include salaries, direct costs and allocated overheads (e.g. building costs and depreciation).

YEAR-END FINANCIAL POSITION

	2018		2017	
	in millions of €	*percentage*	*in millions of €*	*percentage*
Cash and cash equivalents	726.1	57%	839.6	63%
Other current assets	266.1	21%	230.3	17%
Non-current assets	289.6	23%	257.8	19%
TOTAL ASSETS	**1,281.8**	**100%**	**1,327.7**	**100%**
Restricted funds[2]	**41.9**	**3%**	**43.3**	**3%**
Unrestricted funds[3]	927.6	72%	996.4	75%
Other funds[4]	35.2	3%	22.3	2%
Organisational capital	**962.8**	**75%**	**1,018.7**	**77%**
Current liabilities	202.6	16%	185.0	14%
Non-current liabilities	74.5	6%	80.8	6%
Total liabilities	**277.1**	**22%**	**265.7**	**20%**
TOTAL LIABILITIES AND FUNDS	**1,281.8**	**100%**	**1,327.7**	**100%**

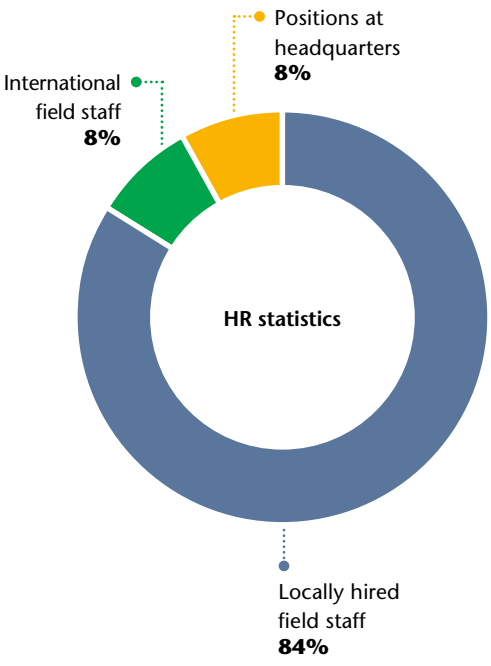
The result for 2018, after adjusting for exchange gains/losses, shows a deficit of €72 million (deficit of €104 million for 2017).

MSF's funds have been built up over the years by surpluses of income over expenses. At the end of 2018, the remaining available reserves (excluding permanently restricted funds and capital for foundations) represented 7.2 months of the preceding year's activity.

The purpose of maintaining funds 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.

HR STATISTICS

	2018		2017	
	no. staff	*percentage*	*no. staff*	*percentage*
Staff positions[5]				
Locally hired field staff	39,519	84%	37,986	84%
International field staff	3,824	8%	3,721	8%
Field positions[6]	**43,344**	**92%**	**41,707**	**92%**
Positions at headquarters	**3,974**	**8%**	**3,724**	**8%**
TOTAL STAFF	**47,318**	**100%**	**45,431**	**100%**
International departures				
Medical pool	1,743	22%	1,603	20%
Nurses and other paramedical pool	2,439	31%	2,640	33%
Non-medical pool	3,684	47%	3,715	47%
TOTAL DEPARTURES	**7,866**	**100%**	**7,958**	**100%**



The complete International Financial Report is available at www.msf.org

[2] **Restricted funds** may be permanently or temporarily restricted: permanently restricted funds include capital funds, where the assets are required by the donors to be invested or retained for long-term use, rather than expended in the short term, and minimum compulsory level of funds to be maintained in some countries; temporarily restricted funds are unspent donor funds designated to a specific purpose (e.g. a specific country or project), restricted in time, or required to be invested and retained rather than expended, without any contractual obligation to reimburse.

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

[4] **Other funds** are foundations' capital and translation adjustments arising from the translation of entities' financial statements into euros.

[5] **Staff numbers** represent the number of full-time equivalent positions averaged out across the year.

[6] **Field positions** include programme and programme support staff.

GLOSSARY OF DISEASES AND ACTIVITIES

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 63,700 people for cholera in 2018.

Ebola

Ebola is a virus that is transmitted through contact with the bodily fluids of an infected person, including someone who is deceased, or through surfaces contaminated with these fluids. 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 90 per cent and starts with flu-like symptoms, followed by vomiting and diarrhoea, symptoms that are common to many illnesses. As the disease progresses, people in some cases experience haemorrhaging, and 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. An investigational vaccine is available to help protect health workers and the contacts of infected people. Anti-viral drugs have also been used in outbreaks to treat people on a compassionate use and experimental basis. Otherwise, patient care is centred on rehydration and treating the symptoms such as fever and nausea.

Preventing transmission is essential: patients are cared for in Ebola treatment centres where strict infection control procedures are reinforced. Identifying people the patient was in contact with when they were ill becomes a priority to protect them and prevent further transmission, as do safe burials. Community health promotion is also important to inform the community about the risk of exposure and how to try and keep themselves safe, and what to do if they develop symptoms of the disease.

MSF treated 1,740 people for haemorrhagic fevers, including Ebola, in 2018.

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.

Hepatitis C

Hepatitis C is a liver disease caused by the blood-borne hepatitis C virus (HCV). It is most commonly transmitted through unsafe injection practices, reuse or inadequate sterilisation of medical equipment, and the transfusion of unscreened blood and blood products.

The virus can cause both acute and chronic infection, ranging in severity from a mild illness lasting a few weeks to serious, lifelong illness. Infected people often do not show symptoms for many years, although those with acute infection may experience fever, fatigue, decreased appetite, nausea, vomiting, abdominal pain, dark urine, joint pain and jaundice.

It is estimated that 71 million people are chronically infected with hepatitis C. The disease kills an estimated 400,000 people each year, the vast majority of whom live in developing countries where there is little or no access to diagnosis and treatment.

Staff in an Ebola treatment centre in Bikoro get dressed in full personal protective equipment. Democratic Republic of Congo, May 2018.

While hepatitis C is found worldwide, Central and East Asia, Egypt, China, and Pakistan are the regions and countries most affected.

In the last few years, new drugs called direct-acting antivirals (DAAs) have been developed that allow for treatment to be given orally, with few side effects, over a course of three months. These new drugs are very effective – with different combinations curing well over 95 per cent of patients – but can be very expensive in high- and middle-income countries. Prices for a three-month course of treatment in wealthy countries started at well above US$100,000, and today, treatment remains unaffordable for many, particularly in middle-income countries. Through the use of generic DAAs, MSF has been able to secure a price of just US$120 per treatment in most projects.

MSF treated 14,400 people for hepatitis C in 10 countries in 2018.

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, most commonly 10 years – 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. 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 176,200 patients with first-line or second-line ARV treatment in 2018.

Kala azar (visceral leishmaniasis)

Largely unknown in high-income countries, kala azar – Hindi for 'black fever' – is a tropical, parasitic disease transmitted through bites from certain types of sandfly. Of the estimated 50,000 to 90,000 annual cases, 90 per cent occur in Brazil, Ethiopia, India, Kenya, Somalia, South Sudan and Sudan, where the disease is endemic.

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.

Today, liposomal amphotericin B is becoming the primary treatment drug in Asia, either alone or as part of a combination therapy. While safer and shorter than previously used medication, it requires intravenous administration, which remains an obstacle to its use in local clinics. An oral drug, miltefosine, is often added to optimise treatment regimens in patients. 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 other treatment combinations is underway.

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

MSF treated 9,900 patients for kala azar in 2018.

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 piloted a seasonal malaria chemoprevention (SMC) strategy in Chad, Mali and Niger. Now used in several countries, children under five take oral antimalarial treatment monthly over a period of three to four months during the peak malaria season.

MSF treated 2,396,200 people for malaria in 2018.

Malnutrition

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

Malnutrition in children 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 their clinical state, undernourished children are diagnosed with moderate or severe acute malnutrition.

MSF uses ready-to-use food to treat malnutrition. These ready-to-use foods contain fortified milk powder and deliver 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 74,200 malnourished children to inpatient and 132,900 to outpatient feeding programmes in 2018.

Measles

Measles is a highly contagious viral disease. Symptoms appear on average 10 days after exposure to the virus and include a high fever, rash, runny nose, cough and conjunctivitis. There is no specific treatment against measles; all cases receive vitamin A to prevent eye complications, antibiotics to prevent respiratory tract infections, and nutritional support. Other case-based care can include treating symptoms for stomatitis (a yeast infection in the mouth) and dehydration.

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 up to 10 per cent, rising to 20 per cent in outbreaks with limited access to care. Death is mostly due to severe respiratory infections, such as pneumonia; diarrhoea and stomatitis that can lead to malnutrition; and, more rarely, neurological complications such as 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 children 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 vaccinated 1,479,800 people against measles in response to outbreaks in 2018.

continued overleaf ›

Glossary of diseases and activities continued ›

Meningococcal meningitis

Meningococcal meningitis is a bacterial infection of the thin membranes surrounding the brain and spinal cord. Symptoms may occur 1 to 4 days after infection. It can cause sudden and intense headaches, fever, nausea, vomiting, sensitivity to light and stiffness of the neck. The infection can progress rapidly, and death can follow within hours of the onset of symptoms. However, even with treatment, up to 10 per cent of people infected can die; in the absence of treatment this may rise to 50 per cent. Among survivors, 10 to 20 per cent are left with lifelong conditions such as deafness, mental retardation and epilepsy.

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 treated with specific antibiotics.

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. Prior to the introduction of a meningitis A conjugate vaccine in 2010, epidemics were mostly caused by meningococcus A. The first large-scale meningococcal C epidemic was recorded in Niger and Nigeria in 2015. Conjugate vaccines against multiple meningococcus strains (ACWY) are in extreme shortage, are very expensive and therefore are impossible to use for wide-scale preventive campaigns. However, a new meningococcus conjugate vaccine against the ACWYX strains is currently being developed and expected to be available at an affordable price in 2021 or 2022.

In total, MSF vaccinated 33,900 people against meningitis in response to outbreaks in 2018.

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 provided 404,700 individual mental health consultations in 2018.

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 125,200 relief kits in 2018.

Reproductive healthcare

Emergency obstetrics and newborn care are an important part of MSF's work. Medical staff assist births, performing caesarean sections when necessary and feasible, and mothers and newborns receive appropriate care during and after delivery.

Many of MSF's programmes offer more extensive maternal healthcare. Several ante- and postnatal visits are recommended and include, where needed, prevention of mother-to-child transmission of HIV. Contraceptive services are offered, and safe abortion care is available. The need for medical care for terminations of pregnancy is obvious: in 2018, MSF treated over 24,000 women and girls with abortion-related concerns and complications, many of which resulted from unsafe attempts to terminate pregnancy; we also provided safe abortion care to over 11,000 women and girls who requested termination of pregnancy.

Skilled birth attendance and immediate postnatal care can prevent obstetric fistulas, a stigmatising medical condition resulting in chronic incontinence. MSF provides surgical care for fistula repair in some of the most remote areas.

Since 2012, MSF has piloted cervical cancer screening and treatment. Human papillomavirus infection is the main cause of cervical cancer and particularly affects HIV-positive women.

MSF assisted 309,500 births, including 25,900 caesarean sections in 2018.

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.

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 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 aims to raise awareness among local authorities, as well as the armed forces when they are involved in the assaults.

MSF provided medical care to 24,900 victims of sexual violence in 2018.

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 98 per cent of reported cases are caused by the parasite *Trypanosoma brucei gambiense*, which is found in western and central Africa. The reported number of new cases fell by 95 per cent between 1999 and 2017 (from around 28,000 to 1,450).

A 14-year-old victim of sexual violence comes for medical and psychological care at Castors hospital in the Central African Republic, January 2018.

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 three different laboratory tests, including a sample of spinal fluid.

A new drug, fexinidazole – the first all-oral treatment that works for both stages of the disease – has been developed by Drugs for Neglected Diseases *initiative* (DND*i*) and received approval in late 2018. While it is being made gradually available, nifurtimox-eflornithine combination therapy or NECT is a safe, highly effective but cumbersome treatment developed by MSF, DND*i* and Epicentre in 2009.

MSF treated 80 people for sleeping sickness in 2018.

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, over 10 million people develop active TB and 1.6 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. Among people living with HIV, TB incidence is much higher, and is the leading cause of death.

Diagnosis of pulmonary TB depends on a sputum sample, which can be difficult to obtain from children. A molecular test that can give results in two hours and can 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, and can take up to two years and cause serious 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 of the newest drugs – bedaquiline and delamanid – can improve treatment outcomes for patients with drug-resistant versions of the disease, but their availability is currently limited.

MSF initiated 19,400 patients on treatment for TB in 2018, of which 2,840 for DR-TB.

Vaccinations

Immunisation is one of the most cost-effective medical interventions in public health. However, it is estimated that around two million children die every year from diseases that are preventable by a series of vaccines recommended by the World Health Organization and MSF. Currently, these vaccines are BCG (against tuberculosis), poliomyelitis, DTP (diphtheria, tetanus, pertussis), hepatitis B, Haemophilius influenzae type b (Hib), conjugate pneumococcal, rotavirus, measles rubella, yellow fever, and human papillomavirus – although not all vaccines are recommended everywhere.

In countries where vaccination coverage is generally low, MSF strives to offer routine vaccinations for children under five as part of our basic healthcare programme. Vaccination also forms a key part of MSF's response to outbreaks of vaccine-preventable diseases such as measles, cholera, yellow fever, and meningitis. In humanitarian emergencies, frequently involving population displacements or the rapid deterioration of living conditions and health, MSF conducts large-scale preventive campaigns to reduce the burden of vaccine-preventable diseases as well as to reduce the risk of outbreaks, such as measles or cholera.

MSF conducted 412,300 routine vaccinations in 2018.

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 we work.

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 sanitation facilities and ensure good hygiene practices.

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Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, exclusion from healthcare and natural disasters. MSF offers assistance to people based on need and irrespective of race, religion, gender or political affiliation.

MSF is a non-profit organisation. It was founded in Paris, France in 1971. Today, MSF is a worldwide movement of 24 associations. Thousands of health professionals, logistical and administrative staff manage projects in 74 countries worldwide. MSF International is based in Geneva, Switzerland.

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COVER PHOTO
18-year-old Ali takes part in one of his twice weekly rehabilitation sessions at the MSF hospital in Mocha, Yemen, November 2018. Ali was injured when a landmine exploded in the fields of Mawza, east of Mocha.
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