

## DEAR FRIENDS



Abiy Tamrat,  
President of MSF Switzerland

2010 was marked by a series of large-scale disasters affecting millions of people throughout the world. It was also a very demanding year for Médecins Sans Frontières, which launched the largest emergency operation in its history after the earthquake that devastated Port-au-Prince and its surroundings on 12 January, 2010. In the earthquake's aftermath, MSF deployed massive resources to face the needs of hundreds of thousands of Haitians. Later in October, we responded to the cholera epidemic that spread all over the country, affecting more than a quarter of a million people. In between those two main events, MSF also developed other major emergency operations. Caring for patients affected by epidemic outbreaks such as cholera, meningitis and measles in several African countries, providing therapeutic feeding to thousands of severely malnourished children in countries of the Sahel belt and, over the summer, assisting people affected by the political violence in Kyrgyzstan.



Christian Captier,  
General director of MSF Switzerland

If these tragedies have stretched the resources of our association to its limits, one has to underline the formidable mobilisation of the members, staff, volunteers and donors of MSF in Switzerland and worldwide. The challenge has been particularly critical in terms of human resources, with almost 1,000 departures of international staff this year – compared to 620 in 2009 – in support of the work done by our 3,700 national MSF colleagues in the field. Without their relentless commitment and skills, we would not have been able to face these situations. In line with this level of operational reactivity, our budget has also significantly increased from CHF 103m in 2009 to CHF 148m in 2010 with around 40% of the operational budget dedicated to emergencies.

These resources have enabled us to provide medical consultations to more than 1.2 million people – almost 450,000 more than in 2009. Most of these cases are located in destitute and “off-radar” crises like in Dagahaley/Dadaab Somali refugee camps in Kenya or in the northern part of the Democratic Republic of Congo (DRC). With more than 63,500 patients admitted in our hospitals all around the world, 7,500 surgical interventions, 12,200 deliveries and more than 100,000 children treated for severe malnutrition, MSF medical teams were active throughout the year. Each of these lives matters and even though technical developments of tools and new innovative approaches have enabled a better and larger level of care, still too many people remain out of our reach in Somalia, Iraq, Sudan, DRC and even in the remote parts of Haiti affected by cholera.

Timely access to populations in need remains a critical challenge that is too often hampered by political logic which we denounce publicly when it is endangering assistance to these populations. Beyond access, our teams were and are confronted to the limits of the current aid system, led by the United Nations, with insufficient capacities to respond to emergencies like the cholera epidemic in Haiti or to adapt to the growing needs of refugees like in the world's largest refugee camp in Dagahaley/Dadaab. Safety and risk management also remain major issues of concern in many of our missions where the civilian population continues to bear the brunt of the violence. As sad reminders of this dark reality, the fate of the son of one of our national colleagues abducted in March 2009 in DRC remains unknown, while in April 2010 another colleague died in a dramatic accident in Djibouti.

However, despite these difficulties, our commitment to respond to people in need in an impartial and independent manner remains intact. With the crises in Libya and Côte d'Ivoire, the earthquake in Japan, and several generalised epidemic outbreaks, the first months of 2011 are calling for the same level of mobilisation as in 2010. These efforts are only possible thanks to the commitment of all those who support the action of MSF in one way or another. This report, an overview of our 2010 activities, is a token of our gratefulness to all of those people, to each of you.

Sincerely yours,

Abiy Tamrat,  
President of MSF Switzerland

Christian Captier,  
General director of MSF Switzerland

“Our commitment to respond to people in need in an impartial and independent manner remains intact.”

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**Chad:**  
Immunisation of  
131,000 children  
against measles.

MARCH



© Olivia Blanchard/MSF

MAY

**Guatemala:**  
Emergency relief  
following the eruption  
of the Pacaya volcano  
and tropical storm  
Agatha.

JUNE

**Somalia:** Distribution  
of plastic sheeting  
following floods  
affecting Belet Weyne.

< JAN 2010

**Haiti:** MSF  
launches an  
emergency response  
following the deadly  
earthquake of  
12 January.

JANUARY



© Bruno Stevens/Cosmos

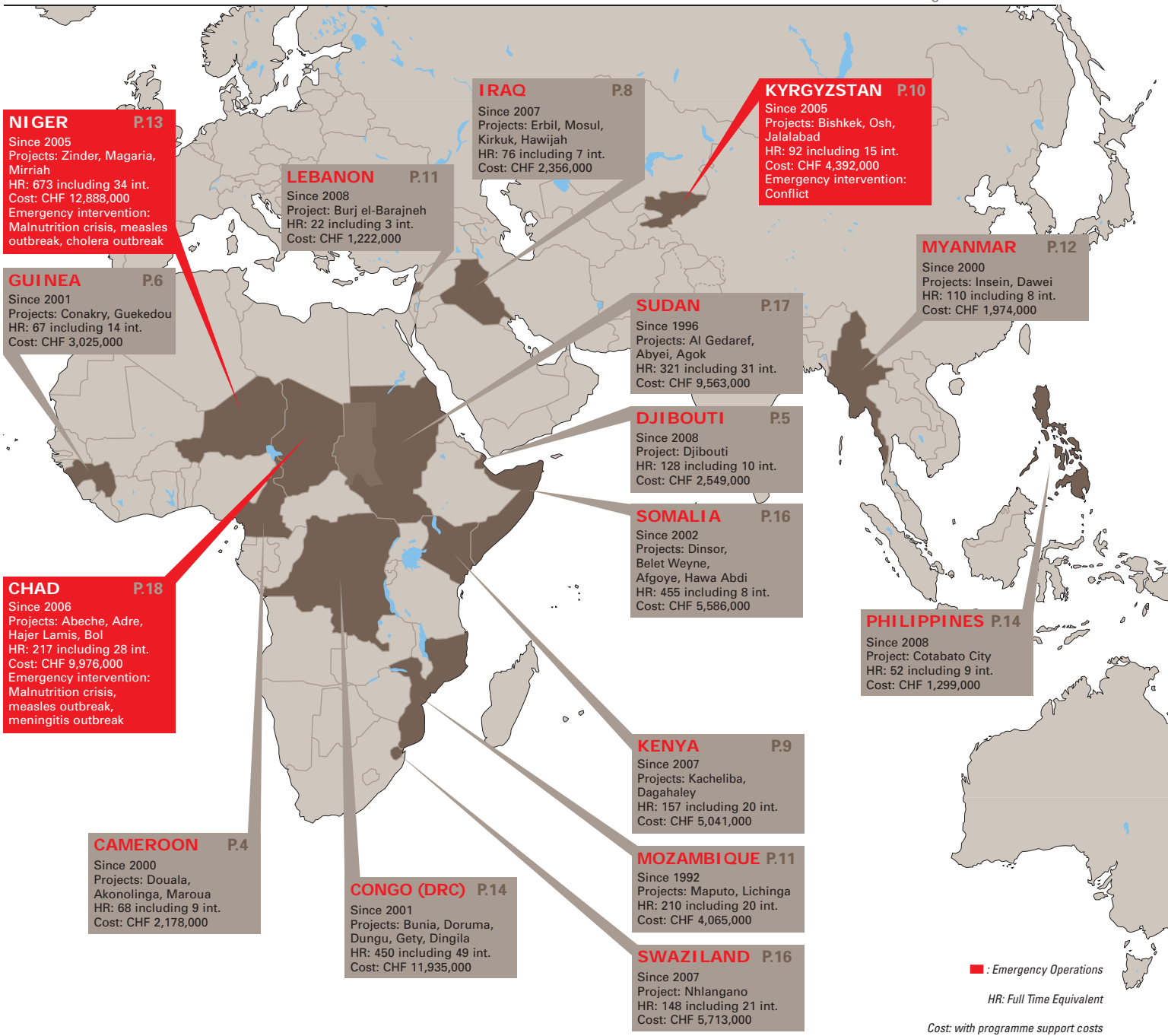
**Cameroon:**  
Cholera epidemic  
in Far North  
province.

**Kyrgyzstan:** MSF  
provides emergency  
relief in Osh and  
Jalalabad for victims of  
the violence that broke  
out in the region.



© Aleksandr Glyadyelov

EMERGENCY



© Claude Mahoudeau/MSF

AUGUST

**Djibouti:** Distribution of essential supplies following a fire in the district of Ambouli.

SEPTEMBER

**Sahel:** After the malnutrition, cholera hits Niger and Chad. MSF opens treatment facilities in both countries.



© Yann Libessart/MSF

**INTERVENTIONS**

**DEC 2010 >**

**Sahel:** Malnutrition rates exceed the emergency threshold throughout the region. MSF provides aid in Niger, Chad and Sudan.

JUNE



© MSF

**Mozambique:** Immunisation of 250,000 children against measles.

OCTOBER

**Haiti:** A cholera epidemic in Haiti spreads throughout the island, affecting tens of thousands of people. MSF Switzerland treats more than 24,000 sufferers.

## PROGRAMMES 2010



Buruli ulcer patient during a physiotherapy session. © Marcell Nimfuehr/MSF

### CAMEROON

**Pilot project to treat HIV/Aids patients who have developed resistances to previous medication, and treatment for people suffering from neglected disease Buruli ulcer**

According to a study carried out by MSF in Douala, about ten percent of all people on first-line antiretroviral (ARV) drugs develop resistance to the medication after a number of years. These patients then need to switch to a second-line protocol in order for their treatment to remain effective. However, second-line treatment is generally unavailable in developing countries, primarily because of its prohibitive cost. MSF started providing ARV treatment in Cameroon in 2000. In Nylon District Hospital, Douala, MSF now supports a pilot project for the country to help switch patients to second-line therapy. MSF is providing medical expertise, training, medication and advocacy. The organisation hopes that the project will help prove the feasibility

and necessity of implementing second-line treatment in developing countries. Fifty-eight patients began this lifesaving treatment in the last months of 2010.

Staff are also working to improve care for those still on first-line treatment, replacing the most widely used type of medication with one that has fewer side effects, and which should result in fewer patients developing resistance. In 2010, around 190 patients were transferred to the new medication and 295 people began their ARV treatment on the new medication.

#### Treating Buruli ulcer

In Akonolinga, a town in central Cameroon, MSF is treating patients with Buruli ulcer. This infection is related to leprosy and tuberculosis and can cause painful wounds and physical deformations, often leading to social stigma for sufferers of the disease. MSF has set up a "Buruli pavilion" in the town's hospital, where 120 patients received care in 2010. MSF is

conducting outreach activities from the pavilion so that people living further away can access care more easily. In 2010, the Ministry of Health declared the pavilion a national reference point for the treatment of Buruli ulcer.

In early May 2010, a cholera outbreak affected the far north of Cameroon as well as neighbouring countries. MSF assisted the authorities' response by donating sanitation and medical supplies, and set up and managed two cholera treatment units. Between May and September, 6,200 cases were registered in the region of Extrême Nord.

**Reason for intervention:**  
Endemic/epidemic disease

**In the country since:**  
2000

**Human resources:**  
68 staff including 9 international staff

**Costs for 2010:**  
CHF 2,178,000

## DJIBOUTI

### Reducing levels of malnutrition among children in the slums of Djibouti City

Djibouti is a small republic in the Horn of Africa, consisting mostly of desert. Over the past couple of years, drought, rising food prices and increased numbers of migrants passing through the country have had severe consequences on the food security of the country. Therefore levels of malnutrition have exceeded emergency thresholds in a number of locations.

In 2010, MSF provided medical care for acutely malnourished children in the districts of Balbala, Hayableh, Arhiba and PK12. These districts are home mainly to migrants, asylum seekers and poverty-stricken Djiboutians who have moved to the city from rural areas.

In order to reach as many of the 200,000 inhabitants of the slums as possible, teams travelled from door to door to identify acute malnutrition in children and to raise awareness about the disease. Based on their level of malnutrition, children were referred to one of MSF's six feeding centres that provide care on an outpatient basis in the slums, or to MSF's 35-bed therapeutic feeding centre, where children suffering from malnutrition with complications receive 24-hour medical care. Almost 1,030 malnourished children were hospitalised in 2010 and more than 3,620 received outpatient care.

MSF also vaccinated young patients against measles and provided medical follow-up. In 2010, almost 140 malnourished children in

the feeding centres tested positive for tuberculosis (TB). Staff treated the children for both TB and malnutrition before referring them to the national TB programme.

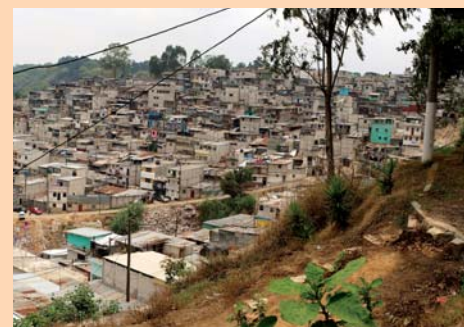
In August 2010, a fire in the district of Ambouli left 125 families homeless. MSF organised a distribution of food and other relief items for the affected families.

**Reason for intervention:**  
Endemic/epidemic disease

**In the country since:**  
2008

**Human resources:**  
128 staff including 10 international staff

**Costs for 2010:**  
CHF 2,549,000



MSF treats victims of sexual violence in one of the most violent regions of Guatemala. © Marcell Nimfuehr/MSF

## GUATEMALA

### Treating victims of sexual violence and assisting victims of natural disaster

In 2010, MSF was providing medical, psychological and social care to victims of sexual violence in two clinics in Guatemala City, in the General Hospital, and in the Ministry of Justice, where assaults have been reported. Although thousands of cases of sexual violence are reported each year, it is estimated that 75 percent of sex crimes go unreported.

There is a national protocol in place for treating victims of sexual violence, but it is implemented in only one clinic in the capital. Many survivors of sexual violence are unable to access treatment, and are often unaware that their physical and mental symptoms can be treated.

MSF's programme takes a multidisciplinary approach to treating sexual violence. MSF offers medication that significantly reduces the likelihood of patients contracting HIV and other sexually transmitted infections, if taken within 72 hours of the assault. In 2010 around 57 percent of patients arrived early enough for this treatment to be effective. A psychological team provides counselling to help patients cope with the acute stress, anxiety and other effects arising from their experience.

In 2010, MSF treated 870 new patients. Including those that had started treatment in previous years, 1,200 patients received medical care, and 2,800 had psychological counselling.

In late May 2010, the eruption of volcano Pacaya and tropical storm Agatha killed almost

200 people. Overflowing rivers, collapsed bridges and the damage caused by mudslides resulted in the displacement of tens of thousands of people. MSF assisted people in the departments of Retalhuleu, Escuintla and Santa Rosa. Over 20 days, teams distributed hygiene kits (containing toothbrushes, soap, sanitary towels, buckets, etc.), and provided medical care, drinking water and mental health support to people affected by the flooding.

**Reason for intervention:**  
Social violence/Healthcare exclusion

**In the country since:**  
1986

**Human resources:**  
38 staff including 4 international staff

**Costs for 2010:**  
CHF 1,123,000

## GUINEA

### Providing paediatric care and care for malaria

Health facilities are poorly distributed across Guinea, and the health system lacks staff, medicine and equipment. Residents of Matam, a district of the capital city Conakry, can rarely afford to go to public health centres, and this has a particularly heavy impact on the well-being of young children and on pregnant or breastfeeding women. Almost half of all children who die before they are one month old have never been taken to a health facility.

MSF is working with the national health authorities to implement a paediatric programme in three centres in Matam. Sixty community health workers have been hired to help encourage people to make use of the health centres. More than 42,400 consultations were carried out in 2010, including 14,200 for malaria.

MSF staff also work at the National Institute for Children's Health in Conakry, training and advising medical staff and ensuring free care and drugs for children referred to the neonatal and nutrition wards of the institute. Almost 2,300 children were admitted to the neonatal department in 2010 and more than 1,000 were admitted to the feeding centre from March to December.

### New approach to fight malaria

Each year, malaria affects more than a quarter of the population of Guéckédou, an area in the south of the country. Artemisinin-based combination therapy, which is more effective than the drugs traditionally used against malaria and prevents the development of drug resistance, is now available to treat malaria in Guinea, but the drugs are still hard to obtain in remote areas. MSF has begun a project in Guéckédou to build a community-based malaria prevention and

care system. Teams support the emergency and paediatric departments in Guéckédou hospital, but also work in 15 health centres. MSF's community health workers distribute mosquito nets, conduct awareness raising campaigns, and implement early detection measures.

In the last quarter of 2010, when MSF started activities, more than 9,700 consultations were held with patients thought to be affected by malaria. More than 5,800 were diagnosed with and treated for malaria.

#### Reason for intervention:

Social violence/Healthcare exclusion

#### In the country since:

2001

#### Human resources:

64 staff including 14 international staff

#### Costs for 2010:

CHF 3,025,000



In less than three months, the cholera outbreak infected more than 180,000 people. © Spencer Platt/Getty Images

## HAITI

### From the earthquake to the cholera outbreak, a full year of medical emergency care

In the wake of the devastating earthquake of 12 January 2010, which killed an estimated 222,000 people and left 1.5 million people homeless in Haiti, MSF mobilised the largest emergency response in the organisation's 40-year history. Just ten months later, MSF staff supported their Haitian colleagues in tackling a nationwide cholera outbreak that would infect more than 180,000 people in less than three months.

### A long history of medical need

Before the earthquake struck, healthcare was out of reach for most Haitians, as fees charged by both public and private health facilities made it unaffordable. Public hospitals and clinics were plagued by management problems and strikes, and shortages of staff, drugs and medical supplies. Patients could be turned away because the hospitals were full, or would have to abandon treatment when they ran out of money. Giving birth was a risk: Haiti's reported maternal mortality rate was 630 deaths per 100,000 live births. Then the



In Léogâne, MSF built a container hospital, with a 120-bed capacity. © Yann Libessart/MSF



## VOICE FROM THE FIELD

"I have to come to work because this is a disaster and it is my business. If people from other countries can risk their lives and come here to cure people, me, as a Haitian, I must do the same"

MSF social worker Charles Joseph, who lost his home in the earthquake.

earthquake hit and threw Haiti into a period of turmoil that went beyond anything even its most beleaguered residents had known.

Thousands of Haitians, most of whom were directly affected by the disaster, mobilised along with hundreds of international staff to help MSF provide assistance. Within hours of the earthquake, medical teams were overwhelmed by critically injured patients. In the capital city of Port-au-Prince, the MSF Swiss section set up emergency field hospitals in all kinds of structures that were not destroyed: a tourism house, a nursery or a school. In these temporary structures, doctors carried out over 200 surgical interventions. Some 14,200 consultations were provided. These health centres closed in March or April and patients were referred to other MSF structures.

### Hospital in Léogâne

Since January 2010, MSF has been providing emergency medical assistance in the city of Léogâne, in the Département de l'Ouest. This city was 80 percent destroyed by the earthquake. The majority of its inhabitants were left without homes and had to find refuge in temporary shelters. Even before the earthquake, the population of Léogâne had to travel to Port-au-Prince to receive any kind of secondary or tertiary medical assistance. Health structures which existed before the earthquake had either been destroyed or had not been functional for years. The earthquake aggravated people's poverty and need of assistance, particularly in the health sector. MSF interventions focused on providing emergency medical assistance to the wounded. In Léogâne, MSF made distributions of tents and relief supply kits (made up of items such as cooking utensils, hygiene products and blankets) to 3,000 families.

In view of the needs and the absence of secondary medical structures, MSF stayed in Léogâne beyond the January earthquake. At the end of February, the project shifted its focus to chronic emergencies, more specifically gynaeco-obstetrics and neonatology and traumatology. In 2010, almost 4,500 surgical interventions were carried out, including obstetrics. Post-earthquake medical activities started in March in provisional tent structures and the Chatuley container hospital was inaugurated in October 2010. The MSF project in Léogâne is filling a gap in the health sector as it is the only one offering second level health care in the city. Hospital staff provided a total of 88,730 consultations in 2010.

### Cholera outbreak

In mid-October, suspected cases of cholera, a disease not reported in the country for decades, emerged in the Artibonite region, western Haiti. MSF dispatched teams to the town of Saint Marc who immediately began treating patients for severe dehydration from diarrhoea in the Ministry

of Health hospital. The outbreak would eventually touch every province in the country. In the Département du Nord, MSF launched on 5 November cholera treatment activities in the northern city of Cap-Haïtien, the country's second largest city. Within two months, MSF deployed and/or supported 19 health structures and between 80 and 90 Oral Rehydration Points (ORP) to treat patients. In Léogâne, cholera treatment activities started in the course of November, as the epidemic also spread to the Département de l'Ouest. From early November 2010 to mid-January 2011, MSF treated over 25,000 cholera patients in the Département du Nord and Léogâne.

#### Reason for intervention:

Endemic/epidemic disease, Natural disaster

#### In the country since:

2010

#### Human resources:

774 staff including 54 international staff

#### Costs for 2010:

CHF 28,058,000

## CONTAINER HOSPITAL IN LÉOGÂNE

With the destruction of most of the health infrastructures in Haiti, MSF had to be creative. An inflatable hospital was sent there and hosted the first patients only ten days after the earthquake. In Léogâne, where patients were treated under tarpaulins and tents, MSF constructed a hospital with containers. Structure modules had the advantage of being able to be assembled quickly and adapt to needs. After five months of construction, the hospital was inaugurated in October 2010, with the presence of the Haitian authorities. The containers provide a surface of 1700 m<sup>2</sup>, 120 beds, two operating rooms, a radiology department and seven consulting rooms. The building is also independent in terms of water and energy. The construction cost US\$ 2 million. The example of the containers in Léogâne has already been copied. The inflatable hospital, located in Port-au-Prince, will be replaced by a structure similar to that of Léogâne. Another hospital, which functions as a reference for the establishment of an emergency unit in the slums of Cité Soleil and Martissant, will be built by the end of 2011.

## HONDURAS

### Medical and psychological care for young people living on the streets

Honduras has the highest murder rate in Central America, and people living on the streets of Honduras capital city Tegucigalpa are especially vulnerable to violence. In an MSF survey carried out in 2010, almost 59 percent of homeless people under the age of 18 reported having been subjected to physical violence in the last year, and 45 percent claimed to have suffered sexual violence.

From 2005 to August 2010, MSF staff operated a centre providing medical treatment for people under the age of 24 and living on the streets. Staff gave medical and social support

to 460 young people in five years. Patients most often required treatment for respiratory diseases, skin infections and injuries resulting from violence. The centre also provided a space where visitors could wash, eat and try to recover from the effects of drug abuse. Patients received psychological support, which helped some to move on and find work or a place to live.

In 2010 MSF undertook an evaluation of the services it was providing to street-based people in Tegucigalpa, and decided that a new approach would meet the people's needs more effectively. The centre was closed at the end of August and a team has begun preparing for a new programme. This will provide broader

services to all age groups in a larger geographic area. Instead of expecting people to visit a centre, MSF staff will go out in to the streets and actively reach out to vulnerable groups living in the most deprived areas of the capital. This approach should enable MSF to assist more people and to respond better to the full range of their needs.

**Reason for intervention:**  
Social violence/Healthcare exclusion

**In the country since:**  
1998

**Human resources:**  
27 staff including 4 international staff

**Costs for 2010:**  
CHF 756,000



In Iraq, the quality of care is affected by a shortage of specialised staff and a lack of training. © Laurence Hoenig/MSF

## IRAQ

### Addressing basic and specialised medical needs in a war-affected country

The seventh year of violence and political tension since 2003 saw continuing pressure on the emergency capacity of the health system in Iraq. The needs are not only for trauma care but for a whole range of specialist services.

Activities are still considerably restricted by the remaining threats to staff, but the response to pressing needs in the country developed in new directions in 2010. The ability to travel and work in some of the more stable parts of the country has meant a greater capacity by MSF to support these more complex areas of medicine and to raise standards of care.

Although many health facilities are functioning, the quality of care has been affected by

a shortage of specialised staff and lack of training. According to the Iraqi Health Ministry, hundreds of medical employees have been killed in the course of the conflict and great numbers have fled the country. Iraq is short of nurses and of specialist doctors.

There has been no upgrading of skills since the early 1990s. Iraq's doctors once provided some of the highest quality and best resourced services in the region, but now the quality of some medical services is seriously impaired.

In the city of Kirkuk, MSF supports the dialysis unit of the public hospital and started a renal treatment programme in June 2010 for patients with severe kidney failure. The target is to treat around 80 people who need the complex dialysis procedure. In the neighbouring city of Hawijah, despite a highly volatile

context, an MSF surgical team of Iraqi doctors in the General Hospital is working in the operating theatre around-the-clock. It performs around 300 operations a month for both conflict and non-conflict related pathologies.

The pattern of remote support for Iraqi staff and for Ministry of Health facilities still prevails, with MSF providing training to doctors from three hospitals in Kirkuk, and in the governorate of Ninewa.

**Reason for intervention:**  
Social violence/Healthcare exclusion

**In the country since:**  
2007

**Human resources:**  
76 staff including 7 international staff

**Costs for 2010:**  
CHF 2,356,000

## KENYA

**Providing relief and healthcare to hundreds of thousands of Somali refugees and treating kala azar in western Kenya**

Kenya was for a long time one of Africa's most stable countries, but inter-ethnic violence linked to unresolved issues of land property and competition for the control of power and economic resources is today very much alive. Poverty is another major issue and the sharp deterioration of living standards in Kenya over the last decades is well demonstrated by the worsening key social indicators, such as life expectancy and child mortality. In this context, MSF is providing life-saving medical care to refugees and to the Pokot population.

### Healthcare for Somali refugees

For many Somali refugees, there is little solace to be found on the Kenyan side of the border. MSF has taken charge of the healthcare needs of refugees living in Dagahaley camp, part of a complex of refugee camps near Dadaab. The Dadaab camps are bursting at the seams, with 300,000 people in a space made for 90,000. With the camps already overcrowded, new arrivals have been forced to settle in makeshift shelters outside the camps' boundaries.

Each week, 1,400 to 1,500 new refugees arrives from Somalia. This is making the camp very overcrowded, and it means there is less space and many more difficulties for those who are already living there. MSF has been working in the camp since 2009, running a 110-bed hospital and four health posts. In 2010, on average 10,000 general consultations were held and 600 patients were admitted to the hospital every month.

In July MSF signed a Memorandum of Understanding with the UNHCR, the UN refugee agency, for the provision of health services in a second camp, Ifo 2, to be located less than 10 kilometres away from Dagahaley with the capacity to accommodate 40,000 refugees. Construction work began and refugees were due to be relocated in November, when the rainy season began and conditions in and outside the camps got even worse. However, negotiations between the Kenyan authorities and the UN have stalled and by the end of 2010 no relocations had taken place.



The paediatric ward in Dagahaley is always full. © Julien Rey/MSF

In addition to continuing medical services in Dagahaley camp, MSF also provided shelter material to 700 families and together with other organisations ensured the supply of water for the new arrivals.

### Making kala azar a national priority

After seven years of working with kala azar (visceral leishmaniasis) patients in Pokot area, near the border with Uganda, MSF started a kala azar training programme to support Ministry of Health staff in the neighbouring districts of Turkana Central and Turkana South on the use of first-line medication, and, where that fails, second-line medication. Kala azar is spread by sand flies and is fatal if left untreated.

MSF is lobbying for treatment to be provided free of charge by the Ministry of Health and for rapid testing methods, which are ideal for resource-poor settings, to be implemented more widely.

**Reason for intervention:**  
Armed conflict, Endemic/epidemic disease

**In the country since:**  
2007

**Human resources:**  
157 staff including 20 international staff

**Costs for 2010:**  
CHF 5,041,000

## VOICE FROM THE FIELD

Joharu Ibrahim Ahmed aged 30, from Jilib in Somalia, has lived in Dagahaley for three years. The previous day she gave birth to twins Khadija and Amina, in MSF's maternity ward

"I'm 30, and I already have five children aged from two to 12. We left our home in Jilib three years ago. There was heavy fighting in the town — it was chaos — and the family all fled in different directions. I lost my husband in the confusion, but — with my mother and children — made for Kenya, hoping to meet up with him in one of the camps at Dadaab. It was a year before I found him. Now I live with my mother, husband and two brothers-in-law. The future will be whatever God proposes, but I hope my children will be healthy and will grow up and get educated in a good environment. I think Dagahaley will be a good place for them to grow up."



In the emergency room of the MSF-supported Shahit Tepe clinic in Osh. © Aleksandr Glyadyelov

## KYRGYZSTAN

### Response to a major emergency When inter-community violence erupted in the south of the country

The year 2010 was particularly troubled in Kyrgyzstan. In April, President Bakiyev was ousted by a popular revolt. Then in June the south of the country was shaken by violence between Kyrgyz and Uzbek communities. MSF, already working in the country on projects to treat prisoners infected with tuberculosis (TB), was able to assist those in need during the emergencies.

### Political and inter-community violence

When rioting began in the capital Bishkek, MSF provided drugs and medical material to four health centres. In the south, MSF donated medical material and drugs to hospitals and clinics in the provinces of Osh and Jalalabad within days of violence breaking out. Almost 400,000 Uzbeks were displaced, and around 2,000 homes were destroyed. Many people in need of treatment were too afraid to leave their communities, so between June and August MSF ran mobile clinics to reach people in need of care. MSF psychologists held over 660 mental health consultations and 3,700 patients participated in over 550 group therapy sessions.

Months later, tension and mistrust between the communities still hindered access to healthcare. MSF identified 50,000 people from all ethnic groups, in ten districts of Osh city, as particularly vulnerable: some because they had lost their homes, businesses or livelihoods in the clashes, others – single mothers, the elderly living on very small pensions or large families with no income – were already in precarious situations before the June events. MSF operated in seven public health facilities, where staff helped to ensure the provision of care in a non-discriminatory and neutral manner.

### Treating TB in prison

MSF has been treating prisoners infected with TB in Kyrgyzstan since 2005. The incidence of the disease in prisons has declined over the years: the number of patients detected each year dropped from 700 to 350 between 2006 and 2010. This is mainly because of a reduction in the prison population. Around two-thirds of infectious TB patients in the penitentiary system have drug-resistant TB (including all forms of drug-resistant TB – such as multidrug-resistant TB, extensively drug-resistant TB and polydrug-resistant TB), which often requires a particularly long and difficult treatment programme. In 2010, MSF treated 230 new TB patients,

including 20 affected with drug-resistant TB. Patients diagnosed with TB are referred to treatment facilities in three prisons in and around Bishkek, where staff work in collaboration with the Ministry of Health, the prison authorities and international organisations such as the International Committee of the Red Cross.

One of the most important challenges is to assure uninterrupted treatment after release as one-third of TB patients are released from prison before treatment is finished. MSF provides medical and social support to former prisoners with TB and is working to find ways to motivate them to complete their treatment. In 2010, 78 TB patients were released, and 57 of them were still receiving treatment at the end of the year. MSF is advocating for a national TB control policy in the penal system.

**Reason for intervention:** Armed conflict,  
Social violence/Healthcare exclusion

**In the country since:**  
2005

**Human resources:**  
92 staff including 15 international staff

**Costs for 2010:**  
CHF 4,392,000

## LEBANON

### Mental health care for Palestinian refugees

Following the 2006 war in Lebanon between Israel and Hezbollah, an MSF evaluation of the medical needs indicated that one in six people in the country were in need of psychological care.

In 2008, MSF opened a mental health centre in Burj el-Barajneh, in the southern suburbs of the capital city, Beirut. Close to the mental health centre is Beirut's most densely populated refugee camp: some 18,000 Palestinians live in an area of just 1.5 square km. Despite some improvements made in 2010, general conditions in Burj el-Barajneh camp remain poor. Running water and electricity are available for only a few hours a day, and one room is shared by on average of four people. There are few education and employment opportunities, and minimal health and social service provision. This has a serious

impact on the mental wellbeing of individuals. Many Palestinians are also deeply affected by the absence of prospects for the future.

The MSF mental health centre provides free mental healthcare, including home visits, counselling and social support. It primarily serves Palestinian refugees. In 2010, 780 new patients, mainly aged between 25 and 40, received care from the MSF team of psychiatrists and psychologists. The main diagnoses observed so far are depression, anxiety, psychosis and personality disorders. MSF mental health services have also been established within the United Nations Relief and Works Agency (UNRWA) clinic and the hospital run by the Palestinian Red Crescent Society, which are both located inside the camp. MSF's community mental health centre serves as a referral clinic for the most complicated cases. This

set-up should facilitate the future integration of mental healthcare into the health system available for Lebanese as well as Palestinian refugees in Lebanon.

To reduce stigmatisation of mental health issues among the people of Burj el-Barajneh, and to mark World Mental Health Day in October 2010, MSF organised an art exhibition in its mental health centre and a theatrical performance in the camp.

**Reason for intervention:**  
Social violence/Healthcare exclusion

**In the country since:**  
2008

**Human resources:**  
22 staff including 3 international staff

**Costs for 2010:**  
CHF 1,222,000

## MOZAMBIQUE

### At the forefront of the HIV battle

For the majority of Mozambicans, access to healthcare remains very limited and the high number of people infected by both HIV and TB is a heavy burden on a frail healthcare system. Of the 1.6 million people living with HIV, about 430,000 are in urgent need of life-extending antiretroviral (ARV) treatment. Along with HIV, tuberculosis (TB) presents a serious public health concern, and up to 60 percent of TB patients are also infected with HIV.

MSF started caring for patients with HIV in Mozambique in 2001, striving to demonstrate the feasibility of treating HIV in Mozambique's poorly resourced urban areas, such as Chamanculo in the capital Maputo, and in remote areas, such as Niassa province in the north of the country. Over the past decade, MSF has established standardised procedures for HIV care and treatment, paying special attention to treating HIV and TB co-infections.

The comprehensive HIV/AIDS programmes offer testing, pre and post-test counselling, treatment and prevention of opportunistic infections that can occur as a result of a compromised



Children waiting to be vaccinated in Niassa province. © MSF

immune system, psychological support, paediatric diagnosis and treatment, and prevention of mother-to-child transmission. At the end of August 2010, more than 200,000 patients were receiving ARV treatment in Mozambique, of whom over 33,000 were being treated with the assistance of MSF.

In September 2010, MSF teams conducted an epidemiological survey in Niassa province following reports of measles cases and an epidemic in neighbouring Malawi. As a result, MSF staff worked with the Ministry of Health to conduct a measles vaccination campaign: 250,000 children were vaccinated in six districts. MSF staff

helped plan the logistics of the campaign and trained ten vaccination teams from the Ministry of Health. MSF has an emergency preparedness system in Mozambique that is ready to respond to natural catastrophes and outbreaks of disease in support of the national emergency bodies.

**Reason for intervention:**  
Endemic/epidemic disease

**In the country since:**  
1992

**Human resources:**  
210 staff including 20 international staff

**Costs for 2010:**  
CHF 4,065,000



Providing primary healthcare through a mobile clinic in Pa Daw Gyi. © Véronique Terrasse/MSF

## MYANMAR

### Fighting the epidemics of HIV/AIDS and tuberculosis as well as preventing malaria

Low national and international investment in the health sector, combined with tensions and low-intensity conflicts in parts of the country, limits access to health in many areas of Myanmar. Myanmar remains largely isolated on the international stage and faces severe restrictions from the international aid community. Despite the return of the Global Fund, the country continues to suffer from a chronic lack of resources to tackle diseases like HIV/AIDS, tuberculosis (TB), and malaria.

#### Tuberculosis and HIV

Working closely with local communities, MSF offers lifesaving treatment to people living with HIV/AIDS and/or TB, malaria prevention and basic healthcare in the Dawei and Myeik districts. More than 240,000 people are living with HIV in Myanmar, and an estimated 120,000

are in need of lifesaving antiretroviral treatment. Furthermore, Myanmar ranks among the 22 countries with the highest burdens of TB in the world. The national TB programme is underfunded and the lack of adequate regulation of the private sector means that there is no proper regimen for treatment, which leads to high levels of treatment failure and increased drug resistance. TB is the most common opportunistic infection and the main cause of death for people living with HIV.

In Dawei, south of Myanmar, MSF runs an HIV and TB clinic for a local population consisting mainly of migrant workers and fishermen. The organisation is currently giving free treatment and counselling to more than 3,000 TB patients, most of whom are also HIV-positive.

Staff also conduct outreach activities in the surrounding district, going out in the community to test patients and to see patients who

may not be following their treatment regime. In October 2010, MSF set up a new HIV and TB programme in Insein prison in Yangon. Over the last months of the year, 57 patients started on antiretroviral treatment.

#### Malaria

Malaria is one of the leading causes of mortality in Myanmar. MSF clinics provide free diagnosis, treatment and prevention in areas where the disease has high prevalence rates. In Dawei, MSF treated more than 9,000 patients for malaria in 2010.

**Reason for intervention:** Endemic/epidemic disease, Social violence/Healthcare exclusion

**In the country since:** 2000

**Human resources:** 110 staff including 8 international staff

**Costs for 2010:** CHF 1,974,000

## NIGER

### Responding to chronic malnutrition crisis

Nutritional crises are a chronic problem in Niger, but a particularly poor harvest in 2009 made the crisis in 2010 far worse than usual. Global acute malnutrition rates among children passed the emergency threshold of 15 percent, with more than three percent of under fives suffering from severe acute malnutrition.

### A preventive approach

Even when receiving good care in a high quality nutrition programme, between three and five per cent of patients suffering severe acute malnutrition will die. For some years, MSF's nutrition projects in Niger have been implementing a preventive approach. Children under two years of age who are suffering moderate malnutrition or are at risk of malnutrition are given ready-to-use supplementary food before their condition can deteriorate to the level of severe acute malnutrition.

In 2010, for the first time, this innovative approach was also taken up by the Niger government, the UN and their partner organisations. An ambitious target of reaching more than 650,000 children was set. In Zinder region, MSF provided supplementary food rations to more than 110,000 children aged six months to three years. Preliminary results of a survey carried out in Zinder



Measuring a child's mid-upper arm circumference is a way to diagnose malnutrition. © David Di Lorenzo/MSF

region during the second half of 2010 show that this strategy had a significant impact on mortality rates.

### Malnutrition care in regions severely hit by the food crisis

In Zinder region, MSF supported 19 health centres with feeding programmes in the departments of Mirriah and Magaria, providing extra staff and essential drugs to ensure free care for children under five. A network of 250 community health workers was built in Magaria, who were then dispatched across the department to screen children for signs of malnutrition and encourage parents to seek treatment for their children. MSF managed two therapeutic feeding centres. More than 34,000 children were treated for severe and acute malnutrition. The supplementation programme in Mirriah district reached more than 106,500 moderately malnourished children or children at risk of malnutrition. MSF also provided technical support to BEFEN/ALIMA, a local association running a nutritional programme in another 15 outpatient feeding centres and one therapeutic feeding centre in Mirriah department.

### Malaria

Malnutrition and malaria create a vicious spiral: malnutrition weakens a child's immune

system, making it more difficult to fight against malaria. In turn, symptoms of malaria in children include anaemia, diarrhoea and vomiting, all of which can cause or complicate malnutrition.

In Zinder, MSF treated more than 72,500 cases of malaria. More than a quarter of the children hospitalised for malnutrition were also suffering from malaria.

### Epidemics

MSF supported the Ministry of Health's vaccination campaign against meningitis: in Zinder more than 170,000 people were vaccinated against the disease.

Following a cholera outbreak in September, MSF teams treated 250 patients in two treatment centres and cleaned four wells to help halt the spread of the disease.

## PATIENT STORY

### Kelima, 32, and her son Djamilou

Kelima is a mother of four. She brought her son, Djamilou, 15 months, who had lost a lot of weight, to MSF's Intensive Nutritional Care Unit in Zinder. The doctor diagnosed both severe anaemia and malaria and immediately fed the boy intravenously. Later, he was given therapeutic food. Day by day, he gained weight, until, two weeks later, he was smiling again. "We will soon go back to our village," said his relieved mother. "This year, it was really too difficult to feed the children, we had only a few handfuls of millet for the whole family..."

**Reason for intervention:**  
Endemic/epidemic disease

**In the country since:**  
2005

**Human resources:**  
673 staff including 34 international staff

**Costs for 2010:**  
CHF 12,888,000

## PHILIPPINES

### Responding to trauma until stability returns

In May 2010, following the presidential election, efforts were made to settle the conflict between the government and the Moro Islamic Liberation Front (MILF). The renewed outbreak of the conflict in 2008 resulted in the displacement of more than 750,000 people. At that time, MSF started working in Maguindanao, in the Autonomous Region in Muslim Mindanao, and in North Cotabato in a neighbouring region of Mindanao, because the local health system was overwhelmed and struggling to meet people's basic health-care needs.

Today, the situation on the ground remains fragile, but displaced people have started moving back home or integrating into host communities. The number of displaced people is back to the level it was before the acute crisis of

2008. As a consequence, MSF reduced its medical activities. In October, MSF handed over its projects in Mindanao to the public authorities.

In 2010, MSF provided healthcare in five evacuation centres that it had identified as in need of support. These government-run centres provide a temporary home to people displaced by violence. Special attention was paid to children, women and individuals suffering severe consequences of trauma and violence. MSF held more than 27,500 consultations through mobile clinics or in existing health centres, treating 270 children for severe acute malnutrition and 3,455 pregnant women.

Mental health problems were a major unaddressed issue in the evacuation centres. Many of the displaced people had had traumatic experiences, losing family members and their homes, and living in precarious circumstances for long periods of time. The public health system did

not offer treatment of post-traumatic stress disorder, so MSF integrated a mental health component into its medical response to trauma and violence and treated 1,155 people in 2010.

The organisation helped rehabilitate health structures by setting up clinical and non-clinical waste disposal and improving water supplies and sanitation in health structures at centres in the districts of Datu Piang, Libutan, Lumpong and Libungan Torreta. MSF also distributed relief items, including plastic sheeting and soap, to 800 families.

**Reason for intervention:**  
Armed conflict

**In the country since:**  
2008

**Human resources:**  
52 staff including 9 international staff

**Costs for 2010:**  
CHF 1,299,000



Testing a boy for sleeping sickness. © Claude Mahoudeau/MSF

## DEMOCRATIC REPUBLIC OF CONGO

MSF is the only humanitarian medical organisation working in many areas in the east of Democratic Republic of Congo

In the east of the Democratic Republic of Congo, civilians have borne the brunt of more than a decade of violent conflict. Villages have been pillaged and destroyed, armed men have forced people to flee, and rape has been used as a tool of war. In 2010, thousands more people were displaced from their homes by violence. Throughout the country, decades of neglect of the health system have resulted in a rise in infant and maternal mortality rates, and according to the World Health Organization, life expectancy is among the lowest in the world.

### Assisting victims of armed conflict in and around Gety

Clashes between the Congolese army (FARDC) and rebels groups resumed in the territory of Irumu, Ituri province, after a relatively stable period in 2007 and 2008. MSF has been present in Gety since 2009 and is the only international medical organisation keeping a medical



Patients waiting at an MSF supported facility in Haut-Uélé. © Julie Rémy/MSF

and logistics team in the area and who ensure neutral and impartial assistance to victims of violence and internally displaced people (IDPs).

Medical, psychological and social support is provided in the Gety hospital or through mobile clinics for hundreds of victims of sexual violence.

In 2010, MSF provided more than 100,000 consultations for the population in Gety or for IDPs via mobile clinics. Non-food items and water were also distributed to populations who had fled the fighting. Almost 5,100 people received routine vaccinations.

### Enclaved population in the Uélé

In Haut and Bas-Uélé, attacks by Lord's Resistance Army (LRA) rebels continued to cause displacement of populations. More than 250,000 IDPs remain in the area. Insecurity means they cannot return home. Insecurity also means that many displaced people can only be reached by plane.

In 2010, MSF provided more than 58,600 consultations in health centres or via mobile clinics. In Dungu hospital, more than 1,100 surgical interventions were carried out. MSF treated 110 victims of sexual violence.

The Uélé region is one of the areas in Africa most affected by sleeping sickness (human African trypanosomiasis). MSF staff treated some 830 patients for this deadly disease, which is transmitted to humans through the bite of the tsetse fly.

### Closure of Bon Marché hospital

After three years of relative stability in the Bunia region, Ituri province, MSF handed its

activities in Bon Marché hospital over to the Ministry of Health. MSF had opened an emergency surgical unit in an empty warehouse called Bon Marché in 2003, when Bunia was in the midst of an ethnic conflict. Bon Marché then became a 300-bed structure entirely managed by MSF, with paediatric, maternity and internal medicine services. Victims of sexual violence were treated in a special department.

The Bon Marché hospital closed at the end of June 2010. MSF will continue to support Bunia's referral hospital to ensure the quality of medical care until late 2011. The process of handing over the women's health department also began. SOFEPADI, a Congolese

non-governmental organisation which specifically helps female victims of sexual violence, will take on responsibility for the department. Teams provided care for almost 680 women in the six months before the handover began.

#### Reason for intervention:

Armed conflict, Endemic/epidemic disease, Social violence/Healthcare exclusion

#### In the country since:

2001

#### Human resources:

450 staff including 49 international staff

#### Costs for 2010:

CHF 11,935,000

## VOICE FROM THE FIELD

Amisi is a 20-year-old father. He travelled to the MSF transit site in Aveba near Gety, via a corridor opened by the military for the safe passage of civilians following urgent demands by aid organisations and the civilian society of Gety.

"My wife and my three children are still in the 'exit corridor' with other groups of people. We had to separate at Mabhili because I had terrible headaches and vertigo. I heard that MSF was treating people at the exit, so I went on ahead. It was too unbearable.

We decided to leave Kule because we were suffering too much, particularly from a lack of food. I usually went to work in the fields every day, but for several weeks the fields have been used by the military. In the bush or around the group site, we would find some mushrooms growing at the foot of the trees and sometimes some wild fruit that is normally eaten by monkeys. But it wasn't enough, and we had to try to forage at night in the fields where the FARDC (the Congolese army) were.

If you were caught there, you risked your life. Several times I would hear in the morning that such and such a person had been killed during the night."

## SOMALIA

### Supporting three hospitals in central Somalia and on the outskirts of Mogadishu

The security situation in Somalia deteriorated still further in 2010 and, while needs have grown, basic medical services continue to dwindle. Despite a number of incidents directly affecting its staff in recent years, MSF is still working in the country. International staff are unable to stay for long periods in Somalia due to the security risks, so MSF's projects in the country depend heavily on the commitment of Somali staff, supported by teams of specialist staff based in Nairobi who visit the projects when possible.

### Two hospitals in central Somalia

Teams provide care in two hospitals in the Bay and Hiraa regions, central Somalia. In Dinsor, MSF runs a 65-bed inpatient department as well as providing outpatient consultations. The structures serve the population of the entire districts' approximately 110,000 people. In 2010, more than 2,300 patients were admitted to the inpatient department. It includes medical care for adults and children, treatment for

tuberculosis and kala azar therapeutic feeding for severely malnourished children with associated pathologies. In 2010, the outpatient department provided almost 60,000 consultations.

MSF runs a project within the regional 99-bed hospital in Belet Weyne offering free, secondary level healthcare to the 280,000 inhabitants of the region. Some 2,300 patients were admitted in order to receive emergency and elective surgery, trauma care, medical care for adults, paediatric care or treatment of severe malnutrition. The team also provided some 14,220 outpatient consultations.

After severe flooding led to the displacement of over 10,000 people in Belet Weyne, MSF teams distributed plastic sheeting to help build temporary shelters and screened children for malnutrition.

### Outskirts of Mogadishu

In September 2010, the agreed collaboration between Dr Hawa Abdi and MSF came to an end and MSF ceased its activities in Hawa Abdi hospital, an area on the outskirts of Mogadishu

mainly inhabited by displaced residents of the city. Over three years, the team had admitted over 8,000 children to its paediatric department, more than 34,000 children received treatment for malnutrition, and more than 330,000 consultations had been provided.

MSF continues to support the community hospital in Afgooye. Afgooye Corridor, outside Mogadishu, is temporary home to the world's largest concentration of internally displaced people. Staff provide maternity and general medical services, consultations and an outpatient feeding programme for children under five. In 2010, almost 1,400 patients were treated in the community hospital and more than 31,900 consultations were given.

**Reason for intervention:**  
Armed conflict

**In the country since:**  
2002

**Human resources:**  
455 staff including 8 international staff

**Costs for 2010:**  
CHF 5,586,000

## SWAZILAND

### Facing a deadly dual epidemic of HIV/AIDS and TB

Swaziland is facing a health emergency of immense proportions. According to the World Health Organization (WHO), HIV prevalence is at 25.9 per cent among adults aged 15 to 49, and there are more than 1,250 cases of tuberculosis (TB) per 100,000 people. TB is the leading cause of mortality among HIV-positive patients and, to make matters worse, cases of drug-resistant TB are increasing: ten per cent of all TB cases diagnosed are resistant to TB medication. MSF has developed a decentralised, community-based approach to care. People living in the community have been trained as HIV counsellors and to carry out tests for the disease. Swaziland is desperately short of doctors. For MSF, the solution is to entrust more tasks and responsibilities to other medical personnel, for example by training nurses to prescribe medicine or treat cases of uncomplicated, non-resistant TB.



Daily treatment for a MDR-TB patient co-infected with HIV/AIDS.  
© Krisanne Johnson

In line with this idea, MSF has enlisted the support of "expert patients". These are people living with HIV/AIDS who carry out screening, advise and inform new patients about treatment, and raise awareness of HIV in their

communities. In 2010, 80 expert patients were working for MSF in Swaziland.

Throughout 2010, MSF supported all 21 clinics in Shiselweni, the country's poorest and most remote region. Each of these clinics now provides fully integrated care for HIV/AIDS and TB. MSF tested some 14,500 people overall for HIV, tripling the number of tests given each month. The number of people starting antiretroviral treatment doubled. More than 2,550 new TB patients began treatment, including over 100 patients infected with drug-resistant TB. The results of TB treatment, which is a notoriously long and difficult process for the patient, also saw marked improvement.

**Reason for intervention:**  
Endemic/epidemic disease

**In the country since:**  
2007

**Human resources:**  
148 staff including 21 international staff

**Costs for 2010:**  
CHF 5,713,000



Treatment of a woman whose hand became infected from an embedded thorn. © Kate Geraghty/ Fairfax Media

## SUDAN

**Medical needs among the people of Sudan remain high, both in the north and the south**

Despite the 2005 peace agreement between the government of Khartoum and southern rebels, which ended 22 years of brutal civil war, insecurity and conflict persist in southern Sudan. As the south of the country headed towards a self-determination referendum in January 2011, MSF teams were preparing to assist wounded and displaced people in case of violence.

### On the frontline of Abyei

Since 2006, MSF has been the only medical-humanitarian organisation providing much needed healthcare in Abyei and Agok, located in the Abyei region. This strategic region is disputed between northern and southern Sudan and its status remains unresolved. Intervening in this tense area has become more and more difficult and access to provide assistance in many areas has been blocked, due to insecurity.

In southern Sudan, according to the World Health Organization (WHO), one out of seven mothers die during pregnancy or childbirth, one of the world's highest maternal death rates. A major component of MSF's assistance in Abyei and Agok is the provision of a comprehensive antenatal and maternal care programme. Through community education in the region, as well as the referral system that is offered to pregnant women from MSF's nearby programme in Abyei, more and more women are coming to the hospital to give birth.

### Treating malnutrition and kala azar in Al Gedaref

In 2010, MSF teams in Abyei and Agok provided 6,190 antenatal consultations. A total of 31,200 outpatient consultations were carried out. Severe cases were referred to the Agok hospital. 2,730 children were treated for severe malnutrition.

In the north of the country, MSF launched emergency nutrition programmes in Al Gedaref state. Staff treated more than 6,000 children under the age of five.

Following the emergency response, MSF began an observation project with the Ministry of Health in order to formulate a quicker response if needed in the future.

In Al Gedaref state, MSF also opened a kala azar treatment centre in collaboration with the Ministry of Health, and treated 1,100 patients.

**Reason for intervention:**  
Armed conflict, Endemic/epidemic disease

**In the country since:**  
1996

**Human resources:**  
321 staff including 31 international staff

**Costs for 2010:**  
CHF 9,563,000



Weighing a malnourished child in MSF nutrition center in Massakory. © Natacha Buhler/MSF

## CHAD

### Responding to a major malnutrition crisis, several epidemics and treating obstetric fistula

In 2010, the heaviest rains for 40 years destroyed crops, flooded wells and cut off entire villages in Chad. These floods followed a long drought in 2009, which had already resulted in a significant drop in farm production. Chadians had to face a major food crisis and several outbreaks of disease, including cholera, meningitis, measles and malnutrition. One quarter of children under five were suffering from acute malnutrition in the Sahel region of western Chad in 2010. In eastern Chad, conflict continued.

The political relationship between Chad and Sudan improved in 2010. However sporadic clashes continued to be reported in eastern Chad and humanitarian staff were targets of kidnapping, robberies and violence. Insecurity has made it excessively difficult to reach the population and, as a consequence, MSF

handed over to the Chadian Ministry of Health its project in Adré hospital at the beginning of 2010.

### Responding to outbreaks

During the first months of 2010, there was an outbreak of measles in the capital city, N'Djamena. Staff cared for more than 2,200 patients. In March and April, MSF immunised over 131,000 children.

While responding to the measles outbreak, MSF staff observed high rates of acute malnutrition among children. This led to the opening of nutritional programmes in the western regions of Hadjer Lamis, Kanem, Lac and Mayo Kebbi Est. In total, MSF treated more than 22,000 children, of whom over 11,900 were severely malnourished.

In September, there was an outbreak of cholera. In total, MSF treated close to 1,230 patients. Heavy rains and floods hit a population that was already weakened. Due to recent outbreaks of measles and high levels of malnutrition,

people's immune systems were low – a typical scenario for cholera outbreaks.

### Obstetric fistula

In the city of Abéché, MSF responds to the high prevalence of obstetric fistulas (injuries to the birth canal) and high maternal mortality. The project focuses on a large population with poor access to medical care who are suffering from a completely neglected and very stigmatising disease.

In 2010, MSF assisted more than 3,400 deliveries and treated 144 women with obstetric fistulas.

**Reason for intervention:** Endemic/epidemic disease, Social violence/Healthcare exclusion

**In the country since:** 2006

**Human resources:** 217 staff including 28 international staff

**Costs for 2010:** CHF 9,976,000

# HUMAN RESOURCES

The Haiti earthquake and cholera epidemic, as well as the various other epidemics and crises that marked 2010, had the Human Resources Department at MSF Switzerland working flat out.

In Haiti, between the deadly earthquake of 12 January and the treatment of cholera sufferers from October, almost a thousand MSF Switzerland employees helped at medical facilities in Port au Prince, Léogâne and Cap-Haïtien. In the first phase of the emergency, staff from headquarters went to support the teams deployed in the field, to make it possible to quickly mount a large-scale response. They were soon replaced by international and national employees. Some 450 international volunteers were posted to our medical facilities in Haiti during that period. Due to the increase in operational activities linked to this disaster of unprecedented proportions, we had to considerably increase the resources allocated to recruitment, career management, field administration and general support for operations. From the first weeks of the intervention, psychological support was also provided to all MSF staff working in Haiti.

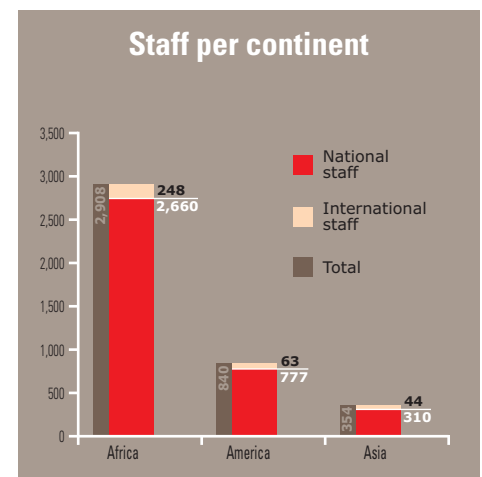
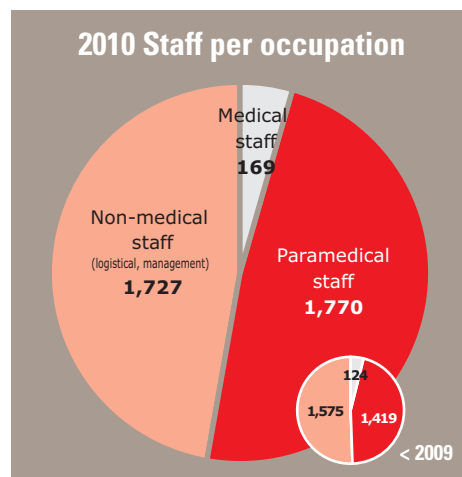
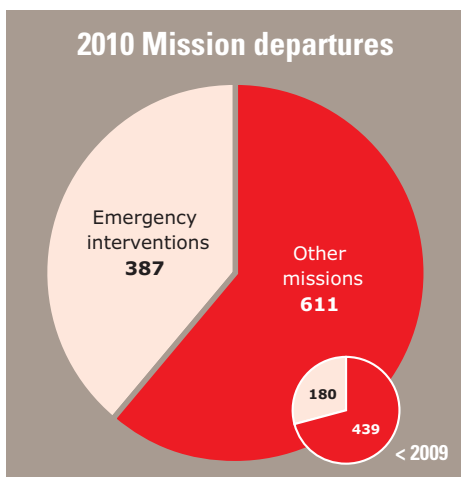
An emergency operation like the 2010 Haiti crisis is a long-term commitment, and places considerable pressure on all our resources. It was a daily challenge for the teams to manage the crisis operation without neglecting our other ongoing projects. At every level, our colleagues responded in an exemplary fashion.

Despite the high peaks of activity that our department had to cope with, we did a thorough job of ensuring the professionalism of the human resources on the ground, particularly by appointing a trained and experienced HR Coordinator to each capital team. Measures were taken to improve the "health and stress at work" problem, in particular with the recruitment of a doctor dedicated to all our employees, and the first positive effects of this were felt, both at headquarters and in the field, over the course of the year. Our human resources, which are central to our ability to fulfil our humanitarian role, are more international now than ever, and MSF needs to find global solutions to optimise its processes and practices. In coordination with the MSF movement's other four operational centres (Amsterdam, Barcelona, Brussels and Paris), we have undertaken several major projects to harmonise our policies and tools in the field, to review the pay policy for our international staff, and to rationalise recruitment.

In 2010, 4,800 men and women of more than 80 different nationalities helped us implement our operational policy with professionalism and commitment. We thank them for having made our actions possible.

Franck Eloi, Human Resources Director

“An emergency operation like the 2010 Haiti crisis is a long-term commitment, and places considerable pressure on all our resources.”

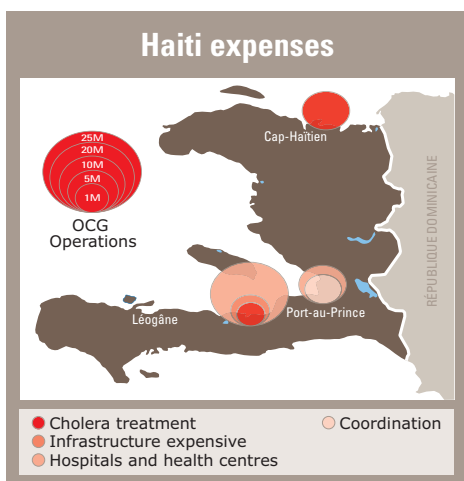


## FINANCIAL RESULTS FOR 2010

2010 was certainly the most active year since MSF Switzerland was created in 1981, and saw the organisation manage a greater volume of operations than ever before.

With expenditure of CHF 148M, last year MSF Switzerland carried out the three largest operations of its history, in Haiti (CHF 28M), after the earthquake and during the cholera epidemic, in Niger (CHF 13M) in response to the nutritional crisis, and in the Democratic Republic of Congo (CHF 12M) with victims of violence. The medical statistics gathered reflect the increase in operational activity over the past year:

- In 2010, more than 1.2 million people received outpatient consultations, organised in mobile clinics, health centres or hospitals managed or supported by MSF. (2009: 750,000 consultations).
- MSF Switzerland admitted more than 63,500 people to its hospitals, for serious and potentially fatal pathologies (severe malaria, severe malnutrition, meningitis, surgical cases, obstetric cases). (2009: 50,700 admissions).



### Numerous emergency interventions

In 2010, programme expenditure totalled CHF 116M. MSF Switzerland managed or financed 59 projects in 2010, compared with 50 in 2009.

In total, CHF 47M was allocated to emergencies in 2010, CHF 28M of which was used exclusively in Haiti (see boxed text).

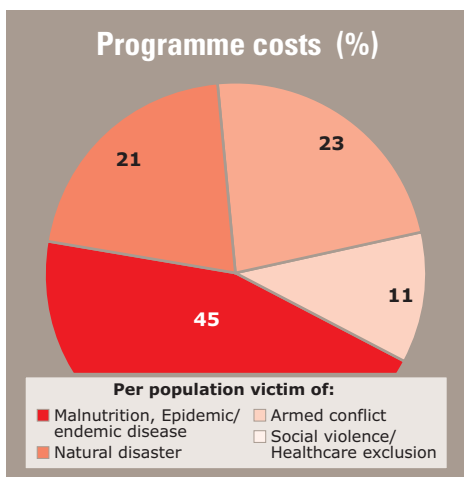
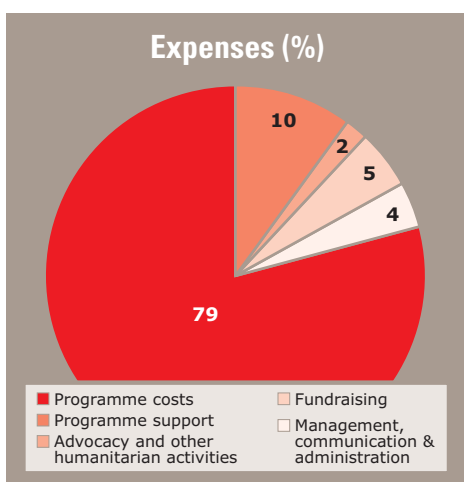
The other interventions took place in Niger and Chad, in response to the nutritional crisis; in Haut Uélé and Ituri (Democratic Republic of Congo), two regions in the grip of violence from armed groups; and in Kyrgyzstan, following violent outbreaks in Osh and Jalalabad in particular.

Spending on regular programmes also rose to CHF 70M: the Somali context accounted for a significant amount of expenditure, both in Somalia itself (CHF 5.5M) and in Kenya, where MSF offers primary and secondary healthcare to refugees (CHF 5M).

The organisation still also has a strong presence in northern and southern Sudan, where total spending was in the region of CHF 9.5M.

In Iraq, MSF Switzerland began new activities in surgery and nephrology, to support a hospital in northern Iraq (CHF 2.3M).

In addition, MSF Switzerland has stepped up the treatment of HIV/AIDS patients, some of whom are co-infected with tuberculosis, especially in Mozambique (CHF 4M) and Swaziland (CHF 5.7M).



Spending at the headquarters saw a more modest increase: +14%, a third of which was due to the creation of a provision linked to the new exit policy for employees at the MSF HQ; not including that operation, the rise in spending was just 10%.

- The main increases were linked to the strengthening of the operational support departments (CHF +1.8M), to enable them to cope with the exceptional volume of activity in 2010.
- An additional CHF +0.5M was invested in fundraising in Switzerland, mainly for face-to-face canvassing activities.
- The strengthening of the IT teams and costs linked to the replacement of financial and logistics software in the field represent an increase of CHF +0.7M (partially offset by dedicated funding).

In total, expenditure for the year was CHF 148M, exactly double that of 2005, five years earlier. In the same period, the proportion of spending allocated to humanitarian work rose from 88% to 91%.

“With expenditure of CHF 148M, MSF Switzerland carried out the three largest operations of its history.”

### Thank you to our donors!

Revenue also followed an upward curve in 2010, rising by CHF 43M. This increase is explained by several factors:

- Firstly, CHF 33M came from funds raised following the earthquake in Haiti. Those Haiti funds were completely spent in 2010.
- In addition, fundraising activities in Switzerland were very successful, generating around CHF 60M, with the public responding generously to our campaigns.
- The MSF sections in Germany, Austria, Australia, Canada and the US increased their contribution to the projects of MSF Switzerland: the mobilisation of donors abroad also remains strong.
- Finally, a concerted effort was made to further increase public funding, which totalled CHF 28M, CHF 5M more than in 2009, or 17% of total revenue. Consequently, MSF Switzerland remains 83% financed by private funds.

2010 ended with a surplus of CHF 12.4M, after taking into account a book loss from foreign exchange of CHF 4.2M. Thus, the financial reserves were equivalent to 6.1 months of reserve at the close of 2010. It is important for MSF to have adequate reserves so that we are able to finance future emergency operations and fulfil our current medical commitments to our patients.

We would like to express our gratitude to the 211,170 donors in Switzerland who responded to our appeals in 2010; thanks also to the hundreds of thousands of others who – in Germany, Austria, Canada, Italy, Mexico and the Czech Republic – financed our operations through donations to MSF partner organisations. We would also like to thank our institutional partners, local authorities, cantons and the Swiss government for their support over many years, as well as the European Union and the foreign countries that contribute funding for our operations.

Geneva, 21 May 2011  
Gilles Carbonnier  
Treasurer

Frédéric Vallat  
Financial Director

## HAITI 2010: EXCEPTIONAL MOBILISATION

The intervention in Haiti led to an unprecedented deployment of human and financial resources by the MSF movement. When the earthquake hit, the Brussels, Amsterdam and Paris operational centres were managing three hospitals in Port-au-Prince; the organisation responded as quickly and comprehensively as possible to the medical and humanitarian needs of the victims of the disaster.

### MSF Switzerland operations in 2010

On 17 January, five days after the earthquake, the MSF Switzerland teams arrived in Léogâne, a town in the immediate vicinity of the earthquake's epicentre. An 80-bed health centre was set up, with a focus on surgical treatments. In late February, MSF began the construction of a semi-permanent hospital with a 120-bed capacity, which was opened in October 2010. The MSF Switzerland teams were also deployed in Port-au-Prince, to provide assistance to the displaced populations. These activities were carried out until spring, when they were transferred to other organisations.

In October 2010, a cholera epidemic spread throughout the north of Haiti, quickly affecting tens of thousands of people. In November and December, MSF Switzerland treated more than 24,000 cases of cholera at the 19 treatment centres opened in the Nord department and the Léogâne region, with a fatality rate of around 1 percent.

### Mobilisation of donors

The general public was deeply moved by the Haiti earthquake and rallied to the country's aid. Hundreds of thousands of people worldwide made generous donations to MSF totalling some EUR 106M, making it possible to mount the largest relief operation ever undertaken by the movement. In Switzerland, MSF received nearly CHF 3.3M in donations for Haiti.

### Rendering of accounts

MSF Switzerland spent a total of CHF 28M in Haiti. A specific financial report, which has been duly audited, addresses operations in Haiti in 2010. This report is available on our website ([www.msf.ch](http://www.msf.ch)). More generally, the MSF movement has produced three quarterly activity reports, presenting all the movement's operations, medical statistics and financial figures. These reports can also be consulted online ([www.msf.org](http://www.msf.org)).

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- ANRS – Agence Nationale de Recherche sur le Sida
- Swedish Embassy
- CIDA – Agence Canadienne de Développement International
- DANIDA – Danish International Development Agency
- DFID – UK Department for International Development
- Swiss Agency for Development and Cooperation
- European Commission Humanitarian Aid Department
- Ministry of Foreign Affairs (Germany)
- Ministry of Foreign Affairs (Norway)
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- NORAD – Norwegian Agency for Development Cooperation
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- SIDA – Swedish International Development Cooperation Agency
- Unicef
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## THE BOARD

### President (since May 2010)

**Abiy Tamrat** joined MSF in 1999. After holding the position of Head of Regional Health in the Ethiopian Ministry of Health, he worked for MSF first as a national staff member and then as an expatriate volunteer. In 2002, Abiy Tamrat came to MSF's Geneva headquarters as Emergency Deputy Programmes Manager. In 2006, he was appointed to the position of Medical Director of the Swiss section, where he contributed to developing the organisation's expertise, innovative approaches and medical policies. At the General Assembly of 21-22 May 2010, he was elected to the organisation's Board of Directors and took on its presidency for a term of three years.

### Vice President

A doctor of general medicine, **Antoine Chaix** joined MSF in 1997 for an initial mission in Nagorno-Karabakh in the south Caucasus. He worked on various missions in the field until 2002, when he took up the position of Medical Coordinator for Sierra Leone. A member of MSF Switzerland's Board of Directors since 2004, Antoine Chaix currently works for a private practice in Einsiedeln, near Zurich.

### Treasurer

**Gilles Carbonnier**, a socio-economist by training, teaches development economics at the Graduate Institute of International and Development Studies (IHEID) in Geneva. A former ICRC delegate, Gilles Carbonnier has been a member of MSF Switzerland's Board of Directors since 2008.

### Members

**Anne Perrocheau** is a French doctor and epidemiologist. She joined MSF in 1991 as Medical Coordinator in Mozambique and has also worked at MSF's headquarters, in the field and at Epicentre, a non-profit organisation created by MSF for medical research and training. Anne Perrocheau currently works as an independent consultant.

**Dominique Legros** is a public health doctor and epidemiologist who worked for MSF in Mali, Peru, Malawi, Haiti and Uganda before becoming Director of Epicentre in Paris until 2003. After that he headed the WHO's Disease Control in Humanitarian Emergencies Unit in Geneva, and is now an independent consultant.

**Alexia Cusini** works as a doctor in the infectious diseases division of the University Hospitals of Zurich and Bern. She joined MSF in 2004 for an HIV project in Mozambique.

**Gaëlle Fedida** is a doctor of humanitarian law. She joined MSF in 1998, first in the field and then at the French section's headquarters in Paris, where she was Programme Manager. Gaëlle Fedida has been a member of MSF Switzerland's Board of Directors since 2009.

**Joanne Liu** is an emergency paediatrician who joined MSF in 1996 for field missions. She then worked at the headquarters of the French section of MSF and later became President of MSF Canada. She currently works as a full-time clinician in the emergency paediatrics department of Sainte-Justine University Hospital in Montreal.

**Thomas Nierle**, a doctor, joined MSF in 1997 for an initial mission in Afghanistan. He was then appointed Emergency Programmes Manager at MSF Switzerland and subsequently held the position of Director of Operations until 2004. At present, he is Senior Doctor of the accident and emergency department of Moutier Hospital and has been a member of the Board of Directors since May 2010.