MSF-OCBA Annual Report 2011

Independent humanitarian-medical intervention in a changing world

MEDICOS SIN FRONTERAS

Summary

Chronology 2011

January
Start-up of the campaign “Pills against other people’s pain”

This campaign was launched by MSF for the second year running to make Spanish society more aware, and to raise funds for patients suffering from forgotten diseases.

Haiti, 2010. © Tristan Pfund

February
Closure of the Jacmel Project in Haiti

After being present for two years in the country responding to the earthquake and outbreak of cholera, MSF-OCBA transferred the Jacmel hospital to the Ministry of Health.

Libya, 2011. © Tristan Pfund

March
Intervention in Libya

MSF carried out two evacuations by ship of patients wounded in war, and contacted the two conflicting sides in order to allow medical care access to the wounded.

Democratic Republic of Congo, 2011. © Robin Meldrum

April
World Cholera Day

MSF asks that the populations of the African countries have access to new treatment for this disease, above all, for children suffering from severe malaria.

Somalia, 2011. © Peter Casaer

May
Presentation of the nutrition study to the G8 in Deauville

MSF claims that food with a high nutritional quality should become the spearhead of the world fight against infant mortality.

France, 2011. © Bruno De Cock

June
Birth of the International MSF

The International MSF association was officially founded, and with it the International General Assembly and the International Board.

Somalia, 2011. © Peter Casaer

July
Massive exodus in search of food in Somalia

In spite of the difficult security problems MSF increased its medical response in Mogadiscio and Jowhar.

Kenya, 2011. © Brendan Bannon

August
Alarm in the refugee camps in Kenya

The refugee camps are overflowing – Dadaab receives over more than 350,000 people even though its capacity is only for 90,000.

Democratic Republic of Congo, 2011. © Gwenn Dubourthoumieu

September
A permanently critical situation in the Dem. Rep. of the Congo

MSF highlights the problems of access for the aid teams in a country where the population suffers from epidemics and violence and which has great difficulty to arrive at the health structures.

Cambodia, 2011. © Eddy McCall

October
The fight against tuberculosis

MSF asks that more funds be assigned to the diagnosis, treatment and prevention of this illness.

40 años de acción humanitaria independiente

MEDICOS SIN FRONTERAS

November
The 40th anniversary of MSF

MSF is 40 years old and takes advantage of this to express its gratitude to the members, donors and other people who have supported their work and allowed them to intervene.

Zimbabwe, 2011. © Salomé Limón

December
Launch of the “Positive Generation” campaign

This musical project is based on the songs of the choirs made up of HIV patients in Zimbabwe. A number of Spanish and international musicians have participated.

Democratic Republic of Congo, 2011. © Robin Meldrum

Ethiopia, 2011. © Lali Cambra

A strategic summary of 2011 operations

*By **Raquel Ayora***
Director of Operations of MSF OCBA

A quick look at the figures and indicators of our projects shows a decrease in the number managed by the operational centre at the end of 2011 (44 – although during the year, at some point or other, we managed up to 53 projects). The dynamics of closures and start-ups impeded 10 projects which had to be transferred or cancelled and only 5 start-ups (with 1 new mission opened) took place. Nevertheless, the global project indicators show a huge increase in terms of medical activity. Many key activities (OPD, IDP, cases of malaria diagnosed by laboratories and treated, reproductive health, attention for victims of violence, including sexual violence, patients helped with nutritional therapy, amongst others) have grown at percentages between 30 and 50%.

Half our projects provide at least secondary medical attention. At the end of 2011, the OCBA independently managed 7 hospitals and intervened in all the hospital services of 10 of them. All of which has had a clear impact on the financial costs and the human resources deployed in the field (in the same way, the necessary accompanying support has been provided from Barcelona and Athens) which obviously has meant a growth in the volume of activity. In spite of these reasons to be content, there is still a great deal to be done in the consolidation of quality standards, such as the implementation of certain transversal components (PMTCT and routine vaccination) which deserve a greater effort.

Looking at the year in general, it is positive with respect to our goal of increasing the complexity and reach of our operations; although evidently we would like that in the future there would also be an increase in the diversity of contexts and populations that we assist.

Emergency response: positive and negative aspects

In 2011, OCBA assisted 27 emergencies, 10 of which were headed by the Emergency Unit. Two important crises were: the nutritional crisis in the refugee camp at Liben (Ethiopia) and the measles vaccination programme in Zambia. Response to epidemics (10 in 2011) and nutritional crises continue to occupy a central location in the emergency response of our Operational Centre. It is worrying that only 2 of the interventions of the Emergency Unit responded to new acute conflicts. As in 2010, the majority of the interventions took place in countries where MSF OCBA was already present, and the teams of these regular missions are those who manage most of the response to crisis related to conflict and violence (a fact that led in previous years to the creation of Teams of Emergency Response in key missions, although the model still needs many improvements, and at the end of 2011 only one of these teams, in the CAR, continued to be active).

The crisis of displacement and malnutrition that affected Somalia (and by extension Kenya and Ethiopia) has without doubt been the most complex operation for the OCBA in 2011. In spite of finding ourselves in an optimum situations in terms of prepositioning our regular teams in the zones most affected by the crisis, this did not serve as an early warning system and did not accelerate our response in proportional manner

considering the seriousness of the situation. The reaction not only of the OCBA, but also of the whole MSF was inadequate. Especially in the case of Liben, the slow handover of the regular cell to the Emergency Unit had severe consequences for the management of the crisis and revealed dysfunction in the mechanism of coordination between the EU and the normal cells. This intervention also demonstrated the loss of response expertise in the Displacement-Refugee camps. Global management of the intervention was evaluated in 2012 and there are hard lessons to be learnt.

Access, access, access

Whether it be for reasons of security or due to control carried out by the states on humanitarian acts, access for the OCBA continues to be very limited in many key contexts. Although we are still present in Sudan, Yemen, Somalia, CAR, DRC, Columbia and Niger, which is in itself obviously positive, we find ourselves confronting severe problems of access in the most vulnerable zones and populations which are most affected by violence and insecurity. In addition, we must bear in mind the security incident that took place in Ifo, Kenya. The OCBA suffered two other serious incidents in the DRC and CAR where our activities have been inevitably affected by the deteriorating context. Whilst our commitment with a model based on persuasion and dialogue with all the actors (whether they be Repressive-Assertive States or non-state armed actors) will continue in the future. It is clear that, apart from Acceptation and Engagement, the key for access to those States and contexts of extreme insecurity will be probably in the improvement of non-traditional operational models (without the presence of international personnel) and in the definition of adapted medical packs for the contexts of restricted access.

In this sense, together with sustained and reinforced investment and the management of security and engagement, we continue to explore and reflect about non-traditional models (through the regional recruitment of personnel for positions of coordination in the field, ways of partnership with other organizations, remote or semi-remote control management for projects and the incorporation of new technologies, amongst others). In 2012 we hope to carry out a systematic and exhaustive evaluation of the opportunities (the risks and challenges) of alternative operational models.

Reflection, Capitalisation, Communication and Advocacy

During 2011 we progressed in the capitalisation of our experiences and reflections with respect to interventions in migrations and urban settlements in the Middle East, an area that continues to give us complex operational problems. Besides the restrictions in access experienced by our teams in Syria, the OCBA continues to fight to find an adequate angle in order to operate in this kind of context where the health services are relatively good. The Inter-sectional Workshop on Interventions in Urban Contexts, held at the end of 2011, recommended an adaptation of the evaluation and intervention guides and tools, and context analysis and security management in these contexts. This is something we shall invest in during 2012. The reflection on and capitalisation of the models of assistance for migrants will be started in 2012. As in previous years we have not managed to reach the objectives foreseen in the evaluation plan, and the application of recommendations continues to be unsystematic. In most cases, the cancelled evaluations were due to situations of insecurity or political instability. In others, they were replaced by Operative Investigation initiatives (12 in 2011) or by a lighter form of capitalisation of learnt lessons.

Communication

2011 has been a relatively silent year for the OCBA. We participated in some inter-sectorial positioning initiatives (Somalia, DRC and CAR. We contributed to the Somali Positioning Document which analyses the perverse effects of the profound politicizationof aid in Somalia (although MSF was one of the few organizations which highlighted the political aspect of the malnutrition and displacement crisis in Somalia, globally it played a minor role in terms of communication). The Centro-African Mission took part in the drawing up the Report of a Silent Crisis, based on the access to health and the humanitarian crisis. The strategy of engagement with the authorities in Ethiopia and the Sudan

prevented us from adopting a more aggressive public position. The lack of stock of Benzinazol (which affected the Chagas programme in Latin America) and Ambisome in India was well answered using strategic combinations of lobbies and communication in which the OCBA networked with other entities and MSF offices.

Support and structural changes

In 2011 we continued with the regionalization of the missions and the optimization of the Mission Coordination Teams (MCT). Cell 5 was created in 2011 and together with CO4, Nairobi and Buenos Aires will be decentralized in mid-2012. Two Operative Units with asymmetric structure and composition will take over the two cells and help to incorporate experience and local knowledge to our operational management. A post of Senior Assessor for Security and Emergencies has been created in the operational Directorate. The Emergency Unit continues progressing towards a model of pool decentralization. The team of Operational Assessors is being restructured in order to guarantee the best possible support for our projects.

As I stated previously, the balance for 2011 is clearly positive although it must be pointed out that security in Kenya, the unplanned replacement of the Head of Operations, the structural changes due to the creation of the CO%, the decentralization initiative, and the redistribution of mission portfolios have given rise to dysfunctions which have affected some specific aspects of operational management.

In 2012 we hope to progress with our global objectives as laid down by the Operational Policy and current Executive Plan. Next year will be one of consolidation for our investments, and capitalization of lessons learnt. And also celebration, when Blanca and Mone return home, something that is present in all our hearts and efforts.

A practical focus on accountability to the beneficiaries

*By **Maddalena Basevi***
Accountability to the Beneficiaries Project Leader of MSF OCBA

During the last decade accountability to the beneficiaries has acquired increasing relevance as much in the development world as in the humanitarian one. Under the term "accountability" a series of frameworks and standards has been widely adopted as precondition in order to obtain public and Public Institutional Funds. On a number of occasions MSF has questioned the standardisation of such initiatives in the accountability to the beneficiaries which underestimates the differences in the quality of help offered, the role of politics in a humanitarian crisis, and the impact it can have on the quality of humanitarian aid that a particular crisis can receive. Far from denying the need to improve accountability to the beneficiaries, MSF considers the need to do so from a pragmatic focus which takes into account the organisational capacities and the specifications of the context. This pragmatic focus is based on a study by MSF OCBA and a future Guide to improve accountability to the beneficiaries, our patients, their families, and the population in general that we propose to help.

During the last decade we have witnessed a vertiginous growth of initiatives dedicated to the implantation of international standards and agreements for accountability with the aim of offering some kind of regulations for the, to describe it one way, "irresponsible and unregulated"[1] world of humanitarian aid. As an answer to the criticism brought about by the humanitarian crises of the 90s in Ruanda, Somalia, Sierra Leone and Afghanistan and a number of scandals which all too often have marked the exponential growth of "aid system", the humanitarian agencies started to organise themselves into networks and platforms, and develop a series of standards, codes and basic norms to regulate it[2].

MSF initially contributed to this self-government exercise for the humanitarian system by participating in the identification of minimum standards at the beginning of the Sphere Project[3].

However, it soon abandoned the Project. The position of MSF did not question in essence accountability or the need to improve the work of the humanitarian agencies. Its preoccupation was centred on the emphasis the Sphere Project placed on the technical aspects (minimum standards and achievement indicators) as a measure of ensuring quality and accountability

[1] Eric Stobbaerts and Nicolas de Torrenté, MSF, Humanitarian Exchange Magazine, Issue 41,December 2008, "MSF and accountability: from global buzzwords to specific solutions" in www.odihpn.org.

[2] Margie Buchanan Smith, ODI, Overseas Development Institute, Working Paper 215, "How the Sphere Project Came into Being: A Case Study of Policy-Making in the Humanitarian Aid Sector and the Relative Influence of Research", July 2003.

[3] Jacqui Tong. Op. Cit.

whilst at the same time underestimating the role of politics in humanitarian crises. MSF believes that politics – which is not measurable by minimum standards or achievement indicators – plays a fundamental role in the commencement and development of humanitarian crises and in the quality of humanitarian aid which the agencies are capable or not of providing to the victims[4]. Besides, according to MSF point of view, to associate good help with quantity and quality results denies the existence of differences in the quality of aid provided. The differences in roles, and the responsibilities of the United Nations and those of the NGOs which have between them different mandates and visions, mean that everything becomes a blurred amalgam of one unique and homogeneous humanitarian system[5].

In spite of the criticism towards these initiatives, MSF considers that accountability is an inherent part of its responsibilities as humanitarian organisation. One of the principal documents which defines the social mission of MSF, the Mancha Agreements, states that: "Mutual accountability and active transparency within MSF, both in sections and in the international arena, are essential in order to improve the pertinacity, efficiency and quality of our interventions. MSF carries out accountability and active transparency with its beneficiaries and donors, and with respect to public opinion ...."[6]. MSF's approach to accountability is based on the principle that, as a humanitarian medical organization, we are responsible for what we set out to do and the means we employ. However, within this framework we must be realistic when establishing our objectives, taking into consideration the contexts in which we work, recognizing the fundamental differences in our commitment to humanitarian medical work, and the fact that, as we provide response in real time in exceptional circumstances, we have to accept our errors and failures as an inherent part of the learning process[7].

Whilst external MSF accountability to its donors and the general public, and the responsibility within its various areas (international and national) of its executive and associated organisms is consolidated, accountability towards its beneficiaries has always been difficult to obtain.

On one hand, the practical realities and operational priorities inherent to intervening in emergencies, and the principal objective of saving lives which characterizes MSF humanitarian medical work, make it difficult to put into practice[8]. On the other hand, within the organization there are voices that consider accountability to the beneficiaries to be not only impractical, but hypocritical. These voices insist that if it implies two complementary actions – accountability for what has been done and, at the same time, being responsible for it - the nature of humanitarian intervention is to *avoid the State*, providing response directly to the victims[9], and, what is more important, operating in contexts of failed-states or internal wars. In such contexts, who can ensure that the organization that failed to supply the promised aid be held responsible? Neither the State nor the elite class, often partners in the conflict , are in the best position to represent all the community and, consequently, the beneficiaries who, due to their condition as victims are – according to this perspective – by definition weak and impotent.

Whilst it would be naive to deny the very limited power of those who receive aid with respect to the suppliers, the absolute victimization of our patients and their communities is very often not correct or, at least oversimplified, and they are denied any capacity to recuperate.

Moreover, the absolute victimization of the patients and their communities contradicts the principle of self determination as a basis of medical ethics where, in spite of the difficult circumstances in which the receivers of our help so often find themselves in, the individual remains the final agent in his life with the capacity to think chose, decide and act for himself[10]. As a humanitarian medical organization with the individual in need of humanitarian aid as its core, MSF should be consistent and prepared to revise

[4] Jacqui Tong. Op. Cit.
[5] Austen Davies, Op.Cit.
[6] La Mancha Agreements 2006.
[7] Eric Stobbaerts, Op. Cit.
[8] Eric Stobbaerts, How do we Approach Accountability in MSF? Internal Document, Draft for EXDIR, Nov. 2007.
[9] Austen Davies, Op. Cit.
[10] D. Schopper, An Ethical Framework for MSF, Medical Ethics and Beyond, 2007.

its relationships and improve the way in which it can be responsible to itself. This concept could be broadened to take into consideration the receiving communities of our aid such as a more extensive group of (potential) patients and, consequently, with the same right to self-determination which we recognize in our patients.

In addition, providers of aid do not always operate in acute humanitarian crises where the devastating circumstances impede any other action than that of saving lives. Apart from this, although in contexts of conflict the notions of the victims' impotence, based on international humanitarian law, is what enables them to be offered protection and help, experience shows that we should listen to them if we want to avoid standardized responses which can be unsuccessful when addressing the real needs of the beneficiaries.

Experience has shown us that consulting the beneficiaries improves the pertinence and impact of our interventions, and thus the patients and their communities, so – in most cases – they become responsible for their own lives. The way in which the beneficiaries can make the providers of aid responsible is, however, not evident.

In spite of all this, instead of giving up the providers of aid need to work more keenly to ensure their responsibility. In the words of Eric Stobbaerts, former General Director of MSF Spain and present head of Latin America DNDI[11], "more responsibility is needed in the humanitarian field (…) it is still important to link discussion about accountability to the specific responsibilities of humanitarian organizations … to develop a specific framework for responsibility with this premise may prove more productive than adopting initiatives that are too broad or ambitious"[12]. Parallel to the suggestion of Eric Stobbaerts to use concrete solutions to focus accountability, other voices within MSF ask for accountability to patients, their families and communities to be a priority, and they emphasise its importance as a way to improve understanding of MSF intervention and the pertinence of its projects. These voices that appear often come from people working in the field, in direct contact with those we want to help[13].

MSF OCBA a step forward to increase accountability to the beneficiaries: work in progress

As the result of a strong demand within the organisation asking for an improvement in dialogue and responsibility towards the receivers of aid, MSF OCBA has recently committed itself to the development of a specific framework for accountability to beneficiaries. The project has meant an initial definition of accountability to beneficiaries based on some minimum requirements which have four pillars: to make accountability a value shared by all MSF employees; to obtain information; to involve the population being consulted and incorporate their answers whenever possible; and to establish management mechanism for complaints.

Research based on action developed through these four pillars was the second step of the project and included a questionnaire sent to all the missions. In addition, five areas were visited in countries with MSF OCBA operations. In the questionnaire and the field visits, MSF personnel were asked about their knowledge of the organisation's principles, its social mission, its capacity to behave in agreement with these principles and communication (both direct and indirect) with the beneficiaries. The study also investigated the way MSF informed patients and the communities about the project, asking their opinions, and the existence or not of complaint management mechanisms. The possibility of setting up a complaint system that guaranteed confidentiality, security and accessibility for patients was explored. The field visits included both individual and group sessions with the field staff, interviews and focus groups with the direct beneficiaries, their communities and members of

[11] Drugs for Neglected Diseases Initiative.
[12] Eric Stobbaerts. Op. Cit.

[13] Internal Documents: MSF Ethiopia Field Associative Debates Recommendations: Motion 1: The participants of the FAD 2009 in Addis Ababa – Ethiopia strongly suggest that the empowerment of beneficiaries should be mainstreamed in all MSF projects to increase accountability and transparency of our action towards them and to increase their active participation. Therefore we request to the board of directors and the executive to come forward with their vision and establish policies and take actions destined to the practical implementation of the above.

society. These visits gave the participants an opportunity to ask for examples of good practice.

The third and final part of the project was the composing of the "Guide to Accountability to Beneficiaries"[14]. The Guide, still in process, contains s series of recommended activities, tools and examples of good practice in order to help people in the field and attain the four minimum requirements previously described. Working in a humanitarian intervention often means operating in contexts with high insecurity levels, where the indiscriminate use of standard approaches in the processes of consultation and participation exposes the vulnerable population and, also MSF personnel to greater risk. During chronic emergencies certain activities may be difficult to implement due to limited time and the need to prioritise the saving of lives. Rather than negating these difficulties, and unrealistically proposing a series of norms to be uniformly applied to all sites, irrespective of local context and available resources, the "Guide to Accountability to Beneficiaries" adopts a pragmatic approach. It proposes a series of simple, feasible activities that can be adapted to each context and concrete need and applied as far as possible considering the circumstances. The activities are aimed at not only helping field personnel carry out accountability to the patients and, on a wider scale, their communities, but also to contribute to the strategy of reinforcing our perception and acceptation. Instead of considering ourselves as something exclusively related to an often impractical accountability to the beneficiaries, this guide should be considered as a series of tools which can greatly contribute to improving our global operational approach, our strategy of internal and external communication, and the coherence of our values and mission. Flexibility and adaptation are therefore the key words for the the Guide's use, taking into account that it is the first step in developing an authentic policy of accountability to the beneficiaries. The Guide will be tested in the field, revised and improved with feedback obtained from its use. It will also be enhanced with additional material and acquired experience.

Views expressed in this article are the author's and do not necessarily reflect those of the MSF official version.

[14] The Guide will be published in summer 2012.

Libia, 2011. © Tristan Pfund

Healthcare protection during conflict

*By **Dr. José Antonio Bastos***
President of MSF-Spain

Attacks against medical staff and installations at times of conflict have always existed. Although they are clearly described as a violation of International Human Law (IHL), until 2011 efforts in an organized form to dissuade such actions have been timid and disperse.

The ambulance, with a woman who urgently needs a caesarean, detained at a military checkpoint for hours; the shelled hospital; the medical center in which an armed group enter by force looking for enemies amongst the patients; the doctors arrested for helping people who supposedly sympathize with the opposite side; the clinic used as a command post by international forces involved in the conflict; nurses fleeing the zone and abandoning the dispensary; the ambulance that is shot at; the refusal of armed groups to let much needed vaccinations campaigns be carried out … All of these are real examples that have taken place over the years. In all conflicts, professionals, organizations and health care activities are often subjected to interruptions and direct attacks. This affects the population precisely at a time when it most needs medical attention.

Organized efforts to avoid this situation occurring have been almost exclusively in the hands of the International Committee of the Red Cross (ICRC) as part of its activities of protection in what has been traditionally known as the protection of medical missions.

A historical problem

The image of thousands of wounded soldiers left to suffer after the battle of Solferino in 1859 moved Henri Dunant to such an extent that not only did he immediately organise groups of volunteers to provide aid, but he also managed to draw up the first Geneva Convention in 1864 to improve the conditions of soldiers who were ill or wounded in the battle field. The convention defined the neutral character of military medical staff and their protection and identification. It later developed into the protection for all the health care activities that assisted combatants and civilians in situations of war. In this way, the creation of a mechanism to protect medical activity in armed conflict became the historical roots and embryo of the IHL and the ICRC.

Moreover, medical ethics have always included the obligation to treat human beings without discrimination which implies the imperative to also assist those considered to be the enemy. As a result, health personnel treating the wounded from both sides should be treated with respect, or at least tolerance, by the combatants.

Doctors without Borders (MSF) is an organization that defines itself as medical-humanitarian taking its inspiration from the principles of medical ethics and the very humanitarianism that gave rise to, and provided guidelines for, the ICRC. During its forty years of experience all over the world the MSF has frequently been witness, and sometimes direct victim, of these attacks against medical aid for the population. It is curious that, in spite of this, the problem has rarely been explicitly or systematically confronted.

With respect to discourse, conceptual framework, formal complaint and witness, historically the MSF was first involved in the protection of refugees and, more recently, in terms of access to health

care. Work in refugee camps was an important part of MSF activities during the 1980s and 1990s. The United Nations High Commissioner for Refugees (UNHCR) was its first critical counterpart, and international agreements concerning the protection and care of refugees became issues to be constantly wielded, managed and promoted. However, the concept that has surely been the most solidly defended by the MSF has been that of access to health. This took place at first with a conventional public health and health service management focus. During the last decade the perspective of political and social activism, which appeared with the creation of the Campaign for Access to Essential Medicines, was incorporated. The rights of the population assisted by the MSF, who are victims of crisis, exclusion and some diseases, to have access to health services has been, and still is, a constant reference in the discourse, analysis and values of the organization.

In contrast, the protection of medical activities within the context of conflict has never been the center of interest for MSF which has always accepted the more prominent role of the ICRC with respect to this issue. And, once more, it should be highlighted the fact that the populations trapped in conflicts are the biggest group to which the MSF provides aid. They present the biggest operational challenges which have never received any explicit attention from us – the problems of access to health directly linked to situation of conflict, especially attacks directed intentionally against our health services.

“Healthcare in danger”

Fortunately, in 2011 there has been a confluence of initiatives and interests which have led to the fact that from now on the protection of health services will occupy a more relevant space for the MSF. Acknowledging that until now the problem has not received the attention or support it deserves, the ICRC has launched a very ambitious campaign to draw attention to the problem and promote preventive and palliative initiatives under the slogan “Healthcare in danger”. The campaign is a serious effort that gives strong priority to the theme and involves all the Red Cross and Red Crescent Societies together with some governments. The MSF has been invited as the sole principal member.

Almost simultaneously, during its interventions in response to the wave of protests and violence known as the Arab Spring, the MSF has suffered on various occasions from deliberate attacks against its activities and health institutions. This is particularly the case in Bahrain where the only third level hospital in the country became a center for the State’s Security Forces who detained and interrogated patients there. In addition, there were reprisals against the doctors and other medical staff who had cared for the patients.

Similar problems occurred in Libya and Syria. The determined response from the MSF, and the debate generated by these issues, has strongly encouraged the organization to seriously and explicitly tackle the theme of protection of medical activities within the context of conflict.

The ICRC initiative, joined with the MSF awakening, has signified a guarantee that this problematic situation is going to receive the attention it deserves. Whilst the general principle is the same, and it is very probable we will see a great deal of collaboration and synergy between the two organizations, the reasons for the MSF to involve itself in the protection of medical activities within the context of conflict are slightly different to that of the ICRC. It is not a question of enforcing international agreements or humanitarian principles, or even making the combatants more human in terms of accepting that their wounded enemies or the civilian population should receive medical attention. And of course it is not a case of giving health professionals special status. For the MSF it is principally a question of defending the right for the population to have access to healthcare within the context of conflict which is precisely when they most need it.

A step forward

Protection of patients, medical staff, structures and activities should have been one of the priorities of the MSF years ago. In a similar manner to some other very relevant themes, such as sexual violence and mental health, which were ignored for a long time, but which now form an integral part of the MSF discourse and activities, it

appears that 2011 has been the year when finally protection will become one of our principle concerns. If we want to see the bottle half empty we could feel guilty for not having taken the step before. If, however, we accept that the aspirations of the MSF are enormous and diverse, that the work we do is extremely challenging and, if we want to see the bottle half full, we should acknowledge the capacity of the organisation to recognise and integrate extremely relevant lines of action.

The problem of lack of access to health services for the population that lives in conflict zones is possibly the most serious drawback the MSF faces and one that receives the least explicit attention. Acknowledging that this limitation is due mainly to lack of respect, deliberate interference or attacks against health agents and activities is a great step forward, not only conceptual but also in the fight to improve health access for people and entire populations.

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Projects 2011

- Bahamas Islands
- Bolivia
- Central African Republic (CAR)
- Colombia
- Democratic Republic of Congo (RDC)
- Ethiopia
- Ghana
- Greece
- Guatemala
- Haiti
- India
- Iraq
- Kenya
- Libya
- Mexico
- Morocco
- Niger
- Nigeria
- Occupied Palestine Territoires (OPT)
- Paraguay
- Syria
- Somalia
- Southern Sudan
- Sudan
- Turkey
- Uganda
- Western Africa
- Yemen
- Zambia
- Zimbabwe

Types of projects

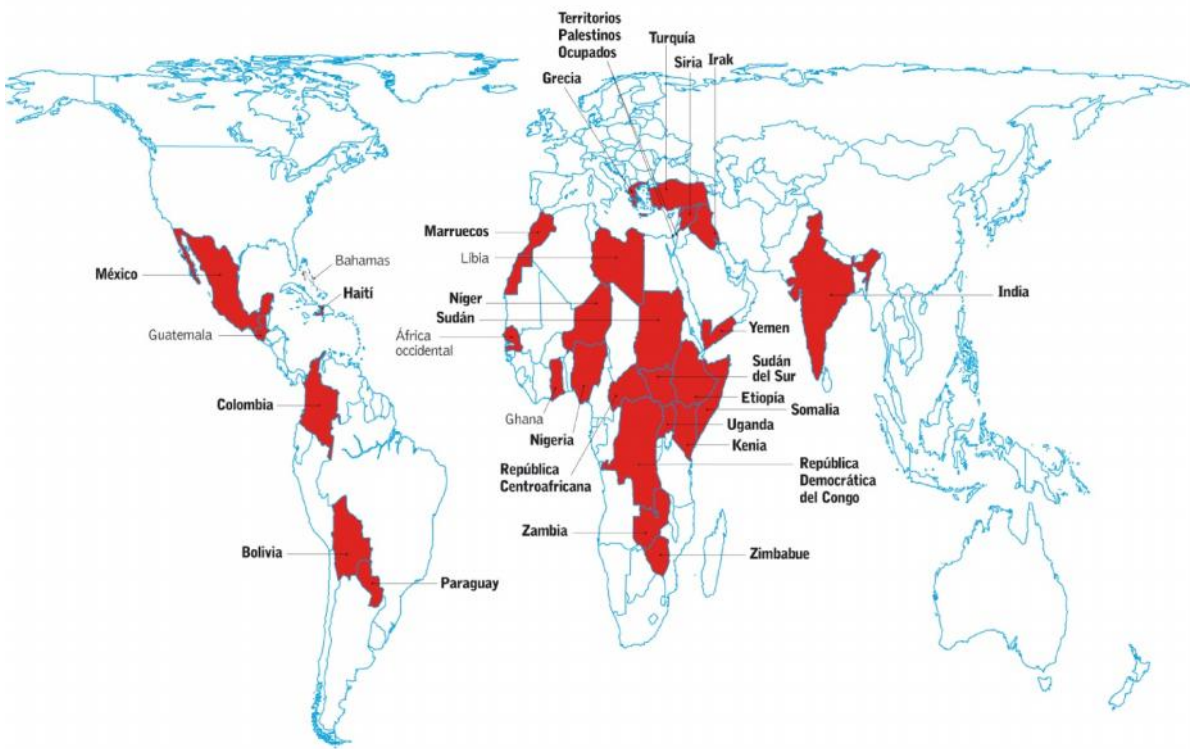
Victims of armed conflict

Victims of social violence and people excluded of the medical assistance

Victims of endemic and epidemic diseases

Victims of emergencies

Victims of disasters


Territorios Palestinos Ocupados
Turquía
Siria
Irak
Grecia
Marruecos
Libia
México
Bahamas
Haití
Niger
Sudán
India
Guatemala
África occidental
Yemen
Sudán del Sur
Etiopía
Somalia
Colombia
Ghana
Uganda
Nigeria
Kenia
República Centroafricana
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Bolivia
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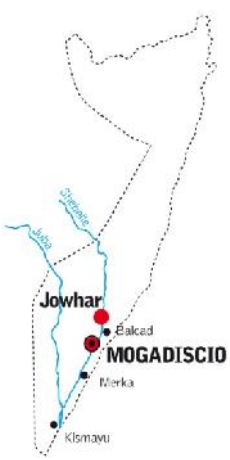
- Article: Darfur: Mission impossible. By Alberto Cristina
- Southern Sudan
- Democratic Republic of Congo (DRC)
- Zambia
- Zimbabwe
- Uganda

Somalia



Introduction and background

Since the fall of Siad Barre in 1991, Somalia has become a country without a state, a land of conflict and violence, abandoned to the mercy of armed groups who have taken the civilian population hostage. The few social indicators available are the worst in the world, with a life expectancy of 51 years; the mortality rate of children under 5 is 183 per 1,000 live births and there is one doctor per 100,000 people.

The systematic violence against civilians has generated massive population displacements and with them diseases, malnutrition, epidemics (measles, cholera and HIV / AIDS), maternal and child deaths, and a general lack of protection.

In 2011, major political tensions had a great impact on the work of MSF as a whole, as well as on other aid organizations. Al-Shabaab, which controlled much of the territory, withdrew from Mogadishu, leading to the reorganization of the two areas. The power vacuum in the capital was filled by other armed forces, and the military moved into the Jowhar area. With the arrival of international aid, Al-Shabaab passed a law prohibiting access to religious humanitarian organizations and UN agencies. MSF's work has been hampered by administrative harassment, taxes and mandatory contributions in the form of registration costs, and frequent cases of harassment of local staff, rarely reported for fear of reprisals. Traditionally defiant of Western organizations, Al Shabaab has greatly reduced the freedom of movement and action of humanitarian organizations, denying access to new areas affected by the conflict and nutritional crisis, and hindering vaccination campaigns, family planning and some components of sexual and reproductive health care.

The nutritional crisis, predicted months previously and officially declared by the United Nations in July, has also been a challenge for regular MSF activities in Somalia, as well as for the presence of the organization, in terms of legitimacy, credibility, respect and security.

Present in Somalia since 1992, MSF-OCBA has responded to the situation of chronic emergency by providing access to primary health care through

health clinics, water supply, nutritional programmes, and sexual and reproductive health care, with special attention given to women and children, who constitute the most vulnerable sectors of the population.

In mid-2011 we reflected on the Somali people and their aid requirements and concluded that the traditional models of operational management in Somalia, Kenya and Ethiopia did not fit the profile of the vulnerable Somali population, since each mission had different objectives and management methods. Therefore, a new organizational model was proposed, which broke with the mission logic, and promoted a regional response adapted to the movements of the Somali population. This model involves structural changes, including the development of strategies for remote management of activities, seeking a partnership with local organizations (an NGO that can be created or promoted by MSF, and composed of staff that has been working with MSF for several years), and gathering the three countries together in a single operational cell to develop joint projects, diversify the portfolio and think about the regionalization of activity coordination.

Financial data

Expenses	**€**	**%**
SOMALIA, CAPITAL	€ 579,910.90	12.88%
MOGADISHO-YASQUID, PHC/SHC nutrition	€ 922,475.27	20.48%
JOWHAR, PHC/SHC nutrition	€ 1,574,117.76	34.95%
SOMALIA, EPP	€ 27,392.40	0.61%
MOGADISHU, IDPs	€ 1,400,124.42	31.09%
Total	€ **4,504,020.75**	**100.00%**

Financing	**€**	**%**
Danish Ministry of Foreign Affairs MFA	€ 3,365.31	0.07%
Total Public Institutional Funds	€ **3,365.31**	**0.07%**
Inditex	€ 700,000.00	15.54%
Total Foundations Funds	€ **700,000.00**	**15.54%**
MSF UK	€ 137,071.37	3.04%
MSF United States	€ 2,249,550.00	49.95%
MSF Denmark	€ 13,678.94	0.30%
MSF Sweden	€ 28,031.02	0.62%
MSF OCBA	€ 1,372,324.11	30.47%
Total Private Funds	€ **3,800,655.44**	**84.38%**
Total Financing	€ **4,504,020.75**	**100.00%**

Human Resources Capital

National Staff	**11.95**
International Staff	**5.03**

Mogadishu **Mogadishu, primary and secondary medical care, nutrition**

Since the withdrawal of Ethiopian forces in early 2009, Mogadishu has been practically in the hands of Islamist militias. During 2011, fighting between TFG troops and Al-Shabaab militias has resulted in considerable population displacement, and has created a difficult working environment for the expatriate staff. In addition to fleeing from conflict, the Somali population were driven to search for food when the nutritional crisis erupted in spring. Mogadishu became an immense urban displacement camp, where the "old" refugees (displaced by fighting in the city) mixed with the "new", mainly shepherds who were fleeing the drought and the loss of their livestock. The displacement camps ranged from the enormous urban camp in Badbadoo, which contained 35,000 people in October, to smaller concentrations like the one in the Jazeera neighbourhood.

2011 was also the year that other MSF sections with expatriates returned to Mogadishu. The magnitude of the crisis led to the massive arrival of United Nations agencies and international aid organizations, particularly Arab and / or Islamic (Qatar Crescent, Turkish organizations). This represented a heightened security risk due to the increased presence of humanitarian actors, expectations created by the situation for local suppliers, and a particular problem for MSF due to its relative inflexibility regarding conditions and principles.

Between July 2009 and October 2011, the security situation in the north of the city deteriorated to the extent that MSF-OCBA activities in Yaqshid and Karan health centres and the Lido hospital had to be suspended. The incessant fighting forced the populations of these areas to flee, and the impossibility of negotiating with Al-Shabaab meant that the project could not be reopened until November 2011. It was then possible to open a distribution centre of oral-rehydration salts in the old Yaaqshid OPD in response to the epidemic of Acute Watery Diarrhea. Following the kidnapping of Blanca Thiebaut and Montserrat Serra, the expatriate teams withdrew and all outreach activities were stopped.

The mission is operating by remote management, providing vaccination programmes, sexual and reproductive health care and outpatient services at the health facilities of Wadajir and Dharkenley in the south of Mogadishu. In the north of the city, it is hoped that after the end of the Acute Watery Diarrhea epidemic the activities of the Yaaqshid health centre can be resumed as in Dharkenley. It is also hoped that relations with the leaders can be resumed, thus gaining a source of information on developments in the north of the capital, and perhaps an entry with expatriates.

Location	Mogadishu
Target population	254,000 people
Start and end date	October 1992 / no end date
Project aim	Provide the victims of violence with primary, secondary and nutritional health care

Type of population	Displaced and conflict-afflicted
Context	Armed Conflict

Activities	
Quantitative indicators	Total
Outpatient consultations	26,639
Malaria (total)	286
Malaria (confirmed)	286
Admissions	194
CNT hospital	133
CNT primary care centre	1,566
CNS	679
Antenatal visits (total)	1,481
Antenatal visits (new)	1,296
Postnatal care	91
Sexual violence	3
Measles (treatment)	237
Cholera	127
Measles vaccination (routine)	2,259

Project cost	**€ 922,475.27**

Human resources	**National**	**International**
Health workers	**40.20**	**0.29**
Non health workers	**19.26**	**0.23**

Jowhar

JOWHAR, primary and secondary health care, nutrition

MSF-OCBA has been present in the area for 13 years, providing primary and secondary health services and nutritional support in Jowhar and Balcad, with the ultimate goal of reducing mortality and morbidity in the Somali population, focusing particularly on women and children.

In 2009, Al Shabaab took control of the town of Jowhar and the Middle Shabelle region, restoring some stability to the area. However, the presence of this armed group has also brought negative consequences, including more restrictions on the local population (forced recruitment, limitation of movement, war tax) and more control over NGOs (prohibiting expatriate staff in the projects, tighter controls of activities and provision of NSF, prohibiting vaccination campaigns).

MSF is the only organization that provides free medical assistance to the people of Jowhar, offering services of primary health care, vaccination, nutrition, reproductive health, and OPD consultations at 5 health facilities (Kulmis, Bulo Sheikh Mahaday, Gololey and Balcad). It also provides a tuberculosis programme, begun in 2010. Vaccination campaigns against measles, planned for 2011, could not be carried out due to the lack of agreement with Al-Shabaab. Many children have died of this disease, mainly in the areas of Balcad and Mahaday.

Location	Jowhar and Balcad
Target population	105,000 persons
Start and end date	October 1992 / no end date
Project aim	Provide the victims of violence with primary, secondary and nutritional health care
Population type	Displaced and conflict-afflicted
Context	Armed Conflict

Activities	
Quantitative indicators	Total
External consultations	126.714
Malaria (total)	939
Malaria (confirmed)	939
Hospitalisations	3.673
CNT hospital	600
CNT primary care centre	1.960
CNS	5.242
Prenatal visits (total)	31.098
Prenatal visits (new)	3.872
Births	1.834
Postnatal care	1.748
Surgery	357
TB (total)	22
Measles (treatment)	667
Cholera	150
Staple items	154
Measles vaccination (routine)	6.178

Project cost	**€ 1,574,117.76**

Human resources	**National**	**International**
Health workers	**86.80**	**0.69**
Non health workers	**49.01**	**0.23**

Mogadishu

Mogadishu Emergency, internally displaced persons

The severe food crisis of 2011 in areas of the Horn of Africa has been the worst in decades. It had all the characteristics of a complex, oversized emergency: A massive population displacement, a drastic rise in food prices, and sudden increase of acute malnutrition and mortality. This catastrophic scenario of food security (level 5 in MSF food security classification) took place against a background of chronic conflict, successive crop failures and livestock deaths.

The crisis was successfully predicted by the early warning systems, which pinpointed the factors responsible: la Niña and its impact on the rains of autumn 2010 and winter 2011; the massive displacements in the Mogadishu region that increased the vulnerability of a population already weakened by years of conflict; poor access to food and health; and ultimately, death of livestock. The early warning systems were able to predict the food security situation. The first alerts were sounded in August 2010, but despite that, the alarm call did not come until April 2011. Finally, in May the early warning system was adamant about the severity of the situation. On July 20, 2011, the United Nations officially declared a famine in two regions of southern Somalia: the southern areas of Bakool and Lower Shabelle, with an estimated 2.8 million inhabitants. In addition, on the other side of the country 3.7 million people (half the country's population) were now in crisis. The situation was worsening due to the large increase in Somali asylum seekers at the Dolo Ado (Ethiopia) and Dadaab (Kenya) camps in the first half of 2011.

In spring, thanks to a long-established presence in the country, MSF was able to react to the crisis from existing projects, even though nutritional surveys gave no hint of the magnitude of the situation. The aim of the organization was to provide an immediate response to the crisis, and implement a prevention strategy.
In July, MSF reopened a project for the local and displaced populations in Dharkenley and Wadajir. It established a stabilisation centre, two outpatient treatment centres, permanent feeding centres, and three mobile teams providing nutritional care. Primary health care was also provided at all sites with nutritional services. Programmes to treat measles were established as well as nutritional supervision for all the resident and displaced persons where MSF-OCBA had access.

This emergency intervention was piloted from the organisational cell and the regular project, relying on knowledge of the area and local staff already trained and accustomed to working with MSF-OCBA. Nevertheless, the emergency situation was challenging due to the extreme insecurity in Somalia, which increased after the massive influx of international aid via organizations unaccustomed to the Somali context. An example of the volatile situation was the kidnapping of two MSF workers, Montserrat Serra and Blanca Thiebaut, in Kenya on October 13, and the assassination of two colleagues, Philippe Havet and Adrias Karel, of the Belgian section of the organization in Mogadishu.

MSF has responded to two emergencies in the region of Jowhar: a cholera epidemic in Balcad in May and the distibution of Non Food Items to a burnt village in July (Buulo Harray). The control exerted by Al Shabaab greatly impedes our capacity to assess and respond to emerging needs. Nevertheless, the team has managed to make decisions and respond to the emergencies, preserving its criteria of independence, and avoiding the requirements imposed by Al Shabaab.

Location	Mogadishu
Target population	250,000 people
Start and end date	July 2011 / without end date
Project aim	Emergency nutritional suport of internally displaced persons
Type of population	Displaced and conflict-afflicted
Context	Armed conflict

Project cost	**€ 1,400,124.42**

Human resources	National	International
Health workers	0	0.23
Non health workers	0	0.40

Somalia, 2011. © Martina Bacigalupo

Somalia, 2011. © Yann Libessart

Regional focus for the management of projects in the Horn of Africa

*Interview with **Alfonso Verdú***
Manager of Operational Cell 3 of MSF-OCBA in 2011

The world changes and with it the nature of humanitarian crises. Analysts speak of a greater number of situations that are, for example, more complex, chronic, unpredictable, urban and fragile. MSF is not unaware of this transformation and is evolving towards new models of intervention. In this interview, Alfonso Verdú, who was previously in charge of operations in Somalia, Kenya and Ethiopia, describes the move towards the regional management of our projects in these three countries in the Horn of Africa.

1. Why did you consider a change of operations in Somalia and Kenya?

For more than 10 years MSF has been carrying out a project of prevention and treatment of HIV/AIDS in Busia, Kenya. The long handover period hand greater vulnerability for the population, including the risk of political violence due to the elections. Kenya, therefore, continued to be a country with a propensity to short and medium-term emergencies which could be covered by a standard mission[15].

However, in Somalia, the so-called remote control model, which consists of the management of projects by local personnel who have been working for years in MSF whilst being controlled from Nairobi by a co-ordination team made up of international personnel, did not appear to be totally satisfactory and required a through revision.

In Kenya the situation of the Somali population living in a complex of refugee camps in the north already occupied by more than 250,000 people (Dadaab), and also in the surroundings of Nairobi and in the south east of the country (Ijara), made us look at the zone from another perspective. Additionally, at this time we took over project management in Ethiopia, one of the projects (also remote control) was located on the border with Somalia (the Dolo Ado project in Liben).

2. What are the advantages of carrying out a regional analysis?

Our operational cell already had previous experience of regional and trans-border reading and analysis. The paradigmatic example was perhaps the mission in Morocco with a backdrop of trans-border migration. Looking at it from a regional point of view made us aware that migrant flows (and, thus, population vulnerability) does not respond to borders drawn on a map. We, therefore, looked at what was happening in both Mauritania and Algeria, for example. The same thing occurred in Jordan, Syria, Iraq and the Occupied Palestine Territories.

[15] A stable MSF base of operations with co-ordination team that is normally located in the capital and manages one or more projects in various parts of this territory.

Regarding the Horn of Africa, by bringing together the projects and operational objectives in Somalia (increasing activities in Mogadiscio to cover not only the north, but also the south of the Somali capital, and incorporating new components such as remote control tuberculosis treatment for the first time in the Jowhar project), Kenya (with the opening of two new projects on the border with Somalia: one in the Dadaab refugee camp and another in the Ijara district – located 13 kilometres from the border), and Ethiopia (with the idea of consolidating the presence of our local and international personnel in Dolo Ado), we realised that almost 95% of our target population in the three countries were Somali.

If the vulnerability of this population was not argument enough to warrant the enormous advantage of approaching operations from a regional perspective, in addition, there was the indisputable interconnection present amongst these countries and others in the zone. Ethiopia, Kenya and Somalia together with Djibouti, Eritrea and Yemen share dynamics with respect to trends in populations shifts, geopolitical interests, humanitarian intervention, clash of ideologies and religions and so on and the most defenceless and vulnerable citizens are affected. Adopting in these three countries a project management model that would help us understand their complexity in the best possible way was a foregone conclusion.

3. What strategic and operational strategies arose from this reflection?

First, that the mission in Kenya should continue and was justified, but always on the condition that our presence was in the Somali refugee camps on the border as a project of reference for our new positioning in Kenya. The other project in Ijara, in the south, was conceived as a pilot project with regular evaluations in order to facilitate operational decisions. Moreover, at the same time the Swiss MSF section decided to call for a second operational centre in the Dadaab camps and the only entity to show interest was Spain.

Second, a change in the collaboration model with the national personnel, above all with the Somalis and the perception they had of themselves, was called for. For years remote control had been talked about, to the point of the role of the international personnel being conceived as mere supervisors, even in monitoring the local personnel in the projects. Speaking about remote control thus demonstrated willingness for shared management in which national personnel initiative and maneuver margin in project management was recognized. This implied a medium and long term investment plan to help experienced national personnel do even better, and a general hierarchical reorganization which would oblige the international field teams to count on these personnel as a key resource.

And finally, all of the above meant that we had first of all to think about considerable modification in the architecture of management for the missions in Kenya and Somalia and, some time later, Ethiopia. So for Kenya and Somalia we set up a model called the SOMPOP mission (Somali Population mission) which transcended the idea of “one country, one mission” in an intent to obtain the previously described advantages of efficiency in the rationalization of resources, avoiding the presence of two (and later three) co-ordination teams and what all of that implied. A single line of management was proposed for the previous projects of Kenya and Somalia, centralizing the support services (only one Medical Department, one Human Resources Department and so on) on the basis of a number of key points: counting on Kenyan, Kenyan-Somali and Somali personnel, and investing in their development as the authentic keystone of the project; organizing each department according to the needs of the population

(e.g. through the specialization of logistics in intervened families: help, supplies, water, sanitation etc.) or including posts adapted to the huge challenges of the regions (e.g. assessor of humanitarian affairs or security). If you will permit me, this SOMPOP model, from the perspective of the operational cells, contributed to the model of decentralisation of operations that we have today in Nairobi and which started with the delocalisation of the Emergency Team in Nairobi in 2008.

4. How do the projects in this zone function nowadays?

The nutritional crisis of 2011, together with the chronic armed conflict in Somalia, has been the biggest challenge the population of the Horn of Africa has experienced. It has convinced us that we were right to adopt this alternative management model based on the regionalization of the operations. Thanks to a single management in Nairobi for Somalia and Kenya, together with a synergy search with the Ethiopian mission after it joined the countries managed by Operational 3 Cell, the projects aim to respond to the needs of the populations with similar circumstances who undergo processes of displacement (in Somali or outside as refugees) in extremely high-risk contexts. It has been observed that a situation that was already very precarious has deteriorated to unimaginable limits.

Possibly the most interesting evolution has been the remote control management model. On one hand, since 2009, we have been researching (the information available from other organizations' experience is enormous), capitalizing (our accumulated experience dates back to the 1990s) and adjusting technical protocols of care which range from which range from how to carry out a correct context follow-up to how to design the best medical strategies, and their challenges, within the broad term of remote control. On the other hand, I would dare say that as the most qualitative element, I believe we have managed to consolidate the understanding and acceptance of this management system as an operational alternative to the conditioning of presence of international personnel in Somalia.

Having said that, I have to recognize that this change of focus has not been easy. You have to remember that MSF and the people in it are not used to working with different, non-traditional models, including the sacrosanct presence of international personnel in the projects. There are a great many predictive using foreknowledge models in which humanitarian action is medium and long term, and most of them agree on one thing: the crises are and will be more complex, more unpredictable, more chronic, more urban and more fragile, to quote some of the characteristics highlighted by the University Tufts of Boston or the Intergovernmental Panel on Climate Change (IPCC), for example. It is interesting to see the strong concurrence that exists with respect to the need to begin to adapt operational models of intervention to the new realities.

It is here that we clearly see that MSF in general, and our operational centre in particular, have enormous difficulties with visions and execution. It is surprising how we often continue thinking in the traditional rural parameters, of proximity, of equating "international personnel presence" with "quality of operations". It appears to be difficult to develop new alternatives, complementary models and other response strategies, and that it is easier for us to fall into dogmas and simplistic readings. For example, I believe that we have been capable of creating an extraordinary system such as the remote control one in Somalia towards a real operational alternative, present day remote control. Whilst we have a great deal to learn, what I can not understand is that we confuse its validity as a response model with our own limitations at the time of ensuring medical quality, management of security or emergency response. All this and much more are our challenges and not

the motives to forget a model which, together with other ones, can help us continuing to reach those who need us. In Kenya, our teams entered the Dadaab camps with three levels of medical attentions and 12 international personnel members to attend the Somali refugee population. In Ethiopia we were present in Liben, in a number of Somali transit camps. Our response to the nutritional emergency in the Horn of Africa required an intervention restructure in all the region which was performed through reorganization.

5. Have these alternative models provided more efficient or adequate responses for the population needs?

In my opinion, and from the perspective of time, this type of operational models demand a lot from MSF: from obtaining and training suitable human resources for the positions without losing constructive criticism, to managing that all our departments have sufficient capacity at strategic level to maximize their performance, amongst other things, by giving more and better support to our projects.

In other words: our responsibility, once the vulnerability of these populations has been examined and seen that we can have relevant medico-humanitarian impact, is to do all that we can to make these alternative methods function.
This is our obligation and I am sorry to say that sometimes we give up to soon when we have left the traditional frameworks. In both Somalia and Syria working with another organization has not been easy. It has required a medium-long term vision and to be very professional and meticulous and, in addition, tenacity and perseverance – some qualities of which are not necessarily associated with our identity in times of emergency.

Short term vision for certain contexts is not now feasible, we are talking about projections of one, two, three , five and even more years. The example of Somali is clear: the Somali situation as is much temporal one (a number of years) as a geographic one (not only in Somalia but all the region), and, additionally, there are multiple factors (geopolitical, economical, ethnic, religious) to be considered. It is easy to fall into simplistic readings of what MSF can do or Manichaean interpretations of the reality.

In these types of field models we should not forget to be critical, this is understood as being demanding with ourselves in a continuous way, as a continuous follow-up and evaluation of the key indicators. But neither should we go to extremes: complacency does not help at all, but then neither does precipitated criticism serve for much. To say that the reports of activities from the remote control model can be manipulated, that resources misplaced or that the fact that the lack of international personnel does not permit independent evaluations only serves if at the same time solutions are provided or work is done to improve these aspects.

Besides which, it is curious how we ourselves are capable of generating vicious circles. For example, an almost paradoxical effect of remote control is that we have had to strongly reinforce our Somali personnel, as much in training as their inclusion in decision-taking. Another example: with the support of the Manson Unit[16] we managed to implement tuberculosis activities in one of our first distance-managed projects with impressive help on the part of the Medical Department based in Barcelona. Or, a number of small, Somali groups with great mobility managed to give emergency response, even though on a small scale, to the displaced population in the south of Mogadiscio long before the withdrawal of Al Shabab allowed the access of international

[16] An MSF medical support unit specialised in field projects, based in the United Kingdom.

personnel to the Somali capital …. I could give dozens of more examples.
In summary, the key, in my opinion, is to first takeover institutionally these kinds of operational models if we want to intervene in complex situations at a regional level, when the traditional model is not useful; from then on, and in second place, provide all the necessary means to obtain the best results from these alternatives, using both accumulated experience and existing knowledge from within and without MSF; and, finally, in third place, not lose the capacity for self-criticism through the follow-up and evaluation of our interventions (adapting our own system and not replicating standard methodologies) which will help us carry out a continuous adjustment of the model and orientation of the same towards its maximum capacity.

Ethiopia

Introduction and background

The first camp in Ethiopia, located in the zone of Liben, for Somali refugees was opened at the end of 2009. It followed the withdrawal of the Ethiopian army which had been present for two years in Somalia. The causes for the Somalis fleeing were multiple, they included chronic food insecurity, generalised violence, lack of access for the humanitarian agencies and saturation at the Dadaad refugee camp (the biggest in Kenya, it is placed near to the Somali border).

These circumstances led to an emergency intervention by MSF OCBA in the Liben refugee camps towards the end of 2009. It grew into a regular project during 2010 with the aim of improving the humanitarian situation of the refugees. MSF OCBA provided medical and nutritional services in the transit camp (for the newly arrived), in the Health Centre (HC) at Dolo Ado (the capital of the Liben zone), and in the existing refugee camps at Bokolmay and Malkadida.

In Somalia, at the beginning of 2011, the already complicated situation deteriorated when a number of factors worsened. They included a severe drought caused by the lack of two consecutive rain seasons, lack of humanitarian access due to rampant insecurity, and the new restrictions for humanitarian aid imposed by the al-Shebab group. In addition, the conflict between the al/Shebab and the Transitional Federal Government militias at numerous points in the centre and south of Somalia blocked the commercial networks ensuring the provision of food.

In agreement with United Nations estimates, towards March there were 2.5 million people facing a critical humanitarian situation in Somalia due to drought and instability.

The worsening of the nutritional and sanitary situation in the camps is clearly reflected in the quantity of admissions to MSF nutritional programmes. In February the number increased from approximately 1,455 children to 12,359. The refugee population in December arrived at a total 140,000 divided into five camps. Mortality rates

only began to decrease in September when the situation started to stabilise.

In addition to the two existing refugee camps, Malkadida and Boqolmay, three more were opened, Kobe, Halowyen and Buramino, in order to accept the enormous flow of Somali refugees that were arriving.

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This was the organisation's biggest intervention in 2011. It required a huge effort in terms of finance, human and medical resources, and logistics.

On the other hand, the drought that had affected various zones in Ethiopia, in the area of Sidama in the SNNPR (Southern Nations Nationalities and People's Region), caused a nutritional crisis. MSF OCBA responded for four months until the situation became stable. At the same time, Ogaden, in the Somali Region, not only suffered the effects of the drought and was faced with the arrival of Somali refugees, but also experienced a chronic crisis due to conflict between the independence movement of the ONLF and the Ethiopian government. MSF OCBA has intervened in the region, at Degehbur, since 2007, providing medical and nutritional aid to the population. During 2011 the access restrictions for humanitarian aid have been constant and have hindered a number of routine activities such as vaccinations of epidemiological follow-ups.

Financial Data

Expenses	**€**	**%**
Capital	€ 714,128.53	6.54%
SNNPR, Aroresa MCH[17]	€ 2,067.95	0.02%
ASAYTA, short intervention[18]	€ 30,961.53	0.28%
ETHIOPIA, EPP	€ 52,583.06	0.48%
DEGAHBUR OGADEN, Medical and nutritional assistance	€ 1,243,416.42	11.42%
LIBEN, health care and nutrition	€ 980,934.69	9.01%
SNNPR, measles emergency	€ 123,471.67	1.13%
LIBEN, Nutritional Emergency	€ 7,506,378.26	68.96%
SIDAMA, nutritional emergency	€ 232,582.46	2.14%
Total	€ **10,886,524.57**	**100.00%**

Financing	**€**	**%**
Spanish Government – AECID	€ 1,300,000.00	11.94%
Catalan Generalitat - ACCD	€ 200,000.00	1.84%
UE / ECHO / European Commission for Humanitarian Aid	€ 1,000,000.00	9.19%
German Government Auswärtiges Amt der Bund	€ 500,000.00	4.59%

[17] End of 2010 project.
[18] 2010 intervention.

MAE Luxemburg	€ 250,000.00	2.30%
Children Investment Fund Foundation (CIFF UK)	€ 341,305.00	3.14%
Swedish Government – AIDS	€ 551,055.27	5.06%
Danish Ministry of Foreign Affairs MFA	€ 12,908.88	0.12%
Total Public Institutional Funds	€ **4,155,269.15**	**38.18%**
Inditex	€ 1,000,000.00	9.19%
Total Foundations Funds	€ **1,000,000.00**	**9.19%**
MSF Germany	€ 402,036.00	3.69%
MSF Japan	€ 1,591,367.93	14.62%
MSF United States	€ 906,545.44	8.33%
MSF Denmark	€ 267,580.43	2.46%
MSF OCBA	€ 2,563,725.62	2.55%
Total Private Funds	€ **5,731,255.42**	**100.00%**
Total Financing	€ **10,886,524.57**	**100.00%**

Human Resources Capital

National Personnel	**78.49**
International Personnel	**5.38**

EPP Human Resources

National Personnel	**0.25**
International Personnel	**0**

Degehbur | **Medical and humanitarian aid for the population affected by the conflict in Degehbur and Degaxmado, in the Regional State of Somalia**

Even though a peace agreement between the ONLF and the Ethiopian government was signed in October, 2010, the fact that a minority group did not agree to it meant that the government continued to put pressure on the ONLF. As a consequence, clashes between both groups and abuse of the civilian population carried on.

The government continued to limit access for humanitarian organizations to the communities called “anti-peace” because they were accused of supporting the ONFL. During most of 2011 the state security corps denied MSF access to the zones located beyond the principal road. As a result, outreach activities were reduced.

During 2011, MSF OCBA carried on with its primary care activities giving support to the outpatient services of the hospital at Degenbur. They had a vaccination programme with 8 mobile clinics which incorporated such activities as nutritional triage and malnutrition treatment, health education, response for malnutrition treatment, health education, response for victims of sexual violence, and mental health.

For secondary care MSF OCBA concentrated its efforts on the hospital of reference at Degehbur, principally supporting the maternity, paediatrics, surgery and laboratory services.

The programme provided nutritional assistance to more than 300 children suffering from malnutrition in the zone of Degehbur.

Localization	Degehbur and Degaxmado, in the Somali Region Province
Target Population	163,100 people
Start-up and finish dates	December 2007 / up to the present
Project aim	To contribute to the reduction in the morbidity and mortality of the population affected by conflict in the zone of Degehbur.
Type of Population	Refugees
Context	Armed conflict

Activities	
Quantitative indicators	Total
Outpatients	15,884
Malaria (total)	402
Malaria (confirmed)	225
Admissions	1,688
CNT hospital	231
CNT primary care centre	2,814
Selective nutritional support	382
Prenatal consultations (total)	3,855
Prenatal consultations (new)	1,611
Births	519
Postnatal care	121
Sexual violence	3
Surgery	270
Direct violence	232
TB (total)	640
TB (MDR)	2
Mental health 1	65
Mental health 2	48
Measles vaccination (routine)	2,614

Project cost	**€ 1,243,416**

Human resources	National	International
Health workers	64.76	4.64
Non health workers	51.32	2.22

Liben

Medical and nutritional emergency aid to Somali refugees at Dolo Ado Woreda, Liben

Thanks to the regular project began in 2009 in Liben, MSF OCBA started to respond to the increasing flow of Somali refugees who arrived in Ethiopia. MSF emergency unit intervened from June, 2011, to confront the serious situation in which the refugees found themselves with mortality and malnutrition rates well above emergency thresholds. The situation was critical, due as much to their weak condition on arriving at the border as the lack of humanitarian aid once they were installed in the refugee camps.

The principal objective of the intervention was to reduce mortality and morbidity in the refugee population with nutritional, health access (primary and secondary) and mental health care programmes directed at the most vulnerable population – children aged less than five years, and pregnant or lactating women.

The fact that from the end of 2009 MSF already had a regular project in the zone made a rapid response easier, even though the exodus of Somali refugees at its most critical point reached more than 10,000 arrivals daily. It was necessary to tackle not only high rates of malnutrition, but also an epidemic of measles which increased mortality even more.

From May to December MSF OCBA provided health services for the newly arrived refugees in the pre-register zone in the transit camp at the health centre of Dolo Ado (capital of the zone) and the Kobe refugee camp. In a parallel fashion, MSF OCBA started up nutritional programmes in three of the refugee camps: Bokolmayo, Malkadida, and Kobe. It also carried out a vaccination campaign against measles in the Kobe camp.

From July onwards other international actors began to arrive in the zone. This allowed MSF Spain to transfer some of its activities with the objective of concentrating resources, and thus having a greater impact on the vulnerable population. Therefore, in August MSF Spain transferred all its activities with arrivals at the pre-register zone in the transit camp of Dolo Ado to MSF Holland, in order to concentrate its efforts on the refugee camps at Bokolmayo, Malkadida and Kobe. In a similar way, at the end of the year it transferred some of its nutritional activities to the international NGOs, Medical Corps and Save the Children-US.

In December the refugee population reached a total of 140,000 people divided into five refugee camps (three of which were new). From September, MSF managed to decrease the elevated levels of mortality. This was the greatest intervention of the organization in 2011 and it required enormous efforts in financial, medical, logistic and human resources terms.
It is important to highlight that there are still serious humanitarian problems in the refugee camps which are managed by the ACNUR and the ARRA, the influential government department of Ethiopia in charge of the refugees. They do not receive adequate housing, the water and food supply is insufficient, and there is no access to quality medical assistance. The prevalence of epidemic illnesses is high and the indices of malnutrition and mortality are above those levels of an emergency.

Location	Refugee camps in Boqolmayo, Kobe and Malkadida, region of Dolo Ado Woreda, Liben
Target population	163,100 people

Start-up and finish dates	December 2009 / the emergency response is on-going
Project's objective	To reduce morbidity and mortality in the refugee camps at Dolo Ado
Type of population	Refugees
Context	Conflict

Regular Project activities	
Quantitative indicators	Total
Outpatients	32,069
Malaria (total)	236
Malaria (confirmed)	3
Admissions	2,971
CNT hospital	1863
CNT primary care centre	20,474
Prenatal consultations (total)	1,262
Prenatal consultations (new)	2,497
Births	150
Postnatal care	450
Sexual violence	3
Direct violence	36
Measles vaccination (routine)	895

Project cost	**€ 980,935**

Human resources	**National**	**International**
Health workers	**67.92**	**1.79**
Non health workers	**31.77**	**1.24**

Emergency activities	
Quantitative indicators	Total
Out patients	35,031
Admissions	949
CNT hospital	1,208
CNT primary care centre	14,874
CNS	5,637
Prenatal consultations (total)	1,404
Prenatal consultations (new)	540
Births	154
Postnatal care	261
Sexual violence	3
Mental health 1	558
Mental health 2	108
Measles (outbreak)	11,584

Project cost	**€ 7,506,378**

Human resources	National	International
Health workers	128.97	10.49
Non health workers	72.62	11.37

Sidama

Nutritional emergency in the districts of Bensa and Aroresa, Sidama, SNNPR region

The district of Sidama is one of the fourteen zones making up the SNNPR region in the south of Ethiopia. It is the biggest and most highly populated one. At the end of 2011, MSF carried out an exploratory study in this region, and the results of this rapid evaluation indicated that the nutritional situation was problematic with a 5% SAM and an 18.2% GAM. Such figures are alarming within a context known to have insufficient nutritional programmes, few reliable data and with frequent breaks in the provision of therapeutic food. The high malnutrition indices were due to a number of factors - no access to medical services, strong dependence on the "false banana" (cassava - a food that is poor in nutrients), a high population density, and a deficient health system.

MSF decided to act by supporting the health districts of Aroressa and Bensa through the improvement in management of nutritional programmes, concentrating on children with acute malnutrition and a general improvement in the nutritional situation in Bensa y Aroressa. To do this they gave support to the health centres with supplementary services such as units of stabilization and day centres.

They also supplied free food to those accompanying the children suffering from malnutrition, distributing blankets and soap to the patients during their stay. When they were discharged MSF made sure that they had electricity 24 hours a day and provided drinking water to the patients and health centre employees. Work on water and sanitation was performed and a system for the proper management of residues was set up. Additionally, MSF started a support programme for outpatients – seven mobile clinics were responsible for identifying and transporting to the health centres patients who needed nutritional hospitalization. Bridges were repaired to ensure the service. Soap was also distributed to all the children registered in the programme.

In addition, a programme of measles vaccination was performed.

Localization	Districts of Bensa and Aroresa, Sidam region, SNNPR
Target population	400,000 people
Start-up and finish date	September 2011 / December 2011
Project aim	To contribute to the improvement in the management of nutritional programmes and to improve the nutritional situation of the children in the districts of Bensa and Aroressa.
Type of population	General population
Context	Armed conflict

Activities	
Quantitative indicators	Total
Admissions	97

CNT hospital	97
CNT primary care centre	615

Project cost	**€ 232,582**

Human resources	**National**	**International**
Health workers	**6.88**	**0.62**
Non health workers	**20.18**	**1.08**

Somalia, 2011. © Sven Torfinn

Hunger in the Horn of Africa: A delayed and challenging response

*By **Nuria Salse***
Nutrition Adviser of MSF-OCBA

For over 20 years Somalia has been the site of one of the most neglected humanitarian crises. In 2011, international community response – not only late, but also insufficient - struggled to cope with the severity and magnitude of the complex nutritional disaster on site. However, and despite the severity of this massive crisis in the horn of Africa (mass population displacement, extreme rates of acute malnutrition and mortality, epidemic measles) and the extreme challenges of the Somali context (armed conflict between militias and restrictions on humanitarian assistance), MSF intervention in Somalia -one of the biggest nutritional interventions ever done- was an efficient and good intervention.

MSF, concerned about the rising numbers of refugees arriving at the camps in Kenya and Ethiopia, has been trying to call attention to the nutritional situation in Somalia since June 2011.

On 20th July 2011, the United Nations officially declared famine in two regions of southern Somalia: the areas of southern Bakool and Lower Shabelle, with an estimated 2.8 million inhabitants, whilst across the country 3.7 million people (half the country's population) were considered to be in crisis[19]. In fact, the situation was already grave as the Somalia situation had been previously externalized by the greatly increased influx of Somalis asylum seekers to the Dolo Ado (Ethiopia) and Dadaab (Kenya) camps since the first semester of 2011.

The severity and magnitude of the 2011 nutrition crisis in the Horn of Africa has been the worst seen for decades. The crisis had all the features of a massive complex emergency: mass population displacement, major increase in food prices, extremely high acute malnutrition and mortality rates, the worst food security scenario to be ever reached (level 5 out of 5 in MSF food security classification[20]), and epidemic measles that affected even the older adults in the Dadaab camp (Kenya). All of which occurred against a background of chronic conflict, successive crop failures, and the death of livestock.

The severity of the crisis was reflected in the various nutrition surveys, assessments and surveillance systems that were carried out by MSF, Epicenter, and UN agencies. Even as early as April a nutritional survey[21] had revealed alarming malnutrition and mortality percentages in the Dolo Ado refugee camps which were above the emergency thresholds. The global acute malnutrition (GAM)

[19] Source: OCHA.

[20] MSF Food security classification February 2011.
[21] Joint Health and Nutritional Survey implemented by ARRA, UNHCR, WFP, and MSF Spain.

according to WHZ WHO 2006 standards22 was above 33% and the severe acute malnutrition (SAM) above 11% (and above 22% among the newcomers). In the Malkadida camp, where the situation was even worse, the overall crude mortality rate (CMR) was 1.47 deaths/10,000 persons/day, and the under-five mortality rate (U5MR) was 4.04/10,000/day. These figures worsened in some areas. **Table 1** shows nutrition and mortality data for different periods and areas in the Horn of Africa. In contrast with other nutrition crises, not only were children less than 5 years affected.

The crises also involved older children aged from 5 to 10 years (the UNHCR Dagahaley survey reported 18.3% of children from 5 to 10 years with MUAC below 140mm). When acute malnutrition reaches older groups it is considered more serious as this population is usually less vulnerable, their reserves are higher, and they have more resistance in order to maintain their nutrition status. Another sign of population vulnerability is that children represented a very high percentage of the refugees. More than 50% of the population were children aged less than 12 years (approximately 25% were children under five years and 25% from 5 to 12).The magnitude of the crises was due to the high number of population affected, the mass displacement of mostly Somalis fleeing from the drought and conflict to the Ethiopian and Kenyan camps, and the internal displacement to Mogadishu.Approximately 120,000 Somalis entered Ethiopia or Kenya during June and August. In the Dolo Ado refugee camps in Ethiopia (where there were 120,000 people in five camps), the weekly arrivals reached a peak of 9,758 in July while in the Dadaab refugee camps in Kenya (where there were 460,000 people in four camps) from May to October there were 6,000 arrivals per week (in August alone there were 37,000 new arrivals[23]).

The new Somali refugees arrived in shocking health and nutritional conditions after days and weeks of travelling without enough food or water (walking or on donkey carts) to cross the border into Kenya or Ethiopia.

Failure in response: A delay of 20 years

Somalia has been gripped in an armed conflict between militias and the radical Islamic group al-Shebab in Southern and Central Somalia for two decades. The international community has neglected to provide an adequate response during all these years. In addition to the lack of access to the insecure areas in order to provide assistance, all sides of the conflict restricted the provision of aid to the areas with highest needs. The international community had for a long time preferred to direct aid to the areas under control of the TFG. The US ban (considered as a criminal activity) on the distribution of assistance to areas under control of Al-Shebab has long been present and was only lifted in August when the crisis came out into the open. Al-Shebab themselves imposed tight restrictions on humanitarian assistance to areas under their control.

As a result of the combination of strong political bias from the two sides of the conflict with respect to access to assistance in Somalia, in August 2011 the civil population in Southern Somalia was left without adequate humanitarian assistance to suffer the worst drought in the last 60 years. Moreover, the phenomenon of La Niña was responsible for the driest period in the Eastern Horn of Africa since 1995, a situation exacerbated by the armed conflict. Two consecutive rain failures (October-December 2010 and March-May 2011) resulted in crop failure and animal deaths. The situation was much worse in southern and central Somalia and the pastoralist population was the most affected.

Late response in spite of early warnings

Food security and nutrition crises do not suddenly occur - they can be predicted. For the current crises, the early warning systems were more than adequate in order to timely

[22] MUAC was not available in this survey.
[23] Source: UNHCR/ARRA.

predict the food security situations[24]. The first alerts, caused by La Niña which predicted worse than usual food insecurity in East Africa, were in August 2010. Following the prediction of the next two poor rain performances, the following warnings were in October–November 2010, and in February and March 2011. The alarm appeal took place in April and, finally, in May most early warning systems were clear on the severity of the situation. As previously mentioned, the declaration of famine in Somalia from the United Nations did not, however, come until July 2011 when the population was already suffering malnutrition.

Despite the alarms and early warning systems, and the fact that the predictions about the impact of the drought were clear, a response was not triggered in a timely manner.

Failure in the nutrition prevention strategies

A factor that aggravated the weakened condition of the newcomers to the camps was that the food assistance at the arrival point did not cover the whole duration of the stay which included the period prior to registration and arrival at the final allocated camp. This signified that the refugees could stay one or two weeks without receiving any food assistance. Good quality water and shelter were scarce: factors that had a crucial impact on increasing the already severe acute malnutrition rates and, consequently, mortality rates, especially for the most vulnerable population - children aged less than five years.

Moreover, and *this particularly concerns Dolo Ado*, apart from the General Food Distribution, an appropriate strategy to prevent nutrition status deterioration and reduce mortality in children under five years by covering their particular micronutrients needs and add energy support, normal intake was not correctly implemented as coverage was low. There were frequent nutrition breaks at the peak of refugee arrivals, and high value food for children under two years was not included. In an attempt to cover the gaps, MSF proposed being in charge of this preventive strategy but this was not allowed by the Ethiopian authorities.

MSF OCBA response to this challenging context

MSF OCBA has carried out emergency interventions in the three most affected countries: Ethiopia, Kenya, and Somalia (where MSF was already present when the 2011 crises started). MSF OCBA had its biggest intervention in the Dolo Ado refugee camps, followed by Modadishu, and finally IFO outskirts/extension refugee camps in Dadaab. The insecurity and lack of access to the most affected population in Somalia made the intervention highly complex.

MSF OCBA in the Dolo Ado refugee camps has run one of the biggest nutritional programmes ever performed in terms of number of facilities, quantity of children enrolled in the programme, protection rations distributed, and resources invested. Overall, 155 foreigners and 1,332 national staff were deployed in the three countries with a total cost of almost 11 million of euros.

Activities in Ethiopia

MSF, working in the Dolo Ado camps since 2009, started as a short-term emergency intervention but the worsening situation in Somalia, and the constant influx of refugees, made the continuation of the activities relevant. In May 2011, the project, supported by the emergency team, was up-scaled. Until August 2011, when the rest of humanitarian organizations were deployed, MSF OCBA was the only organization providing nutrition assistance and health care (this last in transit and in the Kobe camp, the rest were covered by ARRA[25]) for the more than 100,000 refugees living in the pre-registration site, the

[24] Ververs, M. The East African Food Crises: Did Regional Early Warning Systems Function? Journal of Nutrition 2011. Doi:10.3945/jn.111.150342.

[25] Ethiopian authorities for the refugees.

transit camp, Dolo Ado town, and the 3 final camps (Boqolmayo, Malkadida, and Kobe).

In the pre-registration camp, MSF identified the acutely malnourished and sick children on the first day of arrival, and treated them in the transit camp. Four ambulatory therapeutic feeding centres, two supplementary feeding centres, and four stabilization centres were implemented with community health worker activities. Protection rations of CSB + and oil of 1000 kcal were given to all the families of the children enrolled in the programme. Plumpy nut for the children U2 was planned, but the ARRA did not allow permit its distribution as they did not accept the product. In September 2011, the transit camp and Dolo Ado town activities were transferred to MSF OCBA.

The reinforcing of the emergency unit took place in May-June, although it is acknowledged that it should have started earlier as the nutrition status of the population was already very severe. This late upscale had a negative impact on the quality of the response as MSF OCBA capacity to cope with such a complex, large and severe emergency was affected.

In addition, in July the number of arriving refugees with seriously affected general health and nutritional conditions was excessive for the programs' capacity in the initial weeks of the reinforcement.

Indeed, the mortality in the stabilization centers (specifically in Boqolmayo) had a peak of more than 20% during the initial months of the emergency as most of the patients were children recently arrived from Somalia, in bad nutritional condition and with severe medical complications. From September-October, the quality of care improved and the population in the camps became stable. In addition, the general food distribution improved, making less vulnerable the population.

An epidemiological (*disease, nutrition and mortality*) surveillance system at household level, supported by Epicentre, was installed by MSF OCBA in all the camps. For example, in the Kobe camp, as seen in the graph (**figure 1**), mortality was extremely high in August (weeks 33-34) and drastically decreased during the initial weeks of MSF intervention. After that it remained under control for the duration of the emergency. An outbreak of measles occurred in the Kobe camp in July. A vaccination campaign was carried out by MSF-Spain in August 2011. A total of 12,961 children were vaccinated. Measles coverage in the nutrition survey of October–November was above 95%.

In addition to the emergency intervention in the refugee camps, MSF OCBA has also deployed significant interventions since 2007 at Deghabur, in the Somali region, which was less affected by the crises.

Activities in Kenya

MSF OCBA was supposed to start working in the newly built camps (IFO extension) in July 2010. However, due to difficulties with satisfying the Kenyan authorities' procedures, the opening of the camp was delayed for more than one year. From May 2011, MSF OCBA provided primary health care and nutrition services for acutely malnourished children, and pregnant and lactating women, on the outskirts of IFO2 (new arrivals) with two ambulatory therapeutic feeding centres and two supplementary feeding centres. The operations were suspended in October due to the abduction of two MSF aid workers.

Activities in Somalia

MSF OCBA has been present in Somalia (Jowhar) for 17 years. In Mogadishu there was also a previous intervention in the past. Due to the 2011 crises there was a reopening of activities in July 2011 for the displaced and resident population in Dharkenley and Wadajir. One stabilization centre and inpatient facility, two ambulatory therapeutic and supplementary feeding fixed centres plus three mobile teams for the IDPs were offering nutritional care. Primary health

care also was offered in all the sites where there were nutrition services. Measles campaigns and nutrition surveillance were carried out for all the resident and displaced population where MSF OCBA had access.

Somalia, with its extreme insecurity and reduced access to the population, has been a highly complex intervention (two MSF aid workers were killed in December 2011). In addition to the emergency intervention in Mogadishu, the regular projects continued their activities in Jowhar, a less affected area.

The main MSF OCBA compiled data

Tables 2 and 3 show the services offered and the main nutrition and health indicators of the three countries during 2011.

Conclusions

• MSF OCBA presence in the three most affected countries has facilitated the response to the nutrition crises.
• This nutrition emergency has been exceptional in terms of complexity, severity and magnitude. The lack of access to the population, and the highly insecure context in Somalia, are the most important challenges to having a good response impact.
• The population of Southern Somalia has been the victim of the consequence of a combination of a restriction of aid from Al-Shebab and the main international donors, particularly from the US.
• Despite the good overall response, MSF OCBA made all the necessary efforts to implement a considerably effective intervention, the response came late.
• As seen in the large numbers of acute malnourished children admitted (44,779 children). MSF OCBA had a direct impact on reducing mortality associated with malnutrition.
• In the Dolo Ado camps, MSF OCBA activities contributed to drastically reducing the overall mortality in children less than five years old in the camps, and to increasing measles vaccination coverage.
• Lessons learnt to assure a good quality care include the fact that the up-scaling of activities and increased capacity should start as soon as the nutrition indicators begin to deteriorate.
• Our remaining humanitarian challenge is to ensure continuous access to the population affected by the conflict and the droughts in order to offer nutrition and health care before their status deteriorate.

This article is dedicated to the professionalism and commitment of the field teams working in the Horn of Africa during 2011, and especially to our colleagues Mone and Blanca- kidnapped and still in captivation.

Many thanks for the collaboration of Jose Antonio Bastos, Pedro Pablo Palma, Guillem Pérez and Lali Cambra.

Figure 1: Mortality rates in Kobe refugee camp (deaths/10000/day).[26]

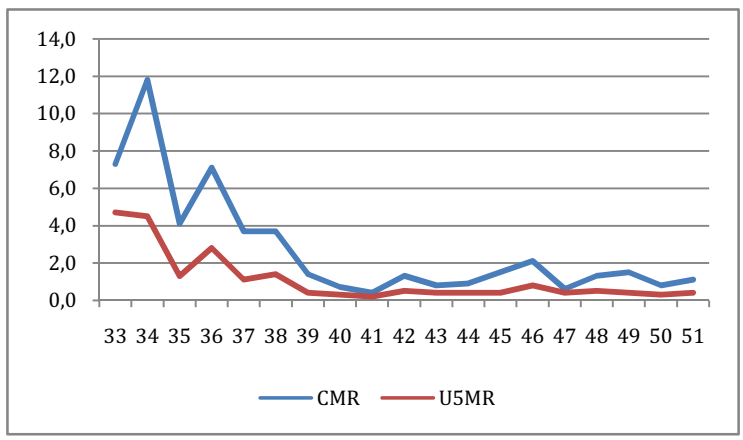


Table 1: Nutrition and mortality data from nutrition surveys and rapid nutrition assessments in different periods by different locations (2011).[27]

Age groups	Indicator	Ethiopia (Dolo Ado)	Kenya (Dadaab)	Somalia	
		Kobe[28]	Dagahaley Outskirts[29]	Mogadishu IDPs[30]	Bay[31]
		October-November	September	August	July
6-59 months (65-109.9 cm)	Global Acute Malnutrition: MUAC < 125mm	30.8% (C.I 27.5-34.3)	26.9% (C.I 23.3-30.5)	39.2%	46%
	Severe Acute Malnutrition : MUAC <115mm	19.9% (C.I 15.9 - 22.3)	9.7% (C.I 6.3-13.1)	8.3%	13.9%[32]
All population	Crude Mortality Rate (CMR)	1.90 (C.I 1.42-2.55)	1.23 (C.I 0.73-2.06)	5.68[33] (C.I 4.48-6.88)	1.1 (C.I 0.17-2.03)
0 to 59 months	Under Five Mortality Rate (U5MR)	5.95[34] (C.I 4.40-8.00)	3.02 (C.I 1.72-5.24)	15.43[8] (C.I 11.4-19.5)	4.12 (C.I 2.47-5.77)

[26] The emergency thresholds are for U5MR >2/10,000/day and for CMR >1/10,000/day.
[27] Acute malnutrition is expressed by MUAC as it better represents the nutrition status of a pastoralist population. Weight for height score in children is associated with body shape (tall and thin) and may overestimate the prevalence of acute malnutrition in these populations. Source: Myatt. Met al. The effect of body shape on weight- height and mid upper arm circumference based case-definitions of acute malnutrition in Ethiopian children.
[28] Source: Report of Nutrition and Health Survey inKobe and Hileweyn camps of Dollo Ado, Somali Region of Ethiopia during Mid October to Early November 2011. UNHCR, WFP, UNICEF, ARRA and GOAL Ethiopia.
[29] Source: UNHCR nutrition survey Dadaab. ENN as a technical advisor.WFP and UNICEF as a partner. And IRC, GIZ, MSF Swiss and ADEO as implementing partner.
[30] MSF OCBA nutrition data from Gen Daud IDP camps in Wadajir (Mogadishu) during a measles vaccination campaign.
[31] Source: FSNAU SMART survey. Baidoa, Dinsor, Bur Hakababa.
[32] Oedema is not included and was 7.7%.
[33] Source: FSNAU SMART survey. Hodan, Hamarweyne, Waaberi+Wadajir.
[34] 90 days recall period. According to MSF weekly surveillance system, this high mortality is more related to August than November.

Table 2: Services offered by MSF in Ethiopia, Kenya, and Somalia during 2011, MSF OCBA.

Type of service	Ethiopia		Kenya	Somalia	
	Dolo Ado	Deghabour	Ifo	Mogadishu	Jowhar
Stabilization centre	4	1	0	1	1
Ambulatory feeding centre	4	9	2	5[35]	5
Supplementary feeding centre	2	0	2	5	5
Target feeding programme (protection rations)	yes	yes	no	no	no
OPD (primary Health Care)	2	1	2	1	5
IPD	0	1	0	1	1
Vaccination	yes	yes	yes	yes	yes
Sexual and Reproductive health programme	0	1	0	0	1
Sexual violence programme	0	1	0	0	0
TB programme	0	1	0	0	1

Table 3: Main nutrition and health indicators in Ethiopia, Kenya, and Somalia during 2011, MSF OCBA.

Indicator	Ethiopia		Kenya	Somalia		Total
	Dolo Ado	Deghabour	Dadaab	Mogadishu	Jowhar	
Children admitted in the programme with MAM	7,753	0	816	2,142	5,242	15,953
Children admitted in the programme with SAM	19,934	3,045	2,202	1,685	1,960	28,826
Children vaccinated (measles and other EPI vaccines)	53,224	14,451	11,000	50,000	6,627	135,302
OPD consultations	61,406	10,782	26,264	26,232	76,624	201,308

[35] Two ATFC fix and three mobile teams.

Kenya

Introduction and background

The humanitarian crisis in Somalia is still one of the worst in the world. During 2011 it was exacerbated by the effects of drought, the endless internal conflict and the absence of a public health system. The crisis affected the already congested refugee camps in Kenya and Ethiopia, which experienced a massive influx of people, arrivals increasing from 10,000 to 30,000 per month. In May, this provoked a deterioration of living conditions in the Dadaab refugee camp in Kenya, the largest in the world with 450,000 people. The camp is divided into three zones: Dagahaley, Hagadera and Ifo. The camp could be described as overwhelmed after growing without control or recognition from the authorities.

The severity of the crisis was reflected in various nutritional surveys conducted by MSF, ACNUR and Epicentre, which showed alarming rates of malnutrition and mortality, well above the emergency threshold, not only in children under five but also in the following age group of children between five and ten. The new Somali refugees were arriving in the camps in appalling conditions of health and malnutrition after days and weeks of travelling (on foot or in donkey carts) with insufficient food and water to cross the border into Kenya.

The huge influx of refugees impeded the proper or timely distribution of food rations. The UNHCR (United Nations High Commissioner for Refugees) had problems registering all the newcomers, which caused deterioration in the health of many recently arrived women and children. In this situation, MSF-OCBA was forced to change its strategy of action from May 2011, adapting to the new emergency by increasing the amount of resources and level of activities both in and outside the Dadaab camp. Its activities were focused on two health posts and mobile clinics that provided primary health services, reproductive and antenatal care, routine vaccination programmes, feeding programmes and hospital referrals, as well as epidemiological surveillance.

However, in October 2011, two MSF workers, Montserrat Serra and Blanca Thiebaut, were kidnapped while working in the construction of a

hospital in the Ifo camp. As a result, MSF-OCBA temporarily suspended its activities in Dadaab, scene of the kidnapping, while assessing and analysing the situation.

The military intervention of the Kenyan army in Somali territory led to confusion among the humanitarian organizations and the regional objectives of the government. In addition, this intervention coincided with a marked decrease in the influx of refugees, which led to the suspension of MSF activities at the border with Somalia.

It should be pointed out that following the kidnapping of MSF workers, the number of international organizations present in the camps fell, and this had an immediate impact on the population, whose living conditions deteriorated.

The extreme situation in the Dadaab camps has little hope of improvement in the short term. Although political and media attention has focused on the stabilisation of the situation in Somalia, we cannot ignore the pressing needs of thousands of people living in subhuman conditions. The international community has failed to meet the most basic requirements of these men, women and children fleeing from conflict and drought. Thus, the role of MSF is not limited to providing medical care but is also to campaign for long-term solutions for these refugees, whether through their integration in Kenya, settlement in other countries or safe return to their places of origin.

Financial Data

Expenses	**€**	**%**
KENYA, CAPITAL	€ 537,467.13	15.5%
IJARA, MCH & TB	€ 610,192.74	17.20%
IFO (Dadaab), Somali refugees	€ 308,517.38	8.70%
IFO I, PHC	€ 1,981,968.79	55.87%
KENYA, EPP[36]	€ 107,339.43	3.03%
DADAAB, drought[37]	€ 2,180.14	0.06%
Total	€ **3,547,665.61**	**100.00%**

Financing	**€**	**%**
Danish Ministry of Foreign Affairs MFA	€ 6,730.62	0.19%
Total Public Institutional Funds	€ **6,730.62**	**0.19%**
MSF UK	€ 17,414.63	0.49%
MSF United States	€ 84,280.14	2.38%
MSF Greece	€ 330,105.00	9.30%
MSF Hong Kong	€ 822,078.36	23.17%

[36] Emergency preparedness.
[37] Exploratory mission.

MSF Denmark	€ 1,015.10	0.03%
MSF OCBA	€ 2,286,041.76	64.44%
Total Private Funds	€ **3,540,934.99**	**99.81%**
Total Financing	€ **3,547,665.61**	**100.00%**

Human Resources Capital

National staff	**21.18**
International staff	**5.32**

KENYA NET
(Regional Emergency Response Structure)

Financial data

Expenses	**€**	**%**
NAIROBI, Regional Emergency team	€ 236,884.40	97.47%
NAIROBI, Regional Epp	€ 6,139.12	2.53%
Total	€ **243,023.52**	**100.00%**

Financing	**€**	**%**
Inditex	€ 150,000.00	61.72%
Total Foundations Funds	€ **150,000.00**	**61.72%**
MSF OCBA	€ 93,023.52	38.28%
Total Private Funds	€ **93,023.52**	**38.28%**
Total Financing	€ **243,023.52**	**100.00%**

Human Resources Capital

National staff	**8.88**
International staff	**3.62**

Dadaab

Medical aid in the Somali refugee camp Ifo2 and the Dadaab emergency

MSF-OCBA planned to start work in the newly built refugee camps (an extension of IFO) in July 2010, but due to bureaucratic difficulties of the Kenyan authorities the opening of the camp was delayed by almost a year. At the beginning of 2011 the construction of a secondary health centre was completed in the IFO 2 camp and it began providing primary health and nutritional care, as planned the previous year. The main activities up to June were: Epidemiological surveillance, primary health care including SRH, HIV / AIDS prevention, detection of tuberculosis and other neglected diseases, response to sexual violence, mental health care and mobile feeding activities.

In May, with the massive influx of refugees, the malnutrition figures became alarming, so MSF-OCBA installed therapeutic feeding centres and two supplementary feeding centres in the outskirts of IFO. The emergency situation returned to the Dadaab camp. From then until October, MSF-OCBA provided primary health care and feeding services for children with acute malnutrition, and pregnant and lactating women in the outskirts of IFO2 (newcomers). By October 2011, MSF OCBA had treated more than 3,000 children with symptoms of malnutrition, carried out 26,000 medical consultations, and vaccinated more than 11,000 people.

The kidnapping of two colleagues, Montse and Blanca, in October was a turning point in the intervention of MSF-OCBA in the Dadaab refugee camp. After the kidnapping, all activities came to a standstill while the security situation in the area was assessed.

Location	Ifo2 refugee camp, Dadaab
Target population	60,000 persons
Start and end date	October 2010 / October 2011
Project aim	Help reduce refugee morbidity and mortality
Population type	Refugees
Context	Armed conflict

Project cost (regular)	**€ 308,517**

Human resources	**National**	**International**
Health workers	**0.20**	**0.44**
Non health workers	**0.33**	**0.91**

Emergency activities	
Quantitative indicators	Total
Outpatient consultations	26,217
Malaria (total)	15
Malaria (confirmed)	2
CNT primary care centre	2,652
CNS	1,490
Prenatal consultations (total)	468

Prenatal consultations (new)	239
Postnatal care	72
Measles vaccination (outbreak)	11,306
Measles (treatment)	219
Measles vaccination (routine)	19

Project cost (emergency)	**€ 1,981.969**

Human resources (emergency)	**National**	**International**
Health workers	**13.62**	**2.01**
Non health workers	**7.63**	**2.45**

Dadaab

Ijaara, MCH and TB

The project is located in northeastern Kenya, in an area of drought and chronic malnutrition, high maternal mortality and high prevalence of tuberculosis. The proximity to Somalia means Somali people cross the border to the Ijaara district to feed their livestock, access Kenyan health services, do business in the local markets, travel and seek asylum.

The nearest medical service with hospitalisation and surgery is 217 kilometres away in the provincial hospital at Garissa or the hospital at Malindi 300 kilometres away. This is why MSF-OCBA are involved in the health centres of Sangailu and Hulugho and in the Hulugho Subdistrict Hospital. Located near the Somali border, only these facilities can provide emergency obstetric and neonatal care.

By supporting these two health centres, which provide the population with emergency obstetric services, maternal and child health care, health education, vaccination for children under five, medical and psychological aid for rape victims, and diagnosis and treatment of tuberculosis, MSF-OCBA aims to learn more about the community and gain their acceptance. In this way it is hoped that management of security and potential emergencies across the border in Somalia will improve.

After several incidents (threats of kidnapping foreigners, military operations by the Kenyan army on the border and within Somalia), MSF-OCBA reconsidered its intervention strategy in the area, particularly in October 2011, when it was decided to evacuate the expatriate team from the capital and leave the national staff in charge of activities. Some outreach and health education activities were also halted.

Location	Ijaara, North Eastern Province
Target population	59,000 people of the local community + refugees
Start and end date	December 2009 / Regular project continues
Project aim	To improve the quality of reproductive health services, vaccination programmes, tuberculosis treatment and obstetric surgery in the Hulugho and Sangailu health centres
Type of population	General population and refugees

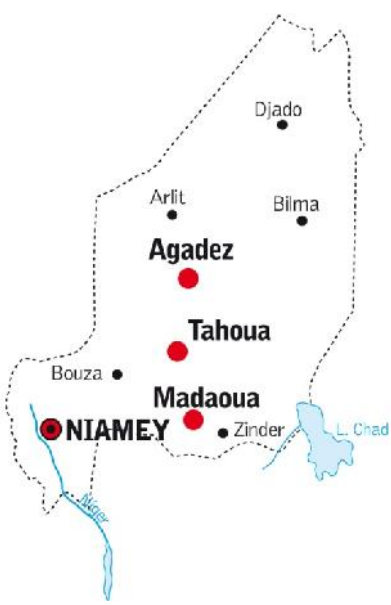
Context	Internal instability

Activities	
Quantitative indicators	Total
Outpatients	5,031
Malaria (total)	43
Malaria (confirmed)	2
Antenatal consultations (total)	2,157
Antenatal consultations (new)	703
Births	208
Postnatal care	343
Surgery	17
Measles vaccination (routine)	568

Project cost	**€ 610,193**

Human resources	National	International
Health workers	**10.99**	**0.85**
Non health workers	**25.40**	**2.52**

Niger



Introduction and background

The military junta led by Salou Djibo, who came to power after dismissing President Mamadou on February 18, 2010, won their bid for a peaceful return to normal constitutional life in the country. The process was accompanied by seven electoral contests in 2011. The restoration of republican institutions and a new constitution was controlled by a Consultative Committee and supervised by the Constitutional Council. For more transparency, all military and paramilitary personnel and ministers were declared ineligible.

In January 2011, the kidnapping of two Frenchmen, subsequently found dead, again raised the issue of security in the Sahel. The war in Libya and the proliferation of weapons has further complicated the situation. The proposal of the Touaregs to take over security in the Sahel posed the problem of their social reintegration two years after disarmament.

On March 12, Mahmadou Issoufou was elected as president with 57.8% of the votes. His mandate has been reduced to 5 years, renewable only once. The moralization of public and economic life has resulted in the return of funds diverted by dignitaries of the former regime, a gesture celebrated by the international community, which supports the democratic process.

Given its geographical location, Niger is in danger of destabilisation, due to the entry of people who are leaving West Africa and the Sahel countries on their way to Europe. As a neighbour of Libya, it has also experienced the fall of Gaddafi, and is at the forefront of tensions in northern Mali, and the expulsions by the Algerian government. The most vulnerable groups, mainly nomads and rural populations, are subject to discrimination and lack of access to primary health care.

Niger is one of the poorest countries in the area, with a highly vulnerable population. Extreme poverty of families, especially in rural areas, harsh climate conditions, recurrent epidemics (cholera, measles), rapid population growth, lack of access to drinking water and health care all

contribute to an on-going humanitarian crisis. Severe malnutrition and associated diseases are the main cause of infant mortality, one of the highest in the world. Epidemics of measles, meningitis and diarrhea contribute to mortality in children under 5.

MSF-OCBA has been present in the area since 2005, responding to the different nutritional crises as well as to overall maternal and child health needs, and implementing preventive health strategies. Services are currently being provided in Madoua and Bouza to prevent and treat malnutrition, and in Agadez to support the most vulnerable populations, such as women, children and migrants, through primary health care.

Financial data

Expenses	**€**	**%**
NIGER, capital	€ 693,444.44	12.30%
MADAOUA, Nutrition	€ 3,140,475.94	55.69%
AGADEZ, maternity care	€ 642,431.56	11.39%
BOUZA, Handover – Nutrition	€ 336,969.92	5.98%
NIGER, EPP	€ 443,520.35	7.86%
TAHOUA, nutritional	€ 266,326.35	4.72%
DIRKOU, explo transition camp	€ 63,465.41	1.13%
NIAMEY, emergency	€ 29,696.28	0.53%
DIRKOU, explo migrants[38]	€ 22,928.16	0.41%
Total	€ **5,639,258.41**	**100.00%**

Financing	**€**	**%**
Swedish Government - SIDA	€ 542,793.87	9.63%
Total Public Institutional Funds	€ **542,793.87**	**9.63%**
MSF German	€ 2,300,000.00	40.79%
MSF Greece	€ 100,000.00	1.77%
MSF OCBA	€ 2,696,464.54	47.82%
Total Private Funds	€ **5,096,464.54**	**90.37%**
Total Financing	€ **5,639.258.41**	**100.00%**

[38] Exploratory mission on migration.

Human Resources Capital

National staff	**50.24**
International staff	**5.11**

Madaoua **Nutritional programme, Madaoua**

Despite all the efforts of the state and its collaborators, malnutrition continues to be a problem throughout the country, particularly in the Madaoua region. The lack of adequate programmes of food security and health care for the most vulnerable leads to a permanent situation of malnutrition and lack of access to health. In 2011, MSF teams saw a significant increase in cases of malaria (84,184 cases and 36 deaths compared to 19,210 cases and 2 deaths in 2010). Together with the drought and rising prices, this factor has resulted in a dramatic 65% increase in consultations: 27,664 consultations by the end of August 2011 compared to 16,766 for the whole of the previous year.

Therefore, strategies for transferring projects to the country's health institutions are not very feasible, as shown by the examples of Bouza and Madaoua. The Madaoua project aims to reduce morbidity and mortality in children and pregnant women by a strategy designed to prevent and treat malnutrition and associated diseases. The emergency system in the Madaoua district and Tahoa region has also been reinforced. In countries like Niger, where access to health is not guaranteed, the consequences of malnutrition are particularly serious. The programme aims to have an overview of the child, and work in three areas: access to health (including women), prevention of malnutrition (distribution of food in the most difficult season) and treatment of malnutrition.

In the Madaoua hospital and the 6 district health centres, MSF gives support for the prevention and treatment of child malnutrition and associated diseases like malaria, measles and meningitis. A paediatric service provides routine vaccination. Sexual and reproductive health care, including family planning, is also provided. Unfortunately, given the fragile security (and the kidnapping of two French citizens in the capital in January), various security measures had to be taken that disrupted peripheral activities as well as the IEC. These are more effective in preventing disease, particularly malnutrition. Their services are more accepted by the population, who are given tips on hygiene and newborn care.

In 2011, there were no emergencies (measles, cholera, meningitis), therefore preparedness plans were not implemented.

Locality	Madaoua, Madaoua District, Region of Tahoua
Target population	66,136 persons
Start and end date	January 2012 / December 2015
Project aim	Prevent and treat malnutrition in Madaoua
Type of population	General population
Context	Internal instability

Activities	
Quantitative indicators	Total
Outpatients	124,422
Malaria (total)	33,033
Malaria (confirmed)	33,033
Admissions	6,639
CNT hospital	2,468
CNT primary care centre	20,072
Measles (treatment)	51
Meningitis (treatment)	49
Measles vaccination (routine)	16,458

Project cost	**€ 3,140,475.94**

Human resources	National	International
Health workers	**89.94**	**2.64**
Non health workers	**33.09**	**3.10**

Bouza — Nutritional programme

The prevalence of malnutrition and associated diseases in Bouza is similar to Madahoua, and a strong coordinated response from the state is also lacking. In the first quarter of 2011, MSF transferred the project to the Bouza health authorities, but after a month, given the difficulty of providing a suitable programme at the peak of the nutritional crisis, MSF resumed its fight against malnutrition and its treatment.

The aim of MSF in the district of Bouza is to improve the nutritional status of children from 6 to 59 months, and an INRC (Intensive Nutritional Rehabilitation Centre) has been implemented in the hospital, focusing on the prevention and treatment of malnutrition and providing paediatric care. A surveillance team provides peripheral support, and contributes to the monitoring and gathering of information. It includes two persons responsible for public awareness, particularly of mothers.

MSF also supports 5 health centres through CRENAS (Centre for Outpatient Nutritional Rehabilitation). In a few months, the number of cases of malnutrition and children under five suffering from other diseases increased significantly. In the paediatric centre the period was characterised by an overload of malaria cases.

No epidemic occurred in 2011, but the health district organized several vaccination campaigns against polio to which MSF gave logistical support.

MSF is looking for a reliable national or international collaborator that can take charge of the project, whose transfer has been delayed. Training and reinforcing the skills of hospital and health centre staff will be essential for the integration of hospital services.

Locality	Bouza, region of Tahoua
Target population	120,243 children between 6 and 59 months

Start and end date	January 2012 / December 2015
Project aim	Prevent and treat malnutrition in the Bouza district
Type of population	General population
Context	Stable

Activities	
Quantitative indicators	Total
Malaria (total)	459
Malaria (confirmed)	459
Admissions	1.825
CNT hospital	564
CNT primary care centre	3.003
Meningitis (treatment)	19
Measles vaccination (routine)	686

Project cost	**€ 336,969.92**

Human resources	**National**	**International**
Health workers	**44.23**	**0.00**
Non health workers	**13.79**	**0.10**

Agadez — Maternal / child health services

MSF intervention in Agadez began in 2009 following the conflict between the Tuaregs and the army, and is targeted at vulnerable populations in an economically and politically unstable region. Insecurity is due to the situation in Libya and the return of former combatants with no prospect of reintegration into society. MSF's priority population is the women, children and migrants who are crossing this area (including refugees). The health system in this region is weak due to a lack of medicines, human resources and referral system, and to regularly occurring emergencies, such as epidemics (meningitis), natural disasters (floods) and population displacement.

MSF supports five integrated health centres in Agadez and one in Dirkou, with a special focus on reproductive health, paediatric care for children under 5, and providing free health care for the migrant population. After analysing the needs of these populations, it was clear that the support of Integrated Health Centres (IHC) needed to be redirected to the IHC of the most isolated rural areas. It was therefore decided to discontinue support for IHC 2 of Agadez and start working in the IHC of Dabaga and Tabelot, located in the remote mountainous area of l'Aïr.

Locality	Agadez, Tahoua region
Target population	47,948 in Agadez, 11,076 in Dabaga, 12,518 in Tabelot

Start and end date	January 2009 / December 2012
Project aim	Prevent and treat malnutrition in the district of Bouza
Population type	General population
Context	Stable

Activities	
Quantitative indicators	Total
Malaria (total)	87,535
Malaria (confirmed)	10,295
Activities	4,233
CNS	288
Prenatal consultations (total)	14,284
Prenatal consultations (new)	5,174
Deliveries	3,908
Postnatal care	3,540
Direct violence	27
Measles vaccination (outbreak)	7,500
Measles (treatment)	246
Meningitis (treatment)	6

Project cost	**€ 642,431.56**

Human resources	**National**	**International**
Health workers	**26.30**	**0.00**
Non health workers	**27.38**	**1.85**

Tahoua — Nutritional emergency

For this nutritional emergency, MSF-OCBA briefly intervened by distributing basic goods to the affected population in Tahoua.

Project cost	**€ 266,326.35**

Human resources	**National**	**International**
Health workers	**26.90**	**0.23**
Non health workers	**9.74**	**0.34**

Niamey — Cholera emergency

In early June, a cholera epidemic broke out in Niamey, the capital of the country. MSF-OCBA set up a Cholera Therapeutic Centre (CTC) in Ndounga and an Emergency Treatment Centre in Libore in the Kollo district, 25 kilometres from Niamey. 290 patients were treated and no deaths reported. In November, given the low number of patients, the emergency response was closed.

Activities	
Quantitative indicators	Total
Cholera	510

Project cost	**€ 29,696.28**

Human resources	National	International
Health workers	**0**	**0**
Non health workers	**0**	**0**

Nigeria

Introduction and background

In April 2011, after a particularly agitated period of electoral campaign, the interim president, Goodluck Jonathan, was proclaimed the winner with 58.9% of votes in his favour. The electoral result was openly criticised by the leaders of the northern states of the country as they did not feel represented in the central government. The wave of violence increased after the elections and exacerbated inter-ethnic conflict and latent religious sentiments. At the same time, terrorist attacks attributed to the Boko Haram sect intensified during the year and culminated at Christmas when dozens of people died after a number of bombs exploded in Christian churches.

MSF OCBA began the Nigerian mission in 2007 with the intention of starting up regular projects and a team dedicated to rapid emergency response. During 2011 the operations consisted of implementing and reorienting the primary health care project in the marginalized neighbourhoods of Lagos, and following closely the epidemiological and emergency situations. However, in October of the same year, the rapid emergency response team was dissolved and responsibility was shifted to the general coordination team of the mission.

During 2011 the possibilities of establishing a new project, especially in the states of Plateau, Kaduna and Bayelsa, were explored although finally the findings did not reveal an intervention necessity.

Financial data

Expenses	€	%
NIGERIA, CAPITAL	€ 464,424.59	21.70%
NIGERIA, emergency team response	€ 180,746.30	8.44%
LAGOS, Urban setting	€ 1,453,386.61	67.90%
NIGERIA, EPP	€ 36,258.34	1.69%
EAST NIGERIA, cholera	€ 5,668.13	0.26%
Total	€ **2,140,483.97**	**100.00%**

Financing	€	%
MSF United States	€ 92,111.54	43.31%
MSF OCBA	€ 1,213,372.43	56.69%
Total Private Funds	€ **2,140,483.97**	**100.00%**
Total Financing	€ **2,140,483.97**	**100.00%**

Human Resources Capital

National Personnel	**17.00**
International Personnel	**5.02**

Lagos **Urban intervention**

Lagos is the most highly populated city in Nigeria, and probably in the whole African continent, with an estimated number of 18 million inhabitants. Thousands of people live in marginalised neighbourhoods where the sanitation conditions are deplorable and the health structures few and far between. For the occupants of the marginalized neighbourhoods access to medical attention is complex and, in addition, it is not always free.

Whilst Lagos has traditionally attracted rural populations from other areas in Nigeria, there is also a considerable flow of migrants from the surrounding countries who consider the city to be a starting point for the migratory routes to Europe.

The aim of MSF OCBA project was to reduce the morbidity and mortality of the most excluded population in the areas of Makoko, Badia and Ottomara. To this end, MSF OCBA provided primary health care, reproductive health care, and an emergency service at the Health Centre in Aiyetoro and three mobile clinics.

In 2011, there were 18,177 outpatient

consultations, 6,805 prenatal consultations, 1,027 postnatal consultations, 1,215 births, 900 hospital admissions, and 18,000 vaccinations.

The mobile clinics meant that the more remote populations could be reached and helped to promote better understanding of local dynamics. In one particular case, the floating population at Riverine, before the setting up of MSF mobile clinic there had been absolutely no access to health care. The inhabitants of Riverine come from Benin and belong to the ethnic group of the Egun. They speak their own language and live from fishing. Due to their being migrants, and the fact of language difficulties, the Egun people are even more marginalized.

Reorientation of activities at the end of 2011 showed the need to focus on sexual and reproductive help and mother-infant care, At the beginning of 2012 a survey was carried out in Badia to improve the project in the future.

Localisation	Lagos, neighbourhoods of Makoko, Badia and Ottomara
Target population	108,955 people
Start-up and finish date	January 2009 / May 2012
Project aim	To provide accessible and quality health services to the vulnerable population of Lagos
Type of population	General population
Context	Stable

Activities	
Quantitative indicators	Total
Outpatients	30,148
Malaria (total)	2,819
Malaria (confirmed)	2,112
Admissions	995
CNS	436
Prenatal consultations (total)	10,142
Prenatal consultations (new)	4,718
Births	1,216
Postnatal care	1,083
Direct violence	82
Yellow fever (outbreaks)	491
Haemorrhagic fever	3
Measles vaccination (routine)	488

Project cost	**€ 1.453,386.61**

Human resources	**National**	**International**
Health workers	**52.15**	**3.70**
Non health workers	**21.06**	**3.28**

Nigeria — Rapid emergency response team (RRT)

In October, 2010, the three sections present in Nigeria (Spain, Holland and France) arrived at an agreement to share out the various Nigerian states according to coverage of epidemiological vigilance and response to emergency situations.

During 2011, the RRT gave support to the Ministry of Health for the vaccination campaigns in Kaduna and Plateau during the outbreaks of measles.

In addition, the team maintained a continuous presence in two health centres in Jos, during the pre and post electoral periods, in order to give support to the population suffering from the constant outbreaks of violence in the zone.

In October, 2011, the decision was taken to dissolve the RRT and reorganize the follow-up and emergency response responsibilities within the coordination team from the mission.

Project cost	€ 180,746.30

Human resources	National	International
Health workers	1.21	0.49
Non health workers	0.00	0.96

Central African Republic (CAR)

Introduction and background

The outgoing president, François Bozizé, was re-elected with more than 64% of the votes and the Constitutional Court declared his victory on February 1, 2011. He was sworn in on March 5, 2011, for a second five-year term as president of the Central African Republic. The opposition and international observers (including the European Union, which funded the elections) reported many irregularities. Bozizé decided to ignore them, triggering protests from the opposition, which called for a boycott of the elections of March 2011.

This forced victory, in a country destabilised by several rebellions, has caused new tensions at a time when the disarmament, demobilisation and reintegration (DDR) of armed groups is at a standstill. At least ten rebel groups, including the Central African People's Democratic Front (CPF), the Convention of Patriots for Justice and Peace (CPJP), the Popular Front for Reconstruction (FPR), and the Lord's Resistance Army (LRA), continue to destabilise the country after not being included in the peace agreements and DDR. Despite some progress in the official negotiations between the government and various rebel forces, and the demilitarisation and reintegration in the northwest, seven of the seventeen prefectures are affected by conflict.

CAR has about 103,153 displaced persons, 22,180 of whom have had to move because of the violence in 2011. The widespread insecurity, associated with the government abandonment of rural areas, explains the collapse of the health system.

According to the Bank of Central African States (BCAS), the country's GDP grew by 3% in 2010. However, this growth has not been accompanied by human development. The country ranks 159 out of 169 countries in the human development index. It has a life expectancy of 48 years (the lowest in the world) and infectious disease mortality of 745.5 deaths per 100,000 inhabitants (the fifth highest in the world). The presence of malaria, human African trypanosomiasis (HAT) (with

four of the few remaining foci in Africa), and HIV / AIDS (highest prevalence in all Central Africa) is holoendemic (affects virtually the entire population). The health system lacks infrastructure, medicines and vaccines as well as qualified staff, which prevents the population having access to health.

Insecurity on the roads, population displacement and pillage form part of daily life for the country's inhabitants.

Financial data

Expenses		
Capital	€ 1,340,990.11	18.75%
Kabo, medical assistance	€ 1,407,62.,52€	18.71%
Batangafo, medical assistance	€ 2,261,8.02	30.06%
Gadzi, paediatrics	€ 964,220.32	12.81%
Ndele, medical assistance	€ 1,227,027.86	16.31%
Batangafo Kabo, emerg. Measles	€ 66,336.69	0.88%
BANGUI, emergency cholera	€ 256,965.50	3.41%
Total	€ **7,525.003.02**	**100.00%**

Financing	**€**	**%**
Basque Government	€ 200,000.00	2.66%
Canadian Government - CIDA	€ 326,532.10	4.34%
UE / ECHO / European Commission of Humanitarian aid	€ 800,000.00	10.63%
German Government Auswärtiges Amt der Bund	€ 357,534.00	4.75%
Danish Ministry of Foreign Affairs MFA	€ 5,427.95	0.07%
Government of Sweden - SIDA	€ 542,793.87	7.21%
Total Public Institutional Funds	€ **2,232,287.92**	**29.66%**
MSF Germany	€ 700,000.00	9.30%
MSF Japan	€ 1,379,185.54	18.33%
MSF OCBA	€ 3,213,529.56	42.70%
Total Private Funds	€ **5.292,715.10**	**70.34%**
Total Financing	€ **7,525.003,02**	**100.00%**

Human Resource Capital

National staff	70.44
International staff	11.97

Batangafo — Addressing the medical needs of the population affected directly or indirectly by violence

The precarious situation of Batangafo is due to various factors. It forms part of the area affected by the political events of 2005; it is on the route of nomadic shepherds who sometimes become involved in confrontations with the sedentary population, for example, over access to water; this region suffers emergency epidemics (outbreaks of malaria, measles and meningitis) and population displacements; and finally, it is a historical focus of HAT that MSF has been treating for more than 10 years. In addition, there is no state agency to take charge of health services, which leaves MSF as the main agent in the area.

MSF is working in the subprefecture hospital, offering a comprehensive package of primary and secondary health care, including outpatient consultations, maternal and paediatric services, surgery and internal medicine, and assisting 15-20 deliveries per week. It also provides diagnosis and treatment of HAT and other diseases such as tuberculosis and malaria (which remains the most frequent cause of consultation and treatment), as well as testing and treatment of HIV / AIDS.

MSF also operates in institutions of the surrounding area, with six health posts in Bongonon, Gbadene, Ouogo, Kambakota, Ngonikira and Bessé (the latter will become a health post in 2012). The aim is to monitor and reinforce the staff through training activities and exchanging hospital staff, sanitation activities, implementation and monitoring of protocols, and supporting the programmes of nutrition, vaccination and reproductive health.

MSF intervention in Batangafo has been designed to provide three types of medical care: community, primary in the health posts, and secondary in the hospital.

Localisation	Subprefecture of Batangafo
Target population	49,700 persons
Start-up and finish date	June 2006 / December 2012
Project aim	Address medical needs of the population affected by the direct or indirect consequences of violence
Type of population	General Population and refugees
Context	Stable

Activities	
Quantitative indicators	Total
Outpatients	116.870
Malaria (total)	60.630
Malaria (confirmed)	50.862
Admissions	9.673

CNT hospital	398
CNT primary care	686
Prenatal consultations (total)	10,297
Prenatal consultations (new)	4,717
Births	1,634
Postnatal care	1,672
Sexual violence	8
Surgery	660
Direct violence	88
HIV	337
1st line ART	171
New 1st line ART	99
Vertical transmission prevention (mothers)	21
Vertical transmission prevention (children)	21
TB (total)	108
Mental health 1	210
Mental health 2	53
Measles (treatment)	1.718
Meningitis (treatment)	47
Measles vaccination (routine)	1,384

Project cost	**€ 2.261.841**

Human resources	**National**	**International**
Health workers	**180.72**	**3.47**
Non health workers	**53.4**	**3.03**

Kabo

Reducing morbidity and mortality of the population of the Kabo region

Kabo's population continues to suffer a situation of low-level violence due to the presence of rebel groups, several of which are still operating in the area: the Popular Army for the Restoration of Democracy (APRD) who are working with the Central African Armed Forces (FACA), FPR and FDPC. Another factor is the marginal role played in the region by the state, which lacks means of intervention. This situation has serious consequences for the local population, much of whom regularly suffer violence (assassinations, attacks on villages, forced displacement, rape), and an almost total lack of access to health, which is reflected in the very high mortality rate. MSF has been intervening in the area for three years and each year prepares for emergencies caused by conflict-provoked displacement. In 2011 it supported the creation of a new camp for displaced people in Kabo.

MSF provides primary and secondary health care in the health centre (which functions like a hospital due to the scale and diversity of services provided) and the health post of Kabo. Hospitalisation, outpatient consultations, maternity and paediatric care, surgery and internal medicine are available. In addition, it provides diagnosis and treatment of HAT and other diseases such as tuberculosis and malaria (which remains the most frequent cause of consultation and treatment), as well as HIV / AIDS testing and treatment.

Two serious security incidents prevented the proper functioning of the project. On January 29, two MSF vehicles of the mobile clinic team were kidnapped for 10 days, which resulted in a reduction of activities that did not resume normality until the end of September. There was an immediate negative effect on health indicators.

In addition, MSF teams have been supporting the network of health centres and posts through outreach teams in the Moyenne Sido region. This activity has been under remote management since the security incident, and in 2012 the possibility of returning will be assessed, based on a safety analysis linked to the presence of rogue elements in the Kabo-Moyenne Sido axis.

Locality	Subprefecture of Kabo
Target population	57,000 persons
Start and end date	June 2006 / in process of decision according to context
Project aim	Reduce morbidity and mortality of the population of the Kabo region
Population type	General population and refugees
Context	Stable

Activities	
Quantitative indicators	Total
Outpatient consultations	65,383
Malaria (total)	42,806
Malaria (confirmed)	32,881
Admissions	2,153
CNT hospital	124
CNT primary care	339
Prenatal consultations (total)	4,441
Prenatal consultations (new)	2,320
Births	1,131
Postnatal care	717
Sexual violence	43
Surgery	253
Direct violence	186
HIV	201
1st line ART	159
New 1st line ART	80
Vertical transmission prevention (mothers)	7
Vertical transmission prevention (children)	84
TB (total)	46
Mental health 1	283
Mental health 2	8
Measles (treatment)	56
Meningitis (treatment)	59
Necessities	1,522
Measles vaccination (routine)	913

Project cost	**€ 1.407.622**

Human resources	National	International
Health workers	108.96	2.78
Non health workers	30.02	1.54

Ndele

Addressing the medical needs of the population directly or indirectly affected by violence

MSF has been present in Ndele since July 2010, and provides medical services to the areas of the northern axes of Ndele, which were left without health care after clashes between rebels and government forces. The population of the Ndele sub-prefecture is also receiving assistance, in particular the city of Ndele, which is suffering considerable instability and lack of medical infrastructure. The confrontation between the CPJP and the Union of Democratic Forces for Unity (UFDR) and the conflict between the FACA, CPJP and the UFDR have resulted in attacks on major cities, destruction of villages, and road blocks, as well as ethnic violence between the Runga and Gula militias. In June and July of 2011, the two factions of the CPJP signed the Libreville Agreement with the government, but in September serious violence broke out between the CPJP and the UFDR, resulting in widespread killings, burning of homes and forced displacement. About 12,000 refugees fled to neighbouring Chad, while 6.000 moved to the town of Bria. The rest are trapped, cut off from outside help and unable to flee.

The population of Ndele remains in a precarious situation, with little access to water and health. The only available health services were provided by MSF mobile clinics, which had to be suspended for safety reasons between December 2010 and June 2011. A large part of the area's population has been displaced in the bush for over two years. Their villages have been burned, so those returning have to rebuild everything. In the meantime, they live without access to water (especially after the rainy season) and are subjected to regular attacks by the armed forces. The last one, by the CPJP, caused a further displacement towards the city of Ndele. After the signing of a ceasefire agreement between the government and the CPJP, the situation stabilised, and the population expressed a desire to return to their villages in early 2012.

MSF provides health services for the local and displaced population at the hospital in Ndele. It supports outpatient consultations, and maternity, surgery, pharmacy and laboratory services. The hospital capacity has increased significantly since MSF started working there, and now has 64 beds after the opening two new pavilions.

MSF also supports four health posts (Aihou, Djamassinda, Tiri, Miamani) by remote management of permanent local staff (a manager, pharmacist, and midwife), who periodically travel to Ndele to exchange information with the nurse of the international team responsible for such monitoring. In addition, a referral system was launched with motorbike-taxis and bicycles, and there were few drug stock shortages.

In September 2011, the mobile clinics began working again, but given that the intention of the population is to return to their villages of origin, it might be more feasible to support the health posts of these villages, a less costly option with fewer security risks.

Locality	Subprefecture of Ndele
Target population	73,848 persons
Start and end date	July 2010 / in process of decision according to context

Project aim	Address the medical needs of the population directly or indirectly affected by violence
Population type	General population and refugees
Context	Armed conflict

Activities	
Quantitative indicators	Total
Outpatient consultations	71,475
Malaria (total)	26,174
Malaria (confirmed)	19,905
Admissions	1,386
CNT hospital	61
CNT primary care	28
Prenatal consultations (total)	3,422
Prenatal consultations (new)	1,435
Births	852
Postnatal care	685
Sexual violence	3
Surgery	155
Direct violence	37
TB (total)	29
Mental health 1	298
Mental health 2	34
Measles vaccination (routine)	9
Meningitis (treatment)	50
Necessities	135

Project cost	**€ 1,227,028**

Human resources	**National**	**International**
Health workers	**80.12**	**3.23**
Non health workers	**34.21**	**3.44**

Gadzi

Reduction of morbility and mortality in children under 15

Gadzi is located in the southwestern region of the country and has traditionally been an economically privileged area due to its diamond mines, as well as enjoying relative political stability. In the last year, the economy of the region was badly affected by the crisis in the diamond market as well as the restriction of mining concessions granted to foreign investors. Indicators of health and nutrition declined significantly, and the area entered a chronic health crisis, which it has still not overcome.

The baseline study conducted by Epicentre between January and December 2010 revealed a mortality rate well above the national

average, and particularly worrying in children under five. One of the causes is malnutrition, which reached figures well above the national average.

MSF addressed this situation by launching a programme in October 2010, which lasted throughout 2011. With the aim of reducing morbidity and mortality in children and adolescents, MSF set up a number of services in the eight health posts (Djomo, Sassele, Gontikiri, Mayaka, Boy Bale, Zaoroyanga,Zaorossongo and GadziI) and in the rehabilitated health centre, including hospitalization, outpatient consultations, treatment of paediatric diseases and nutritional care. In the latter, 8% success was achieved, first with a specific programme and later with a programme in the health centres and posts. A protocol was designed for cases of acute malnutrition, with systematic screening of all children from 2 to 59 months, and medical staff received training. The cold chain for vaccines was improved, and a widespread vaccination programme of children aged under five was carried out. Tuberculosis patients received attention. Community activities to promote awareness of child health were organised for the families of the region.

The project went ahead earlier than planned after the recent results published by Epicentre. Before handing over the management of health facilities to the respective health committees (COGES), training activities were organised for medical staff and health facility management. In October, teams began to hand over the health posts and centres to COGES, finishing the process in November. Special effort was made in terms of lobbying and advocacy to ensure the long-term presence of agents in this forgotten area, which presents such alarming morbidity and mortality indicators.

Locality	Subprefecture of Gadzi
Target population	57,000 people
Start and end date	October 2010 / November 2011
Project aim	Reduce morbility and mortality in children under 5 in the subprefecture of Gadzi
Population type	General population
Context	Stable

Activities	
Quantitative indicators	Total
Outpatients	48,794
Malaria (total)	28,647
Malaria (confirmed)	19,980
Admissions	1,417
CNT hospital	69
CNT primary care	695
TB (total)	12
Measles (treatment)	11
Meningitis (treatment)	32
Measles vaccination (routine)	890

Project cost	**€ 964,220**

Human resources	National	International
Health workers	74.28	2.39
Non health workers	31.60	1.89

Sudan

Introduction and background

The opposition of Darfur participated with little interest in the Doha Process sponsored by Qatar and Djibril Bassolé, jointly representing the African Union and the UNO. Khartoum, conscious of the growing disinterest on the part of the Western powers in Darfur, multiplied its military operations and encouraged division in the opposite side. The most important rebel movements counted on the deterioration of the economic situation and the search for regional support: the Justice and Equality Movement (JEM) in Libya, the Sudan People's Liberation Movement (SPLM), the Sudan People's Liberation Army (SPLA), and the SPLA in Uganda. The SLA-MM, a splinter group from the Sudan Liberation Army (SLA), a traditional ally of the Sudanese Government, changed its strategy and supported the rebellion thus losing its powerful role in the region. In the Kordofon and Blue Nile states a new rebel group was formed made up of the JEM, the SLA-AW, the SLA-MM, and the Sudan People's Liberation Movement (SPLM).

However, the Doha Process, presented by the mediators in April, took into account significant demands on the part of the rebels which included individual compensation for victims of violence and the appointing of the original Darfur leaders for high-powered positions in the State.

Additionally, based on a ruling from the Security Council from the UN, the head prosecutor of the International Criminal Court (ICC), Luis Moreno Ocampo, asked for four arrest warrants which included the President, Omar al-Bashir, and the Minister of Defense, Abdelrahim Mohamed, for crimes against humanity and war crimes carried out in Darfur between August 2003 and March 2004. There is already a search warrant for the former Minister of Humanitarian Affairs, Ahmed Harun, and the chief of the *yanyauid* militia, Alí Kushaib, on the part of the ICC within the framework of the investigation into the Darfur genocide. This situation, plus the total refusal of the Sudan President to surrender and handover the other imputed individuals, has resulted in the country being isolated by the international community.
In 2011, the political tension led to a critical deterioration in the context and conditions of the

ONGs' work. In January, Doctors of the World were expulsed by the Government accused of spying.

The expulsion of international NGOs, which commenced in 2009 with the exit of two MSF sections, has intensified. In their place the Sudan Government has promoted a "Sudanisation" of aid which now arrives from countries in the Middle East such as Saudi Arabia and Qatar.

MSF OCBA has been present in the zone since the beginning of the conflict in 2004. It has helped multiple displaced populations fleeing violence in four locations: Shangil Tobaya, Tawila, Dar Zaghawa and Kaguro.

Its activities include basic healthcare, patient triage, nutrition, reproductive health, paediatrics, vaccination programmes, attention for victims of sexual violence, psychosocial attention, political incidence activities and emergency response.

Financial data

Expenses	**€**	**%**
NORTH SUDAN, CAPITAL	€ 714,169.07	18.75%
SHANGIL TOBAYA, Medical and nut assistance	€ 803,283.96	21.09%
NORTH SUDAN, EPP	€ 23,406.75	0.61%
TAWILA, Medical and Nut ass.	€ 616,124.69	16.17%
EL FASHER, MCT Darfur	€ 458,707.39	12.04%
NORTH DARFUR TEAM.	€ 431,118.57	11.32%
KAGURO, PHC	€ 383,023.14	10.05%
SUDAN, international[39]	€ 35,821.41	0.94%
DAR ZAGHAWA, NFI distribution	€ 326,104.02	8.56%
ZAM ZAM, IDPs	€ 2,088.09	0.05%
MELLIT, explo nutrition[40]	€ 15,595.13	0.41%
Total	€ **3,809,442.22**	**100.00%**

Financing	**€**	**%**
MSF United States	€ 1,212,376.63	31.83%
MSF Greece	€ 600,000.00	15.75%
MSF OCBA	€ 1,997,065.59	52.42%
Total Private Funds	€ **3,809,442.22**	**100.00%**
Total Financing	€ **3,809,442.22**	**100.00%**

[39] I nternationally representing the MSF for Sudan.
[40] Exploratory mission in Mellit.

Human Resources Capital

National personnel	**24.40**
International personnel	**7.58**

Human Resources Representing MSF Sudan

National Personnel	**18.68**
International Personnel	**0.58**

Human Resources El Facher MCT (Coordination base) Darfur

National Personnel	**37.53**
International Personnel	**0.51**

Human Resources, Darfur team

National Personnel	**12.00**
International Personnel	**7.63**

Shangil Tobaya

Medical and humanitarian aid to victims of violence and local communities

The area of Shangil Tobaya is controlled by the Sudanese Government with the presence of 400 young policemen lacking military discipline. Whilst in 2010 the number of newly arrived displaced people had decreased, by 2011 the situation had radically changed due to the inter-ethnic conflicts in the area. The Tunjur and Berti tribes, recruited by the local police, harassed the Zaghawa tribe which caused them, and also the 20 local workers contracted by MSF, to flee the area. MSF is the only organisation offering medical assistance in the zone. Given the violence that took place in May and June, it was decided to retire the international personnel and direct activities by remote control with the help of well-trained Sudanese staff.

The services offered by MSF are the following: Patient triage, outpatient consultations, vaccination, reproductive health, nutritional emergencies (stabilization centre and ATFC), and a treatment room. MSF was present in two infrastructures: The Shangil camp and a centre from the Ministry of Health.

In spite of difficulties with access and the volatile context, MSF teams have managed to maintain acceptable health indicators although data collection has been difficult and could be more rigorous.

Due to the large presence of the organisation in Shangil Tobaya one of the challenges has been to reinforce the national team's capacities, which was necessary before the project transfer. An analysis of the

needs of the beneficiaries (there are still 20,000 displaced people in the camp), the strategic location of Shangil Tobaya (the hub between El Fashir and Nyala), and the future relationship between the Sudanese Government and the SLA-MM was carried out.

Localisation	Shangil Tobaya
Target population	32,000 people
Start-up and finish date	July 2009 / June 2012
Project's objective	To provide medical and humanitarian aid to victims of violence and local communities
Type of population	Refugees/displaced population
Context	Armed conflict

Activities	
Quantitative indicators	Total
Outpatients	31,570
Malaria (total)	95
Malaria (confirmed)	95
Admissions	787
CNT hospital	151
CNT primary care	902
Prenatal consultations (total)	4,534
Prenatal consultations (new)	1,807
Births	366
Postnatal care	87
Sexual violence	9
Direct violence	83
Mental health 1	842
Mental health 2	477
Measles (treatment)	10
Meningitis (treatment)	12
Measles vaccination (routine)	486

Project cost	**€ 803,283.96**

Human resources	**National**	**International**
Health workers	**56.61**	**0**
Non health workers	**25.16**	**0**

Tawila — **Medical and Humanitarian aid to victims of violence and local communities**

This has been the first year the project has been able to function without interruption since 2007. Security conditions have improved considerably which has permitted the presence of international personnel from time to time even though the project is permanently managed by remote control. This has resulted in the reinforcement of the national teams and loyalty from the population attended in the health camp rather than at the site in the town.

During the year 3,216 newly displaced people fleeing from the conflict amongst the Zaghawa tribes have arrived at the camp. MSF has been present in the health centre and has offered the following services: Outpatient consultations, admissions (maternity and paediatrics), patient triage, reproductive health (prenatal and postnatal care and family planning), nutrition (stabilization centre and ATFC) and basic laboratory services. In addition, there is a 24 hour emergency service with the possibility of hospital admission, maternal care, and distribution of food to admitted patients and their careers.

In the next few months it will be necessary to look at some aspects. In first place, to consider the challenge of broadening the target population to 60,000 including the local population that is suffering the consequences of the conflict. The strategy would be possible with implementation of mobile clinics if the contexts permitted. In second place, to supervise the national personnel and train them in order to increase the quality of services offered thanks to external activities.

Location	Tawila
Target population	21,391 people
Start-up and finish date	July 2007 / 2013 if the selected strategy fails
Project's objective	To give medical and humanitarian aid to victims of violence and local communities
Type of population	Refugees/displaced population
Context	Stable

Activities	
Quantitative indicators	Total
Outpatient consultations	44,335
Malaria (total)	206
Malaria (confirmed)	200
Admissions	708
CNT hospital	59
CNT primary care	962
Prenatal consultations (total)	5,617
Prenatal consultations (new)	2,630
Births	168
Postnatal care	64
Sexual violence	3
Direct violence	63
Mental health 1	865
Mental health 2	842
Meningitis (treatment)	6
Measles vaccination (routine)	3,619

Project cost	**€ 616,124.69**

Human resources	National	International
Health workers	**42.87**	**0**
Non health workers	**21.38**	**0**

Dar Zaghawa — Medical and humanitarian aid to victims of violence and local communities

Dar Zaghawa, located on the border with Chad, is a zone that traditionally suffers from violence and conflict. It is where all the armed forces in Darfur confront each other. The zone is divided into one area controlled by the Sudanese Government (where Um Baru is), and another controlled by the JEM/SLA-MM (including Furawiya and Muxbat). It is a zone that has been abandoned by the NGOs and MSF finds itself alone in responding to medical and humanitarian emergencies. Its presence in the three localities permits a certain equilibrium in the area and reinforces some aspects such as its image of neutrality.

The team provides support to two Ministry of Health centres at Um Baru and Muxbat, and to three primary care centres in Um Haraz, Jurajem and Furawiya. The principal activities are: Reinforcing the capacities of the national personnel (to improve quality of aid amongst other things through the correct use of protocols), management of the pharmacy, primary health care, reproductive health, outpatient consultations, and referrals to second level facilities.

The unstable context and lack of human resources have limited MSF expectations for 2011. Moreover, there are logistic difficulties due to the zone's isolation. An effort has to be made so that the local population comes to know MSF and visit their health centres. On the other hand, the area that it covers is going to be reduced and an exercise of rationalization performed with respect to the means employed. In 2012 an evaluation will be carried out to measure the real impact of activities in relation to its strategic location, near the Chad camps which are expecting a possible return of the population.

Localisation	Dar Zaghawa
Target population	29,725 people
Start-up and finish date	July 2009 / end of 2012
Project's objective	To give medical and humanitarian aid to victims of violence and local communities
Type of population	General population and displaced population
Context	Stable

Activities	
Quantitative indicators	Total
Outpatient consultations	23,947
Malaria (total)	203
Malaria (confirmed)	177
CNT primary care	4
Prenatal consultations (total)	1,608
Prenatal consultations (new)	957
Births	126
Postnatal care	31
Sexual violence	1

Direct violence	62
Measles (treatment)	6
Meningitis (treatment)	3
Measles vaccination (routine)	267

Project cost	**€ 326,104.02**

Human resources	**National**	**International**
Health workers	**14.92**	**0**
Non health workers	**15.10**	**0**

Kaguro — Medical and humanitarian aid to victims of violence and local communities

Kaguro is located in the mountainous region of Jebel Si, under the rebel control of the SLA-AW. It is a politically and geographically isolated area due to the total lack of transport and the role of the Sudanese Government which has blocked the area with checkpoints. The nearest health infrastructure is more than three hours away by truck and, at present, MSF is the only organisation providing medical and humanitarian aid in the zone.

The Belgian section of MSF started a project in 2004 which they transferred to MSF OCBA in June, 2011. The second semester has been spent getting to know the zone and its inhabitants better, re-evaluating needs and managing a number of difficulties which include scarce human resources, logistical problems resulting from fewer flights, and cuts in the medical supplies (supplies were not permitted to be sent from January to September).

The services that MSF currently provide are the following: Primary health care, support for secondary activities, reproductive health, hospital admission, outpatient consultations, psychological help, nutrition and referrals.

Location	Kaguro
Target population	100,000 people
Start-up and finish date	June 2011 / December 2013
Project's objective	To give medical and humanitarian aid to victims of violence and local communities
Type of population	General population/displaced population
Context	Stable

Activities	
Quantitative indicators	Total
Outpatient consultations	9,116
Malaria (total)	37
Malaria (confirmed)	37
Admissions	113

CNT hospital	30
CNT primary care	400
Prenatal consultations (total)	1,589
Prenatal consultations (new)	993
Births	38
Postnatal care	142
Sexual violence	1
Surgery	12
Direct violence	17
Measles vaccination (routine)	306

Project cost	**€ 383,023.14**

Human resources	**National**	**International**
Health workers	**20.00**	**0.79**
Non health workers	**14.08**	**1.01**

Sudan, 2012. © Asia Kambal

Sudan, 2012. © Asia Kambal

Darfur: Mission impossible

*By **Alberto Cristina***
Responsible for Operational Cell 1 of MSF OCBA

This article is a collective effort from some of MSF workers involved in our activities in Darfur, Sudan, during 2011. It tries to make an analysis of the main challenges and dilemmas faced by MSF OCBA teams, advocating for the need for a deeper reflection on our present and future role in the country. Firstly, it analyses the main events concerning the complex Darfur peace process negotiation. Later, it highlights the violence of the conflict in the areas of our intervention and the administrative barriers imposed on our organization by the Government of Sudan (GoS). And, finally, it ends by highlighting the reasons for the urgent need of a comprehensive review of the engagement strategy chosen by all MSF sections in 2010.

Darfur Peace process and new coalitions in Sudan

2011 was marked by several important changes in the anti-GoS coalition, challenging and once again postponing the implementation of the Darfur Peace Agreement signed in 2006. After renewed international support for the Doha peace talks, the Liberation and Justice Movement (LJM) and the GoS signed the Doha Document for Peace in Darfur (DDPD) on July 14th, only five days after South Sudan officially became an independent State. The Justice and Equality Movement (JEM), the Sudan Liberation Army - Minni Minawi (SLA-MM) and the Sudan Liberation Army - Abdul Wahid (SLA-AW) did not sign the agreement.

The new DDPD does not really differ a great deal from the Darfur Peace Agreement of 2006. Nevertheless, in comparison to the original version, some chapters related to justice, compensation, and power sharing solutions have evolved. In addition, the possibility of dispersing funds to the Darfur population via a compensation mechanism could obtain some kind of larger popular support.

The new conflict between the Sudan People's Liberation Movement - North (SPLM-N) and the GoS in South Kordofan and the Blue Nile States has allowed SLA-AW, SLA-MM and JEM to articulate a national, rather than regional, agenda. The alliance among SLA-MM, SLA-AW, and SPLM-N was announced in August, the JEM officially joined it a short time later. While there may be some substantive points of disagreement on the Doha agreement among the non-signatory groups, their motives appear to be largely tactical.

Parallel to the DDPD, an All Darfur Stakeholders Conference (ADSC) was organized in Qatar. The final document issued by the ADSC endorsed the draft of the Doha agreement, however, a number of important stakeholders, such as the Fur IDP representatives and the Zaghawa traditional leaders, were absent. Both ethnic groups, the Zaghawa and the Fur, are today among the most vulnerable population in Darfur and represent a significant percentage of our

target populations in the Shangil Tobaya, Dar Zaghawa and Kaguro projects. The ADSC agreed to the creation of a Follow-up Committee led by Qatar and supported by the European Union and the United States. Both the UN and the AU expressed discomfort over the Follow-up Committee as it was perceived as interfering with the ongoing DPPD process.

In September, the first meeting of the International Follow-up Committee (IFC) for the DDPD took place. During the same month, Al-Haj Adam Youssef was appointed vice President, in line with the DPPD's stipulation that a Darfurian receive a vice presidential appointment. The JEM and SMA-AW issued statements opposing the appointment. In the same month, Tijani Sese, leader of the LJM, landed in Khartoum and started touring the Darfur States to lobby for the DDPD among local populations. Residents of the IDP camps raised several concerns about the agreement enabling forced returns to be prevented, securing the disarmament of the Janjaweed, compensation, and general accountability for the war crimes committed.

Attacks and population displacement in the south areas of El Fashir

Whilst the attention of the international community was completely absorbed by the referendum and the creation of the new State of South Sudan, from December 2010 until June 2011, the areas in the south of El Fasher, bordering South and West Darfur, experienced the most intense violence witnessed by the whole Darfur region during 2011. Deaths and injuries were caused by indiscriminate attacks and, in some cases, also by deliberate attacks on civilian settlements. The wider humanitarian impact of the violence and military confrontation, involving SAF, allied militias and a group of armed opposition, the SLA-MM, resulted in an estimated 70,000 new IDPs.

This area of Darfur, Shangil Tobaya, where MSF carries out activities in one project, remained under the direct authority of the forces of the SLA-MM faction after it signed the May 2006 Darfur Peace Agreement, and joined the Sudanese government. In December 2010, the SLA-MM's leader, Minni Arku Minawi, withdrew from the government and called on his troops to resume armed opposition. A cycle of violence began.

Traditional leaders and local government officials began openly and publicly advocating the expulsion of all Zaghawas from the area. New local Popular Defence Forces (PDF) militias opposing Zaghawa residents were formed. Traditional leaders, elected officials and commanders of the subsequently created PDF militia in Shangil Tobaya and Dar-es-Salam stated that they did not distinguish between Zaghawa armed fighters and Zaghawa civilians. With UNAMID apparently unable to carry out its mandate to protect civilians and prevent violent actions, more than 20,000 Zaghawa IDPs finally abandoned the Shagil Tobaya camps and left the region altogether.

Trapped in the middle of the violence, MSF team was forced to leave the MoH rural hospital structure where we had been working since 2010 in coordination with local authorities. Nevertheless, our national team was able to resume basic medical activities inside the IDP camps, re-organizing a health centre in the old MSF structure, converted into a school for the displaced population living in the area after MSF departure. Since this dramatic period of time, we have been negotiating our return to a rehabilitated MoH facility with the local authorities, planning the handover of our activities before the end of 2012.

Jebel Si and Jebel Mara population left without medical services

The Kaguro rural hospital provides outpatient and inpatient care, an immunisation programme, an outpatient therapeutic feeding centre, an inpatient therapeutic feeding centre, a women's health clinic, and surgical treatment to an estimated target population of over 100,000 people. We also run five health

posts in the isolated mountain villages of Burgo, Bourey, Lugo, Useige, and Bouley, where teams provide primary healthcare along with nutritional support and immunisations. Patients with complicated medical conditions are referred to the Kaguro hospital. The population of the Jebel Si and Jebel Mara area has extremely poor access to medical care. MSF is the sole provider of healthcare in the region: there are no local health services, and there are no other international organizations providing medical assistance.

Despite the dire situation and significant medical needs, since July 2011, the date of the handover of activities with MSF OCB, we have been encountering extreme administrative difficulties whilst working in the region. Recently, it has become increasingly hard to obtain the necessary authorisation to operate in the area, making it almost impossible to continue our activities. The main obstructions involve permits for international staff, transport of staff, and medical and logistical supplies.

In order to carry out activities in Darfur, Technical Agreements (TA) need to be signed on an annual basis. Work and travel permits for international staff depend on such agreements. In the 2012 TA, MSF requested authorisation for nineteen (19) international staff, all considered essential for running our four projects in Darfur. However, so far the authorities have agreed to a total of just five (5) members of international staff.

Getting sufficient medical supplies to MSF hospital and health posts is absolutely critical. To transport drugs and other supplies to the Kaguro hospital, we must obtain authorisation from the regional authorities. During the past months, this authorisation has frequently been denied, resulting in stock ruptures of vital drugs, with serious consequences for patients.

The direct result of these obstacles is that MSF has been forced to radically scale down its activities in all the predicted settings. Now, in early 2012, as a result of the serious shortages of medical staff, material and drugs, the only activity offered is a reduced antenatal care service. The hospital inpatient department and the surgical theatre have had to shut down. The end result of the forced reduction in MSF services is that the people living in the region are no longer able to access the healthcare they need, and lives are being unnecessarily lost. With MSF forced to reduce its activities, the more than 100,000 people living in the area are in danger of being left entirely without healthcare.

Engagement strategy review needed

Sudanese opinions with respect to MSF vary according to time and location. It is, however, a fact that since 2009 MSF activities have been drastically reduced as a result of the lack of trust in it acting as a neutral partner. A breaking point in our relationship with the GoS was the well-known MSF OCA's Rape Report, perceived to have stimulated the ICC (International Criminal Court) indictment against the President of Sudan.

Nevertheless, the views of the Sudanese authorities concerning MSF can be divided between local authorities on one side, and central authorities and their security body extension at State level on the other. Such a difference was once again underlined during the latest negotiation tour carried out by the President of MSF OCBA in Khartoum and El Fashir. Local authorities have a relatively good opinion of MSF because of the medical and humanitarian services provided by the organization. Central authorities, on the contrary, tend to perceive MSF as a threat to their national security, principally because are evaluating our action from a different perspective.

With the overall objective of improving our capacity to respond to medical crisis all around the country, including crisis related to conflict, as of 2010 all sections developed and implemented a medium long term positioning and engagement strategy. This was carried out in order to enhance our capacity to be

perceived as a neutral partner by the GoS, and improve our image so as to gain legitimacy and trust thus achieving a better response.

During 2011, the lack of access to the most vulnerable population affected by the violent clashes between militia groups supported by the SAF and SLA-MM in the areas of Shangil Tobaya, later on displaced to the Zam Zam camp, and the refusal to grant authorization to supply our rural hospital in Kaguro, could force MSF OCBA to resign from this medium long term engagement. The strategy of engagement does not seem to have increased our ability to respond to medical crisis in this country, especially in case of crisis resulting from armed confrontation.

The change of context in the country, the lack of access for independent assessments and interventions for the general population affected by armed confrontation and violence in Darfur, Abyei, South Kordofan and the Blue Nile States, and the forced reduction of our medical services in the Kaguro project settings all deserve a coordinated reflection in order to better plan our future strategic choices in and outside the country.

Southern Sudan

Introduction and background

In January 2011 a referendum was held for Southern Sudan's self-determination. Votes in favour were more than 99.9% and the separation that ensued was approved by the international community. By the 9th of July the new Republic of Southern Sudan should have gained its independence, however, there were too many unanswered strategic questions: The delimitation of borders and the issue of Abyei, agreement about income from petroleum, the status of the inhabitants from the south who live in the north of Sudan and so on. The referendum could not be held in the zone of Abyei because both governments claimed the area. In January, due to this discrepancy, the two sides gathered troops and arms near the zone thus infringing agreements signed in 2005.

In addition, there were clashes in the states of South Kordofan and the Blue Nile which led to the displacement of millions of people to the south of the country. On the 20th June, under pressure from the UN, north and south signed an agreement to jointly manage Abyei.

The economic and sanitary situation of the country is worrying. The increase in inflation left the population in a situation of extreme vulnerability and increased the existing problems. The lack of health infrastructure for minimum services is acute and in many hospitals healthcare has to be paid for. This fact limits or impedes access for most of the population.
Moreover, the situation continues to be very unstable with population displacements and a strong risk of clashes amongst the rival tribes (the Zande-dinka, Mbororo and Jonhlei) which threatens the security and stability of the civil population.

MSF OCBA has been present in Southern Sudan since 2004 with primary and secondary health projects. It also has care programmes for patients suffering from such diseases as

human African tripanosomiasis (HAT) or malaria. MSF OCBA is in the states of Western Equatoria
and Western Bahr El Ghazal where it looks after displaced people and the local population in the hospitals of Yambio and Raga. In these zones the population is permanently exposed to hyper-endemic diseases (always present in the community and with a high incidence). The risks of outbreaks of measles (due to lack of vaccination coverage), meningitis, malaria, viral haemorrhagic fever and acute diarrhoea are high.
Insecurity and possible ethnic clashes combined with a negative economic situation make the situation dangerous for the country's civilian population.

Attacks in the border regions between the Democratic Republic of the Congo and the state of Western Equatoria are a constant source of population displacement with the addition of refugees from the Congo coming from such places as Yambio.

Financial data

Expenses	**€**	**%**
SOUTH SUDAN, CAPITAL	€ 1,077,120.38	25.77%
RAJA, paediatrics and Health Care	€ 1,446,195.59	34.60%
SOUTH SUDAN, EPP[41]	€ 33,815.59	0.81%
YAMBIO, paediatrics and health care	€ 1,622,246.40	38.82%
Total	€ **4,179,377.96**	**100.00%**

Financing	**€**	**%**
Spanish Government - AECID	€ 900,000.00	21.53%
UE / ECHO / European Commission for Humanitarian Aid	€ 333,000.00	7.97%
Danish Ministry for Foreign Affairs MFA	€ 15.050,10	0.36%
Total Public Institutional Founds	€ **1,248,050.10**	**29.86%**
MSF Germany	€ 1,000,000.00	23.93%
MSF OCBA	€ 1,931,327.86	46.21%
Total Private Funds	€ **2,931,327.86**	**70.14%**
Total Financing	€ **4,179,377.96**	**100.00%**

[41] Emergency preparation.

Human Resources Capital

National Personnel	**56.87**
International Personnel	**9.33**

Yambio

Response to the medical needs of the population affected by the direct and indirect consequences of violence

The county of Yambio suffers a severe lack of both primary and secondary health services. The public hospital (Yambio State Hospital), for example, has a number of factors that impedes it being able to offer the population a correct medical service. There is a lack of equipment, an absence of trained personnel and a scarcity of medication. The situation is even more dramatic in the rural regions where lack of support from the Ministry of Health is notorious and there are few NGOs (most of these working in the refugee camps or in the cities), all of this leaves the population in a situation of extreme vulnerability. In addition, the only health care available must be paid for.

The situation is reflected in worrying health indicators, for example, the maternal mortality rate (2,325 deaths per 100,000 births) and the infant mortality rate (110 deaths per 1,000 live births).

MSF is providing attention with the following activities: Outpatient consultations, patient triage, reproductive health (pre and postnatal care), nutrition (ATFC support), mental health, sexual and gender violence, vaccination and surgery.

The aid that has been offered has meant that the health indicators have substantially increased which shows that access to both primary and secondary healthcare has improved.

During the year, as part of a strategy to reach the most vulnerable population, it was decided to cease activities in the health centre at Ezo and refocus work towards supporting the state hospital and the rural areas of the Yambio county in function of the beneficiaries' needs. The beneficiaries included refugees, displaced people, returned people and the local population.

At the beginning of 2012 the mental health activities ceased (the episodes of violence that justified such activities no longer existed) and the team centred its efforts on primary care in the rural areas which were the places most lacking in such services.

A new collaboration agreement was signed with the Health Ministry with the objective of obtaining a better management of the hospital and medical services. The plan against malaria was implemented in 2011 to give support to more than 20 medical structures with training for personnel.

Location	County of Yambio, state of Western Equatoria
Target population	187,268 people
Start-up and finish date	June 2008 / December 2013
Project's objective	To give a response to the medical needs of the population affected directly and indirectly by violence
Type of population	General and displaced population
Context	Stable

Activities	
Quantitative indicators	Total
Outpatient consultations	23,130
Malaria (total)	17,964
Malaria (confirmed)	17,095
Admissions	6,768
CNT hospital	17
CNT primary care	329
Births	1,327
Sexual violence	32
Surgery	318
Direct violence	117
Mental health 1	528
Mental health 2	79
Measles (treatment)	12
Meningitis (treatment)	36
Staple necessities	1,100

Project cost	**€ 1,622,246.40**

Human resources	**National**	**International**
Health workers	**43.53**	**6.80**
Non health workers	**48.74**	**4.17**

Raga

Medical and humanitarian aid to a population affected by violence (displaced people, refugees and local population)

The county of Raga is part of the state of Western Bahr el Ghazal and has a total population of 55, 970 people (2008 census). The population is dispersed around the state and has very limited access to health care through the Raga Civilian Hospital (RCH) and the 15 primary health centres dues to the lack of medications and trained staff.

The increase in the price of food and the unfavourable currency exchange rate have meant that the economic situation is very fragile and the rural zones can expect possible nutritional crisis and an increase in the rate of malnutrition.
In January, 2011 MSF began a primary and secondary care project in the Raga Civilian Hospital which hoped to give support to the following services: Outpatient consultations, patient triage, reproductive health (pre and postnatal care, family planning), nutrition (ATFC support), mental health, assistance for sexual or gender violence, community health, vaccinations and surgery. In addition, a strategy to reach out to the community was implemented thanks to activities such as information, education and communication (IEC) activities with the aim of bringing the patients closer to the health services.

Moreover, MSF started in September a series of activities in the rural zones near Raga using four of the 15 primary health care centres in the area. These included: A training programme for the staff of the primary health care unit and sanitation activities. .

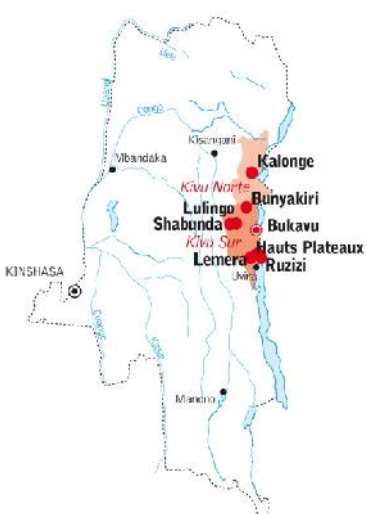
Location	County of Raga, Western Bahr el Ghazal state
Target population	55,970 people
Start-up and finish date	January 2011 / December 2012
Project's objective	To give medical and humanitarian aid to a population affected by violence (displaced people, refugees and the local population)
Type of population	Displaced and general population
Context	Stable

Activities	
Quantitative indicators	Total
Outpatient consultations	15,627
Malaria (total)	9,055
Malaria (confirmed)	8,352
Admissions	2,667
CNT hospital	57
CNT primary care	135
Prenatal consultations (total)	3,159
Prenatal consultations (new)	1,168
Births	648
Postnatal care	41
Sexual violence	3
Surgery	255
Direct violence	50
Meningitis (treatment)	1

Project cost	**€ 1,446,195.59**

Human resources	**National**	**International**
Health workers	**31.15**	**5.47**
Non health workers	**46.82**	**4.46**

Democratic Republic of Congo (DRC)



Introduction and background

Numerous conflicts have caused devastation and violence throughout the country, from north of Katanga to the borders with the Central African Republic and Sudan. These involve the Mai-Mai; Rwandan rebels of the Democratic Forces for the Liberation of Rwanda (FDLR) in the Kivu and Maniema provinces; Ugandan fighters from the Lord's Resistance Army (LRA) still active in the Eastern province; the Ugandan rebel group, the Allied Democratic Forces fosr the Liberation of Uganda (ADF-NALU) in North Kivu; and the Burundi rebels in South Kivu. Insecurity dominated 2011, resulting in extortion, rape and pillage. The disorganised Congolese army has little credibility.

At the beginning of 2011, under international pressure, military structures in the Kivus have been reorganised. Members of the military, including high-ranking officers, were brought to justice. In the political sphere, a calendar of local, provincial, legislative and presidential elections had been established for 2011-2013. In February 2011, a new independent electoral commission (IEC) was created to replace the one that supervised the 2006 elections. In the same month, a reform of the Constitution changed the voting system in the presidential and legislative elections. Both elections were held in November 2011, and were marked by massive fraud. The election of Joseph Kabila as president was criticised by opponents, and when he took power on December 20, the only head of state present was Robert Mugabe. In addition, given the large discrepancies in the parliamentary election results, these were suspended until the arrival of international experts, who had to "save" the results. They were to be announced in January 2012.

The campaign period (since October) and the elections have resulted in a resurgence of insecurity and violence in the locations where MSF-OCBA has projects.

Numerous clashes provoked by the regular armed forces have caused population

displacement, and new cases of violence (particularly rape).

MSF has been working in the DRC since 1981. The five operational sections are present in nearly all the provinces of the country, trying to meet the needs of the population. Current projects aim primarily to provide medical care to victims of violence. MSF-OCBA is present in three locations in the Kivus: Kalonge, Hauts Plateaux, and Shabunda, working in remote areas where the only available services are those of the organisation, as well as an emergency response team. This intervention has involved logistical difficulties and security risks.

Financial data

Expenses	**€**	**%**
Capital	€ 1,134,270.72	19.70%
KALONGE, Medical assistance	€ 1,219,285.50	21.18%
KINCHASA, base	€ 9,632.37	1.66%
HAUTS PLATEAUX, Medical assistance	€ 717,312.86	12.46%
SHABUNDA, intervention Matidi	€ 1.780,795.67	30.94%
SOUTH KIVU, emergency	€ 321,729.48	5.59%
SOUTH KIVU, emergency Buniakiri	€ 50,271.51	0.87%
LULINGU, emergency IDPs	€ 160,678.02	2.79%
BUKAVU, emergency cholera	€ 6,434.81	0.11%
DRC, EPP[42]	€ 267,040.71	4.64%
SOUTH KIVU, explo measles	€ 3,266.71	0.06%
Total	**€ 5,756,718.36**	**100.00%**

Financing	**€**	
MSF Japan	€ 2,015,732.71€	35.02%
MSF United States	€ 1,426,325.45	24.78%
MSF OCBA	€ 2,314,660.20	40.21%
Total Private Funds	**€ 5,756,718.36**	**100.00%**
Total Financing	**€ 5,756,718.36**	**100.00%**

[42] Preparation for emergencies.

Human Resource Capital

National staff	**59.26**
International staff	**9.40**

Human resources EPP

National staff	**12.47**
International staff	**1.02**

Human Resource Base Kinshasa

National staff	**1.63**
International staff	**21.53**

Kalonge **Reduction of morbidity and mortality in conflict-displaced and local populations**

This project began in 2008 with the aim of providing adequate health care for the victims of violence and those forcibly displaced by extortion and sporadic fighting. MSF supports 8 of the 17 health centres in the area, as well as a general hospital in Cifunzi, providing the following services: Primary health care, nutrition, tuberculosis treatment, PMTCT, support of secondary services in the hospital, mental health care, sexual and reproductive health care (including aid for rape victims), and support of surgical activities.

In 2011 we tried to improve the quality of the supported activities (by training staff in the health centres and hospital), the primary health care in the 8 health centres, and secondary care in the hospital. Three new health centres have been renovated and included in the network of centres supported by MSF. The implementation of comprehensive primary health care packages has been reinforced, but the required level of quality and supervision was not achieved, partly because of the lack of human resources (taking into account frequent outbreaks of cholera in 2011) and the difficulties of access to part of the area due to outbreaks of violence and insecurity.

In 2012, the strategy of joint monitoring with Health Ministry teams will continue.

Locality	Kalonge
Target population	135,545 persons
Start and end date	July 2008 / December 2012
Project aim	Reduce morbidity and mortality in conflict-displaced and local populations
Population type	Displaced population
Context	Armed Conflict

Activities	
Quantitative indicators	Total
Outpatient consultations	10,4640
Malaria (total)	3199
Malaria (confirmed)	778
Admissions	2,529
CNT hospital	364
CNT primary care centre	1,391
Selective nutritional support	23
Prenatal consultations (total)	10,988
Prenatal consultations (new)	4,096
Deliveries	4,669
Postnatal care	3,349
Sexual violence	324
Surgery	738
Direct violence	16
Vertical transmission prevention (mothers)	8
Vertical transmission prevention (children)	3
TB (total)	12
Mental health 1	2,980
Mental health 2	633
Measles vaccination (routine)	5,876

Project cost	**€ 1,219,286**

Human resources	**National**	**International**
Health workers	**13.61**	**4.50**
Non health workers	**24.20**	**1.43**

Hauts Plateaux — Aid for displaced and local populations affected by violence caused by the conflict

The Hauts Plateaux area is very strategic because of its location on the border with Burundi and Rwanda. Armed groups are still present (FNLC[43], FDLR, FRF, Mai Mai, self-defence groups and FARDC[44]), and incidents and clashes on the three borders (DRC, Ruanda and Burundi) occur frequently. It is also an inaccessible mountainous area without health services, where international NGOs have no regular activities due to logistical and security problems. The population lives in a precarious state of complete isolation, and the few health services available require payment. MSF has been working since 2010 in collaboration with the Ministry of Health, and supports 4 schools and 2 health posts. It also provides mobile clinics in the south and north. Lack of access to the area due to frequent security incidents has prevented a proper monitoring of health centre activities, which calls into question the quality of medical actions. Moreover, the mobile clinics had to be suspended, which undermined the system of joint monitoring.

In 2012 it is planned to reinforce the monitoring of the quality of health care provided

[43] Front for the National Liberation of the Congo.
[44] Military of the Democratic Republic of the Congo.

in health centres, improving the referral systems to hospitals in the area (Katanga, but also Uvira depending on the level of expertise required) and the counter-referral system. The inaccessibility of the location, which can only be reached on foot, greatly hampers the supply logistics, and alternative ways of working will have to be found. Finally, the zone of action for attending rape victims will be extended, as they are numerous in the area and lack aid.

Locality	Hauts Plateaux
Target population	78,004 persons
End and start date	July 2007 / April 2011
Project aim	Provide aid for victims of violence in displaced and local populations affected by the conflict
Type of population	General and displaced population
Context	Armed conflict

Activities	
Quantitative indicators	Total
Outpatient consultations	41,424
Malaria (total)	1,370
Malaria (confirmed)	606
Prenatal consultations (total)	2,482
Prenatal consultations (new)	1,402
Deliveries	938
Postnatal care	952
Sexual violence	709
Direct violence	18
Mental health 1	2,902
Mental health 2	239
Measles vaccination (routine)	24,454

Project cost	**€ 717.313**

Human resources	**National**	**International**
Health workers	**14.78**	**2.00**
None health workers	**34.79**	**0.00**

Shabunda

Provide aid for displaced population, refugees, local populations affected by the conflict

The area of Shabunda has been historically affected by armed conflict and displacement. Civilians suffer attacks by armed groups acting with total impunity in this unstable area, which has great mineral wealth. The result is injured civilians and combatants, and many rape victims.

MSF has been intervening in Shabunda since July 2010 to provide free medical and humanitarian aid to the population of the Shabunda health zone. Conceived as a short-term emergency intervention, the continued action of MSF in the area was necessary for the following reasons: Shabunda is an endemic area for malaria, measles, and cholera; there are no free quality health services; the services offered by the Shabunda referral hospital are few and of low quality.

Therefore, MSF decided to rethink the intervention as a 4-year project, with health centres (offering primary and secondary care) and a continuous improvement of its response to the emergency situations. Consequently, MSF supports 6 health centres providing primary health care, organises mobile clinics, supports Shabunda referral hospital, particularly the surgical and emergency services, and organises referral systems to the Shabunda hospital and the Hospital Centre of Matili. Internal medicine, paediatrics, maternity, surgery, laboratory and 24-hour outpatient consultation services are supported. The team has worked hard to monitor medical care and its improvement is due to the availability of tools (protocols), reorganisation and training of local staff.

In the hospital centre of Matili, MSF is intervening directly to improve the quality of paediatric and maternity care and surgery, making this centre a reference facility for the whole area.

Locality	Shabunda
Target population	16,000 persons
Start and end date	July 2011 / December 2015
Project aim	Provide aid for victims of violence in displaced and local populations affected by the conflict
Type of population	General and displaced population
Context	Armed conflict

Activities	
Quantitative indicators	Total
Outpatient consultations	122,380
Malaria (total)	23,483
Malaria (confirmed)	11,773
Admissions	3,610
Selective nutritional support	1
Prenatal consultations (total)	7,622
Prenatal consultations (new)	3,585
Deliveries	3,043
Postnatal care	4,596
Sexual violence	948
Surgery	655
Direct violence	23
Mental health 1	3,834
Mental health 2	165
Measles vaccination (routine)	69
Meningitis (treatment)	46

Project cost	**€ 1,780,796**

Human resources	National	International
Health workers	12.85	3.62
Non health workers	37.27	2.52

South Kivu — Buniakiri emergency

In south Kivu, an area marked by conflict and violence, the humanitarian agencies have a limited capacity to respond to epidemics or population displacements. As a remedy for this situation, MSF has deployed a team to fill the gap and provide a satisfactory response to 3 types of emergency: Epidemics (cholera, shigellosis, meningitis, measles, malaria, VHF, etc.); population displacements and arrival of war wounded; victims of natural disasters.

The aims of the emergency team are to provide a good early warning system (early detection of emergencies); a systematic, rapid and appropriate response to identified emergencies; and to improve the capacity of the regular teams to intervene in specific emergencies.

In 2011, MSF team intervened in 3 places: Shabunda (before it becomes a regular project), Bunyakiri (providing care for people displaced by the conflict) and Lulingo (providing care for people displaced by the conflict).

Several exploratory missions were carried out (Ziralo, Mwenga, Mulungo and Kitind) but due to capacity limitations (particularly of human resources), it was impossible to respond to all the emergencies. In the future, collaboration with the emergency team of the Dutch section will allow resources to be mutualised and response capacity enhanced.

In the context of a new series of attacks and battles, civilians in the area were subjected to violence, including the burning of villages and sexual violence. MSF-OCBA decided to intervene, setting up 3 health centres, which were attended by many victims of violence. In three weeks more than 60 rape victims were treated by MSF team, and 40% of them were able to receive the full treatment by arriving within 72 hours of the attack.

The project was transferred in July to two organizations, PIN (People in Need) and IMC.

Locality	Buniakiri
Target population	5,500,000 persons
Start and end date	2011 / December 2012
Project aim	Reduce the morbidity and mortality of a conflict-affected population by an early warning system and rapid assistance
Type of population	General and displaced population
Context	Armed conflict

Activities	
Quantitative indicators	Total
Outpatient consultations	14,750
Malaria (total)	2,061
Malaria (confirmed)	1,344
Prenatal consultations (total)	524
Prenatal consultations (new)	225
Deliveries	122
Postnatal care	216
Sexual violence	240
Mental health 1	265
Mental health 2	511
Measles treatment	2
Meningitis (treatment)	1
Measles vaccination (routine)	41

Project cost	**€ 50,272**

Human resources	**National**	**International**
Health workers	**0**	**0**
Non health workers	**1**	**0**

Lulingu **Displacement emergency**

Activities	
Quantitative indicators	Total
Outpatient consultations	10,011
Malaria (total)	878
Malaria (confirmed)	612

Admissions	744
CNT hospital	210
Prenatal consultations (total)	515
Prenatal consultations (new)	304
Deliveries	247
Postnatal care	356
Sexual violence	31
Surgery	154
Direct violence	16
Mental health 1	504
Mental health 2	43
Measles vaccination (routine)	2
Meningitis (treatment)	1

Project cost	**€ 160,678**

Human resources	**National**	**International**
Health workers	**0**	**0**
Non health workers	**0**	**0**

South Kivu — Measles emergency

NET, based in Nairobi, launched the first vaccination campaign in the health zone of Lemera, and continued in the one of Ruzizi. As a result of the detection of numerous cases in the four districts of South Kivu, MSF carried out an exploratory mission to evaluate the necessity of a collaboration with the Ministry of Health and a vaccination campaign. MSF and WHO divided up the areas, and MSF was in charge of Lemere and Ruzizi, as well as the monitoring of 2 other areas. 108,000 children and adolescents under 15 were vaccinated. In April the mission was closed and the team was the victim of an attack in which two members were shot and evacuated to Bujumbura.

Activities	
Quantitative indicators	Total
Measles vaccination (outbreak)	108,672

Project cost	**€ 321,729**

Human resources	National	International
Health workers	**0**	**0.72**
Non health workers	**0**	**1.11**

Bukavu — Cholera emergency

A small cholera emergency was declared in December 2011, and during two weeks MSF-OCBA responded by supporting the city's health facilities.

Activities	
Quantitative indicators	Total
Cholera	690

Project cost	€ 6.435

Human resources	National	International
Health workers	**0**	**0**
Non health workers	**0**	**0**

Zambia

Introduction and background

The prospect of legislative and presidential elections on September 20, 2011 accelerated the restructuring of the political stage. The president, Rupiah Bwezani Banda, made numerous changes in government and was increasingly focused on taking over security and defence forces. These events coincided with the debate on constitutional reform, which stipulated that an absolute majority was needed for the election of the president, whose powers were to be reduced.

Economically, Zambia has experienced significant improvement over the past two years, thanks to a strong demand in the international market for copper and cobalt, which have been sold at high prices. In 2010 growth was 7.5%. As part of the economic cooperation with China, leading investor in the country, the first Zambia-Malawi-Mozambique railway line was opened.

Despite this growth, living conditions remain difficult for the population. It is estimated that 59% live below the poverty line, life expectancy is 52 years[45], and the mortality rate of children under five is 141 deaths per 1,000 live births.

The budget for health doubled between 2005 and 2009, without reaching the provisions of the Abuja agreements (which advocated devoting 15% of the total state budget). There have been tangible improvements in the areas of vaccination, antenatal care, obstetric care, and diseases such as tuberculosis (TB): All these programmes have been successfully carried out. However, the results differ greatly depending on the provinces, and have been much better in urban areas.

In addition, the health system faces a number of difficulties: lack of qualified medical staff, the devastating impact of HIV / AIDS (with a prevalence of 18% in the population over 15) and malaria, inadequate and poor infrastructure, and lack of essential drugs and equipment. The country suffers frequent epidemics of cholera and malaria, and has had to face several nutritional crises that have weakened the population.

[45] According to World Bank data: http://donnees.banquemondiale.org/pays/zambie.

MSF has been in Zambia since 2004, with a project of providing access to the diagnosis and treatment of HIV / AIDS. In 2010 a second HIV / AIDS project was opened in the Luwingu district in the northwest, and there was a response to epidemics of cholera and measles in Lusaka.

Financial data

Expenses	€	%
ZAMBIA, CAPITAL	€ 771,522.61	20.58%
LUWINGU, PMTCT	€ 1,359,334.84	36.26%
LUSAKA, oral cholera	€ 4,240.80	0.11%
ZAMBIA. Cholera Preparedness plan	€ 19,832.25	0.53%
ZAMBIA, EPP	€ 42,142.85	1.12%
LUSAKA, cholera prevention	€ 158,409.70	4.23%
LUAPULA, emergency measles	€ 1,393,058.06	37.16%
Total	€ **3,748,541.11**	**100.00%**

Financing	€	%
Spanish government - AECID	€ 950,000.00	25.34%
Total Public Institutional Funds	€ **950,000.00**	**25.34%**
MSF United States	€ 285,265.09	7.61%
MSF OCBA	€ 2.513,276.02	67.05%
Total Private Funds	€ **2.798,541.11**	**74.66%**
Total Financing	€ **3.748.541,11**	**100.00%**

Human Resource Capital

National staff	**32.68**
International staff	**6.62**

Luwingu

Prevention of mother-to-child transmission of HIV and reproductive health support in rural areas of Luwingu

In an exploratory mission in 2009, it was found that access to treatment for the prevention of mother-to-child transmission of HIV (PMTCT) and to reproductive health care in general was quite limited, especially in rural areas.

Moreover, maternal and neonatal mortality in remote rural areas remains high, with no figures reflecting the seriousness of the situation.

In June 2010, MSF teams began working in the referral hospital and five rural health centres, providing services for sexual and reproductive health care, pre- and postnatal check-ups, emergency obstetric care and PMTCT services.

The health clinics lacked trained staff and equipment to provide adequate reproductive health care and HIV /AIDS treatment. Therefore, facilities were renovated, which included the installation of a water and sanitation system, and a waste conditioning area. Training programmes in family planning and pre-and postnatal care were organised for traditional midwives and staff in rural clinics. In October 2011, the programme was treating 80 seropositive pregnant women, with approximately 100 deliveries per month in Luwingu district hospital and 40 in the rural clinics.

One of the biggest challenges in the area of PMTCT was the lack of adherence of 18 women, which made us realise it was necessary to improve the adherence strategy and that the community services of information, education and communication (IEC) should emphasise the importance of treatment to prevent transmission

Another major challenge has been the lack of qualified staff in health centres. The failure to secure staff from the Ministry of Health has greatly limited the programme's impact in the medium term.

Locality	Luwingu district
Target population	138,996 persons
Start and end date	June 2010 / April 2014
Project aim	Prevention of mother-to-child transmission of HIV and reproductive health support in rural areas of Luwingu
Type of population	General population
Context	Stable

Activities	
Quantitative indicators	Total
Outpatient consultations	10,818
Prenatal consultations (total)	8,233
Prenatal consultations (new)	3,395
Deliveries	1,281
Postnatal care	1,100
HIV	58
1st line ART	26
New 1st line ART	20
Preventing vertical transmission (mothers)	32 (82%)
Preventing vertical transmission (children)	38 (86%)

Project cost	**€ 1,359,334.84**

Human resources	National	International
Health workers	16.61	5.04
Non health workers	25.98	2.61

Zambia — Preparing for emergency response

In the last five years, many emergencies have erupted in Zambia, which has inspired MSF team to implement training with the aim of providing a rapid response in the following five scenarios: cholera epidemics (medical and logistic response by water and sanitation), floods, vaccination campaigns, nutritional crises, and population displacements (internal and particularly external).

Cholera epidemics are regular, breaking out in the rainy season (November-March). In 2010-2011, about 200 people died, 85% from the capital, Lusaka. The capacity of the Ministry of Health to address the cholera crisis (for example, with sanitation facilities) is insufficient, although it improved after the advocacy campaign launched by MSF in 2010. The hard work of recent years has been reflected in the prevention campaign of the last period, in which the role of MSF was very limited (monitoring only). In 2011 we received the green light for the cholera vaccination programme, although it has still not been carried out since fortunately there was no epidemic that year.

The extremely poor vaccination coverage partly explains the frequent epidemics in Zambia. For example, the regular measles epidemics require specific training and a vaccination strategy, with a previous logistical study (eg. maintenance of the cold chain, etc.).

Each year the population is affected by local nutritional crises, despite grain storage. Therefore, MSF is preparing a response, and is closely monitoring the situation.

In recent years, the south and west of the country have suffered flooding. In 2010, floods in the capital were serious, affecting 700 families. MSF is preparing a response involving medical treatment, distribution of basic necessities, food distribution and psychosocial care.

Population movements are not very common, although in the past Zambia has been a land of refuge for Congolese people fleeing armed conflict. The team monitors the situation in case there is a flow of refugees into Zambia.

Locality	Zambia
Target population	Depends on area of intervention
Start and end date	January 2011 / December 2010
Project aim	Prepare emergency response (cholera, measles, nutrition, displacements, vaccination programme)
Type of population	General population
Context	Stable

Project cost	**€ 158,409.70**

Human resources	National	International
Health workers	**0**	**0**
Non health workers	**0**	**0.59**

Luapula — Measles emergency

The first cases of measles in Luapula and the provinces appeared in February. 12 weeks later, 6,113 cases had been identified, and 10 people had died. MSF-OCBA implemented a detection and treatment programme in 2 provinces, and prepared a mass vaccination campaign (500,000 people) for children and adolescents aged between 6 months and 15 years in 6 districts, including regions of the North and Laaupula, which was launched on May 6.

Other fact-finding missions have been carried out, including in the Lundazi area (Malaui border), where 451 cases were recorded in a few days, to extend the vaccination campaign.

The lack of reaction from the Ministry of Health, which never officially declared the epidemic (thus paralyzing the institutional response mechanisms), obliged MSF-OCBA to carry out a long advocacy campaign. By the end of the intervention, the team had treated 3,500 patients and vaccinated 558,543 children.

Activities	
Quantitative indicators	Total
Measles vaccination (outbreak)	558,772

Project cost	€ 1,393,058.06

Human resources	National	International
Health workers	**0**	**2.19**
Non health workers	**0**	**3.87**

Zimbabwe

Introduction and background

In the global political agreement signed in February 2009 between the party of President Robert Mugabe, ZANU-PF[46], and Morgan Tsvangirai of the MPC[47], the prime minister proposed the drafting of a new constitution approved by a people's referendum, and presidential elections for early 2011. Considerable delays and social tension prevented this schedule being carried out. In December 2011, Robert Mugabe was elected by his party as candidate for the next presidential elections, which were announced for 2012.

After five years of record hyperinflation, economic prospects are slightly more positive, due to an improved political environment and a reform of the banking system. Inflation, although still high (7.5%), is returning to an average level for the countries in the area. Also, relations with the international community have improved, as attested by Zimbabwe's recovery of the right to vote in the IMF, after seven years of exclusion, and a grant of 150 million euros from the European Union for development projects. South Africa continues to be one of the main economic partners of Zimbabwe, along with China.

In spite of these promising factors, living conditions remain difficult. Nine out of ten people are unemployed, and it is estimated that the poverty rate rose from 42% in 1995 to 70% in 2010[48]. The Gini coefficient that measures social inequality is the highest of the whole continent. 72% of the population live below the poverty line.

Nevertheless, despite the recession, it must be recognised that some social indicators have improved. The HIV epidemic is receding, since prevalence in people over 15 years of age in 2010 was 13.7%, in comparison with 23.7% in 2001. However, the health system continues to deteriorate due to the lack of trained professionals, funding for medicines,

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[46] Zimbabwe African National Union-Patriotic Front.
[47] Movement for Democratic Change.
[48] According to the *2010 Human Development Report* of the United Nations Development Programme (UNDP).

medical equipment and required renovations of rural health facilities. Finally, the cholera epidemic that killed over 11,000 people, and the drought-induced food crisis also affected the basic health indicators.

Financial data

Expenses	€	%
ZIMBABWE, CAPITAL	€ 1,066,358.58	20.58%
TSHOLOTSHO, HIV/AIDS	€ 1,482,046.84	28.60%
BEITBRIDGE, HIV	€ 1,352,846.26	26.11%
BULAWAYO, HIV/AIDS	€ 1,241,212.48	23.95%
ZIMBABWE, EPP	€ 39,168.65	0.76%
Total	€ **5,181,632.81**	**100.00%**

Financing	€	%
Rose Foundation	€ 188,948.77	3.65%
Total Foundations Funds	€ **188,948.77**	**3.65%**
MSF Greece	€ 180,000.00	3.47%
MSF Japan	€ 2,546,188.69	49.14%
MSF OCBA	€ 2,266,495.35	43.74%
Total Private Funds	€ **4,992,684.04**	**96.35%**
Total Financing	€ **5,181,632.81**	**100.00%**

Human Resource Capital

National staff	**43.47**
International staff	**6.73**

Bulawayo

Supporting tuberculosis (TB) and HIV / AIDS programmes, and promoting access to adequate health care for the population, especially children and pregnant women

The aim of the project in Bulawayo was to treat and prevent HIV, as well as reduce mother-to-child transmission. Initially, the HIV prevention and treatment activities for adults

in general, pregnant women, children and adolescents were carried out in Mpilo Central Hospital (MCH), in the city of Bulawayo, and were later extended to different urban clinics managed by the Bulawayo City Council.

The project started in 2003 as a pilot antiretroviral (ARV) treatment programme to reduce HIV transmission from mother to child. In 2004 it evolved into an HIV / AIDS prevention and treatment programme.

After a critical review of the project by MSF-OCBA in 2009 and its subsequent redirection, it was decided to transfer adult patients to the MCH and the Bulawayo City Council at the end of 2009, and in 2010 and 2011 concentrate on the prevention and treatment of HIV / AIDS in children and adolescents, and the prevention of HIV mother-to-child transmission (PMTCT). MSF continues to be present at the Mpilo hospital and the two urban clinics of the Bulawayo City Council. In 2011 it was also decided to proceed with the transfer of activities to various counterparts, which would culminate in the definitive transfer of the project in late 2011.

To ensure the sustainability of activities, as well as the quality and coverage of the intervention, the transfer was organised in various phases throughout 2011. A steering committee was created from the main agents involved in the project (MCH, Bulawayo City Council, Department of HIV and TB of the Ministry of Health in Harare, United Bulawayo Hospitals, the HIV patient collective, and other organizations).

Various problems were identified whose resolution was necessary for a successful transfer, including reinforcement of the capacity of the national teams, supply of ARV drugs, management of human resources, strategies of information, education, and communication (IEC) and patient adherence. After the transfer (November 24, 2011), and until June 2012, MSF will still be supporting the programme through the provision of drugs in cases where stock runs out, and close monitoring of the progress of the project.

Locality	Bulawayo
Target population	170,528 persons
Start and end date	January 2002 / December 2011
Project aim	Support tuberculosis (TB) and HIV / AIDS programmes, and promote access to suitable health care for the population, especially children and pregnant women
Type of population	Displaces population
Context	Stable

Activities	
Quantitative indicators	Total
Sexual violence	681
HIV	4,334
1st line ART	3,833
New 1st line ART	806
2nd line ART	137

Project cost	**€ 1,241,212.48**

Human resources	National	International
Health workers	**20.40**	**2.25**
Non health workers	**33.08**	**1.07**

Tsholotsho

Reduction of HIV transmission and increased access to treatment for the population of the Tsholotsho district

The main aim of MSF project in Tsholotsho is to provide access to the diagnosis of HIV / AIDS and TB in the district, paying special attention to children and pregnant women. This involves making available a minimum package of free medical care in the communities, supervised by qualified staff.

Tsholotsho is severely affected by HIV, with 12,828 cases estimated in 2011 and 18.8% of pregnant women diagnosed as positive. This situation is partly due to the presence of migrants who work in South Africa and Botswana, and the lack of partners to implement HIV and TB programmes in the district.

In December 2011, 7,875 patients were receiving ARV treatment, some of whom lived in other districts. In this context, the effort of decentralisation and integration of ARV treatment in primary health facilities has been a success. Half of health facilities now provide ARV treatment (both start-up and follow-up) and 100% of them are covered by the PMTCT programme.

In addition, the new WHO protocol for the PMTCT programme and ARV treatment has been fully implemented, with 27% of patients in the new 1st line regime based on the drug tenofovir (TDF).

Finally, compared with previous years, the proportion of patients with TB / HIV has increased from 40% in 2010 to 73% in 2011, while decentralisation of treatment for TB/HIV has been limited for technical reasons.

The nutrition programme has been implemented in eight health centres. There are still difficulties in detection and treatment of malnutrition, partly because of a lack of trained staff and an ineffectual monitoring system.

Today, MSF is the only agent involved in supporting TB/HIV programmes in the district, providing services that also include nutritional care and sexual violence aid.

Locality	Tsholotsho
Target population	170,528 persons
Start and end date	July 2007 / April 2011
Project aim	Reduction of HIV transmission and increased access to treatment for the population of the Tsholotsho district
Type of population	General population
Context	Stable

Activities	
Quantitative indicators	Total
CNT primary care centre	429
CNS	955
Sexual violence	77
HIV	7,615

1st line ART	7,459
New 1st line ART	215
2nd line ART	16
Vertical transmission prevention (mothers)	658 (97%)
Vertical transmission prevention (children)	691 (98%)
TB (total)	241
TB (MDR)	5

Project cost	**€ 1,482,046.84**

Human resources	**Nationa**	**International**
Health workers	**29.51**	**2.08**
Non health workers	**40.23**	**1.10**

Beitbridge

Prevention and treatment of HIV and TB in the district of Beitbridge, especially in the population of vulnerable migrants, orphans or vulnerable children, sex workers, and the victims of sexual or gender violence

Beitbridge is a district on the border with South Africa. As in all border areas, thousands of people pass there every day: those looking for work in South Africa, sex workers, and asylum seekers. They are all vulnerable because of their lack of access to basic health services.

MSF began working in Beitbridge in February 2009, focusing its activities on the most vulnerable groups in the area (migrants, orphans or vulnerable children, sex workers and victims of sexual or gender violence) and providing them with primary health care. Due to improvements in sanitary conditions and the political and economic context, MSF redirected its project to a HIV / AIDS and TB programme. A very high prevalence of HIV / AIDS (18.1% in 2010) was identified in a relatively large population (113,441 people in 2011) that was particularly vulnerable due to its migrant status, and the response from the Ministryof Health was found to be very limited. In January 2011 the project for prevention and treatment of HIV / TB began.

In this first year, priority has been given to a strategy of collaboration, acceptance and integration with the Ministry of Health. The project has several aims: to facilitate access of the city and rural Beitbridge populations to diagnosis facilities and ARV treatment, promote access to the PMTCT programme through prenatal diagnosis, TB diagnosis and treatment, and to treat victims of sexual violence in MSF centres (which includes access to the full medical package). To carry out this task, MSF is working in the Beitbridge hospital in the area of opportunistic infections, supporting the laboratory and pharmacy, as well as four rural health centres, and promotes staff training and community activities.

Locality	Beitbridge
Target population	20,533 persons
Start and end date	November 2010 / December 2014
Project aim	Prevention and treatment of HIV and TB in the district of Beitbridge especially in the population of vulnerable migrants, orphans or vulnerable children, sex workers, and the victims of sexual or gender violence

Population type	General population
Context	Stable

Activities	
Quantitative indicators	Total
Sexual violence	62
HIV	3,501
1st line ART	3,032
New 1st line ART	2,236
Vertical transmission prevention (mothers)	337
Vertical transmission prevention (children)	516
TB (total)	630

Project cost	**€ 1,352,846.26**

Human resources	**National**	**International**
Health workers	**26.25**	**1.84**
Non health workers	**37.72**	**1.71**

Uganda

Introduction and background

General elections took place on February 8, accompanied by demonstrations and repression. On February 20, the Election Commission declared Yoweri Museveni the winner with 68.4% of the votes. He began his fifth term on May 12.

The economic situation is worrying, with inflation at 14%, and a 31% increase in prices of food staples. Throughout the month of May, demonstrations of the population and the main opposition parties (Forum for Democratic Change and the Democratic Party) were forcefully suppressed, and the leader Kizza Besigye was detained and put under house arrest.

In the first months of the year, the attacks of the LRA (Lord Resistance Army) intensified in the Central African Republic, Democratic Republic of Congo, and South Sudan, with 120 attacks counted. Although the security of northern Uganda has not been directly affected, the economic and social situation remains difficult. The public health system lacks financial resources and trained staff, while most of the facilities need renovation and are rarely supplied with drugs.

In addition, the lack of secondary and tertiary health care, and of specialised treatments such as the diagnosis and treatment of HIV or human African trypanosomiasis (HAT) are significant gaps in the medical services for the population.

During 2011 MSF-OCBA mission in Uganda redirected its support towards victims of violence and marginalisation, with the ultimate aim of transferring the projects to the Ministry of Health at the end of the year. The Karamoja project, providing aid to victims of violence, was maintained, reinforcing paediatric and reproductive health care in the area, as was the HAT project in the West Nile region. There was also a response to two emergencies: outbreaks of yellow fever and hepatitis E, and an Ebola alert.

Financial data

Expenses	€	%
UGANDA, CAPITAL	€ 461,596.12	23.15%
OR Convalescence study[49]	€ 122,703.36	6.15%
HAT, West Nile Region	€ 252,213.19	12.65%
UGANDA, EPP	€ 17,836.86	0.89%
KARAMOJA, nutritional and medical assistance	€ 773,877.16	38.82%
UGANDA VHF, Suspected VHF emergency	€ 40,632.36	2.04%
KAABONG, emergency hepatitis E	€ 59,22.32	2.97%
BOMBO, hemorragic fever management	€ 261,263.61	13.11%
ABIM, Suspected VHF	€ 4,365.98	0.22%
Total	€ **1,993,610.96**	**100.00%**

Financing	€	%
UE / ECHO / European Commission for Humanitarian Aid	€ 500,000.00	25.08%
Total Public Institutional Funds	€ **500,000.00**	**25.08%**
MSF OCBA	€ 1,493,610.96	74.92%
Total Private Funds	€ **1,493,610.96**	**74.92%**
Total Financing	€ **1,993,610.96**	**100.00%**

Human Resource Capital

National staff	**18.26**
International staff	**4.02**

[49] Medical research study.

Human resources OR Convalescence study

National staff	**0**
International staff	**1.02**

West Nile — **Human African Trypanosomiasis (HAT)**

In 2010, in support of the national programme for monitoring, treatment and control of Human African Trypanosomiasis (HAT),MSF team started a complementary project with the main aim of identifying and estimating the true rate of the disease in the West Nile region.

We implemented an epidemiological surveillance system and contacted counterparts involved in research and response to HAT in the region. The results obtained in some areas showed that the initial estimates of prevalence had been excessive, but it was not always possible to persuade enough people to come to the detection points, which undermined the final prevalence results.

The Ugandan Ministry of Health, in collaboration with WHO, formed teams for the prevention and detection of HAT, but in view of the almost non-existent prevalence in the monitored areas, the project was closed in late August.

Locality	West Nile
Target population	125,000 persons
Start and end date	June 2010 / August 2011
Project aim	Reinforce the network of prevention and treatment of victims of HAT
Population type	General population
Context	Post-conflict

Activities	
Quantitative indicators	Total
HAT	24

Project cost	**€ 252,213.19**

Human resources	**National**	**International**
Health workers	**5.45**	**1.04**
Non health workers	**1.91**	**1.48**

Karamoja

Medical and nutritional assistance

The project, implemented by MSF-OCBA in 2006, aimed to meet the needs of the victims of violence caused by the internal conflict between members of the LRA (Lord's Resistance Army) and the regular army. Violence was based on a strategy of kidnapping local people, who were forced to cooperate with the guerrillas and constantly threatened with attacks and forced recruitment.

In 2008, an evaluation showed that the level of violence affecting the population had declined, and their main problems were now related to lack of financial and human resources. There was a shortage of health professionals, who showed a low level of motivation due to poor working conditions and a lack of quality control.

In this context, the population suffers from diseases related to living conditions and poverty, lack of income and exposure to epidemics and malnutrition.

MSF-OCBA provides services to help improve primary and secondary paediatric and reproductive health care, providing consultations, nutrition and vaccination programmes through 5 mobile clinics in areas of difficult access (in Timu, Sangar, Usake, Kotome and Kawalakol, in 6 health centres in the districts of Karenga and Kaabong, as well as in the hospital of Kaabong (paediatric and maternity services).

In 2011, preparing for the departure of MSF, we carried out a survey on access to health and levels of morbidity and mortality This provided us with updated indicators and to gauge the impact of MSF activities in the Kaabong district.

In March, MSF-OCBA launched an operational research study on the impact of the three most prevalent diseases in the area on the nutritional status of children. This study would continue even after the planned closure of the mission in December, with the participation of over 2000 children selected according to established medical criteria.

MSF-OCBA has also launched an advocacy campaign to draw attention to the violence and health conditions in Kaabong and Karamoja, as well as the scarce resources devoted to health budgets.

Locality	Karamoja, Kaabong district
Target population	138,996 persons
Start and end date	June 2007 / December 2011
Project aim	To improve access to paediatric, nutritional, sexual and reproductive care for the vulnerable population of the Kaabong district
Population type	Displaced population
Context	Internal instability

Activities	
Quantitative indicators	Total
Outpatient consultations	25,493
Malaria (total)	1,821
Malaria (confirmed)	898
Admissions	1,295
CNT hospital	97

CNT primary care	565
Prenatal consultations (total)	9,691
Prenatal consultations (new)	3,804
Births	918
Postnatal care	5,066
Sexual violence	32
Surgery	254
Direct violence	32
Measles (treatment)	3
Meningitis (treatment)	5
Measles vaccination (routine)	1,232

Project cost	**€ 773,877.16**

Human resources	**National**	**International**
Health workers	**63.73**	**2.03**
Non health workers	**30.47**	**2.29**

North Uganda — Suspected yellow fever emergency

From October 2010 to February 2011, MSF was involved in the response to an epidemic of yellow fever in northern Uganda, working in the districts of Kotido, Abim and Napak. MSF adapted different referral health facilities for the specialised treatment of this disease, with the training of several sanitary technicians and inclusion of the referred communities. 42 patients were treated and there was active participation in the subsequent vaccination campaign in which 70,126 people were vaccinated.

Activities	
Quantitative indicators	Total
Yellow fever (outbreak)	70,126
Yellow fever	42

Project cost	**€ 40,632.36**

Human resources	**National**	**International**
Health workers	**0**	**0**
Non health workers	**0**	**0**

Activities	
Quantitative indicators	Total
Hepatitis E cases	691

Kaboong — Hepatitis E Emergency

A significant rise in the number of cases of hepatitis E in the area of Kaabong required an emergency intervention by MSF-OCBA. After 29 weeks of action, the team had diagnosed and treated 454 people. A study was made on the attack rate in different localities, which allowed a prioritized response according to the geographical areas affected. A specific programme of community awareness was implemented, numerous water points were rehabilitated and medical personnel were trained to perform early diagnosis and treatment of the disease, strengthening the referral system for critical patients. At the end of the intervention, activities were transferred to the Ministry of Health to ensure continuity.

Project cost	€ 59,122.32

Human resources	National	International
Health workers	**0**	**0**
Non health workers	**0**	**0**

Bombo — Haemorrhagic Fever of Ebola Emergency

On 14 May, a 12-year-old from the district of Luwero was diagnosed positive for Ebola fever. MSF-OCBA carried out a response plan and launched an active search for cases in the area. An isolation unit was established, as well as a response protocol for suspected and confirmed cases (primary emergency psychosocial support), families were provided with support, community action was implemented, including the transportation of cases to the unit, and water and sanitation activities were initiated in relation to the isolation unit. On May 31, after no other case had been confirmed, the emergency was suspended.

Project cost	€ 261,263.61

Human resources	National	International
Health workers	0	0.13
Non health workers	0	0.50

Projects 2011

Middle East and Northern Africa

- **Article: A Humanitarian Spring among the Arab Surprise: MSF's response to the uprisings in the Arab word. By Kate Burton**
- **Iraq - Syria**
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- **Yemen**

A humanitarian spring among the Arab Surprise: MSF's response to the uprisings in the Arab world

*By **Kate Burton***
Middle East Operational Advisor of MSF-OCBA

The term "Arab Spring" was coined early on by the media to describe the new wave of uprisings in the Arab world, and its attractiveness enabled the term to stick hard and fast. However, this term – not to mention the other one "Arab Awakening" - has also been controversial. Some perceive these terms as containing a condescending overtone and strong Orientalist angle that many in the West have been trying to eradicate or downplay over the past decade as they try to bridge the growing rift between the West and the Muslim world.

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In another sense, it can certainly be said that these events sprang up on the world. Neither the analysts, geo-politicians, academics nor the United States were prepared for such an eruption and its subsequent domino effect. And neither were the humanitarians. Organisations such as the MSF have had to move abruptly towards understanding the intricacies of unfamiliar contexts and, when choosing to respond, adapt accordingly in order to ensure added value is being brought and real needs are being met.

The MSF response in these contexts has been patchy, and at times hesitant, due to the constant probing questions on the forefront of the house discussions, and the differing MSF sections not always agreeing on approaches. The more the MSF engages in such contexts, the more experience it gains in being able to better identify both its intervention criteria and also its best method of operating in the new humanitarian environment. What is clear, however, is that across the movement a changed mindset is essential to ensure that work in such contexts is conducted without a kind of white man's burden hanging over us while we operate – in other words once the decision has been taken to intervene we must do so full-heartedly by thinking and feeling the context, and adapting to it accordingly

The unique evolution of each context

The Arab Surprise, as we might term it, especially for this article in view of the controversy detailed above, evolved differently in each context and, although the domino effect links them all to the same catalytic events, it is important operationally to consider the individualities of each. The following provides a few elements from each context to feed the discussion that follows (note that numbers are contested so are to be taken simply as indicative figures):

The **Jasmine Revolution of Tunisia** broke out in December 2010 and – with the push of the armed forces - took just 28 days to oust and send into exile a President who had been in office for 23 years. With some 223 dead and 94

injured, and no apparent urgent medical needs to respond to, the MSF did not intervene.

The world was gripped by **Egypt's Tahrir Square** from January 2011, watching the entirely unexpected revolution unfurl. Mubarak finally ceded power less than a month into the protests, but some 846 protesters had already been killed and over 6000 injured. Nonetheless, that initial uprising was over within only a few weeks and the MSF assessed that it would have no added value in a crisis where health structures were developed, still accessible and functioning well.

The Yemeni uprising occurred almost simultaneously and skirmishes continued until the elections of February 2012; however, the conflict has been hugely multi-faceted, comprising of a complex quagmire of opposition and governmental power struggles in addition to the peaceful protesters. Although the Arab Surprise may have encouraged these various groups, the "usual hotspots" in the country were rather neglected by the government and thus calmer than previously. On the whole, there were no urgent and large-scale medical needs and the health system functioned. MSF previous support continued in parts of the country and additional assistance – such as training and drug supply – was provided to Ministry of Health hospitals.

The **Libyan uprising and civil war** produced the most severe humanitarian consequences to date. Beginning in February 2011 and briskly developing into an armed opposition front in control of parts of the country, the uprising was subsequently supported militarily by international forces and brought down Ghaddafi's decades' old regime in October. Tens of thousands of people were killed, injured and disappeared. Facing such high numbers of casualties, and bearing in mind that health structures were now failing and much of the specialised medical expertise had fled – the MSF responded (only being able to access opposition-held areas) by providing training and material support in obstetrics, paediatrics, surgery and mental health.

The **Syrian uprising** began in March 2011 and continues. The initially peaceful opposition has become increasingly armed; however, it also remains highly fragmented and the government and armed forces retain overall control. At the time of writing, there are no clear "opposition pockets" as we saw in Libya and protests are ad hoc, localised and not at the level observed in Tunisia or Egypt. Over 5,000 are said to have been killed, and medical needs are certainly present – seemingly on both sides – but the government is not allowing outside assistance nor is physical access in the least bit easy. The MSF has thus been supporting, through creative means, the medical networks set up by the opposition in certain parts of the country to treat wounded protesters.

These individualities matter in terms of deciding whether we should intervene or not in such contexts. The two situations where the civilian opposition did not become militarised (Tunisia and Egypt) did not divide the country to a notable extent, make large areas inaccessible, severely affect nationwide health services or produce significant medical needs. Nor did they endure for many months: both were over (the crisis stage, in any case) within a month. As for the other two more militarised contexts (Libya and Syria), all these elements were present which thus required the MSF to consider a medical intervention.

Changed mindset: The honest admittance of the need to work differently

For Tunisia and Egypt, the international humanitarian law that requires States to allow humanitarian and medical relief to affected areas does not apply per se to these "other situations of violence" which are generally not characterised as reaching the level of armed conflict. This would not necessarily deter the MSF, but can make negotiating access more difficult although, in the end, even for the two more militarised contexts access to the country (e.g. Syria) or to government-controlled areas (e.g. Libya) was extremely difficult for international humanitarian actors and security risks high. Coupling this with the facts that medical personnel are well-educated, health structures are advanced and the unmet urgent

medical needs can be quite low, makes emergency- humanitarians often question their own presence in Arab Surprises while overwhelming needs exist in much poorer regions of the world. To many, it was not clear-cut that MSF action was imperative, and many endless discussions took place to decipher what the humanitarian role should be in these contexts and whether mandates applied.
It is imperative, however, that the MSF and its practitioners be able to clearly describe the justification for its interventions. It is therefore necessary to not quantitatively compare with other contexts, but rather examine qualitatively the peculiarities of this situation: severe human rights abuse… medical needs… unwillingness by the Government to assist (and sometimes active obstruction of efforts)… and, importantly, perceived and real isolation of victims due to lack of access for independent organisations. Due to this lack of access, the principle humanitarian response mechanism present constitutes civil society organisations (if they exist). Sometimes the mere fact of an international humanitarian organisation like the MSF being present for these communities can be extremely reassuring, at a time when they feel abandoned by the world and by humanity. This has a humanitarian importance that cannot be measured and nor should it be underestimated. We might say that humanity, and more specifically a sense of solidarity with human suffering, constitute our rather unorthodox mandate for intervening in such contexts. And we must redefine momentarily the fundamental principle of "impartiality" so that needs-based becomes tied closely to this solidarity and support rather than being solely linked to mortality and morbidity rates, we need to feel comfortable with this.

Following this initial raison d´être, the new MSF humanitarian involvement in the Arab Surprise will also need to accept that maintaining the perception of neutrality becomes increasingly difficult when physical access is almost impossible in government areas and offers of assistance to the government side are ignored or refused. Being forced to only be able to work on one side (that of the opposition) can often be used by governments as "evidence" of foreign conspiracies and the like, thus making the MSF fall prey to the propaganda which is used in such contexts as a tool of warfare.

Finally, another element that has emerged throughout the different uprisings has been religion. Islam has played a part in unifying people during the uprisings and giving them space and locations to gather. It has also played a major role in the opposition groups that have formed, as well as the transitional political process post-revolution. It is not so much evidence of growing conservatism in the region as the linkage with the socio-economic element to the uprising, and the solidarity which religion can often provide people in times of economic duress. For the MSF, putting resources into understanding the religio-cultural specificities of these contexts, and using them to enhance the quality of our communication messaging and networking across all State or non-State actors concerned, will much enhance perceptions among local populations. It will also improve their acceptance of MSF as an important humanitarian actor at a time when the Arab world largely distrusts the West and, more specifically during these uprisings, where people and groups within their own communities do not always fully trust each other.

Conclusion

The Arab Surprise uprisings have not been new for the more legal human right actors whose classic advocacy at regional and international levels works well in the face of abuse, whatever the country. Humanitarianism, on the other hand, has traditionally always been linked to impartial assistance for the most urgent, large-scale needs, and a close presence on the ground. These new contexts certainly offer a space for humanitarians where human rights advocacy efforts cannot fill the gaps that are unheeded by unwilling governments. However, humanitarians need to be honest in their approach, recognising the principles of humanity and solidarity with human suffering as the compelling factors to intervene, and understand that maintaining standards or perception of neutrality and impartiality will be diluted, if not impossible, in such contexts. MSF practitioners, and the movement as a whole, need to accept this and be comfortable with new

and amended definitions of impartiality instead of spending endless hours, weeks and months trying to define how their mandate fits. Creating networks and relations, passing suitable messages and, where possible, maintaining closeness to the populations and putting resources into understanding local religion-cultural norms and motivations which have been a backbone of these people's symbolic uprisings, will reduce any perceived Orientalist angle in our approaches and allow us to become better versed through experience in tackling the quagmires of the Arab – or other – Surprises. If humanitarians can learn from this and approach such contexts more efficiently in the future – without all the wrangling and self-questioning – we may veritably have had our own Humanitarian Spring.

Libano, 2012© MSF

Libya, 2011. © Benoit Finck

Iraq - Syria

Introduction and background

For more than nine months the political situation in Iraq has been dominated by the incapacity of the winners of the legislative elections held on the 7th march, 2010, to form a government. An agreement amongst the various parties was finally signed in order to form a government which did not satisfy any of the factions, beginning with the Shiite party. In addition, it left some of the most delicate ministries, such petroleum, interior and defence vacant.

Within the framework of responding to the Arab Spring, a protest movement appeared in Bagdad, in Tahrir Square. It became, like Cairo, a symbol for young people coming together answering the calls from the social networks. The movement threatened to disrupt the regimen as it protested against the ruined public services, political corruption, nepotism and unemployment. Faced by these demonstrations, Al Maliki gave his government 100 days to find a plan, and 37 billion dollars were set aside in order to try and reconstruct the inexistent infrastructures after three decades of war and economic sanctions.

Within this context the Security Council voted to end the sanctions and close the Iraq development Fund which was involved with Iraq after the fall of Sudan Hussein.

President Obama announced the withdrawal of American troops at the end of the year even though he knew that the Iraqi authorities were not ready to take over control. Insecurity was present the whole year with the continued presence of Al Qaeda and a dissimulated religious war between Shiites and Sunnis.

Whilst other MSF sections had chosen regions that were politically and ethnically complex regions to intervene, MSF OCBA opted for a relatively stable zone with a hospital of reference where it was possible reaffirm its identity and humanitarian principles thus demonstrating its added value at a medical level. The stability in the Najaf zone allowed the presence of international

staff and permitted a better understanding of the Iraqi population.
In spite of being a country with medium income, Iraq is at the same level as Afghanistan and Haiti with respect to neonatal mortality (23/1000). The second cause of death after violence is maternal mortality and the rate of mortality for children aged less than five years is 53 children per 1000. In this context the MSF OCBA decided to give support to the Al Zahara de Najaf Hospital.

Financial data

Expenses	€	%
DAMASCUS, liaison office	€ 47,216.05	3.27%
DAMASCUS, Iraqi refugees	€ 134,669.34	9.56%
AMMAN, CAPITAL	€ 457,543.41	31.64%
NAJAF, Neonatal Care	€ 789,882.42	54.62%
SYRIA, unrest	€ 13,282.10	0.92%
Total	€ **1,442,593.32**	**100.0%**

Financing	€	%
MSF OCBA	€ 1,442,593.32	100.00%
Total Private Funds	€ **1,442,593.32**	**100.00%**
Total Financing	€ **1,442,593.32**	**100.00%**

Human Resources Capital

National Personnel	**6.35**
International Personnel	**5.18**

Human Resources Liaison Office

National Personnel	**2.83**
International Personnel	**0**

Najaf

To improve the quality of neonatal care and the obstetrics services at the Al Zahara Hospital for population of Najaf

The MSF IOCBA chose a hospital of reference whose dimensions and activities represented a challenge and would permit an accumulation of experience in the field of third level health care in a hospital environment. Al Zahara has 400 beds, 20 gynaecologists, 17 gynaecologist/obstetric residents, 15 paediatricians, 7 anaesthetists and 19 anaesthetist technicians, and 283 nurses. They have all worked for almost 30 years in the hospital without any sense of responsibility, being answerable to no one and unmotivated (there is a chronic lack of motivation). Malpractice was rampant.

During the first semester the MSF OCBA team carried out a series of exploratory visits in the areas of logistics, sanitation, gynaecology, obstetrics and paediatrics.

A collaboration agreement was signed with the KAUH hospital in Jordan where the nursing staff (operating theatre, emergency room, and maternity) and the specialists and some residents of the Iraqi hospital would receive training in neonatal reanimation.

Protocols were revised and training about hygiene was given to cleaning staff in the hospital. However, because of MSF OCBA being unable to have the necessary human resources (doctors, paediatricians, gynaecologists and anaesthetists) the process was delayed and had to be adapted to the reality, for example training staff in modules that could be done by various specialist without the need for continuous presence.

Location	Najaf
Target population	44,000 people
Start-up and finish date	October 2010 / October 2015
Project's objective	To improve the quality of neonatal care and the obstetrics services at the Al Zahara Hospital for the population of Najaf
Type of population	General Population
Context	Armed conflict

Activities	
Quantitative indicators	Total
Admissions	3,895

Project cost	**€ 789,882.42**

Human resources	**National**	**International**
Health workers	**0**	**1.92**
Non health workers	**26.90**	**2.50**

Morocco

Introduction and background

The beginning of 2011 was marked by movements against the political regime and, in spite of a number of announcements which tried to appease the discontent (increase of subventions for staple goods, for example), on the 20th of February at the initiative of a group of young people,encouraged by the Egyptian and Tunisian revolutions, the first protest march was held asking for the abolishment of the institutional monarchy. On the 9th of March, King Mohamed VI announced a constitutional reform which gave more power to the prime Minister, the Government and the Parliament and which was approved on the 1st of July.

On an economic level the country has continued with its strategy of investment in large public works which have attracted foreign investment to develop the rural zones.

Morocco is an obligatory transit country for migration from Sub-Saharan Africa to Europe. It has been forced by the demands of European policies to exercise a greater control on its borders with the European Union. Sub-Saharan migrants (SSM) are retained for long periods in the country in situations of extreme vulnerability (settlements, begging, exploitation by human traffickers) without any kind of access to basic care because they are illegal.

The SSM, and in particular women and minors, are exposed to all kinds of violence and abuse during their journey and stay in Morocco. In recent years, the growing role of delinquents and human smugglers has been responsible for numerous violent actions such as the repressive behaviour of the Moroccan Armed Forces.

The MSF OCBA has been present in Morocco since 1997 and reoriented its actions towards the SSM in 2000. At present, it is carrying out 2 projects, one in Oujda about sexual and reproductive health, and another in Rabat responding to the phenomenon of sexual violence against female migrants.

Financial data

Expenses	€	%
MOROCCO, CAPITAL	€ 349,944.56	40.93%
RABAT II, assistance	€ 171,616.76	20.07%
OUJDA, Immigrants	€ 332,593.75	38.90%
MOROCCO, EPP	€ 923.35	0.11%
Total	€ **855,078.42**	**100.00%**

Financing	€	%
Inditex	€ 300,000.00	35.08%
Total Foundations Funds	€ **300,000.00**	**35.08%**
MSF OCBA	€ 555.078,42	64.92%
Total Private Funds	€ **555,078.42**	**64.92%**
Total Financing	€ **855,078.42**	**100.00%**

Human Resources Capital

National personnel	**6.69**
International personnel	**4.59**

Oujda-Berkane-Nador

To improve the health and living conditions of the most vulnerable Sub-Saharan Migrants (SSM)

Moroccan law allows foreigners present in its territory access to health services. The MSF, therefore, adapted its strategy by developing these patients' autonomy in accompanying them to the state institutions to look for health care.

However, due to the lack of financial and human resources in some of these health institutions, the MSF offers physical and mental health care free to the SSM. This is thanks to their presence in three health centres and the Al Farabi Hospital. MSF staff work together with the Ministry of health to guarantee primary health care services, sexual and reproductive health programmes, psychological support and referrals in necessary cases.

In addition, the MSF has mobile clinics in Nador to help the many SSM who are often the victims of violent round-ups and do not dare go to the state institutions for fear of being deported.

After having heard the numerous stories of violence the SSM have suffered, and faced with a lack of operational structure to give support to victims of sexual violence, the MSF has come up with an integral medical and psychological service. In spite of the difficulty of gaining access to most of the women trapped in human smuggler networks, the MSF managed to contact these women in 2011, and slowly drew up its profile response to this particular kind of violence. In general, the SSM suffer from anxiety due the pressure and violence they are submitted to (round-ups, violence form the Armed Forces and human traffickers).

Given that many of the SSM pathologies are related to their living conditions (skin infections, respiratory infections, problems due to lack of drinking water …) the MSF has made numerous hand-outs of staple products such as blankets, cooking kits and products for hygiene. It has also carried out activities of sanitation and drinking water.

Location	Oujda-Berkane-Nador
Target population	1,000 people
Start-up and finish dates	September 2004 / December 2012
Project's objective	To improve health and living conditions for the most vulnerable SSM
Type of population	Refugees and displaced population
Context	Stable

Activities	
Quantitative indicators	Total
Outpatient consultations	1,838
Malaria (total)	1
Admissions	21
Prenatal consultations (new)	58
Births	17
Postnatal care	21
Sexual violence	43
Direct violence	77
Mental health 1	223
Mental health 2	115
Basic necessities	1,250
Measles vaccination (routine)	5

Project cost	**€ 332,593.75**

Human Resources	**National**	**International**
Health workers	**5.35**	**0.66**
Non health workers	**7.73**	**1.12**

Rabat

To guarantee access to medical services for SSM women and children who have been victims of sexual violence

After a number of months of reflection and study of the needs of the SSM, and in particular women and minors, the MSF OCBA decided to focus its attention on responding to sexual violence. Episodes of sexual violence imply a series of medical consequences such as wounds, sexually transmitted diseases, unwanted pregnancies, gynaecological problems, foetal death and also psychological factors such as post-traumatic stress, sleep disorders and anxiety.
With respect to sexual violence, there are state structures specifically created to give a response, the Health Care Units for Women and Children Victims of Sexual Violence (UPC/FEVV in French. Although at present their functioning has been hindered by lack of financial and human resources.

Thanks to an agreement with Terre des Hommes (through a local NGO Oum El Banine) service for victims of sexual violence have been integrated into their clinic for mother-infant care so that both groups of patients can be referred to the same centre. Because of the lack of mental health services, the MSF has incorporated a psychologist to its team. This has been well accepted by the population.

The mid-term objective of the MSF is to collaborate with them in order to refer patients and help in their treatment. In addition, and parallel to the collaboration with the hospitals in Rabat (which transferred their support to the UPC/FEVV), the MSF has inserted its action within a network of organisations with the objective of guaranteeing an integral service and avoiding the stigmatisation of a project solely dedicated to the victims of sexual violence.

Location	Rabat
Target population	2,400 people
Start-up and finish date	January 2011 / June 2013
Project's objective	To guarantee access to integral medical service for SSM women and children victims of sexual violence
Type of population	Refugees and displaced population
Context	Stable

Activities	
Quantitative indicators	Total
Outpatient consultations	1,411
Prenatal consultations (new)	52
Births	34
Postnatal care	56
Sexual violence	175
Direct violence	6
Mental health 1	106
Measles (treatment)	1

Project cost	**€ 171,616.76**

Human Resources	National	International
Health workers	5.35	0.66
Non health workers	7.73	1.12

Occupied Palestine Territories (OPT)

Introduction and background

In spite of efforts to reopen negotiations in 2010, no agreements were reached. Some of the main pitfalls being the recognition of the Jewish State of Israel by the Palestine Authorities and vice versa, the position of Jerusalem as a capital, security, delimitation of borders, the Palestine refugees, and the presence of Israeli colonies within the Occupied Palestine Territories (OPT).

The moratorium for the building of new colonies expired in September, 2010 and, from this moment on, the scale of construction of new colonies and buildings on the West Bank, and the incidents of violence related to the activity of the members of the colonies, have multiplied exponentially.

2011 also witnessed an increase in the indiscriminate launching of explosive rockets from the Gaza side against territory in southern Israel. The attacks and bombarding from the Israeli Army were against more or less selective objectives in Gaza, but they have caused dozens of civilian causalities during the year.

President Mahmoud Abbas, representing the Palestine Authorities, uneasy with respect to the real intentions of the Israeli negotiations, launched a unilateral strategy for official recognition from the United Nations of the Palestine State with the borders that existed at the ceasefire of 1967. This was accepted by approximately two thirds of the member countries. The proposal (not accepted by Hamas) was accompanied by speeches from Prime Minister Netanyahu and President Mahmoud Abbas before the General Assembly of the United Nations in September. The proposal by Abbas to continue a pacific campaign to find a favourable solution for both nations was of major importance. UNESCO recognised the Palestine State in October this caused reprisals from Israel and the United States in the form of financial cuts in the contributions to UNESCO and the Palestine Authorities.

Within the context of the mobilisation of the Arab Spring, the Palestine Social networks have taken a clear position against the division between Fatah and Hams. They announced their reconciliation in April and their intention to form a united government with the mandate to hold elections in the POT and resolve other pending problems such as the exchange of prisoners.However, no outstanding progress has been observed between the two factions since then.

In another initiative promoted by the social networks, during the celebrations held in May and June for the Arab defeats in 1948 and 1967, thousands of refugees demonstrated at the borders and even managed to penetrate into territory controlled by Israel. This led to a violent response on the part of the Israeli Army and dozens of deaths.

For the Palestine civilians, 2011 has been a year with a great deal of violence related to the conflict and occupation of the POT. There has been a substantial increase in the number of people arrested without charges ("administrative" arrests that can last up to 6 months and may be renovated without a court case), and this has affected many minors. In addition, aggression by the members of the colonies, vandalism, destruction of Palestine property, "official" demolition of homes and buildings (for agricultural use, water fountains, schools etc.) that are supposedly illegal, night round-ups, abuse and humiliation at military controls etc.

All of this is reflected in the deterioration in the situation of eastern Jerusalem and its surroundings, where the number of attacks, expropriations or non-Jewish population displacements has increased in a significant manner during this period.

Financial Data

Expenses	**€**	**%**
PALESTINE, CAPITAL	€ 374,743.18€	34.85%
PALESTINE, EPP	€ 9,620.34€	0.89%
HEBRON, Violence - Mental Health	€ 669,825.38€	62.29%
WEST BANK, explo	€ 21.186,14€	1.97%
Total	€ **1,075,375.04**	**100.00%**

Financing	**€**	**%**
MSF Greece	€ 455,560.00	4.,36%
MSF OCBA	€ 619,815.04	57.64%
Total Private Founds	€ **1,075,375.04**	**100.00%**
Total Financing	€ **1,075,375.04**	**100.00%**

Human Resources Capital

National Staff	**5.00**
International Staff	**4.34**

Hebron/Western Jerusalem

To provide psychological and medical attentionand social support to the victims of violence related to the conflict

In Hebron the MSF provide medical and psychosocial support to the victims of violence related to the conflict. The teams are in a network with agents and relevant actors from the community and carry our exploratory evaluations with the objective of detecting possible cases to refer to the programme.

In 2011 a series of reforms made it possible to improve the psychosocial programme in terms of quality and efficiency. These including stimulating the clinical therapy sessions by reducing the time needed for displacements and time spent for each consultation; training of the psychosocial workers in the following issues – psychological first aid (PFA) for those patients who had suffered a recent traumatic event, and identification and evaluation of the need for referral of the patients.

The medical support service has maintained an average of 40-60 patients per month, in part for pathologies related to the anxiety and post-traumatic stress in which the inhabitants of Hebron are exposed to. Some of the patients come on their own initiatives, others are referred by MSF psychosocial groups (60%) and in general suffer from other chronic problems associated with their life styles.

Most of the patients suffer from symptoms of hyper-vigilance, anxiety, insomnia, and depression due to the violence they have experienced. This includes harassment (20%) from the colony inhabitants, physical attacks (18%), and destruction of their homes (14%). The MSF teams have noted a lengthening in the treatments (going from 4 to 6 sessions) related to other causes which make the cases more complex. 100% of the patients come from zones located near the Israeli colonies or the security and segregation barriers (the wall, check-points etc.).

In January the MSF carried out and exploratory mission in eastern Jerusalem (occupied Palestine territory in the municipality of Jerusalem) in order to evaluate the mental health situation and the possible needs of the most problematic zones of this part of the city (Shufat, Isawiya and Silwan) and its surroundings. These include problems with access to treatment and lack of response mechanisms. It was concluded that the needs are much greater than the current response capacity.

The camp at Shufat and its surroundings has been made a priority due to the almost complete lack of services and the state of degradation in which its refugees and illegal residents live. Most of its inhabitants are out of work and lack access to education, health care and employment opportunities – all the fruit of the isolation and lack of mobility imposed by Israel. The existing basic services in the camp and the neighbourhood are minimum and insufficient. The situation provokes high levels of domestic violence, sexual harassment, aggression on the part of both adults and children, drug abuse, stress, frustration and crime.

The MSF OCBA decided to launch an intervention of psychological help for people who are victims of violence. The programme is made up social support to those patients needing it and it does not rule out offering medical services if appropriate in the future. Consultations commenced in July and little by little the system of referral for specific cases was reinforced and IEC activities carried out. In

2011 the team had a psychologist, a psychosocial worker and a driver.

The model was repeated at the end of the year in Silwan, another neighbourhood affected by the conflict, and in the surroundings of Shufat, where the Bedouin population lives in very difficult conditions. The team hopes to be able to give a response as soon as possible to other needy communities in eastern Jerusalem.

Location	Hebron/eastern Jerusalem
Target population	804,977 people; direct beneficiaries: 1,100
Start-up and finish date	October 2000 / no final date
Project's objective	To provide psychological and medical care and social support to victims of violence related to the conflict.
Type of population	General population
Context	Armed conflict

Activities	
Quantitative indicators	Total
Outpatient consultations	337
Mental health 1	1,949
Mental health 2	46

Project cost	**€ 669,825.38**

Human resources	**National**	**International**
Health workers	**4.00**	**3.16**
Non health workers	**10.71**	**1.12**

Yemen

Introduction and background

Within the context of the Arab Spring, Yemen since the end of September has been the setting for unheard of protest on the part of the general population. The young people started the unrest in the cities whilst the political parties were marginalised.

During April and May the President announced a series of reforms, yet the massacre on the 18th of March of 52 demonstrators in Sana caused members of the government to abandon their posts and a state of emergency was declared.
From then on the protest was managed by the principal actors who took advantage of the situation to confront the president.

In this context, the Gulf Cooperation Committee composed of countries in the zone (Saudi Arabia, Kuwait, Bahrain, United Arab Emirates, Qatar and Oman) put forward a plan to overcome the crisis in a pacific manner. They proposed that the President retired voluntarily which would give him immunity, and the creation of a transition government until elections were held in a maximum of 2 months after signing the agreement. In spite of the President and the opposition accepting the plan, it was not signed until December which provoked more instability and protest movements in the country.

On the 3rd of June, the President who had been wounded during an attack on the presidential palace was transferred to Saudi Arabia for health care. This created a power vacuum until the end of the year. He left management in the hands of the government and the army who were trying to contain the various fronts of instability: The Houthistas in the north of the country and the Jihadists in the south. The latter launched an offensive against the city Zinjibar in August which led to population displacements towards Aden.

From June to October life was very hard for the population with vertiginous increases in prices combined with a scarcity of water and

fuel. These factors affected the population's already diminished capacity to survive.

The MSF OCBA has been present in the country since 2008, first with a medical and psychosocial project for the SSM who arrived from Ethiopia by sea. In 2010, the humanitarian situation was increasingly more chaotic, it was decided to reorient activities by closing the initial project and opening up at strategic points in the country to give humanitarian medical aid and support the HIV/AIDS sector.

2011 has been marked by the effects of the Arab Spring and the conflict around the capital and in the south of the country. Serious difficulties related to unstable security have had an effect on carrying out activities. Cancelled international flights which have affected the movement of staff and supplies, the restrictions on domestic journeys for reasons of security, and constant evacuations all led to the closure of the HIV project and hindered emergency response.

Financial data

Expenses	**€**	**%**
YEMEN, CAPITAL	€ 661,255.60	11.83%
SANAA, HIV	€ 217,608.62	3.89%
HAJJAH, IDPs	€ 2,829,958.56	50.61%
HABILAIN, hospital	€ 80,3719.37€	14.37%
AL MALAHEET, West Saada	€ 762,797.48	13.64%
YEMEN, EPP	€ 58,052.54	1.04**%**
ADEN, emergency violence	€ 144,894.92	2.59%
SANAA, emergency violence	€ 105,583.33	1.89**%**
YEMEN, unrest	€ 7,907.49	0.14%
Total	€ **5,591,777.91**	**100.00%**

Financing	**€**	**%**
MSF United States	€ 2,482,296.16	44.39%
MSF Greece	€ 500,000.00	8.94%
MSF Germany	€ 2,000,000.00	35.77%
MSF OCBA	€ 609,481.75	10.90%
Total Private Founds	€ **5,591,777.91**	**100.00%**
Total Financing	€ **5,591,777.91**	**100.00%**

Human Resources Capital

National Staff	**32.68**
International Staff	**6.62**

Hajjah

To give support to the health services for the displaced people and local population in the district of Haradh

In the district of Haradah, the displaced population caused by the combat that has been taking place since 2008 in Sa'ada continues to be numerous. According to the figures from the ACNUR some 20,000 people are in the Al Mazraq camp and surrounding areas. Whilst in the last twelve months there has been some regression of IDPs, the majority refuse to return to a non-pacific zone with destroyed buildings, lack of activity to generate income, and threat of reprisals.

The MSF OCBA works in the hospitals at Al Mazraq which for its size and installations is a point of reference for both the rural and local population.

The MSF teams give support to primary health care services which mainly consist of outpatient consultations, emergencies, emergency surgery, admissions, sexual and reproductive health, nutrition, mental healthcare and psychosocial support.

In addition, and as a priority, the MSF OCBA is developing activities for secondary health such as obstetrics surgery and general surgery.

Finally, the team has introduced activities of Information, Education and Communication in the area of health with a particular focus on nutrition and reproductive health in the camps of Al Mazraq and the zone of Al Golf. Mosquito nets will be distributed to prevent malaria in the camp.

The difficulty in finding local trained personnel and expatriate specialist (above all in mental health, surgery and gynaecology), and the lack of hospital resources have hindered the MSF OCBA operations, especially in the field of reproductive health where, for cultural reasons, female staff are needed.

Location	Hajjah
Target population	160,303 people
Start-up and finish date	June 2010 / April 2012
Project's objective	To give support to the health services for the displaced people and local population at the district of Haradh
Type of population	Refugees and displaced population
Context	Unstable

Activities	
Quantitative Indicators	Total
Outpatient consultations	39,225
Malaria (total)	1,687

Malaria (confirmed)	1,085
Admissions	2,238
CNT hospital	358
CNT primary care	2,733
Prenatal consultations (total)	3,933
Prenatal consultations (new)	2,300
Births	567
Postnatal care	256
Surgery	270
Direct violence	7
Kala azar	45
Mental health 1	3,781
Mental health 2	4,104
Measles (treatment)	149
Meningitis (treatment)	6
Measles vaccination (routine)	1,255

Project cost	**€ 2,829,958.56**

Human Resources	**National**	**International**
Health workers	**102.00**	**5.57**
Non health workers	**78.92**	**4.43**

Habilain

To reduce the mortality associated with violence from the clashes in the districts of Radfan, Al Malah, Halmainy Habeer and Jabel

The Project started in July 2010 with the aim of providing free health for emergencies and admissions at the hospital of Radfan. However, due to the security conditions in the zone the expatriates were forced to evacuate several times whilst 60% of the population were displaced to the surrounding areas of Aden and Habilain.

2011 has been marked by the attacks on the cities of Abyan, Zinjibar and Ja'ar which led to the arrival of wounded soldiers at the hospital at Al Razih. In September the hospital at Zinjibar was bombed and no structure of reference remained in at least 70 kilometres. This meant that the MSF OCBA presence in Habilain became strategic.

The MSF OCBA intervenes in the hospital at Radfan by giving support to emergencies and admissions thanks to the revision of the protocols, the training of medical personnel from the Ministry of Health (doctors and nurses), and an amplification of the portfolio of services provided within the framework of emergencies: Emergency surgery, improvement of 24hour /7 day emergency system and admissions. In addition, we offer a referral service for patients whose needs cannot be met by our hospital.

At the end of January, the fighting forced the teams to evacuate the hospital which had a very negative impact on the project. In April the team was able to reintegrate the health structure, but the patients did not return until May due to lack of access or fear. In addition, the external activities, such as outreach ones, which were planned so that the work of the MSF would be better known and to transmit health messages, have not been possible due to the unstable security situation.

Location	Habilain
Target population	160,303 people
Start-up and finish date	June 2010 / April 2012
Project's objective	To reduce the mortality associated with violence of the clashes in the districts of Radfan, Al Malah, Halmainy Habeer and Jabel
Type of population	Refugees and displaced population
Context	Armed conflict

Activities	
Quantitative Indicators	Total
Outpatient consultations	6,948
Malaria (total)	19
Malaria (confirmed)	19
Admissions	668
CNT hospital	4
Surgery	180
Direct violence	40
Measles (treatment)	27
Meningitis (treatment	2

Project cost	**€ 803,719.37**

Human resources	**National**	**International**
Health workers	**6.92**	**3.91**
Non health workers	**18.23**	**2.19**

Sana

To improve care for patients living with HIV/AIDS in Sana

The MSF OCBA decided to intervene in the HIV/AIDS epidemic in Sana due to the high level of stigmatisation and exclusion that the patients were experiencing from the medical corps in the country. In some cases the patients were not even accepted for urgent medical proceedings such as surgery or caesarean interventions.

The project aims to reduce the stigma and improve the quality of care offered by the State to these patients

The MSF OCBA worked in the hospital at Al Gumhouria where it made the health teams aware of the discrimination that people living with HIV experience. In addition, in 2011 a communitarian project was implemented in order to inform the population about the importance of detecting and treating HIV/AIDS.

Due to the growing deterioration of the situation in Sana during the first semester, and the impossibility of the team to reach the hospital for weeks (with the added problem of storing medication for weeks to avoid

treatment being interrupted) it was decide create and follow-up a protocol of easy use for the local teams, with the idea of withdrawing halfway through the year. In August, the lack of access and difficulty to ensure medication meant that the project closed.

Location	Sana
Target population	160,303 people
Start-up and finish date	May 2010 / August 2011
Project's objective	To improve care for patients living with HIV/AIDS in Sana
Type of population	General population
Context	Unstable

Activities	
Quantitative Indicators	Total
HIV	720
TAR 1st line	331
TAR new 1st line	45

Project cost	**€ 217,608.62**

Human Resources	**National**	**International**
Health workers	**2.09**	**0.67**
Non healthworkers	**5.19**	**1.03**

Al Malaheet

To provide humanitarian medical care to victims of conflict in the region of Al Malahat (Western Saada)

The MSF OCBA proposed opening a project in the region of Western Saada, in the north of Yemen, which had been badly affected by the conflict between the Government and the rebels of Al-Houthis. The conflict had been intermittent since 2004 and had a clear influence on the MSF OCBA project in Hajja. During the war, which broke out between August 2009 and February 2010, the region's infrastructures were seriously damaged. The health services in the zone are, at present, inexistent and MSF OCBA hopes to remedy the situation.

After trying to begin activities during 2010, the MSF OCBA finally decided to takeover the work of the French section which wanted to terminate its presence at the hospital in Razeh.

The objective of the project was to give support to primary health care, emergencies, nutrition and maternity. After contacting the authorities and opening communications and negotiations with members of Al Houthi and community leaders, the MSF OCBA began its work in May. A generator was installed to allow medical procedures, and the team was based at Haradh for the first months until a complete, operational one was ready in July.

However, on the 27th of September, due to the new demands from the local authorities the team decided to suspend the

project. Their demands included the MSF ceasing independent evaluations of medical needs, the prohibition of international personnel supervising activities, and the obligation to substitute the Yemen Ministry of Health personnel who worked with the MSF for personnel suggested by the Executive Council. These measures, in contradiction to the MSF principles of independence and quality, were unacceptable.

The idea of returning has not, however, completely been abandoned due to the fact that the humanitarian situation continues to worsen although a margin of negotiation with respect to MSF intervention must be maintained.

Location	Al Malaheet
Target population	400,000 people
Start-up and finish date	September 2010 / September 2011
Project's objective	To provide humanitarian medical care to victims of conflict in the region of Al Malahat (Western Saada)
Type of population	Displaces and general population
Context	Armed conflict

Activities	
Quantitative Indicators	Total
Outpatient consultations	26,376
Malaria (total)	102
Malaria (confirmed)	71
CNT primary care	263
Prenatal consultations (total)	1,685
Prenatal consultations (new)	817
Births	411
Postnatal care	200
Measles (treatment)	4

Project cost	**€ 762,797.48**

Human Resources	**National**	**International**
Health workers	**10.58**	**1.98**
Non health workers	**18.24**	**1.25**

Aden

Support for the displaced population, victims of violence

Due to the fighting between the southern movements and the State Army there were numerous population displacements. Right from the beginning, the team reacted forming

criteria of selection for the massive flow of wounded and providing support for the student committees. As a first step, existing structures were reinforcedand the necessity for a direct intervention on the part of MSF personnel was considered. With the passing of time, it was seen that the local structures were sufficient for the necessities of the population during days of violence and help was only needed on occasions. In August the team started to work in the health centre of Al Hosen (with the presence of the AQAP) with a mobile clinic. This intervention allowed the team to gain visibility, strike up relationships with regional leaders, evaluate the medical necessities of the zone (including vaccination programmes) and understand the situation in Abyan better, with the idea of leaving a door open to future negotiation.

Project cost	€ 144,894.92

Human resources	National	International
Health workers	1.24	0.38
Non health workers	4.09	0.30

Sana — **Support for the displaced population, victims of violence**

As a result of political violence and repression against the civilian population, the MSF OCBA gave support to a number of hospitals with the reception and treatment of the wounded and medication distribution.

Project cost	€ 105,583.33

Human resources	National	International
Health workers	0	0.40
Non health workers	0	0

Projects 2011
Latin America

- **Article: Financial and political commitment for the neglected disease oriented programmes. By Gemma Ortiz Genovese**
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Financial and political commitment for the neglected disease oriented programmes

*By **Gemma Ortiz Genovese***
Neglected Diseases Adviser of MSF-OCBA

Neglected tropical diseases (NTDs), neglected populations, forgotten diseases, the most neglected diseases, invisible patients…These are just some of the titles used to describe some or all of the 17 ´NTDs´ mentioned by the World Health Organisation (WHO). Each of the titles gives a clue to the nature of the diseases that affect the 2.7 billion people living on less than $2 per day. Those who live in the most remote areas, some in areas of conflict, many with no health service to go to. Each individual affected by one of these diseases will have his or her own story: stories of how it took time to get diagnosed, or of long and painful treatments, or tedious journeys to get medical care.

In a recent meeting held in London, Bill Gates, Margaret Chan, Director General of the WHO, along with other leaders in the health and development sectors as well as directors from leading pharmaceutical companies, came together to announce financial donations totalling more than $500,000,000 over the next five years, and to extend their commitments of all current drug donations to continue up to 2020. This meeting was a positive step in the direction towards fusing the financial commitments with the political ones made through the WHO “roadmap for implementation”. Symbolically bringing together donors, policy makers, ministries of health, NGOs and the pharmaceutical industry, the intention was to call for a coordinated approach to meeting patient needs and controlling neglected tropical diseases[50].
Overall, this was good news, especially when representatives from the WHO AFRO region, as well as the Minister of health of Bangladesh, advocated for the inclusion of these diseases into existing platforms and health care systems and programmes. However, during the discussion, the focus was slowly narrowed down to the seven diseases often referred to as being “tool ready” (ascariasis, hookworm, lymphatic filariasis, onchocerciasis, schistosomiasis, trachoma and trichuriasis). So, where does this leave the tritryps?

[50] Buruli Ulcer, Chagas disease(American trypanosomiasis), Cysticercosis, Dengue/dengue haemorrhagic fever, Dracunculiasis (guinea-worm disease), EchinococcosisFascioliasis, Human African trypanosomiasis, Leishmaniasis, Leprosy, Lymphatic filariasis, Onchocerciasis, Rabies, Schistosomiasis, Soil transmitted helminthiasis, Trachoma and Yaws.

For many donors (foundations, governments, and pharmaceutical companies) the key to giving funds or donating medications is the measurable outcome that can show "value for money". So when it comes to giving, key questions need to be answered – how many patients will be treated? How many will be cured? Will this lead to elimination? How cost-effective will this intervention be? For some of the most neglected diseases these are difficult questions to answer.

It can be argued that the seven "tool ready" NTDs are prepared for, or have already undergone large scale interventions, as the diagnostics are user-friendly, treatments are effective and cheap, and interventions are relatively easy to carry out. All these factors have a potentially strong impact on populations as they are all working towards reaching the objectives of an elimination programme. These NTDs have received drug donations (such as the ivermectin donation), and funding for the commencement of the control programmes has been constant. But where does this leave the other NTDs?

Medecins Sans Frontieres (MSF) has been actively engaged for more than 25 years in the case management and disease control of a subset of the NTDs, known as the tritryps: namely visceral leishmaniasis (VL), Human African Trypanosomiasis (HAT), and Chagas disease. These are life-threatening parasitological infections that are transmitted by insects. They collectively affect hundreds of thousands of people on four continents. Visceral leishmaniasis (VL) alone causes more than 50,000 deaths annually. It is difficult to estimate precisely the mortality associated with sleeping sickness. The 7,139 reported cases in 2010 are only a partial reflection of the burden of the disease[51]. There are still thousands of cases that are left undiagnosed and untreated, therefore, at high risk of death. Chagas disease affects between eight to ten million people worldwide and causes 12,500 deaths every year; it kills more people than any other parasitical disease in Latin America.

Another shared characteristic of these diseases is that they have been labelled "tool-deficient" because the majority of available diagnostics and treatments are antiquated due to lack of research and development (R&D), and they require specially trained staff and strong logistical support. Investment in R&D that might improve the situation is minimal and political will is weak. In this context, the MSF seeks to both meet the medical needs of patients and to speak out about the ongoing neglect at many levels in order to work towards bringing about a positive transformation.

While new tools are desperately needed for these diseases, this does not mean that nothing can or should be done at present. MSF's experience has shown that quality care can be delivered to most of those affected - including hard-to-reach communities -through innovative strategies and adapted, improved diagnostic and treatment protocols.

There has been some significant progress in efforts to control HAT, VL and Chagas disease. The MSF has contributed to this through collaborations with the Ministries of Health of various countries and other partners. Since the late 1980s, the MSF has screened more than 2.8 million people for HAT and treated more than 50,000 cases, while also treating more than 100,000 patients

[51] This number refers to reported cases of both *t.b. gambiense* HAT (6,939) and *t.b. rhodesiense* HAT (200). But in the following chapter, sleeping sickness or HAT will refer only to *t.b. gambiense* HAT, the most common form of sleeping sickness.

for VL. From 1999 through to the present day, the MSF has screened over 80,000 people for Chagas disease and treated more than 4,100 patients.

These data are encouraging, but they also illustrate the need to extend access to quality case-management and control tools for all endemic areas. Greater national and global support for vector control, as well as treatment programmes, is needed, as is enhanced R&D to develop better and more affordable field-adapted diagnostics and treatments.

With this encouraging focus on patients afflicted by neglected tropical diseases, it is important to ensure that all of these diseases are addressed in each country. As suggested by the leaders of endemic countries, this may need to be through reinforcing health care systems, addressing the development of infrastructure, and improving water and sanitation in the country. However, as we see through many of our projects, there are countries where there is a limited health care system, or patients are in areas of conflict, which restricts their movement to healthcare providers, and vice-versa. There remains a place for funding of vertical projects.

Conclusions and recommendations

Given the growing collaboration, and increased political and financial interest being given to neglected tropical diseases, it is essential to include those diseases such as the tritryps that are perceived as being more difficult to tackle.

For the diagnosis and treatment of HAT, VL and Chagas it is important that the Ministries of Health (MoH) in Endemic Countries reinforce outreach and active case-finding at community level; promote the use of the available rapid diagnostic tests; prioritize these diseases (including financially); and train more treatment providers on case management. **Donors** need to include VL, HAT and Chagas disease in the recent and future NTD financing initiatives; to fully support the reinforcement of screening and treatment; and to maintain surveillance when the incidence of disease decreases. The World Health Organization (WHO) must provide enhanced guidance to endemic countries in order to implement the latest treatment guidelines;extend the mandate of the Prequalification Programme to NTDs in order to assess quality assurance of drugs. Pharmaceutical companies needto register relevant drugs in all endemic countries. WHO, MoH in endemic countries and donors have to better shape the drug market through fully-financed, pooled orders and give support for generics suppliers; donation agreements with pharmaceutical companies should remain the first-line procurement strategy only for diseases with limited numbers of patients (HAT).

We must also remember the need to stimulate R&D for HAT, VL and Chagas disease in response to patients' needs. WHO and its Member States should implement the recommendations of the Consultative Expert Working Group on R&D Financing and Coordination, and begin negotiation towards the establishment of a binding convention under the WHO constitution for R&D needs in developing countries. Donors need to provide additional grants to product development partnerships as their pipelines of new diagnostics and drugs mature. They should also support new incentive mechanisms based on "delinkage" to spur innovation on neglected diseases, including prizes for early-stage discovery of biomarkers for follow-up of patients after treatment and

other greatly needed tools. Pharmaceutical companies ought to invest more significantly into R&D for NTDs, and amplify the geographic scope of open innovation platforms for neglected tropical diseases (e.g. WIPO Re:Search) in order to cover all disease-endemic developing countries, not only the least developed countries.

If all the political and financial actors could collaborate in such a constructive way as we saw during the London meeting, there would be real hope for populations living in these disease-endemic areas. There is optimism for removing the “neglect” out the title “neglected tropical diseases”

Sudan, 2006. © Juan Carlos Tomasi

Paraguay, 2012. © Anna Surinyach

Bolivia - Paraguay

Introduction and background

The management of Chagas programs with a regional approach was launched in January 2011 with joint coordination between Bolivia and Paraguay. The coordination team is based in Asuncion, and the La Paz office is considered an intermediate base that carries out support functions and has a representative role before the authorities.

This regional strategy aims to maintain a working link between the two countries in the following terms: Capitalizing on the experience of over 10 years working in Chagas in Bolivia for the new MSF context of Paraguay; human and financial resource optimisation; and sharing learning experiences.

It was decided to open a Chagas mission in Paraguay because it is a widely neglected endemic disease in this country. The real impact of the disease on the population is unknown (data, protocols and mandatory screening and reporting are non-existent). There is also non-acceptance among the medical and scientific community of its impact on health.

The Chagas intervention of MSF in this region has an added value, (besides that of offering comprehensive care to patients with the disease) in that a regional approach offers greater legitimacy / data / operational experience when intervening in national and international forums, which can potentially affect the health policies of the countries involved in this problem.

It is estimated that Paraguay has an overall prevalence of 7%, but in areas such as the Chaco the figure is 12%. It is estimated that around 150,000 people are infected in the country.

The case of Bolivia is particularly dramatic, since there are still regions, including those where MSF works, where the prevalence reaches 40%; in the country as a whole it is estimated that 1,000,000 people are infected.

Financial data

Expenses	€	%
PARAGUAY, CAPITAL	€ 429,358.28	26.19%
BOQUERON, Chagas	€ 437,507.79	26.69%
LA PAZ, base	€ 173,641.15	1059%
COCHABAMBA, Chagas	€ 134,208.33	8.19%
COCHABAMBA, Chagas rural	€ 386,491.22	23.58%
CHAGAS, RDT study	€ 24,396.27	1.49%
PARAGUAY, EPP	€ 29,381.53	1.79%
BOQUERÓN, emergency	€ 24,385.46	.49%
Financing	€ **1,639,370.03**	**100.00%**
Junta Andalucia	€ 163,560.31	9.98%
Total Public Institutional Funds	€ **163,560.31**	**9.98%**
MSF United States	€ 4,499.10	0.27%
MSF OCBA	€ 1,471,310.62	89.75%
Total Private Funds	€ **1,475,809.72**	**90.02%**
Total Financing	€ **1,639,370.03**	**100.00%**

Human Resources Capital

National staff	**9.00**
International staff	**5.19**

Human Resources Base

National staff	**6.41**
International staff	**0**

Boquerón (Paraguay)

Comprehensive health care for Chagas disease

In 2011 the MSF team consolidated the comprehensive care program for Chagas disease, which involved prevention, diagnosis and treatment. Training was provided for the staff of ten health facilities, the centre of diagnosis was established in the regional hospital of Boqueron, where laboratory and equipment were refurbished. 442 patients were confirmed, and over 50% of them started treatment.

To promote public access to the Chagas programme, methodological guidelines were developed and distributed to communities. The awareness campaign involved information and communication activities in all the communities where MSF is active, and health staff were trained to give educational talks. Similarly, community leaders were contacted and trained to help with treatment monitoring and to communicate with the medical team if necessary.

A total of 29 community leaders were trained in 100% of target communities where vector control activities are underway.

In October 2011, MSF was forced to curtail Chagas screening activities, due to disruption of the supply chain of Benznidazole, the main treatment drug. MSF called on the Brazilian state laboratory, LAFEPE, which is the only supplier of the drug in the world, and the Health Ministry of Brazil, to take immediate measures to make the drug available and meet the high demand throughout Latin America.

Location	Department of Boquerón, Paraguay
Target population	57,700 persons
Start and end date	April 2010 / April 2013
Project aim	Provide the population of the department of Boquerón, in the Paraguayan Chaco, with a comprehensive system of health care for Chagas disease
Population type	General population
Context	Stable

Rural Cochabamba

Comprehensive health care for Chagas disease in rural Cochabamba in Narciso Campero province, Bolivia

In 2011, the rural Cochabamba project, set up in May 2009, gave priority to the community strategy. The MSF team, acting as a mobile clinic, launched the Chagas Package, in which IEC and vector control were the main factors in preparing the community for eventual diagnosis and treatment. The intervention for each community was approximately 3 months.

In 2011, although the project was conceived with a clear aim of integrating Chagas diagnosis and treatment in the health centres, MSF activities were mainly focused on providing direct care to the community. Consequently, the strategy was divided into Community and Integration, with the aim of continuing the former, and reinforcing and prioritising the

latter throughout 2011. As well as reviewing the criteria for entry into communities and health centres, the way health teams work was reorganised, with a gradual involvement of the communities, avoiding work overload for the teams.

The community strategy has achieved a high impact, with 6150 patients screened, 2254 confirmed positive cases, and 1131 patients treated.
The integration strategy has successfully established diagnosis and treatment in the Carmen López Hospital and the Omereque and Pasorapa Health Centre. Although these have reached a certain degree of autonomy, they still require monitoring and periodic assessments to identify areas that need reinforcement. MSF community activities and training of staff have continued at the 15 health posts, which have been allocated population screening tasks while diagnosis and treatment is done by the health centres.

Location	Cochabamba, province of Narciso Campero, Bolivia
Target population	45,568 persons
Start and end date	May 2009 / May 2012
Project aim	Establish comprehensive health care system for the prevention, diagnosis and treatment of Chagas disease / infection in the province of Narciso Campero
Population type	General population
Context	Stable

Activities	
Quantitative indicators	Total
Chagas	2,039

Project cost	**€ 386,491.22**

Human resources	**National**	**International**
Health workers	**2.67**	**0.22**
Non health workers	**2.96**	**0.82**

Cochabamba City

Comprehensive health care for Chagas disease in the health centres of Cochabamba City, Bolivia

In April 2011 the 42-month programme in the city of Cochabamba, one of the areas most affected by Chagas disease in Bolivia, was concluded. The programme's goal was to provide diagnosis and free treatment for Chagas disease in 24 health centres.

During the MSF intervention, more than 20,000 people were screened for Chagas, 3,000 of whom tested positive. More than 1,900 patients aged between one and sixty years began treatment with MSF.

For the first time comprehensive health care for people with Chagas disease was integrated into primary care activities.

The project was transferred to the Bolivian Ministry of Health.

Location	Cochabamba City, Bolivia
Target population	23,500 persons
Start and end date	January 2008 / April 2011
Project aim	Integrate the prevention, diagnosis and treatment of the Chagas infection / disease in the Cochabamba city health service
Population type	Victims of endemic or epidemic diseases
Context	Stable urban

Project cost	**€ 134,208.33**

Human resources	**National**	**International**
Health workers	**0.33**	**0.19**
Non health workers	**1.72**	**0.51**

Narciso Campero (Bolivia)

PCR study in the province of Narciso Campero, Cochabamba

The PCR study, implemented jointly with the Community Strategy, was organized in 2010, and after initial delays due to lack of authorisation from the National Chagas Programme / Ethics Committee, began operating in April 2011.
The aim of the study was to validate the optimal amount and frequency of blood sampling. This study is being carried out with DNDi and is expected to continue for one year after the last patient of a total of 220 has been included. It was estimated that the final sample would be collected by January 2012, entailing a probable end date for the study of February 2013, since an additional month will be required to send the results to patients.

Location	Cochabamba
Target population	220 persons
Start and end date	March 2010 / January 2013
Project aim	To determine the optimal amount and frequency of blood sampling for the PCR study (Polymerase Chain Reaction)
Population type	Victims of endemic or epidemic diseases
Context	Stable rural

Boquerón (Paraguay)

Dengue Emergency in the department of Boquerón, Paraguay

In April 2011 an outbreak of dengue was declared in the department of Boqueron, where the Chagas project is being carried out. The response focused on the donation of medicines, other medical supplies, and mosquito nets, and the installation and chlorination of water in the most affected districts of the municipality.

More prolonged intervention was not necessary as the health authorities had the situation under control. A meeting was held on the subject in the central department of Alto Parana, but no intervention was considered necessary.

Location	Boquerón, Paraguay
Target population	Urban
Start and end date	April 2011
Project aim	General population
Population type	Stable

La Paz (Bolivia)

Landslide emergency

In March 2011, after the winter season, a mega landslide affected several neighbourhoods of the city of La Paz. MSF supported this emergency with the installation of water tanks and water chlorination at 9 of 11 shelters. The remaining needs were covered by the country's health authorities.

Location	La Paz, Bolivia
Target population	Urban
Start and end date	March 19 to 13 May 2011
Project aim	General population
Population type	Stable

Haiti

Introduction and background

After the 7.0 magnitude earthquake that struck Haiti on January 12, 2010, hundreds of thousands of people were left with living conditions well below what is regarded as the minimum for the dignity of human beings.

The earthquake left behind more than 1 million displaced, 220,000 killed (the official figure as far as is known), 300,000 injured and thousands of people with serious psychological scars. The mission in Haiti was the largest run by the OCBA section, both in terms of variety of activities implemented, and human and financial resources.

A few months after the outbreak that ravaged the Caribbean island in October 2010, cholera continued to be out of control in the early months of 2011. The precarious living conditions of the population and lack of water and sanitation favoured the spread of the disease. After the last outbreak in June 2011, cases of cholera in the capital Port-au-Prince increased again.

According to the Ministry of Public Health and Population, at the end of August more than 446,000 people had been infected with the disease and about 6,300 had died from it. Since the first confirmed cases of cholera in October 2010, MSF-OCBA has treated over 9,000 patients with a rapid response, and opened five emergency projects, focusing on treating cases in the various facilities that were implemented throughout the country (Saint Marc, Dessalines, Bicentenaire, Jacmel and Les Cayes). A total of 5 CT's, 12 CTUs and 7 ORPs were set up, with complementary IEC. The epidemic lasted about five months and the projects were gradually shut down during February, March and April 2011.

Three months after the earthquake, only two projects continued to operate: the reconstruction and support of the General Hospital in Jacmel (managed by the Ministry of Public Health and Population, MSPP) and support of the Bicentenaire Hospital (a private building in Port au Prince.) These activities continued without major setbacks, and in

February 2011 the Jacmel program was closed and transferred to MSPP. The support of Bicentenaire Hospital came to an end on July 18, 2011 (without finding any organization to which the project could be transferred). The mission of MSF-OCBA in Haiti was closed on August 13, 2011.

Haiti earthquake

Financial data

Expenses	€	%
HAITI, CAPITAL (emergency)	€ 3,163.02	0.10%
HAITI, CAPITAL	€ 582,908.27	18.35%
HAITI, Bicentenaire	€ 1,978,767.82	62.30%
HAITI, Jacmel hospital	€ 260,554.46	8.20%
HAITI EPP	€ 54,187.81	1.71%
PORT AU PRINCE, cholera	€ 80,837.75	2.55%
SAINT MARC, cholera	€ 77,607.03	2.44%
LES CAYES, cholera	€ 137,921.39	4.34%
Total	€ **3,175.947.55**	**100.00%**

Financing	€	%
Fundación la Caixa	€ 250,000.00	7.87%
Total Foundations Funds	€ **250,000.00**	**7.87%**
MSF United States	€ 905,074.99	28.50%
MSF German	€ 1,470,912.00	46.31%
MSF OCBA	€ 549,960.56	17.32%
Total Private Funds	€ **2,925,947.55**	**92.13%**
Total Financing	€ **3,175.947.55**	**100.00%**

Haiti cholera

Financial data

Expenses	€	%

HAITI CHOLERA, Capital	€ 176,482.29	10.63%
PORT AU PRINCE, cholera	€ 481,048.98	28.98%
SAINT MARC, cholera	€ 365,686.32	22.03%
DESSALINES, cholera	€ 9,278.13	0.56%
JACMEL, cholera	€ 231,297.69	13.94%
LES CAYES, Cholera	€ 395,866.38	23.85%
Total	€ **1,659,659.79**	**100.00%**

Financing	**€**	**%**
Spanish government – AECID	€ 300,000.00	18.08%
Swedish government - SIDA	€ 169,434,09	10.21%
Total Public Institutional Funds	€ **469,434.09**	**28.28%**
MSF United Sates	€ 923,094.63	55.62%
MSF OCBA	€ 267,131.07	16.10%
Total Private Funds	€ **1.190,225.70**	**71.2%**
Total Financing	€ **1,659,659.79**	**100.00%**

Human resources capital Earthquake

National Staff	**29.69**
International Staff	**4.58**

Human resources capital Cholera

National Staff	**0.1**
International Staff	**1.74**

Port au Prince **Providing primary and secondary health care at the Bicentenaire Hospital**

MSF's intervention in the Bicentenaire Hospital aimed to ensure access to free, quality primary and secondary health care for both adults and children. In early 2011 hospital workers were

trained to strictly comply with MSF protocols and diagnoses, and paramedics were trained in the care and cleaning of wounds. The emergency and intensive care wards were consolidated and the smooth operation of the 24-hour tetanus unit in paediatric and neonatal wards was ensured. The number of patients referred from other hospitals increased and functional physiotherapy and rehabilitation was organized for operated patients.

A psychological response to identified cases of violence was set up at Bicentenaire Hospital, creating a service of psychosocial support for victims of either the earthquake or urban violence in the area.

Mobile clinics or consultations outside the hospital were also launched this year, where patients were treated, high-risk pregnancies and cases of child malnutrition detected, vaccinations administered for children and pregnant women, and morbidity and mortality surveys carried out. The project was closed in July as the emergency and post-emergence phase finished, and entered the development phase. Unfortunately, no appropriate counterpart was found to take over the project.

In the case of a new emergency, the four operational sections of MSF remaining in the country could provide an adequate response.

Location	Port au Prince
Target population	36,400 persons
Start and end date	January 2010 / July 2011
Project aim	Guarantee access to free, quality primary and secondary health care for women and children
Population type	General population
Context	Instability

Activities	
Quantitative indicators	Total
Outpatient consultations	28,511
Malaria (total)	69
Malaria (confirmed)	29
Admissions	1,483
Prenatal consultations (total)	2,101
Prenatal consultations (new)	908
Births	162
Surgery	266
Direct violence	5,058
Mental health 1	2,078
Mental health 2	1,000
Measles (treatment)	1
Meningitis (treatment)	27
Cholera	892
Measles vaccination (routine)	151

Project cost	**€ 1,978,768**

Human resources	**National**	**International**
Health workers	**62.27**	**3.39**
Non health workers	**62.41**	**1.83**

Jacmel — Management of the Hospital of Jacmel

The hospital in Jacmel, managed by the MSPP, was supported by MSF-OCBA in surgery, paediatrics, internal medicine and emergency services until February 2011, when it was transferred to the Ministry of Public Health and Population.

Location	Jacmel
Target population	150,000 persons
Start and end date	November 2010 / February 2011
Project aim	Contribute to the reduction of morbidity and mortality in the municipality of Jacmel, especially among children, by providing quality medical humanitarian assistance.
Population type	Affected by natural catastrophe
Context	Natural catastrophe

Activities	
Quantitative indicators	Total
Outpatient consultations	788
Malaria (total)	10
Admissions	246
Deliveries	144
Surgery	53
Direct violence	67
Cholera	561

Project cost	**€ 260,554**

Human resources	**National**	**International**
Health workers	**0.58**	**0.46**
Non health workers	**4.14**	**0.47**

Port au Prince — Cholera emergency in Port au Prince

With the outbreak of cholera in Port au Prince the MSF-OCBA team had to step in and install a CTC in the Bicentenaire hospital, where they had been providing support since January 2010. 1,736 cases were treated in the Bicentenaire CTC during 2011.

Limited access to water and very poor sanitation provided an optimal medium for the

transmission of cholera. The pass of a tropical storm in late 2010 and the arrival of the rainy season brought flooding to several areas, thus further promoting the spread of the disease. That is why, at the same time as treating patients, MSF continues to encourage the Haitian health authorities and their international counterparts to distribute treated water and soap to ensure good hygiene practices, and to install and maintain latrines in order to control the spread of the epidemic.

Location	Port au Prince
Target population	23,500 persons
Start and end date	December 2010 / June 2011
Project aim	Reduce morbidity and mortality caused by the cholera epidemic
Population type	General population
Context	Instability

Activities	
Quantitative indicators	Total
Cholera	1,736

Project cost	**€ 561,887**

Human resources	**National**	**International**
Health workers	**28.99**	**0.83**
Non health workers	**86.32**	**0.48**

Artibonite — Cholera emergency in Artibonite

MSF OCBA treated 2,430 cholera patients at the facilities of Saint Marc and Dessalines in the Artibonite region, the original focus of the outbreak in the country. At the beginning of the epidemic, a cholera treatment area was prepared in the hospitals of Saint Marc and Dessalines but patients were quickly moved to the cholera treatment centres (CTC) that were created to allow hospitals to continue providing health care in other departments. In parallel, IEC activities were carried out to heighten awareness of the disease and its transmission pathways and treatment, as a way of controlling the spread of the epidemic.

Location	Saint Marc
Target population	15,350 people
Start and end date	October 2010 / April 2011
Project aim	Reduce mobility and mortality caused by the cholera epidemic in the affected zone

Population type	General population
Context	Instability

Activities	
Quantitative indicators	Total
Cholera	2,241

Project cost	**€ 443,293**

Human resources	**National**	**International**
Health workers	**24.40**	**0.57**
Non health workers	**26.10**	**0.70**

Les Cayes — Cholera emergency

The cholera epidemic in the Artibonite region was stabilized in late 2010, but different epidemic foci continued to appear in the rest of the country. Les Cayes is the fourth largest city in Haiti and in early 2011 needed a CTC to treat 3,054 patients who were affected by cholera. Mortality remained below 2%, and MSF also conducted IEC activities on the causes of cholera and its treatment, particularly in areas where the epidemic had recently emerged. The aim was to allay fears and help communities understand why installing a CTC is crucial for treating patients and controlling the spread of the disease.

Location	Les Cays
Target population	15,350 persons
Start and end date	October 2010 / April 2011
Project aim	Reduce mobility and mortality caused by the cholera epidemic in the affected zone
Population type	General population
Context	Instability

Activities	
Quantitative indicators	Total
Cholera	3,054

Project cost	**€ 533,788**

Human resources	National	International
Health workers	**13.50**	**0.68**
Non health workers	**19.50**	**0.85**

Jacmel

Cholera emergency in Jacmel

In Jacmel, a southeast department, a cholera treatment unit with a capacity of 50 beds was initially installed pre-emptively at the Hospital Saint Michel, where MSF-OCBA has been supporting the MSPP since January 2010. In mid-November, the epidemic reached Jacmel and a new 100-bed capacity CTC was opened, with the previously installed centre in the hospital being transformed into a CTU.

The team had to cope with an influx of 260 patients in one day, having to place up to four patients in one bed. In the first months of 2011 the CTC treated more than 563 patients.

Location	Jacmel
Target population	525 persons
Start and end date	November 2010 / February 2011
Project aim	Reduce mobility and mortality caused by the cholera epidemic in the affected zone
Population type	General population
Context	Internal Instability

Actividades	
Quantitative indicators	Total
Cholera	525

Project cost	**€ 231,298**

Human resources	National	International
Health workers	**5.00**	**0.38**
Non health workers	**13.75**	**0.79**

Colombia

Introduction and background

The presidential elections held in Colombia in 2011 were marked by violence and coercion of candidates and voters, and a rise in guerrilla activity. FARC and ELN expressed interest in advancing the peace negotiations, but failed to take any concrete actions or establish a dialogue with the incoming government. In turn, the guerrillas increased their numbers through a "Rebirth" plan and the new paramilitary groups consolidated their control, which has increased the vulnerability of civilians in 31 of 32 departments (347 municipalities).

In Colombia a total of 259,146 people were displaced in 2011 as a result of the following: Clashes between armed groups; operations to eradicate illicit crops; acts of violence and intimidation against civilians by the new paramilitary groups and guerrillas; and actions of the security forces, or their failure to act[52].

In 2011 there continued to be irregularities in the functioning of the health system, resulting in a lack of access to health services for much of the population. Problems include a lack of control and high levels of corruption in the Ministry of Health; deficiencies in the data collection system; an acute crisis in the public hospitals; and labour abnormalities, among others. Expectations of health reform are very low, as this would need an amendment to Law 100, on which the system is structured, and there is currently no political will to make this happen.

In view of the crisis of the Colombian health system and in order to report the difficulties encountered by the population to obtain timely and quality medical care, in 2011 MSF launched its report, "Access to Health Care is Access to Life: 977 voices". Through this document, MSF provided medical evidence of the physical, geographical, economical and administrative barriers Colombians face when trying to access health services. Two dynamics were

[52] According to the consultancy on Human Rights and Displacement (CODHES).

identified as major impediments to health access: The health system itself and the armed conflict. The people living in rural areas where MSF is working proved to have considerable difficulty in benefitting from medical care. Many of these people are not even registered in the social security system. The report outlined the need to improve services provided by the State, quantitatively and qualitatively, and ensure free health care for a higher number of citizens. The availability of essential drugs in health facilities also needs to be increased. The intrinsic relationship between conflict and lack of access to health care was clarified, thus revealing the importance of developing strategies to reach rural communities often isolated by the conflict.

Finally, interviews and surveys carried out for the report reflect what MSF has been observing for years: The neglect of medical facilities (especially in rural areas, where many of the posts are regarded as unprofitable according to the logic of the current system, since they generate more costs than benefits for the government); a lack of services, and the deterioration of health, which is related to the scarcity of economic resources of the poor.

The importance of the MSF action in Colombia is based on the lack of access to health care of the victims of armed conflict and violence. The challenge for MSF operations is to reach the places most affected by the reality of conflict where other humanitarian and institutional actors are not present, with the goal of providing medical care and psychological support.

Given the dynamic nature of the conflict, whose intensity and geographical impact change over time, it is important for MSF to maintain a continuous monitoring of each department. In this way, trends and priority areas of intervention can be identified, and sites where the organisation regularly works can be reassessed. Therefore, in the past year particular emphasis was placed on team flexibility and responsiveness.

Mental health activities have gained significant weight in the programme as a whole, with more than 3,000 patients treated by MSF psychologists in the four departments where interventions are carried out: Nariño, Cauca, Caquetá and Putumayo.

Throughout the year 2011, our teams have offered medical and psychological assistance to a total of 3,976 people in 12 emergencies related to armed conflict, most caused by mass displacement due to fighting and threats to the population. Another 4,476 people benefited from the distribution of hygiene kits, blankets and mosquito nets, within the emergency response to winter flooding in Cauca.

Financial data

Expenses	€	%
Capital	€ 625,409.37	15.83%
PUTUMAYO, Rural PHC	€ 567,307.58	14.36%
NARIÑO, Primary Health Care	€ 1,074,533.24	27.20%
CAQUETA, violence	€ 652,118.78	16.51%
CAUCA Primary Health Care	€ 1,027,391.31	26.00%
COLOMBIA, EPP	€ 4,020.92	0.10%
Total	**€ 3,950,781,20**	**100.00%**

Financing	€	%
MSF Japan	€ 1,359,115.95	34.40%
MSF United States	€ 1,49,64.72	3.91%
MSF OCBA	€ 1,094,02.53	2.69%
Total Private Funds	€ **3,950,78.20**	**100.00%**
Total Financing	€ **3,950,781.20**	**100.00%**

Human Resources Capital

National staff	**18.23**
International staff	**4.42**

Nariño — **Provide victims of violence with primary and mental health care**

Nariño is currently one of the departments most affected by conflict in Colombia, experiencing an increase in the number of threats, assassinations, kidnappings, extortion and displacements caused by fighting between various armed groups, especially in the Pacific coast, the border with Ecuador and some municipalities in the central part of the range. The continuous mass displacements due to armed conflicts, harassment by public security forces, direct threats, eradication and fumigation of illicit crops placed the population of Nariño in a delicate humanitarian situation.

The population of the areas most affected by the conflict in Nariño has no access to health care because of mobility restrictions at certain times and the presence of mines, while the health staff of the hospitals in certain areas have to work accompanied by armed actors.

The transition to the PASP scheme (Semi-permanent assistance points) in the Department of Nariño has gone satisfactorily. In the first half of 2011, 9 health posts that were previously covered quarterly by mobile clinics have been converted to PASP. The monitoring of chronic patients, acute disease management, monitoring of mental health patients and above all the level of acceptance by the community have all improved.

In 2011, assistance was provided in the areas most affected by armed conflict: the municipalities of Tumaco, Policarpa, Cumbitara, Samaniego, Barbacoas and La Llanada.

Location	Nariño
Target population	36,400 persons
Start and end date	April 2009 / December 2012

Project aim	Improve the quality and access to health care of the populations most affected by armed conflict in the department of Nariño
Population type	General and displaced population
Context	Armed conflict

Activities	
Quantitative indicators	Total
Outpatient consultations	20,088
Malaria (total)	32
Malaria (confirmed)	31
CNS	103
Prenatal consultations (total)	446
Prenatal consultations (new)	181
Births	3
Postnatal care	24
Sexual violence	35
Direct violence	38
Mental health 1	1,163
Mental health 2	259
Yellow fever (outbreak)	222
Yellow fever	10

Project cost	**€ 1,074,533**

Human resources	**National**	**International**
Health workers	**18.62**	**4.00**
Non health workers	**13.43**	**2.09**

Cauca

Provide victims of violence in Cauca with primary and mental health care

The Cauca population is suffering the direct consequences of the conflict in various ways: Civilians wounded by fighting and harassment; civilian casualties of MAP/MUSE; massive displacement; confinement and mental disorders due to the constant presence of armed actors; and the frequency of clashes in populated areas. In 2011, full access was maintained to all prioritized villages in the municipalities of López de Micay and Timbiquí, and regular mental health care was provided in the urban centres of Santander de Quilichao, Corinto, Caloto, Caldono, Toribio and Jambaló. The formal start of the project has involved an extension of intervention areas, currently covering the basins of the Naya and Micay Rivers in the municipality of Lopez de Micay, and the Saija and Timbiquí rivers in the municipality of Timbiquí.

In 2011 the strategies of PAPs (Points of Permanent Assistance), providing

continuous health care for 3 weeks a month, was implemented in Noanamito (Lopez de Micay) and Puerto Saija (Timbiqui), and PASP in Zaragoza, Bocagrande, San Bernardo, Boca de Patia, Santa Mary and Concepcion.

There was a considerable increase in queries related to acute diseases, improvements in monitoring chronically ill and mental health patients, a closer link with the population was established and a better understanding of the context was achieved.

In the 13 priority areas of intervention the number of mental health consultations doubled.

Location	Cauca
Target population	30,863 people
Start and end date	January 2011 / December 2013
Project aim	Improve the quality and access to health of the populations most affected by conflict in the department of Cauca
Population type	General and displaced population
Context	Armed conflict

Activities

Quantitative indicators	Total
Outpatient consultations	17,153
Malaria (total)	99
Malaria (confirmed)	86
CNS	157
Prenatal consultations (total)	961
Prenatal consultations (new)	459
Deliveries	11
Postnatal care	74
Sexual violence	105
Surgery	304
Direct violence	2,071
Mental health 1	314
Yellow fever (outbreak)	165
Yellow fever	17
Measles vaccination (routine)	1

Project cost	**€ 1,027,391**

Human resources	**National**	**International**
Health workers	**15.26**	**4.18**
Non health workers	**10.28**	**1.35**

Caquetá

Provide victims of violence in Caquetá with primary and mental health care

The change in strategy by FARC (Rebirth Plan) and the associated response of the military have had a direct impact on the department of Caquetá, with a greater number of attacks on roads and at security force checkpoints. The increase in attacks with explosives and mines and the intensification of harassment has directly affected the civil population. Displacement rates are becoming more alarming: according to a study of the Florencia town hall, almost 50% of the population living in the capital of the department are displaced.

The population of the prioritized areas in Caquetá live in scattered small towns that rarely reach 1,000 people, so they are mainly provided with assistance through the mobile clinics scheme.
In the first months of 2011, the opening of the shared area and that of Yari in the municipality of San Vicente el Caguán has positively influenced the possibility of implementing 13 Mobile Clinics in new assistance points. As well as achieving a continuity of activities, good relations with social and community action boards are being strengthened.

Location	Caquetá
Target population	23,500 persons
Start and end date	March 2008 / December 2012
Project aim	Improve quality and access to health care for the populations most affected by armed conflict in the department of Caquetá
Population type	Displaced population
Context	Armed conflict

Activities	
Quantitative indicators	Total
Outpatient consultations	8,390
CNS	17
Prenatal consultations (total)	195
Prenatal consultations (new)	115
Postnatal care	6
Sexual violence	107
Direct violence	71
Mental health 1	1790
Mental health 2	439
Yellow fever (outbreak)	220
Yellow fever	4

Project cost	**€ 652,119**

Human resources	National	International
Health workers	**12.56**	**2.18**
Non health workers	**8.28**	**1.94**

Putumayo — Provide victims of violence with primary and mental health care

The department of Putumayo has always been a strategic corridor in the Colombian conflict due to its position on the border. This year, with the Government's determination to wrest control of Bajo Putumayo from the FARC, the conflict in the border area with Ecuador has worsened. The civilian population, as well as being a direct victim of attacks, has suffered continuous threats and accusations of collaboration by different armed actors, and a general stigmatisation by the public institutions.

During 2011, MSF has managed to provide care in 12 of the points most affected by armed conflict in the municipalities of Puerto Guzmán, Puerto Caicedo, Puerto Asis and San Miguel. However, access to five points of assistance has been blocked by the armed actors in the area.

Throughout this year, hospitals in the municipalities of Puerto Asis and Puerto Caicedo have gradually regained their health brigades in rural areas. These initiatives have been relatively well received by communities and so far there have been no attacks or threats to their medical projects. Recovery of the space by these hospitals has led MSF to withdraw from five villages, transferring responsibility for assistance to the hospitals. However, in both municipalities certain areas remain without coverage due to insecurity, where hospitals have asked for support. Moreover, the frequency and quality of the brigades is low, so MSF has developed a lobbying strategy and training activities to improve these aspects.

Given the dynamics of conflict, which increasingly tends to focus on the border with Ecuador, during the year MSF has opened three locations on the border: El Afilador, San Francisco and Bajo Lorenzo.

Location	Putumayo
Target population	22,205 persons
Start and end date	March 2008 / June 2012 for integration in the Caquetá-Putumayo project
Project aim	Improve the quality and access to health care of the populations most affected by the armed conflict
Population type	Displaced populations
Context	Unstable

Activities	
Quantitative indicators	Total
Outpatient consultations	9,308
CNS	92
Prenatal consultations (total)	190
Prenatal consultations (new)	108
Postnatal care	25

Sexual violence	33
Direct violence	21
Mental health 1	895
Mental health 2	184
Yellow fever	0
Hemorrhagic fever	8

Project cost	**567,308**

Human resources	**National**	**International**
Health workers	**8.90**	**2.24**
Non health workers	**8.47**	**1.25**

Mexico

Introduction and background

Mexico, which in recent years has been increasingly affected by violence, is currently the world's busiest migratory axis. Each year, thousands of irregular migrants, mostly from Central America (mainly Guatemala, Honduras and El Salvador), cross Mexican soil in the hope of a better life in America. Crossing the border with Guatemala and Belize, they embark on a perilous journey to the north, riding on freight trains. During the journey, many are victims of assault, kidnapping, rape and murder. Despite their extreme vulnerability, the vast majority have inadequate access to the primary and mental health care they need.

In order to improve medical and humanitarian conditions in this population, MSF plans to initiate a project in the states of Chiapas and Oaxaca on the southern Mexico border. The aim of the project is to provide quality medical and psychological care for both transmigrants and local people, giving special attention to victims of violence. Due to the difficult travel conditions and the vulnerability of this population, promotional and preventative activities in physical and mental health are essential components of our intervention. To improve living conditions and hygiene, water and sanitation facilities were rehabilitated in the Ixtepec and Arriaga shelters, which put up 5180 and 8713 migrants, respectively, in 2011. Medical and psychological activity will begin in 2012.

The mission in this country is based on the following operations:
- Medical and humanitarian aid for the transmigrants crossing the country's southern border, giving special attention to victims of violence;
- Reinforcing the fight against neglected diseases, especially Chagas disease
- Assisting victims of natural disasters that may affect the Mexican territory, in constant coordination with the Emergency Unit of Panama.

Financial data

Expenses	€	%
MEXICO, CAPITAL	€ 221,354.00	67.39%
MEXICO, migrant intervention	€ 207,199.00	32.61%
Total	€ **428,553.00**	**100.00%**

Financing	€	%
MSF OCBA	€ 428,553.00	100.00%
Total Private Funds	€ **428,553.00**	**100.00%**
Total Financing	€ **428,553.00**	**100.00%**

Human Resource Capital

National staff	**4.00**
International staff	**2.09**

Southern Mexico

Medical and humanitarian aid for the transmigrant population at the Southern Mexico border.

In 2011 project activities were essentially to establish and preparea strategic and practical operational framework, but by the end of the year humanitarian medical care activities had still not begun.

The planned activities are to be carried out in clinics established near existing hostals in the South Pacific corridor of the Chiapas-Mayab railway, which transmigrants use to reach the U.S. border.

In the MSF-OCBA clinics of Ixtepec and Arriaga it is planned to provide direct primary health care, along with health promotion activities. Both the local and transmigrant populations will be assisted, and a space created for the detection and treatment of cases of sexual violence and mental health problems.

The rehabilitation of hostal infrastructure and work on water and sanitation has helped improve the living conditions and health of the migrant population.

Locality	Arriaga - Ixtepec
Target population	25,000 persons
Start and end date	March 2011 / March 2013
Project aim	To improve the medical and humanitarian conditions of the transmigrant population at the southern Mexico border, giving special attention to the victims of violence
Population type	Refugees/displaced population
Context	Instability

Projects 2011
Eurasia

- Greece - Turkey
- India

Greece - Turkey

Introduction and background

During the last ten years the southern European countries that border the Mediterranean Sea have experienced intense population movements coming from Sub-Saharan Africa and Eastern Europe. Millions of people have flown from poverty, hunger and violence looking for a better future in Europe. The migratory routes have changed according to the politics of repression at the borders of Spain, Greece and Italy.

From 2009, Greece has been the main entrance to Europe and is considered a transit country for those migrants who wish to continue their journeys to other European countries. The majority arrive at the island of Lesvos and, more recently, to the northern border between Greece and Italy in the region of Evros. Between January and September, 2011, 35,544 people have entered through this route in contrast to 32,000 the previous year. Due to the internal conflicts in Syria, Iraq and Kurdistan, and equally delicate situations in the Maghreb countries, plus a Turkish migratory policy considered lax by the European governments, even more movements are expected for 2012.

In fact, in a few years Turkey has changed from a country that generated migrants to one that is receiving them and is an alternative route to those that go via Spain, Italy and Malta. It is difficult to give an estimation of the number of migrants passing through Turkey, but it is thought that some 600,000 people are living there with the idea of continuing their journey to Germany, Great Britain, or Holland. Their living conditions in Istanbul are disastrous and their medical and humanitarian needs are not being met by the government.

At present, and given the socio-economic situation of Greece, it is impossible for the country to commit its efforts. This was shown by the first attempt to transfer the humanitarian medical care project in Evros, abandoned by the Greek medical authorities two months after it was started. In Turkey, the fundamental rights of the migrants (whether without papers or asking for asylum) such as access to health are denied. The migrants survive thanks to the work of local organisations which are principally focused on

medical protection for the most vulnerable members of this marginalised group.

Because of this, and with a regional perspective adapted to migrant flow, the MSF OCBA is carrying out two projects, one in Istanbul and the other in the region of Evros to respond to needs. Both projects include a local and international advocacy strategy with the aim of drawing attention to the medical needs that are not being provided to an invisible and stigmatised population: People that represent a burden for two countries with unsatisfactory regulations for both within and without Europe.

Financial data

Costs	**€**	**%**
Capital	€ 136,844.00	7.12%
EPP	€ 13,281.00	0.69%
Istanbul, Health Assistance Migrants	€ 123,859.00	6.45%
EVROS, Migrants	€ 503,530.20	2.21%
Turkey, post emergency earthquake	€ 61,514.00	3.20%
Turkey, emergency earthquake	€ 1,081,815.00	56.32%
Total	€ **1,920,843.20**	**100.00%**

Financing	**€**	**%**
Swedish Government–AIDS	€ 221,773.75	11.55%
Total Public Institutional Funds	€ **221,773.75**	**11.55%**
Griega Niarxos Foundation	€ 134,699.00	7.01%
Total Foundation Funds	€ **134,699.00**	**7.01%**
MSF Germany	€ 6,000.00	0.31%
MSF OCBA	€ 1,558,370.45	81.13%
Total Private Funds	€ **1,564,370.45**	**81.44%**
Total Financing	€ **1,920,843.20**	**100.00%**

Human Resources Capital

National staff	**2.00**
International staff	**1.80**

Istanbul (Turkey)

To provide psychosocial support to the most vulnerable migrants

In 2008 and 2010, the MSF OCBA carried out two exploratory missions focused on the vulnerable situation of the migrants asking for asylum. It was decided to implement a humanitarian medical intervention in Turkey. The MSF signed an agreement of cooperation with local organisation, Helsinki Citizen's Assemble (HCA) specialised in helping undocumented migrants seeking asylum. In May, the MSF OCBA commenced its first mental health activities with referrals from other NGOs.The consultations were carried out in a discrete location known as "The House" where a pool of Turkish psychologists, a psychiatrist, two community social workers and an interpreter attended the migrants. From September a community work team was added which started external activities (outreach) in the neighbourhood settlements composed of people from western Africa. This signified that one third of those attended by the medical team came directly from these places. Most of the patients suffered from panic attacks, hyperactivity, lack of concentration, and depression and felt threatened.

The team offered individual consultations and group therapy where they responded to the psychological and social needs of the patients, with the reference of a community social worker.

Psychiatric follow-up was also available for those patients who needed it from an external professional.

Educational sessions and social activities were organised with the objective of linking the migrants to community associations and networking was set up.

In addition, the MSF OCBA has set mapping of the present migrant community as an objective in order to have greater information about their places and living conditions, the characteristics of each ethnic group, their mechanism sof adaptation, and the presence of leaders. It has adapted its operational strategy to focus on the most vulnerable members of this collective. The first report was available in July and ready for to be used by the team, to complement their work in organisation of advocacy actions, and other organisations working in the same field.

Location	Istanbul
Target population	50,000 people
Start-up and finish date	April 2011 / December 2012
Project's objective	To provide psychosocial support for the most vulnerable migrants in Istanbul
Type of population	Refugees/displaced population
Context	Stable

Activities	
Quantitative Indicators	Total
Mental health 1	327
Mental health 2	37

Project cost	€ 122,216	
Human resources	**National**	**International**
Health workers	**0**	**0.18**
Non health workers	**0.5**	**0.20**

Turkey — Support for earthquake victims

On the 23rd of October, an earthquake that was 7.1 on the Richter scale affected the eastern coast of Turkey. On the 25th of October an MSF team left Istanbul in order to evaluate needs and design a possible intervention plan. From the 2nd to 8th of November the MSF OCBA developed activities which included the distribution of 1987 tents prepared for the cold weather and 200 kitchen kits. Distribution took place in the area of Van, located a few kilometres away from the earthquake's epicentre, a remote rural area.

From the 67 villages that the MSF visited, 37 received supplies from the MSF OCBA teams working in collaboration with Hayata, a local NGO. There was a total of 27,909 beneficiaries.

Location	Van
Target population	27,909 people
Start-up and finish date	October 2011 / November 2012
Project's objective	Support for earthquake victims
Type of population	Victims of a natural disaster
Context	Stable

Project cost	€ 1,082,018	
Human resources	**National**	**International**
Health workers	**1.20**	**0.00**
Non health workers	**1.00**	**0.27**

Turkey — Post emergency intervention

Following the emergency intervention and the distributions the MSF OCBA, in collaboration with the Helsinki Citizens' Assembly (HCA), planned a short intervention with the objective of giving support to the earthquake victims with mental health service together with Centre of Psychosocial Coordination of Van. Between the 5th of December and the 3rd of February, three teams composed of a psychologist, an

assistant social worker and a driver, carried out activities of psychological support through individual and group sessions in 31 villages.

5,320 people suffering from symptoms of post- traumatic stress, anxiety and depression benefitted from this service.

The teams also formed a women's association, the Maya Women's Association,in the Bostanici municipality and they gave a talk on the local radio, Tutku Radio FM, about the mechanisms of adaptation and recuperation after an earthquake and the mental health support services available.

Location	Van
Target population	5,320 people
Start-up and finish date	December 2011 / February 2012
Project's objective	Support for earthquake victims
Type of population	Victims of a natural disaster
Context	Stable

Activities	
Quantitative indicators	Tota
Mental health 1	53
Mental health 2	236
Staple necessities	2,000

Project cost	**€ 61,514**

Human resources	**National**	**International**
Health workers	**0.20**	**0.11**
Non health workers	**0.20**	**0.23**

Evros (Greece)

To provide humanitarian medical first aid to migrants

During the two last years, migrants have entered Greece by crossing the river Evros which separates it from Turkey. The number of migrants in the southern area of the river triplicated between 2010 and 2011 whilst a decrease in their number was observed in the northern part. Some of them are living in detention camps (some 1,000 people are still detained in infra-human conditions at the five detention/transit centres of the zone for a period of no longer in principle than three months). Whilst others are waiting to obtain their expulsion papers so that they can continue their routes towards other European countries.

Both within and without the centres the conditions of hygiene are deplorable. There are no baths or showers, there is overcrowding in the cells, and a lack of personal hygiene products. Moreover, the Greek authorities do

not distribute even basic necessities. Medical attention is the responsibility of the Greek Ministry of Health whose presence is irregular and no association is in charge of giving legal advice with respect to asylum rights.

After five months primary health care intervention and the distribution of basic necessities, from December to April 2010, the MSF OCBA transferred the project to the Greek Ministry of Health. However, in June the Ministry suspended its activities due to lack of resources. The MSF OCBA decided to re-intervene in September with a greater emphasis on emergency response during the winter period in the five detention centres (Fylakio, Tyechero, Poros, Soufli and Venna) with medical and sanitation activities.
The team distributed basic necessities (Non Food Items NFI) such as blankets, gloves, socks, kits to sleep in the open air (especially pregnant women and children).

It also provided basic medical care for the most common pathologies such respiratory disease, and psychological support. It endured that the most complex cases were referred to the region's central hospital.

Location	Evros
Target population	50,000 people
Start-up and finish date	December 2010 / December 2012
Project's objective	To provide humanitarian medical first aid to migrants in Evros
Type of population	Refugees/displaced population
Context	Stable

Activities	
Quantitative indicators	Total
Outpatient consultations	2,689
Mental health 1	99
Basic necessities	13,500

Project cost	**€ 368,650**

Human resources	**National**	**International**
Health workers	**2.00**	**0**
Non health workers	**1.00**	**0**

India

Introduction and background

The year 2011 was marked by a number of corruption scandals which have seriously affected the government of Manmohan Singh and the president of the party, Sonia Gandhi. In addition, the world economic crisis has worsened the country's situation. Although the country has responded well, thus confirming its status with Brazil and South Africa as an emerging power, inflation in the price of staple food products has affected the acquisitive power of the Indian population. The withdrawal of foreign investment has delayed development of the infrastructures which needed modernisation to support the increasing population growth. In February 2011, the Parliament voted for the social costs destined for the development of the health and education sectors, two of the weakest points of the country which is growing at a rate of 17% per year.

With an annual population growth of 1.76%, Indian currently has 1.21 billion inhabitants. The literacy rate is 74% (65% for women) and there is a huge disparity between the health services offered in the richer states and the three poorest ones (Bihar, Madhya Pradesh and Jarkhand). There the rates of chronic or severe malnutrition have reached approximately 70% and UNICEF calculates that 56% of the children aged less than fifteen suffer from some degree of anaemia.

In Bihar, one of the public health problems comes from the prevalence of Kala Azhar (KA) (Black Fever) which represents 50% of the cases at world level, and 90% of the cases in India. KA is a forgotten disease that affects the poorest population and, as a result, has never represented a priority for the Indian public health policy or benefitted from any kind of eradication plan. Consequently, the national protocols do not respect the WHO suggestions and use treatments that are less effective with teratogenic effects that hinder its correct application.

Another huge concern is malnutrition which affects more than 8 million children in the country. It has resulted in retarded growth for

33% of children aged under 5 years according to data collected by the National Family Health Survey (NFHS).

MSF OCBA started a KA detection and treatment Project in 2007. It has successfully treated more than 9,000 patients using Ambisome® with a 98% cure rate. The good work over the last years and the fact of being linked to the Rajendra Memorial Research Institute (RMRI) has provided the MSF with credibility in the field of KA. In addition, the great efforts done in parallel to reduce the cost of Ambisone ® has made it easier to include this medication in the protocols without substantially increasing the cost of treatment. In 2009, after a nutritional survey in Darbhanga, a second nutritional aid project was opened.

Financial data

Expenses	**€**	**%**
INDIA, CAPITAL	€ 491,395.97	23.82%
DARBHANGA, Nutrition	€ 684,252.64	33.16%
BIHAR, Kala Azar	€ 884,952.53	42.89%
INDIA, EPP	€ 2,710.90	0.13%
Total	€ **2,063,313.86**	**100.00%**

Financing	**€**	**%**
Inditex	€ 500,000.00	24.23%
Total Foundations Funds	€ **500,000.00**	**24.23%**
MSF OCBA	€ 1,563,313.86	75.77%
Total Private Funds	€ **1,563,313.86**	**75.77%**
Total Financing	€ **2,063,313.86**	**10.,00%**

Human Resources Capital

National Personnel	**16.73**
International Personnel	**5.44**

Darbangha, Bihar

To prevent and treat severe-chronic malnutrition in children ages under 5 years

The rates of malnutrition in India are alarming as shown by the figures gathered by the National Family Health Survey (NFHS) with severe-chronic malnutrition representing from 4.1% to 8.7%. This means that 8 million Indian children suffer from severe malnutrition and 800,000 of these come from Bihar. Chronic malnutrition affects 30% of children aged less than 5 year and, to a lesser degree, affects the whole population. In fact, it is practically a condition that is inherited from mothers to children, generation after generation. In 2008, after a nutritional survey which showed that 4.8% of the children suffered in Darbangha suffered from severe-chronic malnutrition, the MSF OCBA decided to intervene.

In 2011, the team diagnosed and treated 2,085, 68% of whom had been cured. This signified and improvement with respect to 2010 (48%). The main concern continues to be the number of children who do not follow the treatment and abandon it voluntarily, 700 in 2011 which represents 35% of the total. Two factors are harvest time, when the children work, and the floods which restrict the mothers' ability to attend the programme. In most cases, the children who leave the programme do so at an advanced stage which makes their mothers believe that the treatment is no longer a priority. There is also another factor, in Darbangha the rate of morbidity and mortality is very low so, in the perception of the population, severe malnutrition is not associated with mortality.

In order to improve patient identification and retention, the team has given importance to its collaboration with the community health workers who play a fundamental role in relieving the Information, Education, and Communication team by basing their strategy on communication with the population.

Finally, for the first time a better acceptation of ready-to-use therapeutic foods (RUTFs), the prices of which are decreasing in India, has been observed.

During the last thirty months the MSF has diagnosed and treated 7,116 children with severe-chronic malnutrition. At present, it is the only nutritional structure in Bihar providing care to so many children. This fact forces the Indian government to come to terms with its responsibility and capacity to establish programmes on a large scale to look after 8 million children suffering from severe-chronic malnutrition.

After three years of working with the project, the MSF OCBA has acquired expertise in both knowledge of the context and its treatment. This knowledge allows us to propose new ideas of how to treat malnutrition in this context and reorient our activities in 2012.

Location	Darbangha, state of Bihar
Target population	92,620 people
Start-up and finish date	January 2009 / February 2012
Project's objective	To prevent and treat severe-chronic malnutrition in children ages less than 5 years in the district of Darbangha, state of Bihar
Type of population	General population
Context	Stable

Activities	
Quantitative Indicators	Total
Admissions	408

CNT hospital	408
CNT primary health care	2,945
Measles vaccination (routine)	3,033

Project cost	**€ 684,253**

Human Resources	**National**	**International**
Health workers	**42.53**	**3.06**
Non health workers	**26.39**	**2.82**

Vaishali, Bihar

To reduce the morbidity and mortality caused by Kala Azar

Treatment was carried out in primary care health centres and in hospitals, if necessary. In addition, treatment camps were organised in places where there was no primary care.

During 2011, the MSF OCBA consolidated its amplification plans, started the previous year, in five primary care centres: Vaishali, Goraul, Mahua and Raghopur, and continued with treatment at the hospital in the district of Hajipur Sadt and at the Rajendra Memorial Research Institute (RMRI) where patients with more complicated pathologies are referred.

Additionally, a system of support and follow-up was set up for the health structures in ten other districts in the state of Bihar. Advocacy and Information, Education and Communication (IEC) activities were also reinforced, particularly, in the rural areas where the MSF did not directly give support to the health centres.

Due to an agreement signed with the Drugs for Neglected Diseases Initiative (DNDI) it was decided to incorporate the project within a study about the implementation of different combined therapies (Miltefosine + Paramomycin, L-AmB+ Miltefosine, L-AmB + Paramomycin) or 10 mg/Kg of LAmB taken alone. The aim was to show the Indian government the reliability and efficacy of each treatment, with the idea it could choose the treatment with the best results and offer it to its patients including it in the national protocols. During 2011 we concentrated our efforts on performing the necessary paperwork for this kind of study.

Within the context of awareness about the importance of the illness, the MSF has put forward two initiatives. The first is the activation of a task force from the Health Ministry to respond to epidemics and emergencies linked to KA through capacity-building for personnel and the co-ordination of first aid. The second is the simplification and certain adaptation of the projects to make quality attention coincide with the local capacity of the Indian Health Ministry.

Location	Vaishali, state of Bihar
Target population	2,300 people
Start-up and project finish	July 2007 / June 2013

Project's objective	To reduce morbidity and mortality caused by Kala Azar in Vaishali, district of Bihar
Type of population	General population
Context	Instable

Activities	
Quantitative indicators	Total
Kala Azar	1,774

Project cost	**€ 884,953**

Human resources	**National**	**International**
Health workers	**42.88**	**2.90**
Non health workers	**22.76**	**1.18**

Projects 2011

Exploratory missions and short emergencies

- Bahamas Islands
- Ghana
- Guatemala
- Libya
- Western Africa

Bahamas Islands	The prevention and management of natural disasters

Financial data

Costs	€	
Bahamas, hurricane	€ 3,574.81	100.00%
Total	€ **3,574.81**	**100.00%**

Financing	€	
MSF OCBA	€ 3,574.81	100.00%
Total Private Funds	€ **3,574.81**	**100.00%**
Total Financing	€ **3,574.81**	**100.00%**

Ghana	Care for displaced people from the Ivory Coast, distribution of hygiene kits and the construction of 51 showers and latrines in 3 camps (Ampain, Eagle Star and Berekum)

Financial data

Costs	€	
West Ghana, Ivory Coast IDPs - Emergency	€ 51,732.23€	79.43%
West Ghana, Ivory Coast IDPs – Exploratory	€ 13,400.44€	20.57%
Total	**65,132.67**	**100.00%**

Financing	€	
MSF OCBA	€ 65,132.67	100.00%

Total Private Funds	€ **65,132.67**	**100.00%**
Total Financing	€ **65,132.67**	**100.00%**

Project cost	**€ 51,732**

Human resources	**National**	**International**
Health workers	**0.00**	**0.07**
Non healthworkers	**0.00**	**0.18**

Guatemala **Distribution of 1,000 kits (hygiene, blankets and mattress) to flood victims in Nueva Concepción**

Financial data

Costs	**€**	**%**
Guatemala, exploratory flood	€ 3,885.53	5.26%
Guatemala, emergency flood	€ 70,024.68	94.74%
Total	€ **73,910.21**	**100.00%**

Financing	**€**	**%**
MSF OCBA	€ 73,910.21	100.00%
Total Private Funds	€ **73,910.21**	**100.00%**
Total Financing	€ **73,910.21**	**100.00%**

Guatemala, exploratory mission

Human resources	**National**	**International**
Health workers	**0**	**0.03**
Non health workers	**0**	**0.03**

Guatemala, emergency mission

Human resources	National	International
Health workers	**0**	**0.05**
Non health workers	**0**	**0.04**

Libya **Mental health support for victims of violence in Dehina and Choucha**

Financial data

Costs	€	%
TRIPOLI, violence	€ 269,795.79	100.00%
Total	€ **269,795.79**	**100.00%**

Financing	€	%
MSF OCBA	€ 269,795.79	100.00%
Total Private Funds	€ **269,795.79**	**100.00%**
Total Financing	€ **269,795.79**	**100.00%**

Human resources

National staff	**0.00**
International staff	**1.03**

Activities	
Quantitative Indicators	Total
Mental health 1	333
Mental health 2	176

Human resources	National	International
Health workers	**0**	**0.52**
Non health workers	**0**	**0.52**

Western Africa **Emergency plan preparation (EPP) in Western Africa (Dakar)**

Financial data

Costs	€	
WEST AFRICA	€ 21,666.54	100.00%
Total	€ **21,666.54**	**100.00%**

Financing	€	
MSF OCBA	€ 21,666.54	100.00%
Total Private Funds	€ **21,666.54**	**100.00%**
Total Financing	€ **21,666.54**	**100.00%**

Human resources	National	International
Health workers	**0**	**0.09**
Non health workers	**0**	**0.25**

Zambia, 2011. © Serene Assir

Improvements to enhance the medical support to the field projects

*Interview with **Dr. Pedro Pablo Palma***
Medical Director of MSF-OCBA

In the last three years the medical department has undergone substantial changes, both in the form and the content of its work. With the objective of responding in a better way to the humanitarian medical changes facing the MSF OCBA operations, an ambitious reorganisation has been carried out which the director here explains against the background of the events of 2011.

1. **What has 2011 meant globally for the medical department?**

In some ways, 2011 has been the culmination of a three-year cycle for the re-adaptation of the Medical Department to Operations. From 2008 we have been working on creating a department to give optimum support to the humanitarian and medical needs of the organisation. These efforts came to a head in 2011 with the arrival an assistant director who joined the operational unit; the reorganisation of medical units and areas; and the more systematic start-up of the Mobile Implementing Officers (MIO). In addition, we have added new medical areas that were necessary for better operational support, including hospital management (which I will talk about later in the interview) and stock logistics. In terms of context, 2011 has been a year of consolidation of a number of strategies, mutualisation and rationalisation of resources with the rest of the movement, and the results of the great efforts we have made in recent years with respect to operational research. A number of articles have been published with data from the analysis of our operations. We have improved analysis capacity and the capitalisation of our interventions.

2. **Has the nutritional emergency which has been part of MSF operations presented a challenge for the Medical Department?**

For us, and for Operations, the nutritional crisis has been a challenge which, amongst other things, has shown us our own capacity for massive response. It is clear that there are many elements to analyse – the crisis coincided with the change in nutritional reference in our section which meant incorporating new skills, some of these were related to Action against Hunger. In addition, we have managed to establish response on a large scale, combining the traditional response based on an ambulatory plan of product distribution together with a preventive strategy based on the focalised distribution of specialised preventive products. Of course, an operation of this type presents challenges and limitations. First, we have had to enhance human resources, creating and deploying fast courses to update the

medical personnel. We learnt from this experience and we are now organising courses beforehand in Barcelona with a view to future possible needs. The other limitation is related to the difficulty of combining the regular mission response with an emergency the size of that which took place in the Horn of Africa. There were a number of positions with respect to that, and we are aware that it is not possible to maintain the level of normal activities (primary care, outpatients, vaccinations etc.) knowing the energy and resources consumed by a response of that magnitude. I firmly believe that this emergency showed us that we were correct with our humanitarian medical response, both the Spanish section and the international movement were able to respond. One of the most important questions pending concerns early warnings. We know that our reaction could have been a little faster (one or two months) and in this way lives are always saved. It helped us propose the creation of an early warning system through information gathered from all the operational sections.

3. **The reappearance of measles has also played an important role. How do you analyse the MSF response to the outbreaks and the question of routine vaccination?**

The Medical Department has spent years analysing the reappearance of measles not only in developing countries, but also in developed ones. Clearly, it is the result of a failure in the prevention programmes which have, in general, been overlooked even knowing that measles can be prevented, that there is an effective response, and that there are public health policies established at an institutional level. The MSF has never considered vaccination programmes to be routine and compulsory within its health programmes. However, seeing that the regular vaccination programmes did not function, the MSF has had to consider adding this activity to its basic pack. Obviously, it has to be accompanied by an element of advocacy to remind the authorities in charge of regular vaccination of their responsibilities and obligations. In Zambia, the MSF response to the epidemic of measles in 2010 and at the beginning of 2011 combined advocacy (thanks to well documented assertions on the part of the teams) and routine vaccination. We think that this strategy could be repeated. The teams will have to make a supplementary effort when they plan to integrate the new component, which until now has not been present in the regular missions, into the basic medical pack.

4. **Could you explain what the work of the Mobile Implementation Officers (MIO) consists of?**

The Mobile Implementation Officers are temporary posts the objective of which is to respond to humanitarian medical needs in the field. Consequently, the MIO specialities are according to the operational portfolio. In 2011, four MIOs worked giving support to operations in PMTCT, sexual violence, obstetrics-gynaecology, and mental health. The MIO visit those missions which require support for the implementation of a component in their health programmes. Sometimes it can be the contrary - a proposal arises from the headquarters after difficulty in implementing a component has been detected. In 2012, the post of MIO PMTCT was not renewed as it was thought that the implementation of the HIV strategies was well consolidated. The idea of this model is that a product and expertise are created, which stay in the field and can, in the necessary case, be incorporated directly into the field structure. We have a concrete example with the post of MIO in the management of pharmacies and the implementation of isystocks. The MIO was employed during 2011 and the following year it was decided to consolidate the work by creating a position. A similar thing took place in Zambia where the necessity for a

more structural support in PMTCT was seen. It is clear that with the opening of decentralised units there is the possibility of regional support posts substituting the temporary MIOs.

5- Has the Spanish section consolidated its relationship with the Brazil Medical Unit (BRAMU), Epicentre and other entities with networking and resource rationalisation?

2011 has been the result of efforts that started a number of years ago to rationalise and share our efforts in all the movement. In 2011 the MSF OCA signed an agreement of collaboration valid until 2013. It allowed the sharing of knowledge and investment in medical fields with such issues as chagas, dengue, and paediatrics. Dengue is a good example of this collaboration, thanks to the competence provided by the BRAMU there was an intervention within the context of an epidemic, and for the first time a guide was written in 2011 with a later second edition.

In 2011, close collaboration between MSF OCBA and Epicentre during the previous three years led the creation of a post of Epicentre epidemiologist based in Barcelona whose objective was to provide support for operational research. Thanks to this collaboration a large number of studies have been carried out in fields such as cholera (based on cases in Zambia, Guinea Bissau and Haiti); the design for a protocol for the implementation of an oral vaccine in the Republic of Central Africa (a prospective mortality survey which contributed to the orientation and information of strategic decisions); and in the area of nutrition (nutritional crisis in the Horn of Africa).

6- In November, 2011 telemedicine was officially launched. What does it consist of and what do you expect from this tool?

Telemedicine consists in creating a network of specialist who can give support and reply to doubts concerning complex cases being handled in the field by medical teams. It is a project that brings together the five operational sections in which each section is responsible for one language. MSF OCBA is in charge of the network in Spanish. The telemedicine network which employs a method called “store and forward” patented by the Swifen and Trust Foundation (with which the MSF signed an agreement to use its licence) allows doctors in the field to send consultations by e-mail to a network of specialist in which almost 80% are former MSF professionals, well known in their specialities. Since the project was launched two consultations have been received, one for a case in the Democratic Republic of Africa and another for the Republic of Central Africa.

With time we hope to continue improving this tool. For example, we could one day carry out consultations in real time with the use of video conferences, or a hybrid solution that combines both methods. This type of work methodology is particularly interesting in countries where there are few doctors, especially specialists, and where the cost of these consultations is considerably reduced thanks to the use of internet. For 2012 this network should have extended to all the MSF OCBA missions. Our mission will coordinate the needs of the other Spanish speaking sections through a reference based in Barcelona who will be responsible for managing the whole consultation process.

7- With the increase of interventions MSF OCBA and the other sections have started to analyse management quality in hospitals. What does the analysis consist of and what are the plans for the future?

In recent years we have decided to reinforce our presence in secondary health care, entering hospitals and even managing

them in times of crisis. This investment in hospitals permits, on one hand, the possibility to have a centre of reference in the case of conflict or violence, and, on the other hand, reinforces the periphery system of reference from the health structures in the zone. Finally, it constitutes a key stone in the training and turnover of its medical personnel. Within this context, it appeared necessary to develop a greater technical capacity in hospital management from operational, logistic and medical perspectives. A task force was created made up of members from different departments and headed by our Medical Department.

At present, of the eighteen hospital interventions in the MSF OCBA portfolio, five were performed with complete autonomy - the MSF owns the hospital and manages it according to internal protocols. In the other thirteen cases, the MSF shared partial or total responsibility with the Health Ministry of the country where it worked, and with United Nation agents when they were present.

With the Task Force it is expected to create protocols of intervention that will permit a harmonious management of human resources, funds, technologies and medical stocks.

Human resources management in 2011

*By **Silvia Moriana***
Human Resources Director of MSF-OCBA

“I feel that I have personally contributed to our humanitarian work. Although I am not in direct contact with the beneficiaries I am helping the people who help our patients”.

Manar Arafeh, Palestine Occupied Territories, 2011

“For meMSFis a humane job…Here the work is face to face. It’s about seeing the results, seeing the people who are suffering, the response, and the final results… It’s the thanks we get from the people we work for.”

José Ramón Benito, Logistics Coordinator, 2011

The motivation and commitment of our teams are definitely one of MSF’s most important assets. They are the driving force when it comes to helping people in precarious circumstances, without which we would be unable to fulfil our social mission. Our main tasks are to attract people who are both committed and in possession of the necessary skills, and then to manage and, above all, hold on to them. In order to overcome the humanitarian challenges facing us, the growing difficulties we have in accessing populations,or the increasing complexity of our medicalactions,we increasingly need to expand the diversity of people working for us. A diversity that brings a range of skills, knowledge, expertise and wealth of vision.

Innovation has also become of utmost importance in the way we deploy our teams, manage our projects and ensure the best possible resources are available. Every day we need to be more adept, flexible and proactive to tackle the needs of the organisation, bringing in new skills and being able to define the best strategy to apply within the standardised limits.

The challenges of 2011 have not been about meeting a sudden increase in demand. In contrast with 2010, we have dedicated less effort to strategic issues, and concentrated on improving the quality of our actions and human resource management. There have been important improvements, which we are proud of, but we are still encountering difficulties and issues that need to be dealt with differently if we are to achieve better results.

The three main goals this year continue to be: Investment in the improvement of team skills and supporting the development of talented people to enable them to assume positions of responsibility; effective integration of field staff, ensuring that everyone is included in the decision-making processes depending on their role and not their origin; and to ensure that MSF is a responsible employer, according to the movement’s policy, providing decent work

conditions, opportunities for professional development and, as far as we can, guaranteeing the safety of our teams.

How we have improved

Overall, the balance of 2011 has been positive. We are pleased by the growth in availability of international personnel (8.8% in 2011), allowing us to increase our future capacity. We are also pleased with the number of people we have been able to train this year and the improvements in the training of new and existing staff. We are proud to say that our virtual classroom at the MSF e-Campus, thanks to the efforts of voluntary tutors, has become a benchmark on distance learning for the entire organisation. Proud, because we have a highly valued security management course, which is attracting a growing number of students. We have been able to take our training into the field with mobile units that can be rapidly deployed to train 150 people in three weeks (as was the case in Liben, Ethiopia). We have taken on the necessary resources, tools and policies to improve the management of field staff (with specifically assigned teams). Although difficult to measure, we believe we have improved the management of some missions, while others still require special attention. Finally, albeit slowly, we have made progress in international projects that will enable us to harmonise our national staff remuneration policies, andin the future we hope to be able to provide a more accurate overview of the human resources available within the movementthrough a single system.

To be improved

But there have also been problems and in some areas we have not been able to progress as much as we would have liked. Despite improvements, we are still unhappy with the difficulty in filling crucial positions in certain missions. Nor have we been able to improve the people management skills of our coordinators, of vital importance if staff are not to leave our organisation. Our ability to optimise existing resources also needs improvement. Although 94% of our field staff are of local origin, very few of them achieve a position of responsibility (88% of our coordinators are from an international background). Finally, the inflow of new people in the organisation (first missions) is not what we would wish for.

In the international projects, progress has also been slower than we would have liked in certain issues, and a lack of consensus has brought delays in, for example, thereview of remuneration policies of the international staff, or the application of a single classification of field positions for the whole organisation.

Looking to the future

Above all, after achieving improvements in some fundamental issues, in 2011 we have identified the need to focus on other more critical and strategic goals. We have to go hand in hand with the Operations department and together define and implement Human Resources strategies more tailored to operational needs, at the same time being more flexible and proactive. The time to innovate has come.

We have advanced and even improved in people management, which overall is now more professional, effective and efficient, but there is still more to do. On these foundations we must now go a step further and strategically align the management of our personnel with our needs to build future capacity.

The challenges and difficulties we have faced in recent times call on us in 2012 to reflect in depth on what is the best model for the coming years: A model for an organisation with growing challenges of access, ever more complex interventions, in contexts that require new profiles and

modus operandi. An organisation that wants to remain international, which believes in the value of each employee, whether national or international, and which recognises the necessity of fusing more effectively the strengths and skills they contribute, without denying the problems or limitations we can come across, which day by day force us to be more flexible, efficient and bold in the way we face them.

This will undoubtedly lead us to adopt strategies more closely defined by circumstances. Emergency interventions do not have the same requirements as long-term hospital projects, or those for treating neglected diseases. Neither does working in areas of conflict pose the same challenges as it does in a stable totalitarian environment. Nor do all the people who make up the organisation require the same management or investment: A sporadic volunteer is not the same as someone who wants to spend long periods with us working in the field.

Our future lies in being able to recognise our differences while guaranteeing overall capacity and being able to adapt to changes. What we do today may not be what we do tomorrow but we should be able to do both.

Haiti, 2012. © Mathieu Fortoul

MSF-OCBA finances. Finance in times of crisis and the strength of belonging to an international movement

*By **Andreu Maldonado***
Financial Director of MSF-OCBA

Difficult times do not necessarily mean a decrease in the social support we enjoy nor in the solidarity do we receive from the population as a whole. Nevertheless, the MSF is not unaffected by the crisis. In order to confront the situation, we have to strengthen the movement's international financial structure, investing in the levying of funds from the emerging countries and looking, in a more active way, for public, institutional financing. From the point of view of operations, we will consolidate the present ones and define a more flexible operational one, increasing the proportion of financial volume for emergencies and being even more rigorous in our budget control.

The much feared and now hackneyed crisis has affected everyone and, clearly, the MSF is no exception. A paradigmatic case is that of our colleagues in Greece where the effects have been devastating. Society as a whole is seeing its income being steadily reduced whilst the growing deficiencies in public services leave the disadvantaged once again in a vulnerable position. From 2009, private incomes in the Greek sector have diminished by 30%. Nevertheless, we can see that the number of members remains constant and that the response to newsletters and specific calls is not particularly lower than at other times. However, donations have on average fallen substantially.

Experience from the Greek sector shows two clear issues. On one hand, social commitment to MSF work can not merely be measured in terms of total income. The legitimacy that the MSF obtains from social support depends on the number and quality of the donations and not on their global amount.

On the other hand, it appears that in times of crisis society as a whole does not renounce its social commitment – quite the opposite.

At the same time, the necessities the MSF must also cover have also increased. The drought of public, institutional funds is reducing the operative capacity of other organizations so that the response mechanisms of the international community weaken and, as a consequence, the MSF is confronted by greater challenges in the field.

Faced with such a situation how should we respond from the MSF-Spain? We must highlight that the strategic bet to base our financial structure on the support of thousands of members has paid off. There are now approximately 300,000 people in Spain who regularly support the organisations and their contributions are considerably more stable than private companies or public institutions. This signifies that the

Spanish section is the second largest economic contributor to the movement, in absolute terms, after the United States.

The search for funds

During 2011 the international agreements for the distribution of resources were revised. We established that the movement would be responsible for the operational challenges of the entirety of the MSF centres which carry out field operations. In this way, once the annual plans of the operational centres had been approved, they were collectively financed by the movement's sections. Given that currently more than 25 sections and entities provide and share the collected funds, this scheme grants enormous solidity to the MSF financial structure. As not all the sections and entities find themselves in the same economic cycle, or at the same moment of revenue capacity development, the possible decreases in the income of some sections could be compensated by increases in others.

On the other hand, in the MSF we are aware that we cannot base our future growth exclusively on the social support coming from the same group of countries as now. Consequently, in the following four years we are going to invest in the development of collecting private funding from new countries such as Brasil, Mexico, Argentina, India, South Korea, the Czech Republic and South Africa. And, apart from purely financial aspects, we firmly believe that the legitimacy of MSF actions stems from the support and engagement shown by the societies in which we interact. Therefore, the international movement should not be removed from the considerable changes that are taking place in the world today and the emergence of new agents in the international community.

One way to compensate for the possible drop in income is to approach in a more decided manner public, financial institutions. This would permit us to maintain other ties with our original societies and complement political and civil actions. In recent years we have considered this source of funding as a key element in compensating our financial balances. And, in the future this element will be even more important. In spite of this, we are aware that in our own surroundings institutional funding is increasingly scarce and political conditioning more evident. We should, therefore, place our hopes in the co-operative agencies in those countries that maintain their financial commitments and, in addition, look for new sources that have not been previously explored.

Growth and budget control

It is important to remember that the financial volume of the operations of the MSF movement has experienced a significant growth in the last four years. In the MSF-OCBA the direct cost of projects has grown at an accumulated annual rate of more than 15%. As a result, at the closure of 2011 our operations represented more than double that of 2007.

This growth has been due to various factors ranging from huge emergencies, such as those in Haiti and The Horn of Africa, to the increase in the complexity and quality of our operations. We are conscious that in the near future we can not maintain similar growth patterns. For 2012 we plan to consolidate our operational volume at the same level as 2011, with modest budget increments between 2013 and 22015.

In a similar manner, in times of crisis and uncertainty, it is imperative to maintain flexibility in the composition of the MSF-OCBA operational projects. We will be particularly prudent with those projects which may signify long term commitment and we will maintain a greater proportion of funds reserved for emergency response. In this way we can guarantee the pertinence of our actions and ensure our presence for commitments acquired with populations affected by forgotten conflicts in which we are already present.

In addition, we must be even more rigorous with the annual planning and budget exercises and their revisions. We are dealing with a collective effort which will allow us to take better decisions with respect to the evolution of both activity and income. We should, therefore, improve our capacity of budget follow-up.

Moreover, we ought to be innovative and, at the risk of falling into a recurrent cliché – do more with less. The strong tendency to decentralisation and networking permits the identification in the field of new members who can complement our actions.

Finally, we have to learn how to manage our financial risks better. Up to the present, in the MSF we have stated that we should establish an objective of short-term reserves equivalent to six months or, what is the same, a quantity equivalent to half our annual budget should be available to guarantee our future operations. Taking into account the current financial volume, both the MSF-OCBA and the movement as a whole, and the international agreements for resource distribution previously described, we should consider the suitability of this policy. From now on, a more accurate evaluation of the financial and operational risks, an improvement in our follow-up capacity and piloting of acquired financial commitments of our projects (both current and future), and the full development of the concept of financial solidarity in the MSF movement should allow us to manage our operational costs with better adjusted reserve levels, thus freeing funds for the development of operations.


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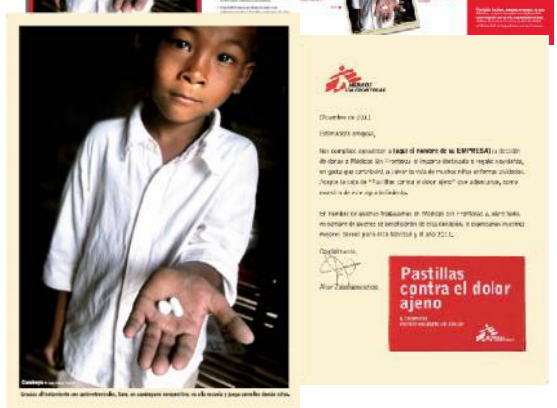
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Encarna ha operado a 8 personas en países en guerra
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Javier ha curado de malaria a 2.808 niños
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Continuous commitment to our members: A guarantee of intervention in times of crisis

*By **Anna Pineda***
Fund Raising Director of MSF-OCBA

Another year has passed during which, thanks to the support of our members and donors, our teams have been able to help and accompany hundreds and thousands of people who need humanitarian and medical aid. Amongst them, thousands of Somali children who suffer from severe malnutrition, and their families who had to abandon their homes fleeing from drought and war in extremely precarious conditions.

It has also been a critical year in our own country where many families have passed difficult moments. It is, therefore, tremendously comforting to see how our social base continues to be able to empathise with the pain of more vulnerable people, and to understand that if the crisis affects us, it is even worse in poor countries.

This reaction has been particularly valued at a time when the official benefits from governments and international organisms appear to be rapidly receding leaving many needs with insufficient funding. It is only economically independent organisations like Médecins sans Frontières (Doctors without Borders) which can attempt to provide aid.

Growth in private contributions in spite of the crisis

All this support has been translated into private contributions of 65.7 million euros in 2011, 1% more than the quantity raised last year. This is an extraordinary figure when taking into account that in 2010 we obtained an extra income of 11 million euros for the earthquake in Haiti.

This excellent result is fundamentally due to the continuous growth in income from the members' regular quotas which reached more than 43 million euros, 10% more than in 2010. It is a figure that represents 65% of the total private income coming from Spanish society. It has been possible thanks to the involvement of many of our members who have slightly increased their monthly quotas and the net increase of more than 24,000 members, reaching 289,812 regular members at the end of 2011 (**figure 2**).

The members represent the principal source of income for MSF Spain and are the guarantee for the intervention of our teams. Their donations, which are steady and not destined for any specific objective, grant us the freedom to intervene immediately in real human needs. In addition, the excellent reaction of the public, and once again our members, to the call for help we made during the summer months for the emergency in Somalia should be

highlighted. The funds raised reached 5 million euros which were assigned for the Somali refugees in the camps at Liben (Ethiopia) and Dadaab (Kenya) and also for displaced people in the interior of Somalia.

Another very positive factor has been the extraordinary support the campaign "Pastillas contra el dolor ajeno" (Pills for other people's pain) received during 2011. Thousands of people bought the pills in their pharmacies or responded to the "grito" (scream) campaign and signed the manifest in favour of support for forgotten diseases at: http://www.msf.es/pastillascontraeldolorajeno/grita
Thanks to this mobilisation we reached the figure of 5 million packets sold from November 2010, which translates into 4.3 million euros (3 million in 2011) directly applied to treatment against infantile AIDS, chagas, kala azar (black fever), tuberculosis, malaria, and sleeping sickness in projects in Africa, Latin America and India. With respect to donations from company collaboration, the continued commitment of Inditex, whose contribution reached 2.8 million euros, should be commented on.

In addition, Inditex is involved with the "Positive Generation" project (http://www.msf.es/positivegeneration) Financing the production of 50,000 playbuttons (rechargeable MP3s with the project's songs) sold in its shops with the wholesale price destined for the fight against AIDS in Zimbabwe.

Many other companies continue to collaborate in the production, distribution and commercialisation of the "Pills against other people's pain". Others have helped with the emergency in Somalia or donations in general. Some companies have also participated in the campaign for "Solidarity presents" with donations for Christmas presents and humanitarian projects. See list of collaborating companies. (http://www.msf.es/colabora/empresas/empresas-colaboradoras)

In spite of all this generous collaboration it must be said that the total quantity of income coming from companies was reduced with respect to 2010, caused no doubt by the economic crisis.

Finally, we would like to highlight another source of income which is quite new in our country, but which is growing yearly. It is the legacy of solidarity. In 2011, 65 people informed us of their decision to include the MSF in their will, either leaving us a donation or naming the MSF as heir or co-heir (http://www.msf.es/colabora/herenciasylegados). In 2011, we received 2.1 million euros in concept of inheritances which we have transformed in to humanitarian and medical aid thus fulfilling their donors' wishes.

Cautious estimations for 2012

In spite of the growth in income in 2011 and the net rise in members, we have to bear in mind that in the same year approximately 30,000 members were forced to cancel their membership for financial reasons. It is clear that these membership losses were amply compensated by the more than 53,000 new members. Nevertheless, we are conscious that in 2012, taking into account the financial situation, many people and companies could take this decision.

We are interested in the people behind the economic contributions.

To all these people we would like to say that there are many ways to continue collaborating with the MSF. Before you cancel your membership consider reducing your donations. Do not forget that every donation, however small it seems to be here, can have an incalculable value once transformed into vital aid for each patient.

With gestures that are apparently symbolic, such as sending a Solidarity SMS to 28033 or buying a packet of “Pills against other people’s pain”, we could, for example, treat three children with malaria.

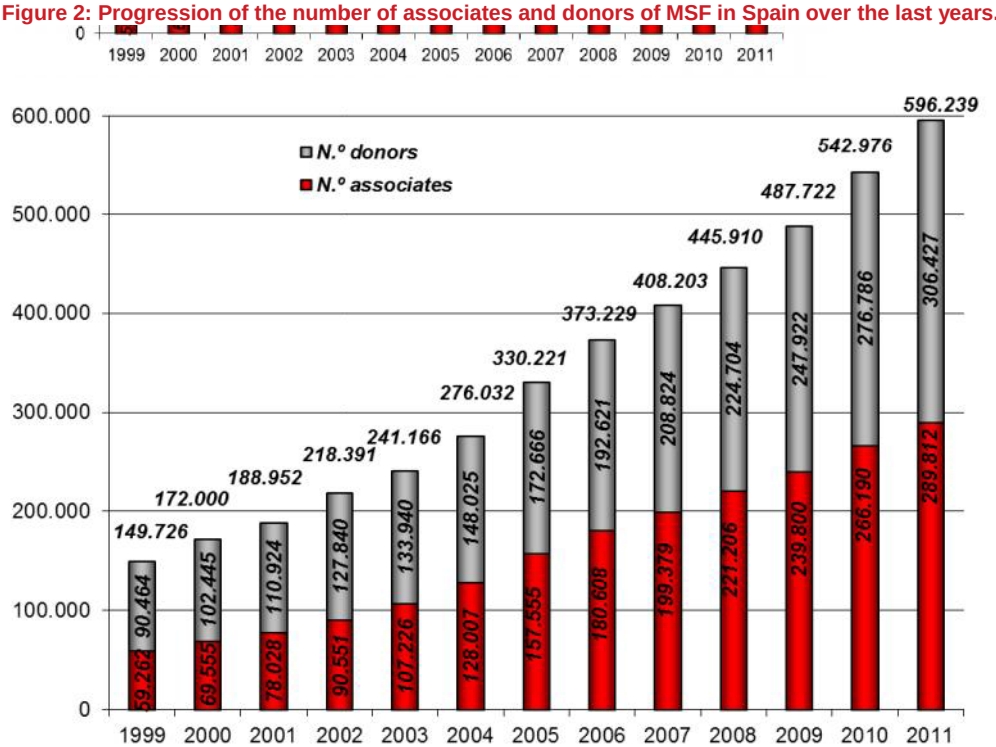
In addition, there are many ways to be involved such as giving support to campaigns that denounce issues (http://www.msf.es/stopnovartis), following us on social networks and spreading our messages, encouraging solidarity initiative in favour of the MSF amongst your friends, buying the CD
“Positive Generation”, giving “donation-cards” or products in the MSF shop (http://www.msf.es/tiendamsf), participating in the events that the MSF organises and so on.

THANKS!!

To all the members, donors, companies and people who have bought the “Pills for other people’s pain”, members who have reduced their donations or who have had no other course but to cancel their membership, people who have signed our petitions, people who follow us on the social networks. To all of them, many, many thanks.

Each and every one of you forms part of the MSF. It is you, with your solidarity that begins the chain which we continue with until it reaches those whose fate it has been to be defenceless, without any kind of protection, and who need the aid and company of others in order to be able to continue their lives.Thank you for making this posisble!

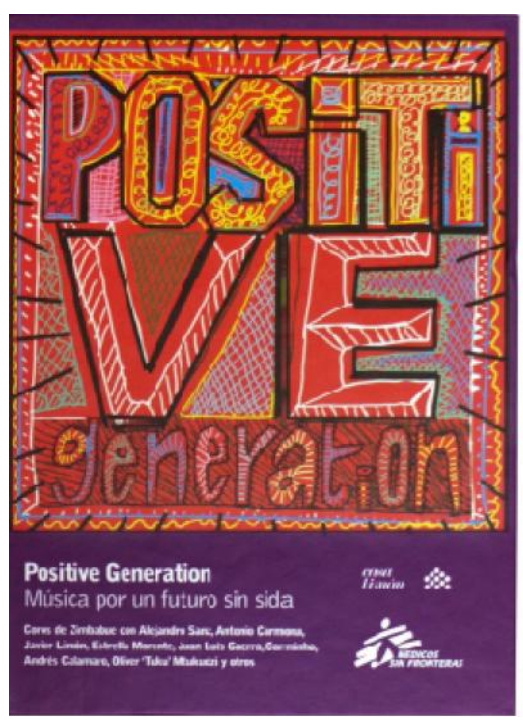
Figure 2: Progression of the number of associates and donors of MSF in Spain over the last years.




Andrés y José
han atendido
a 240
víctimas
de desastres
naturales
Gracias, Andrés.
Gracias, José.
Gracias a ellos y a más de 5 millones
de socios y donantes, cumplimos 40 años.
40 años de acción
humanitaria independiente
MÉDICOS SIN FRONTERAS
Andrés es socio de Médicos Sin Fronteras desde 2006 y José desde 2007.
www.msf.es/gracias


Marta
es socia
de MSF
desde 2007


Pastillas contra el dolor ajeno
Gracias a una espectacular participación de la sociedad española, se han vendido más de 3 millones de Pastillas contra el dolor ajeno. Pero todavía quedan miles de millones olvidados que mueren cada día por no tener acceso a medicamentos. Si esto te duele:
GRITA DE DOLOR AJENO
PONTE EN TRATAMIENTO
Javier Bardem
Luis Tosar
0022917
CONTÁGIATE DE DOLOR AJENO Y GRITA
Pastillas contra el dolor ajeno
Cómpralas por 1€ en tu farmacia.
¡QUÉ HEMOS CONSEGUIDO HASTA AHORA!


POSITIVE
Generation
Positive Generation
Música por un futuro sin sida
Coros de Zimbabue con Alejandro Sanz, Antonio Carmona,
Javier Limón, Estrella Morente, Juan Luis Guerra, Gerardo,
Andrés Calamaro, Oliver 'Tuku' Mtukuzi y otros
MÉDICOS SIN FRONTERAS

Social support and campaigns 2011

*By **Gemma Planas***
Loyalty Coordinator of MSF-OCBA
*And **Laura Calonge***
Public Awareness Coordinator of MSF-OCBA

Doctors Without Borders (MSF) has always sought to involve its supporters in ways that go beyond economic contributions. Campaigns have been designed to give the public greater insight into the work of the organization, harness their support for its causes, and involve people in the task of spreading the word about our mission. In this sense, 2011 has been a busy year.

A social support campaign is a tool that seeks to raise awareness, provide information and, if appropriate, raise funds for a specific target or context in which we are working. In short, its aim is to get our broad social base (members, donors, individuals enrolled in our Newsletter, Twitter followers or Facebook fans, etc.) involved in the dissemination of our campaign.

To make this possible, in recent years considerable work has been done in developing an approach that seeks proximity, innovation and interaction.

Innovative campaigns or the use of creative concepts allow us to attract attention more effectively, at a time when people are being bombarded with thousands of messages every day. They also help to convey certain values that are intrinsic to MSF, for example, the desire to take risks.

A particular value of humanitarian action is proximity, and if MSF campaigns manage to transmit this value, they help convey the message that we are an organization of people who help other people (whether beneficiaries, expatriates or supporting members) and that our action is direct, and without intermediaries.

Finally, it would be pointless to plan innovative campaigns without taking advantage of the interactive potential that certain tools are increasingly making available. That is why we have become interested in campaigns that allow people to get involved in a variety of ways, whether by attending an event, asking for an activist pack, leaving comments on the campaignwebsite or spreading them through social networks.

40th anniversary of MSF

In 2011, MSF marked its 40th anniversary (25th in Spain), and, while turning 40 is not exactly a cause for celebration for an organization like ours, we did not want to miss this opportunity to give thanks for the enormous social support we have, and to explain what MSF humanitarian action involves.

To acknowledge the commitment and support we have received over the years, without which it would be impossible to carry out our social mission, it was decided

that during the summer, our partners and collaborators would be the stars of a highly visible outdoor advertising campaign (bus stops, subways, etc.,) in almost all Spanish cities.

In addition, during the second half of the year, events were held in Vigo, Pamplona, Zaragoza, Valladolid, Alicante, Malaga and Barcelona exclusively for our members and collaborators to thank them for their support and give them an opportunity to voice questions, comments and doubts about the organisation.

A mobile exhibition entitled *40 years of independent humanitarian action* went on the road around the country to explain what MSF humanitarian action consists of and to review the milestones that have marked the organization's history. Talks were also held at universities and other forums.

On the campaign website (www.msf.es/gracias), where members, volunteers and workers had posted their testimonials, visitors were invited to leave their own comments or videos, and they were encouraged to participate in the *Humanitarian Action Quiz* to check their knowledge on the subject. Nearly 40,000 people have visited the site, 6,693 have taken part in the quizand more than 500 people have left comments.

In short, our aim was to bring MSF closer to the people, let them speak and ask questions, thank them and let them take the leading role. We wanted to open the door to dialogue, listen, and explain the MSF experience of humanitarian action.

Screaming with other people's pain

In November 2010 the campaign *Pills for other people's pain* was launched. Thanks to an innovative concept: O*ther people's pain;* a simple system of collaboration: selling *pills* for only 1 euro; a ubiquitous presence in outdoor advertising, and an enormous impact in the media, MSF has been able to connect with specific audiences that it had not reached before. The result of all these factors was that only 3 months after the campaign launch, 3 million boxes of pills had already been sold (entirely devoted to projects in Bolivia and Zimbabwe), and for the first time MSF became the best-known organization among the Spanish population.

The challenge in 2011 was to sell another 3 million pills. To do this, we worked on an attention-grabbing campaign that allowed the public to identify with its cause and empathize with the millions of patients who have no access to treatment, even if it exists.

Two well-known MSF collaborators, Javier Bardem and Luis Tosar, were invited to be spokesmen of the campaign. A video announced the outbreak of a metaphorical epidemic of other people's pain and invited anyone affected to make themselves heard to get treatment.

On the webpage (www.gritadedolorajeno.org) users could sign the manifesto, upload their scream of other people's pain, and above all they could become our spokespersons and disseminate the message on social networks.
We wanted to make people aware of the reality of thousands of forgotten ill people, and to channel their indignation by taking the cause on board and spreading the word.

Over 22,900 people have screamed with other people's pain and 2 million pills have been sold on top of the initial 3 million.

Positive Generation: Voices for a future without AIDS

MSF was one of the first organizations to begin treating HIV-AIDS patients in developing countries. It started in 2000 with

only a few patients, and currently treats more than 200,000 people in over 20 countries.

One of the fundamental aspects of this work is outreach and awareness. Year after year, the organization strives to emphasise how fundamentally important it is for an individual with HIV to have access to treatment. Besides stabilizing the disease, the treatment allows people to lead a reasonably normal life, and to see the future in a positive light.

A good example of such an awareness campaign is taking place in Zimbabwe. There, some of the MSF HIV projects include a strategy of community education and communication through music. Groups of affected people receiving treatment are organised into choirs, and visit the communities singing openly about the issues of the illness, and the right to request actions and solutions.

Several months ago, MSF took the strategy used by our HIV patients in Zimbabwe, and launched it worldwide through *Positive Generation: Voices for an AIDS-free future.* With the help of producer Javier Limón, MSF has recorded these African choirs, full of rhythm and incisive messages about AIDS, and added songs from artists like Alejandro Sanz, Antonio Carmona, Estrella Morente, Juan Luis Guerra and many more. The result is a CD-book full of vibrant music and texts expressing support and resolution. The CD can be purchased at FNAC and El Corte Ingles in CD-book format, and also online at I-tunes. All proceeds from this campaign are used to treat people infected with HIV / AIDS in Africa

The *Positive generation: Voices for an AIDS-free future* strategy also includes a webpage - www.positivegeneration.org - where you can read testimonials from affected people, find out about the history of each choir, and also listen to songs, and share them on social networks.

Positive Generation is also a documentary directed by filmmaker David Trueba, who visited the AIDS projects in Zimbabwe and talked to members of the support groups that visit communities singing openly about the challenges of a disease like AIDS. Spanish TV has shown this documentary several times and has also created a *Positive Generation* microsite on the RTVE webpage, one of the most visited Spanish-language websites.

In short, *Positive Generation* is an awareness campaign that tries to do more than just explain a humanitarian drama. It aims to give a voice to people living with HIV so that through music they can explain their struggle for a full and decent life, showing that you can live with the disease positively.

Zimbabwe, 2011 © Salomé Limón

Zimbabue, 2011. © Juan Carlos Tomasi

Challenges, successes and new imperatives in public communication

*By **Nondas Paschos***
Communications Director of MSF-OCBA

A number of emergencies, incidents, decisions and external factors had an impact on our communication activities during 2011. In this article we briefly revise the main events of the year, and our role with respect to Spanish and international opinion. In addition, we reflect on the challenges that new technologies and social networks are presenting in a world that is becoming increasingly global and where, at times, immediacy is more important than the message itself.

Information from the field

In Libya during the civil war (although there was also international military intervention), information from the MSF about its medical activities appeared in the national and international mass media and augmented knowledge about the organisation in the region. However, the fact of working and, therefore, communicating from zones controlled by the rebels was also dismissed as partisan by some sectors of the social networks. This was compensated for, after the fall of Gadafi, when we denounced the use of torture, on the part of the rebels, in the detention centres where we were providing attention.

The triple disaster in Japan was not accompanied by extended communication due to our limited operational response in the field. This was reflected in the public pressure that was felt at a local level in Japan and the level of fund raising. It demonstrated the huge difference between our desire to provide support and the limited capacity to assign funds to this particular crisis.
In Somalia, Kenya and Ethiopia the rhythm of communication concerning the nutritional crisis first of all came up against the difficulty of confronting the great starvation narratives adopted by other organisations and our limited operational analysis in the region. Once this was overcome we broadcasted a wide variety of communications from the field which received intense coverage from all around the world. The commitment of our operational centre was significant both in terms of human resources (communication personnel in situ from Spain (Barcelona) and Argentina right from the beginning of the crisis, support for the international network and the regional information reference) and our work with communication and content. Whilst the relationship between public communication/political pressure actions and their impact is difficult to establish, the press release about the humanitarian system in the Ifo 2 camp (Dadaab, Kenya), and the inadequate response from the United Nations High Commissioner for Refugees (UNHCR), was followed by a public commitment from the WHO agency and a posterior opening of a refugee camp.
The kidnapping of our two colleagues in Dadaab on the 13th of October had a huge effect on our communication particularly in Spain where the news spread like wildfire. The media began to publish incorrect and potentially harmful

information that could affect finding a solution to the case and distress the families involved. Through a careful system of communication (press releases, summaries, and updates) and media management, great efforts were taken to avoid any kinds of risk that could affect the safe liberation of our colleagues and the welfare of their families. At the moment of writing this article, we continue to try to find the right balance in every piece of information that we emit at local (Somali and Spain) and international level. We carry out a follow-up of all references in the media in order to help the process of liberation of our companions.

In general, our capacity and willingness to explain the nutritional crisis in the Horn of Africa has been affected both In Spain and globally. With our management, however, we publicly demonstrated our commitment to providing vital medical attention to the Somali population in Somalia, Kenya and Ethiopia, even after the tragic deaths of two other MSF members in Mogadiscio.

In Syria the natural reaction, which was to denounce the situation, was challenged by the operational imperatives of security and access. The dilemma between speaking and maintaining silence due to these issues dominated the debates within the very heart of the organisation, with varying operational focuses and communicative points of view. Finally, it was decided to employ low density public communications until the change in 2012. The debate surrounding communication in Syria reflects the differing perspectives within the MSF, the fragmented analysis of the context, and the need to square up our public position in the field.

Campaigns and media coverage

In 2011 we launched three innovative communication campaigns directed at various national and international public sectors which brought us a great deal of notoriety. They were the 40th anniversary of the MSF (identity), “Positive Generation” (HIV/AIDS), and a new impetus for “*Pastillas Contra el Dolor Ajeno*” (Pills for Other People’s Pain) with the “Scream” campaign. These were three strong messages that had a great impact in terms of visibility and awareness. The MSF rose from third to first place in NGO notoriety in Spain, and our coverage by the media increased 18% (two thirds of which was centred on operational medical themes). We also had positive results with respect to key media especially with informative sessions. Our message was rich in operational context, the populations that benefited, and close-ups of staff working in the field with, for example, the documentary “Positive Generation”.

The launching of these three impacting campaigns was the reason for the postponement of another communication initiative centred on MSF response to victims of violence, conflicts and wars. This campaign will be a priority n 2012 and with it we hope to give more importance to the forgotten crises and our work in the Near East, Somali, Darfur, Yemen and Pakistan.

Opening the debate on the perspectives, dilemmas and failures of our interventions, and looking for proximity, awareness and support from society, we have published articles of opinion in key communication media about diverse themes (the two years after the earthquake in Haiti, the 40th anniversary of the MSF, HIV and the World Fund, Libya etc.). In addition, with the campaign “Hungry for Attention”, at grassroots level and on-line, we have provided strong support for the MSF global efforts to make this issue better known. We obtained almost half of all the signatures in the world, thus demonstrating the enormous potential for social mobilisation in Spain. In a parallel manner, we developed actions to improve public acceptance and perception of the MSF at a regional level in those places where we carry out our projects. This was the case in Sudan (Darfur), Somalia, Ethiopia, the Central African Republic, Yemen, Iraq, Columbia and Nigeria. And we continue in the field to work at making the population aware of malaria and sleeping sickness. However, accepting public positions and our capacity to have an influence

were once again the weakest points of our organisation. Yet there were a number of achievements – the press release concerning If0 2; the communication about Chagas disease/benznidazole which led to an immediate reaction from the Brazilian authorities; and the use of "Positive Generation" to transmit messages about HIV to the authorities in Zimbabwe. Nevertheless, overall we need to improve our analysis and positioning capacity for operational and key medical issues.

Internet and social networks

During 2011 we put greater effort into the social networks. We produced and hung more audiovisual material on our webpage, Facebook and YouTube, we announced news and campaigns on Twitter, and we managed a number of blogs from the field. The increase in our presence on the social networks (52% more on Facebook, 388% more on Twitter – with over 120,000 followers, a figure only surpassed by the MSF United States section – and 37% more on YouTube) has meant that we now lead the NGO social network ranking in Spain. Internet is changing from being a mere channel of diffusion to a medium for the generation of content, opinion forming and social mobilisation. As a consequence, we need to rethink and redefine our way of communication.

Fragmented but linked, public opinion (even whilst being already overloaded with messages) seeks information, references and more control. The appearance of Twitter as an alternative to live news has forced us to simplify our messages to 140 letters. Facebook as a source of updating and social exchange has made us adapt our language and produce greater audiovisual content. The new reality within the world of web pages and social networks requires different commitments given the two-way nature of its communication. On one hand, investment in training and the creation of contents, resources and follow-up are required. On the other hand, and more importantly, a certain loss of control must be assumed as the users become the content generators, in the same way as journalists and opinion leaders, which increases their communication control.

The opportunities for the MSF to gain more public and have greater influence through the social networks are infinite. In the era of a participative culture, our actions of politics and citizenship should connect field work with communication campaigns which can mobilise civil society and contribute to positive changes for the populations we aid, people suffering from malnutrition, HIV, tuberculosis, forgotten diseases, displacements and conflicts. In 210 our sole Twitter message for Haiti, when we asked the United States to let MSF planes with aid supplies land in Port au Prince[53], was the strongest Tweet that year according to Twitter and showed us the way to take.

In times of crisis we should be especially reinforcing our visibility, influence and credibility in Spanish society, and making a strong commitment to interact with it. We must improve analysis and reflection about how we take public stands and our political and citizenship actions. We should maintain leadership in Latin America whilst looking for Spain-speaking public from all over the world. It is of great importance to develop our image on-line and thus capitalise our new opportunities. Our future communication should be an amalgam, linking field work and society, influencing public opinion in areas where we intervene, and creating spaces which make possible involvement in our global initiatives to create and share messages, mobilising more people in favour of the populations we aid and the calls to action we carry out.

[53] @usairforcefind a way to let Doctors without Borders planes land in Haiti: http://bit.ly/8hYZOK.


MEDICOS
SIN FRONTERAS