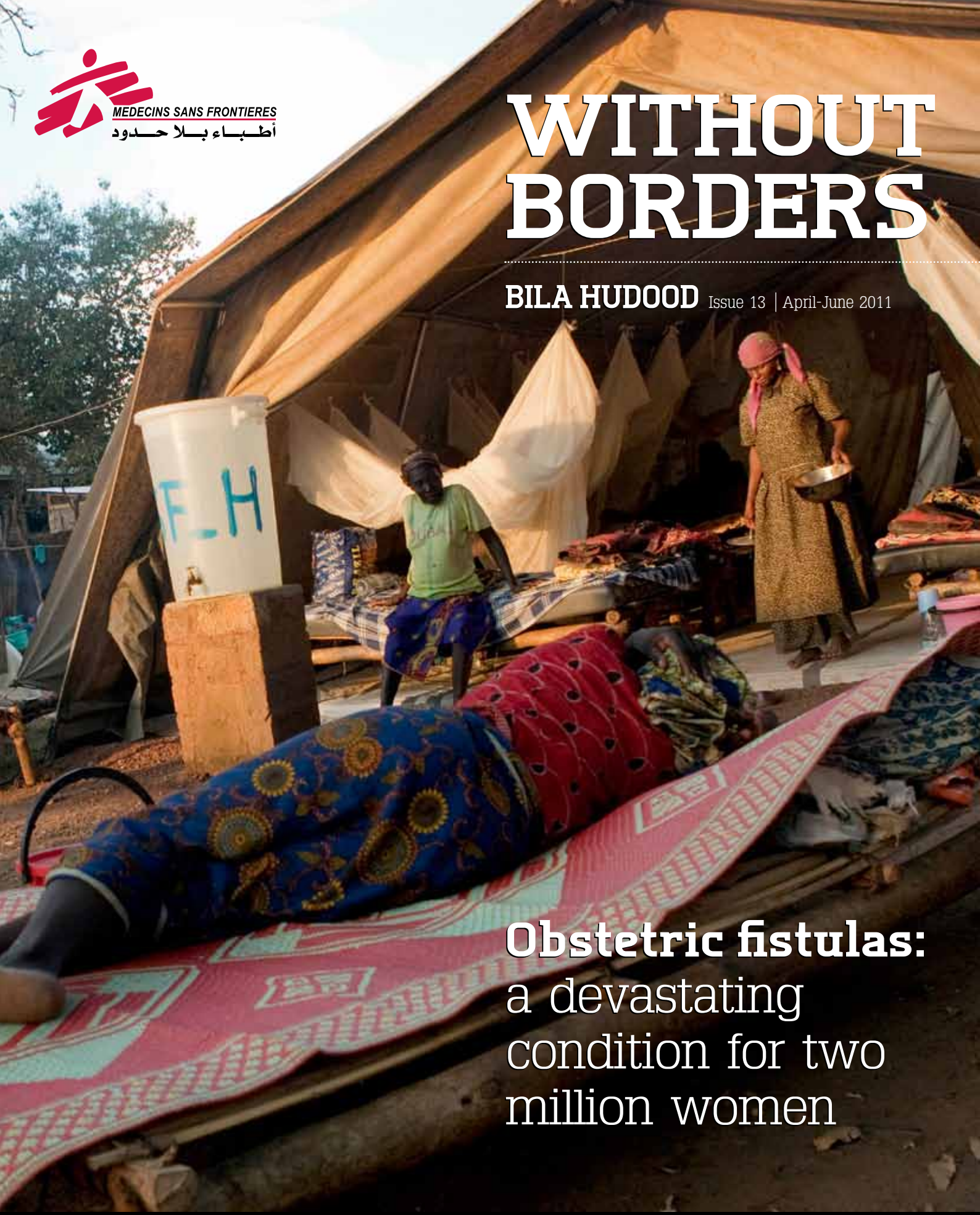
MEDECINS SANS FRONTIERES
أطباء بلا حدود

WITHOUT BORDERS

BILA HUDOOD Issue 13 | April-June 2011



Obstetric fistulas: a devastating condition for two million women

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All parties should respect access to patients

The Arab world has been wracked by civil unrest and violence since the beginning of the year. What started off as a genuine expression of despair and protest in the Arab streets of Tunis and Cairo has since catapulted into a violent struggle for control in the streets of Tripoli and Manama.

MSF, like the rest of the world, has been caught unaware by these developments in the region. In a fast-evolving context, MSF has been quick to react but is finding it hard to access populations that need health care. MSF teams have been supplying and assisting hospitals and health structures where medical staff is facing a marked increase in the numbers of injured people. Teams are also assisting people who are fleeing to neighbouring countries.

In Libya, as the conflict intensifies, MSF is seeking to scale up its assistance by reinforcing its team on the ground, sending additional medical supplies, and facilitating the evacuation of wounded and sick patients to safe treatment areas. Despite several appeals and ongoing negotiations with the authorities, MSF has been denied access to the western part of Libya on the grounds that there are no medical needs. However, the situation in Misrata is reported to be critical, while medical facilities in other cities are also said to be overstretched.

Following medical ethics and international humanitarian law, it is crucial that all parties respect medical facilities, vehicles and personnel, as it is the only way patients will receive the urgent medical care they need. MSF calls for respect of unrestricted access by health professionals to provide health care to the sick and wounded in secure and safe health facilities. MSF also requests the authorities to allow safe and unfettered access of humanitarian agencies to people living in areas affected by the conflict.

What is MSF?

Founded in 1971 by doctors and journalists, Médecins Sans Frontières (MSF) / Doctors Without Borders is an international medical humanitarian organisation.

MSF is neutral and impartial, delivering emergency medical care to people caught in crisis regardless of race, religion, or political affiliation.

MSF is independent from any political, economic or religious power. Ninety percent of MSF's overall funding comes from private sources, not governments.

MSF is transparent and accountable. Every year, MSF provides detailed activity and financial reports including audited and certified accounts.

MSF controls the entire chain of its medical services, from the independent assessment of needs to the delivery of medical care, and does not subcontract to other organizations.

In 1999, MSF received the Nobel Peace Prize

In 2002, MSF received the Emirates Health Foundation Prize

In 2004, MSF received the King Hussein Humanitarian Leadership Prize

MSF in numbers

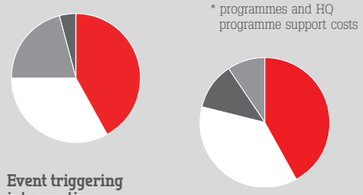
Income

- Private 86%
- Public institutional 12%
- Other 2%

How was the money spent?

- Operations 80%*
- Fundraising 14%
- Management, general and administration 6%

* programmes and HQ programme support costs



Event triggering intervention

- Armed conflict 37.6%
- Epidemic/endemic disease 31.2%
- Social violence/ healthcare exclusion 24%
- Natural disaster 7.2%

Project locations

- Africa 42.1%
- Asia 36.8%
- Americas 11.8%
- Europe 9.2%

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Front cover: (c) Sarah Elliott for MSF A woman rests in MSF's fistula camp, Boguila, CAR

MSF has been in the UAE since 1992 under the patronage of His Excellency Sheikh Nahyan Bin Mubarak Al Nahyan.

Middle East and North Africa unrest: MSF responds to medical needs

© Jehan Bseiso/ Libyan medical personnel and volunteers work together with MSF teams in Benghazi to organize tons of MSF medicine and medical materials including surgical sets, burn kits and antibiotics ready to dispatch to health facilities that need them.

As civil unrest leads to violent clashes in a number of countries in the Middle Eastern and Mediterranean regions, emergency staff from MSF have been helping to fill gaps in the medical services for people injured in protests or conflict.

Libya

In Libya, MSF was able to assist the civilian population through the delivery of medical supplies with the first MSF team able to enter eastern Libya on 24 February. By mid-March, 33 tons of medical supplies had been made available. In addition, MSF teams of doctors and psychologists have been working at frontier points on the border to assist with the medical needs of migrants crossing the border, and small teams in Malta and the Italian island of Lampedusa are offering medical assistance, mainly through mobile clinics, to migrants who have crossed the Mediterranean.

On 3 April, MSF evacuated 71 patients by boat from the Libyan capital of Misrata, where ongoing violence had overwhelmed medical facilities with injured people. "We managed to dock at Misrata on Sunday afternoon, despite intense fighting in the city over the past few days" said Helmy Mekaoui, an MSF doctor who coordinated the medical evacuation. "The violence caused an influx of wounded people and it was fortunate we could be there and get them onboard". Among the evacuated patients were 3 people on life support, 11 people suffering from major trauma, and many others with abdominal wounds and open fractures. Intensive medical care was provided on board as the boat sailed to Tunisia.

However, security conditions are greatly affecting MSF's work in Libya with teams turned back from some areas and postponing their activities in others. MSF reiterates its call on all parties to allow unhindered access to medical assistance for all Libyans affected by the violence. MSF also calls for the respect of medical facilities, healthcare personnel, and vehicles transporting patients.

Other countries where tension is high

During the protests in Tahrir Square in Cairo, Egypt, MSF supplied medical materials to Egyptian doctors in two hospitals and in an improvised clinic in a mosque. The team also provided training in how to manage a high number of injured people in a short period of time, and helped set up additional emergency preparedness systems. In Tunisia, MSF donated orthopedic surgery equipment to two hospitals in the south.

In Bahrain, MSF is in contact with a number of medical facilities and ready to assist if needed. Earlier this year, an MSF assessment team made contact with medical organizations in the country, visiting Salmanya Hospital in the capital city of Manama to offer support.

Since the beginning of demonstrations in Yemen in January, MSF has been closely following the evolution of the situation and the regular medical activities of MSF in different areas of the country continue. At the time of writing, MSF was also following the situation in Syria where unrest had recently started in Daraa city.

MSF is an international medical humanitarian organization that delivers emergency aid to populations in distress. MSF's response is based solely on the humanitarian principles of neutrality, impartiality and independence and on the medical needs of patients.

Mozambique: HIV/AIDS, malaria and tuberculosis are widespread in Mozambique

© Niklas Bergstrand /The pharmacy at Lifidzi health centre, one of the health centres supported by MSF.

HIV/AIDS, malaria and tuberculosis are widespread in Mozambique. 15 per cent of people aged 15 to 49 are infected with HIV making it one of the worst affected countries in the world. Maternal mortality is high and diarrheal diseases are endemic. Furthermore, the national healthcare system was shattered during the 16 years of civil war that ended in 1992, as were most social and economic infrastructures.

All MSF projects in Mozambique are focused on HIV/AIDS treatment and care, including the prevention of mother-to-child transmission of the disease. In the capital Maputo, teams work in two districts, supporting two day-hospitals and nine health centers. Teams train staff, and provide psychosocial counseling for HIV-positive patients, including children. 18,000 patients are receiving antiretroviral therapy (ART).

MSF is developing and promoting innovative models to help meet the high demand for healthcare and is lobbying the government to introduce a 'task shifting' approach in hospitals to help to counter the shortage of doctors and nurses. This includes training local medical staff to prescribe ART drugs and administer repeat prescriptions, and permitting the use of lay counselors.

MSF is supporting the care and follow-up of HIV-positive patients in provincial hospitals in the northwest of the country and is providing technical support to health centers. In Tete city, following a decentralization of patient care from hospital to health center level, the project is now focused on training and supervision of Ministry of Health staff, with the view to handing back the project.

During 2009, MSF carried out 240,500 consultations and provided ART to 25,500 patients.

A look back at 10 years of HIV projects: an MSF special report

In the late 1990s, the introduction of antiretroviral (ARV) treatment transformed AIDS from a death sentence to a chronic lifelong disease. However, the extremely high cost of ARV drugs meant that treatment was restricted to people in richer parts of the world, and the millions of people suffering from the disease in places like Africa remained untreated.

National and international decision-makers actively refrained from embarking on the fight against HIV/AIDS, believing that an insufficient budget and a scarcity of both technical means and human resources would lead to inadequate HIV care and management. Their fear was that this would ultimately lead to the emergence of widespread drug-resistant strains of the virus, which would exacerbate an already dire situation.

MSF, determined that the plight of people with HIV/AIDS in African countries would not be ignored, has been working with HIV in Mozambique since 2001, where it has been helping the Ministry of Health develop a comprehensive plan for widespread provision of ARV treatment. During the first few years, around half of all patients on treatment were supported by MSF. MSF's objectives were to demonstrate that it was feasible to provide ARV services in low-resource settings, to explore possible modes of operation and to help create a national capacity for treating people with HIV/AIDS.

At the time, the organization of the Mozambican health system needed to be adapted to allow the development of comprehensive ARV treatment programs, in terms of human resources (both numbers and skills), laboratory capacity, technical means, and the overall management of HIV/AIDS. MSF has spent a total of 58 million euros on its HIV/AIDS activities in Mozambique since 2001, of which the majority comes from private funding.

The number of patients on treatment has risen dramatically over the last few years. At the end of August 2010, more than 200,000 patients were on ARV treatment in Mozambique, of whom more than 33,000 were being treated with the assistance of MSF.

The growing number of patients on treatment shows that the scale-up and provision of ARV treatment is indeed possible in a country like Mozambique.

MSF has helped to put HIV/AIDS firmly on the national health agenda and, along with the Ministry of Health, has developed innovative strategies for HIV care and management. MSF's report *A Look Back at 10 Years of HIV Projects* details MSF's work and achievements in Mozambique in the field of HIV/AIDS over the last ten years, as well as pointing to the challenges that lie ahead. A copy of this special report is available on MSF's website.

Patient story

'My name is Margarida. I live in a village outside the city of Tete, in northwest Mozambique. Other people know that I'm HIV-positive, but I'm not worried or ashamed of my disease. MSF encouraged me to help others with HIV. I am now the leader of one of MSF's HIV patient groups. My role is to collect medication at the health center and distribute it to the others in the group. Before, each member used to pay one hundred meticals (US$3.40) to travel back and forth to the health center. Now, each member pays me seven meticals ($0.24) to support my travel, and I bring the medication to their house. The patients in the group appreciate this, because many don't have enough money to travel to the health center.

It's great to be able to help others to take care of their illness. I'm taking medication but I am healthy and working like other people. I want other HIV-positive people to join me and enjoy life.'

© Niklas Bergstrand
In Tete province, MSF is pioneering a model of HIV patient groups, where a designated group leader is responsible for collecting medicine at the health centre. The leader will then bring the medicine back to the other members of the group. In this way, both patient travelling costs and time are reduced. The number of consultations at the health centre is also reduced, alleviating some of the burden on the health services. Margarida is one of the patient group leaders. Her group members pool together money for her to cover travel costs.

© Gaël Turin/VU. New Yourpea Refugee Transit Camp, Nimba district, Liberia, at the border with Ivory Coast. Ivorian refugees who stayed for days or even weeks in some Liberian villages are gathered in this transit camp before going to the Bahn Refugee camp, set up by UNHCR for 15,000 people. The truck is arriving with 80 people coming from three villages of the Nimba district. They will stay at least two days at the transit camp before joining the Bahn Refugee Camp. The vast majority of refugees is staying with host families, scattered in more than 70 different villages of the Nimba district, which is also putting pressure on the local communities and their access to basic services such as water, food and medical care. MSF is currently providing medical assistance to the refugees and local population by organizing mobile clinics in several locations of the district.

Ivory Coast

marked deterioration of situation

MSF has expressed concern over the deteriorating situation in the west of Ivory Coast and the border region with Liberia where increasingly intense armed confrontations together with political gridlock, have had serious consequences on the country's population. MSF has asked all parties to the conflict to allow its medical teams to care for patients, regardless of their affiliations.

Fighting has led to new displacements of people in the capital, Abidjan, and in the western region of the country. Insecurity and shortages of medicine resulting from international sanctions have made it very difficult for victims of violence—and all those in need—to obtain care.

"In this context of difficult access to care and population displacement, our teams must be able to reach people, particularly so that they can conduct epidemiological monitoring," said MSF Emergency Coordinator, Renzo Fricke.

Since December, MSF teams have been working in Liberia and western Ivory Coast, providing primary health care in facilities abandoned by healthcare staff and lacking in medicines. The recent resumption of fighting has further worsened the situation for the population.

MSF teams in Ivory Coast are providing care to displaced persons and residents in the cities of Duékoué and Guiglo, and, at the time of writing, were preparing to provide care in Bangolo and Zouan-Hounien. However, instability makes it difficult to access the displaced populations, particularly in areas close to the front line.

Armed conflict is not the only obstacle to treatment. Commercial and financial sanctions imposed by the international community against Ivory Coast, coupled with transportation problems, have led to shortages in medicines and medical supplies.

*MSF opened its first project in **Ivory Coast** in 1991. Until 2007, MSF teams were working in MACA prison in Abidjan, in the hospital of Bouaké city, and in the western regions in the hospitals of Danané, Man, Bangolo, and Zouan Hounien. The teams conducted primary and secondary healthcare activities as well pediatric and obstetric care. During the crisis period, MSF also provided surgical treatment to wounded people, ran a nutrition project and an integrated HIV/AIDS and tuberculosis treatment program. MSF withdrew in September 2007, when the situation in the country had stabilized.*

*MSF has worked in **Liberia** since 1990. In June 2010, MSF transferred the last of its hospital-based health care projects to local authorities. MSF continues its work in the capital of Monrovia, supporting the Ministry of Health and Social Welfare with the medical needs of victims of sexual violence.*

Kenya

launch of a new vaccine for resource-challenged countries

A vaccine to protect children against pneumococcal diseases—such as meningitis and pneumonia—has been launched in Africa as part of an international program to bring the vaccine to resource-challenged countries. Kenya is the first African country to receive it, and MSF is contributing to this national effort by starting to vaccinate children in its Kenyan projects.

For more than a decade, infants in wealthy countries have benefitted from a pneumococcal vaccine, and two improved versions were introduced in Europe and the U.S. in 2009 and 2010. Now, children in developing countries will finally have access to this newest generation of vaccine.

But a look at the financing mechanism to support this program, called the Pneumococcal Advance Market Commitment (AMC), reveals that two multinational pharmaceutical companies—GlaxoSmithKline (GSK) and Pfizer/Wyeth—are receiving a significant payout as part of the scheme: the companies have each agreed to sell 30 million doses annually for ten years in exchange for US$10.50 per child vaccinated, plus a total "subsidy" of $225 million for each company.

Even before the subsidy, compared to other routine vaccines, this one is priced beyond what most developing countries can afford. The high price is contributing to financial woes at GAVI (Global Alliance for Vaccines and Immunization), which helps developing countries pay for new vaccines, but is also of great concern for the many developing countries that need to pay for the vaccine themselves.

"It's great news that children in developing countries will finally be protected against pneumococcal diseases by getting this new vaccine," said Dr. Tido von Schoen-Angerer, executive director of MSF's Campaign for Access to Essential Medicines. "But it's very disappointing that the prices agreed with two big pharma companies will be too high for countries to afford when donor support is not, or is no longer, available. Prices need to come down so that as many children as possible can benefit from this vaccine."

As we celebrate the introduction of the pneumococcal vaccine in Africa, MSF is advocating for efforts to find long-term pricing solutions for vaccines so countries can continue to afford and implement improved vaccination coverage, even independent of donor support.

"Pneumonia is a primary morbidity for young children in Dagahaley Camp where we provide health services to Somali refugees and we are excited about adding this vaccine. During our conversations with the Ministry of Health about the roll-out, the plans for continuing to use it in the rest of the country after the GAVI supply were unclear though, and we are concerned about whether Kenya will be able to purchase it. We plan to continue emphasising the importance of keeping it in the vaccine schedule."

—Dr. Nitya Uday Raj, Medical Coordinator for MSF in Kenya

Democratic Republic of Congo

measles epidemic spiralling out of control

MSF is raising the alarm and calling for concerted action to halt the spread of a measles epidemic which has been sweeping through the Democratic Republic of Congo (DRC).

"The measles epidemic is spiralling out of control," says Gaël Hankenne, MSF head of Mission in the DRC. "Since September 2010 we have vaccinated more than 1.5 million children in response to the crisis. But the disease is spreading like wildfire. All parties involved in health in the DRC must now make this epidemic a national priority."

Over the past months MSF has provided a complete emergency response (treatment, vaccination and epidemiology) in Katanga, Kasaï Occidental and South-Kivu, but new outbreaks have flared up in Bandundu, Kasaï Oriental and Maniema provinces and the epidemic is moving north fast.

The treatment and vaccination needs are huge and the requirements in terms of human resources, finances and logistical capacity mean that MSF cannot be the only organization providing a hands-on response throughout the entire country. "We are asking the Ministry of Health to launch a response immediately to outbreaks that occur in the other provinces or in any new health zone that is affected," said Geza Harzi, MSF Head of Mission in Katanga. "At the same time, we are asking international donors and institutions, and health organizations with activities in the DRC – particularly UN agencies (such as the WHO and UNICEF) and NGOs – to take action immediately. If this international response is not rapid, it will be impossible to check the spread of measles in the DRC."

Measles is an extremely contagious disease that can cause medical complications such as pneumonia, malnutrition, severe dehydration, ear infections and eye infections that can lead to blindness. Mortality rates vary considerably depending on the context. When a population has not been vaccinated, measles can kill between 1 and 15 percent of afflicted children. The mortality rate can rise to 25 percent if people have limited access to health care, as is the case in many health zones in the DRC.

MSF is expanding its emergency response in three provinces: Tshikapa in Kasaï Occidental province, at Fizi in South-Kivu province and at Kolwezi and Likasi in Katanga province. More than a million children will be protected by these emergency vaccinations. "Since September 2010 we have counted more than 21,000 measles cases in the DRC," says MSF's Gaël Hankenne. "Concerted action needs to happen right now."

© Northan Hurtado/MSF. Measles vaccination campaign, Democratic Republic of Congo

Japan

MSF working in isolated communities

Following the earthquake and resulting tsunamis that hit northeast Japan in March, MSF teams have been assessing needs and offering medical assistance in isolated areas of need. With the Japanese authorities devoting enormous resources to the relief operation that began as soon as the tsunami receded, MSF's work has been limited, but ongoing. "We are not looking at a very big intervention like in Haiti, Pakistan or in Indonesia for example," said Eric Ouannes, MSF Tokyo General Director. "But in front of such a disaster, even the most organized groups have difficulties to reach some areas," he said.

As access improved to the most affected region MSF found serious needs among pockets of populations in areas that had previously been impossible to reach by road. MSF personnel were divided into three teams conducting mobile clinics and assessments in Miyagi prefecture.

Although injured people had been evacuated by helicopter, there were a lot of elderly people, some of whom were dehydrated, according to Mikiko Dotsu, the coordinator of the MSF team.

"The chronic diseases of some of these elderly people are a cause for concern," MSF is now identifying specific needs - which include oxygen, non-food items, medical items and water - and will work with Japanese authorities to assist these populations. MSF ordered 25,000 blankets from its supply base in Dubai and at the time of writing, more MSF personnel staff were standing by in Japan and other countries, to head to Miyagi prefecture.

© Yozo Kawabe/MSF. MSF doctor Yoshitaka Nakagawa consults with a patient in Kesennuma.

Obstetric fistula

© Martina Bacigalupo/VU
Opening of an MSF fistula facility

Obstetric fistula affects two million women worldwide, mostly in Africa, and can be a cause of great shame. MSF is working to improve the treatment of this condition.

"The sun should not rise or set twice on a woman in labour." Despite this proverb, endless labours before delivery are legion in Africa, where a majority of women give birth at home. When they finally come to the hospital, it is often not only too late for the newborn, but sometimes for the mother.

Among women who survive this ordeal, many emerge infirm. Obstetric fistula is one of the most serious consequences of obstructed labour and occurs when the soft tissues of the pelvis are compressed by the baby's head. The lack of blood flow causes the tissues to die, creating a hole between the vagina and bladder, the vagina and rectum, or both. It results in urinary and/or faecal incontinence. Women with fistula live in shame and are often rejected by their own families and communities.

An estimated two million women live with fistula worldwide, most in Africa. This problem is largely hidden because it often affects young women who live in poor and remote areas, with very limited to no access to maternal health care. Women affected are like Zanaba, 16, a patient treated by MSF last year in the Central African Republic (CAR). At the end of her pregnancy, and after three days of intense pain, her mother went looking for a traditional birth attendant.

On the seventh day, Zanaba was brought to the nearest hospital after travelling the entire day on a motorcycle. When she arrived, the baby had already died. The young mother was saved but the prolonged, obstructed labour caused a fistula, which required a second surgery. "I did not know that fistulas exist and how they can occur. But I am glad that I receive the operation," she said.

Improve access to obstetrical care

Fistulas are largely preventable and have disappeared in developed countries where there is universal access to obstetric care.

The operation to close a fistula is delicate and requires specific skills. Depending on the severity of the case, the operation may take several hours. In order to operate on fistula, a long and specific training is needed and there is only a few specialised centres in Africa.

Treating fistulas far exceeds the surgical aspect. Because of the flow of urine and faeces, affected women can develop multiple infections or skin diseases. Following childbirth, they may also have difficulty walking and, because of their exclusion, they are likely to suffer from malnutrition. After surgery, in case of residual incontinence, patients often require physiotherapeutic rehabilitation. Psychosocial care is also needed in order to reintegrate the affected women into their communities.

Three permanent centres in Burundi, Chad and Nigeria

Today, MSF treats obstetric fistula in three permanent centres in Burundi, Chad and Nigeria.

The latest location to open its doors is the Urumuri centre, backed by the regional hospital in Gitega, in the heart of Burundi, and opened its doors in July 2010. This is the first centre specialising in fistula in Burundi, able to treat women seven days a week and MSF has built four houses to accommodate the patients before surgery and during rehabilitation.

"This kind of project ensures a better monitoring of patients and it is possible to do research to improve treatment," said Geert Morren, surgeon and fistula specialist at MSF in Brussels and who operated on many of the women in Gitega. "The objective is to operate on 350 women per year over three years. This time frame should allow us to train three Burundi surgeons and to transfer our activities to the Ministry of Health."

In Burundi, in addition to the specialised centre in Gitega, MSF built a maternity unit in another region of the country. The plan is to prevent the occurrence of fistulas by improving the obstetrical care available in Burundi.

In Abeche, eastern Chad, the project "butterfly" started in 2008. The butterfly symbolises the transformation of women who lived secluded lives and can begin a fresh start after their operation. In 2009, MSF built a "village of women" to accommodate patients with fistula during their weeks long stay. During the first consultations, a preoperative evaluation is done to screen malnutrition cases that will be taken care of before the surgical intervention. After their operation, counselling and rehabilitation sessions allow them to regain a place in society.

MSF works with a Chadian surgeon, Dr. Valentin Valandi, who graduated in Dakar, is specialising himself in fistulas thanks to the visit of international experts. "Each case is different, I learn every day," he said. "In Chad, too many women have already been operated upon inappropriately, which further complicates the procedure."

In Abeche, MSF also supports the regional maternity hospital, next to its "butterfly" centre. The objective is to improve obstetric care in order to prevent new cases of fistula occurring because of poor management of difficult deliveries.

In Nigeria, finally, MSF works with the staff of the Ministry of Health at a hospital in Jahun in the north of the country. The teams provide obstetric and neonatal care to the local population. The objective is not only to reduce maternal and infant mortality but also to prevent and treat fistula. In 2010, the MSF team carried out 400 fistula repair surgeries. Upon discharge from the hospital, women receive six months of outpatient follow-up care to ensure the fistula has healed and that continence is maintained.

In 2010, MSF teams operated and treated about 1000 women suffering from obstetric fistula.

This story is continued in the photo essay on page 13

© Claude Mahoudeau/MSF
In the "women's village" of a fistula camp where the women and their care takers stay during the surgical fistula session. Post operation period can last 6 weeks.

Sudan: insecurity remains a reality

With almost 99 percent of the Southern Sudanese population voting for secession from North Sudan, the newest country of the world is expected to become officially independent in July 2011. But at such a pivotal time and amidst the hope for a better future, the humanitarian situation in Southern Sudan remains precarious at best. Moses Chol Maper, a medical technician and the emergency coordinator for MSF in Southern Sudan, gives his perspective.

"There are big hopes now that the referendum for independence has taken place. Like most people here, I am happy with the result. I am from Lakes State and the civil war has been present almost my whole life. Now I am slightly optimistic. There are so many open questions however. Abyei, the oil-rich region disputed between the North and the South is still a tinderbox. If the peace agreement is broken, violence can escalate very quickly. Insecurity remains a reality and we have to be prepared for that.

"I have been working with MSF for almost 13 years, most of the time here in my home country. I know well the effects of instability, displacement, poverty and the lack of infrastructure. And now, in addition to that, many Southern Sudanese people who had fled the war to the North and neighbouring countries are now returning to places where there are not enough basic services, where the roads, if they exist, are bad, where there is no work, not enough schools and limited healthcare. According to figures from the UN, more than 190,000 people have returned between October 2010 and the end of January 2011.

"In terms of the medical sector, statistics are dramatic: it is estimated that 75 percent of people in Southern Sudan have no access to basic medical care. The few health centres or hospitals are just too far away and transportation is often too expensive and unaffordable to a population where 90 percent live on less than one US dollar per day. Moreover, during the rainy season, many regions are very hard to reach. I know of many patients who have come to our clinics after weeks or even months of being sick. The local authorities do not have enough resources and capacity to deliver the services and without organisations like MSF, the situation would be even worse.

"Far too many people in Southern Sudan die of diseases like diarrhoea or malaria. Many children and adults do not have enough to eat. When they have to flee from insecurity, they may not have safe drinking water, and are more vulnerable to diseases. Last year, our emergency team had to respond to a massive increase of malnutrition in Unity State. In 2010, we also experienced a very high prevalence of kala azar, a neglected, tropical disease that is in most cases deadly if not treated. We saw eight times the number of cases than in the previous year .

"'Without your help we would not be alive' – these are words I have heard from our patients several times. But our work will also be at risk if fighting increases, as we can only treat people who manage to get to our clinics or those we have the access to reach. The insecurity can make it impossible for many patients to get help. If violence increases, we will have to adapt our work accordingly. I hope we will still be able to help many people. In spite of all difficulties, I am very happy to work here and have the chance to contribute to improving the situation for some people."

MSF has been providing emergency medical-humanitarian assistance in Sudan since 1979. Currently, MSF runs 13 projects across 7 states of Southern Sudan, providing a range of services, including primary and secondary healthcare, responding to emergencies as they arise, nutritional support, reproductive health care, kala azar treatment, counselling services, surgery, paediatric and obstetric care.

© MSF. Moses Chol Maper at work in an MSF project.

MSF's mental health programmes

© Dina Debbas. Hala Yahfoufi psychologist at MSF during a session with Amira. Amira has already had 17 therapy sessions. She suffers from loss of identity. She has been waiting for 15 years to see a therapist because of the cost as well as the stigma associated with mental health . PRCS Haifa Hospital in Burj el-Barajneh Palestinian refugee camp in the southern suburbs of Beirut, Lebanon

In one year, in programmes and projects around the world, MSF provided 109,755 individual mental health consultations and 7, 895 counselling or support group sessions. Here, we take a closer look at one of MSF's mental health programmes, this one being run for vulnerable Palestinian refugees living in and around Burj el-Barajneh camp in southern Beirut.

The programme in and around the Burj el-Barajneh camp has been running since 2008, during which time, more than 1,000 people have received more than 8,000 consultations. The programme is based on a community approach which brings together psychiatric and psychological care with social and community support.

"MSF always tries to set up a community-based and multi-disciplinary approach," says Pierre Bastin, MSF's mental health advisor in Geneva. "This means that we do not limit ourselves to prescribing drugs, but try to provide comprehensive bio-psycho-social care. We like using this model. As the factors behind the illness are of a biological, psychological, and social nature, so the treatment must also address these three issues. In practical terms, this means that the biological factor will be treated with drugs by the psychiatrist, and the psychological aspect will be treated by the psychologist working with the patient and possibly relatives. As for the social side, there are also social conditions that must be addressed to help the patient improve."

Good mental health is the cornerstone of individual and communal well-being. MSF's medical teams offer care and social support through home visits as well as consultations in its consultation rooms and clinic. Visits to the specialized mental health clinic are increasing, while MSF also ensures that mental healthcare forms part of the primary health care on offer in medical facilities throughout the camp. This approach is helping to spread the idea that good mental health is an essential part of general physical health because of its influence on the way people behave, perceive the world, and interact with others.

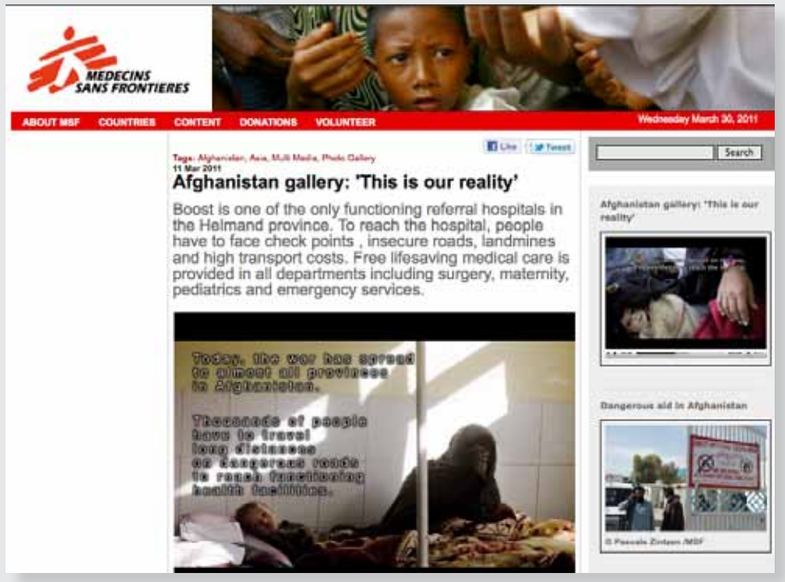
© Dina Debbas. Mahmoud Abou Hamdi social worker and Roula Sharkieh health promoter at MSF, presenting MSF and their activities in the camps to Cheikh Mohammad Afif Abou Hassan, Burj el-Barajneh Palestinian refugee camp in the southern suburbs of Beirut, Lebanon

www.msf-me.org

Afghanistan: "This is our reality", is an MSF slideshow featuring testimonies of Boost hospital patients and caregivers.

In Afghanistan today, the war has spread to almost all provinces. Thousands of people have to travel long distances on dangerous roads to reach functioning health facilities. In 2009 MSF started working in Boost hospital in Lashkar Gah, the capital of Helmand province. It restored the 145-bed Boost hospital into a functioning referral, weapon-free hospital, one of only two for the whole of southern Helmand. Around 1200 patients are treated monthly.

In "This is our Reality", patients tell us how it is for them living in Afghanistan today, and especially the challenges of accessing healthcare in a war-torn country. This moving account of their lives is available for viewing at www.msf-me.org



© Kate Holt. A grandmother feeds her malnourished grandson, after his mother died, in the Therapeutic Feeding Centre, where MSF works alongside hospital staff to provide free medical care in Boost Hospital, Lashkar Gah, Helmand. After nearly ten years of war in Helmand, thousands of people are unable to access healthcare, having to travel long distance along dangerous roads to reach Boost, the only functioning referral hospital in the province.

EUROPE! HANDS OFF OUR MEDICINE

Millions of people in developing countries rely on affordable generic medicines produced in countries like India to stay alive. But the European Commission is pushing aggressive policies that will severely restrict people's access to these life-saving medicines. The attack is taking a number of different forms – free trade agreements, international treaties, customs regulations. If Europe succeeds, millions of people across the developing world could see their source of affordable medicines dry up, as generic companies will no longer have the space to produce or sell them.

"Europe! Hands Off Our Medicine" is MSF's campaign to push Europe to back down.

"We depend on access to affordable generic medicines like those produced in India to treat all kinds of diseases. We buy 80% of our AIDS medicines from India - medicines that keep 160,000 people alive today," said Dr. Unni Karunakara, President of MSF's International Council.

"On their behalf, we cannot remain silent as Europe works to close the door on every aspect of drug supply – the production of a generic medicine, its registration, and its transportation to patients in other parts of the world. So today we are launching a campaign demanding 'Europe! HANDS OFF our medicine."

"What the Europeans are doing is effectively snatching the medicines out of our hands," said Dr. Marius Müller, MSF's Medical Coordinator in Kenya. "Because generic medicines are more affordable, we have been able to put more and more patients on AIDS medicines. This has meant a lot of hope for our patients who can work again, who can bring up their children again. But if Europe has its way and shuts off this source, we risk killing the success of what has been achieved here in the last five years."

For more information on this campaign, including actions for you to take, please visit our website www.msf-me.org

MSF fistula camp in Boguila, Central African Republic

Approximately two million women in Africa have a fistula, which is a hole between the vagina and the bladder or rectum, through which urine or faeces leak continuously. Fistulas can be caused by prolonged obstructed labour and childbirth or sexual violence in addition to lack of medical facilities. Women with fistulas are often outcasts from their communities because of the smell associated with the leaking of urine/faeces, and in some cases they are abandoned by their husbands. Chances for women to have their fistula repaired are slim, as many hospitals or health clinics do not have the proper instruments or knowledge and skills to carry out such a procedure.

مخيم تابع لمنظمة أطباء بلا حدود لعلاج الناسور في بوغيلا، جمهورية أفريقيا الوسطى

تعاني ما يقدر بمليوني امرأة من الناسور في أفريقيا، وهو عبارة عن فجوة بين المهبل والمثانة، والمهبل والشرج، أو في كليهما، ويؤدي ذلك إلى سلس البول و/أو التغوط. ويعود وجود الناسور لولادة متعسرة طويلة والولادة أو العنف الجنسي فضلا عن الحرمان من الرعاية الصحية.

وتعيش النساء المصابات بالناسور في العار وغالبا ما يتم نبذهن من قبل أسرهن ومجتمعاتهن المحلية بسبب الرائحة المرتبطة بتسرب البول/التغوط، وفي بعض الحالات، يتخلى أزواجهن عنهن. وتعد فرص شفاء النساء من الناسور ضئيلة، حيث أن العديد من المستشفيات أو العيادات الصحية لا تملك الوسائل المناسبة أو المعارف والمهارات اللازمة لإجراء مثل هذه العملية.

MSF midwife Sigrid Kopp sits with a fistula patient to make sure she drinks enough water. Patients must drink large amounts of water before and after surgery so that their urine is not concentrated.

تجلس سيغريد كوب، وهي قابلة تابعة لمنظمة أطباء بلا حدود، مع مريضة مصابة بالناسور للتأكد من أنها تشرب كمية كافية من الماء. يجب على المريضة أن تشرب كميات كبيرة من الماء قبل الجراحة وبعدها بحيث لا يكون بولهن مركزاً.

أول شيء تقوم به المريضة في الصباح هو إفراغ الدلاء الذي يحتوي على البول وغسله.

First thing in the morning, fistula patients empty and rinse the buckets which hold their urine.

تمشي إستير فيبوكو رفقة ابنتها أبيغيل إيستر فيبوكو البالغة من العمر سنتين وكانت إستير قد حملت أربعة مرات. وقد توفي أحد أطفالها بعد وقت قصير من الولادة، في حين يبلغ أطفالها الثلاثة المتبقين عامين وستة وأربعة أعوام. وقد أصيبت إستير بالناسور في عام ٢٠٠٨ إذ أنّ المخاض دام ١٢ ساعة لدى إنجابها ابنتها أبيغيل.

A fistula patient walks with her two-year-old daughter. This woman has had four pregnancies. One child died soon after birth, and her three remaining children are six, four and two years old. She developed a fistula after being in labour for 12 hours.

امرأة تستريح في مخيم منظمة أطباء بلا حدود لعلاج الناسور.

A woman rests in MSF's fistula camp.