



MSF
Activity Report
2002-2003

MSF >>>

The Médecins Sans Frontières Charter

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

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

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

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

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

Activity Report

2002 >>> 2003



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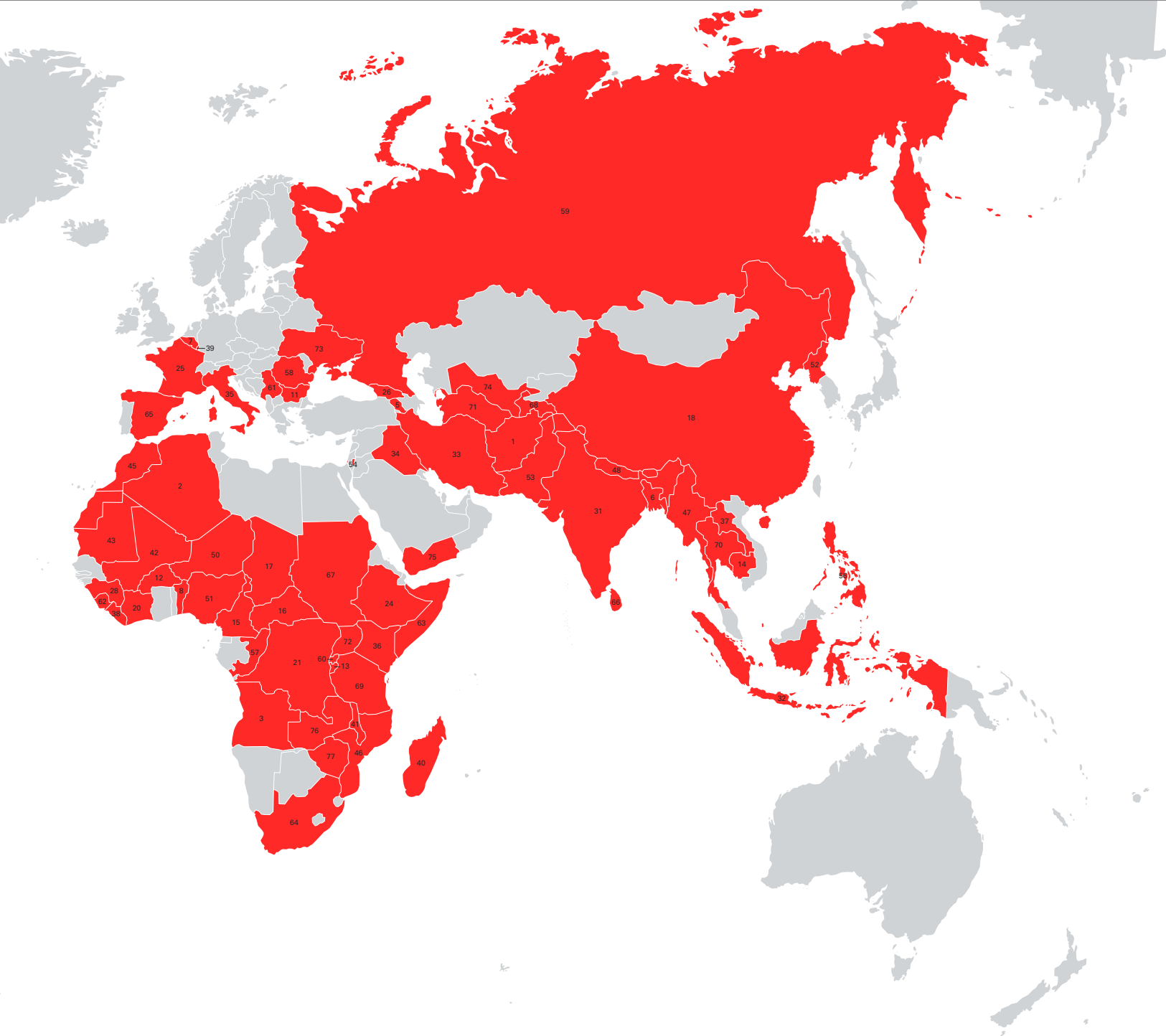


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The year in review

When the families in Maimu camp in Liberia hastily packed their belongings in August this year, it was their fourth time fleeing the devastating civil war that has consumed Liberia for more than a decade, with particular intensity the last three years. These families were not only escaping a combat zone, they were fleeing from violence directed specifically at them. They were trying to avoid being looted again, being raped again – or being killed.

Further south in the camps in Salala, the displaced families were also frightened. They were trying to decide what would be their “best” option: the risk of fleeing or the risk of staying. A cholera outbreak and increasing malnutrition made the situation even more desperate. They had been without food assistance for months.

Once more this year, we witnessed how civilians became deliberate targets of war in Liberia, and how control over the civilian population was one of the main objectives of combatants.

We have seen the same in Democratic Republic of the Congo (DRC), where in May in the city of Bunia (capital of the Ituri region in the northeast), civilians were deliberately raped and massacred. We have seen it in Afghanistan, Sudan, Colombia, Chechnya....

In many places where we are working, war is not just fighting with guns between rivals for power. It is a deliberate onslaught on civilians. It is rape of women and girls; it is all-out assault on the physical and emotional integrity of thousands and thousands of men, women and children.

Although it is not war or direct violence, sheer inaction in the face of disease emergencies – HIV/AIDS, malaria, sleeping sickness, to name only a few – is also causing millions of very violent deaths of each year.

The failure to respond immediately – or to respond at all – to crises borne of conflict and disease has led over time to a perception that they are normal. The longer the response takes, the more people are deceived by this notion of “normalcy,” and the more inertia prevails. As a result, we are tolerating the intolerable. Concerted action to protect civilians and treat their diseases has in so many cases been sorely lacking; it is as if governments and international actors are accepting as normal what is a terrifying, deadly, daily reality for so many people.

Humanitarian action is crucial to alleviate the suffering of those affected, and to point to those responsible for these crimes. Humanitarian action must constantly fly in the face of accepting the status quo. It must struggle against “normal” becoming either a criminal excuse used by governments to avoid real responsibility or a way to make millions of broken

lives palatable to donor countries and rich-country publics who would like to think they are “doing everything they can,” even as people halfway around the world die invisible, anonymous deaths that we would never consider normal in our own communities.

In DRC, 30km away from Bunia, across Lake Albert, or 100km down to the southeast in Beni or north in Mambasa, there are people who have survived unspeakable events this year and who are telling their stories, sometimes. But move beyond this, thousands of kilometres to the north in Europe, or across a continent and an ocean in the United States, or far to the east in Japan, the idea of what is happening in DRC has not even begun to take form. This lack of knowledge and interest was clear in Bunia itself, where since May MSF has been running a small hospital right next to a camp for displaced people. Between the end of May and the end of July, 20% of the patients admitted to our clinic in Bunia suffered from war wounds. One-third of the war-wounded were women. One-fourth of the war wounds were on children under five. Rape and sexual assault in the next-door camp were frequent reasons for visits to the MSF clinic. The same grim statistics remain as this report goes to press.

Again in the Great Lakes region there has been a clear absence of political will on the part of the government and international agencies, and on the part of the warring factions themselves, to protect and assist people in danger. This has spanned years of conflict and millions of deaths. Perhaps this hesitation is because the international community of states persists in seeing fighting in DRC as a “tribal” conflict. However, we feel that this is just another way of avoiding the responsibility to address it: the conflict has been perpetuated by the surrounding countries and needs to be addressed internationally and politically. While some response was offered to the fighting in eastern DRC in the face of the failure of UN peacekeeping battalion, with the deployment of a European force led by France and with an extended UN mandate to protect civilians, the action was essentially inadequate (the European force was on the ground only a few months with limited territorial reach). Many people, especially those in the countryside outside of Bunia, were left with no protection or assistance, while in the city of Bunia, security during the day turned to ongoing violence at night. It seems that the deployment of these forces was based more on the needs of the politicians than on those of the people needing protection.

Also insufficient was the response to the intense fighting in Liberia in spring 2003 that left 75% of the country inaccessible to humanitarian aid and hundreds of thousands of displaced



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Women and children with war wounds: normal? An MSF doctor cares for a small boy at a clinic in Bunia, Democratic Republic of the Congo, in June 2003. One-fourth of all those admitted with war wounds between May and July were children under five.

people crowding in and around Monrovia even as mortars and bullets were flying. This was simply a continuation of the international neglect of Liberia that has been the norm for the last decade or so. MSF teams worked during the height of the hostilities in Monrovia, providing care to civilians caught in the fighting.

Where we have seen an expressed interest in the well-being of civilians it has often been used to promote other goals, such as peace-building, nation-building and reconstruction. Yet these goals, however positive and worthy they may be in and of themselves, should be kept distinct from provision of humanitarian assistance. Unfortunately, we see exactly the opposite happening: politicians are using humanitarian language as a “rationale” or “cover” for war (Iraq); international agencies are incorporating humanitarian work into broader political goals such as peace-building and reconstruction (Angola, Afghanistan, Iraq). Distinctions between humanitarian and political goals are fading. In Liberia, UN peacekeepers continue to work closely with the UN’s humanitarian agencies. In Afghanistan, coalition forces are adopting a “humanitarian” agenda as a way to achieve military goals and extend the Afghan government’s reach. However, we believe that the very different roles and responsibilities of peace-enforcers and those charged with assisting civilians in an impartial fashion cannot be mixed. Confusion leads to increased insecurity for aid workers and decreased ability to provide independent aid to people who need it.

The humanitarian idea that must prevail is one of assistance

given according to needs alone. It is time to destroy the idea that humanitarian work should be used to build peace – or pacify a country – or establish democracy – or anything else, other than assist people who are in need regardless of their nationality, origin, skin color, political affiliation or religious belief. These other goals can be legitimate political goals, but they are based on political analysis and political commitment. Humanitarian action, on the other hand, is based only on an analysis of needs.

It is easy to confuse relief aid with humanitarian aid. Relief aid can be very valuable assistance, given to people in different contexts. However, when it is not given solely on the basis of needs and the principles of independence, neutrality and impartiality, it is not humanitarian aid. There has been much confusion about these two kinds of assistance during the recent war in Iraq.

In the run-up to the war in Iraq, the humanitarian idea was used by the belligerents as a justification for going to war and by opponents of the war as a justification for peace and pacifism. After the main hostilities ceased, we concluded that at that time there was no humanitarian crisis: no mass displacement of people, no epidemics, no famine. What we did see was an abrogation of responsibility on the part of the occupying power, the United States. The coalition did not plan any kind of emergency intervention for the post-war period; in terms of the health care sector, hospitals were looted, their management disintegrated, and the result was that many people who needed care could not get it. At the same time, humanitarian actors had great difficulty carving out a space for truly independent assistance in the country.

August

Arjan Erkel, MSF Head of Mission in Dagestan (a republic of the **Russian Federation**), is kidnapped. Over one year later, as this Activity Report goes to press, he is still missing

MSF begins medical aid to 15,000 people displaced by combat in Mayen Jur, Upper Nile, **Sudan**. Assistance continues until October

Nutritional surveys in Mavinga, **Angola** reveal continuing high levels of malnutrition; despite the country’s newfound peace, hunger and malnutrition continue to beset many Angolans



The bad consequences of this are clear. Security is a constant concern and has deteriorated enormously in Iraq, for Iraqis certainly, and for those trying to assist them. Security is compromised not only by local actors but by outside forces, as local and global interests vie for a stake in the future there. The bombings of UN headquarters there in August, and International Committee of the Red Cross (ICRC) headquarters in October, were heinous assaults on innocent civilians and show how continuing violence is severely limiting the ability of international agencies and humanitarian organizations to assist the Iraqi people. Statements on the part of officials in the US government (that if NGOs pull out of Iraq the “terrorists win”; or in Afghanistan that NGOs are “force multipliers”) only contribute to the vulnerability of organizations to attacks by associating them with the political agenda. Our own team in Iraq withdrew shortly after the ICRC bombing to evaluate the continuation of our work.

Far away from Iraq, in the North Caucasus, conditions for civilians are very difficult and humanitarian assistance is not easy to provide. Chechens living in Chechnya and displaced to neighboring Russian republics of Dagestan and Ingushetia live in an environment of terror and coercion. In Chechnya, conflict marks the daily lives of ordinary civilians; at the same time, independent witnesses are forced out because all actors, including the authorities, have created an environment of hostility, harassment, kidnapping and killing, where hundreds of people disappear, without a trace. The principal victims are Chechen; yet more and more, independent humanitarian aid workers cannot escape the terror and violence.

In August 2002, Arjan Erkel, MSF's Head of Mission in the North Caucasus, was kidnapped in Dagestan, where MSF was assisting displaced Chechens. Well over one year later, Arjan is still missing. MSF has worked tirelessly to secure his freedom. We have also repeatedly called on the Russian authorities to press their investigation into his kidnapping, which so far has been a complete failure. We believe they could be doing much more to find and free Arjan, and that it is their responsibility to do so immediately. In August 2003, the United Nations Security Council passed a resolution on the need to protect humanitarian workers. How can the Russian government vote for this resolution when it is not working sufficiently for Arjan's release? Is there a double-standard here for Security Council members and others?

Inaction by governments and international actors who could be putting pressure on Russia is slowly crushing Chechens in the region. Shouldn't we question the rationale of the Russian government which states that there is no reason for Chechens to be outside Chechnya because conditions are “normal” there? The fact that Arjan Erkel is still missing is really a symbol of the Russian government's success at glossing over what is really happening in Chechnya and selling it to the international community of states, which is all too happy to take refuge in its own inertia and give *carte blanche* to what is happening on the ground.

There are many other people who are equally ignored, and for whom inaction can be equally mortal. These people don't

die the “spectacular” deaths of violent combat. These are the people who die every day because of infectious diseases that are, in many cases, treatable. Nearly 15 million people each year succumb to infectious diseases, especially malaria, tuberculosis (TB) and HIV/AIDS. Curative treatments exist for malaria and TB; life-prolonging antiretroviral (ARV) therapy exists for HIV/AIDS. Why aren't these treatments being given to the millions of people who need them?

Out of the six million people with AIDS in developing countries who are so sick they need ARVs today in order to survive, only about 300,000 have access to treatment, and in Africa (where 29 of the world's 42 million infected people live) only 50,000. What about the others? Has this urgent situation become so big that we just cannot see it anymore for what it is – an emergency that deserves an emergency response? Until now a real emergency response, characterized by rapid reaction backed by sufficient commitment and money, has been an illusion. There is no generally accepted focus on treatment; even prevention policies often do no more than pay lip service to real action.

This lack of urgency in addressing the AIDS crisis has persisted for so long that it has become the status quo; it has become normal. The immediate desperation of millions of people, which should have prompted rapid action, has instead turned into fatalism and hopelessness. Millions of sick people are ready to give up because of our inaction. People with malaria do not fare much better: most of the hundreds of millions of people who get malaria every year don't have access to effective treatments, even though they exist. Is deliberately withholding life-saving medicine from someone who needs it any different from waging war on that person, or failing to protect him in times of conflict?

The AIDS crisis is probably one of the largest humanitarian catastrophes in human history, if measured by the number of affected people, the quality of their lives and the (unused) capacity we have to ease their suffering. In the face of this avoidable suffering, we must offer life-saving treatment to people most in need. Today we can only bear witness to the political vacuum surrounding this crisis. Neglecting treatment for people in need and failing to respond to this emergency should be considered nothing less than a criminal attitude.

Even MSF is not doing enough. We are providing ARV treatment to people in developing countries around the world, with over 10,000 people expected to be under treatment by the end of 2003. We are showing that treatment is possible in places where people are poor and where health infrastructure is not what we would always like it to be. From our experience, when ARV treatment is provided for free, people are as consistent in taking their medicine as people in richer corners of the world. The World Health Organization's goal of providing 3 million people in developing countries with antiretroviral treatment by the end of 2005 will need political commitment and money from donor countries and local governments in order to succeed. But we need to emphasize that 3 million by 2005 must begin with three, five, thirty, one hundred or one thousand patients today. We need to start now. MSF needs to do more to increase the number of people we are treating, and governments and other

August

- MSF starts a water and sanitation program in camps in the state of Jammu and Kashmir, **India**, for some 150,000 displaced people fleeing villages near the India-Pakistan border; work lasts until December 2002
- MSF issues a warning that Iranian authorities are unduly pressuring Afghan refugees in **Iran** to return to **Afghanistan**
- MSF and other organizations in **Kenya** lobby successfully for a new patent law allowing the import of affordable, good-quality generic medicines
- A malaria resistance study done in Kajo Keji, **Sudan**, reveals high levels of resistance to older malaria drugs; as a result, MSF introduces the highly effective artemisinin-containing combination therapy (ACT)





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Arjan Erkel: at the time of going to press, he has been missing one year and counting. The Russian government has failed utterly in its investigation of Arjan's August 2002 kidnapping, but has succeeded in glossing over what is happening in Chechnya and selling it to the international community of states, which is only too happy to oblige, as "normalization."

organizations need to start providing treatment. Every life is valuable.

Public-private partnerships encompassing governments, UN agencies, NGOs, civil society organizations and private enterprises are increasingly seen as mechanisms to find solutions to the AIDS epidemic and other global problems. But in our opinion, politicians have the sole responsibility to solve these problems. Even though partnerships may be useful, politicians must not use partnerships to shirk or dilute their own responsibility, or use partnerships as an excuse for slow action.

For some diseases, there are not even adequate drugs available as treatment. To change this, MSF has joined public health and research institutions in Kenya, India, Brazil, France and Malaysia to become a founding partner in the new Drugs for Neglected Diseases initiative (DNDi) which is working on research and drug development for medicines for diseases such as sleeping sickness, leishmaniasis, malaria and others. DNDi is also trying to provoke local governments and donor countries to take up their responsibilities to address these diseases; we hope that DNDi will put the responsibility – and the response – on the public sector and governments.

We can provide aid based on needs and speak out about the criminal response to civilian suffering due to war and disease emergencies because we are independent. To remain effective in our mission we must safeguard this independence. We must continually work to distinguish ourselves from the ever-expanding pool of relief actors and service providers who do not strictly adhere to humanitarian principles. This is becoming

increasingly difficult. Thanks to the over 2 million private donors who fund us around the world, over 80% of our income comes from private sources. This guarantees our financial independence. For them, but especially for the people we assist around the world, we are working ceaselessly to safeguard our independence of action and spirit.

Pretending that humanitarian action is a way to meet political goals is as erroneous as pretending that humanitarian actors can provide political solutions. At MSF, this is why we define ourselves as confronting power, not becoming part of it. Our aim is to save lives threatened by political interests that leave little room for considering people in need for what they really are: human beings. Our role is to cast ourselves against a reality which ignores this simple idea.

Dr. Morten Rostrup, President, MSF International Council
Rafael Vilasanjuan, MSF Secretary-General

August

- └ A three-month program of emergency nutritional aid begins in Olopa, **Guatemala**
- └ Teams are evacuated from Dundo, a large town in eastern **Democratic Republic of the Congo**, where they had been providing medical and material support to a 120-bed reference hospital; activities restart in April 2003
- └ Nearly 700 hepatitis E patients are treated after a rare outbreak of the disease in Bangui, **Central African Republic**
- └ MSF provides assistance to local health workers and vaccinates 217,000 people during a meningitis outbreak in Karuzi and Ruyigi provinces, **Burundi**



Humanitarian medicine, one person at a time

The humanitarian identity of

Médecins Sans Frontières is

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rooted in medical assistance
to “populations in danger.”

But we never intended to
care for entire populations,
which from a medical
point of view is impossible
anyway.

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Danish anesthetist Vibeke Brix Christensen provides reassurance and comfort to a woman at the hospital in Magburaka, Sierra Leone, after successful Caearean surgery.

Thomas Nierle, MD

Director of Operations,
MSF-Switzerland

August

MSF carries out independent assessments of food security in **Malawi** and other southern African countries. No nutritional crisis is evident, but MSF continues to monitor the situation

After three years of work, MSF ends its program in Yoro, **Honduras** to treat Chagas disease, a parasitic infection spread by small insects. MSF had put in place a strategy of detecting and treating children under 12 and prioritizing villages to receive insecticide spraying

Screening and treatment for sleeping sickness expands from Plateaux to Bouenza province, **Republic of Congo**

2002
2003



The humanitarian identity of Médecins Sans Frontières is rooted in medical assistance to “populations in danger.” But we never intended to care for entire populations, which from a medical point of view is impossible anyway. It’s much simpler, more humane – and a lot smaller! We care for people – one person at a time. Our humanitarian identity puts the individual human being – with all his worries and concerns – at the center of our attention. Through the discovery of our patients, and the recognition of the individual human being and his suffering, we may render the medical act truly humanitarian.

It’s the most vulnerable who need the most attention; they are at the same time the most anonymous and forgotten. It’s the sick, the wounded, children and elderly persons, the aggressed, the poor, the unprotected. Human beings in acute distress need other human beings to get back on their feet and the hand held out by the medical doctor won’t be refused. As much as in the Western world, patients in developing countries – and even more so in war contexts – need more than a prescription and a cold handshake. They expect attention, time and an encouraging word – this is only human! Technical knowledge and competence are important to treat people correctly, but insufficient when we want to care for human beings.

If we keep this in mind, the medical act becomes not only a way to cure a patient of a given disease. There’s a lot more to it. It’s the discovery of a person and the context she or he is living in; it’s a confidential, intimate relationship; it’s a glimpse into the past of a suffering individual – and, hence, offers the possibility to preserve or restore the human condition, which frequently is affected by more than just a physical “health problem.”

Crisis situations in general, but especially those characterized by extreme levels of violence, have a disastrous effect on the self-respect of affected individuals. Being confronted with violence can be a depersonalizing, even dehumanizing experience. In crises like those in Ituri (Democratic Republic of the Congo) or Liberia, human life is too often degraded to mere survival. The local communities have only very limited resources to react to this unimaginable extent of human suffering. The individual is frequently left alone to overcome injuries, hunger, fear, diseases and the terrible feeling of having irrationally been attacked by other human beings. Aid actors, politicians and today’s media frequently reinforce the proliferating anonymity of human suffering when trying to draw attention to a given crisis situation. That’s why we have to constantly remind ourselves that behind the empty eyes, the hungry faces and the infected or wounded bodies, there is the universe of an individual

human being with his own perceptions, ideas and dreams and, thus, specific needs.

Physical presence makes all the difference

Although I have always tried to do my best to save lives and alleviate suffering during my years working as a medical doctor with MSF, I have lacked, now and again, the means to do what could have been done in Western hospitals, where I learned my profession. In the field we are frequently confronted with situations in which we would feel a lot more comfortable if we had an additional laboratory exam or a more efficient drug. We have all experienced moments when decisions were based on medical knowledge and common sense rather than on sophisticated diagnostic equipment. And at one stage or another most of us have lost a patient because the next surgical facility equipped to save a multiple trauma patient was too far away to be reached in time.

There were times when the suffering surrounding us was almost unbearable. I remember the bombing of a town and its civilian population in northern Afghanistan (1997); the endless stream of refugees seeking protection and assistance after having been attacked in their camps in the Guéckédou region of Guinea (2001); the hollow eyes of a malnourished child joining hundreds of others in one of our feeding centers in the bush of southeastern Angola (2002); the woman with a terrible machete wound in her neck after by chance surviving an attempted decapitation in Bunia, Democratic Republic of the Congo (2003).

However, the intense frustration we felt in these situations originated more in the uselessness of human suffering than in our limited capacity to respond to the horrendous consequences or the underlying causes. We did what we could and lives were saved! Moreover, our mere presence in combination with swift and professional action generated a spark of hope where there was only despair before. In these situations, I have realized, it’s our physical presence, our closeness to the people we assist and our solidarity with them that makes a difference.

It has always been difficult to individualize assistance in extreme crisis situations. When tens of thousands are suffering, it is, indeed, hard to devote much time and attention to individuals – especially when resources are limited. According to the needs, aid actors – MSF included – have to distribute food and shelter, ensure the constant supply of drinking water, install latrines and hygiene facilities and prevent epidemics – frequently in very difficult and unsafe circumstances. In my opinion, however, medical assistance cannot be provided successfully if a minimum of personal contact isn’t present. In this respect it is preferable to keep a project

September

- └ A medical program begins for refugees and asylum seekers entering Italy via Lampedusa Island, close to the Tunisian coast
- └ Civil war engulfs Côte d’Ivoire; MSF work aiding prisoners in Abidjan expands to emergency care in hospitals and clinics in areas heavily affected by the fighting
- └ An outbreak of pneumonia occurs in Thoniyor, Sudan; MSF treats 406 cases in one month
- └ MSF launches an HIV/AIDS program in Dogbo, Benin



and, thus, the number of “beneficiaries” smaller in order to devote more time and energy to the individual human being. Or we have to make sure we bring in enough medical personnel to provide human and effective care for larger numbers of people. We can’t save everybody – we have to make choices. We also have to provoke other actors to take up their responsibility to act, thus expanding the number of people who can be cared for.

The humanitarian avalanche (which we have seen rolling over many recent crisis situations) can bring in a lot of drugs, medical equipment and logistical supplies, but not necessarily the human resources necessary to spend time with patients. Indeed, donor agencies are rather reluctant to finance personnel whereas they are more than happy to give huge amounts of money for aid supplies. In the end, “humanitarian coordinators” are discussing in air-conditioned rooms, driving around in comfortable 4x4 vehicles and planning how to best distribute all the material and supplies they have at their disposal. The distance between these people and those they came to help is palpable and the assistance provided unsurprisingly mediocre. This tendency, which we have also experienced within MSF, needs to be countered if humanitarian action is to remain meaningful.

Public health – a humanitarian cul-de-sac?

In 1999, I was sent by MSF on a mission to Madagascar – as a public health manager, not a medical doctor. I contributed to the introduction of a cost-sharing scheme, set up an epidemiological surveillance system and trained health workers who, ill-paid, were ill-motivated. Contact with patients was not a priority – human suffering was all around us, but did not figure in our “action plan.” We cared for the national health policy and not for patients. It took me a while before I realized to what extent I was drifting away from my humanitarian convictions.

Like all policies, national health policies are influenced by societal needs, economic capacities and, sometimes, nationalist sentiments. They do not aim to bring rapid relief to a suffering individual, but set conditions for a given society to become “healthier.” Yet they are undoubtedly necessary, and thus it is understandable that states, health ministries, development agencies and public health experts insist that MSF get involved and concentrate its efforts on these “common and public objectives.” Although valuable, it’s simply not humanitarian to design national health policies. Their elaboration and implementation should be left to politicians and development experts. Public health policies do not cure patients. For a human being in distress it’s the here and now – the physical connection and the act of healing, or at least trying to, which makes a

difference, and not ambitious ideas outlined on pieces of paper, destined for the future.

Keeping the individual at the center of our work also means that we can approach overwhelming or unimaginable problems without despair. The AIDS epidemic is one example. Forty-two million people living with HIV/AIDS is an overwhelming public health problem; a 22-year-old woman with AIDS is a human being who can inspire compassion, who can be listened to and known. She can be treated, and her life possibly made better. The “overwhelming” problem can be approached.

In 2001, I met Josefina in Nairobi, Kenya. Due to AIDS, she was simply too weak to care for her four children. All her financial reserves had been spent on treatment for opportunistic infections, diseases contracted because of her weakened immune system. Her life seemed to be doomed, and the lives of her children too. In 2002, I met her again. In the meantime she had been enrolled in an antiretroviral (ARV) treatment program, gained at least 15 kilograms and restarted her work as a tailor in order to send her children to school. She radiated a touching joy of life during our last meeting – something which had been unimaginable a couple of months earlier. However, only a minority of Kenyan AIDS patients have access to ARVs and political and economic considerations seem to impede a rapid change in the national health policy.

In 2002, during a field visit to Angola, I saw a ten-year-old boy, Avertino, suffering from severe malaria at one of the health posts surrounding Menongue. He didn’t react to the chloroquine treatment he received (not from MSF) at the health post. Resistance of the malaria parasite to chloroquine and other standard anti-malaria drugs is developing rapidly in sub-Saharan Africa. Luckily, I had some tablets of the very effective treatment ACT (artemisinin-containing combination therapy, drugs readily available and widely used in Western hospitals) in my emergency box and started treatment immediately. Three days later, the boy was able to leave the hospital – cured and laughing.

It is true that the treatment which saved him is – compared to chloroquine – expensive and, thus, does not form part of the Angolan malaria treatment standard. But as a medical doctor respecting medical ethics, I had no choice but to “violate” the national malaria treatment protocol, in order to provide the best possible treatment and, thus, give the suffering boy in front of me the best possible chance to survive and recover quickly.

If both Josefina and Avertino had been seen from a distance simply as anonymous members of a large category of patients (AIDS sufferers, malaria patients), it might have been tempting to accept that at the moment they would not have access to the treatment they needed,

September

- └ Suspended after the kidnapping of MSF staff member Arjan Erkel in neighboring Dagestan, operations begin again in Ingushetia. Both republics are part of the **Russian Federation**
- └ MSF delivers medical assistance after floods in Prey Veng province, **Cambodia**
- └ MSF ends emergency medical care in West Timor, **Indonesia** refugee camps as needs become more development-related
- └ MSF’s team in **Nicaragua** assesses the damage done by Hurricane Isidore. The local health authorities put in place a mobile medical team to respond health needs



because the country, the system wasn't ready to provide it (lack of funds, or a protocol not yet in place). But when we see them as suffering individuals, we cannot accept the application of second-class medicine. And by insisting on effective treatments in our programs we may induce change and, thus, ultimately have a positive effect on an entire society.

Violence – a particularly devastating “disease”

Violence in all its forms can also be considered as a “public health problem.” Millions of people suffer direct and indirect consequences of violence each year, leading to physical and psychological trauma in its most severe forms. Integrating this fact into public health planning is certainly necessary, but it can't be done to the detriment of action when it is most needed. And, beyond the fact that lives can be saved, a spark of hope may be lit.

In a Burundian regroupment camp (forced regroupment of people during conflict in an attempt to cut off supply for rebel groups is a well-known military strategy in Burundi), a soldier went berserk and discharged his machine gun into the crowd, which resulted in the death of seven persons and serious injury to another six (Ruyaga, 1999). As the authorities claimed initially that the rebels were at the origin of this deadly aggression, no organization, institution or anyone else wanted to rescue the injured. Despite possible security constraints, MSF decided to act. When we finally arrived in the camp, hundreds of people were gathered around the small health post. As soon as our ambulances were spotted the crowd started to cheer and applaud. While living through a nightmare for hours, the sudden realization that others do care generated hope. All six patients survived after being evacuated to Bujumbura; this morning in Burundi remains engraved in my mind as one of the most striking examples of effective medical, humanitarian action. While public health experts would have registered six more deaths on a sterile epidemiological surveillance sheet, MSF saw these six specific people as humans who needed independent humanitarian assistance, thereby saving them and comforting hundreds of others who were there.

Considering our patients as persons – one at a time – ultimately helps us to bring truly humanitarian aid to people who are victims of wars and other kinds of violence. Millions of people battered by war and conflict can provoke only feelings of helplessness; caring for some among them and bearing witness to what they are suffering can not only restore health and dignity to the injured, but also reinforce the caregiver.

Humanitarian action may be a small remedy given the magnitude of useless, global suffering. However, it can make a huge difference, if we can avoid pretending that

we will change the destiny of entire populations. Once we start shifting our attention from individuals to groups, societies, or populations, we risk adopting an approach which inevitably neglects the individual. If this happens the foundations of humanitarian action start to crumble.

“Humanitarian medicine” – an ambiguous term

During my years with MSF, it has become clear to me that to offer truly humanitarian medical assistance, proximity to our patients and their suffering is fundamental. This is especially true where respect for human life is endangered or has already been destroyed. But being with our patients is one thing. We must also strive to offer them the best possible care and treatment, although (and because) our working environment does not always permit us to reach the necessary quality standards to cure all individuals seeking our assistance. This kind of humanitarian medical action not only provides a chance to offer the most humane care possible, but also gives us the credibility and opportunity to point out and influence the root causes of their problems.

If “humanitarian medicine” is a synonym for medical, humanitarian action as described above, it can and must exist. However, where public health imperatives, manipulation and greed reduce medical action to a low-quality, few-resources approach in a worldwide charity business, the individual patient, while slipping into anonymity, will perceive the presence of a third-world, second-class medicine, which far too often claims to be humanitarian. MSF vehemently opposes this.

Medical, humanitarian action goes beyond the mere analysis and repair of physical disorders; it offers choices where there were none; it provides a human touch in an inhumane environment and it may ultimately help reestablish human dignity. The medical act, the contact between doctor and patient, this closeness to human suffering remains crucial if we want to remain humanitarian in act and spirit.

Humanitarian medicine is medical practice according to universal medical ethics based on a moral concept, which values human life and dignity – the human condition. And this is not utopian; it's very realistic...and desperately needed.

September October

└ In **Mexico**, MSF temporarily suspends activities in one Chiapas community, after a decision by Zapatista authorities to impose compulsory fees on non-Zapatista populations. Work resumes in January 2003 after the decision is reversed

└ MSF provides medical supplies in response to flooding in Dhemaji district, Assam, **India**

└ MSF begins seeing patients at Bouaké hospital in the rebel-controlled area of **Côte d'Ivoire**

└ After an outbreak of cholera in Mbuji Mayi, **Democratic Republic of the Congo**, MSF begins medical treatment, ultimately treating 5,000 people (with 240 deaths) between October and April



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A child is examined in front of MSF's field hospital in Bunia, Democratic Republic of the Congo, in June 2003. Hundreds of civilians were massacred in the city in May. MSF cared for some of the 150,000 people who fled the town for places like Beni, and in Bunia itself for those who then attempted to return despite the continuing insecurity. Untold numbers of people remained outside of town in the bush, without protection or assistance and unreachable by humanitarian workers.

Democratic Republic of the Congo

On the dilapidated road between Beni and Mambasa, there is a constant flow of people, on foot or riding bicycles, transporting all kinds of bags, bundles and objects: onions and bananas, mattresses, saucepans, clothes, wood, jerry cans and children. An attack by armed rebels, the third in as many months, pushed residents from their homes in December 2002, emptying village after village along the road south from Mambasa. "We had to flee in the middle of the night," recounts 20-year-old Kasereka Kasemengo. "I had to carry two of the children, as well as the child I'm carrying inside. It was very hard. We suffered so much, and we still have nothing."

The Democratic Republic of the Congo (DRC) is not yet on the road to "normalization," despite recent progress in the establishment of a transitional government to end the civil war. Peace is elusive: the country's ongoing conflict continues to be a complicated

struggle, perpetuated in part by regional and international interests in the country's rich natural resources.

It is the Congolese people living near conflict areas who suffer most from the war, attacked by all sides, their fields burned, their houses destroyed, their lives undercut by violence. Surveys conducted by MSF have documented that near the front lines of the fighting one in four families has experienced beatings while one in seven has suffered rape, torture or forced recruitment. Some areas, such as Nord- and Sud-Kivu provinces and the Ituri region of Orientale province, have particularly high levels of violence. Years of war and neglect have caused the country's health system to collapse, leaving most people with no access to medical care. Armed conflict, poverty and lack of health care mean enormous medical needs: "Wherever we stop the car, we could open a project," states one MSF project coordinator. In an environment where insecurity, outright conflict and population displacements are commonplace, evacuations of health teams are frequent and logistical problems routine. Despite these challenges, MSF teams work to restore the dignity of people they encounter through responding to epidemics and emergencies and providing basic care to those who have none.

Bunia

"I fled Bunia because of the war. My husband is dead and so are my two children... I was saved because I was in the bedroom when they killed my husband. I heard the noise and when I saw what was happening I went back in the bedroom and jumped out of the window. I landed in the flowerbed I had planted and I stayed quiet. I was there trembling among the flowers for a long time. When I came out, I saw my husband's body." – a woman taking refuge in the town of Erengeti

Despite ceasefire agreements and attempts to negotiate peace, fighting has persisted in eastern DRC since 1998. MSF has medical aid projects in many parts of eastern DRC, including the provinces of Nord-Kivu, Sud-Kivu, Katanga, Equateur and Orientale, but it is events in the northeastern region of Ituri, in Orientale province, that dominated much of MSF's new activities in the last year, and particularly in spring 2003.

United Nations peacekeeping troops arrived in the city of Bunia, regional capital of Ituri, in May 2003. Despite the presence of these 600 United Nations Mission in the Democratic Republic of the Congo (MONUC) soldiers, the power vacuum left by withdrawing Ugandan forces (who pulled

October

- └ MSF issues a report on the situation of Afghan refugees in **Iran**; the report reveals the pressures on refugees to return to Afghanistan and the difficulties – harassment, physical maltreatment, indebtedness and poverty – of life in Iran
- └ MSF opens a mission in **Argentina**, providing medicines and training to help ease the health effects of the country's economic collapse on poor and indigenous people in the northeast
- └ MSF treats around 1,300 people during an unexpected malaria outbreak in Badghis province, **Afghanistan**
- └ MSF launches a primary health care project for Roma (Gypsies) in Fakulteta, a suburb of Sofia, **Bulgaria**



out of the area in April as part of a previous bilateral agreement) was quickly filled with various armed militias. Many were still tied to larger rebel groups or backed by outside powers vying for control in the region. Within days, the tension in Bunia erupted into the brutal massacre of several hundred civilians. In the wake of the violence, the city was emptied of three-fourths of its population, as 150,000 people fled, many hoping to reach Beni, nearly 145km to the southwest in Nord-Kivu; others tried to cross the border into Uganda or stayed in Ituri itself. MSF has been working to support health centers and internally displaced people in Beni since December 2002, and responded quickly to the new influx. As teams supplied medical care, water and shelter to thousands arriving in the area, they also listened to their stories of the escape from Bunia and the perilous journey to reach Beni.

"It was by the grace of God that some people from Bunia managed to get here because many of them didn't make it," said one Bunia resident after arriving in Beni. For those who fled, survival was difficult and fraught with dangers. The journey was exhausting; most people had no supplies and many carried children or elderly relatives in their arms or on their backs. "It was like a human tide along the roads," remembered one woman. "People showed us the way. You saw traces left by the people who had gone before." Dangerous armed groups preyed on civilians, stealing their possessions and money and inflicting senseless violence. "Along the road, four boys we knew well were walking behind us," said one woman. "They were friends of my son and often came to our house. We heard them cry out. They were being attacked with machetes."

The protracted conflict in eastern DRC is particularly horrific because civilians, even children, are frequently targeted. "This is not a war between ethnic militias or between groups," explains Thomas Nierle, MSF Director of Operations in Geneva. "This is more like a war against civilians." In the words of survivors in Ituri, the suffering of the Congolese people becomes clear: "My two-year-old died on the road in my arms," stated one woman. "If you didn't pay at each roadblock, things were difficult. Difficult? They threatened you, beat you and killed

you if they wanted to... I didn't have any more money. I was carrying my baby close to me. He had his arms around my neck. They killed my son to intimidate me. They did it intentionally."

Women and children with war wounds

As teams in Beni helped those able to reach them, other MSF staff responded in Bunia. The first MSF team started work in Bunia at the end of April, supporting surgical activities at the hospital. MSF withdrew for several days when fighting flared up in town in early May. When the team arrived back in Bunia, the hospital was no longer accessible, so the team quickly set up a clinic in an old warehouse. Dubbed the "Bon Marché" clinic, the 70-bed facility began treating war-wounded people in mid-May and has since conducted an average of 300 consultations each day, and nearly 80 surgical interventions and more than 100 hospitalizations each week. Many of those with war injuries were civilians, often women and children, and to make matters worse the wounded seemed to have been isolated from any medical care for some time. "Fighters are brought in with fresh war wounds. But civilians have war wounds that are often more than three weeks old. It is very difficult to help them. These people must have suffered," comments MSF surgeon Birgit Neudecker.

With protection like this...

Violence and insecurity continued even after the arrival of 1,500 soldiers from the UN-authorized Interim Emergency Multinational Force (IEMF). The mandate of the IEMF was limited to Bunia town; villages in Ituri were still facing attacks by armed groups. Desperate for protection, residents began to return to Bunia, many gathering first near the MONUC positions; as their numbers grew, they were moved to a camp on the western edge of town. "Bunia is becoming like a partly surrounded refuge where people from the surrounding areas seek safety," commented MSF Head of Mission Nicolas Louis. But Bunia was far from safe.

Security improved during the day, but at night militias entered Bunia to loot, kill and terrorize civilians. MSF continued activities at the Bon Marché clinic and began

providing health services to the thousands gathering in the camp, adjacent to the clinic. From their patients, teams heard firsthand about the continued violence. Stories of rapes and disappearances were common; the displaced people were easy targets for armed perpetrators.

Inadequate humanitarian aid and no formal registration in the camp also meant that many people lacked minimal supplies and were going hungry. Arriving with nothing after traveling for weeks, many were forced to wait several days for any assistance. Those fortunate enough to receive food rations were given only 700 kilocalories a day, one-third of an adult's daily nutritional needs. With the new influx of people, MSF began medical screenings at the entrance of the city. With more than 1,000 new people arriving in Bunia daily in early July, MSF spoke out about the dangerous conditions faced by the more than 18,000 displaced people crowding into the camp. In July, MSF sent four cargo planes to Bunia to help address the massive needs and opened a new therapeutic feeding center to combat growing malnutrition. MSF staff also began a blanket feeding program to provide nutritional support to 17,000 children in the area of Beni.

Dangerous expectations

In July 2003, MSF released the report *Ituri: Unkept promises? A pretense of protection and inadequate assistance* (see page 16). The report reemphasized the direct and indirect responsibility of neighboring states and various armed groups in fueling the ongoing conflict in Ituri. Through the testimonies of the Congolese people themselves, the report documented the lack of basic assistance and continuing violence in Bunia and in the entire Ituri region. It also showed that, while protection inside the town did improve slightly, civilians' growing perception that safety could be found in Bunia, stimulated by the presence of UN and IEMF peacekeepers, was not always equaled by enough security. At the same time, massacres continued outside of town. It is impossible to forget the brutal massacres of civilians who believed they were being protected by United Nations peacekeepers in Bosnia and Rwanda. In *Unkept promises*, MSF called on the United Nations Security Council to avoid giving an illusory sense of security to

October

└ Courts in Bangkok, **Thailand** rule that the pharmaceutical giant Bristol-Myers Squibb cannot expand the scope of its patent on the AIDS drug ddI; this ruling shows that people living with HIV/AIDS have the right to challenge a patent (two people with HIV as well as one civil group were the plaintiffs) and that civil society groups are key in advocating for pro-public health intellectual property law. MSF has comprehensive HIV/AIDS care and treatment programs, including ARV treatment, in Thailand

└ MSF prepares for a possible refugee influx from **Côte d'Ivoire** by stocking shelter materials and medical supplies in Ouagadougou, Burkina Faso, and sending medicines to border areas



the people of Ituri – and to instead provide them with real protection. Around the same time, MSF also expressed concern about the imminent withdrawal of the IEMF, slated for September 2003.

The fighting in Ituri has left thousands of people out of the reach of emergency assistance. With only small areas secured in and around the peacekeepers' compounds, the majority of those who used to live in Bunia are still displaced, with no access to emergency health care. MSF teams often receive patients who have been in hiding for weeks, and who arrive in very poor condition. That they have somehow found their way to the clinic means they are the lucky ones, the few who will receive medical care and food for their children. The people who are beyond a few kilometers from the city are still very vulnerable, and very exposed, and these are the people whom MSF, and other humanitarian actors, are unable to reach.

Many ways to die in DRC

Far away from the daily terror and intense conflict in Ituri and other troubled areas of eastern DRC, forgotten ills – malnutrition, disease epidemics and lack of basic health care – silently claim thousands of lives. It seems unthinkable that children in Congo die every day from preventable and treatable diseases. But in a country like DRC, where most people do not receive medical care, the unthinkable has become common. Unfortunately, there are many ways to die in DRC.

In a letter home from a basic health care project in Mbandaka, Equateur province, MSF mission administrator Danielle Courtin writes, "Words fail to describe the state of dereliction of the health care centers in this province: the general hospital here is filthy and lacks the most basic equipment. I've seen operating theaters with leaking roofs, centers where there's not even a chair for the consulting nurse, let alone for the patients. In the pharmacies, the shelves are empty and in the wards beds and mattresses are missing or broken." Many clinics around the country are in a similar state, in terrible condition and lacking basic supplies.

Access to communities in need in DRC is not only hindered by conflict. In many parts

of the country, geographical constraints compounded by population movements related to the war have also made access to health care impossible. In November 2002, MSF reorganized a health zone project in Equateur, Katanga and Orientale provinces in order to more effectively reach the people. MSF teams travel extensively throughout the health zones, visiting villages and health centers and conducting clinics and vaccination campaigns. "The major challenge the team faces is transport," explains Courtin. "There are no roads beyond 20km from the city." In many projects, supplies are carried by team members on motorbikes or canoes, or even on their backs. "One of our teams last week walked 58km through swamps to reach a remote health center," continued Courtin. The health zone initiative also enables MSF to reach Congolese who are hiding in isolated areas to escape the violent civil war.

A cruel and unjust end for a child of twelve

With minimal or no health care in many places, preventable diseases claim thousands. The story of Francine, told by MSF volunteers present at the Kabati therapeutic feeding center in Nord-Kivu, where she arrived on May 13, 2003, is illustrative. "Skeleton thin, she lies in the examining room, coughing and in acute pain as the doctor checks her abdomen. She is diagnosed with advanced disseminated tuberculosis, from which she will almost certainly die. A cruel and unjust end for a child of 12 years." (This description was also published in *The British Journal of General Practice*, July 2003.) Less than half the country's children have received basic vaccinations, and outbreaks of disease are a common occurrence. MSF is committed to helping bring the countrywide measles vaccination rate for children up to 85% (it is now less than 40%), so massive vaccination campaigns are routinely implemented in all parts of the country where teams are present. During the past year hundreds of thousands of children were vaccinated in both western and eastern DRC.

Malnutrition and cholera also claim countless lives. Many MSF projects include therapeutic and supplementary feeding centers, which can be either long-term or opened for short periods of time during

emergencies. One example of a typical project: in October 2002, MSF opened a therapeutic feeding center for 100 children and launched mobile clinics in Musao, Katanga province. Soon after, a similar nutrition project began in Mukubu, just on the other side of the Congo river, where people are constantly fleeing combat between different Mai-Mai factions. The Musai project was able to close at the end of the year, but the Mukubu center is ongoing, despite continuing security problems. These two centers were extensions of the many projects of hospital and clinic support already underway in different parts of Katanga province.

MSF teams have become accustomed to receiving people in very poor condition, due to the violent civil war, poverty and the terrible health conditions. "So many people seem completely beaten down by the situation here. They arrive at the feeding centers without spirit, as if the wind had been knocked out of them," described one MSF worker.

To help respond to the year-round outbreaks of cholera, MSF runs a rapid response program. Based in Kinshasa, Kisangani, Goma and Kalemie, the Congo Emergency Pool (CEP) is a base for epidemic surveillance of the entire eastern portion of the DRC. Weekly radio reports from across the region keep the team informed of outbreaks and help shape interventions.

AIDS, unforgotten

MSF has also begun to provide care for people living with HIV/AIDS in DRC, a problem that elsewhere in Africa makes the headlines but that here is overshadowed by so much else. In the city of Bukavu in Sud-Kivu, one project targets a population of more than 600,000. Activities include treating sexually transmitted diseases (STDs) and opportunistic infections, voluntary counseling and testing, and home-based care for some patients (with antiretroviral treatment beginning as this report goes to press). In the capital Kinshasa, many people are infected with STDs which are often not treated properly at existing health centers. MSF teams in Kinshasa provide quality treatment while raising awareness among

(continued on page 18)

October

MSF establishes and provides medical aid at two refugee camps in Zegoua, **Mali**; the camps receive people fleeing fighting in Côte d'Ivoire

MSF releases two advocacy reports based on direct accounts from Angolans, "**Angola**, after the war, abandonment," and "Angola, sacrifice of a people." The reports reveal the difficult health situation (despite the country's newfound peace) of those interviewed and the extent to which the country's warring parties had held them in contempt during long years of conflict

A treatment and information program to fight Buruli Ulcer, a bacterial infection that destroys skin and bone tissue, begins in Ayos and Akonolinga, **Cameroon**



Voices from the Democratic Republic of the Congo

The following accounts were gathered from people in Bunia and Beni for MSF's July 2003 report Ituri: Unkept promises? A pretense of protection and inadequate assistance, and from other MSF project sites in the country.

"It was Monday's attack that prompted us to flee [Bunia]. It began on Saturday at 5pm, with gunfire and shelling from heavy weapons. It went on all night until 6am. When it stopped we went outside to see what had happened... People were running and fleeing. Some were missing their ears – they had been cut off... The fighter who helped us leave was a friend I'd known for a long time. He helped us at night, secretly, so his friends wouldn't find out."

"When we fled, we took our mattresses and our clothes, but those were stolen along the way. They even took my shoes. They took everything from us at the first checkpoint. At the other checkpoints, they hit us."

"I left my town because I wanted to be safe. We slept in the bush, wherever we could, for a month. We ate roots and squeezed the juice out to protect against malaria. We would go into other people's fields to find food."

"There was a granny with a fractured pelvis. Her family left her on the road. She was old and alone. We took her with us on a stretcher that we built. When we reached the next village, we left her in an empty house."

"I've lost everything, everything. I'm not used to living like this."

"At Songwe, they took our chickens, our goats and our crops. They said it was for the 'war effort' but they didn't ask, they just took, with their guns."

"What's the point of planting if the fields are going to be looted and burned a few weeks before the harvest? We've lost everything – three cooking pots, two pans and our tables and chairs. But I was lucky. They didn't burn our house down. We still have a roof over our heads." ■

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October

└ After Russian Special Forces end a theater hostage crisis in Moscow, the **Russian Federation**, with a gas attack, MSF provides medicines and materials to a hospital receiving many people overcome with gas. Chechen separatists strapped with bombs had taken over the theater and demanded that Russia withdraw its troops from Chechnya

└ After the eruption of the Reventador volcano in Napo province, **Ecuador**, MSF provides emergency assistance, including drugs and medical material, to health facilities in the area

└ A project fighting the parasitic infection Chagas disease among children under 14 opens in Tarija, **Bolivia**, the Latin American country with the highest levels of the disease

Ituri: Unkept promises?

A pretense of **protection** and inadequate assistance

The following is taken from MSF's report Ituri: Unkept promises? A pretense of protection and inadequate assistance, issued in July 2003. The report in full can be found at www.msf.org

"Last May, Bunia, capital of the Ituri region in northeastern Democratic Republic of the Congo (DRC), was the scene of extreme violence. In just two weeks, hundreds of people were killed and tens of thousands forced to flee. Those who remain survive from day to day under extremely precarious living conditions.

The most common interpretation of the violence reduces it to a tribal conflict between the Hema and the Lendu. However, the current ethnic violence has been fuelled by neighboring countries and various armed groups, obscuring their competition for political supremacy and control of natural resources. Despite the deployment of MONUC (United Nations Mission in the Democratic Republic of the Congo) reinforcements in Ituri, along with a European Union Interim Emergency Multinational Force (IEMF), protection for civilians is far from assured. Daily life remains fraught with danger for residents who have stayed and for those who risk returning from their exodus. War is always close by. At night, fighters enter neighborhoods to loot, kill and terrorize civilians. Security in Bunia remains extremely precarious.

Fighting and a wave of terror

The war broke out during the first week of May 2003 (just as 600 soldiers from the MONUC reserve battalion were deployed). Bunia's residents remained hidden in their houses for several days. Explosions reverberated day and night in the city. Gun and machete attacks followed, as did killings of civilians, door-to-door searches and looting. People fled their neighborhoods, seeking shelter in other districts or with family and friends. The entire city was gripped by fear.

No security in Bunia

Bunia's residents headed for MONUC positions or adjoining areas in search of protection, but the MONUC base provided no more security than their homes. MONUC troops stood by as violence surged, notifying the UN Secretary General and the media of developments. Militias even entered the MONUC base as the troops watched, and took displaced people away.

October

November

After an attempted coup d'état ignites civil war in **Central African Republic**, MSF begins emergency aid in the capital Bangui and in the southern part of the country, which is controlled by government forces; in February MSF begins work in the rebel-controlled north

MSF begins assistance to "illegal" Rohingya settlers from Myanmar living in homemade huts in a field in Teknaf, **Bangladesh**

An anti-tank mine explodes under an MSF vehicle near Mavinga, **Angola**, killing four MSF national staff members and three patients, and injuring six others. MSF continues work in Mavinga town but suspends operations in the surrounding area; work in the Quartering and Family Areas outside of Mavinga continues via "remote control"

Over the course of several days, more than two-thirds of the population left the city. MONUC was no more capable of protecting the fleeing inhabitants than of averting their flight. The Mission took no steps to evacuate civilians or transfer them to safer areas. Uncertainty and the dangers of flight added to the terror of those first weeks. Displaced people report that men hidden along the side of the road ambushed them, firing heavy weapons and guns. There were deaths and injuries and many families became separated. The militias set up checkpoints along the road leading to Beni. Anyone who wanted to pass had to show identity papers and pay a “travel permit.” Some people were taken away or killed at the side of the road. The individuals interviewed spoke of ill and elderly people who had to be left along the way. Women gave birth, often alone. Some resumed their flight immediately after childbirth.

Insufficient assistance

When a new multinational force was designated for Ituri in June, the stated goal was “to improve the humanitarian situation.” But two months later, residents of Bunia and the surrounding areas still lack the most basic elements of survival. While this situation may be the result of insecurity, it is also the result of failure to anticipate needs and to deploy aid accordingly. More than 12,000 people who had been displaced by the fighting returned to Bunia over a period of several weeks, drawn by the presence of the new international force. People living in outlying areas also came to take refuge there. Food, drinking water and shelter were in short supply.

The newest arrivals at the displaced persons’ camps waited days before being registered and becoming eligible for emergency distributions of food, dishes and building materials, vital for those who have lost everything. Food distributions to date have provided only 700 kilocalories per day per person, one-third of an adult’s daily nutritional needs. As of mid-July, only one piece of plastic sheeting had been distributed for every three families (around 15 people).

Because of security problems, aid workers are still unable to reach the “gray zones” around Bunia. News of killings on Bunia’s outskirts reaches the city every week, often confirmed by the arrival of newly displaced and wounded persons fleeing the violence.

Conclusion

The international forces present in Ituri (MONUC and the IEMF) have proven to be unable to ensure genuine protection for civilians. In the past, UN peacekeeping forces have failed miserably on multiple occasions in their mission to protect civilians. In Bosnia and Rwanda, such failures ended with the deaths of several thousand people. Having witnessed these painful experiences, MSF urges the international community not to give, once again, a dangerous illusion of protection to the civilian population of Ituri. MSF calls on the Security Council to keep its promises to protect civilians – not to sacrifice them to other political objectives, as was the tragic case in the Srebrenica “safe haven.” Furthermore, available aid is far from meeting the region’s needs. UN agencies and institutional donors must be mobilized to provide substantially increased humanitarian assistance to civilian victims of the war in Ituri.” ■

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November

- └ People fleeing civil war in Central African Republic begin to arrive in **Chad**; MSF soon establishes temporary refugee camps and begins medical aid to refugees and residents of host communities
- └ MSF challenges UNHCR on its proposed plan for MSF to hand over health and nutrition programs for Rohingya refugees in Nayapara camp in **Bangladesh** to the government, which is unprepared to take on the projects in the short time frame given
- └ A dramatic increase in the disease kala azar in Lankien, **Sudan**, prompts emergency action; MSF cares for more than 1,800 patients



(continued from page 14)

high-risk groups; 45,000 people with STDs are cared for through 34 health centers each year; 1,500 people with HIV also receive treatment for opportunistic infections, with ARV treatment planned for the near future. HIV/AIDS projects are also underway in Katanga and Equateur provinces. Other specialized projects in the DRC include a program to combat sleeping sickness in Equateur province, with plans to expand this work to Kasai and Orientale provinces.

Significant insignificance

With over 150 international and 1,600 national staff, at any one time MSF teams are trudging through the rainforest with essential medicines and supplies on their backs, listening to nearby explosions and gunfire while operating on wounded in a makeshift clinic, or providing some small assistance to thousands of displaced people who tell their stories of atrocities and survival. MSF is committed to providing need-based emergency medical care in the DRC, but in the face of such a devastating crisis, the scope of the needs can be overwhelming. This is true from the isolated villages deep in the forest, to the capital city, to the crowded camps for the displaced in Bunia and Beni. What becomes clear in the comments of the doctors and nurses and logisticians who continue to work in DRC is that it is the people they help that make it worthwhile. "In Shabunda, people tell us of the hope we have provided by working in the hospital and staying with the them throughout the years of attacks they have faced," says operational director Kenny Gluck. "The insignificance of our actions in terms of the fate of the Congo is only counterbalanced by the effect we have on individuals and communities in the few places where we work."

MSF has been working in DRC since 1981.

International staff: **158**
National staff: **1,600**

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A patient is operated on at MSF's field hospital in the city of Bunia, Democratic Republic of the Congo, in June 2003. Twenty percent of the patients admitted to the hospital suffered from war wounds. One-third of the war-wounded were women, and one-fourth were children under five. Around this time, the team performed about 80 surgeries each week. As this report goes to press, the situation has changed very little: there are still 50-60 surgeries a week, with the same high proportions of women and children with war wounds.

November

- └ A nutrition project begins in the Saada area of Nouakchott, **Mauritania**. Direct food aid is provided to the most vulnerable families, and ways of preventing malnutrition are taught to mothers of malnourished children
- └ MSF carries out a final distribution of essential drugs to 182 primary health care facilities in **Tajikistan**, part of preparations to close the Tajikistan mission as needs in the country become more development-oriented
- └ After achieving its objectives, MSF finishes its mother-and-child health care program in the Temara district of Rabat, **Morocco**; a maternity ward constructed in a local health center is handed over to the Ministry of Health



A drop of hope amid immense suffering

Kenny Gluck, Operational Director, MSF-Holland

MSF volunteers do what they can to pull the world's attention to the Democratic Republic of the Congo (DRC). Dozens of journalists visit the projects each year and the teams dutifully introduce them to their little corner of suffering. The resulting pictures and words inevitably fail to do justice to the immensity of the tragedy here.

Our teams confront the feeling of hopelessness by the provision of assistance and the human contact they establish, but we are also infected by it. The atmosphere is suffocating, says one expatriate who had spoken to a woman whose father had been tortured and then killed. He asked her if she was going to do anything. "If I say anything they will kill my children. If I do anything they will kill me. There is nothing to do," was her answer.

Even though it is one of the largest missions in MSF, the size and breadth of the needs make our interventions seem insignificant. Each time we do intervene, down the road the situation is even worse and we question whether we should go there instead. Some areas are neglected because we cannot reach them for the lack of roads and broken bridges. Other areas we neglect because we cannot convince local fighters to allow humanitarians to work in safety. Some problems go without assistance just because we have decided that we have too much on our plate already.

The insignificance of our actions in terms of the fate of the Congo is only counterbalanced by the effect we have on individuals and communities. With the treatment of AIDS in the city of Bukavu, we are not stopping the epidemic, but we will provide meaningful care for people who have been denied care in the past. With the nutritional programs and tuberculosis treatment in Nord-Kivu province, we are providing quality care, which stands in the face of the years of abuse and displacement.

The scale of the problems that we neglect and the number of victims who will not be reached will endlessly frustrate MSF in DRC. But this makes the care for individuals we do reach – with real assistance and real humanity – all the more meaningful and significant. ■

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November

Training to increase awareness of sexual violence and improve medical care for victims is integrated into refugee health programs in **Sierra Leone** through a pilot project at Taiama camp. Similar projects were also implemented in 2002 in Bo and Pujehun camps in **Sierra Leone** and Boreah camp in **Guinea**

The last remaining areas of Dashoguz province, **Turkmenistan**, are covered by the DOTS (Directly Observed Treatment Short Course) program for tuberculosis (TB); the entire population now has access to free TB treatment

MSF vaccinates nearly 66,000 people during a meningitis outbreak in Rwanguba, Nord-Kivu province, **Democratic Republic of the Congo**. With ongoing civil war and little available health care, epidemics of many diseases occur in the country year-round



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Many hands holding her and a tender kiss on the top of her head cannot erase the pain of this baby girl, who is receiving painful injections to treat for sleeping sickness in Ibba, Sudan, 1999. Still, the touch is important.

Sudan

“We, the citizens, are suffering.”

Diu, from Rupnyagai, Sudan

MSF has been assisting the people of Sudan for over 25 years, offering them primary health care, nutritional relief in times of famine, war surgery when needed, and specialized care and treatment for diseases such as sleeping sickness, kala azar, tuberculosis and malaria. During all of these years, the country has been at war. MSF has spoken out on many occasions about the plight of Sudanese caught in their country's vicious hostilities, a conflict that has been all but forgotten in much of the rest of the world.

Sudan is a place where providing meaningful care is a way to connect both with patients and with the fundamental mission of MSF – aid to the most vulnerable people in their time of greatest need. It is a place where expatriates on their first mission can begin to understand some of MSF's core humanitarian principles. “People on their first mission are exposed to a place of chronic conflict,” says Manu Moncada, MSF Head of Mission, “where 30 years of war have left people vulnerable, poor, destitute, dying from any treatable disease. For experienced expatriates who may have worked in more ‘developed’ contexts on highly specialized programs, coming to Sudan is like coming back to MSF's origins. Places like Sudan, Congo, Chad, Liberia, Afghanistan...these are places where MSF has its roots. They give an essential knowledge of why MSF was created years ago.”

Care where there is none

MSF's work in Sudan revolves around providing care where there is none. In and south of Bentiu (Western Upper Nile), in and around Lankien (Western Upper Nile), Malakal (Upper Nile), Kadugli county in the Nuba Mountains, in Akuem, Gogrial, Wau, and Tonj (Bahr el Ghazal), and Kajo Keji (Western Equatoria), MSF supports primary health structures, often offering the only medical services available for entire regions (for example in Akuem, where the MSF-supported hospital is the only health facility in the region, 47,543 consultations were realized and 2,527 people were hospitalized in 2002). Activities include vaccinations, maternity and pediatric services, nutritional therapy, and treatment for diseases such as tuberculosis, sleeping sickness and malaria. The programs vary from place to place, depending on the evolution of needs. In Bentiu, for example, where MSF

November

December

— Faced with implementation of a paying health care system in **Burundi**, MSF negotiates with authorities in Makamba province for a lower fee for patients; for the poorest people, this lower fee is subsidized by MSF

— A malaria epidemic is declared in **Burundi**; over several months, MSF treats more than 80,000 patients with the artemisinin-containing combination therapy (ACT) Coartem™, which is authorized for use in epidemics. However, ACT will not be permitted for regular widespread use until late 2003

— MSF begins supporting health structures and mobile clinics in Beni, **Democratic Republic of the Congo**, as people fleeing conflict in the Ituri region flood into the area



works with displaced members of the Nuer population, a sexual violence component has been integrated into existing reproductive health services. In Marial Lou a special focus on health training for medical students and staff is raising the level of medical knowledge in this rural region. In the Nuba Mountains, clinics see thousands of patients each year. These are only a few examples of the kinds of assistance MSF carries out in Sudan.

Vaccination campaigns to halt frequent epidemics are extremely important. MSF teams have vaccinated thousands of children against measles in the provinces of Bahr el Ghazal, Upper Nile, Western Upper Nile, Western Equatoria and Eastern Equatoria. In July 2003, MSF worked with the World Health Organization to vaccinate over 30,000 people against yellow fever in Budi County (Eastern Equatoria).

Nutrition

Nutritional support is an essential part of many MSF projects in Sudan, where malnutrition is common and cyclical with the seasons. In April 2003, MSF opened a new therapeutic feeding center and three supplementary feeding centers in Akuem (Bahr el Ghazal), where a therapeutic feeding center was already supporting more than 200 children (more than twice the number of children admitted the previous year). MSF called on the World Food Program to continue general food distribution to ensure that the situation did not deteriorate further. In the capital Khartoum, a therapeutic feeding center in Mayo camp for the displaced cared for 926 children in 2002. In Marial Lou (Bahr el Ghazal), MSF also had to reopen a therapeutic feeding center in March 2003 due to the deteriorating nutritional situation. In Lankien (Upper Nile), MSF opened therapeutic feeding centers in February 2003, admitting several hundred severely malnourished children in the first few months. In Dirror district (Upper Nile), MSF has set up an outpatient therapeutic feeding program integrated into various primary health care units, to better serve the area's nomadic people.

In Mygoma orphanage in Khartoum, until recently, nearly 75% of the mostly newborn babies admitted each year were dying. At the request of the government, MSF

became involved in May 2003. After dramatic improvements in medical and nutritional care, as well as basic care and hygiene, the death rate plummeted to 9%.

Forgotten diseases

"Each one of my patients was special in their own way," says Dr. Nitya Udaraj, who until May 2003 worked in MSF's sleeping sickness program in Kiri. "My worst moment was in December last year when a 12-year-old girl who had just completed treatment and was due to go home the next day started to have convulsions. In spite of all our efforts, we lost her. This girl had been treated with melarsoprol [an older arsenic-based treatment] – it was just before we changed our treatment protocol to eflornithine. If we had been able to give her eflornithine at the time, her life would have been saved. This experience has taught me that life is unfair – in a world that has advanced so much, too many people are still being left behind." MSF has advocated for the production and use of eflornithine to treat sleeping sickness, and is working to secure long-term production of this medicine, which is now being produced by Aventis (but only through 2006). In Kiri and Ibba (both in Western Equatoria) MSF runs programs to screen for and treat sleeping sickness. In 2002, MSF treated 2,623 people for the disease.

In several areas of Sudan, MSF fights visceral leishmaniasis, a parasitic disease common in rural areas and developing countries. Also known as kala azar, this disease is spread by sand flies and is 95% fatal if left untreated. A dramatic increase in cases occurred in Lankien in November 2002. "We see so many people arrive at the clinic each day, more dead than alive," said Dr. José Antonio Bastos at the time. "The state of these people is frightening. They arrive on stretchers after days traveling to reach our health center, very thin and severely anemic." In Malakal, Upper Nile, MSF addresses kala azar while also supporting pediatrics in Malakal hospital. Other activities in this conflict area include treatment for malaria and tuberculosis. It is no accident that epidemics are frequent here. "There is a clear correlation between these endemic regions and the conflict zones," says Bastos. "Insecurity, malnutrition and

mediocre access to health care make natural resistance fragile and create a favorable environment for explosions of epidemics, such as this one." MSF also treats kala azar at a 500-bed treatment center in Um el Kher (Gedaref), where 4,500 people were treated in 2002 and an estimated 6,500 patients are expected to receive treatment in 2003. Insecurity in Western Upper Nile, previously endemic for kala azar, has prevented access for most of the year, so only 185 patients there received treatment.

MSF has also carried out studies on malaria resistance in many project areas, including Kajo Keji, Malakal and the Nuba Mountains.

Precious water

In MSF-supported structures throughout Sudan, particularly in the south, teams are creating new sources of water, educating communities in hygiene promotion and constructing latrines in schools, markets and cultural centers. In Wau county in southern Sudan, MSF fights guinea worm and onchocerciasis (river blindness), diseases directly linked to water quality.

Hindered aid

While medical needs in Sudan are enormous, humanitarian action is often hindered by the civil war. Despite existing ceasefire agreements, MSF staff were repeatedly evacuated from various projects over the past year due to fighting. In December 2002, one local staff member was killed and three were injured when a grenade exploded near the hospital in Ibba.

Rebel and government leaders engaged in a sixth round of peace talks this year, an event hailed by some as an important step toward a real peace accord. For most Sudanese, however, the reality on the ground has not changed much. The humanitarian presence continues to be important, for the specific medical care it can bring, and for other things.

As Dr. Nitya Udaraj, who finished her first MSF mission in Sudan in May 2003, puts it: "Along with the medical care, you are also there talking to patients. You're telling them you're there 'to listen to you, to be with you.'"

International staff: 127
National staff: 1,853

December

More than 50,000 Guineans working in Côte d'Ivoire are displaced by civil war. MSF responds with mobile clinics to support the returnees living in transit camps in **Guinea**

MSF begins medical aid at Zwedru and then Toe Town transit camps in Grand Gedeh county, **Liberia**, near the border with Côte d'Ivoire. At the same time, MSF calls on the United Nations High Commissioner for Refugees to move the Liberian returnees, Ivorian refugees and third-country nationals away from the dangerous border area

A grenade explodes near MSF's hospital in Ibba, **Sudan**, killing one local staff member and injuring three others





© Chris Hondros/Getty Images

MSF aid workers rush an injured girl to MSF's clinic minutes after a fresh round of shelling terrorizes Monrovia, Liberia on the morning of July 25, 2003.

West Africa

At a makeshift MSF residence-turned-hospital in Monrovia, an MSF doctor makes his rounds in what used to be the house's dining and living room. It is July 24, 2003. Wounded people are lying shoulder to shoulder on the floor, on woven straw mats. The entire facility is crowded: one area is now an operating room, another more isolated part outside holds cholera patients. The compound is teeming with sick, injured, dying people, families sleeping under stairwells, children peeping out from under tables – all victims of the vicious fighting that has engulfed Liberia's capital for the third time in two months. Needing to make space

for the wave of injured people expected after the next attack, the MSF doctor is discharging patients who can walk, sending them home.

The irony of home

In Monrovia today, in the rest of Liberia, in many of the countries in West Africa – notably Sierra Leone, Guinea, and Côte d'Ivoire – the idea of “going home” is an ironic, mostly impossible dream.

The patients discharged from MSF's makeshift hospital (one of two) in Monrovia may go home (if they are from Monrovia and if their home is still standing). More likely “home” is a school building where people sleep 60 to a classroom, or the large sports stadium in the center of the city where 40,000 people have sought shelter, or on the street, or anywhere but where the shells

and bullets are falling. Which doesn't leave many places. Often their original homes are hundreds of kilometers away; these towns and villages were abandoned days, weeks, months, sometimes years ago, as people sought to escape the fighting. If home is where a person's loved ones are, people may also have few choices: violence in the city has stripped young children of their mothers, mothers of their newborn babies, families of their fathers, people of their support network.

Unfortunately, this state of affairs is nothing new, nor is it limited to one city in Liberia. Over the last year alone, MSF has cared for people affected by conflict in many parts of Liberia; also in Côte d'Ivoire, Guinea and Sierra Leone. Population flows mean that work in one country can be intimately

December

- └ MSF begins work at Korhogo hospital and health centers in northern Côte d'Ivoire, a rebel-held area inaccessible since the onset of civil war in September 2002
- └ MSF launches Romania's first mobile outreach for homeless people; a socio-medical team begins thrice-weekly visits to people living on the street
- └ A project providing treatment for multi-drug resistant tuberculosis (TB) is handed over to the health authorities of Nagorno-Karabakh; in four years, 500 patients were treated, 15 of them for multi-drug resistant TB



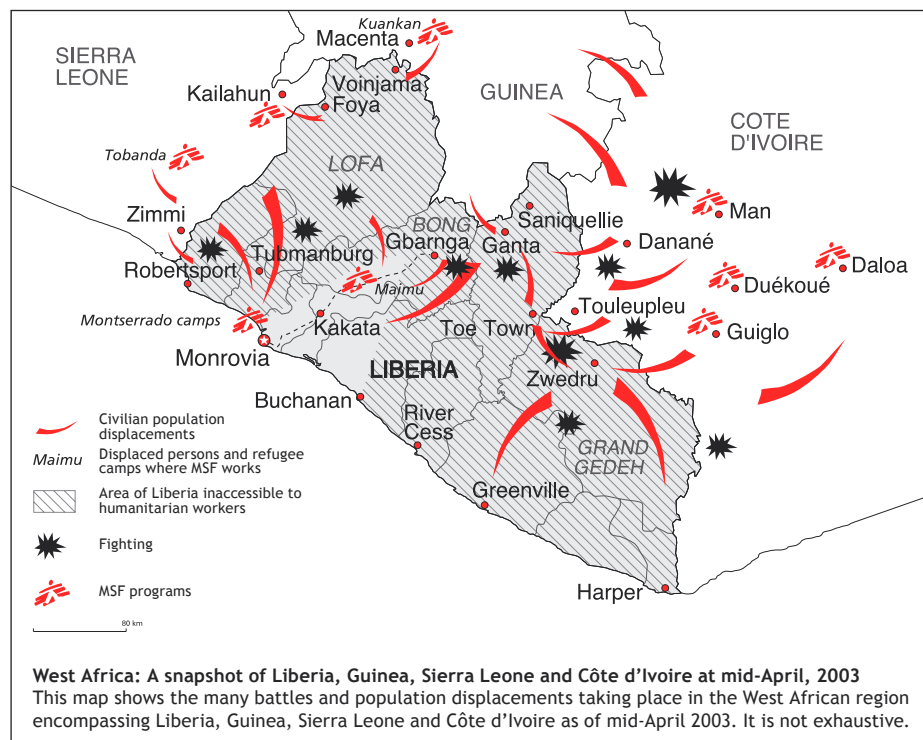
connected to work in another, which is why this single narrative looks at MSF work in all four countries.

MSF has been active in this part of West Africa for more than 20 years: supporting local clinics and hospitals and improving access to health care, responding to epidemics, and assisting vulnerable people, among them street children and prison inmates. Increasingly, however, MSF teams have focused on responding to emergencies associated with armed conflict, providing basic medical care, food, water and shelter to displaced people and refugees. MSF has also repeatedly spoken out about the plight of civilians and called for the protection of civilians, respect for international law, and access to those in need – unfortunately glaringly absent in too many parts of the region. To the contrary, in more than a decade of conflict, civilians have increasingly been targeted by warring factions, manipulated through violence as strategic “tools” of war.

People not populations

“This child was brought to me yesterday and I’ve come to see the doctor because she’s sick with malaria. A hunter found her in the bush, crying next to her mother’s dead body. I think she’s about six years old, but she refuses to speak, only sounds come out of her mouth. She clings to my leg and cries out for her mother all the time. I’ve taken her into my house, I’ve named her Roseline.”
– *Male resident of Danané, Côte d’Ivoire*

Across West Africa, as MSF volunteers have worked to ease pain and save lives, they have also documented the stories of survivors, in order to bear witness to the consequences of armed conflict on civilians. “Every day we listen to our patients telling us the terrible stories of what they have been through over the past months and years,” says Dr. Nathalie Civet, medical coordinator in Liberia. In Côte d’Ivoire, a woman describes fleeing with her family, her husband carrying the baby. When her husband was shot she picked up the baby and kept running. In Guinea, armed men demand money from arriving refugees in exchange for food and safe passage. Because they have none, they are forced to “lend” their daughter for the night in order to survive. A young Liberian woman describes how she had no choice but to leave her sick



grandmother behind to die when they fled the fighting. Endless stories of loss, physical violence, rape and murder.

Liberian cockpit

Over the last year, Liberia has taken its turn as the epicenter of conflict in the region. The civil war which has simmered in the country for more than a decade intensified, forcing thousands to flee their homes and cutting off entire regions from medical services. Many civilians in Liberia have been displaced repeatedly by this conflict, reaching temporary safety only to run again when the fighting comes too close. By August 2002, 50,000 Liberians had already fled to Guinea, 30,000 were present in camps in Sierra Leone and many displaced people had gathered in and around the capital Monrovia. MSF was already working in Monrovia, supporting basic health care at Redemption hospital and five smaller health structures and running a special cholera treatment center. MSF was also working in Montserrado, Bong and Nimba counties, and in the town of Harper in the southeast. As the violence in Liberia escalated, MSF responded by increasing medical services

already in place for refugees in neighboring countries and for internally displaced people inside Liberia itself.

Côte d'Ivoire into the shock of war

At the same time, in September 2002, West Africa destabilized further, with the outbreak of civil war in Côte d'Ivoire following attempts to demobilize part of the armed forces. Nearly one-third of the people in Côte d'Ivoire are immigrants who have come from surrounding countries (including Mali, Burkina Faso, Guinea and Liberia), many to work on the cocoa and coffee plantations. Pierre Bouillet-Desbareau, of MSF's emergency unit, described the situation in neighboring Burkina Faso in late 2002, during an exploratory mission to the region: “When we got to Ouagadougou, the atmosphere was one of a tense wait-and-see. The population would stand holding its breath every time the radio reported on events in Côte d'Ivoire. Everyone has a parent, a cousin or friend working in the cotton or cocoa fields ‘over there.’” As the fighting and breakdown of basic services spread, thousands of people fled. Many tried to reach their countries of origin. Within Côte

December

Former South African President Nelson Mandela visits MSF's AIDS program in Khayelitsha, **South Africa**, where hundreds of people with HIV/AIDS receive ARV treatment and many thousands more regular medical care. Mandela's visit helps put the spotlight on the need to scale up existing ARV treatment programs and implement new ones; it is also an important source of pressure on the South African government to develop a national AIDS treatment policy (which is finally announced in August 2003)

MSF closes its reception center in Brindisi, **Italy**, as refugee influx in this area drops

After 10 years, MSF ends the Kashin Beck (Big Bone) disease program in Tibet, **China**, as well as a related water hygiene and sanitation project in the region

d'Ivoire itself, the civil war cut the country in two, with the north isolated and controlled by rebels. MSF teams traveling through the region were repeatedly approached by people who had messages for their families in the other half of the country. MSF, already providing medical care at the Maison d'Arrêt et de Correction d'Abidjan (MACA) prison since 1997, pressed for access to civilians trapped in the northern part of the country and began assistance (including nutritional programs) to hospitals and clinics in Bouaké, Korhogo and Man, areas deeply affected by the war. MSF was able to provide medical assistance on all sides of the conflict.

Displacement in all directions

As armed conflict in Liberia and Côte d'Ivoire gained in intensity, greater numbers of people were forced from their homes or the shelter of refugee camps. Thousands traveled huge distances on foot carrying what little they could, often trying to hide from armed groups. Many hoped to reach neighboring Sierra Leone or Guinea. MSF was present in all four countries and worked to respond effectively to the crisis, reinforcing teams at strategic points along the borders, identifying where the displaced were gathering, and setting up emergency clinics.

Groups of displaced people, seeking safety and shelter, often moved simultaneously in several directions. In December 2002, tens of thousands of Liberians trying to leave the country had massed in border camps inside Liberia in areas such as Nimba and Grand Gedeh counties, where MSF was present. Some were able to reach other countries in the region. At the same time, large numbers of Liberians were trying to return to Liberia, fleeing the violence in Côte d'Ivoire. Many gathered near the border in transit camps meant to serve as only temporary shelter.

Grand Gedeh cauldron

The fate of Zwedru and Toe Town transit camps in Grand Gedeh county, in eastern Liberia near the border with Côte d'Ivoire, illustrates the danger of leaving fleeing people so close to the border and the fighting, as well as the consequences of failing to provide them with adequate assistance and protection. In December 2002, MSF began

to manage medical activities in Zwedru. In addition to providing health screening, teams carried out measles vaccinations and established a therapeutic feeding center to treat malnourished children. Similar assistance began in Toe Town, about 100km to the north, in January 2003. The camps served thousands of refugees from Côte d'Ivoire, including Ivorians, Liberians who had taken refuge in Côte d'Ivoire and were now fleeing that fighting, and third-country nationals. However, because the camps were dangerously close to the fighting in Côte d'Ivoire and insufficient for the thousands of people pouring into the area, at the time MSF called in vain on the United Nations High Commissioner for Refugees (UNHCR) to move the people to permanent camps in a more secure location.

In March MSF's fears were borne out. As the situation in Liberia and Côte d'Ivoire deteriorated, an attack on Toe Town early in the month and subsequent attack on Zwedru several weeks later effectively cut off the camps – and the whole area – from humanitarian assistance. MSF could no longer reach the camps located along the border with Côte d'Ivoire. "Our teams were forced to leave the area because it was too dangerous to stay," stated Kostas Moschochoritis, an MSF operational coordinator, in March. "We are very worried now about the situation of the people in the region, both the local population and the refugees. Thousands of innocent people remain trapped in an extremely violent and volatile situation, cut off from medical care of any kind." The very transit camps that MSF had urged be moved had become inaccessible, leaving refugees and local residents with no emergency assistance whatsoever. "As long as they are forced to stay in the transit camps close to the border and fighting areas, they are too vulnerable," said Moschochoritis. According to Dr. Hani Khalifa, medical coordinator in Liberia, unofficial reports indicated that most of the refugees had fled the area. "During the attack on Toe Town in early March, refugees fled the camp and the host communities around Toe Town in all directions. Since then we have not been able to get any news about what has happened to them. Unofficial reports indicate that most of them have fled

into the bush and that many families have been separated." MSF repeatedly spoke out about the lack of protection and called for access to the estimated 45,000 displaced people and refugees in the area.

Soon, attacks in Nimba County in the north also prompted many thousands to flee. MSF was forced to reduce its presence in the Saclapea refugee camp there. Fighting then reached Harper, in the southeast, ending MSF's work there. Nearly 75% of Liberia was now out of reach of any humanitarian assistance.

Responding to the regional crisis – Sierra Leone

"There's nothing like home" – Sierra Leonean man, returning to his country after living as a refugee in Guinea

"There's nothing like home" – Liberian man, Taiama refugee camp, Sierra Leone

In Sierra Leone, a country slowly beginning the transition to peace after years of brutal violence, MSF actively supports eight hospitals and over 30 clinics around the country, often caring for Sierra Leonean returnees arriving home after living as refugees in the surrounding countries. By October 2002, 30,000 refugees in camps in the district of Bo were also receiving MSF aid. In order to provide equal access to health care to Liberian refugees and Sierra Leoneans, MSF sent mobile clinics to villages near the camps. Within the camps themselves, MSF established a system of home visits, carried out by Liberian refugees with medical backgrounds, trained and supervised by MSF. Through home visits, the MSF staff were able to refer patients to the mobile clinics and to monitor their progress and medicines. In some camps therapeutic feeding centers responded to malnutrition among the refugees. MSF was also active in refugee camps in Moyamba, Kenema and Zimmi. By February 2003, 200 Liberians were arriving per week in the district of Kailahun, many in poor condition from their journey. Because of Kailahun's location between the Liberian and Guinean borders, MSF teams there work with many Liberian refugees as well as Sierra Leoneans returning from Guinea.

During Sierra Leone's 11-year conflict, numerous clinics and hospitals were destroyed, and the country has only begun to rebuild itself during the fragile peace

January

In **Democratic Republic of the Congo**, teams respond to cholera outbreaks in Kasai and Nord-Kivu provinces, a nutritional emergency in Katanga province, and a flu epidemic in Kinshasa. From October 2001 to the present, a cholera outbreak in Katanga province has continued nearly non-stop; MSF has treated nearly 20,000 people

In **Moscow, the Russian Federation**, MSF launches a campaign called "Indifference = Murder" to raise awareness about the plight of the homeless in winter

MSF begins an exploratory mission on the health conditions of asylum-seekers and illegal immigrants in **Luxembourg**



Liberian voices from **Liberia,** **Guinea** and **Sierra Leone**

The following accounts are taken from Liberian stories: A population caught in a cycle of violence and displacement, issued by MSF in June 2003. To read the full report, go to www.msf.org

"Kolahun was attacked on a Monday, the market day, early in the morning. The town was surrounded and they fired in the air, then in the direction of houses... I was in bed with my two children of seven and ten... People were running in all directions. Once in the bush I heard that my mother and my wife were killed." – Refugee man, 50 years old, Tekoulo refugee camp, Guinea

"I was scared when I left. People were running behind me and tried to force me to be a fighter. This happens a lot. They take people on the streets and force them to fight." – Refugee woman, 25 years old, Jimmi Bagbo refugee camp, Sierra Leone

"The day before yesterday – June 21, 2003 – I went to the bush to look for wood. There were three government soldiers with guns. One of them saw me... he told me 'you are assigned to me for the day.' I was very afraid. He forced me to go far into the bush and he undressed me. Then he raped me." – Anna, 27, Seigbeh camp for internally displaced persons, Liberia

"When we came to the border we had to pay money to the Liberian soldiers. I paid 30 Liberian dollars. If you do not have the money they will take your clothes, anything. If you do not have anything, you will not cross the border." – Refugee woman, 26, Gerihun refugee camp, Sierra Leone

"The rebels came to the house and said they would not hurt us. But they took all our money, food and belongings. They moved from house to house looting everything, even people's jeans and shoes. Everything in the camp has been vandalized." – Displaced man, Plumcor camp for internally displaced persons, Liberia

"Every day there are new arrivals in the camps. People are coming by foot... When UNHCR came for the verification procedure a lot of the foot arrivals were left out... But they are here now and they are not registered. This means that they do not have a food ration card and if there is a food distribution they will not receive any food. So other refugees will have to share food with them." – Refugee woman, 49, Gerihun refugee camp, Sierra Leone ■

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January

– To help reduce the high child mortality rate among area immigrants, MSF begins medical care and surgical support at public health facilities in Siracusa province in southwestern Sicily, **Italy**

– In the **Russian Federation**, alternative shelters built by MSF for displaced Chechens taking refuge in Ingushetia are declared illegal by the Ingush government and ordered destroyed. Many Chechens are living in horrible conditions in camps that are systematically being closed; MSF had built the new shelters to give the displaced a real choice between staying in Ingushetia and returning to Chechnya, where violence and terror continue. As of October 2003, the shelters were still standing - but empty



of the last couple of years. For a country just emerging from its own brutal civil war, the heavy influx of refugees is an extra burden. MSF hopes to ensure that the most vulnerable people are not forgotten during the gradual reestablishment of health services. At the same time, as reconstruction and repatriation gather pace, MSF is concerned that many Sierra Leoneans are being repatriated and “encouraged” to go home without sufficient assistance.

Responding to the regional crisis – Guinea

MSF has had projects in Guinea for 17 years, many focused on refugees from surrounding countries. As of mid-2002, MSF was present in the capital Conakry and several prefectures. In Guéckédou, MSF was supporting four health centers and 11 health posts and in Konkouré MSF teams were working to improve rural health care by training birth attendants. Support to the national tuberculosis program was in its 15th year. As fighting escalated in Liberia and Côte d'Ivoire, MSF teams already in place along the borders responded to provide support in Macenta, Guéckédou, Kissidougou, Nzérékoré and Boreah. In addition to the many refugees seeking shelter in Guinea, many Guineans who had been living in Côte d'Ivoire were displaced. By mid-December, 50,000 Guineans had returned to Guinea from Côte d'Ivoire, many living in transit camps along the border. MSF was present in the Senko region and responded by visiting villages close to the border with mobile clinics. By January 35,000 people were living in Kuankan camp in Guinea, where MSF was providing medical care for 7,000 people.

Sexual violence – a grim tool of war

“When rebels ‘win’ a town they rape the women; when the army ‘wins the town back’, the women are raped again. Some are also taken as ‘rebel wives.’” – Dr. Tonia Marquadt, MSF, Liberia

One of the most damaging acts of war is the widespread sexual violence which often accompanies armed conflict. MSF has documented sexual violence against unprotected civilians in many parts of the world, and West Africa is no exception. Thousands have been raped by participants

in these wars, and countless women have been forced to submit to sexual violence to save their lives or the lives of their children. Refugees tell stories of young women in their families who have been abducted by armed groups. “They took away my 16-year-old sister. We have not heard anything from my sister who was taken by the rebels – we think she is still with them in Bomi County. Lots of other girls were taken by them too,” said a man in Plumcor camp in Liberia.

Sexual violence is perpetrated on vulnerable people by warring parties, soldiers, civilians, even aid workers. A February 2002 report issued by UNHCR and Save the Children outlined abuses of refugees by humanitarian workers in camps in several West African countries. MSF was one of the organizations mentioned. Despite the fact that the allegations concerning MSF could not be substantiated, MSF knows the problem exists and has responded by implementing sexual violence training in many of its projects, to sensitize and educate volunteers and better respond to the medical needs of victims.

In May 2002, sexual violence training was integrated into existing refugee health programs in Boreah camp in Guinea, and in November in Taiama, Bo and Pujehun camps in Sierra Leone. In addition to attending to the immediate medical consequences of rape (treatment for sexually transmitted diseases or to prevent pregnancy or HIV infection), these pilot projects involve psychological support for victims and documentation of the violence. Prevention and consciousness-raising about the problem are also important aspects of sexual violence projects. In May 2003, a new program for survivors of sexual violence began in Liberia, where doctors had reported seeing patients as young as five years old who had been raped (the project was suspended when the conflict escalated shortly thereafter).

In the context where people must leave their homes behind to find refuge elsewhere, women and girls are particularly vulnerable and often subject to violence and exploitation. MSF continues to advocate for sufficient humanitarian assistance for refugees and displaced people and for their protection through UNHCR. See page 34 for

more on MSF's response to sexual violence, in West Africa and elsewhere.

Preventing and responding to outbreaks of disease

People on the run have no access to sanitation and often live near any source of water they can find, including swamps where disease-carrying mosquitoes proliferate. Those lucky enough to reach camps with clean water and sanitation facilities usually live in limited and overcrowded spaces, which increases the spread of contagious disease to what can be epidemic proportions. As part of the response to the crises in West Africa, MSF teams have worked to monitor and treat cases of infectious diseases such as cholera, which is endemic in the region. Cases typically occur during the rainy season, from April to November.

MSF teams also try to halt the spread of disease through vaccination campaigns. In Côte d'Ivoire, for example, MSF responded to an outbreak of measles in the Korhogo region, vaccinating more than 8,000 children in ten different villages. “It was important for us to move fast, because the local health care systems in the area have largely disintegrated,” said Stephane Goetghebuer from MSF operations. “Since the beginning of the conflict in the region, health workers have stopped working in the hospitals and health centers. With the situation as it is, outbreaks such as this one can easily go undetected. Even though this was a relatively small outbreak it was essential that it was addressed quickly, to avoid the risk of the virus spreading more widely.” Measles vaccinations were carried out in all four countries in transit centers, mobile clinics and local health facilities supported by MSF.

Keeping hospitals open

Health services which are limited in times of peace often disappear with the outbreak of war, and many people are left with no access to medicine or the most basic care. During the past year MSF staff in West Africa worked to keep hospitals and clinics open where possible. While teams along the borders received displaced people – providing medical care, clean water and sanitation facilities, and distributing plastic

January

— In Kajo Keji, **Sudan**, reports of sexual violence against women and young girls prompt MSF to set up a targeted medical program and network of psychological support for these patients

— MSF calls on the United Nations High Commissioner for Refugees to protect **North Korean** refugees in **China**, after 48 North Koreans seeking transfer to South Korea and Japan are arrested by Chinese authorities in Yantai City, Shandong province

— MSF opens its first mission in **Nepal**, supporting diagnostic, consulting and inpatient services at a hospital in the city of Rukum

— Medical care and daily necessities are provided to 150 Afghans trying to make their way to the United Kingdom via **Belgium**. MSF shelters part of the group in Brussels for several nights



Voices from Côte d'Ivoire

The following stories were gathered for MSF's report Ça va un peu, maintenant: The collapse of health care, malnutrition, violence and displacement in western Côte d'Ivoire, issued in July 2003. For the full report, go to www.msf.org

"We were hiding in the bush for two weeks. We would keep moving all the time and gave our child whatever we found to eat, in order to keep her quiet. We were scared that her crying would attract attention." – Displaced woman in Ganleu

"They suddenly came one morning and started shooting, we fled in all directions, into the bush. We returned the next morning to pick up our belongings, but everything was burnt: our rice, our tools, our clothes and documents." – Displaced man, 31 years old

"I can hardly breathe, my body aches all over, I have bad dreams. It all started when I saw my neighbor and good friend being killed. Three Liberians, two men and one woman, came to P.'s house and asked him for money. They shot him in the foot when he didn't pay immediately. When he said he had no money they shot him in the chest and he died." – Male resident of Danané, 73 years old

"I was five months pregnant but had a miscarriage... armed men speaking French and English came to my village and started to kill. They just started shooting and aimed for the men. I saw my father-in-law being shot, right in front of my eyes.... They made the women and children sit in the sun for hours. I was so thirsty. They poured gasoline all around us and laughed, saying they would set us on fire. I was terrified and that's when I started bleeding. The next day, we went to Zouan-Hounien.... More armed men came to intimidate us there. They saw me bleeding and said: 'You are already dead.' It was terrible." – Displaced woman, 20 years old, at Man hospital

"We stayed in the bush for two months and had to keep moving all the time. Now I stay there because I have 11 children and I don't know how to feed them. They've destroyed our houses and our food stocks. In the bush we can at least find some fruits and roots to eat." – Displaced man, 41 years old ■

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February

- └ MSF lodges an official protest after Israeli troops fire warning shots on an MSF medical team, which was destined, with authorization, for the Palestinian enclave of Seyafa in the **Gaza Strip**
- └ In **Côte d'Ivoire**, MSF reopens Man hospital near the Liberian border, which had been looted and closed several months before
- └ More than 500,000 people are vaccinated for yellow fever in **Guinea** with MSF support
- └ In **Bulgaria**, the Ministry of Health chooses MSF's sexually transmitted disease (STD) project in Sofia as the country's reference training center for doctors in reproductive health and STD management

sheeting, food, and supplies – other MSF teams worked to continue services inside Liberia and Côte d'Ivoire despite the violent upheaval.

In Côte d'Ivoire, the civil war forced many of the country's trained health professionals to flee. With rebels controlling the northern half of the country, travel in Côte d'Ivoire became increasingly difficult, and many medical facilities began to run out of medicines. In October 2002, MSF reinforced its emergency team in Bouaké and brought much-needed supplies to the central hospital, which had been paralyzed since the beginning of the conflict. In February 2003, MSF was able to reopen the regional hospital in Man, which had been looted and closed months before when the civil war began. As of March, Man hospital had resumed pediatrics, surgery and maternity services and medical staff were carrying out 170 consultations per day in spite of continued insecurity. Fighting

in western Côte d'Ivoire was resulting in increasing numbers of wounded civilians arriving at Man hospital. Many were women, children and elderly people who reported they had been wounded during helicopter attacks. MSF spoke out about the attacks, urging all parties to respect civilians and medical installations. But in the face of the relentless violence of conflict, sometimes keeping a hospital open was in itself not enough. "The situation in the west of Côte d'Ivoire is extremely volatile at the moment and there is a genuine climate of anarchy and fear," stated MSF operations director Christopher Stokes in March 2003. "The people are becoming too afraid to come even for medical consultations. Last week, after hearing about an outbreak of fighting in Bangolo, a village 25km from Man, over 60 people fled the hospital, including a mother whose child was suffering from second- and third-degree burns. With no care he will

probably not have survived." In May, MSF also started a therapeutic feeding program in Man, to help cope with the precarious nutritional situation in the western part of the country.

Between October 2002 and May 2003, MSF teams along the front lines in Côte d'Ivoire carried out more than 90,000 medical examinations, performed 1,650 operations and attended 3,800 births.

Liberian coda

By mid-2003, the situation in Liberia was as dire as the most pessimistic predictions could have foreseen. MSF had played an important role in maintaining health structures for the previous 12 months, despite the civil conflict. With access to health facilities deteriorating daily and many local medical workers forced to flee the violence, an average of 30,000 consultations per month were carried out at MSF-supported facilities (hospitals, clinics,



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People line up at dawn for food distribution near Salala camp for the displaced in Bong County, north of Monrovia, Liberia, in September 2003. People at Salala camp had just fled fighting near Maimu camp, several kilometers to the north; many of them had already been displaced many times before. In September, signs of malnutrition among the displaced at Salala were beginning to be worrisome. Despite a new government and the deployment of a Nigerian peacekeeping contingent, conflict continues in many parts of Liberia; people continue to suffer.

February

MSF supports the Ministry of Health and the World Health Organization in an effort to stem an outbreak of Ebola in Cuvette, Republic of Congo

Shelter materials, cooking utensils and sanitary kits are distributed to 300 immigrants living in precarious conditions in the forest near Ceuta, a department of Spain on the north coast of Africa; as a result of MSF's lobbying around the immigrants' plight, many are moved to more suitable locations

Some 135,000 children get measles vaccinations in the district of Sarh and Danamajdi, Chad

health posts, and camps for the displaced around the country.

However, as the front line advanced toward Monrovia in June 2003, the hospitals and clinics were forced to shut down and some MSF international staff evacuated. At the same time, more and more people crowded into the capital, in increasingly worse condition. The Liberian capital was gasping for breath.

The remaining staff discussed how to best serve the population. "We decided there was nothing for it but to build our own hospital right here in the compound," explained Tom Quinn, an MSF nurse in Monrovia. In response to the massive medical needs, an emergency clinic was created inside the MSF residences where MSF staff and their families were already sheltering, in the Mamba Point area of the city. "Everywhere there are people. You look under the stairs and there is a family. You look under the tables and there are some children," described Tom. "The staff have been working 72 hours straight. We would be nowhere if it weren't for their dedication." Both MSF compounds were transformed into hospitals.

Hundreds of people began arriving at the doors of the compounds as word of the clinics spread. Dr. Nathalie Civet described the massive need for medical services and the crowded conditions, noting that "it was never meant to be a hospital, so we are improvising as we go." The emergency clinics were soon able to accommodate minor surgery. Patients requiring major surgery were transferred to the only functioning unit – trauma surgery – of Monrovia's last functioning hospital (sustained by the Red Cross).

At the end of July (the end of the reporting period for this Activity Report), MSF was still active in Liberia; doctors and nurses, both expatriate and local staff, were working under extremely difficult conditions. Outside of Monrovia, MSF Liberian staff continued to provide assistance to about 60,000 displaced people at several camps in Bong county; MSF clinics in other camps near the capital had been forced to close.

In Monrovia, MSF also continued to provide care at the main sports stadium, "home" to about 40,000 people. Wheelbarrow and stretcher ambulances continued to weave

through mortars and bullets, bringing the wounded to the makeshift clinics in Mamba Point. Stray bullets entering the compounds had become a fact of life. Some people were treated; some lives were saved. Many more had no access to care whatsoever.

Most people weren't able to make it to the clinics.

Editor's note: In August 2003, a ceasefire, the stepping down of President Charles Taylor and the arrival of Nigerian peacekeepers eased the situation in Liberia, particularly in Monrovia. MSF was able to begin extending activities in Monrovia as well as expand work to Montserrado and Bong counties. However, in a September briefing to the UN Security Council, MSF reiterated that while fighting may have ceased momentarily in the capital, Liberia was not a country at peace. Fighting and violence against civilians continued in the countryside. MSF remains concerned that the predominant optimistic understanding among states, UN agencies and NGOs that Liberia is well on the road to peace and reconstruction is undermining the urgent response required to meet the massive needs of the people today.

International staff: 225

National staff: 1,803

Colombia

Soacha just doesn't stop growing. Every day families arrive, coming from all over the country to start a new life up in the hills of this township attached to Bogotá. Soacha is one of the main reception sites for displaced people in Colombia. Despite the precarious conditions (water, electricity or other services are almost non-existent), people keep coming. The land conflict, economic interests, crop fumigations in the war on drugs and threats from paramilitary forces, government soldiers and guerrillas force farmers and indigenous people to leave their homes and their land, displacing them to the ever-growing misery of the outskirts of the main cities. Unofficial estimates put the number of displaced people in Colombia at 3 million. MSF, active in Colombia since 1985, provides medical care to people isolated by

conflict in rural regions and displaced by conflict to the country's urban areas. MSF also cares for people who have become victims of the more generalized violence that plagues Colombia's cities.

Basic care in conflict-scarred rural areas

The conflict is most visible in rural areas and on the periphery of the cities. In the rural areas the war continues to exact a staggering toll. Civilians are the victims of a constantly-shifting division of territories between the warring parties. Human rights violations, assassinations and threats occur in silence, almost without denunciation, almost without ceasing.

The cruelty and the extension of the conflict have left large parts of Colombia isolated; people can easily fall prey to diseases such as malaria, leishmaniasis, tuberculosis, tropical diseases and parasitosis, or chronic malnutrition. Combined with distance from medical care, difficulty traveling because of the conflict and a health system which excludes many people, the result is great difficulty getting access to health care in Colombia.

The geographic dispersal of the conflict and the number of actors in a small area mean that it's difficult to move around; there is a great danger of being blocked or caught in the middle of an "operation." In many areas, warring parties block roads and rivers and prevent transport of medicines and food. The few existing health posts can be situated in territory held by the "other" side. Many are only partially functioning, some are simply abandoned. Hospitals often cannot organize mobile clinics because of insecurity. Threats to medical missions are frequent and made by all actors involved. MSF has been a witness to flagrant violations of international humanitarian law through non-respect of health facilities and medical personnel.

In this context, MSF's mobile clinics in rural zones are of special relevance. MSF has created a space to enter zones controlled by the different actors and can provide neutral, impartial and independent assistance to people in Bolivar, Caquetá, Córdoba, Cundinamarca, Narino, Norte de Santander, Sucre and Tolima, delivering what in some places is the only available medical care. A typical mobile clinic might operate like the one in Tolima: MSF provides services in five different districts. Every six weeks, villages

February

Antiretroviral treatment begins in Yangon, Myanmar, in what is the country's first ARV program; 80 people are under treatment by October 2003

MSF launches a nutrition aid project in Masvingo province, Zimbabwe, starting five therapeutic feeding centers in mission hospitals and training health personnel in protocols for treating severe malnutrition

A two-day kala azar workshop is held in Khartoum, Sudan; it leads the Ministry of Health to develop a national kala azar protocol and strategic five-year plan for addressing the disease



and hamlets receive a visit from a team made up of medical personnel from MSF and the hospital of that district. The team provides basic care and vaccinations; people with severe health problems are referred to the hospital. In Tolima, teams carried out 15,000 consultations in 2002. Similar brigades are ongoing in the Costa Atlántica area and in Caquetá, Cundinamarca, Nariño, and Norte de Santander departments.

In the Magdalena Medio region, MSF was able to end its mobile clinics when the larger communities regained regular access to health care. In the last months before closure, focus was therefore shifted from curative care to training local health personnel. In August 2002, with the end of peace talks between the government and the guerrillas, MSF concentrated its efforts in the northern part of Caquetá department, including San Vicente del Caguán. However, because the situation has become more stable there, mobile clinics have restarted in southern Caquetá.

Access to care is difficult for people remaining in Colombia's fractured rural areas; it can be equally difficult for those who manage to escape this and end up in the cities. Although emergency assistance to the displaced is stipulated by law, claiming that they are displaced rarely brings people the promised aid. As a result, they become almost invisible.

Since late 1999, MSF has assisted some of the 40,000 people, many of them displaced, living in Soacha, near Bogotá. In March 2003 MSF began medical aid to people in Quibdó, which, with a population estimated at 140,000, is one of the largest towns in the province of Chocó and a magnet for rural people fleeing conflict in that region. Daily reality dictates that the people who come to live in places like Soacha and Quibdó have no right to become sick, because nobody will provide services for them. In theory, the government has foreseen their inclusion in the public health system, but in reality the process is so complicated and so far behind the social and economical reality of the country that the most vulnerable have no access. To become integrated into the system, these people – who already live in dire conditions, having to carry the burden of atrocities they have experienced or

witnessed, who often have little education, who are frightened and unaware of their rights – have to orient themselves toward a circus of letters, passes, ID-cards and socio-economic classifications. It can take months or even years to get registered, if it happens at all. Furthermore, new rules complicate access to services. At the same time, the privatization process currently underway in Colombia is having a negative impact on the delivery of quality health services.

All this means that displaced people are isolated, living in conditions (such as overcrowding and poverty) that make them more vulnerable to health problems, sexual abuse and exploitation. MSF runs two health centers and a mobile clinic in Soacha to attend those who are excluded from the system or cannot reach health centers in the city. In Quibdó, MSF works at a health center and reference hospital, and focuses on primary care for mothers and children in order to combat the high infant and maternal mortality rates in the area. In both places, MSF helps people obtain the medical coverage that is their right.

Other programs

MSF deals with the medical consequences of extreme violence in the Aguablanca neighborhood of Cali, providing physical rehabilitation and psychological care to young victims of violence.

International staff: 37

National staff: 126

North Caucasus

The past year has been particularly difficult for MSF in the North Caucasus. Faced with the kidnapping of staff member Arjan Erkel in August 2002, obstruction by the authorities and an increase in security threats and the danger of violence, the organization has been extremely challenged to provide effective independent humanitarian aid in the region. The vast reduction in the capacity to carry out humanitarian work in the North Caucasus has not been echoed by a reduction in needs, which remain pressing. The pressures on humanitarian action,

after all, only matter because the need for assistance continues to be acute.

Refugees pushed back into war zone

"We dread for our lives if we have to return to Grozny, particularly for the lives of our sons." – mothers in Znamenskoye camp speaking to MSF staff before the camp was closed in June 2002

June 2002 saw the publication of a "Twenty Point" plan by the Russian authorities to repatriate nearly 120,000 internally displaced persons (IDPs) from Ingushetia to Chechnya by 1 October 2002. While the plan was never completely fulfilled, it signaled the start of a concerted campaign of harassment and coercion that resulted in the closure of several tent camps and the dispersal of tens of thousands of IDPs to the war zone of Chechnya.

MSF immediately protested the plan, claiming that the current climate of extreme violence in Chechnya was the principal reason why the civilian population fled, as well as why they refused to return to Chechnya. It was also stressed that any repatriation should be voluntary. It was clear that conditions for a secure and voluntary return did not exist in Chechnya.

Coinciding with the "Twenty Point" plan was a marked change in the attitude of the authorities toward NGOs working with the displaced. Increased tax and safety inspections, as well as endless administrative red tape, contributed to an atmosphere of noncooperation. One example: in late June, the Ingush Minister of Health rescinded a Memorandum of Understanding with MSF for the opening of a tuberculosis hospital in Ingushetia. The authorities made it clear that this was linked to the "Twenty Point" plan: since the IDPs would be returning to Chechnya, there would be nobody left to treat.

Within two weeks, the first camp was closed. The camp in Znamenskoye, in Chechnya but right on the border with Ingushetia, had tents torn down and latrines shut in the weeks preceding its closure. Gas, water and electricity were cut off. The 2,200 displaced people who had been living there were dispersed around Chechnya or consigned to overcrowded temporary accommodation centers in Grozny.

February

In partnership with the Nelson Mandela Foundation, MSF begins a new HIV/AIDS program in Lusikisiki (Eastern Cape province), South Africa

MSF carries out a blanket feeding, or general food distribution, for 14,000 children in Mungo, Angola; out of these children, 47 suffer from severe malnutrition, and another 2,228 are moderately malnourished

Thirty tons of food are distributed and 3,000 children vaccinated against measles in Thiekthou, Sudan



Left without a choice

The following is taken from Left without a choice: Chechens forced to return to Chechnya, issued in April 2003. The report is based on an MSF survey of Chechen families living in eight tent camps in Ingushetia. For the full report, visit www.msf.org

"I am afraid of the cleansing operations. I don't even want to think about the closure of the camps. I hope humanitarian organizations will help us."

"I am afraid for my family in Chechnya. Our house was destroyed. I don't know what to do if the camps are closed. I will do the same as everyone else. I am afraid of the camp closure."

MSF's survey shows that 98% of the Chechen population living in tents in Ingushetia do not want to return to Chechnya, mainly because they fear for their lives.

Today, the situation in Chechnya continues to be insecure for civilians: 93% of families who were not planning on returning to Chechnya in the near future give insecurity as a reason. The high levels of violence and insecurity in Chechnya are well documented elsewhere: zatchiskas (cleansing operations), disappearances, murders, torture and bombings are constantly threatening civilians' lives.

Chechen families refuse to go back to Chechnya even though their living conditions in the tent camps continue to be totally unacceptable, with more than half of the families interviewed living in tents that leak, do not have adequate insulation against the cold, or do not have floors (either wooden or concrete). Most importantly, people have no alternative place to stay in Ingushetia when the camps close.

In spite of people's choice to stay in Ingushetia and official statements that no one will be forced back, the provision of alternative shelter by humanitarian organizations continues to be blocked. The families identified by the MSF survey are being offered no alternative. The results speak for themselves, showing the need for construction and provision of alternative shelters for at least 2,827 families (14,443 people) in all tent camps, with those in the official camps probably being in more urgent need. A key point in providing options to people is informing them that alternative shelter in Ingushetia is a possibility.

The displaced Chechen families living in tent camps in Ingushetia are subject to forced return in a subtle yet extremely efficient way. As more families leave, pressure grows on the ones who have decided to stay. Families are not presented with the option to stay in Ingushetia. ■

©Gazelle Gaignaire

March

After 15 years of medical activity, MSF closes down its medical-social center in Lille, **France**, after a decrease in visits to the center indicates that it is no longer needed

In the face of a double epidemic of measles and meningitis in **Niger**, MSF vaccinates 125,000 children against measles and 290,000 adults and children against meningitis

The Tika Bika Viol! I say no to rape! grassroots campaign sweeps through Brazzaville, capital of **Republic of Congo**; street theater, life-size wooden silhouettes, bumper stickers and a colloquium tackle the silence around the "taboo" subject of sexual violence



Early warning system set up

In July 2002, MSF was able to set up a network of community health workers in Ingushetia to improve proximity to the IDPs and knowledge of the field situation. These health workers were also to play an important role as an early warning system, allowing MSF to react in case of an emergency, particularly one that touched the most vulnerable groups. The health workers were made aware of IDP rights as well as MSF's awareness-raising role. They were asked to pass on information about any incidents that put pressure on the IDPs to return to Chechnya.

Even as the first incidents began to be reported, the dangers of returning to Chechnya became increasingly apparent. "My two sons went to visit their father in Samashki, in Chechnya and were detained by the military," says a displaced woman living in a camp in Aki Yurt, Ingushetia. "After a few days, soldiers threw away the dead body of one of my sons. The second survived but was very cruelly beaten. His face was covered with black bruises and his legs and body covered with knife cuts." There were many accounts like this.

Operations suspended in Chechnya

The security situation began to seriously deteriorate after the closure of the camp in Znamenskoye. Mine incidents, security warnings and, most of all, kidnap threats involving aid workers became the norm. On July 23, Nina Davydovich of the Russian NGO Druzhba ("Friendship") was kidnapped in Chechnya (she was released in January 2003). MSF suspended operations there following the abduction but decided to continue to provide direct life-saving assistance in emergency situations. This included supply of medicines and medical material to Chechen surgical facilities and continued work by MSF's Chechen doctors in cases of emergency.

Arjan Erkel kidnapped

On August 12, Arjan Erkel, Head of Mission for MSF in Dagestan, was kidnapped by gunmen in the city of Makhachkala. In Dagestan, prior to the kidnapping, MSF had been providing essential drugs to ten hospitals in the region as well as running a program of psychosocial assistance in the

city of Khazaviurt on the Chechen border. MSF immediately extended the suspension of activities (in place in Ingushetia since Davydovich's kidnapping) to the whole of the Northern Caucasus in response to the abduction but resumed operations in Ingushetia a month later for the sake of the thousands of civilians in the republic in dire need of assistance. (In September 2002, MSF was also deeply saddened by the untimely death of Rori Duncan, one of its project coordinators for the North Caucasus.)

MSF began to work tirelessly to secure Erkel's freedom, repeatedly calling on the Russian authorities to press their investigation into the kidnapping. In the ensuing months, MSF also sought to apply public pressure for his release, through press releases, events marking the captivity, and a worldwide petition that has since received over 380,000 signatures.

When Arjan Erkel remained missing after one year, MSF issued a damning report of the Russian authorities' investigation into the kidnapping. In the report, MSF severely criticized the investigation of the case and expressed doubts for the first time about the determination of the Russian authorities to find a resolution.

Moscow theater crisis – MSF plays a silent role

Autumn saw the beginning of a new phase in the tactics of Chechen separatists in their struggle for independence. A theater full of people was taken over by a group of suicide bombers demanding that Russia withdraw from Chechnya or else they would blow up the theater. Both the separatists and the authorities requested that MSF come to the scene. MSF immediately sent doctors to the theater but they were not asked to intervene during the crisis or during the immediate aftermath of a gas attack by the Russian Special Forces which eventually claimed the lives of nearly 120 people.

MSF quickly turned its attention to the hospitals, which were completely inadequately prepared for the influx of patients overcome by the gas. "There were people dying and dead at the reception area of the hospital," recounted one MSF doctor who visited Hospital 13, where most of the theater-goers were transferred. "They were

just dumped there. I saw doctors getting sick and almost passing out as they gave mouth-to-mouth resuscitation to patients." Over the next three days and nights, MSF secretly delivered medicines, equipment and food to Hospital 13 and the central medical distribution center.

Deportation

Meanwhile, the situation of the Chechens in Ingushetia continued to deteriorate. The tent camp in the district of Aki Yurt, which accommodated 1,500 displaced people, was closed on December 2, 2002. In the run-up to the closure, MSF told the IDPs that it would pay for accommodation in the private sector for those who chose to stay in Ingushetia. Nineteen families took up the offer in what was to become known as the "Cash for Shelter" program. Some people were shipped by the Ingush authorities back to Chechnya, transported on trucks and buses and uncereemoniously left to shift for themselves. Although the government had promised to set up temporary accommodation in Grozny, it was not enough for all who needed it and it was not yet finished. People who had fled the republic in terror now returned in terror and without assistance, finding shelter in cowsheds, kindergartens and abandoned factories.

Suicide bombers strike at heart of Grozny

MSF has maintained the capacity to respond to emergencies in Chechnya through local staff members. One example of a typical emergency intervention: on December 27, 2002, the main administration building in Grozny was blown apart by a truck driven by suicide bombers. Within an hour MSF contributed two dressing kits as well as bandages to the trauma and neurosurgery departments of Grozny's Hospital 9. The following months were to be increasingly characterized by similar emergency interventions as suicide bombers attacked government structures in Znamenskoye, Gudermes and Grozny. In Znamenskoye, MSF delivered infusion kits and dressing kits; additional supplies were sent from Nazran to the Mozdok military hospital in Northern Ossetia, where many of the victims of the Znamenskoye bombing were transferred. The Mozdok hospital was itself destroyed by suicide bombers in August 2003.

March

International Committee of the Red Cross worker Ricardo Munguia is murdered on the road to Tarin Kot, Afghanistan, where Munguia, an engineer, was working to improve the water supply

Bombing by US-led coalition forces begins in Iraq. A six-person MSF surgical team placed in Baghdad several weeks prior to the war provides surgical support and medical supplies to al-Kindi hospital in northeast Baghdad

Thousands of refugees arrive in Sierra Leone, escaping armed conflict in Liberia. MSF adds support to Tobanda camp in Kenema province to its already extensive medical programs for Liberian refugees and Sierra Leoneans in cities, villages and camps in many parts of the country



MSF alternative shelter declared illegal

“If the camps are closed, I will dig a pit in the ground and sit in it together with my children” – displaced person living in Ingushetia

In order to provide IDPs with a real choice between staying in Ingushetia and returning to Chechnya, at the end of November MSF began building alternative shelters with the agreement of the Ingush authorities. As the first 180 out of a proposed 1,200 rooms in structures resembling barracks were completed in January, the project was declared illegal due to new construction legislation. Soon after, in an effort to evaluate the needs and collect testimony, MSF began a survey to identify the most vulnerable families in the tent camps. Over 3,000 families were interviewed, 98% of whom said they did not want to return to Chechnya. Ninety-three percent of those who did not want to return gave the reason as fear for their family's safety. (See page 31 for more on this survey.)

Two months after the shelters were declared illegal, MSF received a letter from the Ingush procurator ordering their

demolition. At the time of going to press, another camp, Bella, was subject to the same pressures as Aki Yurt and Znamenskoye, thus forcing the remaining 1,500 people there to return to Chechnya or else find refuge in other camps. Over a 12-month period, throughout Ingushetia, approximately 40,000 refugees had been pushed back into Chechnya, and the rooms which MSF had built were still standing – but empty.

Tuberculosis treatment in Chechnya – a small success story

In March 2003, a mini-project was started by donating tuberculosis medicines to three facilities in Chechnya; follow-up monitoring revealed that only one patient defaulted out of the 94 participating. The remainder successfully finished their treatment in June.

Every day

Every day is an emergency in Chechnya, and for Chechens who have fled to Ingushetia and Dagestan. The ongoing conflict in Chechnya, the deterioration in security, the continued obstruction by the authorities and, most of all, the abduction of Arjan Erkel

have placed restrictions on MSF's activities throughout the region.

Nevertheless, during this difficult year, MSF continued to provide support to medical facilities in the region overwhelmed by the increase in violence and weakened by under-funding. As of August 2003, MSF was still doing extensive work in the region, though most places were too insecure to send international staff. Often through local staff, MSF was still distributing medicines and material to scores of health facilities and rehabilitating health facilities in Chechnya; still focusing on the humanitarian issue of shelter for displaced Chechens in neighboring republics weighed down by an ever-increasing pressure to return; still running prenatal and gynecological, pediatric, and general clinics in Ingushetia; still reacting to emergencies stemming from the ongoing conflict inside Chechnya itself.

And MSF was still working to secure the release of Arjan Erkel, missing for more than a year.

International staff: **18**

National staff: **255**

A woman has a gynecological consultation in MSF's mobile clinic at a camp for displaced people in Aki Yurt, Ingushetia, in November 2001. This camp was later closed, with many people forced back to Chechnya, where conflict continues.

© Alexander Glyadilov

**March**

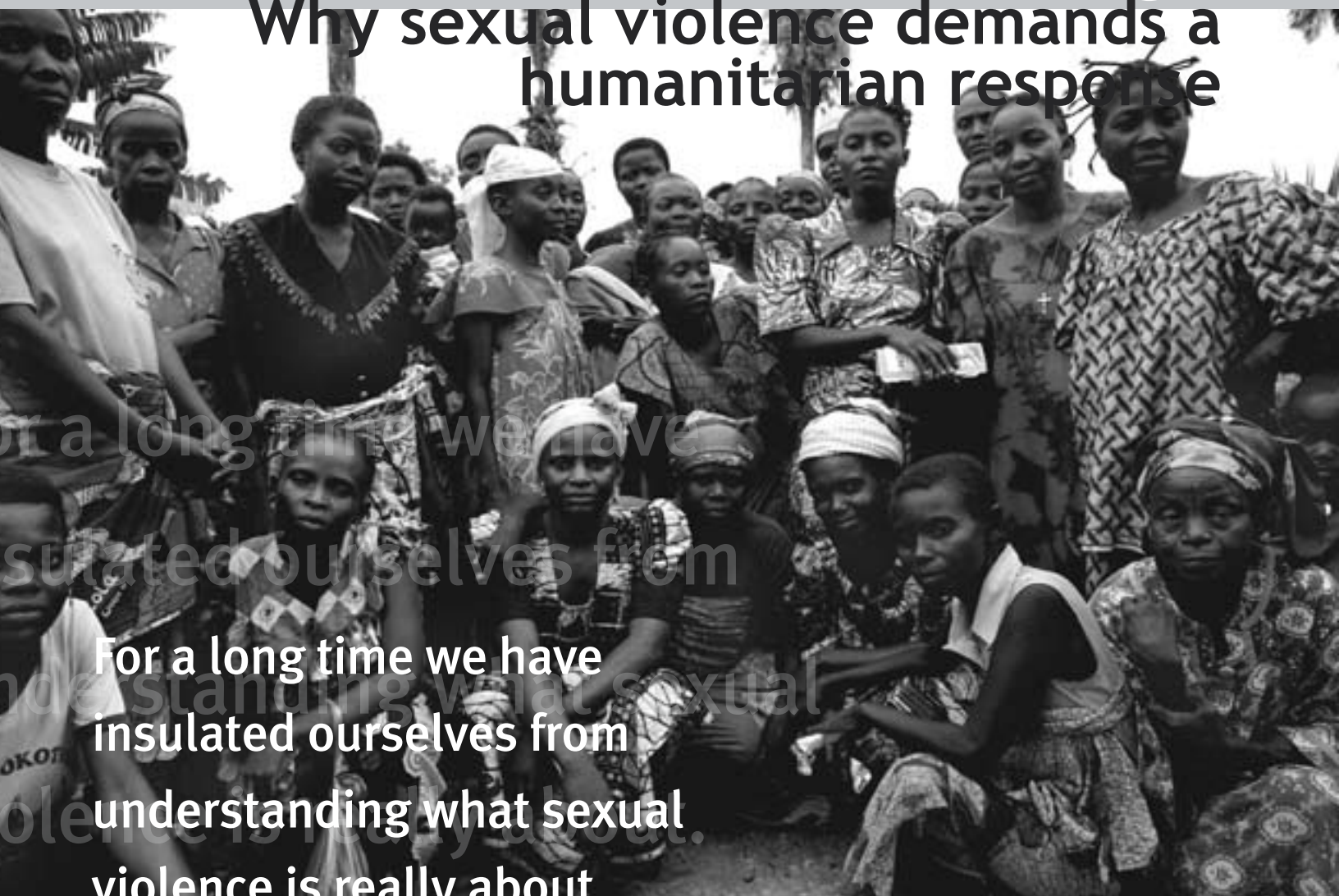
MSF begins medical assistance to clandestine immigrants in the old city of Tangiers, **Morocco**, and in the surrounding mountains

MSF teams are forced to evacuate camps in **Liberia** along the border with **Côte d'Ivoire**, including Toe Town and Zwedru in Grand Gedeh county. MSF calls for access to the 45,000 refugees and displaced people in Grand Gedeh who are caught between conflict in Côte d'Ivoire and an upsurge of fighting in Liberia

After 12 years of work in **Yemen**, MSF closes its projects in the country. Since 1997, MSF had sought to increase access to primary health care for people unable to afford care after the country moved to a cost-recovery (paying) health system

ENOUGH is enough

Why sexual violence demands a humanitarian response



For a long time we have
insulated ourselves from
understanding what sexual
violence is really about.

© Fiona Lloyd-Davies

Women meet together in Shabunda, Democratic Republic of the Congo. Unfortunately, they are bound together by a terrible violence: many of them have been raped. MSF provides medical care for rape survivors and works closely with the local woman's association where these women are meeting.

Tine Dusauchoit, MD

General Director,
MSF Operational Center
Brussels

Cold terms and their
abbreviations are ways of
taking a detour around the
painful reality underneath.

March

- └ A comprehensive HIV/AIDS program launched in Merauke, **Indonesia**, in October 2002, one of the first of its kind in the country, begins offering antiretroviral (ARV) drugs
- └ MSF ends curative, preventive and mental health care services to the rural population of the Magdalena Medio region of **Colombia**, as access to health care improves in the main municipalities. Mobile medical clinics continue in other war-affected areas
- └ MSF speaks out about poor living conditions in resettlement sites in Biddre (Oromya region), **Ethiopia**, after more than 200 severely malnourished children under the care of MSF at a therapeutic feeding center in Shawe camp for the displaced are moved to Biddre as part of a government resettlement program

2002
2003



For a long time we have insulated ourselves from understanding what sexual violence is really about. Cold terms and their abbreviations – sexual and gender-based violence (SGBV), or just gender-based violence, or even just assault – are ways of taking a detour around the reality underneath, a reality that contains so much deep and lasting suffering that it is hard to face.

The kind of violence we are talking about intentionally inflicts harm on (mainly) women and girls. It often means rape or attempted rape, sometimes gang rape and very often rape remaining unpunished. In the humanitarian crises where MSF works, it means women and girls (as young as four or as old as eighty) in eastern Democratic Republic of the Congo (DRC) kidnapped to become sexual slaves in military camps; the 12-year-old in the Philippines whose main concern is “how to get on to the next day after being abused all night”; the young woman in Chechnya raped and murdered by a Russian soldier; the adolescent on the Liberian border “borrowed by soldiers for a night” to ensure her displaced family’s safe passage to Guinea; the five-year-old girl trembling and screaming in a clinic in Monrovia, raped. So let’s not use cold terms that jump over the fact that the physical and emotional reality of a real person may be changed forever. Let’s use straightforward words: violence against women and girls. Rape.

Sexual violence is of all times, societies and social classes. It is directed at women (and sometimes men) of all ages, but younger women and girls are more at risk. Difficult enough to identify and address in its “ordinary” and often hidden occurrence around the world, how can a humanitarian organization like MSF respond to sexual violence in the emergency situations where we work?

A humanitarian response to very human suffering

Humanitarian agencies must deal with the problems and suffering they are faced with. MSF actively seeks to respond to the needs of those who are the most vulnerable, have the greatest needs and suffer most. Women and girls, in many of the places where we work, are the most vulnerable of the most vulnerable.

As a humanitarian medical organization, we have to act in the face of sexual violence, because it is a major problem of many of our patients in the most forgotten places. To respond effectively and with compassion, we have to understand the causes of sexual violence, we have to be aware of its magnitude, we have to know what kind of medical and psychological care is best in different situations. We need to be convinced that we can do something significant and meaningful. We must realize that we have to deal with sexual violence.

Unfortunately, this realization has been a long time coming.

Awakening

MSF and other humanitarian agencies have been late in recognizing sexual violence as a serious problem. We underestimated both the extent and seriousness of the problem; our response did not match the needs. We also failed to understand whose responsibility it was to act – ours.

Before the 1990s, MSF considered sexual violence to be more of a human rights issue. We were unable to identify the added medical value an organization like ours could bring in treating victims of sexual violence. Rooted in emergency work, with its imperative of quick, mass action often geared toward public health (think of cholera tents for hundreds of people or the triage of thousands of refugees arriving in a new camp), humanitarian medical action – in its purest caricature – was not predisposed to see people as specific individuals. Treating the physical effects of rape (not to mention the psychological scars, when they were even addressed) had to compete with other activities, often losing out on the grand scale of priorities to work which favored whole populations rather than the individual.

Our underestimation of the extent of sexual violence in war and conflict, in refugee camps and in other situations of displacement is illustrated by the fact that MSF’s widely known and used handbook, *Refugee Health*, devotes 13 pages to specific nutritional deficiencies compared to just over half a page to sexual violence. As is often the case, more attention was given to prenatal care, delivery and postnatal care than to rape – as if women only mattered to us if they were mothers or future mothers. In this handbook we wrote about what can or could be done, not about what should be done. We simply did not truly consider that, when faced with sexual violence, we had to act.

Awakening for MSF, and for many other NGOs and international agencies, was a long time coming but began to occur in the 1990s. In the early 1990s, systematic rape was used as a weapon of war first in Bosnia (women were raped and then sequestered so they could give birth to a “Serbian baby”) and then in Rwanda (with the systematic rape of Tutsi women – between 300,000 and 500,000 female survivors of the genocide are thought to have been raped). MSF was active in both these crises and this is when our awareness really began. At the same time, with the AIDS pandemic fully upon us, rape and immediate follow-up medical care for victims became matters of life and death. The consequences of rape were “medicalized.” It was becoming clear that much more could – and had to – be done to prevent sexual violence but also in terms of educating and training our staff and providing medical and psychological care for victims.

What happens in times of conflict and displacement

In armed conflict and subsequent displacement, sexual violence is widespread. In armed conflict women and girls

March

- MSF teams provide assistance after the side of a mountain collapses in the mining village of Ancocala in northern **Bolivia**, burying 400 homes
- MSF gets approval from the World Health Organization for a second-line treatment course to treat patients suffering from multi-drug resistant tuberculosis in **Uzbekistan**; this DOTS-plus pilot project will include 100 patients during a two-year course of treatment
- A kala azar treatment center in Um el Kher, **Sudan**, runs at maximum capacity (500 beds) for the fourth straight month; the caseload is the highest since 1997



– even the very young – are raped, abducted by warring parties and forced into sexual slavery. Rape may be followed by murder. During ensuing displacement, both while fleeing and even when settled in camps, women and girls may be forced to trade sex for protection, a way out or simply food or shelter. Violence against women increases in refugee settings. A report by UNHCR and Save the Children in January 2002 (*Sexual exploitation: The experience of refugee children in Liberia, Guinea and Sierra Leone*) highlighted the problem of sexual abuse in refugee and displaced camps in many parts of West Africa. Accusations were leveled at almost every actor in the refugee's lives: soldiers, peacekeepers, civilians and aid workers, including some from MSF. Although none of the cases against MSF could be substantiated, such cases have occurred in the past, leading to disciplinary action. And our medical teams are confronted on a daily basis, in refugee and displaced camps all over the world, with women and children who have been abused. This only underlines what we have been feeling for many years now: how vulnerable those who are forced to flee really are, and how little protection they receive.

Sexual violence is so widespread in contexts of conflict and displacement because the vulnerability of women and girls increases. They have fewer options, fewer resources and even less power than before. This is often linked to the fact that they have lost or been separated from their relatives, who may have been killed. The likelihood of men taking part in sexual violence also increases. It is not hard to understand why that is so. Severe economic and social disruption leads to the reduction and loss of the normal restraints on all forms of violence, including sexual violence.

Physical and environmental factors related to displacement and flight may contribute to increased sexual violence. Refugee camps are often overcrowded, and there is little or no private space available. Camp design (lack of lighting, men's and women's latrines together) further increases the likelihood of sexual violence both from within and outside the camp. Lack of the basic necessities (food, soap, medicine) can create an unbalanced economic dynamic inside a camp. Refugees may also become victims of acts of hostility from local residents, if their living conditions are worse than for inhabitants of the camps, which is sometimes the case. In Boreah and Sambakounya refugee camps in Guinea, where MSF works, young girls have been regularly kidnapped from the camps on Friday by a neo-mafia network to serve as prostitutes in the neighboring city of Dabola and returned to the camps on Monday.

To address this and contribute to preventing acts of sexual violence, MSF is working to improve the design of refugee camps and other structures and facilities, such as feeding centers, in such a way to reduce the risk of sexual violence.

Rape as a weapon of war

It is totally wrong to think of sexual violence solely as a consequence or accident of war and displacement. Sexual violence is also a weapon of war, a weapon often used to destabilize or even break a particular ethnic, national or religious group or to ethnically "cleanse" a whole society. Women and girls are singled out because they belong to a certain group and because the harm and humiliation inflicted on them deeply harms and humiliates their communities. That is why rape is systematic in many armed conflicts. MSF was and is witness to this in the former Yugoslavia, Rwanda, Congo, Liberia, Sierra Leone and so many other places.

Women and girls scarred

The consequences of sexual violence are devastating: it profoundly and deeply affects the health and well-being of the victims. The physical injury can be very serious, especially in young girls. Many rape victims also contract sexually transmitted diseases, including HIV, and develop AIDS. The risk of HIV/AIDS infection significantly increases because forced sexual intercourse is accompanied by injuries and bleeding, which enhance transmission of the virus. Being raped may lead to long-lasting trauma and suffering. Being raped and becoming HIV-positive as a consequence means that still more trauma is added.

Raped women may become pregnant and have to bear and bring up unwanted children. In Rwanda, babies born of rape are called the "enfants du mauvais souvenir" (children of bad memories). Raped women and girls are often stigmatized and ostracized. In the Republic of Congo, women have told MSF of being urged by people in their communities to throw their babies into the river. In Albania, women who have been raped say they are dead, because they consider themselves to have been completely desecrated.

Rape victims are at greater risk of mental health problems, from pervasive fear to suicide. One woman, 30, from Bunia, DRC, tells her story: "I was sleeping with my children. They shot outside our door. I opened.... They ordered me to remove the child from my back with threats to kill me. I obeyed and they raped me.... I never went to the hospital. I have been so depressed, life seems to have stopped for me. I am so lost for words...." Says Clotilde, a 15-year-old girl from Bujumbura, Burundi who was treated by MSF in July 2003: "I think about committing suicide, but my heart tells me not to. I am ashamed. I am not myself."

A compassionate medical response

There is no denying that dealing with sexual violence is difficult (examining a rape victim is extremely stressful for the woman concerned and often for the examiner as well) and that the obstacles to appropriate response can be multiplied in emergency or semi-emergency settings

March

— Around 3,500 children displaced by conflict are vaccinated for measles in Maguindanao and northern Cotabato provinces, the Philippines

— After the approval of South Africa's Medicines Control Council, MSF starts diversifying sources of antiretroviral drugs for ARV treatment in its HIV/AIDS programs in **South Africa**; medicines now come from Indian and Brazilian manufacturers

— Thirteen months after a ceasefire ends **Sri Lanka's** 19-year civil war, MSF is able to close many of its medical programs in the country as the health system in war-affected areas is slowly reestablished. Assistance continues in Puthukkudiyiruppu and Vavuniya



(where, for example, there may be no private clinic space for an exam). But we have a responsibility to provide care and support to persons in need; receiving and caring for victims of sexual violence can be done in a way that is both humane and effective.

MSF is educating and training staff to identify sexual violence and respond to it. In more and more projects, special training is offered on how to receive victims of sexual violence, how to talk to patients, which medical protocol to follow, preparations of medical-legal certificates, and referral of patients to appropriate follow-up care and support. Training also emphasizes empathetic listening to victims. Confidentiality is of the utmost importance.

MSF tries to set up private spaces to receive and treat victims of sexual violence – exactly what is lacking in makeshift hospitals or crowded clinics in many of the places where we work. To cope with this, especially in extreme emergencies, MSF staff sometimes work logistical miracles: in Bunia, DRC, logisticians organized a “wing” in an overcrowded warehouse-turned-hospital where victims of sexual violence could be seen privately. Reception and treatment by female medical personnel can also be extremely important; yet in many contexts where we work, education of girls and women is not deemed a priority, and it can be hard to find qualified female staff. To overcome this, MSF makes extra efforts to find qualified personnel among the refugees themselves.

Medical care must include treating physical injuries and lesions. Patients are voluntarily tested and treated for sexually transmitted diseases, including HIV, and provided antiretroviral drugs to prevent post-rape HIV infection (which must be taken within 72 hours of the rape, one reason why immediate medical assistance for rape victims is so important). MSF also provides emergency contraception, counseling and referral for abortion. Medical care is complemented by psychological assistance, either provided by MSF directly or through another source (see page 41 for the story an MSF psychiatrist who cares for rape victims in the Republic of Congo).

It is not easy for victims of rape to come to health centers and seek help. As MSF has set up specific medical services for rape victims, work has also gone into getting word of the possibility for care into the community, because if there is no care to be expected, women and girls will not come at all.

MSF has begun or is planning special programs on sexual violence, including addition of sexual violence awareness training and protocols to preexisting projects, in countries around the world.

Out of the usual and customary place

Once treated, both physically and psychologically, it would be nice to think that women and girls could obtain legal

redress for crimes of sexual violence committed against them. Unfortunately, this is rare in many of the places where we work.

Providing medical-legal certificates moves the humanitarian worker toward the legal sphere, not our customary place to act. Documenting cases, collecting forensic evidence and issuing medical-legal certificates are essential for breaking the cycle of acceptance of sexual violence and impunity of its perpetrators. It should always be considered, even if the potential for use is often very limited in many contexts with near complete breakdown of the judicial system.

Unfortunately, impunity is often the norm. In Chechnya, a young woman was raped and murdered by a Russian colonel in March 2000. While the officer was arrested and the crime investigated (the first – and only – investigation for such crimes by Russian officers in Chechnya), rape was dropped from the final accusation, despite the physical evidence of rape revealed by the autopsy. The soldier, first judged temporarily insane and acquitted, was eventually convicted on appeal and sentenced to ten years in prison – for murder, not rape.

While the first point of legal reference for such crimes remains national law, rape and other forms of sexual violence can also be serious violations of international humanitarian law. However, while there has been progress in international recognition of rape and other crimes of sexual violence (eg, in the new International Criminal Court), until now there has not been a clear and sufficient international response. These crimes have not often been investigated. These crimes remain largely unpunished.

If not a humanitarian response, then who will respond?

As a medical organization our medical role is clear: we have to provide adequate care to women and girls. As a humanitarian organization our responsibility goes beyond that. We have to expose the pervasiveness of sexual violence and its devastating consequences. We have to talk about sexual violence being used as a weapon. We have to point to those who allow sexual violence to continue. We have to address the responsibility of those who do not provide adequate protection, fail to see vulnerability or do not take it seriously.

Silence, indifference and inaction have been the answer to sexual violence for too long. Enough is enough. In the emergency situations where we work, among some of our planet's most vulnerable people, we can, and must, respond to rape and other forms of sexual violence in a humanitarian – and thus truly human – way. If we do not do this, who will?

March

— A photography exhibition in Sukhumi, Abkhazia, **Georgia**, raises public awareness of the problem of vulnerable and abandoned people living in Abkhazia, a separatist Georgian republic devastated by civil war. MSF has ongoing medical aid programs in Abkhazia and elsewhere in Georgia

— MSF's project fighting mucocutaneous leishmaniasis in Satipo province, **Peru** comes to an end; the two-year program was able to improve detection and treatment of cases as well as the capacity of area health staff to cope with this infectious disease, caused by a parasite transmitted through the bite of a sandfly



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A young woman raped the night before puts her head on a desk while waiting for care at Makélékélé hospital in Brazzaville, Republic of Congo. MSF's comprehensive medical and psychological care program for victims of sexual violence at the hospital has treated more than 600 people.

Republic of Congo

Tika Bika Viol – I say no to Rape! A simple slogan, a shattering subject. The grassroots campaign *Tika Bika Viol!*, led by MSF, transformed the streets of the Congolese capital Brazzaville for a week in March 2003, in response to the sexual violence that has altered the lives of untold thousands of women in Congo for many years.

The vast public education drive attacked the lack of public awareness of rape that has served to hide, and sometimes abet, the persistent problem in the country. *Tika Bika Viol!* grew out of MSF's ongoing work providing medical care and psychological support to rape victims in the capital city. While MSF also has other types of projects in the country – emergency assistance for people displaced by conflict in the south and treatment for those suffering from sleeping sickness – it was the rape care and prevention work that took center stage in early 2003.

“To rape someone is to kill someone,” B., 19-year-old victim

“Rape? Men like it.” The phrase rings out in the warm air of the Nkeoua market neighborhood on the outskirts of Brazzaville.

A theater group sets up a simple set on a flatbed truck; members of the MSF team begin discussions with small groups of men. The subject is provocative, but the uncomfortable glances and silences also speak of the weight of oppression young women bear after nightfall. On the improvised stage, the actors play out the terrible – yet everyday – story of a young girl who meets the wrong man. Facing the inevitable, the young actress cries and pleads. The crowd groans, the tension is palpable and the rape scene is harsh. Everyone in the audience tries to direct the difficult sequence. Laughter, cries, shouts of rage – then jaws clench and eyes turn away. The young woman is left alone with her humiliation.

The silence reveals a collective discomfort. Instinctively, women approach the truck in small groups to support the young actress, who struggles to recover. They know this story all too well.

This street play proved to be the most powerful part of *Tika Bika Viol!*. The campaign touched the raw nerve of rape that is one of the country's grim not-so-secrets. Although it involved an international colloquium attended by a variety of national and international organizations, as well as first lady Madame Antoinette Sassou, the heart of *Tika Bika Viol!* was its grassroots education. Over 300 life-size wooden figures of women haunted the streets; street theater,

banners and buttons promoted discussion of the taboo subject. Taxis sported bumper stickers and helped get the message to out-of-the-way spots and filling stations around the city. The campaign helped put a taboo topic out in the open and fostered discussion of the devastating consequences of this unfortunately common occurrence.

A disturbing phenomenon, encouraged by impunity

In Congo, crimes of sexual violence, including rape, were often perpetrated by fighters from all sides during the country's civil war, which flared up between 1998 and 2000. They continue to be carried out by armed men during times of upheaval in Brazzaville. But now these crimes are mainly committed by civilians, with 60% of victims being very well acquainted with their rapist. Women, children and the elderly are at risk of being raped in their homes, on the street, and when carrying out daily activities such as fetching water. To make matters worse, rape goes virtually unpunished in the country: not a single rapist was convicted in 2002.

The *Tika Bika Viol!* campaign was the natural outgrowth of MSF's sexual violence program, begun in March 2000 at Makélékélé hospital in Brazzaville. MSF provides emergency medical care for rape victims, including treatment for injuries sustained during rape, medication to

March

MSF begins antiretroviral treatment for AIDS patients in **Mozambique**, complementing comprehensive HIV/AIDS programs underway since 2000

Prevention of mother-to-child transmission of HIV begins in MSF's comprehensive HIV/AIDS care program in Thyolo, **Malawi**, providing the antiretroviral drug nevirapine for HIV-positive pregnant women and their newborns. This treatment, combined with support for exclusive infant feeding (either breast-feeding or bottle feeding) can cut by 30% the risk of a baby being born with HIV



In **their** own words

Patients in MSF's sexual violence program in Makélékélé hospital in Brazzaville, Republic of Congo tell their stories:

"When my sisters and I were coming back from the fields, we met some soldiers. They were returning from nearby villages. I was carrying a heavy load on my head so I couldn't flee like the others. They caught me, took off my clothes and raped me. I told the Kindamba police but they didn't do anything. After the rape, my grandmother told me to go to Brazzaville for treatment. In my village, rape is a big problem for women, alone or in groups, who go to the fields or to get water." -P., 15 years old

"I was coming back from my aunt's and an uncle called to me on the road. He said he should walk back home with me. Instead of going to my parents', we went the opposite way. We went to his house. He said he was going to make me a grown-up and then marry me. He raped me on January 2 and then on the next day." -L., 11 years old

"I was going to get a candle on the road going back and I met my brother-in-law, who called out to me. He grabbed me and then raped me in the grass." -L., 14 years old

"I was coming back from Louolo (Kindamba) with my younger sister and my two children. We were heading home to Madzia. I had gone to fetch my children who were in Louolo because of the hostilities at that time. As we were leaving Louolo, we met a group of seven soldiers. First they threatened us and then they beat us and stole 350,000 CFA [around \$600]. After they shot and killed my sister, they hit me with a rifle butt and then they raped me, one after another, in front of the children." -G., 40 years old ■

March

MSF suspends activities in its tuberculosis (TB) program in Siberia, the **Russian Federation**, when Russian medical authorities insist that MSF use an incomplete and inappropriate treatment for multi-drug resistant TB, a treatment that is in total contradiction to that recommended by the World Health Organization. Since the project's beginning in 1996, over 10,000 TB patients had been treated

An MSF-organized symposium in Nairobi, **Kenya**, brings together many public and private actors to share experiences and explore ways to scale up antiretroviral treatment in resource-poor settings

prevent pregnancy and preventive treatment for sexually transmitted diseases including HIV. To prevent unwanted pregnancy and to block the spread of HIV, women should receive medical attention within 72 hours. In addition to medical assistance, MSF national and international staff provide psychological treatment and follow-up, essential for traumatized survivors (see page 41). More than 600 people have been treated in the sexual violence program in Makélékélé. In January 2003, the project was expanded to Talangai hospital in the northern part of Brazzaville.

Many victims of sexual violence are unaware of the free services provided by MSF and the urgency of receiving treatment. *Tika Bika Viol!* helped spread the word about both the problem and the MSF program.

Three weeks after the *Tika Bika Viol!* campaign, the 300 wooden silhouettes installed on all of Brazzaville's main roads were still standing. Not a single one had been stolen, and neighborhood residents had put them back in place if they fell over. The determined-looking women had been transformed from an image of the rape problem itself into a symbol of the rejection of sexual violence.

Other programs: helping those affected by displacement and disease

A year of armed conflict between government forces and Ninja rebel factions was followed by a ceasefire in March 2003. Beginning in October 2002, tens of thousands of people displaced by the conflict were trapped outside the city of Brazzaville, pinned between the conflict zone and government barricades; many others remained unreachable in the forest of the Pool region. MSF intervened with health clinics and a supplementary feeding program. In May 2003, MSF gained access to the Pool region and began surgical, medical and nutritional programs at the reference hospital in Kinkala, along with measles vaccinations in outlying villages. In June, MSF started mobile clinics, nutritional assistance and support to Mindouli hospital, also in Pool. As of July 2003, aid to displaced people still waiting to go home continued.

MSF continued assistance to refugees from Democratic Republic of the Congo as well as local residents in the northeast town of Bétou; in addition to providing basic medical care, MSF has also constructed a new operating room and outpatient ward in Bétou's health center. MSF provides artemisinin-containing combination therapy (ACT) to malaria patients in the region.

MSF has also been actively fighting human African Trypanosomiasis in Congo since 2000, supporting treatment centers in Plateaux and more recently Bouenza and Cuvette Est provinces, conducting mass screening and researching new protocols. Commonly known as sleeping sickness, this neurological disease is caused by a parasite transmitted by the tsetse fly and is fatal if left untreated. It is endemic in 36 African countries and affects an estimated 500,000 people. The Plateaux project closed in May 2003, having screened 58,417 people and treated 913. Since opening in September 2002, the Bouenza project has screened 45,125 and treated 575. Work in Cuvette Est began in June 2003.

In February 2003, an outbreak of the Ebola virus in Cuvette caused the death of more than 120 people. Ebola hemorrhagic fever is deadly in 50-90% of cases. In collaboration with the World Health Organization and the national Ministry of Health, MSF provided essential medical supplies such as isolation kits. A similar outbreak in the region last year killed 66 people.

MSF has been working in the Republic of Congo since 1997

International staff: **31**

National staff: **287**



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Dramatic street theater puts the problem of rape before disconcerted spectators in Brazzaville, Republic of Congo, in February 2003. MSF's campaign *Tika Bika Viol!* helped raise awareness of rape and get people talking about this "taboo" subject.

April

MSF adds antiretroviral therapy to its comprehensive community-based HIV/AIDS project in Thyolo, **Malawi**. ARV treatment is already provided by MSF in a separate HIV/AIDS program in Chiradzulu

A new project in Quibdo, **Colombia** aims to ensure that people displaced from their homes because of the country's civil war have access to existing government health services

MSF begins antiretroviral treatment for HIV/AIDS patients in Pissy district, Ouagadougou, **Burkina Faso**

A psychiatrist offers hope

Dr. Grégoire Gansou, coordinator of MSF's program for victims of sexual violence at Makélékélé hospital in Brazzaville, Republic of Congo, speaks about his work:

"I see five or six victims of sexual violence every day. When I meet a patient, I observe her behavior, how she presents herself, and the expression on her face. I seek to gain her trust and ask her to tell me the story of the rape. That's when the emotions come to the surface. Some women talk at length while others may cry or speak haltingly.

My questions are very specific, which is quite painful. I ask them to explain what has changed for them since the rape, [and] I involve them in the process by asking them to work with me to develop solutions that will work best for them. They are still in pain when they leave, but it's eased somewhat. We see these women at least three times over a two-week period.

I use a therapeutic approach right away. It may include psychotropic medications, relaxation techniques, or even behavior therapy.... We bring together the people who are close to the victim (family and friends) to strengthen the victim's social support network. I believe very strongly in that.

One out of every two rape victims is a minor. They use different words. Their parents often come with them, and they are uncomfortable about expressing themselves. We ask them to draw what happened or act it out with dolls.... With adolescents, you hear words like 'dirty' and 'torn.' I spend more time on these cases because the stakes are higher. Rape and its effects are a shock for everyone, but the forced sexual act is even more traumatizing for a female who has not had sexual relations previously.

Rape can't be forgotten or healed. At the most, a person can learn to live with it. We can help the victim develop the ability to manage the trauma, to make sure that the rape does not become a disability in daily life. I know I've done my work when I observe progress over the course of our meetings. The patient smiles again, her mood is more relaxed, she speaks differently. The day the patient resumes her activities, leaves her home alone to see us, that's when she's doing better." ■

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April

MSF provides emergency nutritional aid in Punia, **Democratic Republic of the Congo**; similar assistance begins in May in Lukutu

MSF begins a primary health care project in the isolated conflict-affected district of Jumla, **Nepal**, a Maoist stronghold

MSF teams vaccinate 80,000 children in the area of Banalia, eastern **Democratic Republic of the Congo**. Measles vaccinations are part of most projects in the DRC, where vaccination coverage for children is less than 40%

2002
2003

Invisible

Do sick people with no money
need to become rich before
we see that we can keep them alive?

Outside of armed conflict,
victims sacrificed to the

creation of the political
order – local, national or
international – are often
hidden from the sight of
ordinary people.

© Gael Turine

Christine, 35, rests after a visit by a nurse as part of MSF's AIDS care program in Thyolo district, Malawi. Tender home-based care and the support of both her 14-year-old daughter and mother (at left) are not enough to hold back the disease; Christine dies a few days after this photo is taken in October 2002.

Jean-Hervé Bradol, MD

President,
MSF-France

April

Ugandan forces pull out of Ituri region, **Democratic Republic of the Congo**. Six hundred soldiers from the MONUC (United Nations Mission in the Democratic Republic of the Congo) reserve battalion arrive in the region at the beginning of May, but are able to do little to protect civilians from intensifying fighting

Twenty-eight Quartering and Family Areas – resettlement camps for ex-UNITA soldiers and their families established after a ceasefire in **Angola** in April 2002 – are closed; many people are sent back to transit camps or to their places of origin, most without adequate assistance

2002
2003



Outside of armed conflict, victims sacrificed to the creation of the political order – local, national or international – are often hidden from the sight of ordinary people. Blatant violence is suited to the conquest and defense of power. Its use on a daily basis, however, is more likely to cover up its deadly character. For those condemned in this daily fashion, the sentence does not take the spectacular shape of violent death; rather it comes in a guise so perfectly integrated into the social landscape as to become invisible – that of extinction through deprivation of the very necessities of life (water, food, energy, medical care and shelter).

Far from denying the existence of these victims, their proponents explain them away by saying that “you can’t make an omelette without breaking eggs.” In the end, the logic of a recipe serves to justify the untimely disappearance of part of humanity.

Skin color, religious belief or political affiliation may lead to execution along the side of a road in a country at war. But for our hidden victims, the essential does not reside in such overt stigma that enable a society to distinguish those who can live from those who might – or must – die.

For the majority of the inhabitants of our planet, survival depends instead on whether they can get treatment for infectious diseases. Clearly, not everybody can be saved – the ideal society is not of this world. But how many more could be, with even a modicum of political will? This is the crux of the matter. This is the question we put to doctors, the pharmaceutical industry and, especially, politicians.

According to estimates by the World Health Organization (WHO), 3 million people die of AIDS each year, while about 300,000 are victims of war. In other words, AIDS kills ten times as many people as war. And AIDS-related deaths are only a fraction of yearly deaths due to the most lethal infectious diseases, nearly 15 million deaths in 2001, according to the WHO’s *The World Health Report 2002*. Many of these are deaths from diseases which have either preventive (vaccines) or curative (antimicrobial) treatments.

The very first treatments capable of prolonging the lives of patients whose immune systems were compromised by the AIDS virus, even those who were at death’s door, appeared in the mid-1990s. In 2000, the price of these drugs ran to several thousand dollars a year per patient, thus making them inaccessible to the majority of AIDS sufferers. The reason behind this high price was not due to especially high production costs; indeed, under pressure from lobbying campaigns, the price of these vital medicines has been divided by 30 in the space of two years, without in any way pushing the pharmaceutical sector to the brink of bankruptcy.

If treatments exist, why aren’t they being used? Why has so little international attention been devoted, until recently that is, to the survival of millions of people?

Driven into a corner by the dedicated campaigning of patient and caregiver organizations, Andrew Natsios, head of the US Agency for International Development, responded with a diatribe worthy of Gobineau, the 19th century advocate of European racial supremacy. Africans, he said, “don’t know what Western time is. You have to take these (AIDS) drugs a certain number of hours each day, or they don’t work. Many people in Africa have never seen a clock or a watch their entire lives. And if you say, one o’clock in the afternoon, they do not know what you are talking about.” (*Boston Globe* June 7, 2001). This explanation merely serves to evade the question of the continued high price of treatments, and thus panders to the short-term interests of the pharmaceutical industry.

The effects of generic competition and the increase in the volume of drugs produced and sold have already had on prices show us that the price of drugs could soon be less than US\$100 per year per patient. The case of Brazil, where the government put into place a policy providing ARV treatment to all people who need it, has taught us that it is possible to treat large numbers of people without bringing the national economy into ruin. Why is South Africa, which is one of the most affected areas on the continent, so slowly committing itself to this line, while its economy is one of the strongest in Africa? The South African leaders’ inertia, criticized by Nelson Mandela, has become so blatant that it can no longer be concealed by arguments about making the fight against poverty a priority. The weak response by politicians to the HIV/AIDS pandemic becomes tragic farce when US President George W. Bush announces that his country will, over the next five years, pump several billion dollars into programs aimed at promoting sexual abstinence in Africa.

In terms of analyzing the responsibility for the destruction of human life, how can we distinguish the bombing of a civilian population during a conflict from the withholding of effective medicines to combat a pandemic that has already swallowed up 25 million human beings (or the promotion of ineffective medicines, as is the case for malaria, another treatable disease which itself claims 1-2 million lives each year)? Bloodshed has for a long time seemed to distinguish war from all other forms of social relations. However, is this a reason valid enough to isolate war as a separate social field to which humanitarian organizations should restrict themselves in accordance with the rights granted to them for this specific context by international law?

To our mind, no. A distinction between war and peace predicated solely on the use or non-use of violence is

April

MSF introduces artemisinin-containing combination therapy (ACT) as first-line malaria treatment in the hospital in Kuito, **Angola** and in area health posts where MSF is working; two ACT efficacy studies also begin. The malaria parasite is becoming increasingly resistant to older treatments such as chloroquine and SP in many places in Africa, and MSF is introducing effective and fast-acting ACT in all of its projects

An MSF medical-surgical team begins working at the central hospital in Bunia, in the Ituri region of **Democratic Republic of the Congo**, despite growing insecurity. MSF also increases international staff and opens 11 new bases in health zones in Equateur, Orientale, Maniema and Katanga provinces



radically transformed when we see the ultimate effects of, on the one hand, spectacular violence, and, on the other, denial of care for people deemed too poor or uncivilized to be treated. In both cases, deaths result, due to deliberate action – or to deliberate inaction. From the point of view of saving human lives, the analogy between a war and a health catastrophe becomes clear when, during epidemics or endemics, a realistic treatment exists but is not being used. This is largely what happens in the field of infectious diseases, which have, in the course of history (and despite the incredible scientific and technical progress of the last century), been responsible for most deaths worldwide. In this case, the work of humanitarian organizations is to show the hidden deadliness of the current order and to show, through actions, that there are scientific, technical and economic ways to limit the number of deaths claimed by the great epidemics and endemics. It is the work of the humanitarian organization to show that the key ingredient that is lacking is political will.

If we refuse to resign ourselves to seeing our patients die (along with the type of medicine we are practicing in the tropics) we need to understand another essential condition – medical innovation. In order to fully grasp its relevance, it is important to understand the reality of practicing medicine in our contexts of intervention. Africa is a good example in this regard: 65% of deaths are due to infectious diseases (WHO 2002), with nearly two-thirds resulting from three pathologies: HIV/AIDS, malaria and tuberculosis. For tuberculosis and malaria, there are curative treatments available; for AIDS, there are treatments that can stop the progression of the disease. If treated correctly, the majority of patients suffering from these three diseases would survive. Obviously, it is clear that for this to happen we must have effective drugs at affordable prices. But we must also be able to use them correctly.

While the physical effects of viruses, parasites and bacteria on organisms are quite similar in all corners of the world, individual people have greatly differing lifestyles. And the aim is, of course, to treat sick people. There is a big difference between an African farmer whose immune system is compromised as a result of HIV and who is unable to pay for a bus fare to go to the dispensary (the initial stage in a multitude of obstacles to be negotiated in order to survive), and a European worker who continues to receive his salary during his illness, and whose health insurance covers 100% of all medical expenses, with a hospital bus coming to pick him up at home. The medicine we practice cannot offer the same level of care in both cases, even if, in an ideal world, this is imposed by a hypothetical universal

medical ethic. The resources available and the living conditions are not the same. But do we have to wait for sick people with meagre incomes to become rich in order to start thinking about keeping them alive?

With the exception of vaccination campaigns, current public health policy recommends that Africans, while they are waiting to “be developed,” live under a mosquito net, genitals wrapped in latex, waiting to be asked (perhaps tomorrow) to wear a mask in order to avoid pulmonary infections. In reality, so-called preventive policies, reduced to sad rituals as a result of budgets that are vastly inadequate to cope with existing needs, are replacing any real response to the millions of deaths each year due to infectious diseases in Africa. Medicine is reduced to asking sick people to become rich in order to get medical care, or at least to avoid becoming ill if they can. To do this, they are advised to isolate themselves from the world by living behind a screen – the latex of the condom and the nylon of the mosquito net.

It is this logic that we reject when we express the ambition to have rates of cure for our patients that are similar to those of sick people in rich countries, in spite of sub-optimal conditions. At the same time, the way to achieve this goal is not described in any manual. In order for anyone to claim to be an expert at this kind of practice it should first be practiced widely. Lest “the medicine of the poor” be reduced to poor medicine, we have to work to invent other medical practices, adapted to the cultures of our patients and their ways of life. Our teams, who take care of HIV/AIDS-infected patients in Africa and who, through the use of tri-therapies, obtain results that are comparable to those of European doctors, are leading the way. Let us hope that tomorrow we can transform these initial trials by exploring the possibility that our patients might be the first to benefit from new protocols that are in the offing: fusion inhibitors, “intermittent” treatments and therapeutic vaccines. These new therapeutic tools could enable us to treat patients whose virus becomes resistant to primary treatment and to relieve some of the heavy burden of daily doses for the follow-up treatments by patients and doctors. These are indispensable stages in order to increase the number of sick people treated, even as nearly six million HIV-positive patients around the world are awaiting treatment that can save their lives.

The medical humanitarian effort, as we see it, is intended to question the logic that justifies the premature death of part of humankind. “Are some of these deaths avoidable?” is the question we repeatedly pose to the powers that be. Why? Because we have committed ourselves to attempting to care for those

April

— In its ongoing comprehensive AIDS care program in Nchelenge, **Zambia**, MSF adds prevention of mother-to-child transmission to the care and services already offered

— Controversial Decree 9-2003 passes in **Guatemala**, effectively preventing generic drugs from being registered even when there are no patents on the corresponding brand-name medicines



that society has chosen to forget. To put it another way, humanitarian aid must as a priority reach individuals whose lives have been stolen by violence, yes, but also those whose lives are threatened by the daily deprivation of vital health care. The subversive nature of this work is revealed when it goes beyond mere analysis of material needs to lay bare the discriminatory policies that cause exclusion from care and hinder effective aid.

If the humanitarian effort is to be true to its mission, it must fly in the face of the established order. It is successful when, venturing off the beaten path, it takes the risk of creating innovative medical care out of the intuition of those who are committed to saving human lives.

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Rosa, 31 (at left) and Dorothy, 54, are infected with HIV/AIDS. Both of them are afraid of revealing their illness to the people closest to them. Dorothy has been on antiretroviral treatment since 2001; Rosa has not yet begun treatment. Chiradzulu, Malawi, November 2002

April

In the yellow fever-endemic province of Norte de Santander, **Colombia**, MSF vaccinates 1,453 people against yellow fever and helps local health authorities contain the outbreak

In Hong Kong, **China**, MSF organizes medical and nursing students to give SARS (Severe Acute Respiratory Syndrome) prevention talks for the local community. MSF also shares knowledge in infection control with local hospitals. In Zhangjiakou city in Hebei province on the Mainland, MSF provides technical expertise, training, logistical support and protective gear to hospitals

© Andrew Njoroge



Comings and goings set the daily pulse in this hospital corridor in Homa Bay, Kenya. The hospital is a place of hope for the many people (30% of all adults) touched by HIV/AIDS in the district: it is here that MSF began antiretroviral treatment in Kenya in November 2001, making it at the time the only public hospital in the country to offer free ARV treatment. The success of the program shows that treatment works even in areas where people have little money, such as Homa Bay, a poor mostly rural area on the shores of Lake Victoria.

no cure. Around 500 people with AIDS die each day. ARV treatment, however, can enhance and prolong the lives of people living with the disease. Because AIDS often strikes the young and economically active, key economic sectors – including agriculture and education – suffer directly from the consequences of the epidemic. ARVs can do much to reverse this loss of productivity: not only do patients feel better, but they can often resume employment and provide for themselves and their families. In Kenya, 220,000 people whose immunity levels have already dropped enough to make them very sick need ARVs right now.

The treatment that has given Dorothy new life is, at as little as US \$200 a year, still too expensive for people in developing countries who need it. Affordability is just one barrier. Structural problems in public health care in many poorer countries, lack of funding and lack of political will to identify and implement solutions, all constitute the major barriers that keep millions of people from getting the treatment they need.

Since MSF became involved in the fight against AIDS in Africa in the early 1990s, the organization has been working hard with other groups to tear down what were once considered insurmountable obstacles to ARV treatment. MSF's projects are showing that it can be done. The focus is now on scaling up the programs and encouraging the government and other actors to do the same.

Showing that treatment works, one patient at a time

In Homa Bay's District Hospital, in Kenya's Western province, MSF started ARV treatment in cooperation with the Ministry of Health in November 2001. Similar MSF projects started in April 2003 at two sites in Nairobi and July 2003 in the town of Busia on the border with Uganda – all areas with particularly high HIV/AIDS prevalence.

For MSF's doctors, the results of their efforts are tangible. "Each time I get discouraged, I think of Paula, one of our first patients," says Agnes, former head of MSF's program in Homa Bay. "When I prescribed her ARVs, she weighed 36 kilograms. Today, she weighs 57."

For people with AIDS, the possibility of getting treated can change everything. Victor,

Kenya

"Six months ago I could hardly walk. Today it's a new life."

Dorothy, 39, Homa Bay, Kenya

Dorothy, infected with HIV/AIDS, receives antiretroviral (ARV) treatment through MSF's program in Homa Bay. She is a widow struggling to raise three children. She now has the courage to speak openly about being HIV-positive, and has regained the strength and energy to care for her children and go to work.

This is the case for increasing numbers of people in Kenya, where irrefutable proof is being built up that people can be treated in resource-poor settings. The proof is undeniable and can be seen in strength regained, lives taken up again, hope in the future given new life. MSF is helping to foster this through ARV treatment at four project sites in Kenya, where 460 people were receiving life-saving treatment as of July 2003. Unfortunately, in Kenya and in most developing countries, there is still a big gap between the number of people who are receiving treatment and the number of people who need it – today – to stay alive.

In Kenya, around 3 million people are infected with HIV, for which there is currently

April

After receiving 50 wounded civilians in one day at Man hospital in Côte d'Ivoire, MSF condemns helicopter attacks on civilians, calling on all parties to respect international law

In the midst of war in Iraq, two MSF expatriates and one national staff member in Baghdad are taken by Iraqi secret police; MSF suspends all activities. The MSF workers are freed nine days later

MSF teams in Kandahar, Afghanistan, and Chaman, Pakistan, are forced to evacuate for a month because of insecurity

MSF's team working in Maimana, Faryab province, Afghanistan, is forced to stay in Mazar-i-Sherif because of fighting in the region



46, had not been feeling well for years. When he heard there was treatment available at the hospital in Busia, he decided to go in and get tested. On treatment since July 2003 through MSF's program there, he is now very active in encouraging others to go in and get tested: "Look at me," he says. "I've been tested and now I'm benefiting!"

These successful programs have taught MSF valuable lessons on the practicalities of AIDS treatment in settings where the medical and financial resources are limited. MSF has now simplified admission criteria patients to treatment programs (it is now based on clinical diagnosis and not lab tests) and adapted protocols. New patients are now given the same standard treatment, in a fixed-dose combination, so it is easier to take. This has made treatment provision easier, but there are still many challenges to the practical implementation and scaling up of these projects.

Nonetheless, and in opposition to many skeptics, MSF is demonstrating that ARV treatment can be used effectively in developing countries and that it is essential in the battle against HIV/AIDS.

Working to promote change

Although MSF's program is a start, the great battle lies in making these drugs more affordable and more available to put them within reach of the greatest number of people possible.

In Kenya, MSF's Campaign for Access to Essential Medicines has been working with local organizations to lobby pharmaceutical manufacturers, distributors and the Kenyan government for more affordable medicines for AIDS and to increase accessibility of treatment. In August 2002, years of intensive advocacy by MSF and other Kenya-based and international organizations paid off, when the Kenyan government signed a patent law permitting importation and local manufacturing of more affordable generic ARVs. To push for passage of the law, MSF and the group of organizations, all together called the Kenya Coalition for Access to Essential Medicines, actively contacted the media, briefed policymakers and organized public events. The result of all these efforts is a patent law that is progressive by

international standards. However, there is still a long way to go.

Despite the number of daily casualties, there has been a lack of political will to fight the AIDS pandemic with the urgency required. "It was such a mess. It was so frustrating to know that we could treat so few people when much more could be done," said Christa Cepuch, MSF's regional pharmacist. "MSF was successfully treating a limited number of patients, knowing that the government wasn't playing its role or making efforts to start its own programs."

Elections in December 2002 and the ensuing change in government brought fresh motivation. The Kenya Coalition is working to inform the new policymakers about what the policy priorities – in terms of access to medicines – should be. As part of these efforts, MSF organized a symposium in April 2003 to share experiences and solutions on how to scale up ARV treatment. The symposium brought together people from the public and private sectors: officials from various ministries, health institutions, mission hospitals and AIDS organizations, as well as business people and journalists. A key aim of the gathering was to entice others to begin providing ARV treatment. During the conference, the government announced that it would strive to provide ARV treatment to 20% of AIDS patients by 2005, hoping to reach 50-60% of those in need by 2008.

Continued lobbying focuses on concrete goals, such as the design and implementation of a national treatment policy and jump-starting production of generic ARVs by local pharmaceutical manufacturers. For the general public, ongoing campaigns to fight the stigma that still surrounds HIV/AIDS in Kenya are instrumental in keeping prolonged public pressure on the authorities. MSF and the other Kenya Coalition groups also plan to become involved in a treatment-literacy campaign to inform and educate Kenyans about ARV treatment and what it means.

"Internationally, many obstacles to increased treatment are being brought down," says MSF's Christa Cepuch. "Drug prices are going down due to increased competition from a growing field of generic producers. There is more money from international donors. Now national

governments are the ones being focused on: to implement policy change, to allocate budgets, and to strengthen infrastructure. This year the Kenya Coalition will be challenging the government to treat the Kenyan people in need."

Other projects: related AIDS care and assistance to refugees

In addition to providing ARV treatment, MSF programs in Kenya treat opportunistic infections related to AIDS, with a special focus on tuberculosis in some areas. Supporting AIDS education and prevention, providing social and psychological assistance and sometimes nutritional supplements are all vital parts of MSF's work. MSF provides voluntary HIV counseling and testing and many of the above services at clinics in the Nairobi slums of Dandora, Kibera, Pumwani and Matharé, as well as at hospitals in Nairobi, Busia and Homa Bay. For pregnant women who are HIV-positive, MSF also has projects to prevent transmission of the virus from mothers to their unborn children.

After 11 years providing medical aid to around 130,000 Somali refugees in camps near Dadaab in eastern Kenya, MSF handed over its work there to a German organization in June 2003. Nutritional aid to Kenyan, Somali and Ethiopian children in Mandera, in the northeast, was suspended indefinitely in June 2003 after a grenade explosion outside the MSF compound severely injured an MSF volunteer.

MSF continues to respond to emergencies in Kenya, such as a nutritional emergency in June 2003 in northern Kenya.

MSF has been working in Kenya since 1987.

International staff: 46

National staff: 243

April

The deteriorating nutritional situation in Akuem, Bahr el Ghazal province, Sudan, prompts MSF to add one therapeutic feeding center and three supplementary feeding centers to the therapeutic feeding center already in place. Over two months, 811 severely malnourished children are cared for in the therapeutic feeding center and 5,300 receive food rations. Another therapeutic and two additional supplementary feeding centers are opened around the same time in Marial Lou, also in Bahr el Ghazal

MSF begins an HIV/AIDS care program at Lagos General Hospital, Lagos, Nigeria





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Evance, a farmer in the village of Namiwa, Malawi, is weighed by a nurse and a home-based care volunteer working in MSF's comprehensive continuum of care HIV/AIDS project in Thyolo district.

Malawi

Paracetamol; first-line malaria treatment; oral rehydration salts; iron tablets; vitamins; condoms; disinfectant solutions; eye ointment; soap; adhesive tape; cotton; disposable gloves; gauze bandages and scissors.

These few basic items can be put into a little kit, carried around by bicycle from home to home, village to village. They might be small, they might be deceptively simple – but, in the right hands, they can mean a big difference in the daily life of a person living with the pandemic disease of the current age: HIV/AIDS. They can help forestall the untimely disappearance of one, two, ten, a hundred people. They can help prevent a part of humanity from slipping away, unnoticed.

In Thyolo district, a densely populated rural district in southern Malawi with a population of about 475,000 people, home-based care volunteers working with MSF carry these items (and others) when they visit their assigned patients. These volunteers are part of the great community web of care and compassion that has evolved in Malawi even as the deadly virus claims over 80,000 lives each year. Around 850,000 Malawians are living with the disease, including about 15% of the adult population.

Compassionate continuum

Malawi's circle of care has many faces: doctors and nurses who treat patients in hospitals and clinics; nurses who zoom from village to village on their motorbikes, examining patients and supervising village volunteers; home-based care volunteers; "guardians," usually close friends or family members who look after one patient, who make sure that he or she has enough to eat, that medicine is taken on time and doctor's appointments are kept; sick people themselves, who meet together, offering one another support and encouragement. All of these people together are trying to hold on to lives the virus has put its claim on.

Since 1996, MSF has been working to fight HIV/AIDS in the district of Chiradzulu, in 1997 expanding work to Thyolo. Both programs are tackling the disease through a comprehensive range of prevention activities and services, medical care and patient support. And both program sites now offer antiretroviral (ARV) treatment, which can enhance and prolong the lives of people living with AIDS. In Thyolo, MSF's project is designed to root nearly every aspect of detection, support, care and ARV treatment for people with HIV/AIDS in a community-based continuum of care network.

Evance Nikoma is a 40-year-old father living in Thyolo. Suffering from a fever and chronic diarrhea, Evance discovered he was HIV-positive. He now has a "guardian" – his brother – who takes care of him. Anne, a volunteer from Evance's village, also helps. Both his brother and Anne were trained by MSF to take care of Evance on a daily basis. An MSF nurse visits periodically, referring Evance to the HIV/AIDS clinic service in the nearby health center, or to the MSF HIV/AIDS

clinic at the district hospital for treatment of opportunistic infections.

Modeled on community-based networks that already have strong roots in Malawi society, the MSF project in Thyolo is the product of collaboration with the Ministry of Health and Population and national and local health organizations to create an HIV/AIDS program centered in traditional community support systems. Through this "continuum of care" people with HIV/AIDS are integrated into a community health care network involving family members, volunteers, local organizations and health care professionals.

People are referred to the program through a wide range of social groups, health structures and community outreach activities. Religious groups, traditional birth attendants and traditional healers help steer patients to MSF-supported facilities, while mobile clinics are organized monthly for commercial sex workers and their clients. MSF and local health staff provide voluntary counseling and testing and mother-to-child transmission prevention services (PMTCT) at seven health centers and two hospitals in the district (MSF also provides PMTCT in Chiradzulu). Currently, more than 1,500 men, women and children are being tested monthly, of whom 30-35% test positive for HIV infection. One-third of those newly identified as HIV-positive can be integrated into the network of home-based care.

The tuberculosis connection

One of the most effective entries to treatment for HIV/AIDS is through offering routine voluntary counseling and testing to all tuberculosis (TB) patients. TB is one of the most common opportunistic infections associated with AIDS, and it is on the rise in Malawi. Countrywide, the annual number of cases increased three-fold between 1987 and 2001. In Thyolo, 75-80% of those with tuberculosis test positive for HIV. All of these HIV-positive TB patients are offered cotrimoxazole prophylaxis (which can help protect them against opportunistic infections) and are entered into the continuum of care network for home-based care and HIV/AIDS clinic services.

Medications for patients who are being treated for opportunistic infections such as tuberculosis can be complicated. To help patients and their loved ones understand

May

In France, MSF collects over 100,000 signatures on a petition designed to force the government to abandon changes in the *Aide Médicale d'Etat*, which provides health insurance to undocumented immigrants and the homeless. The petition is a success

After visiting more than 70 health structures throughout Iraq, MSF finds that reestablishing leadership of the highly centralized health system is the most urgent medical need. MSF calls on the occupying powers to fulfill their responsibility under the Geneva Conventions to ensure basic services in Iraq, including health care

and participate in the process, patients are required to keep a health “passport” recording treatments and medical visits. Care is individualized to each person’s situation and often involves family and friends. Caregivers in the continuum of care program are trained to assist patients with chronic or terminal illness, alleviate pain and suffering and help improve their lives in other ways. As of July 2003, 4,000 people were receiving direct support through the continuum of care initiative in the district of Thyolo. However, over a five-year period (2003-2007) MSF hopes to extend access to the continuum of care network to at least 50% of the estimated 50,000 people living with HIV/AIDS in this district.

Totally taboo

The grassroots education of volunteers, nurses and family members involved in implementing and maintaining this successful program has helped to mobilize the community to respond to HIV/AIDS and raised consciousness about the disease and its transmission. This awareness-raising and education is important in both Chiradzulu and Thyolo. “When AIDS first appeared in Malawi, no one wanted to talk about it,” explains George Maruwo, an MSF health worker in Chiradzulu. “It was totally taboo. Many people got infected because there was no information and no prevention.” Other educational activities include plays and songs presented by People Living With AIDS (PLWA) support groups. Members of PLWA support groups meet monthly to talk about their experiences, supported by MSF counselors. Psychosocial care for people with AIDS and their families is critical.

ARV therapy – offering the future

“I feel like I have a future” – Fred Minandi, Chiradzulu, receiving antiretroviral treatment since 2001

Fred Minandi is expressing a feeling that is commonly found among those who begin antiretroviral treatment. An expanding part of MSF’s work in many countries, ARV therapy can suppress the disease and help the patient’s immune system recover, transforming AIDS from a fatal disease into a chronic and manageable illness. People managing HIV/AIDS with ARVs can often live long, healthy

lives. Since May 2001 in Chiradzulu and April 2003 in Thyolo, antiretroviral medicines, or ARVs, have extended the care available to those with AIDS and helped many people see a future where there was none before. (See page 50 to read excerpts from a speech by Fred Minandi at the 2002 International AIDS Conference in Barcelona, Spain.)

In a country where health facilities often lack even basic supplies, the idea of implementing quality HIV/AIDS care which includes ARV therapy was resisted by some. Maryline Mulemba, Head of Mission in Chiradzulu explains, “Two years ago, when we made the rounds of donors, everyone treated us like we were aliens from outer space who didn’t understand anything about the local situation. How could ARVs be introduced when there weren’t even oral rehydration salts? Today, no one criticizes us and everyone agrees that treatment is necessary.”

MSF nurse Helle Poulsen-Dobbynys notes the amazing difference ARVs can make for patients with HIV/AIDS. Six years ago she worked with children in Malawi. “As one by one I watched the children die, I became increasingly frustrated and angry,” she remembers. After ARV drugs were introduced in Chiradzulu in 2001, Poulsen-Dobbynys decided to return, and was amazed to see patients begin to feel better after only a few weeks of ARV therapy. “We’ve come a long way,” she concluded.

In Thyolo, MSF nurses select HIV-positive people already integrated in the home-based care program as potential candidates for ARV treatment, depending on their medical status and the availability of a family member, friend or neighbor to support them with their ARV treatment. Once accepted into the program, patients select a guardian (if they don’t have one already) who is responsible for helping supervise their doctor visits and medication regime. Usually a friend or family member, the guardian is an essential part of the program, providing individualized support to each participant, and helping alert MSF staff to individual needs or problems. By July 2003, nearly 150 people had begun ARV therapy in Thyolo district through the MSF HIV/ARV clinic at Thyolo district hospital, and 1,000 others had been identified as eligible for treatment. Plans are underway to open a new HIV/AIDS clinic at the Malamulo 7th Day Adventist

Hospital by late 2003. The ambitious five-year goal is to provide access to ARV treatment to at least 50% of the estimated 7-8,000 people in the area continuously suffering and dying of AIDS.

Finding sustainable ways to extend ARV therapy to as many people as possible is currently at the center of discussion within the MSF movement. “Our real challenge is providing services to all the patients knocking on our door,” states Maryline Mulemba. People living with HIV/AIDS in Chiradzulu are eligible to participate in the ARV program if their disease has progressed to a particular stage and they have selected a guardian to help them with the treatment. By July 2003, nearly 1,000 people were undergoing ARV treatment in Chiradzulu.

In addition to providing direct access to essential medications, working to implement change at the level of national policy and fighting to diminish international barriers to affordable drugs are high priorities (see Kenya, page 46 and Guatemala, page 52).

Other projects – emergency preparedness and nutritional monitoring

Since the late 1990s, there have been yearly outbreaks of cholera in Malawi during the rainy season. In 12 districts in the southern part of the country, MSF works with the Ministry of Health and Population and several missionary health centers and hospitals on refresher training for health staff, pre-positioning medical supplies and materials and construction or rehabilitation of cholera treatment facilities. During outbreaks, MSF supports case management, supplies medical materials and disinfectants, and works on outbreak control.

In August 2002, MSF carried out an independent assessment of food security in Malawi. While international reports of impending famine in southern Africa were widespread, MSF teams found the nutritional levels of the population to be similar to previous years. MSF continues to monitor the nutritional situation in Malawi in 2003.

MSF was present in Malawi from 1986 to 1990. In 1996 MSF returned to the country.

International staff: **20**
National staff: **166**

May

MSF opens a free AIDS clinic in Hubei province, **China**. It is one of the first projects of its kind in the country to provide free AIDS care and treatment

MSF’s report *Left Without a Choice* shows that 98% of displaced Chechens living in Ingushetia do not want to return to Chechnya. Both Ingushetia and Chechnya are republics in the **Russian Federation**



A voice from Malawi

The following is taken from a speech by Fred Minandi, a Malawian man living with HIV/AIDS, at the 14th International Conference on AIDS in Barcelona, Spain, July 2002. The speech was first published in December 2002 in MSF's report In the face of AIDS, the only responsible action is to treat patients in danger of dying. The report can be found in full at www.msf.org

"Malawi has [one of] the highest HIV rates on the continent. Fifteen percent of the adult population is infected. Where I live, 24% of the pregnant women who have been tested are seropositive. Ten percent of the youth in secondary school are ill. Those are the statistics, but what I see in my village are young people who are too sick to work in their gardens and feed their families.

I became ill in 1997. Over four years, my health was sometimes better and sometimes worse. Finally it became hard for me to work or do anything. I was tested in 2001 and was lucky to live where MSF was just starting ARV treatments. I am one of the first to have benefited from free ARVs in Malawi. The fact that I can talk to you about this is because I am in treatment.

Some people will say that Africans cannot take their medicines properly because they don't know how to tell time. Maybe I don't have a watch, but I can tell you that since I began my triple therapy in August of last year, I have never forgotten to take a single dose. Why? Because Margo, the MSF nurse, took the time to explain to me how these medicines work. She told me that if I wasn't serious about taking them, they would have no effect. She told me about the side effects and said that I'd feel better after a while, but that it would be difficult.

All my friends in the support group of people with AIDS think as I do. We are 60 in the group and we meet every month to talk. We help each other. We support the people in the group who don't have anyone to talk to about being seropositive or about treatment. This means we go with them to the first session, and we then help them take their medicines at home. We let our community know about the medical services (the HIV clinic, the program for infected pregnant women, the voluntary counseling center, and where to get condoms and information) that are available to everyone who lives in the district.

May

└ MSF reaches an agreement to hand over its project on improving access to water in Kigoma, **Tanzania**, to another organization; the handover is expected to be completed by October 2003

└ In the wake of the Manou cyclone, MSF provides technical and material support to **Madagascar's** National Relief Committee

└ MSF begins support of mental health services in **Nagorno-Karabakh**

When I became ill, I knew I was seropositive but I never wanted to admit it or talk about it. My neighbors saw me get weaker day by day. Of course, they knew what was wrong but no one asked questions. Little by little, they just stopped coming to see me. Most people are like that in Malawi. They don't raise the subject because they don't want to know. That is why my country is dying in silence.

Now I work in my field, I have returned to my church and I can feed my family. I feel like I have a future. My neighbors have started coming to see me again, like they did before. When there is a meeting in the district, I go and talk about my disease because I'm not ashamed anymore. Someone who has AIDS and is very ill frightens everyone because people see their own death in his eyes. But once you are being treated, you feel better, you look better and people don't reject you anymore.

Some people will tell you that treatment is too expensive and that a country like Malawi should only work on prevention. First of all, would that mean that the million people infected in Malawi, and I, myself, must die? It is too late for us to talk about prevention, but I strongly believe that we have the right to be treated. I would like to say that I consider my life to be important, not just to me, but to my family and my whole country.

Second, I think that providing affordable treatment will encourage many more people to face their HIV-positive status. This will allow the silence to be broken. My friends in the PLWA [People Living With Aids] support group and I have been trained as counselors. We have been able to convince many people to take the test because they know they will be treated if they are positive.

Third, we use generic medicines from India for the Malawi program, which lowers the price. The less expensive the medicines, the less costly the program and the more people we can treat.

To conclude, I would like to appeal to the pharmaceutical laboratories that manufacture ARVs to reduce the prices of their medicines for all low-income countries, to our governments to support treatment and demand help, and to the governments of the wealthy countries to give us money so that we can reach our goals." ■

May

After extensive advocacy by MSF and other organizations, the governments of **Afghanistan** and **Pakistan** agree to close the "Waiting Area," a place just inside the Pakistani border where many Afghan refugees had been stranded after the Pakistani government closed its borders to new refugees in February 2002. Half the 25,000 refugees there choose to go to camps inside Pakistan away from the border and are granted refugee status; the others return to Afghanistan, many moving to Zhare Dasht camp near Kandahar. MSF provides medical assistance to Afghans in camps inside Pakistan, in the "Waiting Area," and at camps for the displaced inside Afghanistan

Guatemala

"I have been threatened with death since they found out that I was HIV-positive. My sons were taken away while I was in the hospital."

Angela, Guatemala City, May 2003

Angela (not her real name) is 35 years old. She is an indigenous woman who lives in extreme poverty with her six sons, the youngest of whom is also HIV-positive. Her children are living fatherless because Angela's first husband died of tuberculosis and her second husband abandoned the family. The community where she lives is rejecting her. She is one of the most vulnerable of the most vulnerable: a woman, indigenous, living in poverty, living with AIDS, the object of discrimination.

Improving the quality of life of those with AIDS: a worthwhile goal

Angela is one of the estimated 100,000 people in Guatemala infected with HIV/AIDS. She is also one of only 1,800 people nationwide who are receiving antiretroviral (ARV) treatment, which can make AIDS patients feel better and prolong their lives. Around 550 of these people receive ARV treatment through MSF, at Roosevelt Hospital (where Angela is treated) and Yaloc clinic in Guatemala City and at a clinic in the city of Coatepeque, in the southwest. MSF also reaches thousands more people through prevention programs and through monitoring, care and treatment of opportunistic infections, nutritional support and home care. A key objective of MSF's work is to provide the Ministry of Health with a model for developing a comprehensive public HIV/AIDS program.

To provide ARV therapy, MSF currently imports generic medicines. The Guatemalan government, as of July 2003, was buying a mix of generic and brand-name drugs (countries like Guatemala are often under great pressure to buy brand-name drugs). Should the Guatemalan government decide

to launch a national treatment program and use generic medicines, under today's laws it could freely buy the affordable registered medicines that MSF is purchasing.

Unfortunately, new, more stringent intellectual property rules in Guatemala mean that access to affordable medicines will be much more difficult. "The situation for access to medicines in Guatemala is awful," says Luis Villa, MSF Head of Mission in Guatemala. "If there is any compromise on the ability to buy generics, then it will become almost impossible to treat HIV/AIDS patients here." Although generic competition has begun to bring drug prices down dramatically in some Latin American countries (and elsewhere in the world), this positive dynamic is now threatened by bilateral and regional trade agreements that are putting drug company profits above people's health. These agreements are creating stringent intellectual property protection that is crushing the most vulnerable people underneath. This is not the spectacular, violent death of intense conflict. It is the slowly accumulating, officially sanctioned deprivation of one the basic necessities of life.

Data protection: the back door to profits in Guatemala

In April 2003, under pressure to adopt US standards, the Guatemalan government modified its national intellectual property bill by passing Decree 9-2003, which stipulates five-year data exclusivity for submitted test data used to show that drugs are safe and effective. Practically, this means that drug regulatory authorities will not be able to rely on such data to approve generics for five years, and therefore generic competition will be delayed despite the fact that none of the existing ARVs is under patent in Guatemala today – thanks to the lack of patent protection for pharmaceuticals in the previous patent law. Passage of the decree makes Guatemala the only country in Central America to give five-year data protection. The five-year data exclusivity provision makes this a TRIPS*-plus law: it is even more restrictive than prevailing world standards.

Data exclusivity acts as an obstacle that denies poor people access to affordable medicines. This means that people like

Angela will be less likely to get the drugs they need to save their lives.

Free Trade Agreement of the Americas

Unfortunately, intellectual property provisions such as those in Guatemala's Decree are a foretaste of what is planned for the new trade agreement currently under negotiation in the region, the Free Trade Agreement of the Americas (FTAA). If formally implemented, the FTAA will create the largest free trade zone in the world: a US \$13 trillion market covering more than 800 million people in 34 countries in North, Central and South America and the Caribbean (except Cuba). The draft FTAA contains provisions on intellectual property rights which could reinforce monopolies and put essential medicines out of reach of those who need them most. If the FTAA strengthens patent and data protection, it will destroy the dynamic of competition that has caused ARV prices to plummet in some low- and middle-income countries in the Americas.

The US is already putting bilateral pressure on countries in the hopes of wearing down resistance to the restrictive provisions planned for the FTAA. Guatemala's Decree is one example of how this is being done.

MSF continues to work with NGOs and governments to advocate for a public health interpretation of intellectual property law. In August 2003, MSF formally launched a campaign and petition designed to raise awareness of the potential harmful consequences of certain parts of the FTAA. And, at the time of going to press, MSF and other organizations were still urging the Guatemalan government to repeal Decree 9-2003.

The big picture

In 2001, in Doha, Qatar, World Trade Organization (WTO) member states adopted the groundbreaking Doha Declaration, which unequivocally recognizes that access to medicines should have primacy over commercial interests. However, since that time, the spirit and intent of the Doha Declaration has come under attack. In negotiations in August 2003 aimed at finding a solution for countries with insufficient manufacturing capacity to import medicines, WTO members adopted cumbersome and

*TRIPS: Trade-related aspects of intellectual property rights

May

MSF begins medical, social and psychological assistance to women, children and teenagers living in precarious conditions in the Marcilio Dias slum of Rio De Janeiro, **Brazil**

MSF begins distribution of medicines and laboratory supplies to primary health care centers and hospitals in the city of Basra and in Missan governate in **Iraq**; expatriates are evacuated in August after security deteriorates, and distribution is completed by national staff

MSF provides medical and psychological care to victims of a major earthquake in northern **Algeria**; the intervention lasts seven weeks



“It was April 15th, 2001”

The following text is excerpted from “It was April 15th, 2001” by Dr. Nicolas Durier, as published in December 2002 in MSF’s report In the face of AIDS, the only responsible action is to treat patients in danger of dying. Durier began MSF’s antiretroviral treatment program in Thailand and is now with MSF in Malawi. The report can be found in full at www.msf.org

“February 2001. Surin was one of the six MSF projects about to begin treating patients with antiretrovirals (ARVs). At that time, very few people were recommending this kind of program. Most held pessimistic views, assuming that ‘poor people’ wouldn’t know how to take these medicines properly.

But MSF viewed things differently. The organization wanted to begin ARV treatment programs and to prove that ‘poor people’ do not want to die of AIDS when effective treatments exist and are being used in wealthy countries.

The initial goal was to take in 20 new patients per month. By June 2002, 230 had taken the plunge. Today, 90% remain in treatment. And surprise! They’re full of energy and, what’s more, the vast majority are taking all their medicines.

Imagine that! It’s the same with MSF’s other AIDS projects. The patients are taking their medicines, doing much better, gaining weight quickly and returning to work and normal lives.

The question MSF faces now is: Should we go all out or bring in new patients at a more moderate pace? There are many, many patients who need triple therapy.

We have promised the patients that, once their therapy is started, it won’t be stopped. What happens if, in ten years the Thais can’t carry the program on their own? Will MSF stay for 20 years?

This is an endless debate, made all the more uncertain because no one knows what will happen in the next few years. What if a cure becomes available and we had intentionally limited the number of patients receiving triple therapy? Many whom we could have kept alive will have died waiting for the cure. It’s a difficult issue. We have no idea what the future holds. We know only that [42] million people around the world are living with HIV; that, according to the experts, the problem has just begun; and that too few are willing to risk starting ARV programs in the third world. But we also know that we at MSF do not want to stand around with our arms crossed while we watch patients die.” ■

© Laura Hakongas

May

— Mefloquine+artesunate (an artemisinin-based combination therapy, or ACT) replaces chloroquine as Myanmar’s national protocol for treatment of simple falciparum malaria. MSF had already been using ACT to treat malaria in Myanmar, with encouragement from the Ministry of Health

— MSF’s international staff in Ghazni, Afghanistan, is forced to evacuate because of insecurity; assistance to the provincial hospital and support of a tuberculosis center continues through Afghan staff

economically risky provisions which may actually hamper access to medicines. Hailed as a “success” by many countries, the provisions are instead a sign of the WTO’s failure to safeguard the spirit of Doha. In addition, the negotiating process itself revealed to what extent many negotiators were acting in bad faith vis-à-vis the Doha Declaration.

MSF, along with other NGOs, pointed out that the WTO’s August deal on medicines was a “gift” bound tightly in red tape, and that, as a measure of trade policy, it contradicts the basic principles of the WTO and free trade. Nonetheless, MSF is urging countries to make use of these provisions in order to test them and see what can be improved before they are reviewed and used to amend the TRIPS agreement in 2004.

The failure to safeguard Doha in the recent multilateral talks has made the outcome of regional and bilateral negotiations, such as those underway for the FTAA, all the more important. In a multilateral context, developing countries have more clout. They

can vote in blocks and use their numbers as leverage. In a bilateral or regional setting, it is much more difficult for developing countries to stick up for pro-public health positions, when faced with the enormous pressures exerted by wealthier countries. It is also harder for NGOs to influence the process on these countries’ behalf.

MSF firmly believes that there should be no “TRIPS-Plus” – and no “DOHA-Minus” – intellectual property agreements. The Doha Declaration should be the guideline for providing access to generic drugs. MSF is therefore calling for intellectual property provisions to be dropped from FTAA, to date the most far-reaching and extreme attempt to weaken the Doha Declaration. There is already a multilateral agreement on intellectual property that most countries are happy with. Why negotiate another?

Other programs

In addition to its HIV/AIDS care and advocacy work in Guatemala, MSF continues to address the medical and psychological

needs of children living on the streets in Guatemala City. MSF teams at the Tzitze clinic provide 200 medical and 220 psychological consultations each month. In the therapeutic crèche “Casa del Patojo” in Lomas de Santa Faz, a slum area on the outskirts of the capital, MSF provides medical assistance and psychological and social support to young mothers and their at-risk children.

Recently two new programs opened on the Atlantic Coast: in Puerto Barrios, focusing on HIV/AIDS; and in Olopa, focusing on treatment of Chagas disease.

MSF also responds to natural disasters. In slum areas of Guatemala City, MSF provides structural and logistical support to help mitigate the effects of potential natural disasters and supports a local health center. Community training focuses on developing the capacity to respond to emergencies.

International staff: **18**

National staff: **90**



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Patricia (at right) has AIDS. When this photo was taken, in April 2002, she was on the waiting list to start antiretroviral treatment in Coatepeque, Guatemala.

May

Results of an MSF resistance study of three malaria treatments (sulphadoxine-pyrimethamine (SP) alone, amodiaquine alone and SP+chloroquine) carried out in Bundibugyo, **Uganda**, are presented to the Ugandan Ministry of Health. The study reveals resistance to SP alone to be 37% at 28 days, and resistance to the other two treatments to be 20.6% (amodiaquine) and 22% (SP+chloroquine); it confirms the need to switch protocol for malaria treatment to artemisinin-containing combination therapy (ACT). The Ministry of Health is now conducting effectiveness studies on combination therapy with ACT

Burundi

The dense forests and lush vegetation of Cankuzo, a remote province in northern Burundi, hide the dangers that the local people face on a daily basis. The hills are hideouts for rebels who roam the area and – in their fight against government troops – rob, rape and kill civilians and destroy farms. Government troops are known to be equally merciless with anyone suspected of supporting the rebels. Every night, people from the hills around Cankuzo come down to spend the night in the relative safety of the town.

MSF supports three health centers in Cankuzo, and runs mobile clinics in three areas. (A nutrition program was handed over to the Ministry of Health in July 2003.) Due to the civil war, health facilities in Cankuzo – and many other provinces – have virtually come to a standstill. The people of Burundi face a chronic lack of health care.

Around 50% of the consultations in Cankuzo are for malaria. This parasitic disease is endemic in Burundi, and the number of infected patients regularly swells to epidemic levels. To give just one example: between October 2000 and March 2001, a severe malaria epidemic caused around 3 million cases among a population of 6.5 million people, and many thousands of deaths. More recently, an epidemic that lasted from December 2002 to April 2003 and covered several provinces produced hundreds of thousands of cases.

Unfortunately, until now, people affected by malaria in Burundi have been unable to obtain the treatment that is known to work best. Instead, they have been treated with older drugs, primarily chloroquine, which was the first-line treatment until 2001, and sulphadoxine-pyrimethamine (or SP, commonly known by its brand-name Fansidar®). In many parts of Burundi – and Africa – the malaria parasite has developed alarming levels of resistance to both these drugs.

The treatment that works best right now is artemisinin-containing combination therapy (ACT), which uses a derivative of a Chinese plant in combination with another

drug. Unfortunately, its use in Africa is rare, despite the fact that hundreds of millions of people are infected there each year, and that 90% of the 1-2 million people who die from malaria each year worldwide are African, most of them children. ACT is also a costly therapy, currently about ten times more expensive than older drugs. This is the main reason that African ministries of health have hesitated to make ACT the first-line treatment in their countries. Not wanting to treat patients with ineffective medicines, MSF has pushed for introduction of ACT in its own projects in Burundi and elsewhere. MSF has also been advocating for international donors to step in and assist governments in subsidizing the treatment so that it can become available and affordable for people in Africa. For more on the need to implement ACT in Africa, see excerpts of MSF's advocacy report "ACT NOW to get malaria treatment that works to Africa," on page 58.

Confronting reality in Burundi

Burundi was one of the first countries in Africa to decide to use ACT to treat malaria. This decision to introduce ACT by July 2003 was made in July 2002, after intense pressure from organizations such as MSF (who refused to treat malaria patients in Burundi with older drugs that were no longer effective), and after funds were pledged via UNICEF, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the European Community Humanitarian Office (ECHO) and the Belgian government. The government's decision now seems to have been the easy part. Turning it into everyday reality has proven difficult, with actual use of ACT only now being envisaged for sometime in late 2003. Why has it taken so long?

Implementation of ACT, after all the effort to lobby for its acceptance, has been slowed by difficulties in identifying appropriate sources for artesunate and amodiaquine, the two molecules thought to be most effective in Burundi. The government of Burundi asked the World Health Organization (WHO) to identify sources for these two drugs that were as close as possible to the standards used in pre-qualification, a new process at WHO whereby drugs are identified as being of appropriate quality – but which so far has not included any of Burundi's chosen drugs.

Burundi's health budget is much too limited to pay for ACT for all those who will need it. Burundi applied to the Global Fund for money to fund ACT; this money will be forthcoming in 2004. Until then, MSF has agreed to supply ACT in the five provinces where it works; UNICEF will do the same in the other provinces.

The chosen combination, at about US \$2-2.50 per treatment from the suppliers selected, is also more expensive than the \$1.50 per treatment available from other sources. Because the chosen drugs are more costly than anticipated, donors had to be approached again for additional funds. When funding was finally secured, one of the producers did not have enough of the needed drug in stock nor did it have sufficient short-term production capacity, further delaying the introduction of ACT.

With the new protocol, patients will have to pay a nominal fee for the diagnostic texts (rapid lab tests or microscopy tests) needed to detect malaria, and for the drug itself. While this should be affordable for most people, there certainly will be some who cannot pay. MSF is trying to guarantee access to this treatment as much as possible. Nonetheless, malaria, which once seemed to be Burundi's dark spot in terms of the magnitude of the problem compared with the inadequacy of the solution, may now become one area for which Burundians will have a reasonable chance of getting the care they need at a price they can afford.

Make them pay?

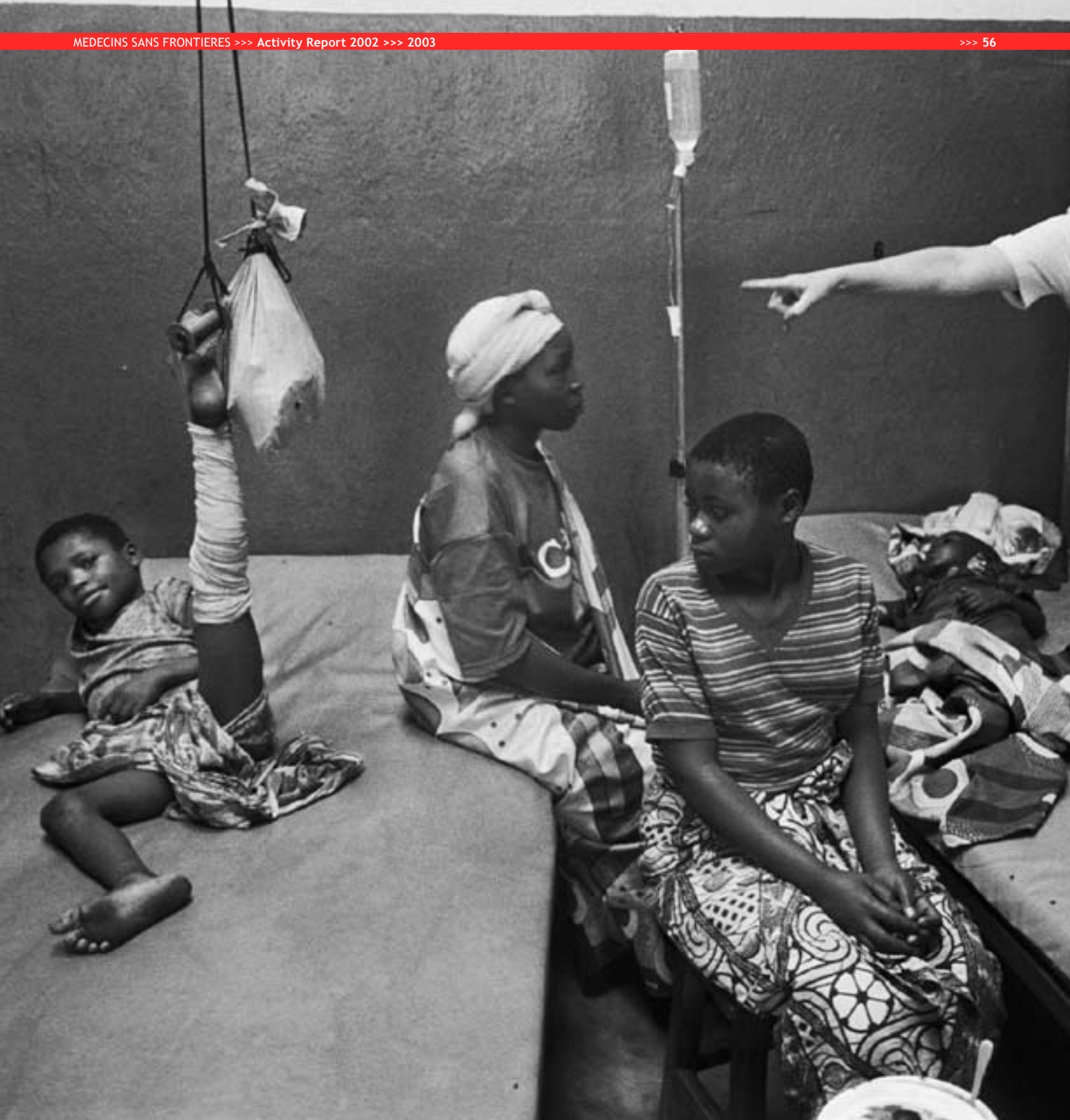
Even as the problem of inadequate malaria treatment is nearing resolution, another threat to adequate health care in Burundi has materialized. In 2001, the government decided to set up a system of cost-recovery in the public health sector. The cost-recovery system requires that health centers and hospitals become financially independent of government support. Patients are supposed to finance all costs of the medicines and the running of health facilities by paying full prices for the drugs they need, plus a fee for all inpatient and outpatient services. In the current climate of conflict, it is unreasonable to ask the people of Burundi to carry that burden. While the system has been unevenly

May

In **Ethiopia**, in response to a deepening nutritional emergency brought on by drought, MSF opens therapeutic feeding centers for severely malnourished children in Boditi and Buge, Ethiopia. By July 2003, MSF was running five therapeutic and seven supplementary feeding centers in Ethiopia

Working in 11 of 33 health zones in Kinshasa, **Democratic Republic of the Congo**, MSF monitors a measles epidemic and treats cases; kits given to various health facilities provide free treatment for 3,200 people





An ordinary moment at the health post in Muyinga, Burundi, August 2002. The country has moved toward a cost-recovery (paying) health system. However, with civil war ongoing now for 11 years, most people cannot pay the costs for consultations or inpatient care.

May

— The town of Shabunda in Sud-Kivu province, **Democratic Republic of the Congo**, is retaken by a rebel group. Much of the population flees into the forest; MSF's team evacuates. The 100-bed hospital where MSF is working is completely ransacked, for the second time in six months. By June, MSF has shipped in new supplies and restarted all departments

— MSF donates medical supplies and organizes water and sanitation for 50,000 people displaced by flooding in Santa Fe province, **Argentina**



© Petterik Wiggers

implemented across the country, its debut has been alarming.

MSF's research indicates that where the system is put in place, it leads to drastic price hikes in health centers and hospitals. The consequences are three-fold: a dramatic decrease of people seeking medical help in clinics and hospitals; an increasing number of patients who fail to pay their bills; and a tendency for patients to buy fewer pills than what is prescribed for them because medicines are priced on a per-pill basis. Not only does this latter phenomenon result in incomplete treatment, but it also contributes to the increasing resistance to drugs seen in the field today.

"For now the system of cost-recovery is not sustainable," says Ellen Rymshaw, a former MSF Head of Mission in Burundi. "Most patients are unable to pay the costs for consultations and inpatient care. It is not feasible for patients, and hospitals cannot possibly manage their costs with such a low number of paying patients. This system not only fails to provide a solution, it actually prevents people from seeking health care in Burundi," she said, pointing out that it is not realistic to expect ordinary Burundians living in up-country settings to pay up to US \$60 for such essential surgical interventions as Caesareans.

While advocating for change, MSF has come up with temporary solutions in the hospitals it is currently assisting. Adhering to the MSF principle that its emergency medical aid should be provided at little or no cost, the organization donates the medicines to the hospitals and health centers it supports. In addition, MSF has entered into agreements with provincial health authorities to limit the negative impact of cost-recovery mechanisms: MSF has introduced a low, lump sum fee covering consultation, tests and drugs, regardless of the disease or the real cost of the drug. MSF also has contracts directly with certain health facilities that cover the costs of the services offered (including salaries) in exchange for strict adherence to quality rules. "We want to make medical care again affordable for our target populations," says Ms. Rymshaw.

"The longer-term approach to this problem should include lobbying on yet another level," adds Ms. Rymshaw. "These policies

are supported by large donor agencies that grant funds on the basis of poverty reduction strategy papers that often contain policies (such as cost-recovery and user fees) that have failed consistently to reach the goals of sustainable health care. The problem with these policies is that they presume the country to be on a development path, or at least in a post-conflict setting. But this is not the case in Burundi! You cannot expect a country that is in its eleventh year of a nationwide civil war to be able to function in a mode of development and sustainability." In addition, financial participation for basic health care should be linked to the real purchasing power of the people, not to the real costs of services.

Although MSF obviously encourages governments to find long-term solutions for problems in their health care systems, the organization is convinced that a cost-sharing system is for the time being not feasible in Burundi, and instead advocates that the Burundian government and lending institutions make money available to ensure an adequate level of medical care.

MSF in the field

MSF continues to support a number of regional hospitals and many local health centers in the provinces that have been most affected by the civil war, such as Makamba, Ruyigi, Cankuzo and Bujumbura. In addition, MSF runs health centers and mobile clinics in these provinces. In Karuzi province, programs treat and feed children suffering from severe malnutrition. The organization has fought outbreaks of malaria and other infectious diseases, such as meningitis, over the last year. MSF also responded several times to meet the immediate needs of people displaced after fighting had taken place between the army and rebel groups. In the capital Bujumbura, MSF runs a treatment and rehabilitation center for war-wounded civilians from areas around the capital; another surgery program is based in one of the city's hospitals. In September 2003, MSF opened a new center to deal with sexual violence in the center of Bujumbura.

International staff: **61**

National staff: **697**

May

During two weeks of violence, hundreds of people are killed and an estimated 150,000 people are forced to flee Bunia, Ituri region, **Democratic Republic of the Congo**. MSF's team is temporarily evacuated. MSF returns within one week and quickly establishes a new 70-bed hospital in a warehouse

More than 8,000 children in the war-affected Korhogo region of **Côte d'Ivoire** are vaccinated against measles



ACT Now

The following is taken from the executive summary of ACT NOW to get malaria treatment that works to Africa, published by MSF's Campaign for Access to Essential Medicines in April 2003. For the full report, go to www.msf.org

ACT Now. This is an urgent call to international donors to join African countries in implementing World Health Organization (WHO) treatment guidelines for malaria. On the advice of international experts, WHO recommends that African countries facing resistance to classical antimalarials introduce drug combinations containing artemisinin derivatives – artemisinin-containing combination therapy, or ACT for short.

Artemisinin derivatives have attributes that make them especially effective: they are highly potent, fast-acting (parasite clearance is fast and people recover quickly), very well tolerated and complementary to other classes of treatment.

Implementation of new malaria recommendations is a matter of life and death in Africa, where malaria kills between 1 and 2 million people each year. Sickness and death from malaria account for 30-50% of hospital admissions and a yearly loss of US\$12 billion on the African continent.

The WHO-led global malaria eradication program launched in the 1950s sought to eliminate the disease via vector control and effective treatment. The eradication program was successful in some parts of Asia, North America and Europe, but bypassed sub-Saharan Africa. In 1969, the focus switched to the less ambitious goal of control through treatment. At the time, the treatment of choice was chloroquine, dispensed in a three-day course. This effective treatment campaign led to falling death rates until the early 1980s.

However, since the early 1980s, the situation has stopped improving, and has in fact been getting dramatically worse. Average annual cases were four times higher between 1982 and 1997 compared to the period 1962-1981. Death rates have also jumped: hospital studies in various African countries have documented a two- to three-fold increase in malaria deaths. The continuing use of ineffective drugs despite spectacular levels of resistance is leading to increased treatment failure.

While African countries are heeding the advice of world experts to switch from old failing single-drug treatments to combination treatments, they are being forced to switch to stop-gap, less expensive combinations because of a lack of resources.

Why is MSF so focused on treatment?

Effective malaria control requires strong political will from endemic country governments that translates into implementation of comprehensive prevention and treatment programs. But while the international community has been willing to do everything possible to augment prevention, there has so far been no concerted drive to support improved treatment.

May

MSF calls attention to the medical, psychological and material consequences on Palestinian families of an Israeli Army incursion into Beit Hanoun, **Gaza Strip**

To assess levels of resistance to malaria drugs in the region, an efficacy trial comparing Coartem™, artesunate+mefloquine, and chloroquine+sulphadoxine-pyrimethamine (SP) begins in Khagrachari District, **Bangladesh**, in close cooperation with the Ministry of Health, the Chittagong Medical College and the World Health Organization

In its projects, MSF supports prevention as an integral part of effective malaria control. There is no controversy there. The debate that we think needs to be stimulated is on treatment. After extensively documenting resistance to current treatments in MSF projects and carefully considering data gathered by ministries of health in endemic countries, MSF decided to switch to ACT in all its programs.

Since October 2002, implementation of this policy has focused simultaneously on switching to ACT in all MSF projects, and on advocating for and giving technical support toward increasing the availability of quality ACT drugs.

MSF is seeking to change the current dynamic in which the lack of political and financial support on the part of donors means that endemic countries are often encouraged to “leave alone” failing malaria treatment and are not given financial and technical help to implement more effective strategies.

Without successful implementation of ACT in the next decade, significant progress in controlling malaria will be impossible. This is because there are no miracle non-ACT combinations waiting in the wings, and because malaria control using prevention without effective treatment is doomed to failure.

How can we “go slow” on malaria treatment when one African child dies of malaria every 30 seconds?

Our recommendations convey what MSF thinks needs to be done to stem the tide of unnecessary malaria deaths in Africa. The idea is a simple one. **Restock Africa with a malaria medicine that works.**

- The World Health Organization must push for implementation of its own recommendation to switch to ACT
- Donors must stop wasting their money funding drugs that don't work and help fund efforts of endemic countries to make the switch to ACT
- Endemic countries need to back up their will to improve malaria control with increased budget allocations
- ACT must be provided to individuals free of charge, or at an affordable price
- International agencies and donors must provide technical support to facilitate both treatment implementation and upgrading international and domestic drug suppliers (with technology transfer and technical assistance to enhance production standards)
- UNICEF, WHO procurement and the Global Fund for AIDS, Tuberculosis and Malaria must pool needs and make large orders to prime the drug production pump and bring down prices
- International and/or regional pre-qualification needs to be augmented to assist countries in identifying quality drug sources
- Concerned parties must undertake operational research to improve use of current tools
- Research & development for new drugs, new formulations and improved diagnostic tools must be placed high on the agenda and implemented through government-supported research and non-profit initiatives such as the Medicines for Malaria Venture.

We need to implement ACT today. We need to ACT NOW. ■

© Roger Job

May

June

— Surgical care, medical aid and nutritional support begin at the reference hospital in Kinkala, in the Pool region of **Republic of Congo**; a flare-up in the country's civil war had made the region inaccessible from March 2002 to March 2003. In June, mobile clinics, nutritional aid and hospital support begin in Mindouli

— An MSF expatriate is severely wounded in a grenade attack outside the MSF compound in Mandera, **Kenya**; programs providing nutritional aid to Kenyan, Somali and Ethiopian children are suspended indefinitely

2002
2003



Not so benign

When lofty political goals have bad humanitarian consequences

By nature, humanitarian action is embedded in politics. The fundamental concept of humanitarian action – that ordinary people must be spared from undue violence and assisted in times of conflict and crisis, in an independent and impartial way...

© Sebastian Bolesch

The face of this young boy in Zhare Dasht camp for displaced people and returning refugees in Kandahar, Afghanistan, reflects some of the realities of Afghanistan today: conditions in the country are difficult, promises of assistance have not been kept and the politicization of aid efforts has diminished the capacity of aid organizations to assist those in need.

Nicolas de Torrenté,
General Director,
MSF-United States

June

└ Preliminary results of MSF studies in **Sierra Leone** show high levels of resistance to the standard malaria treatment chloroquine, the country's first-line treatment for the disease; MSF is advocating throughout Africa for introduction of the more effective artemisinin-containing combination therapy, or ACT

└ MSF opens a supplementary feeding program in Malabon, a slum area on the outskirts of Manila, the **Philippines**

By nature, humanitarian action is embedded in politics. The fundamental concept of humanitarian action – that ordinary people must be spared undue violence and assisted in times of conflict and crisis, in an independent and impartial way – requires political support to exist. These humanitarian principles are set out in the Geneva Conventions.

Yet, more and more, the same powers that have enshrined humanitarian principles into law are subverting them: they are cloaking their political agendas in humanitarian language and co-opting the humanitarian ideal into the service of other causes, whether peace, democracy or the fight against terrorism.

The consequences of this seemingly benign trend are not benign at all: humanitarian workers cannot do their jobs and people do not get the aid they need. It is not only political powers that bear responsibility for this. Many humanitarian organizations have themselves been complicit, either voluntarily or involuntarily, by failing to articulate, defend and act on the core humanitarian principles to which they adhere. MSF has seen the negative effects of this on civilians in need in Angola, Afghanistan and, most recently, Iraq.

Angola – a deadly “coherence”

In early 2002, thousands of Angolans died when the humanitarian response that could have saved them was slowed by political calculations. For four years, humanitarian assistance had been confined to provincial capitals controlled by the government, reaching only a fraction of the population in need. The death of UNITA leader Jonas Savimbi in February 2002 led to a ceasefire between UNITA rebels and the government in April. Vast areas of the country that had been under UNITA control or contested by both sides (the so-called “gray zones”) opened up, revealing hundreds of thousands of starving and sick civilians. Tens of thousands of surrendered UNITA fighters along with many thousands of dependents, in similarly bad condition, streamed into “Quartering and Family Areas” (QFAs) around the country. There was an acute emergency situation in almost all sites, with close to one million people in urgent need of help.

MSF teams mobilized, and dramatically scaled up nutritional and medical programs in April and May. The massive needs certainly outstripped the organization’s capacity; complementary interventions, particularly general food distribution, were urgently required. The Angolan government showed criminal neglect in not beginning an emergency intervention itself and failed to call on others to provide assistance. The response by the UN agencies and other organizations was woefully late and insufficient. The World Food Program actually reduced the number of beneficiaries for May and June because of

supply problems, and UN agencies only started assessing the dramatic situation in the QFAs in early June.

Why was this so? When UNITA collapsed in early 2002, the UN sought to participate in the transition to peace, envisaging a role for itself particularly in the demobilization and disarmament process, the monitoring of human rights and the oversight of eventual elections. Yet the Angolan government remained highly skeptical of the UN, blaming it for UNITA’s failed demobilization in 1994, which had led to a resumption of hostilities. The UN was adamant that the Angolan government, with its plentiful resources, take the lead in providing assistance to the QFAs. It also refused to consider an intervention barring a formal request by the government followed by an agreement covering the modalities of assistance to the QFAs. It insisted that this framework be binding on all NGOs and called upon donor governments to channel funds solely through the UN in order to present a unified front to the government. By delaying an emergency appeal, refusing to act without an agreement and trying to forestall independent NGO action, precious time was squandered and many lives unnecessarily lost.

The Angolan experience underscores the lethal effect of not pursuing humanitarian priorities independently, however desirable other goals such as peace and democracy may be. The essence of humanitarian assistance is that it not be traded or made conditional. When it is, then inevitably the immediate interests of the most vulnerable are sacrificed in the name of supposedly loftier goals.

Afghanistan – the politicization of aid

Core humanitarian principles were also subverted by political designs in post-Taliban Afghanistan. After the Taliban were removed from power in November 2001, the international community of states pledged that it would not abandon the Afghan people, as had occurred in the wake of the withdrawal of Soviet forces in 1989. Indeed, Western powers presented Afghanistan as an ideal case for a “coherent” approach, whereby military forces, the United Nations and NGOs would work together to support the fledgling government of Hamid Karzai in rebuilding the Afghan state. Galvanized by the donors’ sudden interest in Afghanistan, many NGOs embraced this politicization of aid, arguing that to back the new regime was the only real chance to make a genuine impact.

Yet, by mid-2003, as the international community’s focus had shifted to Iraq, Afghanistan has fallen into limbo. Conflict between the United States and ex-Taliban forces persists in the south and southeast. The reconstruction process has stalled. The government has struggled to expand its authority beyond Kabul into the provinces, where warlords resurrected by the US’s anti-Taliban campaign reign supreme. While over 2 million refugees returned in 2002

June

MSF responds to cholera outbreaks in Kasai, Katanga and Nord-Kivu provinces and to a meningitis outbreak in Nord-Kivu, Democratic Republic of the Congo

After 11 years providing medical care to around 130,000 Somali refugees in camps near Dadaab, Kenya, MSF hands over its projects there to a German organization



from Pakistan and Iran, the flow has diminished markedly in 2003, partly because many would-be returnees realize that assistance is not available in rural areas.

The UN and donors' strategy of integration has also backfired for humanitarian organizations. The security of humanitarian aid workers has worsened dramatically, and with it their ability to carry out their work. The execution-style killing of ICRC staff member Ricardo Munguia in March 2003 in the south sent a chilling message that all aid agencies were associated with the Western agenda. This attack, along with others targeting aid workers in southern Afghanistan, has crippled the ability of humanitarian workers to gain access to people in need and provide assistance. In many parts of Afghanistan, MSF has had to periodically suspend activities because of insecurity. To cite only one example: in June 2003, MSF international staff evacuated Ghazni, leaving a tuberculosis and hospital support program in the hands of Afghan national staff who are only somewhat less at risk.

This vulnerability of humanitarian workers is not simply the result of ex-Taliban extremists seeking out soft targets in their fight against the continuing presence of US troops. It is also heightened by confusion born of the US strategy of using relief efforts to promote its security agenda and extend the reach of the Karzai government on the cheap (ie, putting US soldiers into "Provincial Reconstruction Teams" to patch up schools or rebuild clinics, while they support the new Afghan army and quell local opposition).

More fundamentally, it is the broader strategy of requiring all aid organizations to support a struggling Western-backed government in a fragmented and impoverished nation, while a conflict involving Western forces continues to rage, that is the problem. Particularly as donor interest wanes and instability increases, the need for direct, unconditional and unmediated humanitarian assistance to Afghan civilians is as strong as ever.

Iraq – the word "humanitarian" drained of its meaning

The erosion of humanitarian principles – and the consequences this portends for civilians in need – found new and polarizing momentum in the war in Iraq. It began with the US's presentation of the Iraq campaign as a just and humane war merging security imperatives and broadly defined humanitarian concerns. This portrayal not only generated unfulfilled expectations among Iraqis, it also confirmed the presumption within the Saddam Hussein regime and later among violent opponents of the occupation that all aid organizations were associated with the US agenda. UN agencies and NGOs themselves made matters worse by adopting a cooperative attitude toward the coalition's strategy without admitting to it, thereby emptying the humanitarian principles of neutrality and impartiality of much of their meaning.

The US-UK coalition announced that concerns about the welfare of the Iraqi people were central to their decision to attack Iraq, and integral to the way they would wage the war. Humanitarian concerns writ large (human rights, freedom, democracy) were evoked to justify this "just" war, complementing concerns about weapons of mass destruction and terrorism. Painting a grim picture of life under Saddam Hussein, Bush announced that liberating US soldiers would bring food and medicine to the Iraqi people.

Humanitarian concerns became central in the battle for global public opinion. The belligerents used these concerns to cultivate support for the war; opponents to the war trumpeted war's likely devastating impact on the Iraqi people. UN agencies and many NGOs expressed their uneasiness at being cast in the role of "cleaning up" a pre-ordained and largely unpopular war. Catastrophic predictions of civilian suffering were made both to oppose (implicitly) the conflict – and to raise funds. MSF did not speak out on the "rightness" or "wrongness" of the war, on humanitarian or any other grounds, because it understands humanitarian action to be predicated on the reality of armed conflict and dedicated to securing a space for humanity within war.

Contrary to doomsday scenarios, the war did not generate an emergency in humanitarian terms: there were no significant refugee flows, no famine or major epidemics. This should not, however, obscure the fact that civilians in need, particularly war-wounded civilians confined to major Iraqi cities encircled by US forces, were largely out of reach of humanitarian assistance during the conflict. The few humanitarian organizations that had not evacuated the country (ICRC, Première Urgence, CARE and MSF) still faced Iraqi restrictions on their movements and capacity to assist and were also hindered by the intensity of the fighting. As supplies ran short, the Iraqi medical system was left to cope largely unaided with the most acute humanitarian problem during the conflict: the thousands of civilians killed and wounded in the bombing and by fighting on the ground.

While the US-UK coalition did not deliberately block or overtly direct humanitarian assistance efforts during and just after the war, it was intent on controlling assistance in its efforts to win over "hearts and minds." For instance, US sanctions barring humanitarian assistance from the United States were kept in place well after the Iraqi government fell. Only programs funded by the US government were legally authorized, and only in "liberated" areas. This kept independent humanitarian assistance coming from the United States out of Iraq. Only organizations with an international base, like MSF, were able to avoid these restrictions. In addition, the US-UK coalition organized the entry of NGOs into zones they had secured; only organizations like MSF that did not rely on the US military

June

MSF speaks out against a flight ban introduced by the Kenyan government which temporarily blocks the transfer of humanitarian aid into **Somalia**

Two MSF mobile teams begin psychosocial support for around 2,500 displaced people from Kosovo living in precarious conditions in the Vranje area of **Serbia and Montenegro**



for security guidance and permission were able to quickly access other areas in need. Yet this US effort to co-opt NGOs did not result in the delivery of services when most needed. In the weeks following the Iraqi regime's collapse, US forces were not in a position to establish basic security, let alone provide much assistance themselves or manage NGO efforts.

The US's conduct of military operations reflects similar difficulties in making good on its promises of a "humane war." In Iraq, the US made wide use of cluster bombs and munitions, including in populated areas, despite their indiscriminate nature. It has not reviewed practices of using overwhelming force that are leading to civilians being killed and wounded by US soldiers at checkpoints, in response to ambushes, during raids and in riot control actions. The circumstances of many civilian deaths require investigation. Reported violations of International Humanitarian Law (IHL) by Iraqi forces during the war, such as hiding active combatants among civilians and deliberate attacks against civilians such as the bombings of UN headquarters in Baghdad and the Imam Ali Mosque in Najaf, do not exempt the US and UK forces from full respect of IHL, particularly as they have made conduct of the war a litmus test for the justness of their cause.

Iraq did present a major dilemma for UN agencies and many NGOs. While the United States is a unilateral belligerent, it is also a liberal democracy and a major funder of aid efforts. Could organizations have it both ways, invoking humanitarian principles guiding their efforts while opting to work with the US government? US NGOs thought they could, accepting significant amounts of US government funding but refusing direct military control over their activities by agreeing instead to work with US civilian agencies such as the Office of US Foreign Disaster Assistance (OFDA) and the US Agency for International Development (USAID). This "solution" ignored the basic fact that all US agencies are part of the same government waging war and exercising military occupation.

The futility of this compromise was exposed when USAID warned NGOs in May 2003 that by receiving US government money for their activities, they were in effect "arms of the US government" and that if they did not make the origin of their funding (the US government) explicit to beneficiaries, as private contractors do, their contracts would be torn up. In effect, the bombings and threats indicate that all aid organizations are being viewed according to USAID's wishes.

In Iraq today, continuing instability and insecurity is raising the need for direct and unconditional humanitarian assistance; at the same time it is also making this assistance much more difficult and dangerous to provide. The attack on the UN compound in Baghdad in August 2003 and on the International Committee of the Red Cross in October as well as other serious security incidents are certainly part of

a deliberate extremist strategy to sharpen divisions – the application of President Bush's famous quote "you are either with us or with the terrorists" in reverse. However, that UN agencies and NGOs have been unable and largely unwilling to draw clear distinctions with the Occupying Power has strengthened the view that all assistance is ultimately part of the US's agenda, thereby increasing the vulnerability to attacks of all organizations, irrespective of their positions.

As instability and conflict persist in Iraq, the capacity to independently reach out and help all victims, including those that are harmed, neglected or marginalized by coalition forces, will remain critical. Whether that will be possible remains an open, and fragile, question.

Conclusion

It is a delusion to think that there was a time when the integrity of humanitarian assistance was respected, and that it is only now that it is being distorted by politics. The current insistence on a "coherent" approach, however, poses significant new challenges for humanitarian organizations, particularly since the pursuit of peace and security has taken on a new meaning since September 11, 2001.

Projecting the view that the Western world faces an existential threat, the "war on terror" seeks to bring aid organizations into the fold, arguing that fence-sitting is impossible and ultimately immoral. Attempts to push the humanitarian actor to one "side" abrogate the basic right of people in need to get assistance regardless of their political, religious or other affiliation. In addition, in volatile contexts, being identified with a belligerent can have devastating consequences in terms of security and access to victims.

Independent humanitarian action is also threatened by the conciliatory approach of NGOs. Striving to protect and assist all victims, according to need alone, disturbs the designs of the powerful to abuse, exploit or neglect. This necessarily places humanitarian actors in a tense relationship with political powers, even those who declare their intentions to be benevolent. Many organizations eschew this tension and prefer to participate in what they view, overall, as a positive agenda promoted by Western states. Although this stance may yield valuable services covering the needs of some people, it is the work of a service provider, not a humanitarian organization. It also means that certain countries and regions rise to the top of the international agenda while others – where needs are immense – are increasingly neglected (see articles in this report on Democratic Republic of the Congo and the West African region). Instead of following this political lead in selecting certain people to aid and abandoning others, humanitarian organizations should resist and contest these alarming trends, in the name of equal worth of all human life.

June

- └ MSF opens two primary health care centers in al-Ma'amil and al-Muntadhr shantytowns in Baghdad, **Iraq**, where thousands live in metallic shacks near garbage dumps with no access to clean water or medical care
- └ MSF opens a therapeutic feeding center and an outpatient clinic in Marere, **Somalia**
- └ Drugs to treat kala azar are distributed in six governates in southern **Iraq**



Angola

"We want to go home. The war made us flee, but if the war is over, why should we stay here? We want to return to our land. For that we are waiting for the government orders. When the government fixes the bridges, we'll be able to go back by car. But to go back, we need pots, medicine, food, schools for the children, and we don't know if the government is going to help us. We also aren't sure about whether this is really the end of the war...But with or without our doubts, we're going back. When the other displaced people in Congo find out that we've already gone back, they're going to come back too. We'll all be together there, the people who were captured too. We're family."

Village chief from Chilunge, Muconda province. MSF heard his story several days after he rode a bicycle from Democratic Republic of the Congo to Saurimo in Angola's Lunda Sul province, looking for people from his village who might have found refuge there

In one man's words are reflected the uncertainties, difficulties and dreams of post-war Angola. During years of conflict, people here were abandoned to the "scorched earth" strategy of war. In early 2002, hundreds of thousands of starving people were suddenly revealed after cessation of hostilities opened up large parts of the country that had hitherto been inaccessible to humanitarian workers; yet political maneuvering linked to the peace process seemed to supercede obligations to provide them assistance. Many people died for want of food and care, even though the war was over. Now people are trying to go home, rebuild their lives and care for their

children. It is not easy, and in many parts of the country emergency relief is still very much needed. MSF, present in the country since 1983, expanded its activities dramatically during the height of the nutritional crisis following the April 2002 ceasefire, and now continues to provide essential medical and nutritional aid in 14 of the country's 18 provinces.

Continued complicated crisis

By the end of 2002, Angola's widespread nutritional emergency was finally under control, but the difficulties for Angola's people had not ended. Official rhetoric by the Angolan government and international agencies that the country has begun the transition to development is in stark contrast to the needs across the country. The medical infrastructure of Angola was completely destroyed during the war and many people have been without care for years. Children received no vaccinations for more than four years and the potential for dangerous outbreaks of disease is high. In some places, MSF teams reported that children who had been treated months before in therapeutic feeding centers were once again being readmitted with acute malnutrition due to continued problems with emergency relief.

The Mavinga example

The case of Mavinga town in Cuando Cubango province illustrates the health impact of failing to meet emergency needs, even months after the nutritional crisis had peaked. In August 2002, thousands of people were still gathered in "reception sites" in Cuando Cubango awaiting assistance. When food distributions being carried out by the World Food Program were halted for several weeks after a mine was discovered on the airstrip used to fly in supplies, people poured out of the camps toward Mavinga, a town nearly 50km away. "We saw thousands of people start walking in single file down the road carrying bundles on their heads," remembers Thomas Grien, an MSF Epicentre epidemiologist working in the area at the time. The massive flow was mostly made up of people who were ill and malnourished. "The gravity of the situation and the lack of food is so severe that our teams even saw handicapped people, with

prostheses and crutches, start to walk the 50km which separates them from Mavinga," commented Fred Meylan, MSF Head of Mission in Angola. In November 2002, MSF released an epidemiological report showing that, even as late as October 2002, global and under-five mortality rates remained above emergency thresholds in Mavinga town and in Quartering and Family Areas (QFAs, resettlement camps for ex-UNITA soldiers and their dependents) in nearby Matungo and Capembe.

Despite the promise brought by peace, resettlement and repatriation remain complicated and preparations minimal. Thousands of villages have been completely destroyed, and many people have nowhere to go. International aid, insufficient even during the most acute post-war months, is now intermittent, and many Angolans continue to be dependent on food aid. "The vast majority of displaced have not received any seeds to plant," explains Thierry Allafort-Duverger, head of MSF's emergency team. "Their survival depends entirely on the assistance given to them." To make matters worse, destroyed roads and bridges and the ever-present danger of landmines makes access a persistent problem. "Not only does the poor quality of the transport routes hamper our work, especially in the rainy season," says Kostas Moschochoritis, an operational coordinator. "Nine to twelve million landmines are still littering Angola. That is more than one landmine per person." A mine accident 36km from Mavinga took the lives of six MSF national staff members and one child traveling in an MSF vehicle in November 2002.

The failure of "coherent" humanitarian action

During the nutrition emergency of 2002, the mechanisms of international assistance failed the Angolan people. At that time and throughout the last year, MSF has sought to call attention to the way in which political concerns for the outcome of peace distorted the provision of humanitarian aid to many of Angola's most vulnerable people. (For more on the implications of this alarming trend as seen through the examples of Angola, Afghanistan and Iraq, see page 60.)

(continued on page 68)

June

MSF opens a new health center in Doble, **Somalia**. Before the clinic opened, residents of the area were crossing the border to access medical services at a refugee camp in Kenya

In an effort to push the Chinese government to assume responsibility for medical activities in the area, MSF ends its health access program for minority people and rural communities in Danian and Gongdong in Guangxi province, **China**



Voices from Angola

The following stories were collected by MSF and come from two different reports: Angola, after the war, abandonment and Angola: sacrifice of a people, both published by MSF in October 2002. For the full reports, go to www.msf.org

"I walked all the way to Lomba. There I met some people. They had radios and told me that no one was fighting anymore, that the war was over. We were really tired. We stopped running in April." – J., 27 years old. She has four children, one of whom is at an MSF feeding center

"We were attacked in February 2002. Many people were captured or killed during the attack. We fled into the bush.... We didn't eat much, a little honey, some leaves and water from the rivers and roots. My mother died in April from hunger and the rain. We slept under trees without clothes....I don't know who told us that, but afterwards we heard that we should go to the Quartering and Family Areas." – C., 22 years old. She is with her husband and five-year-old daughter

"When I arrived in Mavinga, the government gave me a little food, a few clothes and blankets and a small amount of oil and soap. Since December, my family has been eating manioc that we found around Lomba. But now there isn't any more. What are we going to eat now? Because the seeds and the tools haven't arrived, we still haven't prepared the fields for August." – M., 32 years old. He lives in Mavinga with his wife and two children

"I live in the district named 4 February with my mother, my two children and two cousins. We don't have much left to eat. Here in Mavinga, the soldiers bother people, especially when they drink. They beat people, they marry girls against their will, they rape women who have husbands and girls who are younger than 14. We live in fear, especially at night. We don't know what might happen to us. No one dares talk about it. There's nothing to say. There's only waiting to see what will happen." – E., 20 years old. She has two children

"We have relatives in Huambo, but they have lots of children and nothing to eat. We can't stay there. I'd rather stay here and wait for permission from the regional authorities to go back to my village.... This is the time to sow. I want to go but the government hasn't issued the order. We're waiting for the order." – D. and R. ■

June

MSF opens a permanent 60-bed clinic in the Bo region of **Sierra Leone**. The clinic serves local villagers as well as Liberian refugees living in seven area camps

MSF receives approval from the **Laos** Ministry of Health to import and use antiretroviral (ARV) medicines; already providing care and treatment for people with AIDS-related opportunistic infections, ARV treatment begins in September 2003

Angolans left to **die**:

The failure of humanitarianism

The following text is excerpted from an MSF analysis of the pre- and post-ceasefire humanitarian situation in Angola. These findings were presented to the United Nations Secretary-General in December 2002.

Angolans who had been trapped by war and received no humanitarian assistance since 1998 were failed by the international community once providing assistance became possible after the country's April 2002 ceasefire.

Mortality rates, calculated through a retrospective mortality survey conducted in August 2002 by Epicentre, MSF's epidemiological research center, were well above emergency thresholds; 17.5% of children under five died between June 2001 and August 2002, and one in four children did not survive their first year. The principal causes of death were violence and war for the adult population and malnutrition for children under 15.

The chronic emergency was not an inevitable consequence of war, but a result of the way the war was fought by government troops and the rebel group UNITA. Military strategies involved forced displacement of civilians, indiscriminate shelling, burning of villages, destruction of crops, looting, killings, rape, forced recruitment and abductions. Civilians were the principal victims in the Angolan conflict: up to three-fourths of those who died due to war or violence were women, children or the elderly. These violations of international humanitarian law were largely overlooked by the international community.

The unwillingness of both the government and UNITA to consider negotiated access for humanitarian organizations contributed significantly to the increasing civilian mortality throughout the last years of the conflict. This was also met by a terrible failure on the part of the international community, particularly the UN and its member states, to pursue humanitarian assistance. No serious initiatives were undertaken to maintain a strong dialogue with UNITA on humanitarian issues such as access, despite the fact that humanitarian assistance was explicitly permitted in the various sanctions declared by the UN Security Council.

The unwillingness to address the systematic and large-scale violations of international humanitarian law committed by the Angolan government was linked to the long-term political agenda of the UN, whose main concern was to reestablish confidence and trust with the

June

- └ Fighting in **Liberia** reaches the capital Monrovia and MSF teams are forced to evacuate the last public hospital; medical assistance continues in a sports stadium in Monrovia and several camps for the displaced outside the city
- └ Anti-diarrhea drugs and supply kits are distributed to 24 health posts in southern **Iraq**
- └ MSF begins antiretroviral therapy for HIV/AIDS patients in Douala, **Cameroon**

Angolan government in order to play a role in possible future peace processes – this in spite of the knowledge that those living in inaccessible areas were facing an acute emergency.

Underlying this was the doctrine of integrated approach which stipulates that peace is the prime objective, taking precedence over independent, impartial, neutral, lifesaving humanitarian assistance. The UN sought to control all humanitarian agencies in line with the overall political objective by integrating and subordinating humanitarian action through an excessively rigid and intrusive coordination policy.

Following the April ceasefire humanitarian aid became possible in many previously inaccessible parts of the country. But the UN's insistence on signing a framework agreement with the Angolan government delayed any response. Humanitarian assistance to newly accessible populations started on average six weeks after assessments confirmed the acute emergency situation. The UN aid, most significantly World Food Program food assistance, generally arrived well after the peak of the emergency had already passed.

The delays were not primarily caused by logistical and financial constraints, but by three factors: Firstly, the World Food Program's failure to grasp the scale and the urgency of the nutritional crisis. Secondly, the UN's insistence upon formal agreement with the Angolan Presidency to obtain access to the QFAs [Quartering and Family Areas, where many UNITA fighters and their dependents were regrouped for demobilization after the ceasefire]. This was not forthcoming because the UN was not seen as impartial and neutral; it was also an unnecessary precondition. Thirdly, pressure on NGOs not to intervene in the QFAs until an access framework was established.

The provision of assistance in accordance with fundamental humanitarian principles sustained by a strong humanitarian movement made up of distinct, independent actors is essential. The integrated strategy promoted at the highest level within the UN and implemented through a centralized, rigid coordination mechanism, went directly against this, with disastrous consequences for the people of Angola.

By making humanitarian relief an instrument of a wider political cause, the UN failed the people of Angola. The responsibility for the suffering lies with the Angolan government and UNITA, but the UN deliberately neglected its responsibility to provide relief. The use of coordination as a means of compulsion rather than cooperation deprived the people of any alternative means of support, and cost lives rather than saved them. These failures must be acknowledged before they are repeated.

Editor's note: MSF dramatically stepped up its operations in Angola as the nutritional crisis became apparent, doubling both staff and funds allocated to the country. Between April and July 2002, 12,716 severely malnourished children were admitted to MSF's therapeutic feeding centers; another 16,871 were assisted through supplementary feeding programs. Throughout this period, MSF also called for other humanitarian actors to provide assistance to help meet the immense needs and called the international response "shamefully slow and shockingly insufficient." ■

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July

With most public health facilities shut due to violent conflict, MSF transforms its two residences in Monrovia, **Liberia**, into makeshift hospitals. While fighting engulfs the city, MSF teams provide emergency medical services to those able to reach the compounds or people brought in on "wheelbarrow" stretchers

MSF begins antiretroviral (ARV) treatment for patients at Sotnikum District referral hospital in **Cambodia**; over 950 people receive ARVs in Sotnikum, Phnom Penh, Siem Reap and Takeo through MSF's comprehensive HIV/AIDS programs

(continued from page 64)

Humanitarian action is guided by three core principles: impartiality, independence and neutrality. As an emergency humanitarian organization, part of MSF's mission is to speak out when these principles are violated. Only through adherence to these principles can need-based humanitarian aid be assured. When political concerns are included in decisions about emergency relief, these basic tenets are compromised, and the mechanism fails. In Angola, this meant that response to the nutritional emergency was hindered by concerns about establishing peace. In December 2002, MSF presented its analysis of this to the United Nations Secretary-General. See page 66 for the conclusions of this analysis. In November 2002 MSF also released several collections of temoignage documenting the stories of many people cared for by MSF staff in Angola. See page 65 for some of these stories.

Essential medical care in 14 provinces

MSF teams continue to bring essential medical care to the people in Bengo, Bie, Cuando Cubando, Cuanza Sul, Huambo, Huila, Kwanza Sul, Lunda Norte, Lunda Sul, Malange, Menongue, Moxico, Uige and Zaire provinces, supporting hospitals and health posts, traveling to isolated communities and conducting mobile clinics. Some teams provide assistance to those who are being repatriated or relocated, while other projects focus on specific vulnerable groups such as children and people living with HIV/AIDS. Teams also fight infectious diseases, vaccinating thousands of children and providing care for those with diseases such as tuberculosis, malaria and sleeping sickness.

International staff: **125**

National staff: **1,866**

An MSF midwife assists an Angolan surgeon in the makeshift operating theater in the ruins of Mavinga government hospital, Mavinga, Angola, in October 2002.

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July

- └ MSF works with the World Health Organization to vaccinate more than 30,000 people against yellow fever in Budi County, Eastern Equatoria, **Sudan**
- └ MSF vaccinates 60,000 people in Lunda Norte province, **Angola**, against meningitis
- └ The M'pore program organizes a camp holiday for 53 Rwandan children living in **Belgium** and gives psychological support to these genocide survivors and their families
- └ Technical support to **India's** national tuberculosis program expands to include direct treatment of tuberculosis patients in Mumbai



July

- └ Together with the Red Cross, MSF provides medical assistance to 300 Afghan hunger strikers asking for regularization of their stay in Brussels, **Belgium**
- └ Witness to continuing violence against civilians in eastern **Democratic Republic of the Congo**, MSF releases the report *Ituri: Unkept promises? A pretense of protection and inadequate assistance*. The report calls on the UN to protect civilians and increase humanitarian assistance in the region
- └ Severe cold weather affects thousands in South America. In **Peru**, MSF responds with donations of essential medicines, blankets and food

2002
2003



Afghanistan

A few scenes from Afghanistan today:

At the Arzan Quimat clinic in Kabul, Chazia, 12, comes for a psychiatric consultation with her mother. She is in pain; her head hurts. She can't sleep near windows; she is afraid of cows. Her mother asks for medicine that can return her daughter to what she was like before. This idea of being "like before" is brought up in nearly all the consultations. People want to be as they were before the war, before the trauma; they want to erase the traces of the war in themselves.

On a lonely road in Kandahar province, Red Cross worker Ricardo Munguia is executed in cold blood while traveling to Tirin Kot, where Munguia, an engineer, was working to improve the water supply. He was singled out as a foreigner from the group of people being ambushed.

Just outside the sports stadium near Kabul's historic center, an elderly man approaches an MSF staff member. He carefully unfolds a piece of paper issued to him by the UNHCR in Pakistan, where he used to be a refugee. The paper authorizes him to claim food aid on his return to Afghanistan. He had already received his ration three months earlier; still he clings to the document, crumpled by constant folding and unfolding, as if it were a sacred treasure. He solemnly holds out the paper, with its official seals of international organizations.... "I was told I'd get a house," he says. "[I was told] they'd give me land."

What they were promised was a chance for peace. On offer was some stability, an end to flight and terror and, for the millions of people who fled the country during two decades of brutal war, a chance to go home.

But two years after the Taliban was overthrown, and a new government installed in Kabul by the US-led Coalition, the people of Afghanistan have received very little. The government lacks the administrative capacity and the finances to rebuild the country. People are not prospering. Many have returned only to find they lack even basic access to health care,

shelter or economic opportunities. Others are just trying to cope with the aftereffects of many long years of war. "Afghanistan is currently stuck in a vicious cycle of violence and displacement," says Chantal de Montigny, an MSF field coordinator there. "The promised reconstruction is not as widespread as hoped. Meanwhile, there are millions of refugees returning with no prospects."

At the same time, the politicization of aid, advocated by the international community (with the tacit acceptance of many NGOs) as a way to strengthen the new government and rebuild the country, has proven dangerous for humanitarian organizations and has undercut Afghans' access to assistance that is truly need-based.

Neither safe nor stable

Afghanistan is neither safe nor stable. There is a growing insecurity that is profoundly affecting Afghans and those trying to assist them. Armed clashes, whether between rival warlords or between Coalition forces and remnants of the Taliban, are becoming more frequent. The UN-mandated International Security Assistance Force (ISAF) does not venture out of Kabul, and even there has come under attack; since ISAF was taken over by NATO in August 2003, there have been demands from many sides that it be extended outside of Kabul. As of today, the ISAF remains confined to the capital. Coalition forces control only a few cities. Elsewhere, especially in the south and southeast, banditry and violence are worsening.

Insecurity nearly everywhere is forcing aid organizations, including MSF, to periodically withdraw staff or reevaluate their presence in some areas. Aid workers are increasingly identified not only with the western military presence but also with the Afghan authorities through the reconstruction process; humanitarian agencies have had grenades lobbed at their compounds, cars held up and shot at, offices and warehouses robbed. At various times during the last year, MSF teams were forced to evacuate Kandahar, Spin Boldak, Chaman (in Pakistan), Ghazni and Maimana because of security concerns.

In March 2003, Ricardo Munguia, an engineer working for the International Committee of the Red Cross, was singled out as a Westerner and murdered in cold blood in a deliberate attack on a desolate road near Kandahar. He was

the first international aid worker killed in the country in several years.

MSF calls on all actors and groups to respect the neutrality and impartiality of NGOs. At the same time, MSF has, with increasing urgency, been pushing both aid agencies and the military authorities in Afghanistan to ensure that there is no blurring of lines between the two. If aid agencies are seen as part of the Coalition's political and military efforts, MSF has warned, those agencies will continue to be "soft targets" for violent attacks. Yet this warning has fallen on many deaf – or at least unwilling – ears. "Humanitarian" teams of Coalition soldiers have been sent to work on reconstruction in provincial cities. For their part, many aid organizations have taken lucrative contracts and stepped into spheres traditionally occupied by a government (eg, reestablishing health services in entire provinces).

However, if NGOs, trapped in the need for funding and visibility, accept to become the private contractors of states anxious to delegate political responsibilities, they shouldn't be surprised if they are seen as responsible for any possible failure of the reconstruction process, and they will also have to share responsibility for the loss of independent humanitarian space in the country. Judging by the growing number of attacks directly targeting the aid community, it may already be too late.

Disillusionment

Against this backdrop of increasing insecurity, the situation in Afghanistan has been dominated by another phenomenon: one of the largest and most rapid repatriation processes in modern memory. Close to 2 million people returned from Iran, Pakistan and other neighboring countries in 2002, with another million expected in 2003. But the repatriation process has not been smooth – for many people, it has been just one more trauma added to so many previous ones.

While many refugees are eager to return home at the first opportunity, the repatriation has been far from fully voluntary in many cases. In August 2002, MSF issued a warning after Afghan returnees had told of being forced to leave Iran against their wishes by the authorities there: cars with loudspeakers on their roofs had toured towns ordering the Afghans to leave and television and radio broadcasts had told them that if they didn't leave by the end of August,

July

Along the border with Liberia, MSF workers care for more than 500 severely malnourished children in the "wild west" of Côte d'Ivoire, where health services have failed due to war

A surgical and anesthesia training program for doctors and nurses ends in Saint Marc, Haiti. Nurses were trained in anesthesia and doctors trained for managing surgical emergencies, in particular life-saving Caesarean sections. Saint Nicolas Hospital in Saint Marc now has the capacity to handle obstetric emergencies 24 hours a day, seven days a week

Laboratory equipment for the diagnosis of infectious diseases is distributed to 13 laboratories in southern Iraq



they faced arrest. At the time, MSF reiterated the necessity that any return be voluntary, and that refugees be given adequate information about the conditions in their place of return, both key requirement of refugee law. Many returnees reported being given at best scanty – and at worst false – information on the situation in Afghanistan.

Conditions in Afghanistan have not been, for the most part, conducive to rebuilding a life that had been on hold for one, five or even twenty years. The country has had difficulty providing its returning sons and daughters a proper welcome home. In 2002, Afghanistan was in the third year of drought, leading to food insecurity in large parts of the country, and particularly the north. MSF workers in the north and northeast were at one point in September 2002 feeding 3,500 children and 1,500 lactating women in 10 supplementary feeding centers. In November, MSF shipped more than 600 tons of food supplies to northern Afghanistan, to ensure communities had sufficient stocks over the harsh winter.

Many returnees have had to congregate in camps for the displaced. Outside Herat is one such camp, Mashlak, home to 29,000 people. People here are almost entirely dependent on outside assistance. MSF provides primary health care, vaccinations and nutritional programs, as well as a small program for people suffering from tuberculosis. Similar

medical aid is given to displaced people in camps and nearby communities in Zhare Dasht and Spin Boldak (Kandahar province), Qadis and Jawand districts (Badghis province) Chaman (Pakistan), Sakhi and Camp 65 (Balkh province). In July 2003, Shaydee camp outside of Herat, where MSF was also working, was officially closed, although a few hundred people remained. Many people from Herat are going back north to Baghdis and Faryab provinces; MSF remains concerned about the ongoing conflict reported in certain districts in these provinces, and about the returnees' access to land and services in these areas.

Welcome to Kabul

“The priority is to not go back to Behsud [125 km west of Kabul, in Vardak province]. There we simply can't live, because there is no water. Our livestock was stolen by the Taliban. But here in Kabul, it is really tough: if we don't find a house, a roof, we'll be forced to go....” – *Zahra, 25, who is living in one room with 25 other people in Kabul's Dashte-Barchi neighborhood*

Many returnees, even those not originally from the capital, have found their way to Kabul. By mid-2003, close to one million returnees had settled there.

Joy at getting back to their country can be quickly followed by disillusion. Rents in the capital – where the Coalition, international agencies and many NGOs have their base

– have skyrocketed. And the city is 70% destroyed: many of those returning are forced to find shelter among the ruins. MSF provided some assistance to these squatters as they faced the winter – heating material, blankets, tents, and some medical care. But in a bombed-out city, with international funds for reconstruction scandalously slow in arriving, their futures don't look bright.

“What are they doing to us?”

Some Afghans are even now trying to flee the country again, having found there is so little for them in Afghanistan. On the border between Chaman (Pakistan) and Spin Boldak, in the country's south, until July 2003 MSF provided medical assistance to desperate refugees caught in the Waiting Area, a no-man's land between Pakistan and Afghanistan. Some were Kutchi nomads fleeing the drought, others were Pashtuns seeking refuge from ethnic persecution, but the Pakistani government wouldn't let them enter. “Many have simply exchanged one calamitous situation for another” said Diderik van Halsema, MSF field coordinator in Kandahar. “They are desperately searching for any means of survival.” By July, Afghan authorities and the UN had shifted some people from this area to Mohammed Kheil refugee camp in Pakistan; others were moved to a camp in Zhare Dasht, in the desert near Kandahar, where the food and water situation is precarious: “Life is difficult here,” says one man in Zhare Dasht. “Everything is full of dust. We don't have wood to build. Our tent is totally ripped. Sometimes people are fighting over a jerrycan of water. We are living in a desert here. Our government is letting us down. What are they doing to us?”

MSF has been working in Afghanistan since 1980, throughout the Soviet occupation, the civil war, and during the Taliban regime. MSF has projects in 16 of the country's 32 provinces. They include therapeutic and supplementary feeding centers, vaccination programs, basic health care projects, mother-and-child health care programs, mobile clinics in remote areas, water and sanitation provision, and specialized programs for diseases such as tuberculosis and leishmaniasis.

International staff: **107**
National staff: **1,380**



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A little girl reaches out to her brother at a therapeutic feeding center in a camp for the displaced in Mashlak, Afghanistan.

July

MSF begins support of a hospital in Baraka, Sud-Kivu province, **Democratic Republic of the Congo**; in one week, 26 women who have been raped seek medical care at the facility

MSF completes its HIV/AIDS programs in **El Salvador**; for two and a half years MSF had provided treatment to help prevent mother-to-child transmission of HIV and carried out prevention and education activities for commercial sex workers

MSF conducts a regional training workshop in **Tajikistan** to promote the country's new law on patients' rights



© Alexandre Carle

MSF's team in the al-Ma'amil neighborhood of Baghdad, where MSF runs several health centers, speaks with a man from the area in May 2003. MSF believes that humanitarian aid should be given completely impartially and independently. Unfortunately, the decreasing security for aid workers and agencies, most tragically seen in the deadly bombings of UN and ICRC headquarters, shows how violence is limiting the ability of aid organizations to assist the Iraqi people, and the dangers of aid organizations and agencies being identified with the occupying military force.

Iraq

"Why do you bomb us, and then try to help us?"

The question posed to MSF staff by a woman in Diyala, Iraq, in May 2003

This simple question reveals one of the legacies of the war in Iraq: an erosion of the meaning of the word "humanitarian." Invoked by the United States and the United Kingdom as one motivation behind the war (ridding the country of a tyrant), ignored or manipulated by Saddam Hussein, used as an argument for pacifism by NGOs (the disastrous humanitarian consequences of war would be too great), the essence of the "humanitarian" idea took quite a blow, to the ultimate detriment of those who may have needed assistance.

MSF understands humanitarian action to be a response to conflict. Aid or relief for humanitarian reasons is assistance given independently and impartially, based on need alone, not tied to political agenda, ethnic identity or religious affiliation. It is not tied to being "liberated" or being on one side or another of a conflict.

In Iraq, the concept of humanitarian action was put to the forefront to either justify, prevent, or "spin" hostilities. Humanitarian aid became just another instrument of war, blurring the lines between independent humanitarian aid, military obligation and propaganda.

In terms of the way it was fought, the war was also packaged as a "humane" war; yet the circumstances of some civilian deaths in Iraq require investigation. For more on this, see page 60.

Declining to comment on the possibility of a humanitarian emergency in the event of war

in Iraq, MSF chose instead to do everything to be present when war hit, to be in a position to better understand the suffering of the people in the event of war and provide medical assistance if any were needed. Active in the country in the early 1990s, MSF left in June 1992 because of inability to work independently under Saddam Hussein's regime. MSF was prevented by the Iraqi government from establishing a presence in the intervening years. Finally, as war loomed in late 2002 and early 2003, MSF was able to restart negotiations and was granted permission to begin work in March 2003.

As the US-led coalition began bombing Iraq, a team of six expatriates, including a surgical team, was on the ground in Baghdad, hoping to assist already highly trained Iraqi medical workers who could possibly need support in event of war. There was not much possibility to bring independent assistance in the run-up and opening days of the war. Nonetheless,

July

MSF responds to a cholera outbreak in Goma, Nord-Kivu province, **Democratic Republic of the Congo**

MSF begins emergency assistance to people affected by severe flooding in Sindh province, **Pakistan**, providing basic medical care with mobile clinics

In an effort to promote decentralization of AIDS treatment and care, MSF opens a satellite clinic at the Regional Maternity Hospital in Odessa, **Ukraine**, in conjunction with the American International Health Alliance



the team began assisting Iraqi staff at al-Kindi hospital in northeast Baghdad. MSF teams in Jordan, Kuwait, Syria and Iran prepared for possible outflows of refugees.

At the beginning of April, just as increasing numbers of wounded people were arriving at al-Kindi hospital, two MSF expatriates and one local staff member were taken by the Iraqi secret police. All activities were suspended until their release by their captors nine days later, just after the fall of Baghdad. Ultimately, the main hostilities of the war lasted a little over five weeks.

Real needs – but no humanitarian crisis

With the team safely reunited, MSF began a general assessment of the health situation, visiting hospitals and clinics in many areas of the country. During April and May, expanded MSF teams conducted brief assessments of health facilities in 25 cities, donating supplies and equipment and assisting medical staff as needed. In visits to more than 70 health facilities, MSF teams witnessed none of the characteristics of a major humanitarian crisis, such as massive displacements of people, famine or widespread epidemics. There were no large refugee flows. MSF did, however, assist a group of about 1,000 refugees from Iran (in Iraq since 1980) caught in the no-man's land between Iraq and Jordan in precarious conditions.

An unacceptable number of lives

Despite the lack of acute humanitarian needs, MSF was nevertheless alarmed. The most urgent medical problem in Iraq was the lack of leadership in the highly centralized health system, which had slipped into chaos in the aftermath of the war. With no central organization, the medical infrastructure in Iraq had begun to deteriorate. MSF spoke out about the situation, calling on the occupying power to address the health needs of the Iraqi people and to establish some sort of order within the health system, in compliance with international humanitarian law. According to the Geneva Conventions it is the responsibility of the occupying power to meet the basic needs, including health care, of civilians in an occupied area.

"The lack of leadership and lack of intervention," said MSF International Council President Morten Røstrup, a doctor on the

MSF team in Baghdad during the war, "has cost an unacceptable amount of lives."

Many patients had been discharged from hospitals during the bombing and were afraid to return for secondary surgery or follow-up treatment. Widespread looting stripped many public hospitals of all equipment and drugs; insecure streets prevented the medical staff in some areas from coming to work. Iraqis with chronic diseases such as diabetes no longer had access to life-saving medicines, and limited water and electricity in parts of the country were also contributing to the health problems.

MSF's efforts to support principal hospitals in Baghdad and elsewhere were at first impeded, however. When the main hostilities ended, hospitals quickly became coveted prizes in tense political struggles between hospital administrators and directors, coalition members, and local religious leaders. Such conditions made it virtually impossible to provide meaningful added value through these structures at the time. In May, however, MSF was able to begin work in al-Thawra hospital in Sadr City, Baghdad.

MSF opens primary health centers in Baghdad slums

Many people get their water from wells that are so filthy that when you look down into them you see layers of garbage – *Pierre Boulet-Desbureau, Head of Mission for Iraq, June 2003*

By June 2003, the medical infrastructure in Iraq had deteriorated even further, with shortages of drugs caused by the collapse of the distribution system and widespread looting. MSF responded by supporting the fragile medical structure in several parts of the country. In Basra and Missan, MSF began assistance to 16 health centers, providing essential drugs and supplies and rehabilitating buildings destroyed during the bombing.

MSF also began a primary health care project in the slums of al-Ma'amil and al-Muntadhr in Sadr City, one of the poorest areas of Baghdad. An estimated 300,000 people live in shantytowns in the area, many in metallic shacks on garbage dumps. With no access to medical care, clean water or sanitation, the health situation is critical and the potential for outbreaks of disease is enormous. The people living here are

desperate for medical services: MSF teams carried out 138 consultations in one day when the first of three clinics opened; by early September, teams were carrying out an average of 2,500 consultations each week.

At al-Thawra hospital, also in Sadr City, MSF is working on the emergency ward. MSF is also focusing on safer nursing techniques, organizing practical training sessions, and supervising nurses and junior doctors on the wards.

In addition to providing direct medical services, MSF is working together with the Iraqi Ministry of Health to improve the health situation of the people in Sadr City. Activities include creating a surveillance system to track infectious diseases and provide an early warning system for outbreaks, and improving access to water and sanitation facilities.

Uncertain future

By late summer 2003, basic services such as health care – and water and electricity – were still not being ensured by the Coalition Provisional Authority or the Iraqi Governing Council. The security situation was deteriorating, with stepped-up attacks not only on Coalition forces but on symbols of the western presence in Iraq, including aid workers. MSF teams in Basra were evacuated in August as the situation in that city became increasingly unstable (national staff completed the distribution of drugs to health centers and hospitals).

Perhaps the most visible reminders of the lingering problems are the brutal bombings of the United Nations headquarters in Baghdad in August and the International Committee of the Red Cross headquarters in October. MSF was shocked by the deaths of large numbers of Iraqi and international staff. These assaults were a tragic illustration of how continuing violence is severely limiting the ability of humanitarian organizations and international agencies to assist the Iraqi people.

Ironically, if war as such didn't create a humanitarian emergency, the failure of the victors to ensure basic security and provide essential services for civilians ultimately created many more needs than would have otherwise been the case.

International staff (as of July 2003): **20**
National staff (as of July 2003): **108**

July

August

MSF launches a reproductive health program (including care for victims of sexual violence) in Ruhengeri province, **Rwanda**

A bomb devastates the UN headquarters in **Iraq**, killing 22 people. This tragic event underscores how violence is severely limiting the ability of humanitarian organizations to assist the Iraqi people; the incident also shows the dangers of aid organizations and agencies being identified with the occupying military force

MSF programs around the world

Afghanistan

MSF has been active in Afghanistan since 1980, through the Soviet occupation, civil war and Taliban regime. The politicization of aid underway since the fall of the Taliban, advocated by the international community with the tacit acceptance of many NGOs, has proven dangerous for humanitarian organizations and has undercut Afghans' access to assistance that is truly need-based. Security has deteriorated, and humanitarian agencies have increasingly become targets of attacks aimed against the Western presence. MSF programs in 16 of the country's 32 provinces continue to benefit displaced people and residents. Projects include therapeutic and supplementary feeding centers, vaccination programs, basic health care, mother-and-child health care programs, mobile clinics in remote areas, water and sanitation provision, and specialized programs for diseases such as tuberculosis and leishmaniasis. (See page 70 for more on MSF work in Afghanistan.) 🌿 107 🌿 1,380

Algeria

From May 21 through July 9, 2003, MSF provided medical and psychological care to people affected by a major earthquake in northern Algeria. The earthquake took the lives of 2,700 people (with another 1,000 unaccounted for), injured 7,000 and left tens of thousands homeless. In the city of Zemmouri, 100km to the east of Algiers, MSF doctors and psychologists provided medical care for the injured as well as individual and group therapy for adults and children. Many people were treated for post-traumatic stress disorder. In addition, MSF provided counseling and debriefing to many of the Algerian health personnel and rescuer workers who had responded to the disaster. MSF currently has no ongoing projects in Algeria. 🌿 3 🌿 8

Angola

With the April 2002 ceasefire in Angola, hundreds of thousands of people in areas previously inaccessible to humanitarian workers were revealed to be starving, victims of the "scorched earth" policy that reigned supreme during the country's long civil war. Responding to these needs made Angola MSF's largest emergency operation in 2002. MSF also sought to call attention to the way in which political concerns for the peace process undercut humanitarian aid to

many of Angola's most vulnerable people at this critical time. By the end of 2002, the nutrition crisis was under control, but in many areas needs were still acute. The resettlement of Angola's millions of displaced people and refugees remains complicated, and preparations minimal. Dangers such as landmines are still present: in November 2002, four MSF national staff members and three patients lost their lives when an anti-tank mine exploded under an MSF vehicle in Cuando Cubando province. MSF teams continue to provide essential medical care to people in Bengo, Bie, Cuando Cubando, Cuanza Sul, Huambo, Huila, Kwanza Sul, Lunda Norte, Lunda Sul, Malange, Menongue, Moxico, Uige and Zaire provinces. They support hospitals and health posts, travel to isolated communities and conduct mobile clinics. Some teams provide assistance to those who are being repatriated or relocated. Teams also fight infectious diseases such as tuberculosis, malaria and sleeping sickness. (See page 64 for more on MSF work in Angola.) 🌿 125 🌿 1,866

Argentina

MSF began work in Argentina in October 2002, after an economic collapse left nearly 60% of Argentineans living in poverty. MSF provides medicines, medical material and training to two hospitals in Jujuy and Salta provinces in the northeast, home to a high percentage of poor and indigenous people. At a national level, MSF is working to make essential medicines more accessible to society's most marginalized. In May 2003, MSF donated medical supplies and organized water and sanitation for 50,000 people displaced by flooding in Santa Fe province. 🌿 2 🌿 1

Armenia

MSF provides STD treatment and voluntary counseling and testing for HIV in a clinic in Bagratashen (a town on the border between Armenia and Georgia) and also carries out prevention activities with sex workers in northern Armenia. In Berd, close to the border with Azerbaijan, MSF works with a local women's group to provide peer counseling for the community on family planning, safe pregnancy and newborn care. MSF runs an outpatient mental health center and offers occupational therapy at a day center in Sevan. Support for mental health services in Nagorno-Karabakh began in May 2003. In Yerevan, MSF has run a combined medical, psychological and social care program for young people in the Vardashan Institute since 1997. Work treating tuberculosis in Nagorno-Karabakh came to an end in December 2002. 🌿 14 🌿 91

Bangladesh

For the last ten years, MSF aid in Bangladesh has centered on Rohingya refugees who have fled Myanmar for the Cox's Bazaar area of Bangladesh. MSF provides health care and therapeutic and supplementary feeding in Nayapara camp, home to 13,000 refugees. Continued pressure on MSF and other aid groups to hand over projects in Rohingya refugee camps to the Ministry of Health reflects Bangladeshi government efforts to control – and eventually repatriate – the refugees, voluntarily or not. MSF also aids "illegal" Rohingyas, who are considered economic migrants and not refugees, in the Teknaf area. MSF continues to provide medical care to people in the sub-districts of Panchari and Dighinala, in the Khagrachari district of the Chittagong Hill Tracts, through fixed and mobile clinics focusing on malaria diagnosis and treatment. 🌿 11 🌿 135

Belgium

MSF continues to provide medical, social and psychological health care to marginalized people in Belgium. Clinics based in Brussels, Antwerp and Liege address medical needs of asylum-seekers, undocumented immigrants and homeless people. Together with the Red Cross and the government, in January 2003 MSF assisted 150 Afghan refugees temporarily stranded in Brussels on their way to the United Kingdom. In Brussels, MSF's Elisa Center

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A small connection is made between this serious little girl and an MSF project coordinator in Shombe, Burundi.

continues free and anonymous HIV testing and counseling for about 2,000 people each year. MSF also provides psychological assistance to survivors of the 1994 Rwandan genocide through the M'pore project in Brussels and Liege. 🌿 22 🌿 15

Benin

MSF work in Benin centers on Couffo department. Since 1998, MSF has supported treatment of Buruli Ulcer (a bacterial infection that destroys skin and bone tissue) in the public health center of Lalo. In September 2002, MSF began an HIV/AIDS program in Dogbo, with education and community awareness activities for young hairdressers and tailors, taxi-moto drivers, students and peasants. In December, Couffo department's first voluntary counseling and testing center opened in Dogbo. By late July 2003, around 1,000 people had been tested (using rapid tests for the first time in Benin); 10% of those tested were HIV-positive. MSF also offers prevention and treatment of AIDS-related opportunistic infections through the public health center. 🌿 5 🌿 25

Bolivia

Bolivia has the highest levels of Chagas disease in Latin America. This parasitic infection is one of the most neglected diseases in the Americas; in Bolivia, it is the fourth leading cause of death. In October 2002, MSF opened a Chagas project in Tarija, O'Connor province. The goal is to diminish prevalence among the 8,300 children under 14 living in the area while organizing education, diagnosis and treatment activities. In El Alto, La Paz, MSF continues a health program focused on reducing morbidity of mothers in this poor urban area, improving mother-and-child programs and providing assistance to women from violent homes. A similar project in Chimoré ended in October 2002. 🌿 8 🌿 29

Brazil

Since 1993, MSF has been bringing basic health care and psychosocial support to socially excluded people in Rio de Janeiro. One project targets people living on the streets and provides health care, psychological support and social orientation aimed at their integration into the public system. Another project, opened in May 2003, benefits more than 10,000 people living in Marcilio Dias, a slum in northern Rio de Janeiro with high unemployment and where the dangers of drug and arms traffickers exacerbate the precarious living conditions. Half of the residents of this area are younger than 19 and most have no access to clean water or sanitation. A health center there offers medical and psychological consultations, vaccinations and health education and social services for women, children and teenagers. 🌿 4 🌿 39

Bulgaria

MSF works to increase access to health care for some of Bulgaria's most marginalized people, many excluded from health care by 1999 health-sector reforms, and also runs effective programs targeting sexually transmitted diseases and HIV/AIDS. Between August 2002 and July 2003, MSF provided 6,877 STD consultations, 110 group counseling sessions and 1,021 HIV tests in the capital Sofia. In February 2003, the Ministry of Health chose the program as the site for the training of doctors on reproductive health and STD management. MSF also provides primary health care in the Sofia suburbs, where many Roma (Gypsies) live. 🌿 3 🌿 20

Burkina Faso

This year, MSF added antiretroviral therapy to its HIV/AIDS program in the urban district of Pissy, north of the capital Ouagadougou. Around 600 people get regular follow-up, including treatment of opportunistic infections, and around 100 more have begun ARV treatment since April 2003; 700 people are followed in the program as a whole. MSF offers them comprehensive

care, including home-based care, voluntary HIV counseling and testing and prevention of mother-to-child HIV transmission. Medical and psychosocial health care to street children continues in the capital. Support to rural health centers is ongoing in Sindou, near the borders with Mali and Côte d'Ivoire. In October 2002, to prepare for a possible influx of refugees fleeing civil war in Côte d'Ivoire, MSF sent medicines to Banfora, Bobo, Yendéré and Koupela, and implemented a preparedness plan in the capital with the capacity to support up to 10,000 people. 🌿 10 🌿 84

Burundi

MSF continues to focus on making artemisinin-containing combination therapy (ACT) available to the many malaria patients in this malaria-endemic country; countrywide implementation of this effective treatment is expected by the end of 2003. MSF supports or runs clinics and hospitals in several provinces in Burundi, now in its eleventh year of civil war. In the capital Bujumbura, MSF helps civilians with war wounds in a specialized treatment and rehabilitation center and manages a health center that sees 150-200 patients each day; a surgery program is based in a local hospital. In September 2003, MSF also opened a new center in the heart of Bujumbura to deal with sexual violence. In addition, MSF runs nutritional programs and fights outbreaks of infectious diseases, notably malaria. (See page 55 for more on MSF work in Burundi.) 🌿 61 🌿 697

Cambodia

MSF primarily works to combat AIDS and malaria in Cambodia. Since 1998 MSF has provided voluntary counseling and testing, treatment of opportunistic infections and psychological support to people infected with HIV (since 1995 MSF has been working on HIV/AIDS education and prevention). Beginning in 2001, antiretroviral (ARV) therapy has been included in projects in Phnom Penh (July 2001), Siem Reap (October 2002), Sotnikum (July 2003) and Takeo (August 2003). Today over 950 patients receive ARVs through MSF. Many thousands more come in for consultations and receive treatment for opportunistic infections as well as other care and support. At chronic disease clinics in Siem Reap and Takeo, people with diseases such as diabetes, hypertension and AIDS receive regular care and follow-up. In the fight against malaria, in September 2002 MSF began a trial of Artein, an artemisinin-containing combination therapy (ACT) in Kvav and Anlong Veng. MSF also responds to natural disasters in Cambodia, such as the floods that devastated Prey Veng province in September 2002. 🌿 17 🌿 142

Cameroon

Antiretroviral (ARV) treatment and care for people with HIV/AIDS remains the main component of MSF's work in Cameroon. Over 310 people now receive free ARV treatment through the AIDS programs supported by MSF in the capital Yaoundé and the city of Douala in the west. MSF is also running testing, voluntary counseling and prevention activities in the outpatient departments of two health facilities in Douala (one hospital in the district of Nylon and one health center in the district of New Bell), carrying out an average of 600 consultations per month. Since its launch in October 2002, a new Buruli Ulcer treatment project in Ayos and Akonolinga has provided surgical interventions for 134 people suffering from this bacterial infection, which destroys skin and bone tissue. 🌿 9 🌿 28

Central African Republic

Over the last year, work in Central African Republic has focused on emergency response in the wake of an attempted coup d'état, and on a new sleeping sickness program begun in the country's southeast. After the attempted coup catapulted the country into civil war in October 2002 and divided the country into two parts, MSF intervened immediately to assist the injured and displaced. MSF supplied medicines and material to a hospital and

several health centers in Bangui and the surrounding province, supported a therapeutic feeding center in Bangui's pediatric hospital, and treated sick and injured people via mobile clinics in the southern part of the country. MSF has also assisted people from Central African Republic who have fled the fighting for refuge in transit camps just over the border in Chad. MSF set up an epidemiological surveillance system throughout the country and opened an office in Bangui to assist more than 300 victims of sexual violence. MSF continues to respond to epidemics of diseases such as meningitis, hemorrhagic viral fever, measles and hepatitis E. A maternal health program in Bangui ended in October 2002. 🌿 7 🌿 44

Chad

For the last several years, MSF has been reorienting work in Chad from supporting health districts to focusing on more specialized programs (such as surgical training). Nevertheless, MSF remains ready to respond to emergencies: one of the few aid agencies on the ground when war in neighboring Central African Republic pushed thousands of people to seek refuge in Chad beginning in November 2002, MSF responded by establishing temporary refugee camps and providing medical assistance to both refugees and the overburdened Chadian communities who sought to welcome them. Assistance was ongoing as of July 2003. MSF continues to respond to epidemics in Chad, particularly cholera, measles and meningitis. 🌿 30 🌿 56

China

The opening of an AIDS clinic in Xiangfan city of Hubei province in May 2003 marks a turning point for MSF activities in China. Officially recognized as a pilot project, the program has the potential to be replicated countrywide if it is successful. In addition to treating opportunistic infections related to AIDS, MSF has begun antiretroviral treatment for a handful of patients, hoping to include 500 people in the coming years. After the outbreak of Severe Acute Respiratory Syndrome (SARS) in Hong Kong in March 2003, MSF provided protection and training in Hong Kong and in two hospitals in Zhangjiakou city in Hebei province on the Mainland. MSF continues to provide medical and psychological care, housing and food to marginalized children and minors of Baoji city in Shaanxi province. In Kashgar Prefecture in Xinjiang province, MSF focuses on hygiene promotion and water sanitation. 🌿 17 🌿 64

Colombia

MSF's work in Colombia addresses the pressing health needs created by war, forced displacement and escalating urban violence. MSF, active in the country since 1985, cares for people affected by the war in rural and urban areas. Mobile medical teams bring primary care, prenatal care and vaccinations to forgotten rural dwellers trapped by the ongoing civil war. In urban zones like Bogotá or Quibdó, MSF offers medical attention to displaced people who were forced to flee their homes for the cities. In Cali, young victims of violence receive psychological care and physical rehabilitation. (See page 29 for more on MSF's work in Colombia.) 🌿 37 🌿 126

Côte d'Ivoire

Until recently, work in Côte d'Ivoire has focused on aid to inmates at the MACA prison in Abidjan. As the onset of civil war in September 2002 shocked the previously peaceful country, MSF work expanded to emergency response on both sides of the front line. MSF is present at Man hospital near the Liberian border and Korhogo and Bouaké hospitals in the rebel-controlled north, providing emergency care and responding to outbreaks of disease. Mobile clinics reach isolated people in the country's west, where the health care system has all but collapsed. (See page 22 for more on MSF work in Côte d'Ivoire and in the West African region.) 🌿 57 🌿 454

Democratic Republic of the Congo

Active in Democratic Republic of the Congo (DRC) since 1981, MSF's extensive medical aid work in eight of the country's ten provinces and in the capital Kinshasa makes the mission one of MSF's largest worldwide. Conflict and neglect have left the country's health system in tatters; MSF responds to epidemics and emergencies and provides basic health care to people who have none. In late 2002 and into 2003, fighting in the Ituri region in eastern DRC prompted a mass exodus of people from Bunia, the provincial capital. MSF responded with emergency medical care in Bunia and nearby Beni, where many of the displaced had fled, and with calls for the United Nations to do more to protect the people of the region. (See page 12 for more on this year's activities in DRC.) 🌿 158 🌿 1,600

Ecuador

Since April 2002, MSF has worked to improve the quality of health care for people at three public health centers in Flor de Bastión, a slum of Guayaquil. Activities include training and supervision of health personnel, prenatal and postnatal care, family planning, and prevention and treatment of sexually transmitted diseases (STDs). MSF also promotes STD prevention in schools and community organizations outside the slum. In the province of Sucumbios, along the Putumayo River (which forms the border between Ecuador and Colombia), a mobile clinic program serving Ecuadorian and Colombian communities ended in March 2003 after three years of work. In October 2002, MSF provided emergency assistance after the eruption of the Reventador volcano. 🌿 10 🌿 17

El Salvador

MSF has finished its medical programs in El Salvador, after four and a half years of work in the country. Over the last several years, MSF has focused on HIV/AIDS. One project promoted safe sex and HIV/AIDS prevention to commercial sex workers in four departments, including the capital San Salvador. About 500 commercial sex workers passed through this program. In the San Salvador metropolitan area, in close cooperation with the Ministry of Health, MSF ran a program to prevent mother-to-child transmission of HIV, altogether treating nearly 300 mother-child pairs. Additionally, staff in 12 health centers and at the maternity and children's hospitals received training and information on HIV/AIDS. MSF also improved voluntary counseling and testing as part of prenatal care, and helped raise awareness at the Ministry of Health of the importance of availability and access to AIDS tests. 🌿 6 🌿 24

Ethiopia

In Ethiopia, frequent epidemics are compounded by food security problems. The end of 2002 saw Ethiopia in a severe drought; the government declared that 12 million people were at risk. While responding to increasing nutritional needs in some areas, MSF also spoke out about problems with the emergency response system, pointing out that while emergency relief is critical, it is not a long-term solution. In addition, a government resettlement program began in February 2003 in five regions of Ethiopia; MSF has expressed its concerns about this in the various regions where it works and continues to monitor the situation. MSF continues tuberculosis (TB) treatment in the Somali region through a network of four hospitals and 11 health centers, and in a TB center in Galaha for the nomadic people of the Afar region. HIV/AIDS activities continue in Addis Ababa, where MSF provides comprehensive care for people living with HIV/AIDS as well as reproductive health care, family planning and treatment for sexually transmitted diseases (STDs) for sex workers. MSF also runs an STD project in Tigray. In Humera, HIV/AIDS and the parasitic disease kala azar are the focus of MSF work. There are also kala azar programs in Abduarfi and Mycadra. MSF provides primary health care in Sekota, Wag Hamra; a primary care program ended in

South Omo in February 2003. In the Adfer zone of the Somali region, MSF is also running a water and sanitation project. 🌿 61 🌿 518

France

After the launch of the CMU (universal medical coverage) in France in 1999 gave access to free public health care to the most vulnerable, MSF was able to close some of its medical centers and focus on people who still had difficulties entering the system: immigrants, young people at risk and people who live in poverty. In December 2002, however, the CMU was put in jeopardy after parliament adopted legislation cutting back on the rights it provided. In March 2003, MSF collected over 100,000 signatures on a petition requesting the French government to safeguard the right to free public health care for the poorest; the changes to the CMU were abandoned. Socio-medical support to undocumented immigrants, young people and drug addicts continues in Paris and in l'Etang de Barre near Marseilles; a similar program in Lille ended in March 2003. MSF continues collaboration with the association ESPOIR in Lille and Clausmatt to provide short-term shelter for seriously ill people with nowhere else to go. 🌿 39

Georgia

MSF provides health care for people in Pankisi, Tbilisi and Abkhazia, a separatist Georgian republic devastated by civil war. In Tbilisi, a free polyclinic provides over 1,000 consultations each month. MSF also makes home visits to home-bound patients. In Sukhumi, Abkhazia, MSF screens for and treats tuberculosis, including drug-resistant cases, and also provides general medical care and surgery for vulnerable people through several clinics. In Akhmeta, near the entrance to the Pankisi valley, surgical assistance at the local hospital benefits area residents as well as refugees from Chechnya who have taken shelter in the region. 🌿 11 🌿 62

Guatemala

Much of MSF's work in Guatemala is focused on care and treatment of people with HIV/AIDS. In Guatemala City and in the city of Coatepeque, MSF offers voluntary testing and counseling, care and treatment of opportunistic infections, nutritional support and home care. As of July 2003, 550 people were receiving antiretroviral (ARV) treatment through MSF. Advocacy is also underway to push for affordable medicines for AIDS and other diseases. In addition to AIDS care and advocacy work, in Guatemala City MSF offers care for children and young people living on the street; support is also given

to mothers and their at-risk children through a therapeutic day care center in one of the city's slum areas. (See page 52 for more on MSF's work in Guatemala.) 🌿 18 🌿 90

Guinea

Central to MSF's work in Guinea is medical aid to the country's refugee population. With conflict in Liberia escalating in 2002, a fresh wave of refugees arrived in Guinea. MSF was already present in several camps and responded in Macenta, Guéckédou, Kissidougou, Nzérékoré and Boreah. Guineans living in Côte d'Ivoire also fled the outbreak of civil war there; by December 50,000 were living in transit camps inside Guinea. MSF also provides other assistance: care at health centers and health posts in rural districts; hospital support; training for traditional birth attendants; psychosocial support for street children; and aid to the country's national tuberculosis program. In 2002, a sexual violence component was added to refugee health projects in Guinea. In March 2003, an HIV/AIDS program began in Conakry. (See page 22 for more on MSF work in Guinea and the West African region.) 🌿 32 🌿 332

Haiti

Since 1994, MSF has provided services to thousands of Haitians who have very limited access to health care. Haiti's decentralized health system has left many with inconsistent and minimal medical care; health indicators are the lowest in the western hemisphere, and maternal mortality is a particular problem. In the communes of St. Marc, Desdunes, Grand Saline and Petite Rivière, teams train national medical staff, provide equipment and supplies, and work to rehabilitate health centers and hospitals. Many project activities focus on reproductive and maternal health in an effort to improve care in this area. 🌿 14 🌿 84

Honduras

MSF is focusing increasingly on HIV/AIDS in Honduras, where the government has started to make the epidemic a priority. At a clinic in Tela, on the north coast, MSF teams provide comprehensive quality care, including ARV treatment and psychological support, to people living with HIV/AIDS. As of July 2003, 135 people were receiving ARVs through MSF's program, with many more receiving testing, counseling and care. MSF is also encouraging local authorities and NGOs to promote antiretroviral therapy and follow-up care. MSF wound up a project in Yoro focusing on Chagas disease, a parasitic infection, in August 2002. 🌿 12 🌿 44

India

After providing technical support and follow-up for India's national tuberculosis (TB) program for four years, MSF is reorienting its TB work to be more patient-centered: MSF health workers have now been integrated into a Mumbai health post and dispensary to provide direct patient treatment. TB prevention, training and technical assistance continue. In Assam, MSF's malaria control program focuses on early diagnosis and treatment of the disease, especially in pregnant women and children, aiming to help some 200,000 displaced people in the area. In Jammu and Kashmir, MSF is providing psychosocial education and working to improve mental health care for war-traumatized people in Srinagar and Kupwara. MSF is also rehabilitating health structures and improving medical waste management. 🌿 23 🌿 97

Indonesia

MSF operations in Indonesia have shifted strategically from short-term emergency response to longer-term programs for HIV/AIDS, sexually transmitted diseases (STDs), tuberculosis and malaria. An HIV/AIDS project launched in Merauke in October 2002 began providing antiretroviral treatment in March 2003. In the capital Jakarta, MSF offers social support services and free treatment of STDs to sex workers. In February 2003, MSF

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During the height of the SARS (Severe Acute Respiratory Syndrome) epidemic in May 2003, MSF gives a workshop of how to wear protective gear in isolation wards in Zhangjiakou, Hebei province, China.

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A volunteer reaches – unsuccessfully – for a giant pill as part of MSF's "Suspended Life" demonstration in Evian, France. The live exhibit was designed to call world leaders' attention to the millions of deaths from infectious diseases during the annual G-8 meeting of leaders of key industrialized countries.

began participation in an HIV/AIDS prevention and care network (which includes access to ARVs) in partnership with Indonesian health professionals. MSF responded to malaria outbreaks in Jayawijaya and South Halmahera, introducing the more effective artemisinin-containing combination therapy (ACT) in a country where chloroquine is still the national protocol. MSF is assessing tuberculosis needs in Ambon. In March 2003, MSF started a community-based mental health project to help alleviate trauma caused by the conflict in the Moluccas. Work with East Timorese refugees in camps in West Timor ended in September 2002. ✂ 28 ✂ 174

Iran

After the fall of the Taliban regime in November 2001, millions of Afghan refugees in Iran have been under pressure to return to Afghanistan, despite the continuing insecurity and difficult living conditions there. While speaking out against the forced return of the refugees, MSF continues to assist Afghans in several cities in Iran, providing basic health care and serving as a witness to help uphold their right to voluntary return to their country. In Mashad and Zahedan, MSF provides care to refugees in collaboration with the Iranian health system; 65,000 medical consultations were carried out in 2002. MSF also runs mobile clinics in Zahedan and a health post in Nyatak refugee camp near Zabul, home to 5,000 people. ✂ 8 ✂ 89

Iraq

Prevented by the Iraqi government from establishing a presence in Iraq from 1992 to early 2003, MSF became active in Baghdad shortly before the onset of war in March 2003. After principal hostilities ended several weeks later, MSF evaluated over 70 health structures and found that the most urgent medical problem in Iraq was the lack of leadership in the highly centralized health system, which had slipped into chaos in the aftermath of the war. MSF called on the US-led coalition to carry out its responsibilities as Occupying Power under the Geneva Conventions and provide basic services, including health care, to the Iraqi people. Amid a deteriorating security situation in which aid workers are increasingly perceived as linked to the western military presence, MSF is currently providing independent assistance at several health centers in Sadr City, a slum area of Baghdad; drug and supply distribution to clinics and hospitals in Basra and Missan ended in August 2003. (See page 72 for more on MSF work in Iraq.) ✂ 20 ✂ 108

Italy

MSF operations in Italy focus on illegal immigrants and asylum-seekers, primarily from Africa and the Middle East, who use Italy as an entry point to Europe. In September 2002, MSF began work at a reception center for undocumented migrants on Lampedusa Island, providing medical triage for 9,000 people in the first year. Medical care is also offered to illegal immigrants in Siracusa province, in southwestern Sicily, through an agreement with the local public health service. In Rome, MSF works to improve access to basic care for vulnerable foreigners and continues to lobby the government on issues related to asylum-seekers and illegal migrants. ✂ 10 ✂ 15

Kenya

In Kenya, MSF focuses on HIV/AIDS care, treatment, prevention and policy advocacy. In Homa Bay, Busia and Nairobi MSF supports voluntary counseling and testing centers, treatment of secondary infections like tuberculosis, prevention of mother-to-child transmission, psychosocial care, and patient support centers. Free antiretroviral treatment is offered at four locations, with 460 people under treatment as of July 2003. Until recently MSF was also extensively involved in caring for refugees in Kenya. MSF ran three hospitals and nine health centers in refugee camps for Somali refugees in Dadaab; in June 2003, after 11 years of providing medical assistance there, MSF transferred its projects to a German organization. Aid to Somali refugees in Mandera, in the northeast, was abruptly halted in June 2003 after a grenade explosion outside the MSF compound severely injured an MSF volunteer. (See page 46 for more on MSF's work in Kenya.)

✂ 46 ✂ 243

Laos

HIV infection seems to be on the rise in Laos, a country with a poorly maintained and largely inaccessible public health system. In response, MSF's HIV/AIDS project offers medical care for people living with HIV/AIDS in the southern province of Savannakhet. MSF supports the provincial hospital in Savannakhet city by delivering care to HIV patients, supplying needed medicines and providing technical assistance and training for local physicians and nurses. MSF also treats opportunistic infections and carefully monitors admitted HIV patients, with antiretroviral therapy for approximately 40 patients beginning in September 2003. ✂ xx ✂ xx

Liberia

MSF work in Liberia has shifted exclusively to emergency response with the intensification of the country's civil war in 2002-2003, an upturn in violence that has affected the entire West African region. Tens of thousands of Liberians fled the conflict sweeping through the country. MSF staff worked tirelessly in Monrovia, assisting thousands of displaced people gathered in schools and stadiums, supporting public hospitals until the front line closed them down, even creating makeshift clinics in the two MSF residences. (See page 22 for more on MSF work in Liberia and in the West African region.) ✂ 44 ✂ 300

Luxembourg

MSF continues to support the MSF-Solidarité Jeunes program in Luxembourg, which provides psychological, social, educational and medical assistance for young people, their families and institutions that work with youth around the issue of drug use and addiction. The team provided therapeutic care to 227 young people between August 2002 and July 2003, an increase of 10% over the previous year. MSF has also been assessing the medical and psychological condition of asylum-seekers and undocumented immigrants coming to Luxembourg from the Balkans and Africa. ✂ 4

Madagascar

Young people in difficulty, including those living on the street, are at the heart of MSF work in Madagascar. Three socio-medical centers in the capital Antananarivo provided comprehensive medical care and social and legal support to more than 3,500 street children in 2002. This project was expanded over the last year to include mothers and pregnant women. MSF has also helped improve health and sanitary conditions in three juvenile correction centers and in the juvenile sector of Antanimur prison in Antananarivo. MSF continues to run a therapeutic nutrition unit in the Befelatanana hospital in Tana and to respond to medical and nutritional emergencies caused by Madagascar's exposed climatic position, such as the Kesiny cyclone in early 2002. 🌿 5 🌿 71

Malawi

AIDS-related medical care is central to MSF work in Malawi, and much of that work is rooted in traditional community support networks. In densely populated Thyolo and Chiradzulu districts in the country's south, programs include voluntary counseling and testing, training local personnel, care for opportunistic infections, prevention of HIV transmission from mothers to their unborn children, control of sexually transmitted diseases, and community education for prevention. As of July 2003, more than 1,150 people were receiving antiretroviral therapy. MSF is also carefully monitoring the nutritional situation in the country. (See page 48 for more on MSF's work in Malawi.) 🌿 20 🌿 166

Mali

MSF carries out a variety of activities in Mali, focusing on eye diseases and support of the public health infrastructure. Activities include mass distribution of the generic drug Azithromycin to treat trachoma and mobile surgical clinics to operate for trachoma, cataract and trichiasis. These projects will be replicated at the national level by the Ministry of Health. In the Selingue health district, successful work to improve staff motivation and quality of care through sharing the financing of health care among the government, NGOs and the people has prompted the government to pursue this strategy on a larger scale. MSF continues work with a nursing school in Gao; support for Ansongo health district drew to a close at the end of 2002. Since October 2002, MSF has also provided assistance to people fleeing war in Côte d'Ivoire for refuge in Mali. 🌿 9 🌿 70

Mauritania

MSF projects in Mauritania concentrate on mother-and-child health care and nutritional therapy in marginalized communities. In the Bouhdida health center on the outskirts of the capital Nouakchott, the MSF team provides about 580 consultations every month focusing on primary and reproductive health care, with special emphasis on mothers and children. Mother-and-child health care is also the focus in Selibaby, in the region of Guidimaka. In both Saada, on the outskirts of Nouakchott, and in Guidimaka, nutritional support and malnutrition prevention work targets people at risk. 🌿 7 🌿 18

Mexico

As a result of the post-conflict standoff between the Zapatista movement and the Mexican government, Zapatista communities actively exclude themselves from government services. Since March 2000, MSF has provided humanitarian assistance to marginalized people in self-declared Zapatista autonomous communities in the rural areas of the state of Chiapas. Activities include consultations, basic health care (including mother-and-child health care) and vaccinations, through mobile medical clinics which visit communities 20 days out of every month. In September 2002, MSF suspended activities in the area of San Manuel, after the local Zapatista authorities tried to impose fees on MSF patients who were not part of the Zapatista movement.

The teams resumed work there in January 2003 after this decision was reversed. MSF also responds to natural disasters, such as Hurricane Isidore, which hit the Yucatan Peninsula in September 2002. MSF provided medical assistance to the most vulnerable families in two areas and distributed emergency kits, medicines and cooking utensils. 🌿 6 🌿 22

Morocco

In Morocco, MSF cares for vulnerable people such as sub-Saharan migrants, single mothers and sex workers. In Tangiers, MSF is working to improve the physical and social well-being of street children, single mothers and immigrants, by providing them with medical consultations, health education and information on how to prevent HIV infection. In Casablanca, MSF provides women in precarious situations, particularly single mothers and sex workers, with medical and psychosocial assistance. Work in the Temara district of Rabat came to a close in November 2002 after three years of health education activities and the construction of a maternity wing in the local health center. 🌿 7 🌿 23

Mozambique

AIDS-related medical care is MSF's principal concern in Mozambique, where an estimated 13% of all adults are HIV-positive. Comprehensive care offered in Maputo, Lichinga and Tete includes voluntary counseling and testing, treatment of opportunistic infections, home-based care and prevention of mother-to-child transmission of HIV. Antiretroviral treatment for AIDS patients began in 2003; as of July, around 250 people were receiving these life-prolonging drugs in Maputo and Tete. MSF also continues to promote cholera prevention in Maputo and monitors epidemics around the country in coordination with the Ministry of Health. 🌿 40 🌿 246

Myanmar

Treating malaria is a key component of MSF's medical assistance in Myanmar. Malaria is the leading cause of sickness and death in the country, which has the world's most resistant strains of the disease. MSF has used the highly effective artemisinin-containing combination therapy (ACT) in the country since 1996. Over the last year and a half, well over 300,000 people have been screened for the disease and more than 160,000 patients treated at MSF malaria projects in Myanmar. In Yangon, MSF also provides mother-and-child health care and cholera treatment, and treats opportunistic infections in TB and AIDS patients. The first antiretroviral (ARV) treatment program in the country began in February 2003 in Yangon; by October 2003, 80 people were under treatment. MSF runs HIV/AIDS, malaria, tuberculosis and general health programs in Rakhine, Kachin and Shan states and in Dawei and Myiek districts. In Rakhine state, MSF also assists Rohingya Muslims, who have no access to health care and face hardship because of their lack of citizenship and restrictions placed on their movements. MSF is beginning primary health care, malaria and nutrition projects in Kayah state, home to many displaced people. 🌿 25 🌿 390

Nepal

Since January 2003, MSF has been working to improve medical care for Nepalese whose health system has been weakened by conflict between Maoist rebels and government forces (mitigated somewhat by a ceasefire signed in January 2003), and whose access to health facilities is hindered by the country's isolating mountainous geography. An MSF doctor, nurse and logistician help ensure some 1,200 consultations and 55 admissions each month at the hospital in the government-controlled city of Rukum. In the Maoist heartland of Jumla, MSF supports the hospital in government-controlled Jumla town and is improving primary health care at remote satellite health posts up to four hours' walk from town. In Nepalganj, MSF is assisting a local NGO which offers shelter and psychological care to women fleeing conflict in Jumla and other areas. 🌿 18 🌿 39

Nicaragua

The parasitic infection known as Chagas disease is endemic in Nicaragua. Since mid-2002, MSF has been trying to reduce the incidence and morbidity of the illness in children under 15. Around 8,000 children benefit directly and at least 17,200 others at risk of acquiring the disease benefit indirectly from the MSF program in Esquipulas, Matagalpa department. MSF also runs an urban project in Ciudad Sandino, in northern Managua, where the focus is on improving the reproductive health of 41,082 men and women between 15 and 49 years of age. MSF lobbies the government to improve access to medical assistance as well as access to essential drugs. MSF also carries out active surveillance and monitoring to identify emergency threats in the region, often at risk from natural disasters. 🌿 7 🌿 44

Niger

MSF responds to chronic food problems and epidemics in Niger. In 2002, MSF's therapeutic feeding center in Maradi took care of over 5,200 children; at the end of July 2003, 480 children were under treatment. In March 2003, a double epidemic of measles and meningitis broke out in the Maradi and Zinder regions of eastern Niger; from March to May, MSF vaccinated more than 125,000 children against measles and 290,000 people against meningitis. MSF also provided 300,000 measles and 450,000 meningitis vaccines, and a total of 10,000 curative treatments, for use by the Ministry of Health for a massive rural vaccination campaign. 🌿 8 🌿 70

Nigeria

Malaria is the main cause of death among children under five years old in the Niger Delta area. Since January 2003, MSF has provided basic health care in three health centers in Bayelsa State and has introduced artemisinin-containing combination therapy (ACT) using artesunate-amodiaquine as first-line treatment for malaria patients. A November 2001 study done by MSF showed resistance levels of approximately 40% for the current first-line therapy (chloroquine) and 45% for the second-line treatment (Fansidar®) in children aged 6-59 months. In April 2003, MSF began an HIV/AIDS care and support project at Lagos General Hospital. MSF also maintains an emergency preparedness and response project in the capital Abuja. 🌿 17 🌿 58

North Caucasus

The vast reduction in the possibility of carrying out humanitarian work in the North Caucasus has not been echoed by a reduction in needs, which remain pressing. MSF activity in the region is now focused on two things: securing the release of MSF staff member Arjan Erkel, kidnapped in Dagestan in August 2002 (and as this report was going to press still being held); and assistance to Chechens affected by the ongoing conflict in Chechnya. In the face of mounting official pressure for Chechens in Ingushetia to return to Chechnya, MSF continues to speak out about the distressing living conditions of the displaced and to advocate against pressuring them to return while conflict continues. Despite official obstruction, MSF continues to address the basic living conditions and sanitary situation of Chechens in Ingushetia, particularly through the provision and repair of shelter, targeted distribution of essential basic goods, and improvements in water and sanitation. MSF runs prenatal and gynecological, pediatric and general practitioner clinics in Ingushetia. MSF also donates medical material, equipment and medicine to most government health structures in Ingushetia. In Chechnya, MSF provides medicine, medical material and medical equipment to 30 structures and responds to emergencies stemming from the ongoing conflict. (See page 30 for more on MSF activity in the North Caucasus.) 🌿 18 🌿 255

North Korea

MSF continues to condemn China's forced repatriation of North Koreans and repression of humanitarian aid workers assisting them. It urges the United Nations High Commissioner for Refugees to demand access to North Koreans held by China and to examine their asylum requests. Active in North Korea from 1995 to 1998, MSF withdrew due to a lack of access to people in need and no independence to carry out its programs. Nonetheless, MSF continues to assist North Koreans. In 2002, MSF provided food and medical aid to around 900 people: shelter, clothing and food for those in hiding along the Chinese border; help with resettlement and medical care for some who made it to South Korea; medical care upon request in China and third countries; and assistance to several families and occasional aid supply in North Korea itself. MSF also collects refugees' accounts to raise awareness of their situation in the media and with governments, UN agencies and human rights organizations. 🌿 3 🌿 5

Pakistan

MSF work in Pakistan has been largely focused on assistance to Afghans who have sought refuge there. MSF has worked in camps for refugees inside Pakistan, just across the border in Afghanistan, and in an area just inside the Pakistani border known as the "Waiting Area." MSF advocated consistently for the admission of people in the "Waiting Area" as refugees in Pakistan, and for an immediate improvement in the levels of assistance by other agencies. The "Waiting Area" was finally closed at the end of July 2003; about half the 25,000 refugees there chose to go to Mohammed Kheil camp inside Pakistan near Quetta and were granted refugee status; the others returned to Afghanistan, many to Zhare Dasht camp near Kandahar. MSF continues to provide health care, nutritional support in the form of feeding programs, chlorination of water, and measles immunization to about 17,000 refugees in two of the five camps located inside Pakistan near Chaman; work is also beginning at Mohammed Kheil camp. MSF also works across the border in camps for the displaced near Spin Boldak, Afghanistan (and in many other locations in Afghanistan, see page 70); the future of the Spin Boldak camps is under discussion as people there begin to be relocated inside Afghanistan. In July 2003, MSF mobile clinics brought basic medical care to people affected by floods in Sindh province. 🌿 7 🌿 165

Palestinian territories

Since the beginning of the al-Aqsa Intifada in 2000, MSF has been working to ease the emotional and physical suffering of Palestinian families who have little access to health care and great restriction of movement in Gaza, Hebron



A Palestinian woman holds one of her five children in August 2002. She lost her husband and her home during an Israeli Army incursion into Jenin camp in the West Bank.

and Jenin. Teams of doctors, psychologists, psychiatrists, interpreters, social workers and drivers reach people with curative medical and psychological care via mobile clinics. Home visits and counseling by psychologists or psychiatrists help traumatized individuals cope with stress. More than half of the patients are under 15. In Hebron and Jenin, the MSF team also carries out emergency interventions such as escorting pregnant women and gunshot victims to nearby hospitals. Assistance to Yatta Bedouins is provided in Hebron. 🌿 22 🌿 44

Peru

In Peru, MSF cares for people living with HIV/AIDS in the slums of Lima and in the city's overcrowded Lurigancho prison. Activities include education, treatment of related infections such as tuberculosis, and home-based care for those living in poor urban areas; introduction of antiretroviral therapy is foreseen for 2004. MSF continues to address the problem of violence against children and adolescents in Lima's Villa El Salvador district. In March 2003, MSF's mucocutaneous leishmaniasis treatment program in the San Martín de Pangoa district of Satipo came to an end; the two-year program improved detection and treatment of cases as well as the capacity of area health staff to address the disease. In addition, MSF, through the Campaign for Access to Essential Medicines, helped the health authorities get sodium stibogluconate, used for treating the disease, for a price 20 times cheaper than before. MSF also responded with material assistance and aid to health facilities when extreme cold affected thousands in Peru in July 2003. 🌿 6 🌿 40

The Philippines

MSF continues care and support for street children in the capital Manila. Through a day center and a mobile unit, MSF reaches over 250 children with services including medical consultations, supply of daily necessities, support for family reintegration and job placement, and, since April 2003, paralegal assistance. In Malabon, a slum on the outskirts of the capital, MSF runs a supplementary feeding center. MSF also remains responsive to emergencies arising from separatist conflicts in Mindanao, from February until June 2003 providing plastic sheeting for shelter to displaced people. In March 2003, MSF carried out a measles vaccination campaign for 3,500 displaced children. 🌿 4 🌿 28

Republic of Congo

Aid to people displaced by conflict, care for victims of sexual violence and treatment of sleeping sickness remain at the heart of MSF's work in the Republic of Congo. Over the last year, renewed fighting rendered the Pool region in the south inaccessible to humanitarian aid; MSF assisted the displaced reaching the capital Brazzaville until gaining access to the Pool region in June 2003. A successful public awareness campaign in March 2003 put the spotlight on the country's persistent problem of sexual violence. (See page 38 for more on MSF activity in Republic of Congo.) 🌿 31 🌿 287

Romania

MSF's mission in Romania focuses on access to public medical and social services for homeless people. In the capital Bucharest, an MSF socio-medical center assists around 5,000 homeless adults. There are on average 515 medical consultations and 280 social and 60 psychological consultations at the center each month. Since December 2002, the MSF socio-medical team has gone out on the streets three nights a week to raise awareness of MSF's services. Lobbying and public education, such as the "Caravan of Solidarity" that reached 13 cities in September 2002, remains an important aspect of MSF's work. MSF also finances nutritional and vitamin supplements for children living with AIDS. 🌿 1 🌿 14

Russian Federation

MSF continues to focus much of its energies in the Russian Federation on securing the release of staff member Arjan Erkel, kidnapped in the republic of Dagestan in August 2002, and assistance to people affected by ongoing conflict in the republic of Chechnya. See page 30 for more on MSF work in the North Caucasus. In Siberia, MSF's tuberculosis (TB) program in the region of Kemerovo was halted after Russian medical authorities demanded that MSF use an incomplete and inappropriate treatment for multi-drug resistant TB that is in complete contradiction to treatment recommended by the World Health Organization; MSF had no choice but to end its assistance. More than 10,000 TB patients had been enrolled in the program since its inception in June 1996. MSF's work providing assistance to homeless people in Moscow also drew to a close, though MSF will continue advocacy to ensure social integration of this vulnerable group. This successful project was taken up by the Moscow City Government. In 11 years, MSF had provided more than 200,000 medical and 65,000 social consultations. MSF is currently launching a program to support street children in Moscow. 🌿 11 (not including staff for North Caucasus) 🌿 87 (not including staff for North Caucasus)

Rwanda

In order to fight regular cholera outbreaks, MSF runs a preventive water and sanitation program in the province of Cyangugu, in western Rwanda. In the capital Kigali, MSF supports HIV/AIDS programs at several local health centers. A countrywide mental health care program provides group counseling sessions for traumatized survivors of the 1994 genocide. Most of the people in this program are women, many of whom were raped during the genocide. In Ruhengeri province, an access to health care and reproductive health program in three health centers and in the maternity ward of the regional reference hospital aims to reduce high child and maternal mortality rates in this area. MSF will also provide support for women who are victims of sexual violence. MSF responds regularly to emergencies, such as a meningitis outbreak in September 2002. 🌿 8 🌿 94

Serbia and Montenegro

Over the last year, MSF has worked to improve the living conditions of displaced people in Serbia and Montenegro and help them gain recognition for their status. On a pilot basis, MSF has sought alternatives to resettling some 32,000 internally displaced persons (IDPs), assisting families in the district of Pcinja to rehabilitate and pay for shelter and obtain legal status to settle in Serbia or another country. This relocation project finished in December 2002. In June 2003, a psychosocial program began aid to victims of the Kosovo war. These IDPs live in appalling conditions inside Serbia but are too fearful to return to Kosovo. Two mobile teams reach out to some 2,500 IDPs in and around Vranje; advocacy for a permanent solution to their status is carried out at the national level. In the same area, MSF until recently assisted the most vulnerable local families with small-scale rehabilitation and psychosocial support. 🌿 4 🌿 15

Sierra Leone

Ensuring quality primary and secondary care at health centers and hospitals is the cornerstone of MSF's work in Sierra Leone, a country just emerging from a brutal civil war. Yet, even as reconstruction and repatriation gather pace, MSF is concerned that many Sierra Leonean refugees and displaced are being "encouraged" to go home without sufficient assistance. Over the past year, violence in West Africa has also pushed thousands of Liberian refugees into the country, straining the already damaged health system. In many areas, MSF provides care for both local residents and refugees in nearby camps. (See page 22 for more on MSF work in Sierra Leone and the West Africa region.) 🌿 92 🌿 717

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Former South African President Nelson Mandela dons an "HIV-positive" t-shirt during a visit to MSF's AIDS program in Khayelitsha, South Africa, in December 2002. Mandela's visit helped put the spotlight on the need to scale up antiretroviral treatment for people with HIV/AIDS.

Somalia

Somalis continue to be affected by the fractured nature of their state and by ongoing clashes among the country's many clans. Peace negotiations have not improved security, and the population in the central and southern parts of the country is still deeply affected by instability. Given this, it is not surprising that less than one-third of the population has access to medical care, and that the country's health indicators are some of the worst in the world. MSF provides medical assistance in many locations, offering basic health care through hospitals and health centers and responding to emergencies and epidemics of diseases such as kala azar, cholera, tuberculosis and measles. MSF treats war-wounded non-combatants in Galkayo and Dinsor. Food security and malnutrition are persistent problems in some areas: MSF therapeutic feeding centers for severely malnourished children are currently running in Galkayo, Bakool and Marere. MSF also maintains a presence in Mogadishu, treating cholera and providing outpatient consultations. 🌿 36 🌿 253

South Africa

MSF continues to focus on HIV/AIDS treatment and care in South Africa. During 2003, tension in the country over the controversial government HIV/AIDS policy increased, peaking with a civil disobedience campaign led by the Treatment Action Campaign to protest the lack of government commitment to a national treatment plan. In 2003 the government had constantly delayed key decisions and repeatedly released misleading messages about the efficacy and supposed toxicity of antiretrovirals (ARVs). Policy change only happened in August 2003, immediately after the first national HIV/AIDS conference, when the South African scientific and medical community joined voices with activists and people living with HIV to demand treatment from the government. In less than two months, the Department of Health produced a comprehensive AIDS plan, which is still to be approved by the Cabinet. At MSF's Khayelitsha AIDS program over 650 people are now on ARV treatment, and many thousands more receive treatment for opportunistic infections and medication to prevent mother-to-child transmission of the virus. Since January 2003, MSF has also been working in Lusikisiki, a rural town located in the former Transkei, one of the poorest areas in South Africa. This program is run in partnership with the Nelson Mandela Foundation, and aims to develop a model for implementing comprehensive AIDS services in remote

rural areas. Each month, MSF provides voluntary counseling and testing for more than 500 people and medical care to more than 200 HIV/AIDS patients; ARV treatment will begin in October 2003. 🌿 7 🌿 29

Spain

In Spain, MSF addresses the health needs of undocumented migrants and asylum-seekers who lack access to health care under the country's new immigration laws, and for whom there is little political will to improve reception conditions. Since February 2003, MSF assisted approximately 500 immigrants living in the woods near Ceuta, a Spanish city on the north coast of Africa, providing them with items to improve their shelter and sanitary conditions and with food and medical care. In Ceuta itself, a new project providing medical and psychological assistance to around 150 unaccompanied and undocumented Moroccan children started in October 2002; it was closed in June 2003 because of lack of political will to work toward lasting solutions. Since July 2003 these children have been given medical assistance in the framework of the project for undocumented immigrants. In Barcelona, MSF advocates for harm-reduction programs for drug addicts in the prisons of Catalonia. A tuberculosis program for immigrants and other vulnerable people in Madrid ended in October 2002. 🌿 12 🌿 2

Sri Lanka

After 19 years of war between the Tamil Tigers (LTTE) and the Sri Lankan government, a ceasefire was concluded in February 2002. As the health system is slowly being reestablished in the north and east, which bore the brunt of the war, health personnel are returning to these areas to resume work. Consequently, MSF has closed projects providing medical care and surgery for victims of the civil war in Batticaloa, Jaffna, Madhu, Mallavi, Point Pedro and Trincomalee. MSF continues support to the gynecology department at the hospital in Puthukkudiyiruppu and performs clinical monitoring of health staff and patients in mother-and-child health clinics in the area. In Vavuniya, MSF provides community-based psychosocial support for displaced people. MSF continues to lobby the government and implementing agencies to improve living conditions in camps for the displaced. 🌿 13 🌿 76

Sudan

MSF has been assisting people in Sudan for over 25 years, providing primary health care, nutritional relief in times of famine, war surgery when needed, and specialized care and treatment for diseases such as sleeping sickness, kala azar, tuberculosis and malaria. Although a partial peace process is now underway, the situation on the ground remains worrying. Despite insecurity and frequent program interruptions due to the war, MSF projects have persisted in bringing much-needed relief – and a humanitarian presence – to many Sudanese. (See page 20 for more on MSF work in Sudan.) 🌿 127 🌿 1,853

Tajikistan

After 13 years of aid work in Tajikistan, MSF is winding down all programs as needs become more oriented toward long-term development. In several regions of Rasht Valley, MSF supported basic health care facilities and reproductive health programs. This included distribution of essential drugs, conducting trainings for rural health practitioners, monitoring outbreaks of infectious diseases and carrying out vaccination campaigns. The program of emergency preparedness and response to outbreaks of infectious disease was handed over in full to another NGO in June 2003. MSF's reproductive health care programs will be handed over to an NGO in October 2003. MSF also ran a support program to inpatients of psychiatric institutions, providing food and non-food items and essential drugs; promoting awareness and interest in the issues surrounding psychiatric care among the government and international actors was a key part of this project. MSF will end its mission in Tajikistan by the end of 2003. 🌿 6 🌿 62

Tanzania

In Tanzania, home to many refugees from Rwanda, Burundi and the Democratic Republic of the Congo, MSF runs several primary health care projects while closely monitoring the humanitarian situation of the refugees. In Kigoma, MSF is working to improve access to water in key communities; malaria control efforts include case management, improving diagnosis, training and distribution of insecticide-treated bednets. In Mtwara, special emphasis is put on mother-and-child health care. MSF also works with the Ministry of Health on improving preparedness for the country's regular outbreaks of cholera through training local health staff, treating patients, setting up cholera isolation centers and educating for community awareness and better hygiene. 🌿 8 🌿 41

Thailand

Comprehensive care and treatment for those with HIV/AIDS continues to be the main focus of MSF's operations in Thailand, where one million people are HIV-positive. In Bangkok, and in Surin, Rayong, Non Thaburi (Bang Kruai district), Pethburi (Ban Laem) and Kalacin (Kutchinarai district), MSF provides antiretroviral (ARV) treatment to AIDS patients in a variety of settings, with over 851 people under treatment as of late July 2003, including 113 children. Depending on the program site, MSF projects can include home visits, clinical care, treatment of opportunistic infections, and technical assistance to district and provincial hospitals. MSF has also been an instrumental advocate for lower ARV drug prices in the country. In addition to its AIDS-related work, MSF provides medical care (treatment for tuberculosis, multi-drug resistant tuberculosis and HIV/AIDS) for 44,000 Karen refugees living in camps in Maesot and Ratchaburi, and for about 7,000 Mon people across the Thailand-Myanmar border. In Maesot, MSF runs a tuberculosis program for migrant workers from Myanmar. 🌿 20 🌿 101

Turkmenistan

The tuberculosis treatment project carried out by MSF since 1999 targeting Dashoguz province now completely covers this region of 1,040,000 people. At the end of 2002, the program had a success rate (cured and completed) of 85% among new smear-positive TB cases and 80% among TB patients overall. By the end of 2003, MSF plans to hand over all activities of this DOTS (Directly Observed Treatment Short Course) program to the Ministry of Health and Medical Industry. The MSF office in Ashgabat remains a vital logistic support to all MSF missions in Central Asia, particularly western and northern Afghanistan. 🌿 2 🌿 45

Uganda

In Uganda, MSF treats infectious diseases such as HIV/AIDS, malaria and kala azar. As part of comprehensive care at its HIV/AIDS clinic in Arua, MSF offers antiretroviral (ARV) treatment to 305 people (as of July 2003) and also works to prevent mother-to-child transmission of HIV. At Amudat hospital in Pokot county, MSF's kala azar ward treated 182 patients in 2002. Malaria is the main cause of mortality in this region. In May 2003, MSF began an efficacy study at Amudat hospital comparing three different combination treatments for malaria. MSF is working to introduce the highly effective artemisinin-containing combination therapy (ACT) in all its projects in Africa. In June 2003, MSF assistance to some of the 120,000 displaced people in western Uganda drew to a close. 🌿 28 🌿 158

Ukraine

MSF continues to provide affordable and replicable medical care and psychological support for people living with HIV/AIDS in Ukraine, with special emphasis on the southern region, which is the country's epicenter for the AIDS epidemic. MSF's program aimed at preventing mother-to-child transmission of the disease has been successful in reducing the transmission

rate from 30% (without intervention) to 12%. MSF has also opened a satellite clinic at the Regional Maternity Hospital in Odessa, equipped the laboratory at the Odessa Regional AIDS Center, and established a psychosocial support program for HIV-positive people in three regional centers: Odessa, Mikolayev, and Simferopol. MSF also treats AIDS-related opportunistic infections in these three regions, where 19 children are also receiving antiretroviral treatment. 🌿 5 🌿 34

Uzbekistan

Using the DOTS (Directly Observed Treatment Short Course) program, MSF works to combat TB in several regions of Uzbekistan. MSF is currently in the process of handing over the supervision of treatment to the Ministry of Health. As a part of its TB treatment program, in 2002 MSF launched a pilot project in Nukus city and Chimbay district to treat multi-drug resistant TB. MSF is also conducting research on the Aral Sea area; the goal is to foster a better understanding of the relationship between the degraded environment of the Aral Sea area and human health, and to advocate for policy change and interventions by government and international actors. Over the last year, MSF also addressed the needs of internally displaced people by distributing food to the most vulnerable families at the Istiqol Resettlement Center until May 2003. 🌿 17 🌿 105

Yemen

After 12 years of work in Yemen, MSF finished its programs in the country in March 2003. This closure was planned as the end of MSF's 5-year commitment to the Ministry of Health, covering the period when Yemen was implementing reform of its health system. Since 1997, MSF had provided primary health care and medicines for the destitute in the southern city of Aden. This program was set up to help mitigate the effects of the government's move to a cost-recovery (paying) health service, which left many of the country's poorest unable to afford health care. In 2001, MSF rechanneled resources to support a polyclinic and four dispensaries in Little Aden, on the outskirts of the city. A special emphasis was put on improving the quality of external consultations and mother-and-child health care. 🌿 3 🌿 10

Zambia

MSF continues to focus on HIV/AIDS and refugee health in Zambia. An integrated HIV/AIDS care project in Nchelenge includes education, voluntary counseling and testing, care for opportunistic infections and prevention of mother-to-child transmission, with plans to provide patients there with antiretroviral therapy by the end of 2003. MSF is also closely monitoring the repatriation process and nutritional situation of refugees from Angola. In Maheba refugee camp near Solwezi, MSF supports a dispensary and the government clinic; the clinic is the emergency referral facility for the entire camp of 50,000 mostly Angolan refugees. Malaria and tuberculosis are two key pathologies in the camp. 🌿 21 🌿 149

Zimbabwe

MSF activities are centered around care and treatment for people with HIV/AIDS and response to malnutrition in Zimbabwe, where over 33% of adults (15-49 years old) are HIV-positive and millions of people need food aid. In Bulawayo, the second-largest city, MSF runs a program that works not only to prevent transmission of HIV from mothers to children, but also aims to provide ARV treatment to other family members – fathers, brothers and sisters – who are HIV-positive. In August 2002, MSF set up a therapeutic feeding center in Tsholostho (Matabeleland North). In February 2003, MSF set up therapeutic feeding centers for children with severe malnutrition in five mission hospitals in Masvingo province in the south. In Manicaland province in eastern Zimbabwe, MSF has been treating malnutrition at Murambinda hospital since October 2002. 🌿 17 🌿 38

Médecins Sans Frontières is a private, non-profit, international organization. It is made up of 18 national sections in Australia, Austria, Belgium, Canada, Denmark, France, Germany, Holland, Hong Kong Special Administrative Region of China, Italy, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland, the United Kingdom and the United States, with an international office in Brussels.

Each section of MSF publishes annual, audited financial statements according to its national accounting policies, legislation and auditing rules. Copies of these may be requested from each section.

Based on these audited national statements, the figures presented here provide an estimate of MSF's finances on an international level. These combined international figures have not been audited and are therefore not certified. The figures are for the 2002 calendar year; the Activity Report itself covers the period August 2002 to July 2003. The 2001 figures have been restated according to our new international accounting practices. All amounts are in millions of euros.



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An MSF anesthesiologist holds a baby in the pediatric ward of the hospital in Bouaké, Côte d'Ivoire.

Income

	2002		2001	
	In M €	In %	In M €	In %
Private Income	295.6	80.8%	279.4	81.0%
Public Institutional ECHO* & EU	24.6	6.7%	22.4	6.5%
Public Institutional Other	45.5	12.5%	43.0	12.5%
Total Income	365.7	100.0%	344.8	100.0%

As part of our effort to guarantee our independence and strengthen our link with society, we have been striving to maintain a high level of private income. In 2002, as in 2001, 81% of MSF's income came from private sources. Over 2.2 million individual donors and private funders worldwide made this possible.

Additional public institutional agencies include, among others, the governments of Belgium, Denmark, Luxembourg, the Netherlands, Norway, Spain, Sweden and the United Kingdom.

* European Community Humanitarian Office

How was the money spent?

	2002		2001	
	In M €	In %	In M €	In %
Operations	-256.2	76.0%	-259.5	77.7%
Témoignage	-19.2	5.7%	-17.6	5.3%
Total Social Mission	-275.4	81.7%	-277.1	83.0%
Fundraising	-39.7	11.8%	-36.8	11.0%
Management, general & administration	-21.8	6.5%	-19.9	6.0%
Total Expenditure	-336.9	100.0%	-334	100.0%
Net exchange gains & losses (realized and unrealized)	-6.8		+1.0	
Surplus/(deficit)	22.0		12.0	

Project expenses per continent



Facts and Figures

HR Statistics

	2002		2001	
International departures (full year):	2,950	100%	2,895	100%
Medical pool	837	28%	727	25%
Nurses & other paramedical pool	897	31%	933	32%
Non-medical pool	1,216	41%	1,235	43%
First time departures (full year):	915	*31%	984	*34%
Other HR statistics (average):	16,623		14,925	
Fieldposts	1,714		1,605	
National staff	14,909		13,320	

*of the international departures

Where was the money spent? (Program expenses more than 3 million euros)

Countries/Regions	In M €
Angola	29.6
Democratic Republic of the Congo	15.7
Sudan	15.5
Afghanistan	14.1
Sierra Leone	8.7
Burundi	7.3
Chechnya/Dagestan/Ingushetia	7.0
Kenya	6.5
Ethiopia	6.2
Liberia	5.6
Republic of Congo	5.1
Guinea	4.9
Russia*	4.2
Colombia	3.4
Somalia	3.2
Chad	3.2
Cambodia	3.1
Malawi	3.1
Thailand	3.1

* Excluding the republics of Chechnya, Dagestan and Ingushetia

Balance sheet (year-end financial position)

	2002	2001
	In M €	In M €
Non-current assets	32	25
Current assets	48	56
Cash & equivalents	173	160
Total assets	253	241
<i>Permanently restricted funds</i>	<i>4</i>	<i>3</i>
<i>Unrestricted funds</i>	<i>199</i>	<i>187</i>
Total retained earnings and equities	203	190
Non-current liabilities	6	4
Current liabilities	41	41
Unspent temporarily restricted funds	3	6
Total liabilities and retained earnings	253	241

Permanently restricted funds may be capital funds, where the assets are required by the donors to be invested, or retained for actual use, rather than expended, or they may be the minimum compulsory level of retained earnings to be maintained by some of the sections.

Unrestricted funds are unspent donor non-designated funds expendable at the discretion of MSF's trustees in furtherance of our social mission. MSF's retained earnings have been built up over the years by surpluses of income over expenses. As of the end of 2002, their available part (the unrestricted funds) represented 7.1 months of activity. The purpose of maintaining retained earnings is to meet the following needs: future major humanitarian emergencies for which sufficient funding cannot be obtained, and/or a sudden drop of private and/or public institutional funding, and the sustainability of long-term programs (eg, ARV treatment programs), as well as the pre-financing of operations to be funded by upcoming public funding campaigns and/or by public institutional funding.

The unspent temporarily restricted funds are unspent donor-designated funds, which will be strictly spent by MSF in accordance with the donors' desire (eg, specific countries or types of interventions) as needs arise.

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An MSF staff member has a confidential moment with a woman in Arua, Uganda. This Ugandan woman, already on antiretroviral (ARV) treatment for AIDS through MSF's program in Arua, was worried about a very sick friend of hers who had only recently begun ARV treatment at the clinic.

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A patient shares a light moment with an MSF staff member in the midst of civil war in Côte d'Ivoire in February 2003.

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page 15
A woman holds her child at an MSF feeding center in Kitshanga, Democratic Republic of the Congo, in October 2001.



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page 41
Dr. Grégoire Gansou, a psychologist with MSF's comprehensive rape care program in Brazzaville, Republic of Congo, listens to a patient.



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Thousands of people crowd into a camp for the displaced in the city of Bunia, Democratic Republic of the Congo, in June 2003. Inadequate humanitarian assistance in the camp and the lack of formal registration meant that people lacked minimal supplies and were going hungry. In addition, the camp was not protected: many kinds of violence, including rape, occurred every day.



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A farmer in Chiradzulu district, Malawi, sows his fields in November 2002, just before the rainy season. Access to antiretroviral treatment means that farmers, teachers and others who have HIV/AIDS can feel better, go back to work and support their families.



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Too weak to stand, or to be transported to a health post, this young man stares emptily at the camera in the Yahuma region of Democratic Republic of the Congo, in February 2003. Malnutrition haunts many corners of the country; people like this young man are called locally "living skeletons."



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Antiretroviral medications are dispensed to a young man in Surin, Thailand. Since starting treatment several weeks prior to this photo, he already feels much better.



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A woman holds her severely malnourished child at Salala refugee camp, Bong county, Liberia, in September 2003.



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At the height of Burundi's 2000-2001 malaria epidemic, a mother sits with her malaria-stricken child at a therapeutic feeding center in Karusi, Burundi.



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At a mobile clinic, an MSF doctor examines a woman displaced by civil war in Bouassa Kouamekro, Côte d'Ivoire, in January 2003. Between October 2002 and May 2003, MSF teams near the front lines in Côte d'Ivoire carried out more than 90,000 medical consultations.



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A man watches over his dying grandchild in the pediatric ward at Capembe demobilization camp, Angola, in October 2002. The hospital has no money and no facilities; there is no roof; there are no medicines.



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A view of the Bart tent camp in Ingushetia, May 2002. Displaced Chechens sheltering in camps like this one are facing increasing pressure to return to Chechnya, despite the ongoing conflict there.



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A young boy barely has enough energy to cling to his grandmother's back at this MSF therapeutic feeding center in Angola. Both the boy's parents are dead. After the April 2002 ceasefire, hundreds of thousands of people were revealed to be starving in previously inaccessible areas of the country.



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Defiant wooden silhouettes are a memorable hallmark of the *Tika Bika Viol!* campaign against rape and sexual violence in Brazzaville, Republic of Congo, in February 2003.

