





MEDECINS SANS FRONTIERES

MSF ACTIVITY REPORT 2000-2001

Nobel Peace Prize 1999

The Charter of Médecins Sans Frontières

Médecins Sans Frontières is a private international organization. Most of its members are doctors and health workers, but many other support professions contribute to MSF's smooth functioning. All of them agree to honor the following principles:

Médecins Sans Frontières offers assistance to populations in distress, to victims of natural or man-made disasters, and to victims of armed conflict without discrimination and irrespective of race, religion, creed, or political affiliation.

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

Médecins Sans Frontières' volunteers undertake to respect their professional code of ethics and to maintain complete independence from all political, economic, and religious powers.

As volunteers, members are aware of the risks and dangers of the missions they undertake, and have no right to compensation for themselves or their beneficiaries other than that which Médecins Sans Frontières is able to afford them.

Cover photos (left to right): **Chechnya** Eddy van Wessel; **South Africa** Christian Schwetz; **Colombia** Gervasio Sanchez; **Pakistan** RobertKnoth

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Children in the Buratino collective center in Khazaviurt, Dagestan, home to 1,000 displaced people from Chechnya. MSF provides medical aid at the center.

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MSF missions around the world



© Robert Knoth

In February 2001, flames engulf several dwellings in the Katkama refugee camp, in Guinea. Local residents, opposed to the presence of the refugees, set the buildings on fire.

The Year in Review

People suffering because of war, violence, exclusion, displacement, famine, and neglected diseases have been at the center of the work of Médecins Sans Frontières since the beginning. In December 2001, MSF marks 30 years providing medical aid that is matched by a commitment to witness, debate, and reflect critically on our action and the political failures we confront: weak protection for those in need, especially refugees and the displaced; inability to reach people in danger; lack of medicines for the diseases of the poorest; the dangerous advance of the military into the field of humanitarian aid; and the list goes on….

This year marks the 50th anniversary of the 1951 Refugee Convention, which was created to define protection and rights of those who flee their countries because of insecurity and persecution. In 2001, the plight of refugees and displaced people has animated debate in many international forums. However, the talk hardly disguises the fact that practical action on the refugee "problem" has never been weaker. In a year when people talk of reaffirming the Refugee Convention, never has it been so ignored.

In West Africa, tens of thousands of refugees were trapped in a particularly exposed and dangerous situation in late 2000 and early 2001. In Pakistan, Afghans linger in squalor in overcrowded camps. In Italy, would-be asylum seekers are turned away before setting foot on Italian soil….

The political responses reflect not the obligation to offer sanctuary and protection but rather a desire to contain would-be refugees where they are – no matter how dangerous that place is. Instead of taking responsibility for protecting those who feel forced to flee their homelands, many western countries are protecting themselves. These policies of containment and non-asylum threaten the basic right of people to flee and be given refuge.

As people are being denied refuge, aid organizations are finding it increasingly difficult, if not impossible in some cases, to reach people in distress. This lack of access is strangling humanitarian action.

The reality for many displaced people is far from the picture of masses of people grouped in camps. Displaced people are increasingly seeking refuge outside of camps, for example in Ingushetia, where many dwell in homes or collective centers; in Colombia, where the population is displaced, one person, one family, one village at a time; in Angola, where many people live in areas beyond the provincial cities, where no organization can go. Our operational challenge is reaching these people, understanding their circumstances, assisting them.

Other challenges are also rooted in the field, in daily encounters with patients. As doctors, we can't tell our patients "Go home. We don't have medicine to give you." Yet the reality is that drugs people need often don't exist, or are too expensive, or don't work.

MSF has struggled to make access to medicines a reality. Working within a broader coalition of concerned organizations, we gathered nearly 300,000 signatures from ordinary people worldwide on a petition to press a group of pharmaceutical companies to withdraw a lawsuit against the South African government. The lawsuit would have restricted the country's options for obtaining necessary medicines. The companies dropped the case.

We were part of a global push to lower the cost of antiretrovirals (ARVs) for treating AIDS. Prices have dropped dramatically over the last year. As of October 2001, MSF was able to introduce life-prolonging ARV treatment programs in a number of developing countries. Nevertheless, there is still a lot to be done.

ARV treatment can be effective in developing countries and is essential in the battle against AIDS. It must be given the same support as prevention.

We want to see the successes already underway in the fight for AIDS drugs echoed for other neglected diseases. The human cost of the market and public policy failure to provide lifesaving drugs is etched on the faces of the millions of mostly poor people who are suffering from sleeping sickness, Chagas disease, malaria, and leishmaniasis – diseases for which effective new treatments are not even being developed. We will not stand by and see the ranks of the sick condemned to death by "unprofitable" diseases.

One of these "unprofitable" diseases, malaria, caused one of the largest emergencies we faced over the last year. The disease devastated Burundi, with several million cases counted among a population of 6.5 million people. But we also faced other disasters, outbreaks, and catastrophes, such as earthquakes in El Salvador, India, and Peru. Ebola resurfaced in Uganda. Malnutrition was ever-present in many countries. Alongside the emergencies, in over 80 countries in Africa, Asia, Europe, and Latin America we continued ongoing projects devoted to primary care, mother and child health, hospital support, and staff training.

Assistance is often not enough, or our access is prevented. When people are threatened and the space for providing aid disappears, we must speak out. Our report "The Politics of Terror," issued in November 2000, used firsthand testimony to expose the ongoing climate of fear in Chechnya and the consequences of that war on the lives of ordinary people. Also in November 2000, we released a report entitled "Angola: Behind the façade of normalization – manipulation, violence, and abandoned populations." Excerpts of both documents are included in this report. Meanwhile, the difficulties of providing aid were brought home to us with the kidnapping of two volunteers, in Chechnya and Colombia. Even if both were safely and unconditionally released, these incidents reflect a climate of increasing threats to independent aid in many places.

As we go to press, the brutal attack on civilians in the United States is fresh in our minds. Politicians and their military advisors are now defining new forms of war, which will affect the way aid is carried out in times of difficulty.

As events unfold, the fate of millions of Afghans in and around Afghanistan continues to concern us deeply. Like other aid organizations, we were forced to evacuate our international staff from areas of the country under Taleban control in mid-September 2001; work continued under local staff. International teams began to return to those areas in mid-November. Our first priority was always to return to the people in need.

We have emphatically denounced any kind of military intervention that calls itself "humanitarian." It can be regarded by opponents as an act of war, and aid workers can be denied access to people in need. The needs of the people, and not political objectives, should shape the aid that is given. As a humanitarian organization, we can and must push for this because we see independent assistance as vital for Afghans, and millions of others, in distress. We are militants for independence.

In this sense, our work would not have been possible without the support of the 2.5 million private funders and individual donors around the world who placed their confidence in us in 2000, helping ensure that 79% of our income came from private sources. This matters particularly to MSF, because financial independence from governments and institutions is essential to our freedom to act and to speak. But our responsibility is not only financial. For those who support us, and for the people we try to help, we are also committed to maintaining independence in analysis, spirit, and action.

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



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This woman is crying as she trudges past Boudou camp, in Guinea. Because of insecurity and fighting in the area, she and her husband are trying to get away from the Kolomba refugee camp on the Sierra Leone border and make their way to Massakoundou, further inside Guinea.

Protection for, or protection from?

A call for just treatment of refugees and asylum seekers

By Liesbeth Schockaert
MSF Research Center, Brussels, Belgium

| At night on a beach in Tarifa, Spain, people wash ashore in unsafe boats. MSF provides basic first aid and urges the government to take up its responsibility toward the arrivals. In Brindisi, Italy, MSF visits the local detention center and finds 20 Tamils with an expulsion order in hand, under the illusion that they had received a residence permit. In Brussels, asylum seekers shiver in the December cold, waiting their turn to apply for asylum as the Belgian government takes days or even weeks to accept applications; MSF provides aid and also shelters refugees in its office. Every day MSF is helping people without documents and without legal status in their access to health care, because regardless of their legal status they are human beings. Out of the world's estimated 14.5 million refugees and asylum seekers, only a little over 500,000 are in the European Union, compared to over three million in Africa and six million in the Middle East.

| For those who do knock on the doors of Europe, the reaction of European states is increasingly alarming. EU countries have put repressive policies into practice, including non-arrival policies, diversion mechanisms, a restrictive interpretation of the 1951 Refugee Convention, deterrent measures, and a failure to share global responsibility. Even if only a minority of asylum seekers seeks and finds asylum in the developed world (most of the people stay within their region of origin), the European states seem to protect themselves from refugees rather than protecting the refugees themselves.

| Ultimately, the repressive measures now in place in Europe jeopardize the well-being of asylum seekers, refugees, and undocumented migrants, erode refugee protection standards, and seek to displace the refugee problem to other parts of the world.

| MSF has increased some of its operations in Europe in part due to the consequences of the European states' repressive policies. MSF operations in Spain, Italy, Belgium, and France have asylum seekers and undocumented migrants as the main target population. The assistance addresses the exclusion of these populations, with teams giving first aid upon arrival, enabling people's access to national health care, and tackling the social, psychological, and legal problems related to their situation. MSF brings immediate help to people who most require it, and at the same time advocates on their behalf.

| MSF witnesses both the causes of these movements (war, famine, and deteriorating socio-economic conditions) and their consequences. MSF is present and working in countries of origin and transit, as well as in some countries of final destination: MSF is both working with and for Afghans in Afghanistan, Afghan refugees in Iran and Pakistan, and Afghans arriving in Italy on transit to the UK, Belgium, or other European States. MSF sees firsthand the conditions that are causing people to flee Afghanistan, what life can be like for Afghans in Pakistan or Iran, as well as how they are received by European states. During the Kosovo crisis, MSF was present in refugee camps in Albania and Macedonia – and also aided refugees in Italy and Belgium.

| When we talk of repressive policies, we are referring to border controls and interception measures, whereby governments try to limit the movement of unwanted people into their territories. These range from prohibitive visa policies, carrier sanctions (fines against transport companies who carry undocumented migrants), and sending airline and immigration officers to check documents abroad and possibly refuse flight, to the construction of a two-meter high fence around the Spanish enclave Melilla in order to keep out people who might be trying to come in from neighboring Morocco or sub-Saharan countries.

| The cumulative result is the privatization of border control, a failure to distinguish people needing protection, and increased irregular migration. As it becomes more difficult to cross borders legally, higher risks are taken to cross them illegally. This results in an increased death toll during flight.

| Diversion policies are also put in place to return asylum seekers to safe "third" countries (i.e. transit countries) or countries of origin considered to be safe. For example, Albanian nationals arriving without papers in the port of Brindisi, Italy, will be returned immediately. They do not even have a chance to get off the ship and touch Italian soil, much less put in an application for asylum. The same is true for Moroccans arriving in Spain. Such a policy can lead to direct or indirect repatriation or chain deportation back through countries such as Pakistan, Ghana, Albania, Sri Lanka, Slovakia, Russia, and Morocco – when there is no certainty that the deported person will not end up in the country of origin again, possibly against his will.

| Furthermore, industrialized countries increasingly interpret the 1951 Refugee Convention "à la lettre." Some countries even interpret the Convention in a way that allows them to exclude people who have been persecuted by non-state actors. A whole range of other deterrence measures includes detaining undocumented migrants upon arrival (which can be a violation of Article 31 of the Convention) and restricting their access to social services. A person's access to medical care may depend on what stage of the asylum procedure he or she is in.

| To compound the problem, funding for the United Nations High Commissioner for Refugees (UNHCR) and the number of beneficiaries of resettlement programs have been drastically cut. In 1994, UNHCR received contributions of a little over US$1 billion. This declined to $852 million in 2000. The European Commission contributed $237 million in 1994; by 2000 this had dropped to $41 million, and in 2001 it was a paltry $11.5 million as of May (individual countries also contribute some money separately). All this despite a steady increase in the number of refugees and displaced people.

| European countries have refused to take up their part of global responsibility sharing, in terms of money and action. While Europe is shutting its doors, large numbers of people continue to seek refuge elsewhere in the world. Countries such as Iran, Pakistan, Kenya, and Guinea – to name only a few – are expected to host a large number of refugees, sometimes for decades. Policies toward "reception in the region" are high on the European political agenda. Now some of these third countries are citing European policies as reasons for shutting their own borders. This evolution is aggravated by the growing acceptance of xenophobic arguments in European political debates.

| MSF is publicly asking that European countries receive asylum seekers and respect all their relevant rights as well as those of irregular migrants – not least their right to health care. At the same time MSF is working to highlight some of the causes and conditions of migration and asylum. Through position papers, press conferences, and active advocacy toward politicians, MSF hopes to pressure authorities to respect the relevant national and international standards (humanitarian, refugee, and human rights law) for these populations. MSF programs in European countries also incorporate efforts to sensitize the general public, through exhibitions and information campaigns, about the plight of asylum seekers, refugees, and undocumented migrants.

| MSF is seeking protection for refugees and asylum seekers. Not protection from.



After coming ashore in Tarifa, on Spain's southern coast, this man is photographed by police.

© Juan Carlos Tomasi

Using the law of war to protect the displaced

By Françoise Bouchet-Saulnier
MSF Legal Director and Director of Research at the MSF Foundation, Paris, France

Marking the 50th anniversary of the United Nations Convention on Refugees, the year 2001 saw a flurry of intellectual and diplomatic activity concerning refugees and displaced people, who now number 14.5 million and 25 million worldwide, respectively.

As the numbers of displaced have grown, MSF and other humanitarian organizations have struggled to bring appropriate relief and assistance to those who need it. While it has been possible to bring material assistance to displaced people, it has become appallingly clear that they are not receiving international protection. The reason for this is two-fold. The term "internally displaced person" (IDP) is sometimes intentionally used to avoid recognizing people as victims of war. And people are increasingly subjected to geographic containment inside their country, thus denied the right to flee across borders when they find themselves in situations of danger.

There has been talk of devising a new law covering displaced persons, and granting a special mandate covering these people to the UNHCR or another UN agency. However, while a new law may seem to be an exciting sign of improvement for displaced people, in reality the legal framework for protecting them does not need to be invented. In the many cases where displacement occurs in a context of armed conflict or as a result of it, the legal framework of protection is already widely codified in humanitarian law defining and covering displaced persons as victims of war.

The 1949 Geneva Conventions and two additional 1977 protocols provide for specific international rights and duties with regard to assisting and protecting victims of armed conflict. They also give humanitarian organizations a mandate to implement and monitor these specific rights through their relief activities. If people are displaced because of internal or international armed conflict, they are protected by the law of war. Providing effective care for IDPs relies on the international community's ability to admit the existence of conflict, and therefore call IDPs victims of war.

Take the example of Chechnya. The people who fled the conflict in Chechnya, one republic in the Russian Federation, into Ingushetia, another Russian republic, are not considered to be refugees because there is no international border between these two territories. The fleeing Chechens cannot benefit from the provisions of humanitarian law because the Russian government refuses to recognize the situation as one of armed conflict, choosing instead to speak of an anti-terrorist operation. The international community is reluctant to challenge this, so it relies on the vague term IDP to cover the people who are victims of these operations. But being called an internally displaced person does not give Chechen refugees or displaced any protection from deprivation, arrest, or repatriation. Neither does it give them any right to receive independent assistance. NGOs have to negotiate endlessly with the Russian authorities over who will evaluate the need for assistance and control its distribution. The Chechnya example is echoed in Sudan, Burundi, the former Yugoslavia, and many other places.

The only international right to protection and assistance these people have comes through recognition of the internal armed conflict going on in their countries. This would qualify them as victims of war and give them the right to be assisted by impartial humanitarian organizations. As war victims, they could not be forcibly regrouped, displaced for reasons related to the conflict, or repatriated until the conflict had stopped.

In peacetime, care of the displaced, for example people displaced by drought, is governed only by the rules of national solidarity and international cooperation. Protection is left to national authorities, who remain bound by international human rights standards.

The United Nations Refugee Convention of 1951 determines the legal status of refugees, who have fled persecution at home by crossing into another country. The United Nations High Commissioner for Refugees (UNHCR) has a general mandate for applying the Convention. Refugees no longer benefit from the legal protection of their own countries, because they have fled.

Displaced people have also fled, but they have not crossed an international frontier. Displaced people remain under the law and authority of their own country and can only demand the respect of their most basic human rights.

However, most situations of displacement broadly coincide with situations of chronic internal or international conflicts. Any move to protect displaced persons in such situations should be based on a rigorous use of refugee law and the law of armed conflict.

In recent years, UN actions to assist displaced populations have almost never referred to the law of armed conflict. Various agencies of the UN have led operations assisting the displaced without stressing the existence of armed conflict and its legal consequences. The memoranda of understanding for these operations put more emphasis on governmental authority than on the independence of humanitarian actors. Let us recall: UNICEF in Sudan, the UNHCR in the former Yugoslavia, and the World Food Program in Burundi.

The right to flee and territorial asylum

The protection of refugees and displaced persons is intimately linked. The right of any individual to flee his country when his life and his safety are at risk constitutes the ultimate guarantee of protection, enshrined since World War II in all international texts relating to human rights, law of conflict, and refugee legislation. In reality, the protection of refugees has suffered tragic setbacks over the past few years.

The UNHCR's mandate to assist and protect refugees allows it to provide both material aid and legal protection. This international material aid is necessary to assist people who have lost everything in flight. It is also necessary to share the financial burden of assistance among all countries. Legal protection is just as essential, because these people are no longer entitled to the rights they had in their own country. The 1951 Convention guarantees that even if people are not recognized as refugees according to the convention's definition, they cannot be repatriated unless there is no threat to their life and safety. This fundamental principle of non-expulsion and non-return ("*non-refoulement*") sets out the minimum rights of refugees to remain in the host country. Throughout the Cold War period, this principle of *non-refoulement* sustained the existence of refugee camps that were tolerated by the host countries.

This tolerance, which was more political than humanitarian, has in recent years suddenly disappeared in many countries, radically changing the context in which the refugees were received. Borders are constantly being closed. Obligatory or forced repatriation leaves little hope to defend any kind of right to refuge for a growing number of individuals. Faced with this development, the UN and many states have invoked "realism" as the reason for abandoning the principles of asylum and *non-refoulement*. Humanitarian organizations have also been called upon to abandon the principles surrounding refugee legislation in order to adopt the pragmatic attitude new situations demand. The number of people displaced inside their countries has grown accordingly, and might even be seen as a result of the decreasing willingness to accept refugees or asylum seekers in many countries.



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Southern Sudan: A "refugee-like" situation?

It is important to note that the term "internally displaced person" came into use internationally during this time, beginning with the war in the former Yugoslavia. This war coincided with the increasing reluctance of European countries to play host within their borders to refugees fleeing the conflict. On that occasion, the UNHCR mandate relating to displaced people was extended to an unequalled degree. In 1992, a special representative of the UN Secretary General was appointed to examine the situation of IDPs and compile the rules of international law applicable to them. In 1998, this mission became more operational in scope, with the creation of a special adviser for internally displaced persons within the Bureau for the Coordination of Humanitarian Affairs of the UN. This broadening UNHCR mandate was extended on a case-by-case basis to allow material assistance to the displaced in cases qualified as being "refugee-like situations." However, this terminology has turned out to be deceptive.

Refugee-like situation: a deceptive illusion

It is true that a refugee camp closely resembles a camp for the displaced. In both instances, people have fled their homes and require material assistance including shelter, food, and access to health care. These similarities may have given the false impression that the operational response for refugees and displaced people could be the same.

The resemblance sadly stops at material needs and assistance, however, because, as far as protection is concerned, displaced persons do not have the benefit of the physical screen against violence that a border may provide.

Using the concept of "refugee-like situation" as a basis for assisting IDPs puts them in a legal void where there is no right to or guarantee of international protection: they are not legally considered to be "war victims," so they do not come under the 1949 Geneva Conventions. They are not "refugees," and so miss out on the protections afforded by the 1951 Convention.

While a refugee has found refuge, a displaced person remains at the center of turmoil. Displaced people remain within their country, under the control and the laws of their national authorities, and at the mercy of the threats and violence that may be the very reason for their flight.

In 1995, in Srebrenica – a "safe haven" during the war in the former Yugoslavia – MSF was able to provide material medical assistance, but could do nothing when civilians were rounded up and executed. The agencies charged with protecting civilians were unable to do so. The same year in Kibeho, a camp for the displaced run by the UN in Rwanda, nothing was done to oppose or denounce the massacre of displaced persons by the Rwandan army in an attempt to close down the camp. The massacres of Srebrenica in ex-Yugoslavia and Kibeho in Rwanda are two tragic examples showing that international protection for displaced persons against violence committed by their own country's armed forces is illusory.

Despite huge amounts of humanitarian aid, from Burundi to the former Yugoslavia, via Sierra Leone, Sudan, and Chechnya, material assistance alone has not been able to limit violence to these populations to "acceptable" levels.

So, while extending the UNHCR mandate has made it possible to assist displaced persons, it has not resolved the basic problem of their protection. Although the international law of armed conflict establishes the framework for this protection, its implementation by UN agencies has been limited.

Under cover of an institutional and legal "solution," such as the extension of the UNHCR mandate, lurks the risk of sacrificing the right of these people to flee. Equating refugee and "refugee-like situations" simply legitimizes the closing of borders already undertaken by many countries. In a number of cases, the existence of internally displaced persons is a direct consequence of national and international policies that actively discourage or even prevent people from fleeing their own countries and seeking asylum beyond their borders. Such practices range from closing borders to forcibly repatriating people. This happened in 1994-1996 in Africa's Great Lakes area, and is happening right now as all Afghanistan's neighbors seal their borders.

The case of Afghanistan is a good illustration of the danger. No one can deny that this country has been in a state of civil war for 20 years and that this situation is now compounded by famine and armed confrontation with the United States. However, faced with the movements of people, all of the surrounding countries have closed their borders to those attempting to flee. Iran has even proposed creating refugee camps inside Afghanistan, demonstrating that "containment" is the real political rationale behind assistance *in situ* (in place) to displaced populations.

The reasons for the reticence of UN agencies to refer to the law of war go much deeper than a simple lack of expertise about this specific body of international law. In many countries in conflict, the UN is in fact charged with a double mission: a humanitarian mission and a mission to maintain or restore peace. Within this context, UN agencies prefer to stress the existence of peace accords, however fragile, patchy, and illusory they may be, rather than the ongoing effects of the conflict. This tendency is in keeping with the history of the organization. In 1949, already, the UN decided not to participate in the drafting of the Geneva Conventions on the law of armed conflict to better concentrate on its peace mission.

International protection for internally displaced persons will not miraculously appear by creating a new law, nor by designating a specialized agency in charge of coordination of assistance. The challenge of implementing the law of armed conflict with respect to displace people requires a comprehensive commitment from UN agencies. It also requires humanitarian NGOs to change their operational habits. They should not only concentrate on treating the effects of displacement by giving assistance. They should be able to question and investigate the causes of displacement in order to make sure their assistance does not facilitate the perpetration of crimes and violence against these people. The humanitarian actor has to ask two questions about people displaced within their own country: Why are they obliged to move from their home? Why are they displaced inside their country rather than fleeing the country altogether?

Moreover, in some situations, population displacements are not a secondary effect of conflict but an integral part of military strategies aimed at controlling the population, the territory and its wealth, or controlling supplies and aid. This control leads to forcing the population to flee in order to free territory, directing and controlling its movements in order to obtain military advantage, or grouping people together to act as a human shield, a bargaining chip, a manpower tank, or even as bait for humanitarian aid.

This method of war has been regulated since 1949 by the international law of armed conflict, which forbids such forced movements and qualifies them as war crimes. There is a difference between displacement indirectly caused by conflict and displacement that is an integral part of the military strategy. Since the adoption of the statute of the international permanent criminal court in Rome in 1998, the latter is considered a war crime and a crime against humanity, and falls under the jurisdiction of this international tribunal. It is thus important for NGOs and international humanitarian actors to be able to distinguish between situations that are normal consequences of armed conflict and those that are war crimes.

Differing from human rights law, the law of armed conflict includes the operational responsibility of humanitarian organizations as a way and means to limit violence and crimes against people in danger. This operational responsibility, shouldered by the UN and NGOs, is the most direct way to protect internally displaced people.

For more information, consult the "Dictionnaire Pratique du Droit Humanitaire," (Practical Guide to Humanitarian Law) by Françoise Bouchet-Saulnier (Editions La Découverte, 2000). Available in French, Spanish, and English.

Colombia

The human face of conflict

Photos by Gervasio Sanchez
Text by Amaia Esparza

In Colombia, the civilian population is victim of a protracted conflict that tramples on their most basic human rights.There are no headline-grabbing mass movements of hundreds of thousands of people to draw international attention and condemnation. Yet people are displaced just the same, one family, one group, one community at a time. Colombia has the tragic record of having one of the largest displaced populations in the world. All are victims of a conflict that has been raging for 50 years.



At a rural health post, farmers wait their turn

Bocas de San Francisco

MSF seeks to bring basic medical aid to civilians, in the places where they live, and in the places where they are often forced to flee. Mobile medical brigades provide primary care to people in rural areas isolated due to the conflict and to displaced and excluded people in urban areas. A medical and psychological rehabilitation program benefits young victims of urban violence.

A conflict with deep roots

Today's fighting has its roots in *La Violencia*, a time of civil strife, social violence, and bloodbath between political parties fighting for political supremacy. It is estimated that the conflict, which lasted from the late 1940s to the late 1950s, caused around 200,000 deaths. Nearly two million people fled the countryside between 1951 and 1964.
La Violencia and the bitterness it sowed spawned various guerrilla movements and eventually the *autodefensas*, also known as paramilitaries. Today, armed actors from all these groups, and the State, are engaged in an undeclared civil war that is bleeding Colombia dry. It is a merciless dispute for territorial control in a lush, mountainous country rich in oil, minerals, history and culture and, in the latest decades, coca plantations.

War in the countryside

Fighting takes place mainly in the countryside, and civilians are its principal victims. Forced displacement as a war strategy and government absence from a huge part of the country mean that the civilian population is often completely abandoned, trapped in the crossfire, vulnerable to abuse by all armed actors. The goal of weakening the social base of the "other side" leads to starvation blockades, extortion, threats, kidnappings, massacres, public executions, and indiscriminate attacks.
In many rural villages, basic services are rare. With an attack against health staff every 36 hours and a health worker killed every 15 days (according to the Red Cross), many health posts in rural areas are simply abandoned.
In such areas, MSF is often the only source of medical care. Medical brigades travel by car, boat, or donkey to reach the most isolated communities. A school or any other public house can quickly become a health post. Behind a sheet that acts as a curtain in makeshift consultation rooms, MSF teams provide primary health care and basic drugs to a population that would, otherwise, have no chance to visit a doctor.

A finger prick to test for malaria
Puerto Bolivar



Health education, puppet drama
Puerto Bolivar

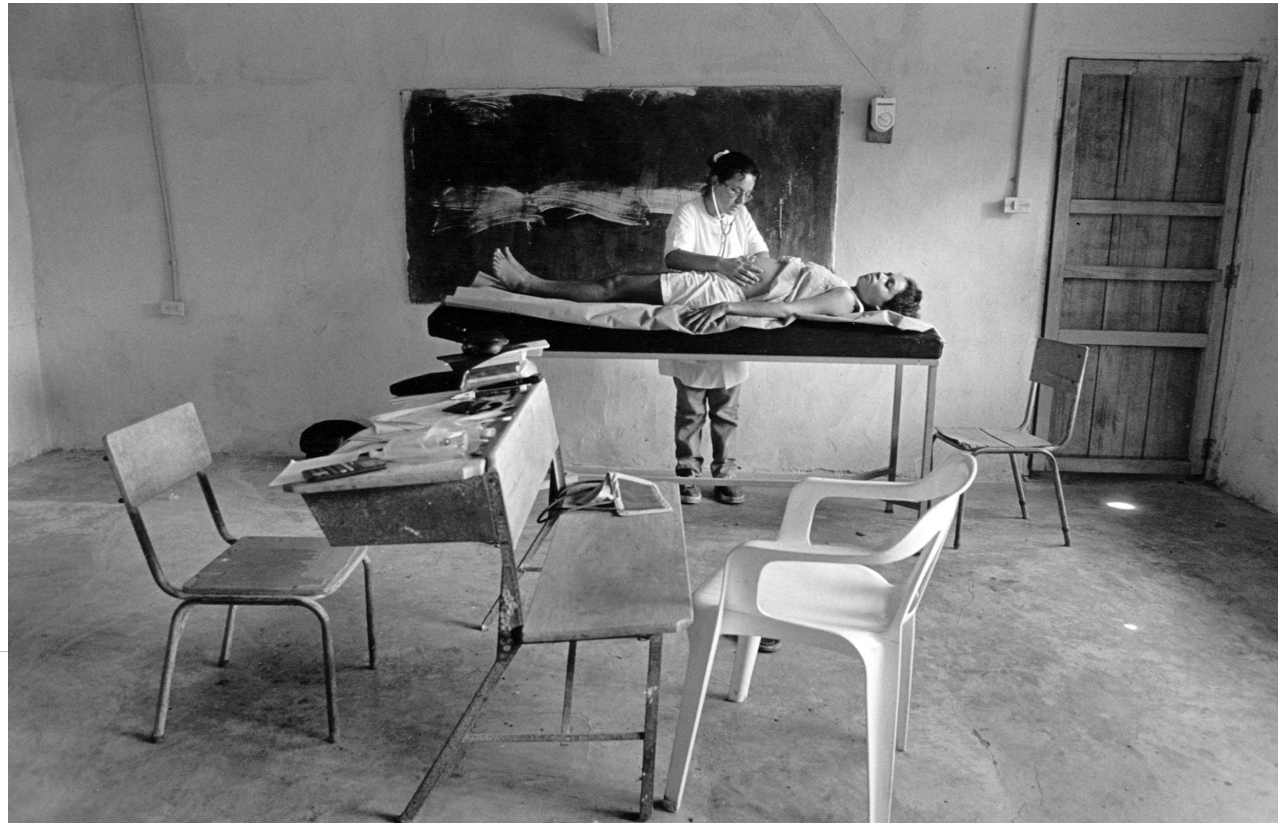




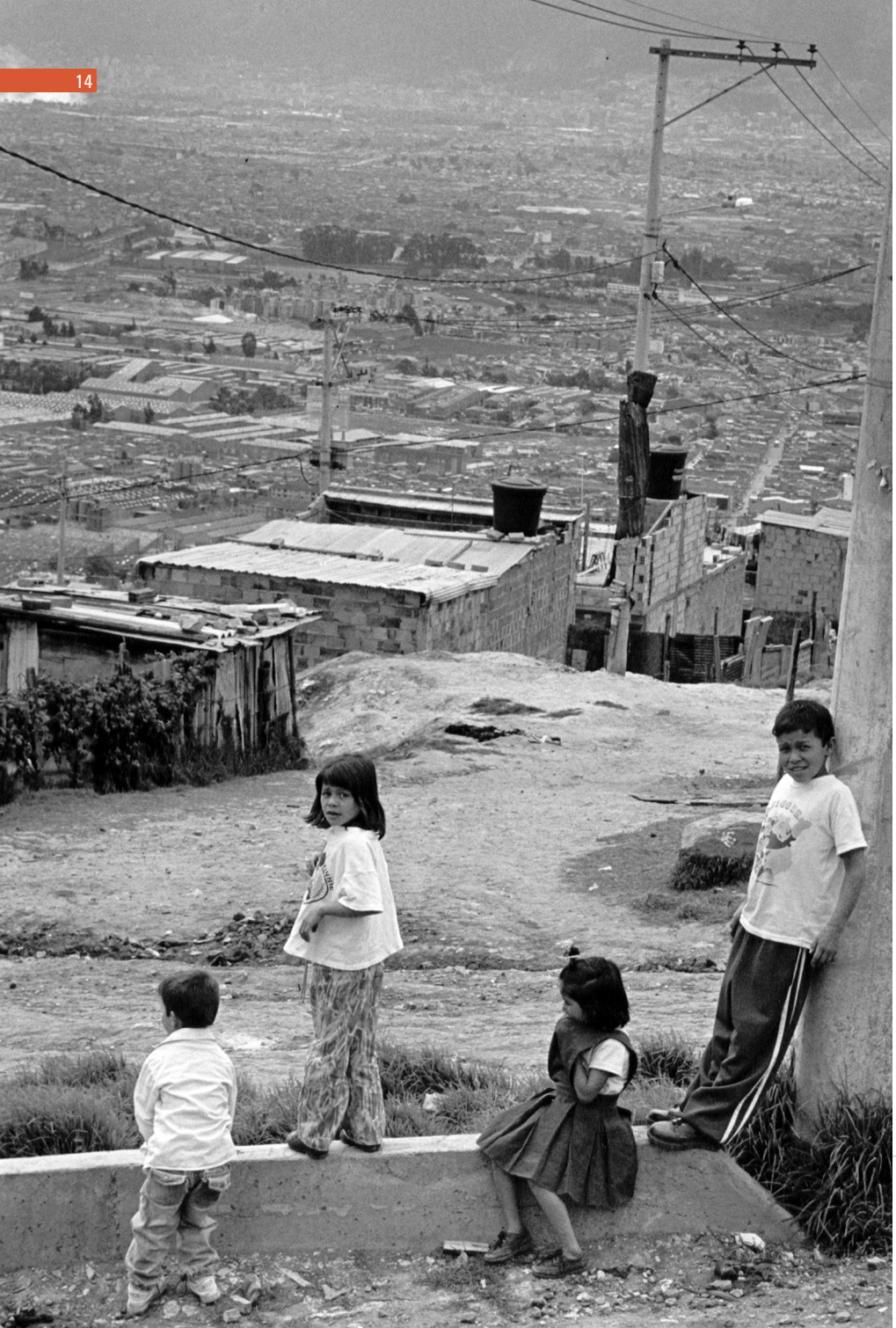
After the consultation: heading home on a donkey
Salitral



Life along the Rio Caqueta
Caqueta



In any available space, a prenatal checkup
Pichiguay



The view from on high
Altos de Cazucá, Bogota

Constantly shifting influence areas of different armed actors make life in the countryside difficult or untenable. Those that choose to stay live in fear; those that leave join two million people who have already been displaced since 1985, pushed from their homes.

Urbanization of misery

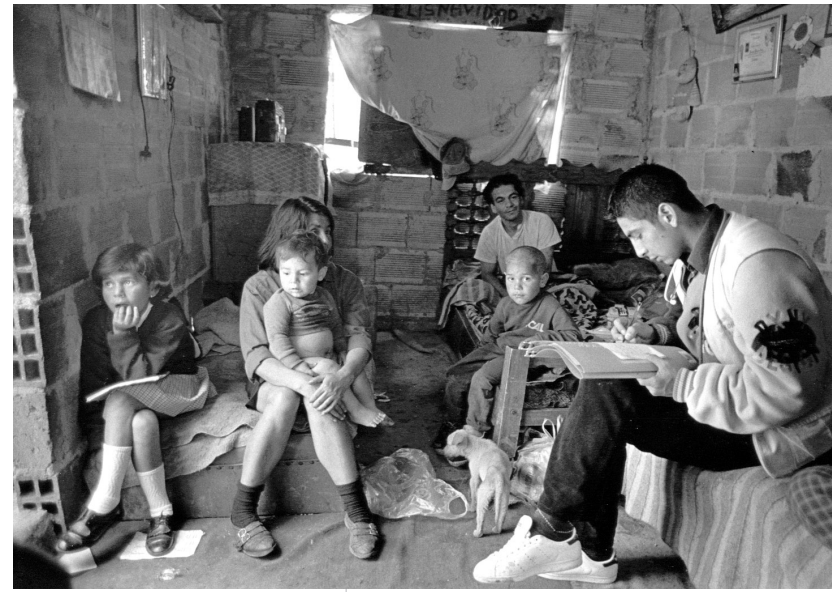
Of the country's 40 million people, 74% now live in urban areas, many pushed there by the war. In Altos de Cazucá, an "invasion slum" perched precariously in a cluster of hills just south of Bogota, overcrowding, poverty, and a lack of access to basic services such as health care erode the health of the population.

Like other such places around the country, it is a shantytown where many people live in unhealthy and subhuman conditions. Roads are dirt and marked with deep erosion ruts. Grey cinder-block shacks are mixed in with flimsier structures. Plastic water pipes, where they exist, lie on top of the dirt. Wastewater runs into a stagnant dirty "lake" below. Whether motivated by actors in the war or resulting from economic and social exclusion, a phenomenon of violence has come to mark Colombia's cities, adding to the climate of fear. Juvenile gangs and violent behavior are ways of adapting to a hostile environment, especially when a young person lacks education, self-esteem, or a sense of roots.

What is being done to help the displaced?

Government aid to displaced people reaches only 20% of the displaced, according to Colombian NGO Human Rights and Displacement Consultancy (CODHES in its Spanish acronym). Aid is limited to a three-month period and can be extended for another three months in exceptional cases.

Law 100, passed in 1993, was designed to guarantee universal access to health care. It mandated the decentralization of health care services from federal to departmental and municipal levels. Yet, in practice, the reality in rural and urban areas is quite



Home visit: a displaced family
Altos de Cazucá, Bogota

different from that intended by the law: many health facilities are shut, there are regular stock breaks, services are overcrowded, and the salaries of health care workers are not always paid. People, especially the displaced, have a difficult time registering for social services that allow them access to the little existing aid.
It is impossible to stop a war with doctors. But we hope that MSF's presence will serve to call attention to the plight of the population and offer civilians the possibility of regaining their human dignity.
For more details on MSF programs in Colombia, see page 82.



At the MSF rehabilitation center, a young man with a spinal injury arrives
Cali



Talking intently with the nurse
Nueva Colombia slum, Florencia

The Access Campaign at two years

Translating success into lasting solutions

Over the last two years, the MSF Access to Essential Medicines Campaign has moved beyond debate to achieve a number of successes that are of real benefit to patients. Production has been restarted or secured for several drugs to treat sleeping sickness. Prices for AIDS drugs have fallen dramatically. Landmark legislation has been passed or affirmed in Kenya and South Africa, making access to certain medicines more likely for some of the world's poorest. Yet, for many people suffering from diseases common in developing countries, accessible treatment options are still out of reach or do not exist.

Production of sleeping sickness drugs secured

A key accomplishment has been the secured production of medicines for sleeping sickness, a painful disease that threatens 60 million people in sub-Saharan Africa. Just two years ago, production of four out of the five drugs needed to treat the disease had either been abandoned or was on the verge of being stopped. Today, because of public pressure, producers Aventis and Bayer will donate enough of the drugs to the World Health Organization (WHO) to meet global needs for the next five years and have committed to looking for long-term solutions. MSF will support this project by assessing needs and storing and distributing the medicines.

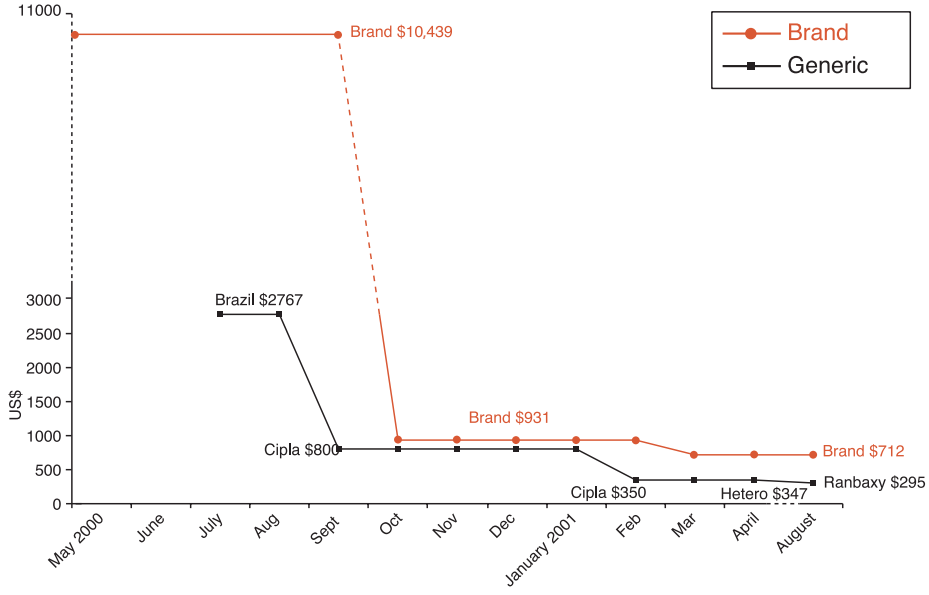
The two companies will also donate funds to support the WHO's programs for disease control and research. There is still much to be done. Donors, governments, and NGOs must all find new resources to commit to the struggle, and well-planned operational research is still needed to develop simplified treatment protocols. But getting the drugs back into production was a vital first step – it brought hope to a situation that appeared desperately gloomy just a year ago.

AIDS drug price cuts bring treatment closer to reality

The quest for affordable AIDS drugs in developing countries – and the debate about treatment versus prevention – has dominated the global agenda over the last year.

At the international AIDS conference in Durban, South Africa, in summer 2000, MSF's assertion that the price of triple-combination antiretroviral therapy could fall to as low as US$200 per patient per year was met with widespread disbelief. Today, that price is within reach (see graph). Various Indian generic manufacturers have offered triple-combinations for as low as $250-$350. The prices offered by proprietary companies also fell dramatically, from $10,000 a year ago to $700-$1,000 in August 2001.

The Effects of Generic Competition
Sample AIDS triple-combination: lowest world prices per patient per year
(stavudine (d4T) + lamivudine (3TC) + nevirapine)



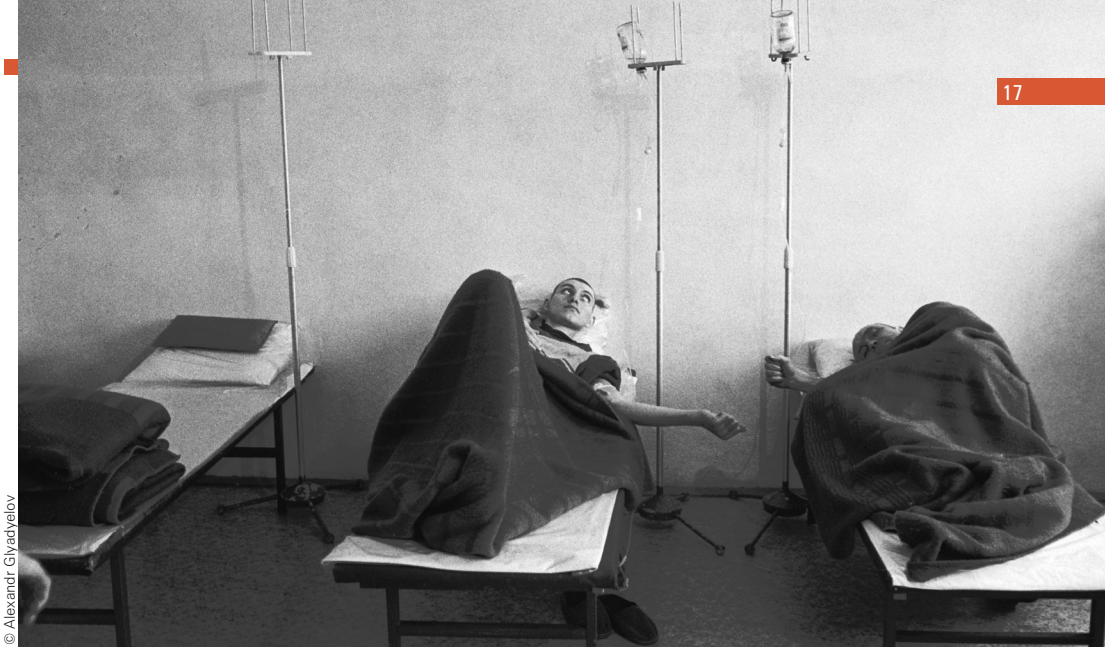
These lower drug prices have led to greater drug access for people with AIDS in Uganda, Senegal, and Cote d'Ivoire, and have also allowed Botswana and Nigeria to launch large-scale AIDS treatment programs. But, although generic competition has forced prices down, only a fraction of all people needing life-extending therapy are receiving it. Now national governments need to focus their energies on getting treatment to more people. There is still an urgent need for the international community to help subsidize developing country efforts.

Prices have fallen not only for AIDS drugs, but also for malaria treatments. The recent agreement announced between the World Health Organization and Novartis for a price reduction on Coartem®, a new antimalarial combination treatment, is a step in the right direction. It is important now to extend these types of price cuts to new antibiotics, vaccines, and diagnostic tests.

Medicines are not Barbie dolls or CDs, but a matter of life and death

Yet competition and voluntary price cuts from companies are not a reliable foundation on which to build access to medicines. To solidify and extend the gains of the past two years, real policy changes are necessary. Here, too, progress has been made. In the area of trade and patent protection, there is growing recognition that the TRIPS Agreement (the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights) should be interpreted to ensure that it protects public health. Medicines are not Barbie dolls or CDs. They are a matter of life and death for millions of people; therefore, patent protection needs to be flexible. Patents, a cornerstone of intellectual property law, should benefit not only the innovator, but also those who need access to the innovation.

The TRIPS Agreement sets out minimum standards for patent protection all WTO members must abide by. It also includes


© Alexandr Glyadyelov

Patients with multi-drug resistant tuberculosis lie in an isolated ward in Prison Colony #16 in Novokuznets, Siberia. Patients are still treated with drugs discovered 40 years ago.

rules to counter the negative effects of patent protection. The critical factor is determining the balance between these two elements on a practical level.

TRIPS already contains safeguards that can and should be used to promote access to medicines. These can be understood through a few examples. Azithromycin is an antibiotic used to treat respiratory and sexually transmitted infections, among the most highly prevalent diseases in developing countries. In Kenya, azithromycin is patented by the pharmaceutical company Pfizer and marketed under the trade name Zithromax®. The Kenyan trade price per 250mg capsule of Zithromax® was US$2.02 in October 2001. In India, where pharmaceutical products are not covered by patents, many generic manufacturers market azithromycin. Because of this competition, the Indian retail price for Pfizer's Zithromax® is much lower than Kenya's trade price: US$0.84 in March 2001 – 2.4 times cheaper.

The TRIPS Agreement allows for parallel imports, enabling countries to obtain patented medicines at the lowest price available on the world market. If Kenya were to use this mechanism to import India's cheaper Zithromax®, more than twice as many people could be treated on the same budget.

However, despite the existence of safeguards, many developing countries are pressured into not implementing them. This is why MSF is calling for not only clarification of some of the articles in TRIPS, but also a clear affirmation by WTO members that nothing in TRIPS can stand in the way of public health. The passage of a pro-public health Industrial Property Bill in Kenya and the capitulation of 39 drug companies in their widely publicized lawsuit against the South African government in April 2001 were signs of hope for other developing countries wanting to make use of such safeguards (see following page for more on the South Africa case).

Prevention versus treatment: the false dichotomy

Until recently, treatment for AIDS was not considered cost effective. Today, political leaders from both developing and donor countries, as well as key leaders at the United Nations, are speaking of the inextricable relationship between prevention and treatment. MSF firmly believes that treatment is fundamental to stemming the spread of the AIDS epidemic.

MSF's experience with AIDS programs shows that medical interventions, such as providing antiretrovirals to treat AIDS patients directly or to prevent mother-to-child transmission of the disease, cause the dynamics in communities to change. When we have something to offer people who are infected with HIV, they begin to seek out voluntary counseling and testing – and this drives more effective prevention efforts.

As of October 2001, we are offering antiretroviral treatment to patients in Malawi, South Africa, Guatemala, Cameroon, Thailand, and Cambodia, with similar programs planned for several other countries as well. Antiretrovirals are used to prevent mother-to-child transmission of HIV in Malawi, South Africa, Ukraine, Uganda, El Salvador, and Kenya. It is important to show that these types of treatment programs can work for people living in developing countries. Effective medicines cannot be reserved only for the rich.

Report reveals empty pipeline

When medicines are more affordable and accessible, when countries can make use of existing safeguards in international law, treatment will still only be possible if effective drugs exist. Unfortunately, research and development (R&D) for new drugs for many diseases has come to a standstill. In September 2001, MSF sought to stimulate debate and action in this area with the publication of a report, "Fatal Imbalance: The Crisis in Research and Development for Drugs for Neglected Diseases." The report is the result of two years' work by the Drugs for Neglected Diseases Working Group, a group of independent experts from developed and developing countries convened by MSF in 1999 to study the R&D problem.

"Fatal Imbalance" revealed that the pipeline for drugs for the diseases of the poor – the "neglected" and "most neglected" diseases that primarily affect people in developing countries – is nearly empty. Out of the 11 respondents to a survey of the world's top 20 pharmaceutical companies, eight spent nothing for R&D for drugs to treat sleeping sickness, leishmaniasis, or Chagas disease, all diseases that exclusively touch people in poor countries. None of the 11 companies has brought a product to market for these three diseases in the last five years, and only two have done so for malaria. The report also showed how government inaction and changing public research priorities are compounding this crisis.

To respond to this crisis, MSF has made several recommendations: among them, that a well-defined and needs-driven research agenda be established at a global level; that governments become directly and proactively involved in the search for solutions; that increased and long-term funding be secured for R&D into neglected diseases; and that a new not-for-profit enterprise be explored as one way to address the shortage of R&D for the most neglected diseases.

The political environment for the discussion of access to medicines has begun to change, with the issue now a part of the international health agenda. Practical successes have brought clear hope to some patients. Yet, after two years of intense campaigning, it is clear that much work remains to be done to translate these successes into lasting solutions.

For the full text of "Fatal Imbalance," as well as additional information on all the topics mentioned here, go to www.accessmed-msf.org or www.msf.org.

South Africa

Big Pharma backs down

On April 19, 2001, people took to the streets and uncorked champagne in South Africa, in celebration of a victory that very emphatically, and very publicly, put patients before profits. Thirty-nine pharmaceutical companies had taken the South African government to court disputing a law intended to protect public health. Their action prompted public outrage worldwide. Support for the South African government poured in....

In 1997, the South African government had passed the "Medicines and Related Substances Control Amendment Act," a law making medicines more affordable by allowing parallel imports (buying the cheapest available patented drug), enforcing generic substitution, and implementing price controls.

Objecting to many of the provisions included in the Act, 39 pharmaceutical companies filed suit to block the legislation. They claimed that the law was unconstitutional and that it violated South Africa's commitments under the World Trade Organization's TRIPS Agreement.

This claim was met with a public outcry at the pharmaceutical industry's desire to put profits before poor people's lives.

Public protests focused on access to antiretroviral treatment: the cost of patented medicines was, at the time, the main obstacle to bringing lifesaving treatment to South Africa's 4.7 million people living with HIV/AIDS.

In spring 2001, when the case went to court in Pretoria, MSF launched an international petition calling on the companies to drop the case. Nearly 300,000 people from over 130 countries signed the petition, and other organizations joined in as well. The European Parliament passed a resolution urging the companies to drop the case, a position echoed by ministers from a number of European governments.

Yielding to the powerful combination of public pressure, solid legal arguments, and government resolve, the pharmaceutical companies announced they were unconditionally dropping the lawsuit.

The companies' capitulation was a positive sign not only for millions of South Africans, but for people in developing countries around the world. However, six months later, only a few of the millions of South Africans living with HIV/AIDS are receiving life-prolonging treatment. Work remains to be done, in South Africa and elsewhere.



© Christian Schwetz



© Remco Bohle



Young Congolese refugees enjoy a light moment jumping rope at the Mwange refugee camp in northeastern Zambia, where MSF provided medical aid until late 1999. When an influx of refugees pushed the camp to capacity in August 2000, MSF established a new camp in Kala, with an initial capacity of 10,000 people. MSF works in three refugee camps in Zambia.

Algeria | Attention to reproductive health and HIV/AIDS

- International staff: 4
- National staff: 10



| MSF has been active in Algeria since 1998 and remains ready to respond to emergencies related to Algeria's ongoing civil war. In April and May 2001, MSF closely monitored the situation as violence flared up in the region of Kabylie, long a flashpoint of the war.

| After the phasing out of some of its projects in 2000, MSF has turned its attention to reproductive health and HIV/AIDS. Despite improvement in some health indicators (such as infant mortality) over the last decade, poverty-related illnesses, particularly tuberculosis, trachoma, and venereal disease, have increased in recent years. Reproductive health education and access to family planning are still limited.

| The number of HIV cases in Algeria is expected to climb upward. MSF is working with the Ministry of Health on an HIV/AIDS awareness program targeting four college campuses. MSF supplies condoms, informative leaflets, and videos to local NGOs for their information campaigns. MSF will continue working with official and private agencies to address these sensitive health matters.

Morocco | Aid to excluded women in Casablanca

- International staff: 9
- National staff: 6

| MSF work in Morocco focuses on excluded populations: women, prostitutes, and other vulnerable people. Program activities take place in Rabat, the capital, Casablanca, and Tangier.

| Morocco's maternal mortality rate is one of the highest in North Africa. In Mers El Kheir, an area of Rabat, MSF helped build a labor and delivery room in an area health center to improve women's prospects for safe delivery of their babies. The delivery facility was finished in July 2001. MSF hopes to eventually provide training to medical staff. In the meantime, MSF continues to offer health education on such topics as maternal health, family planning, and hygiene in the same area.

| In August 2001, MSF began a project in Casablanca to provide basic care to excluded women and others living in vulnerable conditions in this port city. Working with a local association, MSF provides basic health care to prostitutes, and plans to add sexually transmitted disease (STD) prevention and other education activities in the future.

| In Tangier, MSF gives basic care to destitute people, many of them living in the old city. In a first stage, small street teams are seeking to identify vulnerable people, learn about their problems, and document their condition.

| MSF began work in Morocco in 1997.

Mauritania

Long-awaited clinic serves Nouakchott shantytown

- International staff: 3
- National staff: 10

The "Route de l'espoir" (road of hope) runs through Bouhdida, a shantytown on the outskirts of Nouakchott, the Mauritanian capital. It is here, in this corner of the capital, that a clinic constructed by MSF on a piece of land given by the community finally opened its doors in February 2001. The clinic serves about 10,000 people, many of whom were displaced from other areas of Nouakchott after severe flooding in 1995.

An impatient wait for a clinic

The people of Bouhdida had been waiting impatiently for the clinic to open – public health facilities in the area are scarce, and the hospital itself is a long, expensive cab-ride away. In a study undertaken by MSF last year, people from the community expressed time and again their need for a clinic.

The needs of women in the shantytown are particularly strong. Distance from adequate health facilities and the costs involved in getting there have often meant that women gave birth with no outside assistance, and many babies died. The new clinic has a delivery room, examination rooms, and a pharmacy. From its opening in February to the end of May, 29 babies were born there. A local nurse, midwife, and health assistant work with an expatriate doctor to offer nearly 30 consultations a day. Members of the community manage the facility together with the regional health authorities.

MSF also provides food, drugs, and staff supervision at the Nutritional Recuperation and Education Center (CREN) in Saada, in the same area of the capital. Fifteen malnourished babies are cared for every month. MSF is also looking at possible avenues of work in Guidimaka, an underserved area in southern Mauritania, and in Nouadhibou, a coastal city that is a transit point for many people from sub-Saharan Africa hoping to reach Europe.

MSF has been working in Mauritania since 1994.

Mali

Access efforts open pipeline for affordable eye medicine

- International staff: 3
- National staff: 35



© Alain Kazinierakis

People wait outside a maternity clinic in a village in Mopti, Mali.

Since 1999, MSF has been working to improve prevention and treatment of eye disease in the region of Mopti, in central Mali. Poverty, crowded living conditions, and lack of infrastructure and preventive hygiene are key factors in the development of cataracts and trachoma, the main causes of blindness in the country.

Yet treatment for trachoma in Mali has been hampered by the high cost of the brand-name trachoma drug azithromycin, produced by a giant U.S. pharmaceutical company. The MSF team in the field, working with the MSF Campaign for Access to Essential Medicines (see page 16), checked the patent situation and discovered that there was no patent yet registered in Mali. The team then worked with the Malian health authorities to set up import and registration of the same drug made by an Indian pharmaceutical company producing a cheaper, generic version. MSF is set to manage a pilot program using the drug in the district of Bankassa, in Mopti. Community health workers will be trained to distribute the medicine in the villages, direct people to health centers, and educate the population about trachoma.

Throughout Mopti, MSF aids local health workers, who educate the population and perform basic surgery to correct trachoma. In September 2000, MSF also began work with a mobile team performing cataract surgery.

In addition to work on these blinding diseases, MSF continues to support district health services and a nursing school in the north-central region of Gao. There is also a pilot project underway to improve management and performance at a hospital in Selingue, in the south.

MSF has been working in Mali since 1983.

Benin

New wing for Buruli Ulcer treatment center

- International staff: 2
- National staff: 13



MSF continued to focus on Buruli Ulcer throughout the last year. Only surgical intervention can stop this debilitating illness, which causes skin swelling, destroys tissue, and suppresses the immune system, sometimes destroying massive areas of skin and bone. The first phase of the MSF program, begun in 1997, emphasized treating the disease itself and training health professionals in curative and diagnostic techniques. Surgical training was a key part of the program.

MSF also helped build the country's second treatment center for Buruli Ulcer, in the department of Mono, home to about 840,000 people. Overcrowding at the center (sometimes swelling to 200% of capacity) prompted the construction of a new wing, set to be completed in early 2002. At the same time, MSF is putting increasing emphasis on educating the population about the disease and encouraging people to come in early for treatment. MSF continues to work with the Institute for Tropical Medicine in Antwerp, Belgium, on research to discover the exact cause of the disease.

In fall 2001, MSF expects to begin an AIDS program in the city of Dogbo. Activities will include hospital care, treatment of opportunistic infections for AIDS patients, testing and counseling, and public education. In addition, MSF will offer antiretroviral treatment to help prevent mother-to-child transmission of HIV.

Burkina Faso

Meningitis epidemic strikes the east

- International staff: 6
- National staff: 30

Burkina Faso was hit hard by the meningitis epidemic that struck Africa's "meningitis belt" in early 2001. More than 12,000 people contracted the disease, and 1,700 people succumbed. MSF, already present in the country in Ouagadougou, the capital, and the district of Sindou, responded to the crisis.

A small team supervised vaccination and public information efforts in eight districts in the eastern part of the country, where the epidemic hit. About 1.5 million people were vaccinated during the campaign. See page 30 for more on the meningitis epidemic in the meningitis belt this year.

Over the last year, MSF continued its regular programs in Burkina Faso. In Ouagadougou, 400 children and young people living on the streets receive medical care and social support. MSF provides medical care in the streets and supports several medical and reception centers. An information campaign targets people who come in close contact with the children, including police, authorities, hospital workers, and people living near the gathering points of the children. MSF also helped produce a film with the street children, which will be broadcast throughout the country on national television in fall 2001.

Far to the southwest of the capital, the newly established Sindou health district suffers from lack of medical material and lack of well-trained medical staff. MSF has been working since early 2000 to train health staff, and improve care given at first- and second-level health facilities, including health posts, clinics, and the hospital in the city of Sindou, the capital of the district. Community participation in all aspects of health care provision is a key part of the MSF program.

MSF plans to start an AIDS program in Ouagadougou in fall 2001, focusing on voluntary counseling and testing, patient care, and prevention of mother-to-child transmission of HIV.

Niger

Meningitis and measles epidemics prompt MSF action

- International staff: 15
- National staff: 40

MSF began working in Niger in spring 2001, when severe meningitis and measles epidemics struck the country. Much of the population has no access to health care, and for others lack of means meant that many people were unable to pay for treatment when they fell ill with the diseases.

Part of the Africa's meningitis belt (see page 30), Niger was one of several countries to be hit particularly hard by this disease in 2001, even in areas where vaccinations had already been undertaken. MSF worked with local health authorities in the districts of Niamey, Tahoua, and Maradi to improve access to treatment for the sick and provide vaccinations to help prevent the spread of the epidemic. MSF also distributed treatment kits to health workers and local health facilities.

In response to the measles outbreak, MSF offered emergency treatment and helped plan a strategy of vaccination in cooperation with the local authorities. Mobile teams supervised by MSF volunteers vaccinated people in the three districts mentioned above.

Altogether, 370,000 people were vaccinated against meningitis and 330,000 against measles. MSF distributed another 600,000 vaccines for the two diseases to the health authorities.

During the course of the vaccination campaigns, MSF was able to assess the nutritional status in the three districts. It became evident that there was a nutritional crisis resulting from several years of drought and poor harvests coupled with the severity of the measles epidemic. In late August 2001, MSF opened two therapeutic feeding centers in the hospitals of Maradi and Dakoro to care for severely malnourished children.

Côte d'Ivoire

Prison work continues in turbulent year

- International staff: 6
- National staff: 21

The year 2000 was an exceptional year in Côte d'Ivoire. In October, on the eve of presidential elections, over a million people filled the streets of Abidjan to call for the removal of the leader of the 1999 military coup, General Gueï. Two days later, 200 people died in clashes in the capital. At the same time, increasing nationalism and xenophobia resulted in violence against foreigners, particularly those living in poorer districts.

In Abidjan's largest prison

Against this backdrop, MSF continued its work in the Abidjan Prison (MACA). Conditions and medical care in the prison have improved greatly since MSF began work there in 1998, with striking reductions in the mortality rate and improvements in sanitation and in medical care and follow-up.

A plan for the maintenance of the work carried out in the prison by MSF has now been drawn up, so that the detainees themselves, and the government, can gradually take over maintenance of the sanitation system. The year 2000 brought the introduction of regular consultations for female detainees. A review of the situation of minors in the prison revealed the grave abuses to which they are subjected.

MSF hopes to turn its attention to alternative solutions to imprisonment and social work programs that focus on family relationships.

MSF has been working in Côte d'Ivoire since 1990.



© Frederic Sautereau / L'Oeil Public

MSF volunteers and local staff prepare a classroom for use as a measles vaccination center in Maradi, Niger.

Nigeria

Measles ravage the city of Kano

- International staff: 25
- National staff: 90

The people of Nigeria face a climate of increasing social decay and poverty, despite the promise of improved conditions that accompanied the country's return to civilian rule in 1999. The health system suffered under years of military dictatorship and neglect. Diseases such as malaria, cholera, meningitis, and yellow fever continue to affect millions; this year a measles epidemic swept through the city of Kano, in northern Nigeria.

The outbreak of measles reached epidemic status in early 2001. The fatality rate in the main hospital in Kano was almost 20% and the caseload continued to grow into the early summer before peaking. From January through June, MSF treated 2,000 severely ill children. MSF has been helping the hospitals deal with measles, meningitis, cholera, and yellow fever since 1996 by providing drugs, conducting training sessions, monitoring the epidemiological situation in Kano through a sentinel surveillance system, and responding to epidemics when necessary.

MSF also has an ongoing malaria program in the state of Bayelsa, in the Niger Delta, where this disease remains the leading cause of death for children under five. MSF uses boats to reach people throughout this watery lowland in order to carry out diagnosis with mobile labs and provide effective malaria treatment. MSF is also studying resistance to certain anti-malarials.

Violent clashes prompt MSF response

In July 2001, clashes between the Azara and Tiv peoples in Nasawara State resulted in an estimated 200 deaths and the displacement of an estimated 50,000 people. MSF donated drugs and medical materials to a hospital in Lafia, the capital of Nasawara, to care for the wounded. In Benue State, MSF provided medical aid items to clinics in camps for displaced people. MSF also aided victims of the tension between Muslims and Christians in the state of Kaduna in May 2000, after the proposed introduction of sharia – or Islamic – law in that area led to violent clashes.

In light of the HIV/AIDS crisis in Nigeria, MSF expects to begin a program to care for and treat HIV-positive sex workers in Lagos in fall 2001. The program will include antiretroviral treatment for some patients.

Sierra Leone

Coping with a permanent medical emergency

- International staff: 50
- National staff: 451



Although in late 2000 and early 2001 the situation in Sierra Leone did not reach the abysmal standards of its recent history of civil war and massacre, vast parts of the country remained unstable, particularly in the north and east. Periodic clashes among pro-government civil militias (the Civil Defense Forces, or CDF), opposition forces (Revolutionary United Front, or RUF), and the Guinean army have meant very little increased security for the people, half of whom still live away from their own areas as refugees across borders or crammed into camps in unfamiliar parts of their homeland.

Beginning in September 2000, many Sierra Leoneans taking refuge in Guinean border regions were forced to move by fighting and instability near the border (see page 28). Many headed to safer areas in Guinea, or to Conakry (the Guinean capital) and then by boat to Freetown, the capital of Sierra Leone. MSF has supplied medical screening, health clinics, and water and sanitation for their new camps within Sierra Leone.

The broader population does not fare better: MSF is struggling with a permanent medical emergency where one in three children dies before the age of five, where epidemics of cholera, shigella (bloody diarrhea), and malaria are a familiar challenge (MSF first went to Sierra Leone in 1986 to deal with a cholera epidemic), and where health service staff are often unpaid and demoralized. In many areas, insecurity makes humanitarian aid only intermittently possible.

MSF was forced to shut down most of its programs in the RUF-held northern parts of the country last year because of insecurity. Those projects are now being reopened. The hospital and clinics in Makeni are working again and, beginning in April 2001, access to health care was being restored for around half a million people in the RUF districts of Port Loko, Kambia, Bomboli, Koinadugu, and Tonkolili. Helicopters supply additional projects in the government enclaves of Kabala and Bumbuna.

In government areas to the south, MSF continues work in Moyamba with a pediatric ward and nutritional support for children, in Kenema, where MSF provides inpatient care and supports five clinics, and in Mile 91, where around 30,000 displaced people get primary health care and water supplies from the MSF team. In the government-controlled part of Port Loko, MSF opened a therapeutic feeding center for children in May 2001. In the southern provinces, MSF continues to be the medical spine of three hospitals and 21 clinics in Bo, Pujehun, and Bonthe.

In Freetown, MSF provides surgical care in the main hospital and supports two other hospitals and a range of clinics in camps for the displaced. Psychosocial counselors work with war trauma victims. MSF has also started a pain control project, which attempts to deal with the terrible legacy of war wounds and forced amputations.

Liberia

MSF responds to exodus from Lofa County

- International staff: 13
- National staff: 50

Liberia has not escaped the instability, civil war, and refugee flows that haunt West Africa (see page 28). In spring 2001, fighting between government forces and armed groups in Lofa county in northern Liberia – an area caught in instability, civil war, and population movements and also subject to cross-border incursions by armed groups from Guinea and Sierra Leone – prompted the exodus of thousands of people to the central part of the country. MSF brought in 30 tons of emergency medical supplies and set up care for the displaced in several camps. Regular MSF programs in Lofa county have been suspended since mid-2000 because of insecurity.

In Monrovia, the capital, MSF works at Redemption Hospital. A scarcity of health facilities makes overcrowding a real problem at the hospital and in other clinics. To address this, MSF has constructed a small clinic behind the hospital to house the outpatient department, and other clinics where MSF works are being expanded or revamped. In addition to providing basic health care, MSF runs a tuberculosis control program and supports two cholera treatment centers.

In Maryland county, MSF provides surgical and medical support to the regional hospital in the town of Harper. An MSF malaria study in the area – where 40% of all consultations are for malaria – has revealed high levels of resistance to the two main malaria drugs. MSF is working to identify a more appropriate treatment for patients in Harper. MSF has expanded its medical activities to reach isolated people in the surrounding areas.

In February 2001, MSF ended work in Sinje refugee camp in Cape Mount county, when the United National High Commissioner for Refugees and the Liberian government turned over responsibility for water and sanitation to a local association. MSF had been providing the services for about 10,000 Sierra Leonean refugees for about a year.

MSF began working in Liberia in 1990.

Guinea | Refugee crisis in Parrot's Beak

International staff: 25
National staff: 160

MSF's work in Guinea over the last year was dominated in late 2000 and early 2001 by the deteriorating situation of refugees trapped in Parrot's Beak, a volatile area of Guinea jutting into Sierra Leone, not far from the Liberian border.

MSF has been working with refugees in the country for many years and as of summer 2000 was offering medical care and water and sanitation assistance in five camps. At the onset of the crisis, MSF added aid programs in a transit facility in the capital, Conakry (later moved to Mambiya), and a new camp set up in Dabola as well as periodic assistance at numerous other camps – and also pushed for the transfer of the refugees to a safer area. See box (next page) for more on this crisis. Over the last year, MSF also responded to a yellow fever epidemic in Guinea, while continuing regular programs and starting several new projects.

Yellow fever sweeps the country

In late 2000, an outbreak of yellow fever, a mosquito-borne viral disease with a mortality rate of 80% when untreated, threatened several million people in Guinea. MSF quickly reinforced its staff, bringing in 20 additional people to combat the epidemic. Teams vaccinated between 10,000 and 15,000 people each day, eventually reaching over 1.5 million people. Yet it became clear at the peak of the crisis that world stocks of yellow fever vaccine ran 1.5 million doses short of what was needed to provide complete vaccination coverage. MSF brought attention to this shortfall and called on the World Health Organization (WHO) to order additional vaccine stocks from the pharmaceutical companies, which only produce the vaccine when requested by WHO or other international agencies.

Ongoing care for the Guinean population

Over the last year, MSF launched two projects in Guinea. A pilot rural health care program began in mid-2000 in Konkouré. MSF has trained traditional birth attendants who, by mid-spring 2001, delivered nearly 200 babies.

In early 2001, MSF began training local community members to work with street children in Conakry and opened a drop-in center in a busy market area where these children can play, take a shower, and drink clean water. MSF continues to assist the Guinean association Fraternité Médicale Guinée with its clinic in Conakry, and works in other clinics in the city.

A tuberculosis control program, begun in 1990, covers a population of over two million people in and around Conakry. In January 2001, the program was extended to cover the entire Moyenne Guinea region.

MSF began working in Guinea in 1984.



© Robert Knoth

People make their way through the Guinean bush from the refugee camp in Boudou, inside Parrot's Beak, to one in Katkama.

Caught in the crossfire

The refugee crisis in West Africa in 2000-2001

| In early 2001, MSF called attention to the deteriorating situation of hundreds of thousands of mostly Sierra Leonean refugees stuck in a volatile area of Guinea near Gueckedou and "Parrot's Beak." Refugees were living in a wedge of Guinea jutting into Sierra Leone (see map page 26), near the Liberian border – a spot vulnerable to attacks by armed groups from Sierra Leone, Liberia, and Guinea. Sometimes the refugees were fleeing hostilities or caught in the crossfire; other times they were the victims of deliberate attacks by those hoping to steal their relief items, including food.

| The insecurity of the area hampered humanitarian workers and made relief only intermittently possible. Some camps lacked basic humanitarian aid, including medical care and food. Massive delivery of food aid attracted attacks from armed groups and was thus impossible. The refugees – many of whom had been in the area for years – were forced into a daily choice between staying and risking attack while waiting for food aid to arrive, or traveling on foot through insecure territory.

"We want to leave, we want to get out of here. We don't care about food, just take us away."

A woman
in Nyaedou camp

| The situation in Parrot's Beak in winter and spring 2001 was a reflection of a regional refugee crisis going back more than a decade. An ongoing conflict in Sierra Leone has pushed an estimated 330,000 refugees into Guinea over the last ten years and displaced many others inside Sierra Leone itself (all refugee estimations are from UNHCR). Liberia's civil war, from 1990 – 1997, forced 235,000 Liberians to flee to Guinea, where today over 100,000 remain. Still other Liberians have been displaced within their own country, where fighting continues in Lofa province in the northwest.

| MSF, which has been providing medical aid to Liberian and Sierra Leonean refugees in Guinea since 1990, had been pushing to get Parrot's Beak refugees relocated away from the border since 1998, a move broadly accepted by the international community. Yet a lack of financial and human resources at the UNHCR and refusal of the Guinean authorities to grant permission meant that this move was put off.

| Then, in September 2000, fighting at Guinea's borders with Sierra Leone and Liberia flared up, exacerbating the situation of the refugees and causing the deaths of several hundred people. A UNHCR worker was killed, resulting in the agency's complete withdrawal from the area between September and January 2001. MSF, for its part, called again for the quick, voluntary relocation of refugees to safer areas.

| When no international plan materialized, some of the refugees started moving on their own, largely without the benefit of protection or help. Of the estimated 150,000 refugees in Parrot's Beak in January 2001, by April over half had fled the area to escape the fighting, many returning to Sierra Leone. However, conditions in Sierra Leone – where entire regions are still unstable – were hardly welcoming for the returning refugees.

| Thousands of other Parrot's Beak refugees found their way to slightly safer areas of Guinea, including the Nyaedou camp where MSF was working, just north of Parrot's Beak. Yet even this camp was threatened by armed groups and could not be considered safe.

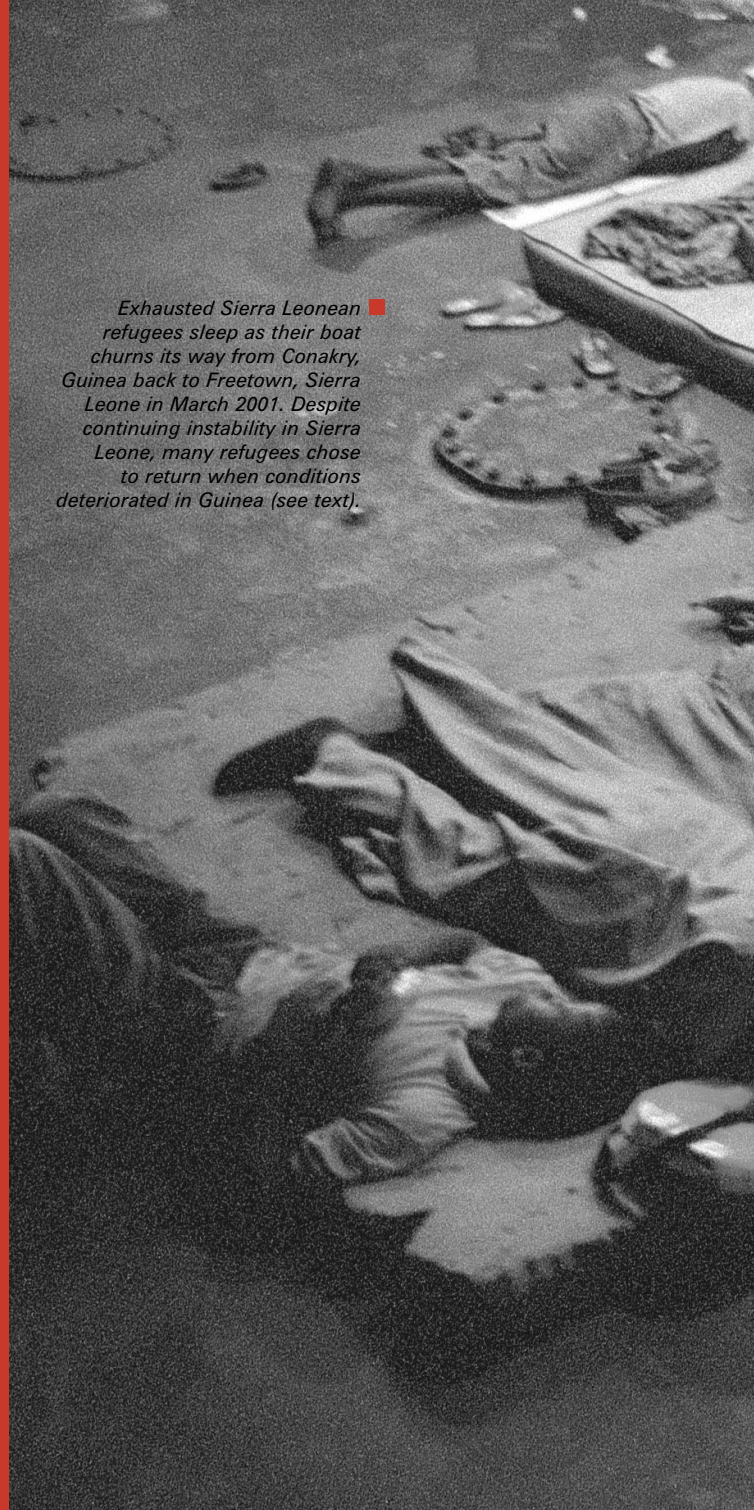
| In spring 2001, many of those wishing to leave Parrot's Beak had begun walking out to safer areas. In early May, trucks were finally organized to bring refugees out of Parrot's Beak to transit camps, where MSF and other organizations provided medical care and water and sanitation services. The refugees then moved to relocation camps near the towns of Albaderia and Dabola. MSF provided medical and water and sanitation assistance in some of the camps. Refugees can stay in these camps, but many try to reach the Guinean capital, Conakry, and from there go by boat back to Sierra Leone.

| Some refugees fled into the bush and left no trace, rather than be relocated. MSF remained strong in its conviction that any relocation must be voluntary.

| While the refugee crisis peaked in early 2001, the situation of the refugees remains precarious. Increasing violence in and around areas with large numbers of refugees has provoked a backlash from the Guinean government. Many refugees have been caught between attacks by armed factions and mounting aggression on the part of the Guinean civil population. As of October 2001, MSF work with the Parrot's Beak refugees continued in Boreah, Dabola, and Mambiya camps.

| The situation remains unstable in Guinea, Sierra Leone, and Liberia, where large numbers of people have been displaced in the northwest since summer 2001 (see page 26).

| MSF continues to work in all three countries, providing medical aid, nutrition programs, and water and sanitation services to refugees and residents alike (see pages 26 and 27).



Exhausted Sierra Leonean refugees sleep as their boat churns its way from Conakry, Guinea back to Freetown, Sierra Leone in March 2001. Despite continuing instability in Sierra Leone, many refugees chose to return when conditions deteriorated in Guinea (see text).

© Robert Knoth

Meningitis: deadly annual epidemic in Africa's "meningitis belt"

MSF assists in vaccination of over 4.5 million people

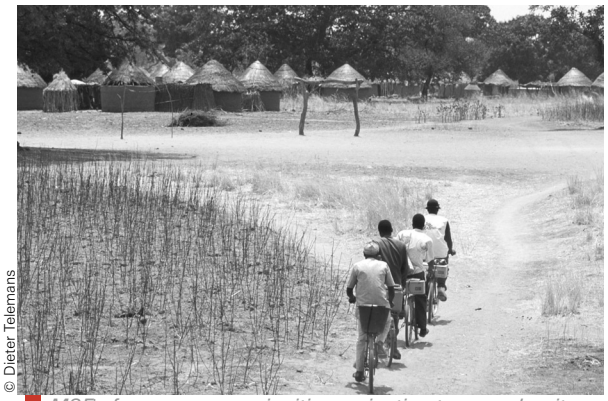
"We drove out of the compound early each morning to go and vaccinate in the villages. The little girl next door would wave till we disappeared round the corner. One morning she waved and grinned as usual, but by the time we got home in the evening she was near death."

MSF doctor

Meningococcal disease is responsible for about 135,000 deaths globally each year, with over one million cases. Most frequently hit are 18 countries in sub-Saharan Africa's so-called "meningitis belt." This is an area where the disease is endemic: meningitis is "silently" present, and there are always a few cases. When the number of cases passes five per population of 100,000 in one week, teams are on alert. Epidemic levels are reached when there have been 100 cases per 100,000 population over several weeks. In 2001, MSF responded to epidemics of meningitis in Burkina Faso, Cameroon, Niger, Chad, and Ethiopia.

Meningitis is a disease of the meninges, a membrane that covers the brain and spinal cord like a sheath. It is caused by either a bacterial or viral germ; Neisseria meningitidis, commonly called meningococcus, is the only bacterium that causes epidemics. It invades the tissues of the nose and throat and eventually reaches the brain. The normally clear fluid that surrounds the brain quickly becomes cloudy and more viscous, increasing the pressure within the skull. The fatality rate of meningococcal meningitis is 50% when untreated.

MSF, working with local health authorities, responded to the epidemics of 2001 with mass vaccination campaigns – the only way to halt an epidemic. In the five countries, MSF assisted in the vaccination of over four and a half million people, and also provided treatment for infected patients.



© Dieter Telemans

MSF's four-person meningitis vaccination team makes its way by bicycle to a small village in Gounou-Gaya, Chad. Each team included one person to vaccinate, two to prepare the syringes, and another to record the number and ages of those vaccinated.

Besides the unpredictability of these epidemics, response can be hindered by lack of available vaccine doses and their cost. During the epidemic season in spring 2001, unavailability of vaccines on the commercial markets led to requests for eight million vaccines from affected countries from the ICG emergency supplies. The ICG (the International Coordinating Group on Vaccine Provision for Epidemic Meningitis Control) had only 7.5 million vaccines in stock. The shortfall was made up through partial replenishment of stocks during the epidemic season. All justified requests were accepted and supplied, which would not have been possible if the epidemics had been of a larger scale. This demonstrated the essential role of the ICG contingency stock and the need to increase it to ten million doses.

Cameroon

New mission provides antiretroviral treatment

- International staff: 5
- National staff:12

In January 2001, the first AIDS patient received antiretroviral (ARV) drugs in the new MSF mission in Cameroon. Although limited ARV treatment was already available, at a cost of US$3,000 – $4,000 per year it was out of the reach of most people.

HIV/AIDS

In establishing a direct AIDS treatment project in Cameroon, MSF goals were two-fold: offer some of Cameroon's nearly 600,000 AIDS patients life-prolonging treatment, and demonstrate that antiretroviral treatment could be effectively implemented in a developing country. ARV treatment is offered for a nominal fee at a clinic in Yaoundé, the capital. It has been administered to five new patients per month since January, with hopes that the number could be increased to ten in the future, and that 85 patients would be under treatment by the end of 2001. Psychological support and treatment of opportunistic infections are key parts of the project. Starting in spring 2001, MSF extended the AIDS project to two clinics in the city of Douala. Here the focus is on encouraging voluntary counseling and testing and providing medical and psychological follow-up to HIV-positive people.

Meningitis

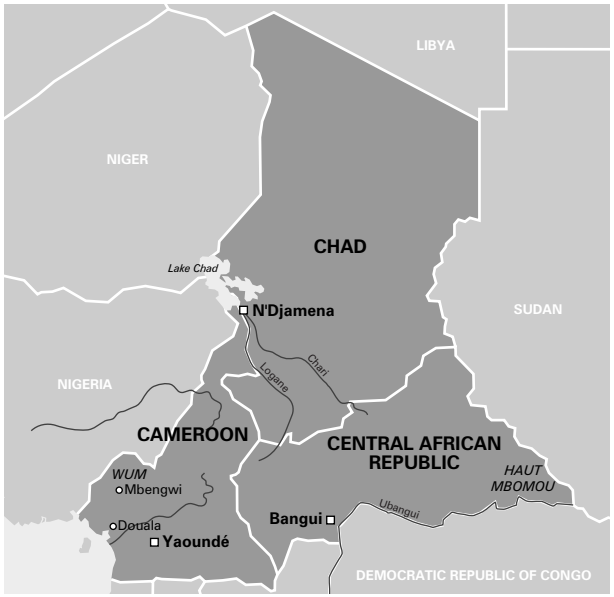
As MSF was setting set up its antiretroviral program, Cameroon was hit with a severe outbreak of meningitis. MSF responded with a massive vaccination campaign carried out in cooperation with the authorities.

The immunization program began in February. Starting in the Wum and Wbengwi districts, where the epidemic began in early 2001, MSF trained local workers and began administering vaccines, ultimately achieving a vaccination rate of over 75% for both districts. In two months, MSF vaccinated a total of 190,000 people. See box for more on the meningitis outbreak that hit Africa's "meningitis belt" early in the year.

MSF has been working in Cameroon since 2000.

Chad | Twin epidemics hit the country

- International staff: 18
- National staff: 40



| In late 2000 and early 2001, Chad was hit with successive epidemics of measles and meningitis. The measles epidemic was first reported in December 2000 in the south, and MSF responded by vaccinating 33,000 children. The disease resurfaced again in February 2001. This time MSF, working with the Ministry of Health, coordinated a team that vaccinated over 800,000 children.

| Following closely on the heels of the measles outbreak, a severe meningitis epidemic struck Chad in February. MSF undertook a massive vaccination of 1.3 million people. To cope with both epidemics, MSF brought in 24 additional volunteers and worked with over 1,600 extra local staff. See page 30 for an overview of the meningitis epidemics that struck Africa's "meningitis belt" this year.



© Dieter Telemans

A young girl stoically receives her meningitis vaccination from the MSF team in Chari-Baguirmi, Chad.

| As if the twin epidemics were not enough, in late spring 2001 it became clear that Chad was faced with an impending nutritional emergency, due to the failure of the harvest for two consecutive years. MSF immediately flew in several tons of high-protein biscuits and other rations. The situation seemed to stabilize, but MSF continued to monitor developments.

Twenty years in Chad

| This flurry of emergency activity marked 20 years of MSF work in Chad. For much of that time, MSF has supported – through care, training, drug donations, and infrastructure rehabilitation – several health districts serving a total of 1.5 million people. Over the years, the country's health system has made great improvements: infrastructure is functional, health workers are motivated (although there is still a shortage of qualified health staff), and response to epidemics has become more rapid. MSF, having obtained its principal objectives, is slowly reducing its general involvement in some of the health districts and hopes to focus more on training, particularly in minor surgery for generalist doctors, and in HIV/AIDS and tuberculosis care.

Central African Republic | A year punctuated by emergencies

- International staff: 11
- National staff:17

| Ongoing MSF work in the Central African Republic was punctuated by several emergencies over the last year.

| From August through October 2000, a large influx of refugees from the Democratic Republic of Congo (DRC) prompted a rapid response. MSF teams aided about 10,000 refugees, providing vaccinations, epidemiological surveillance, training of health workers, and health education.

| Then, in late May 2001, a coup attempt temporarily paralyzed the capital, Bangui, and put in motion a large wave of displaced people leaving the capital for refuge in the south and in DRC. Mortars, gunfire, and tanks resounded for several days. MSF volunteers were initially unable to leave their compound; soon after, part of the team was evacuated, while the remaining staff began responding to emergency medical needs. Before movement around the city became possible, MSF treated people at its compound. An MSF "full charter," a cargo plane with an emergency team and emergency medical supplies, arrived in early June. MSF assisted at Hospital de l'Amitié, where all medical activity had stopped in the days following the attempted coup, and in urban health centers. MSF also monitored the humanitarian situation of people fleeing south, and provided medical aid and basic relief items for families when needed. The situation began to stabilize in July.

| At the time of the coup, regular MSF activities were suspended temporarily. By late June, the violence had receded somewhat but the general situation of the population continued to worsen and instability remained high.

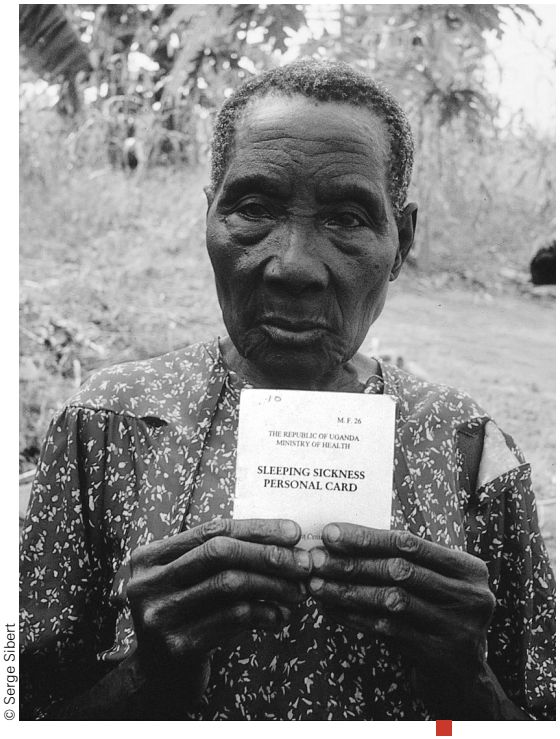
| Access to health services, in a critical state even before the coup, deteriorated. In this context, MSF focused on restarting its ongoing program as soon as movement was possible. This maternal health project covers pre- and postnatal care, delivery, Cesarean sections, and training maternity staff in three maternity wards in the city, all aimed at about 150,000 women of childbearing age.

| A sleeping sickness project planned for the region of Haut-Mbomou has been postponed until late fall 2001.

| MSF has been working in the Central African Republic since 1997.

Sudan | War weighs on the Sudanese people

- International staff: 105
- National staff: 1680



© Serge Sibert

A man holds his "sleeping sickness personal card" from the MSF Sleeping Sickness Treatment Center in Kiri, Sudan. Each patient receives this card after screening or treatment. Since this project began in June 2000, more than 12,000 people have been tested. Nearly 1,000 were diagnosed with the disease and treated.

| Since the late 1970s, MSF has responded to medical needs stemming from war, food crises, epidemics, and other emergencies in Sudan. The country's ongoing civil war has left four million people displaced today. Hunger, violence and "rare" or neglected diseases are all too familiar to the Sudanese people. Sudan is a divided country in chronic crisis, and its people a population in distress.

| MSF has medical programs in the northern, government-held part of the country as well as in the south, controlled primarily by the Sudanese People's Liberation Movement (SPLM) and other armed groups.

Meeting basic medical needs

| MSF is engaged in a continual effort to orient its medical activities to those most in need. In slums surrounding Khartoum, the capital, MSF has three clinics serving people who have been displaced to the area over the last ten years by war or by the economic pull of the city. Because the situation of the population has improved, MSF work in two of the three clinics will finish by the end of 2001. Work in another clinic in the western town of Meiram ended in July 2001.

| Southern Sudan has borne the brunt of the war. MSF offers basic care in Mapel, Ajiep, and Akuem, in Bahr el Ghazal province. MSF supports nine additional health posts and a referral hospital in Bahr El Ghazal and runs another hospital in the district of Kajo Keji, in Eastern Equatoria. Basic care is also provided in Akobo, in Jonglei province. In Wau, a government garrison town, MSF works in the pediatric ward of the civilian hospital.

| In Unity State (also called Western Upper Nile), a disputed region in south-central Sudan, people have been brutally chased off their lands by the fighting. In mid-2000 many of the displaced began to arrive in the town of Bentiu. In August 2000, MSF began work in Bentiu, caring for severely malnourished children, running a small in- and outpatient clinic, and treating kala azar and tuberculosis. MSF also maintains six primary health posts for people in Jekany, Jegai, Leek, and Adok counties in Unity State.

Malnutrition

| The continual upheaval of war was coupled in spring 2001 with drought – and the threat that many thousands of people would go hungry. Severe drought affected Darfur, Kordofan, and Bahr el Ghazal provinces and Unity state. In March, MSF opened a therapeutic feeding center in Akuem in Bahr el Ghazal. In May, traditionally the start of the summer-long "hunger gap," MSF added a feeding center in Kuajok to one already operating in Ajiep, also in Bahr el Ghazal. Other feeding centers serve people in Akobo and in several camps for the displaced near Khartoum.

Target diseases

| Kala azar is a severe parasitic disease affecting primarily poor, rural areas in developing countries. Since 1996, MSF has treated over 16,000 people in two kala azar clinics near the Atbara and Rahad rivers in northeastern Sudan. After levels of infection began to fall, MSF turned one clinic over to the Sudanese Ministry of Health in July 2001; the other will be handed over in December 2001. Kala azar treatment also takes place in Bentiu, Lankien, and Latjor state. In a large "kala azar belt" in southern Sudan, MSF has treated 25,000 patients for the disease since 1989.

| Sleeping sickness is another tropical disease endemic in parts of the country. At sleeping sickness clinics in Ibba, in Western Equatoria province, and Kiri, in Eastern Equatoria, MSF treated over 2,000 patients and screened many thousands more over the last year.

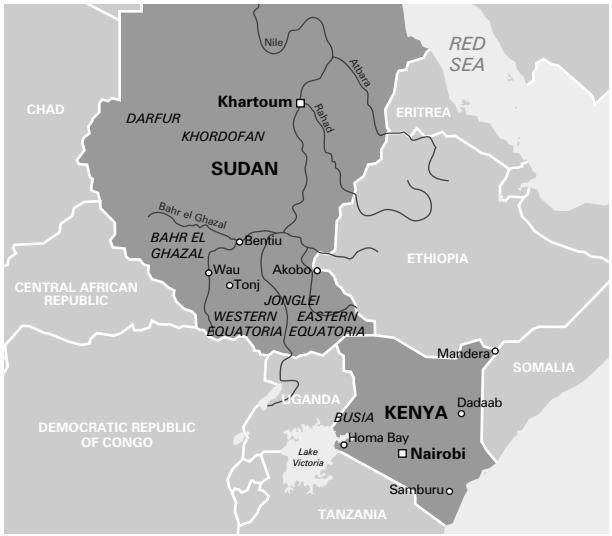
| In Lankien, MSF treats about 250 people for tuberculosis and is also undertaking a study of malaria resistance. MSF continues to treat river blindness and work to eradicate guinea worm, in Mapel, Ajiep, and Tonj, in Bahr el Ghazal province.

Kenya | New law gives hope to people with AIDS

- International staff: 50
- National staff: 731

"My husband and baby died of AIDS. I am a person living with AIDS and, every day, 700 people like me die from the disease because they do not have access to affordable medicines, even though they exist," said Patricia Asero, AIDS outreach worker for MSF in the Kibera slums of Nairobi.

It is estimated that around 2.3 million people in Kenya are living with HIV and that around 700 people die per day of HIV-related infections. What has become a chronic disease in Europe and America, where advanced treatments have reduced mortality by 80%, remains a death sentence in Africa. The antiretrovirals (ARVs) and other essential medicines now used to treat AIDS in the West have been too expensive in countries like Kenya, and legal barriers have prevented the import and production of affordable medicines.



Patient rights over patent rights

Patricia Asero may have more cause for hope now. After a year of campaigning by the Kenya Coalition for Access to Essential Medicines (which includes MSF), the country's parliament passed a law in June 2001 that puts patient rights above patent rights. This new legislation, Industrial Property Bill 2001, remains compliant with WTO/TRIPS agreements. Under pressure from the coalition, multinational pharmaceutical companies have also lowered the price of ARV treatment in Kenya. MSF teams are now preparing to implement ARV treatment programs in the field.

MSF continues to treat HIV-related infections and counsel AIDS patients – along with caring for people suffering from other diseases or health problems – in the Nairobi slums of Mathare, Kibera, and Dandora. Additional HIV/AIDS and tuberculosis programs are running in Homa Bay, on the shores of Lake Victoria, and in the district of Busia. In Nairobi, MSF is also starting a program to prevent mother-to-child transmission of HIV.

Somali refugees linger in Dadaab

Ten years since the outbreak of war in Somalia, the fighting continues. Nearly 130,000 Somali refugees remain in three refugee camps in the Kenyan border town of Dadaab. Partly as a result of donor fatigue, funding for the refugee camps, where MSF is in charge of all health care, is diminishing, leading to decreased daily rations for the refugees. From January to June, this resulted in an increase in the number of malnourished children receiving care in the MSF therapeutic feeding center from 72 to 196.

A severe drought that particularly affected northern Kenya prompted MSF to open a nutritional program in Mandera. In Samburu, MSF provided food to 6,000 children in a medical-nutritional program from October to December 2000.



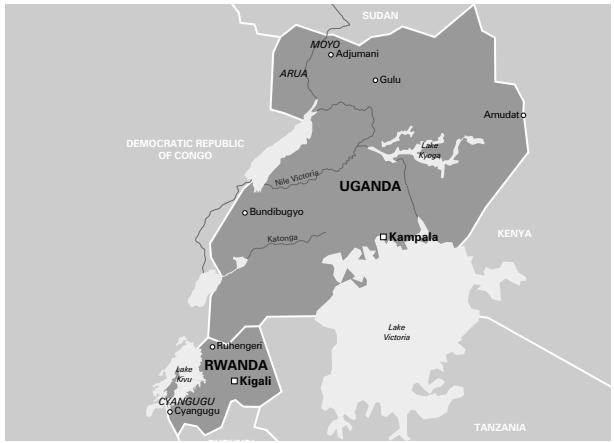
© Juan Carlos Tomasi

A woman seems to share the pain of her husband, who has AIDS, in the hospital in Busia, Kenya. MSF cares for AIDS patients in the hospital, trains staff, and promotes AIDS education in the district.

Rwanda

MSF responds to needs stemming from war and genocide

- International staff: 11
- National staff: 90



Rwanda is still reeling from the genocide in 1994 and the large-scale population displacements that rocked the country in the early and mid-1990s. The country also remains embroiled in war in neighboring Congo.

Pressing health concerns include mental trauma stemming from the genocide, war-related injuries, rising rates of HIV/AIDS, and diseases such as malaria, cholera, and meningitis. The health system lacks investment, with the government continuing to invest much of its budget, and its attention, in the war.

Assisting traumatized women

Many women were subject to torture and sexual violence during the genocide. Many also lost their husbands and faced the strain of taking over as head of the household. To aid these women, MSF joined forces with three Rwandan NGOs in August 2000 to create group therapy and awareness-raising sessions. MSF trains Rwandan trauma counselors, who lead the groups.

Another new project seeks to educate children about HIV/AIDS, which now affects more than 11% of the adult population (ages 15 – 49). This program reaches all primary schools in Cyangugu and Kigali prefectures – a total of nearly 28,000 children. In late 2001, direct care for people living with AIDS will begin in Kigali, the capital.



© Marcus Bleasdale

The Ebola burial team leader in Lacor, Uganda.

Support for Bushenge health district

MSF continues its support of the Bushenge health district in Cyangugu prefecture. Since 1997, MSF has helped improve care in the district's hospital and nine health centers. In 2000, maternity wards were built in two of the health centers. MSF also began a project to improve water and sanitation by constructing water supply and rainwater collection systems to supply five health centers. This program includes response to epidemics related to the water supply, such as the cholera outbreak that hit the area in late summer 2000.

MSF also remains ready to respond to other emergencies. After fighting in northwestern Rwanda in June 2001, MSF began surgical intervention in Ruhengeri.

Witness to past events

In spring 2001, MSF doctor Rony Zachariah was called to testify at a groundbreaking trial in Belgium of four Rwandans accused of genocide and crimes against humanity. He spoke about what he had seen in April 1994, when Rwanda was plunged into the butchery that would claim the lives of one million people. The defendants were eventually found guilty.

Although Zachariah testified as an individual, and not as a representative of MSF, his presence in the Brussels courtroom with the full support of the organization attested to the importance of witnessing, or "temoignage," as part of MSF's mission.

MSF has been working in Rwanda since 1991.

Uganda

Ebola outbreak draws world attention

- International staff: 42
- National staff: 344

In October 2000, the deadly Ebola virus surfaced in northern Uganda, prompting an immediate international response, of which MSF was a part. MSF worked with Ugandan medical personnel, staff from the Centers for Disease Control in the U.S., and the World Health Organization to help care for patients and contain the outbreak (see box). Other MSF staff continued programs focusing on sleeping sickness, kala azar, and HIV/AIDS, three of the major health threats facing the country, and provided basic and maternal medical care to residents and displaced people in some areas.

Fighting diseases

In the northern Ugandan districts of Arua, Moyo, and Adjumani, MSF works to control sleeping sickness through early detection and treatment of sufferers, all in an effort to reduce the prevalence of the disease in this area. MSF also supplies medicines to treat the disease. In east-central Uganda, MSF screens for and treats kala azar, a parasitic disease endemic in the area.

Uganda was one of the first countries in the region to face the threat of HIV/AIDS with a concerted public response. Yet the disease continues to take its toll on the country. In the hospital in Arua, as part of a new mother-and-child care program, MSF uses antiretroviral drugs to help prevent mother-to-child transmission of the HIV virus. MSF also gives financial support to a Ugandan NGO carrying out AIDS education in the districts of Moyo and Adjumani.

In and around the town of Bundi Bugyo, MSF continues to take care of malnourished children, provide basic medical care, and treat endemic diseases such as malaria. In the pediatric ward of the hospital, the introduction of the drug arthemeter under the supervision of an MSF pediatrician has helped decrease the mortality rate from malaria by 70%. MSF also works to improve hygiene and sanitation for about 150,000 displaced people living in camps near the town. In Amudat, in eastern Uganda, MSF supervises a health center that provides 800 outpatient consultations per month. There are 120 beds for inpatient care.

MSF began working in Uganda in 1982.

Outbreak: Ebola surfaces in Uganda

MSF is part of swift international effort to contain deadly virus

In October 2000, the Ebola virus surfaced in Gulu, a district in northwestern Uganda. The outbreak hit in three waves from October 2000 through January 2001. First identified in Zaire in 1976, the last known outbreak before the one in Uganda was in Gabon, in 1996. The virus has no known source, and no known cure.

Ebola is a mythic disease in part because it is brutal, swift, frightening – and rife with paradox. Infected patients are highly contagious, but care must be hands-on, intensive, contact-driven. Medical personnel experienced with the disease are needed, but the virus is so rare that people who have dealt with it are few. Hospital care is essential, but medical staff can be the first to die, with infections in the hospital often high. And a disease so adept at bringing death upsets the rituals and rhythms of death itself.

Swift international response

MSF was part of a team of international organizations and agencies, including the World Health Organization and the Centers for Disease Control in the U.S., that responded immediately after Dr. Matthew Lukwiya, a Ugandan doctor, suspected Ebola in some of his patients in Gulu in early October. MSF was on the ground with a team of 20 doctors, nurses, epidemiologists, and logisticians by October 15th. For four months, MSF focused on case management, which encompassed active case searching, contact tracing, medical care, proper burial of bodies, and reintegration of survivors into the community.

No cure, only care

Ebola patients suffer initially from symptoms that can include fever, headache, vomiting, diarrhea, and rash. As the disease progresses it is often accompanied by liver damage, kidney failure, and massive internal bleeding. Some patients bleed to death from all body orifices. Others go into shock. The disease is spread through bodily fluids, passed through contact as simple as a handshake, a hug, or a shared cigarette.

The principal medical care given to Ebola victims is oral rehydration, mostly in the form of salt. Sometimes intravenous drips are used, or, occasionally, other medication. But there is no cure for Ebola, only care. Severe progressive weakness in Ebola patients is a sign that the concentration of the virus is building up in their bodies; the people most in need of attention become the most hazardous to care for.

One of MSF's activities was training local health staff on how to attend to Ebola patients while protecting themselves. A method called "barrier nursing" is necessary in the Ebola isolation ward. Hospital personnel wear individual non-reusable gowns, two pairs of gloves, masks, goggles, and rubber boots. They wash constantly and are periodically sprayed with bleach, and equipment is continually sterilized. Patients are isolated from all contact with unprotected people. In Uganda, MSF supervised one of the two isolation wards set up during the outbreak.

The key caregiver for each patient was often not part of the medical staff at all, but a member of the family. This is common in many African hospitals, a result of a lack of nursing staff, or because nursing duties do not extend to cooking, cleaning, and attending to bodily functions. Of the utmost importance during the outbreak was making this personal caregiver as safe as possible from infection, through protective clothing and close monitoring by the medical staff.

People who survived Ebola in Uganda often pointed to two conditions that really helped them: fluids when they wanted them, and encouragement from staff and caregivers, sometimes in the form of spiritual support or music playing by their bed.

Information campaign

Mobile teams worked in tandem with the medical care efforts. Small groups fanned out in Gulu district, and later in Masindi and Mbarara, tracing contacts of confirmed patients. They identified suspected cases and brought them to the hospital. About 10% of the cases in the outbreak were identified this way. Because of the frightening nature of the disease, many people were at first afraid to report it – but later swamped the hospitals with any small complaint, fearful that they had contracted the virus. An important part of MSF's work was providing information to try and lessen the stigma. Health workers and recovered patients were shunned because of their association with the disease and their contact with the hospital. Psychological support was also given to local medical staff and international volunteers.

Deadly disease upsets the rhythm of death

In Uganda, as elsewhere, the rituals of death are an intimate part of the rituals of life. Bodies are washed carefully. People watch over a body on the eve of burial, and mourners dip their unwashed hands into a common bowl. The emergence of Ebola changed this. In a time of so much death, a ban was put on traditional funerals in an effort to stem the spread of the disease. The bodies of Ebola victims were sealed in special bags and taken by protected workers and drivers to be buried immediately. People handling the bodies and trucks transporting them were thoroughly disinfected after each trip.

Grim tally

When the outbreak was officially declared over on February 28, 2001, and the virus had slipped away once again, it had infected 425 people and taken the lives of 224, including 21 health workers, among them the doctor who had first sounded the alarm.

Eritrea | War-displaced now vulnerable to malaria

- International staff: 17
- National staff: 129

MSF started working in Eritrea shortly before war with Ethiopia flared up in May 2000. After working through the war and in the post-war period, MSF is now winding down its activities in Eritrea.

However, at the request of the Eritrean Ministry of Health (MOH), MSF is remaining in the Tserona area through the fall malaria season. Malaria is endemic in the area, and, because the population lost much of its immunity after two years in IDP camps in the highlands, MSF will stay on hand to respond to any potential malaria epidemic.

Aid focused on displaced during and after war

Initial activities focused on aid to people displaced by the fighting, in 24 camps in the Debub, Gash Barka, and Red Sea zones. MSF provided basic health care, epidemiological surveillance, care for the malnourished, vaccinations, and water and sanitation support. MSF also distributed jerrycans, blankets, tents, and plastic sheeting.

Hostilities ceased in June 2000, and in the following months thousands of people were able to return home. With the MOH taking charge of most of the needs of the displaced, MSF's work in the camps started to wind down in late 2000 and was finally completed in June 2001.

Meanwhile, MSF turned its attention to Senafe and Tserona, two sub-zones of Debub that had been occupied by the Ethiopian army during the fighting, and to some areas in Gash Barka. In Senafe, the hospital had been destroyed and the health posts closed. In February 2001, MSF opened a small clinic that has about 80 consultations a day, and put up a 30-bed tent hospital. In May, MSF finished its work in the area when the Eritrean authorities returned to the zone, as mandated by the ceasefire agreement. In Tserona and in Gash Barka, during summer 2001 MSF helped prepare for the return of the displaced by focusing on emergency repairs to health facilities and water sources.

Ethiopia | Aid in the face of war, food crisis, and epidemics

- International staff: 58
- National staff: 685

Mid-2000 marked the end of a two-year war between Ethiopia and neighboring Eritrea. During the war and in its aftermath, MSF has responded to the needs of civilians who need access to surgical care, the war-wounded, returning refugees, and internally displaced people. In Tigray, a region bordering Eritrea, MSF provides surgery for civilians and landmine victims, gives medical assistance to hundreds of thousands of IDPs, coordinates medical care in a transit camp for tens of thousands of Ethiopians, and takes care of water and sanitation in a camp for 4,000 Eritrean refugees.

Food crisis

Through October 2000, MSF continued the emergency nutritional aid begun in early 2000 in areas of the country affected by severe drought. MSF opened feeding centers for malnourished children in Amhara and North Wollo, in the north, in Denan and Gode zones in the southeast and in Welayita, South Omo, and Konso/Arero zones in the south.

Massive donations of food were made throughout 2000 and 2001. While the situation improved in some areas, and some MSF feeding programs were able to close, people in Welayita, Wollo, and Somali regions remained at risk. MSF has maintained its feeding programs in Denan, in the Somali region, where a nutritional survey in May 2001 revealed a general malnutrition rate of 51%, with severe malnutrition affecting 9% of the population.

MSF continues to provide health care to Sudanese refugees, displaced people, and area residents in Menkush, near the border with Sudan. District health support is offered in Dubti (in the Afar region) and Woldya (in North Wollo).

Meningitis, kala azar, AIDS, and tuberculosis

Meningitis hit Ethiopia in early 2001, part of a deadly outbreak that swept across Africa's "meningitis belt" (see page 30). In the regions of Gambela, Bench Maji, East Wolega, Amhara, Oromia, Gurage, and Southern People, MSF vaccinated over 1.4 million people.

Kala azar (visceral leishmaniasis) is endemic in several areas of Ethiopia. The parasitic disease is fatal if untreated, but with treatment the cure rate is above 90%. Since 1999, MSF has fought kala azar in the southern area of Konso, where an estimated 70,000 people are exposed to the fly-borne disease, and in Humera in the north. MSF works to reduce the time between detection and treatment and increase local capacity to cope with the disease, and help the health authorities introduce cheaper generic drugs.

AIDS is also a threat in Ethiopia. More than 2.9 million adults and 150,000 children are living with the virus. MSF has started HIV/AIDS and sexually transmitted disease (STD) prevention and treatment programs in the town of Humera in northern Ethiopia, and in big towns along the main roads crossing the country. In the capital Addis Ababa, MSF treats STDs and promotes HIV/AIDS prevention in the city's 22 health centers, and has drop-in centers in four red light districts. STDs are also treated in Tigray.

Tuberculosis (TB) is one of the leading causes of death in the country. MSF TB programs treat about 3,000 people a year at five locations in the Somali region. In early 2001 another TB program began among the semi-nomadic population in Afar.

In Wag Hamra zone in Amhara province, MSF has established and is currently monitoring safe and clean water supplies in five semi-urban and 19 rural communities. In Afder, in the drought-plagued Somali region, a new water rehabilitation project has been started.

MSF started working in Ethiopia during the famine in 1984. After speaking out against forced population movements in 1984, MSF was expelled, but reentered the country in 1985 and has since maintained a permanent presence.

Somalia | Enduring needs in a war-ravaged country

- International staff: 12
- National staff: 126



| Since 1991, Somalia has experienced the complete collapse of its central government, the death or displacement of at least two million people, and a brutal civil war that has destroyed much of the country's infrastructure and productive capacity. Despite a new transition government trying to bring order, the country remains fractured.
| Somalia ranks near the bottom of the United Nations' human development index. The health care system, along with all state services, has collapsed. Most doctors have fled the country and, apart from staff working with NGOs, no doctors or nurses have been trained in Somalia since the outbreak of war. The only available public or free health care is via the few NGOs still working in the country.

MSF suspends programs in Mogadishu

| The security situation has deteriorated over the last year in the capital, Mogadishu, as tension between the government and faction leaders rose. In March 2001, MSF suspended its medical programs and cholera activities in the city indefinitely, after its compound was violently attacked and ransacked during a meeting with a UN assessment mission. MSF medical activities elsewhere in Somalia continued.

| In the south, in the Bakool region, MSF vaccinated 27,000 children for measles and continues to provide in- and outpatient health care for around 150,000 people. In Kismaayo, after nine years of training medical staff and running the 200-bed hospital, MSF handed management of its projects over to the local authorities.
| In Giohwar and Aden Yabal, in Middle Shabele, 11 health centers and six mother and child health care programs provided 160,000 consultations over the last year. Three mobile teams ensure that many of the primarily nomadic people in more remote areas receive care and follow-up.
| Further north, in the town of Galkaayo on the Ethiopian border, MSF runs a 60-bed hospital, which also has 2,000 outpatient consultations per month. Some people walk for hours and sometimes days to reach the hospital, many crossing the border from Ethiopia for treatment.

Treating kala azar

| MSF gives technical support to the kala azar diagnosis and treatment programs of all NGOs in Somalia. Last year, 800 patients throughout the country were diagnosed and treated for this deadly parasitic disease. Although kala azar treatment is difficult and expensive, over the years MSF has developed expertise in training medical staff to treat the disease, and is campaigning for more affordable and simplified treatments through its Access to Essential Medicines Campaign.
| MSF has been working in Somalia since 1986.

A patient with kala azar (visceral leishmaniasis) lies in the corridor of a hospital in Humera in northern Ethiopia. The disease, spread by the bite of an infected sandfly, threatens about 350 million people worldwide, mostly in developing countries. It is still treated as it was in the 1940s.



© Sven Torfinn

Burundi | Fever, hunger, and war

- International staff: 44 (plus 48 additional staff during malaria epidemic)
- National staff: 825 (plus 1,100 additional staff during malaria epidemic and malnutrition crisis)

People crowd outside a makeshift clinic high in the northern hills, hoping for medicine to treat their malaria fever, cure their disease. Feeding centers in several provinces fill to capacity. Nurses don masks against the stench of death, attending to wounded and sick people in the capital after a violent surge in the civil war. The people of Burundi faced no shortage of violence and hardship this year.

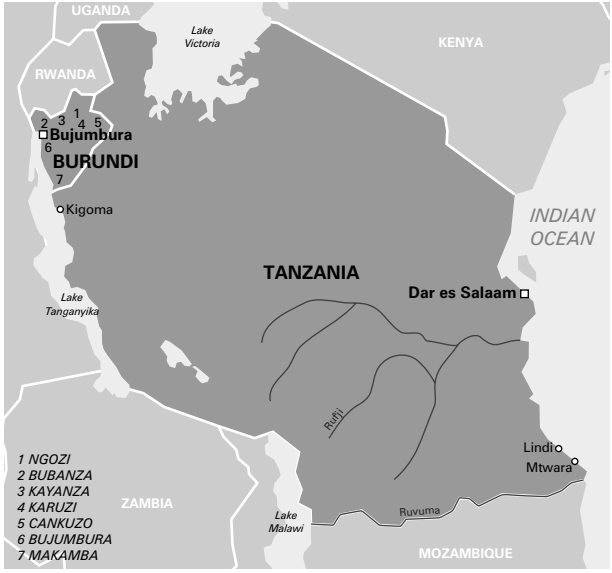
Since 1992, MSF has continued to provide medical aid to stricken civilians in this war-torn country.

An unprecedented malaria epidemic....

Malaria hit Burundi in September 2000. The disease rose to epidemic levels in nine of the country's 16 provinces. In November alone, 720,000 people fell ill countrywide. To help the overwhelmed health system cope with the outbreak, MSF put in place a vast emergency response effort that, by late 2000, stretched to Kayanza, Karuzi, Cancuzo, and Ngozi provinces. Nearly 50 additional volunteers were brought in for the emergency effort, along with many additional local staff.

MSF worked in numerous health centers, diagnosing and treating the disease as well as providing medical material and drugs. Mobile teams fanned out to bring care to malaria sufferers in isolated villages. In December, at the peak of the outbreak, MSF teams held over 75,000 consultations a week. Between the onset of the epidemic and the end of its crisis level in April 2001, MSF treated over 1,200,000 patients and sprayed over 30,000 homes in an effort at vector control. As of July, the caseload was still 6,000 patients a week in some areas.

If the epidemic's direct causes were natural – the parasite-carrying mosquito and climatic factors – its indirect causes were man-made. Virtually all vector control was stopped in 1993, the year the country fell into war. MSF field studies also showed that the parasite prevalent in the outbreak was resistant to the standard Burundian treatment protocol for simple cases, chloroquine-Fansidar® – adding to the virulency of the epidemic. MSF pushed for months for a more effective medicine to be accepted by the Burundi health ministry. After resistance studies by MSF and other organizations, in July 2001 Burundian authorities and the World Health Organization finally accepted the use of another drug, Coartem®, a more effective drug using artemisinine derivatives, in case of another epidemic. MSF is continuing to study the feasibility of other malaria protocols in Burundi and is pushing for more effective treatments to be adopted as the nationwide protocol.



....and malnutrition

In the midst of the malaria epidemic, the nutrition situation in northern Burundi began to deteriorate. MSF was already running long-term feeding programs in Karuzi and Cancuzo provinces. With the first alarming signals, MSF opened new therapeutic feeding centers (TFCs) for the severely malnourished and supplementary feeding centers (SFCs) for those suffering from moderate malnutrition. MSF also called on the World Food Program and its donors to effect a general food distribution to help alleviate hunger.

During the peak of the crisis, from November 2000 through March 2001, MSF opened seven TFCs and ten SFCs in Karuzi province, and one TFC in Ngozi province. Feeding centers in Cankuzo province expanded to meet increased need during the crisis. MSF also supported four SFCs run by the Burundian health service in Ngozi. At one point, the SFCs in Karuzi were treating nearly 20,000 children and pregnant and breastfeeding women at a time, while the TFCs provided aid for several thousand people. A TFC in Kamenge, where MSF also set up a cholera treatment center, aided 60 – 90 children at a time.

The bitter fruits of conflict

In the Bujumbura area and in Kayanza, MSF continues to provide surgical care to civilians wounded by the war. Access to the Bujumbura neighborhoods of Kamenge and Kinama was cut off for several weeks in March 2001 by fighting. Mobile teams worked in Kamenge during the fighting, and a center for war-wounded treated 80-100 patients. After once again gaining access to Kinama, MSF launched two clinics there. MSF also assisted 2,000 families who fled Bujumbura Rural during the fighting for refuge in the Mubone area.

In Makamba, a region in southern Burundi that is home to a large displaced population, MSF was finally able to restart its medical program in May 2001 after being denied access to the area for almost a year. An MSF surgeon works in the hospital.

In Bujumbura, Bujumbura Rural, Karuzi, and Cancuzo, MSF continues its ongoing preventive and curative programs that provide basic medical care, vaccinations, mother-and-child care, and nutrition support, through a network of hospitals, health posts, and mobile clinics.

Tanzania

Strengthening response to cholera and malaria

- International staff: 16
- National staff: 80

The core of MSF's work in Tanzania remains developing local capacity to respond to outbreaks of cholera, malaria, and meningitis, and supporting district health structures.

MSF has been working since 1997 to strengthen official response to epidemics. When Tanzania was hit with limited outbreaks of meningitis (in Mtwara) and cholera (in Dar es Salaam) over the last year, MSF monitored the response of the local authorities and remained ready to assist if requested. MSF is also currently in the second phase of a comprehensive effort to improve cholera preparedness in Dodoma, Lini, and Dar es Salaam.

The leading cause of morbidity and mortality in Tanzania is malaria. MSF is starting a project to strengthen malaria management (in line with the country's new Malaria Diagnosis and Treatement guideline) in the district of Kigoma; the program will also focus on public awareness and education at the community level.

MSF continues work in the Mtwara health district, reaching a population of 200,000 people. The focus is on mothers and children. A similar district health project in Kigoma, which benefited about 230,000 people, drew to a close in November 2000. Work in Kigoma included a strong cholera prevention component.

Intensified fighting in neighboring Burundi has prompted an influx of people seeking refuge in Tanzania. MSF remains ready to assist government authorities and other agencies should the humanitarian situation worsen.

MSF began working in Tanzania in 1993.



© Didier Ruef

After a medical consultation with MSF, mothers and their babies rest outside the village health center in Rutongo, in Burundi's Bujumbura Rural province. The peaceful scene belies a country scourged by war, malaria, and hunger.

Congo-Brazzaville

MSF helps revive national sleeping sickness program

International staff: 25
National staff: 212



© Sebastian Bolesch / Das Fotoarchiv

These young people, displaced by conflict in the Democratic Republic of Congo, are eager to learn at this school in Kanyabayonga. The local population took in about 20,000 displaced people.

After coping with the health crisis created by a year-long flare-up of civil war that began in December 1998, in mid-2000 MSF's programs in Congo-Brazzaville began to shed their emergency focus, as the country began the slow process of recovery.

Basic health care

Aid to massive flows of returning displaced people evolved into support for several hospitals and health centers in and around Brazzaville, the capital, and the cities of Kinkala, Mindouli, Sibiti, and Mussendjo. MSF relaunched medical services, trained health staff, helped reconstruct health facilities, and carried out vaccinations. Work in Kinkala finished in September 2000 and in Mussendjo in April 2001, but continues in Brazzaville, Mindouli, and Sibiti.

Sleeping sickness

The hospital in the eastern city of Gamboma was a public center for treating sleeping sickness until civil war forced the closure of the national sleeping sickness program in 1995. In October 2000, MSF began work in Gamboma, initially helping the Ministry of Health (MOH) revise the national sleeping sickness protocol. In March 2001, 16 Congolese health workers were trained in the new protocol, and in April the Gamboma sleeping sickness unit became functional again, with 62 patients put under treatment in April and May. Additional screening of about 30,000 people along a 120km stretch of the Congo River began in May.

Caring for victims of rape and sexual violence

Since April 2000, MSF has supported the national program to aid victims of sexual violence, based in three hospitals and a health clinic in Brazzaville. While massive rape linked to the conflict has ceased, rape and sexual violence are still common. At Makelekele hospital, MSF provides medical and psychological support to rape victims and offers prophylactic treatment to help prevent HIV and sexually transmitted diseases. There is a similar follow-up of children born as a result of rape. In 2000, 109 women and 10 children received the preventive treatment.

Refugees

When around 5,000 people fled the Democratic Republic of Congo (DRC) for northeastern Congo-Brazzaville in May 2000, MSF established an aid project for refugees in a camp near the town of Ndjoundou. More refugees entered the country in August 2000, with nearly 25,000 people concentrated in the town of Bétou on the Ubangui River. The area health post was ill-equipped, and no other aid was in place. MSF established a mobile clinic and set up dispensaries along the river. A broader program to support in- and outpatient care for refugees and area residents is now underway.

Democratic Republic of Congo (DRC)

Far-reaching programs extend basic care to millions

- International staff: 80
- National staff: 730



The health system of the Democratic Republic of Congo (DRC) is in tatters after years of civil war and government neglect. After the killing of President Laurent Kabila in January 2001, the new regime led by his son has expressed its intention to bring stability to the country. Yet insecurity still reigns in many parts of the DRC. Congolese and foreign armed groups continue to clash inside the country's borders, often in an effort to siphon off some of the country's vast natural wealth.

Caught in the middle are the Congolese people. They are threatened by injury, displacement, and death from the ongoing civil war. They are exposed to diseases already under control or eradicated elsewhere in the world, and to frightening ailments such as sleeping sickness and the plague. Even the most basic health care services are lacking in many areas.

Humanitarian aid is hampered by insecurity. This was underscored in April 2001 when six Red Cross workers were killed in Oriental province. To protest the brutal act, MSF suspended its programs in the country for three days.

MSF works in both government- and rebel-held territory on a wide variety of medical programs.

District health

The cornerstone of MSF's work in Congo remains district health care in several provinces. MSF aids the health structures that make up a health zone – usually a reference hospital and the clinics and health posts that feed into it, covering about 100,000 people. Activities include supplying medicine, supervising and training health staff, ensuring vaccinations and prenatal care, carrying out epidemiological surveillance, and improving water and sanitation practices and facilities.

For the last several years, MSF has assisted nearly 30 health zones scattered in Equateur, Katanga, Bas Congo, Kisangani, Bukavu, North Kivu, and South Kivu provinces. MSF began work in Bandundu province in September 2000, and at Dungu hospital in North Oriental province in March 2001.

Nutrition

Over the last two and half years, MSF has provided intensive (therapeutic) nutritional care in Kisangani to over 10,000 children, and supplementary care to over 17,000 children. Because the situation in that area has improved, this program will gradually be phased out. In Kitshanga, a conflict area, MSF opened a therapeutic feeding center in September 2000. In Basankusu, another scene of fighting, MSF opened a therapeutic feeding center in October 2000. As of July 2001, more than 1,500 children had been treated.

Fighting disease

In its district health projects, MSF works against a variety of diseases, including measles, tuberculosis, cholera, and meningitis. In June 2000, a pilot HIV/AIDS project began in Bukavu, and MSF hopes to open an AIDS treatment center in Kinshasa in fall 2001.

Two sexually transmitted disease (STD) clinics in Kinshasa, the capital, see about 30,000 people a year, and STD work also takes place at an additional 22 health centers in Kinshasa and 15 in Lubumbashi, in Katanga province.



© Roger Job

A malnourished child gets help eating from her mother at the MSF feeding center in Basankusu, Democratic Republic of Congo, in November 2000.

In South Equateur province, MSF runs a sleeping sickness screening and treatment program where 60,000 people were screened in 2000. MSF is looking at starting a similar program in Kinshasa.

MSF also responded to cholera epidemics in Pweto and in the region of Kabalo, both in Katanga province.

Displaced people and refugees

There are an estimated two million Congolese displaced inside Congo, many of them outside the reach of aid workers. MSF aids 3,500 Congolese (returning from Angola, Central African Republic, and Sudan) in a camp in Sicotra, near Kinshasa, and some 4,000 Congolese refugees (returning from Zambia) in a camp in southern Katanga province. MSF also assists Angolan refugees in a camp in Kimpese, in Bas Congo province. The situation in that area has stabilized, and MSF hopes to finish work by the end of 2001.

The first MSF intervention in Congo (then Zaire) was in 1981.

Angola | MSF speaks out on illusion of normalization

- International staff: 80
- National staff: 850

Since 1983, MSF has met pressing medical needs in many parts of Angola, a country torn apart by a civil war that has lasted for more than 25 years. In November 2000, on the 25th anniversary of Angola's independence, MSF issued a report entitled "Angola: Behind the façade of normalization – manipulation, violence, and abandoned populations." MSF drew on its field experience in Angola, as well as testimony from affected and displaced people, to paint a bleak portrait of the plight of the population. See the following pages for excerpts from the report.

The report grew out of work in nine of Angola's 18 provinces. MSF supports provincial hospitals, cares for internally displaced persons (IDPs) in cities and camps, runs feeding centers and clinics, carries out nutrition surveys, supplies medicine, trains local health care workers, and responds to epidemics of cholera and other diseases such as meningitis, sleeping sickness, and pellagra, a vitamin deficiency disease.

Working to expand access to the people

In several program areas, including Luena, Kuito, Huambo, Malanje, and Caala, MSF has been pushing to reach people living beyond the officially defined security perimeter drawn a few kilometers around these provincial towns.

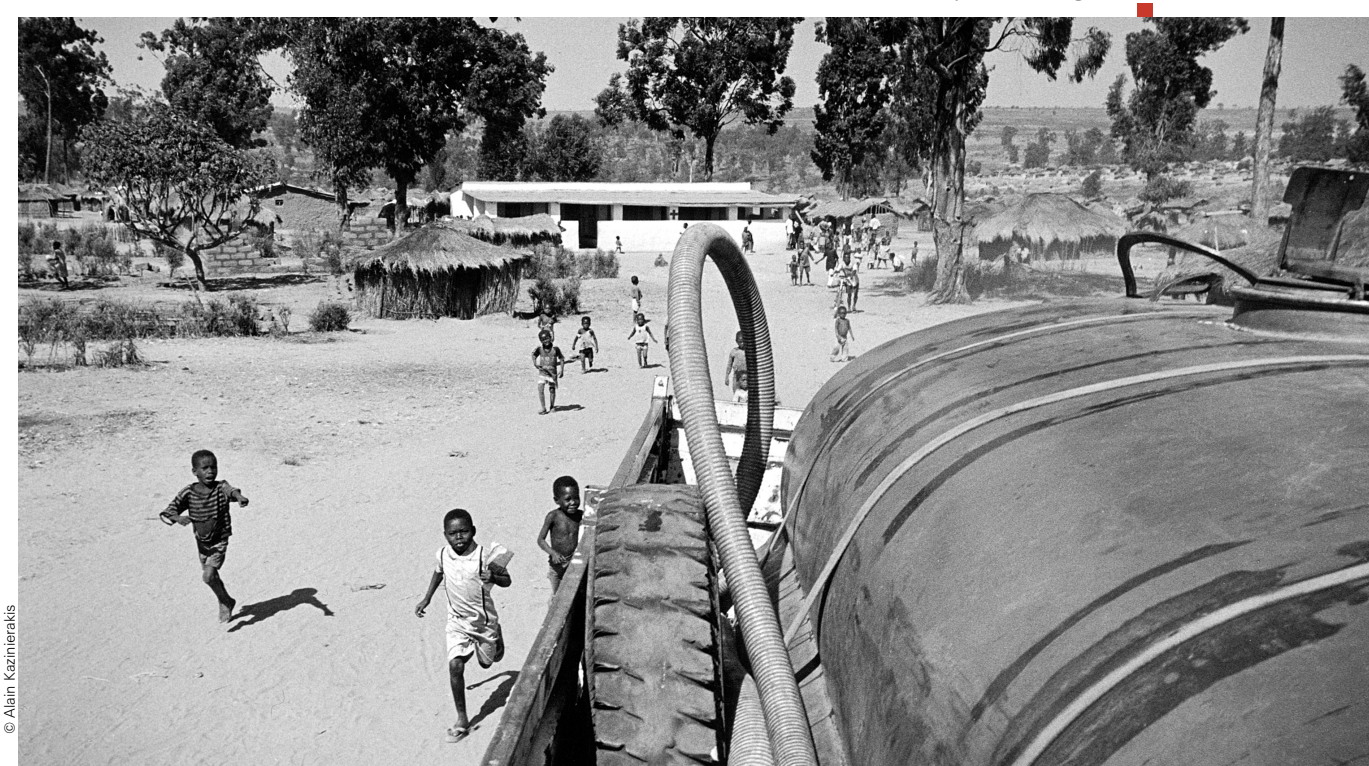
While during the last year access in some areas has slowly started to improve, it remains limited and the security situation fragile. MSF has been able to travel up to 15km outside of Luena, 50km south of Caala to Cuima, and 80km outside of Kuito to Camacupa. Logistical constraints and insecurity have prevented MSF from reaching the town of Mussende, near Malanje; however MSF successfully pushed for a government assessment and vaccination team to enter the town.

Ongoing medical care for IDPs and residents

The provincial cities Kuito, Luena, and Caala are magnets for people fleeing the countryside. MSF supports the hospitals in Kuito and Caala with care, training, and medicine, and carries out epidemiological surveillance. After several years of similar work in Luena, MSF withdrew from the hospital there in February 2001 and now focuses on health posts in IDP camps near the city. Mobile clinics also reach areas of the city where some of the displaced have resettled.

MSF runs feeding programs in Kuito, Luena, Uige, Camacupa, Lombe, Cangandala, and Caala. A nutrition program in Malanje ended in February 2001. While overall the instance of malnutrition has eased somewhat from that of mid-2000, in certain areas malnutrition has been on the rise and MSF has responded by opening new feeding centers as warranted.





Children run after the MSF water truck as it leaves a camp for displaced people outside of Luena, Angola. The truck provides water for camp residents and the MSF health post (in background).

© Alain Kazinierakis

Primary health care and training, through hospitals, health posts, or mobile clinics are provided at the above locations, as well as in Menongue, Matala, and Huambo. In Zaire province, in the city of M'Banza Congo, MSF relaunched a primary care program serving about 30,000 people.

Most of the above projects treat area residents as well as people who have been displaced from their homes because of the war.

Focus on disease

MSF has been treating sleeping sickness in the N'Dalatando area since 1995. In fall 2001, this project will be turned over to the Angolan national sleeping sickness program. MSF hopes to establish a separate operational research project using eflornithine and nefurtimox that will lead, eventually, to their inclusion in the national protocol. These two drugs – which are not currently part of the national protocol and thus could not be used in N'Dalatando – are increasingly available and affordable, partly as a result of MSF's Access campaign. They are also much less toxic than melarsoprol, an arsenic-based drug that is the current frontline treatment for advanced stages of sleeping sickness.

In Luanda, MSF is continuing its emergency cholera preparedness program and is working to establish several cholera treatment centers.

Zambia | Vast refugee camps are the focus of aid

- International staff: 15
- National staff: 36

Over the last year, people continued to flee fighting in Angola and the Democratic Republic of Congo (DRC) to seek refuge in Zambia, as of January 2001 home to an estimated 225,000 refugees. MSF work in the country is centered on refugee camps in three provinces. Work began in the Nangweshi camp in Western province, home to 14,000 Angolan refugees, in March 2000, and MSF established the Kala camp in Luapula province – home to 15,000 Congolese refugees – in August 2000. The Meheba camp in North-West province was established in 1971. Its population of 50,000 mostly Angolan refugees makes it one of the largest refugee settlements in Africa. In early 2000, MSF began providing emergency health care to new refugees at Meheba and also took charge of three clinics.

Activities at the three refugee sites range from basic medical care, family planning, immunization, and treatment of malnutrition, to the training of local health workers, water and sanitation activities, and laboratory work. MSF also provides medicines and medical material to health structures.

HIV/AIDS

A new AIDS/HIV project was launched in April 2001 in the northern district of Nchelenge. The livelihood of residents depends on fishing Lake Mweru. During the fishing season, people from all over the district settle in temporary camps along the shores where little medical aid is available. In addition to local migrants, 12,000 refugees from neighboring DRC also settled near the lake. MSF focuses on medical care for AIDS patients, voluntary counseling and testing, and training community health workers and health center staff.

MSF has been working in Zambia since 1999.

Zimbabwe | New mission joins fight against AIDS

- International staff: 5
- National staff: 7

Zimbabwe has been gripped by the AIDS crisis. As in so many countries in southern Africa, the statistics are numbing. Over 25% of the adult population has AIDS. The disease has already claimed the lives of half a million people, out of a population of 12 million. Yet the AIDS epidemic has not been a priority for the government, which is preoccupied with other domestic and international affairs and has made little effort to implement an effective national AIDS policy. To help cope with this, MSF launched a program focused on HIV/AIDS prevention and treatment in October 2000.

MSF works at the Inyathi hospital in the district of Bubi in Matebeleland North province, which had the highest number of HIV/AIDS cases in the country in 1998. Little international aid has been directed here. MSF has begun working with local health authorities to improve strategies and techniques for dealing with the epidemic. MSF is also trying to increase knowledge of HIV/AIDS among the general population, through bottle stores – places where people often meet for a drink – and by the creation of an HIV/AIDS resource center, where voluntary testing and counseling are also offered.

One of MSF's key partners in Bubi is Bekezela, an NGO created by the local community. This organization has taken on AIDS-related challenges such as health education, and has established a network of village volunteers who visit AIDS patients and their families.

Nevirapine, an antiretroviral drug, has recently been registered in Zimbabwe. In this country where 100 babies are born with the virus every day, MSF is preparing a pilot program targeting mother-to-child transmission of HIV using Nevirapine. Yet, in general, introduction of antiretroviral drugs in Zimbabwe is still at a very early stage. MSF is supporting Zimbabwean health authorities in their efforts to obtain information on drug prices and on ways to get access to affordable treatments.

In November 2000, on the 25th anniversary of Angola's independence, MSF issued a report on the ever-deteriorating humanitarian situation of the Angolan people. MSF drew on its experience in the field, as well as testimony from affected and displaced people, to paint a bleak portrait of the plight of the population. The following is taken from the report, which is available in full at www.msf.org.

Angola: Behind the façade of 'normalization'- manipulation, violence, and abandoned populations

"On November the 11th Angola will celebrate 25 years of independence. This date also marks 25 years of war between the Angolan Government and rebel group Unita (União Nacional para a Independência Total de Angola). Today, the Angolan government, which claims to control more than 90% of the territory, is trying to demonstrate to the world that the situation is returning to normal. Since December 1998, however, the conflict has entered a new and particularly violent phase.

| It is not just the Angolan government that is speaking of "normalization" in the country. The international community and the United Nations echo this talk of newfound stability. Support from the international community in the form of substantial economic investments, whose impact is only visible in Luanda and on the Atlantic coast, makes this façade of stability possible.

| This pretence of normality is unacceptable. Angolans are increasingly bearing the cost of the war: forced displacement of populations, cynical manipulation and abuse by the parties to the conflict, total dependence on humanitarian aid. The high price Angolans are paying can be seen in the demographic and health data, in the mortality and malnutrition rates, in the recurring epidemics. It can be understood through the stories told by the people themselves.

Forced displacement and increasing violence

| At the end of 1998, after a few years of relative peace following the Lusaka Agreements, war again took hold of Angola. Since that time, internally displaced persons (IDPs) have flooded into those cities controlled by the government, while others have sought refuge in neighboring countries.

| This massive body of men, women, and children has been displaced into many of the cities where MSF is working. Kuito, for example, currently has 240,000 inhabitants, of which 130,000 are displaced. In Uige, there are over 55,000 displaced among a total population of approximately 146,000. In Caala, MSF estimates the displaced to number nearly 24,000, of which 12,000 live in camps, among a population of approximately 80,000.

| Accounts from the displaced reveal that their home villages are in extremely unstable areas, in turn captured, lost, and recaptured by the two parties over the past few years. On the one hand, the population suffers from the effects of frequent conflict, looting of food reserves, and theft of their harvest. On the other hand, they suffer reprisals from both warring parties who accuse them of collaborating with the enemy. For these people, escape then becomes the only option for survival.

Deterioration of the medical and nutritional situation

| The resumption of the conflict at the end of 1998 has had a serious impact on the medical and nutritional status of Angolans. In the cities, and especially in the IDP camps, precarious living conditions have resulted in distinctly high mortality rates, as evidenced by the significant number of admissions to the health structures and emergency services where MSF works. MSF has noticed in particular a substantial increase in the numbers of war-wounded and mine victims.

| The large population displacements have provoked a severe food crisis, affecting both residents and IDPs. Following the surge of IDPs into the provincial capitals, MSF has had to open a total of 26 nutritional centres in the districts of Kuito, Luena, Uige, Huambo, Caala, Malanje, Cangandala, and Lombe. Looking at the information coming from the nutritional centers, it is clear that the IDPs have been the hardest hit by the food crisis.

Wilful neglect of the health system by the Angolan authorities

| In general, the authorities' commitment to the health sector remains remarkably weak. Supplies of drugs and medical materials from the Ministry of Health to the provinces are woefully insufficient. In the provinces there are very few doctors, compared to several hundred in the capital Luanda. This situation forces MSF and other organizations to substitute for the Ministry of Health; the population would otherwise not have access to health care.

| The lack of medical supplies, the absence of qualified medical personnel, and the poor salaries may not seem unusual for an impoverished developing country, but Angola has substantial oil and diamond resources. Oil production in the country is estimated at close to 800,000 barrels per day, yet there is not a drop of diesel for the hospital generators, the only source of power in most large hospitals. Clearly, the Angolan population is not benefiting from the country's wealth.

Many have been deprived of assistance since 1998

| MSF has been present in Angola since 1983. Until 1997, MSF teams assisted the Angolan population in both government and Unita-controlled zones, and in 1997 under the GURN administration (the Government of Unity and National Reconciliation). The resumption of the conflict in 1998 and the resulting insecurity forced MSF to close numerous programs, leaving the population in many areas without assistance. MSF no longer has access to a large part of Angola and its population, in particular in Unita areas. The displaced people report that there have been no functioning health structures in the Unita zones since fighting resumed.

| Even in the zones claimed to be under Government control, MSF can only work in the provincial capitals or in a handful of large towns. Beyond a supposedly secure perimeter of 5 to 30 kilometers around these towns, roads and fields remain mined and prone to attack.

| For the last two years, the United Nations has given up demanding access to Unita zones and ensuring the protection of civilians there. Hundreds of thousands of people are paying a heavy price for this lack of initiative.

Conclusion

| The Angolan government claims that the situation in the country is returning to normal, but this is a far cry from the reality witnessed by the MSF teams working in nine provinces throughout the country. In this new phase of the conflict, the population has been increasingly subjected to the violence of war, abused, displaced, and relocated according to military strategies and political interests, exposed to epidemics and malnutrition.

| Contrary to the claim made by the Angolan authorities that the situation is simply a consequence of the war, MSF finds that it is the result of deliberate choices, on the part of the government, Unita, the international community, and the United Nations."



© Didier Ruef

Early morning sun streams into this warehouse in Caala, Angola, home to families displaced by the war.

With each offensive of the government, Unita moved and took all the people along with them. It is the tactics of Unita! Each time, we went where they told us to go. Indeed, there had to be nobody left behind because any lost person was a person more for the government!

Displaced person from Huambo Province

We left because of death and famine. We did work but were left with almost nothing: we were farming but everything was always either taken by the government or by Unita. If it wasn't the FAA that came during the day for the batidas, it was Unita that came at night. At some point, we had almost nothing left to eat, so we decided to flee through the bush, hoping to be able to reach Kuito.

Displaced person from Bié Province

Before, the FAA [the government army] did not use to rape women. They have started with this war. Single or married women, it doesn't matter. They break into houses, tell the man to leave, threatening them at gunpoint and then they rape the woman. I don't know any cases of one woman raped by many troops, but cases of women raped by one soldier I know many.

Displaced person from Bié Province

Madagascar

Natural disaster and nutritional emergency

- International staff: 13
- National staff: 103

Work in Madagascar over the last year was dominated by response to a nutrition emergency that hit the eastern region of Mahanoro. In the capital Antananarivo and in Antsirabe, MSF continued its work with children living in the streets or placed in institutions such as reeducation centers or prisons.

After the cyclones

Two cyclones and a tropical storm hit Madagascar between February and April 2000. For five months, MSF teams, together with the Malagasy National Security Office, provided shelter, safe water, and medicine to several thousand families in the Antahala, Maroantsera, and Mahanoro regions. Several months after the storms, the food situation in this part of the country began to deteriorate because of a failed harvest. In response, in fall 2000 MSF opened four therapeutic feeding centers, which ultimately treated a total of 3,400 children. MSF also distributed rations to more than 4,000 families during the difficult period from November to February. This program closed down at the end of May 2001.

Children in the streets, in institutions, in detention

MSF continues to provide medical and support services to almost 4,500 street children in Antananarivo and 1,500 children in Antsirabe. Volunteer Malagasy physicians, pharmacists, and dentists provide nearly 10,000 consultations a year. Street teams reach out to children during night rounds; they also seek them out during the day, offering care and encouraging mothers with young children to come in for consultations.

A legal team helps resolve questions related to civil status and bears witness to abuse and acts of violence. Around 600 minors placed in institutions, as well as women prisoners, also receive medical and social support services from MSF. MSF hopes to begin work at the Antananarivo City Children's Center, with a view to improving maternal and infant care and protection.

MSF has been present in Madagascar since 1993.

Malawi

Community volunteers are backbone of AIDS home care

- International staff: 18
- National staff: 122

MSF, which has been working in Malawi since 1986, has increasingly focused its activities on the prevention and treatment of HIV/AIDS, which afflicts nearly 16% of the adult population. The virus is taking a toll on an already crippled health system, and the government lacks the economic resources to deal effectively with the epidemic. MSF has HIV/AIDS projects in two southern districts.

Caring for AIDS patients in their homes

In the district of Thyolo, a comprehensive, holistic approach to AIDS care and prevention has been in place since 1997. This home-based care program began with the establishment of voluntary counseling and testing at the hospital in Thyolo and several area health posts. A network of 120 community volunteers was then trained to follow patients through regular home visits, supervised by a doctor and nurse from the community. As of July 2001, over 600 patients were receiving regular home care through this system. Social mobilization and advocacy are also important elements of the program, as are care and referral of children orphaned by AIDS.

Also in Thyolo, MSF works to improve referral, diagnosis, and care for people with tuberculosis (TB). Cases of TB have tripled in Malawi over the last ten years, an increase linked to the spread of AIDS.

Mothers and babies get antiretrovirals

At the hospital in the district of Chiradzulu, MSF focuses on hospital-based treatment for AIDS patients, who make up 70% of admissions. In summer 2001, MSF received permission to extend this care to include antiretroviral treatment, with treatment for the first patients beginning in August.

In May 2001, MSF received authorization to begin giving mothers and babies the antiretroviral Nevirapine, which helps reduce mother-to-child HIV transmission. Mothers receive the medicine 72 hours before delivery, and babies in the three days after birth. In Thyolo and Chiradzulu, public information campaigns, reaching schools, prisons, and the general public, are key to MSF's work. A separate HIV/AIDS program in the district of Mwanza finished in December 2000.



Emergency response to floods

In early spring 2001, severe floods hit 14 out of Malawi's 26 districts. MSF provided emergency medical aid and water and sanitation services in several areas, and across the border in isolated areas of Mozambique.

In the districts of Thyolo, Mulange, and Phalombe, MSF has been involved in cholera prevention activities since 1996, benefiting a total population of 850,000 people.

Mozambique

Spotlight on floods, buts AIDS will not go away

- International staff: 16
- National staff: 115

For the second year in a row, floods struck Mozambique, still struggling to recover from a civil war that lasted from 1978 to 1992. The Zambezi River, which flows through four provinces in Mozambique, overflowed its banks in spring 2001 and forced nearly 200,000 people to flee their homes.

Rising waters

MSF helped evacuate people from their homes. Numerous emergency camps ranging in size from 200 to 7,000 displaced people were set up in the provinces of Manica, Tete, Zambezia, and Sofala. MSF activities differed according to each camp, and included running mobile health clinics and vaccination campaigns, managing medical supplies, setting up health posts, distributing materials for shelter, and setting up safe water and emergency sanitation systems.

Programs tackle alarming AIDS epidemic

The floodwaters have receded, but the other emergency affecting Mozambique will not go away. It is HIV/AIDS. During the civil war, the life expectancy in Mozambique was 42 years. The AIDS epidemic has pushed it down to 38 years. Official estimates are that 16% of the population is HIV positive. Despite these alarming statistics, the epidemic has not been a top priority of the government. As of July 2001, use of antiretrovirals was still not allowed, even to prevent mother-to-child transmission of the disease.

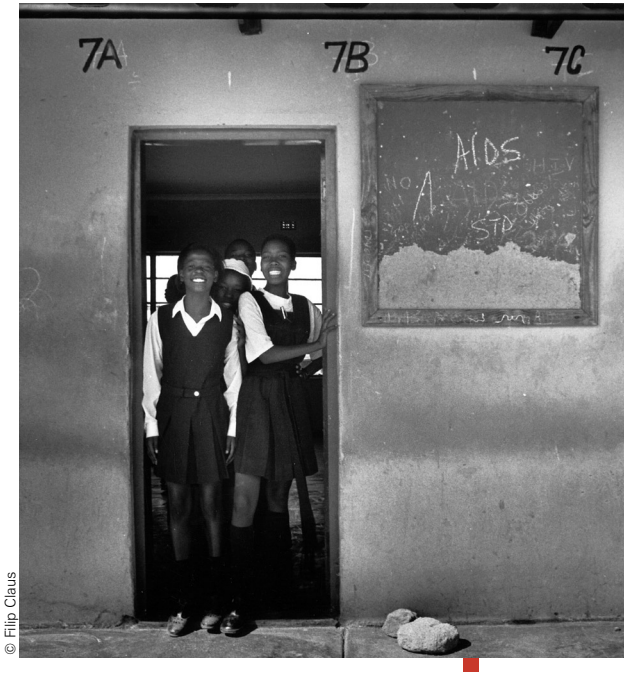
MSF has started AIDS prevention and treatment programs in the capital city of Maputo as well as Lichinga and Tete provinces. MSF treats opportunistic infections, cares for AIDS patients, and supports them psychologically. Voluntary counseling and testing is encouraged. Radio programs, traveling exhibitions, and advocacy campaigns promote prevention.

MSF also helped build a rural hospital and expand a vaccination program in the district of Mutarara. A primary care program in Niassa province is expected to end in December 2001, and a cholera preparedness project in Cabo Delgado was completed in November 2000.

South Africa

Landmark court case opens door to medicine

- International staff: 6



© Filip Claus

Discussions about AIDS prevention are vital for these South African schoolgirls.

In April 2001, the South African government prevailed in a landmark court case against a group of 39 pharmaceutical companies. The companies wanted to block South African legislation – already passed – permitting imports of the cheapest available patented drugs and use of generic substitutes, and promoting drug pricing transparency.

With an estimated 4.2 million HIV-positive people, 1,700 new infections per day and 68,000 HIV-positive newborn babies each year, South Africa had everything at stake. When the companies finally dropped their case in the face of enormous international public pressure, new hope came to people suffering from AIDS and other diseases in South Africa, and in other developing countries searching for affordable, equitable access to lifesaving medicines (see page 18 for more on the court case and MSF's involvement). MSF has been present in South Africa since 1999 with combined AIDS prevention and treatment programs.

Over 16,000 have come to the clinics

In Khayelitsha, a township with 500,000 inhabitants in Western Cape province, MSF works to prevent mother-to-child transmission (MTCT) of HIV in three clinics. The MTCT program, initiated by the government and supported technically by MSF, includes rapid HIV testing and counseling for expectant mothers. Since the program's inception in late 1999, over 16,000 women have come to the clinics. Nearly 12,000 have been tested for HIV. Two-thirds of over 2,000 women who tested positive decided to start AZT treatment in their 34th week of pregnancy.

In another arm of the program, MSF is caring for 1,800 AIDS patients, half of them coming from the MTCT program. A first group from among these 1,800 patients began antiretroviral triple therapy in spring 2001. MSF is committed to offering antiretroviral treatment to 150 adults and 30 children, and more if drug prices continue to drop.

The courage to speak about their disease

In 1999, Khayelitsha had just one support group for mothers with HIV; now there are more than ten. Through visits to schools, clinics, and support groups, these women are helping break a vicious circle of denial. MSF is also working to develop sexually transmitted disease (STD) clinics for young men, underrepresented in the other clinics and support groups.

In addition to its work in Khayelitsha, MSF has been promoting use of new malaria combination drugs in response to an explosive outbreak of malaria in the province of KwaZulu Natal.

MSF started working in South Africa in the 1980s and was until 1993 providing assistance to refugees from Mozambique. MSF returned to South Africa in 1999.



© Juan Carlos Tomasi

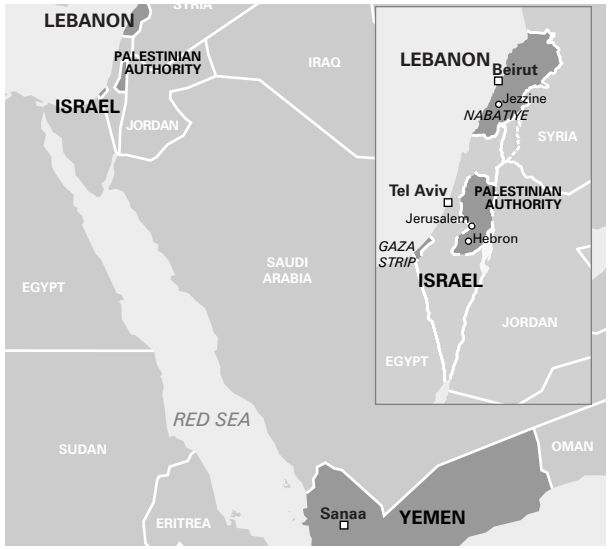


After crossing from North Africa by boat, would-be immigrants sit in the sand on the beach in Tarifa, Spain. From September 2000 to April 2001, MSF provided first aid on the beach while pressuring the Spanish government to take up its responsibility toward the undocumented arrivals.

Lebanon

Shift in context leads to MSF departure

- International staff: 4
- National staff: 5



Israel's 25-year occupation of southern Lebanon had a profound effect on the population, and left many people suffering from post-traumatic stress disorder (PTSD). Since 1998, MSF has been involved in psychosocial support for PTSD sufferers near the front lines in Jezzine and Nabatiye by offering individual counseling and education programs. Fear still grips southern Lebanon even after Israeli forces pulled out in the summer of 2000, and late in 2000 MSF extended its mental health program into the former occupied zone. After training six psychosocial assistants to provide counseling, support, and professional referrals, MSF handed this project over to the Lebanese Ministry of Social Affairs in April 2001.

With ammunition- and mine-related casualties remaining high even after the occupation, MSF, in cooperation with the International and Lebanese Red Cross, worked to provide greater emergency care in front-line areas. It was important for MSF to complete its extensive training program for Red Cross volunteers in southern Lebanon, which it did in late 2000.

Palestinian Authority

Medical and psychological care for people in distress

- International staff: 11
- National staff: 20

An already difficult situation for the Palestinian people has dramatically worsened since a new intifada began in September 2000. Violence has sprung from extremists on both sides, with Palestinian and Israeli civilians often the main victims, killed or wounded by bullets, deliberate and stray, or in suicide bombing attacks.

A campaign of intimidation has been carried out against Palestinian civilians. The Israeli army has reacted to stone-throwing with bullets, bulldozing houses and olive groves, barring off access roads to homes and villages and multiplying the number of checkpoints. The effects on the health of Palestinians have been twofold: the economic and logistical consequences complicate access to health care, and the violence provokes stress-related problems evidenced by symptoms ranging from nightmares in children to post-traumatic stress disorder.

MSF shifts into emergency gear

Present in the region since 1994, MSF was concluding a mother-child mental health program based in Hebron and a psychological care program for ex-detainees in the West Bank when the Al'Aqsa intifada began. The second phase of a primary health care support program in Hebron was also ending, but a project aimed at improving health services for the Bedouin people in the Yatta region was continuing. In September 2000, all this gave way to the new emergency. MSF provided support, including emergency surgery kits, to hospitals receiving the wounded. Mobile clinics and a home-visiting program were also set up focusing on the most vulnerable groups.

Doctors and psychologists: a joint practice

Because exposure to daily violence provokes both physiological and psychological problems, MSF decided on a dual approach. Medical examinations enable detection and treatment of the former, while psychologists, working in parallel, encourage the expression of fear and treat the trauma, leading to a reduction of stress. With so many obstacles to free circulation and many afraid to leave their houses, teams focus on visiting families in their homes in both Hebron and Gaza. Also in Gaza, an MSF psychologist provides individual consultations and group therapy for children under twelve and women attending a locally run social center.



© Christine Marcilly/MSF

A small MSF convoy makes rounds near Hebron. Teams offer medical and psychological aid to people living in Hebron and Gaza.

An essential presence

Trauma is usually treated at a remove from the circumstances that originally caused it. In Palestinian territory this is not possible. But the MSF presence in proximity to this vulnerable population is proving to be a source of support and encouragement in itself, sometimes the only sign that they are not abandoned. MSF has also encouraged individuals to document their experiences and in January 2001 published a short report entitled "Palestinian Chronicles," detailing the deterioration of conditions in Hebron and Gaza (accessible at www.paris.msf.org).

In a step toward helping raise awareness in Israel, MSF organized a conference at the psychological department of Hebrew University, explaining MSF work and presenting testimonies about the unbearable life of two Palestinian families in Gaza and Hebron.

Yemen

Medical attention for some of the poorest

- International staff: 11
- National staff: 36

In Yemen, the recent implementation of a cost recovery system in the health care sector has diminished access to care for people who have already seen their means depleted by economic crisis. MSF is focusing on the poorest people in some areas, to help them get access to quality medical care. MSF is working with the local authorities to try and ensure that these people are able to benefit from an exemption scheme regarding health care charges.

In Aden, the second-largest city in the country, most of the health facilities had been ransacked during the country's 1994 civil war. MSF rehabilitated and equipped three polyclinics in Aden, and is now focusing its efforts on facilities in outlying areas. MSF is also working to improve medical and nursing care, concentrating in particular on maternal and infant care.

March 2001 brought the closure of a program in Al Hazm, which had sought to provide primary health care to this particularly poor and isolated region. Despite having revamped the Al Hazm health center and despite three years of program activities, MSF had not achieved satisfactory results in outlying areas.

MSF has been present in Yemen since 1987.



An MSF worker puts a young Palestinian girl at ease during an initial visit to her family's house in a precarious spot near an Israeli army checkpoint in Gaza. After the first visit, the family was given psychological follow-up and social assistance.

© Christine Marcilly/MSF

Belgium | MSF calls for just treatment of asylum seekers

Staff: 14

| Over the last year, MSF work in Belgium was dominated by a large influx of refugees and asylum seekers in late December 2000 and early January 2001. A mid-January date for changes in some of the country's asylum provisions (notably replacement of monetary assistance by assistance in kind for applicants) prompted a significant increase in asylum seekers in the weeks before the deadline. Yet the Belgian government was unprepared to deal with high number of requests. While officials processed only 250 applications a day, thousands of people were left outside in bad weather or in makeshift tents, or transported to temporary shelter in Belgian military camps. MSF denounced the government's inaction and inefficiency in the face of overwhelming demand.

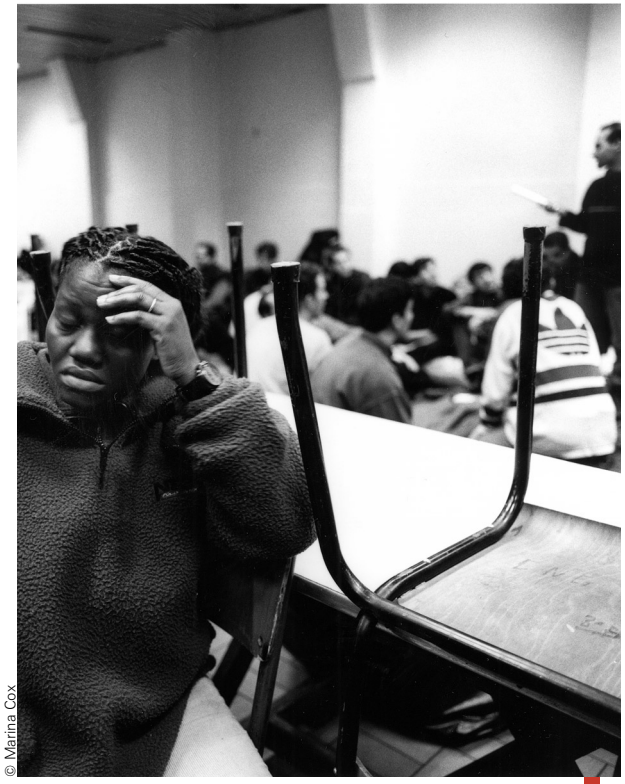
| MSF tried to ease the daily difficulty of the asylum seekers by providing first aid and basic goods (food and blankets) to many thousands of people who came to the foreign ministry to apply for asylum. At the peak of the crisis, MSF opened its own office to 70 refugees who stayed overnight for three or four days. MSF continues to push for just and equitable treatment of people seeking asylum in the country. See page 6 for information on MSF advocacy on asylum and immigration-related issues in Europe.

| In other work, several clinics continue to serve disadvantaged people in Brussels, Verviers, Liege, and Antwerp. In early 2001, this project began to explore ways to improve referrals for people in need of mental health assistance. In Brussels, MSF also offers free and anonymous HIV testing, with psychological help and follow-up.

| The "Mpore" project, which began in 1999, offers psychological assistance to Rwandans traumatized by the Rwandan genocide of 1994.

France | MSF monitors implementation of health law

Staff: 30



© Marina Cox

This asylum seeker holds herself apart from the group at St. Mary's school in Brussels, Belgium. She and other asylum seekers were sheltered at the school while they waited - often for days - to put in their asylum application at the Ministry of Foreign Affairs.

| Over the last year, MSF activity in France focused on medical and social aid in several cities, and on monitoring France's new CMU (Universal Health Coverage) law launched two years ago. The right to free access to health care has remained a central issue for MSF in France, with the focus on pending problems: access for young people (not yet a reality), discriminatory admissions regulations, standardization of waiting procedures for access to care, the rights of asylum seekers, and specific structural problems inherent in the application of the law.

Paris

| A medical and social welfare center at Paris's East train station is open to young people in precarious situations. In 2000, MSF provided 3,000 medical consultations and more than 1,000 social welfare interviews. MSF works with partners to welcome mainly young people at risk in refuges in the countryside and in other urban areas. A similar project is in place in Lille.

| Street teams, launched in 1995, continue meeting vulnerable people who have lost every contact with the health and social system. MSF seeks out people who are living and sometimes prostituting themselves in the street, and invites them to benefit from the medical and social center.

| These young people often suffer from multiple drug dependency and are at great risk for diseases such as hepatitis and AIDS. MSF provides Distribox distributors of sterile injection materials to pharmacies in eight districts of Paris.

Marseilles

| Thanks to the launching of the CMU, an MSF medical and social welfare unit in Marseilles itself could be closed, after providing 60,000 consultations and 20,000 social welfare interviews since 1988. MSF has broadened its activities in l'Etang de Berre, near Marseilles, to embrace not only medical care but all social welfare rights. A medical and social services facility assists children over six and adolescents, in this area that has been cut off from the city, where many people (especially foreigners) live in precarious conditions.

| An MSF social and legal team continues to visit temporary immigration shelters around the country. In 2000, the team conducted a lobbying effort on behalf of sick people arriving from abroad, to make all countries of the European Union aware of the right of these people to health care and to protection against deportation.

Italy

Key services reach vulnerable immigrants

- International staff: 1
- National staff: 10



MSF activities in Italy focus on immigrants and asylum seekers in need of assistance. Although health care is theoretically available to all people, with or without papers, in practice the sometimes vague and contradictory Italian law is often interpreted arbitrarily. In addition, many people are not aware that they have a legal right to health care.

In March 2001, MSF opened a reception center in the town of Brindisi on the Adriatic Sea – a key entry point for immigrants reaching Italy by boat. The center, open to people with or without papers, is in an apartment building near the train station and offers social, medical, and psychological assistance. Food, clothes, and hygiene supplies are available, and ten beds provide accommodation for up to five days.

In Rome, an MSF van reaches vulnerable people without papers in some of the city's outlying neighborhoods. MSF offers medical consultations and organizes information meetings explaining how to register with the national health system or get to the nearest health post. About 2,500 people were helped by this service in 2000.

These projects are part of a broader effort to care for and bring attention to the plight of asylum seekers in Europe (see page 6).

Spain

MSF connects to "Fourth World"

- Staff: 25
- Volunteers: 60

Over the last year, MSF continued providing medical aid to disadvantaged people, immigrants, and asylum seekers through its "Fourth World" programs in Barcelona and Madrid. In September 2000, MSF also began aiding the many people – mostly from Morocco and sub-Saharan Africa – who were arriving on the beach in precarious conditions in the southern city of Tarifa.

As the Spanish authorities began to take up their responsibilities toward the new arrivals, MSF was able to shut down the program in April 2001. Mobile teams continue to monitor the situation, collect information, and provide aid where necessary.

Teams also visit other coastal areas, including Ceuta and Melilla, Spanish departments on the northern coast of the African continent. Immigrants in these areas often live in deplorable conditions. In addition to offering medical aid, MSF works to raise awareness of the plight of this vulnerable group among the Spanish public. See page 6 for more on MSF advocacy on asylum issues.

Speaking out against a new law

A Spanish law which came into effect in January 2001 restricts regularization of immigrants, permits the expulsion of immigrants without a work or residence permit, and denies "irregular" immigrants the right to meet, associate, unionize, and strike. MSF participated in public demonstrations against the legislation and cared for people who went on hunger strikes in opposition to the new law.

"Fourth World" projects

MSF provides first aid and needle exchange for intravenous drug users in Barcelona, and is working to get a space where these drug users can safely and cleanly inject. MSF also runs a clinic serving the city's disadvantaged population. Work in Barcelona began in 1994.

Since April 2000, MSF has also worked in Madrid, offering psychological care to those in need and guiding immigrants and asylum seekers toward social, health, educational, and cultural services. Another arm of this program works to detect and treat tuberculosis, particularly in undocumented immigrants.

Luxembourg

Support network tackles drug abuse

- Staff: 5

Luxembourg, a small country of about 425,000 inhabitants, is one of the richest countries in the world. However, as with many countries in Western Europe, it has also experienced some of the social problems that are a byproduct of a changing society.

Since 1997, MSF has been engaged in a countrywide program focusing on young people who abuse mind-altering drugs, considered to be one of the most urgent problems in the country. Starting with the premise that drug abuse may be a reaction to deeper personal, family, or social problems, MSF psychologists offer support to these young people and their families.

The team works to establish links among various institutions and social services. Institutions that work directly with young people – schools, the judicial system, and home and family services – can also request help from MSF. A key goal of the program is to coordinate work with relevant services to approach the problem in a holistic way. MSF trains educational teams who work on a day-to-day basis with the young drug users. The deepening problem of drug abuse in schools has also prompted MSF to increase its involvement in that area.

An initial 27 requests for aid came in 1997; 132 were received in 2000, and the number of requests continues to rise.

Bosnia

Mission closes after decade with war-affected population

- International staff: 2
- National staff: 9



| MSF activities in the former Yugoslavia began in 1991, with an evacuation of wounded from Vukovar, then under siege. Initial programs responded to emergency needs of people confronted by war; the peace agreement in 1995 brought a shift in Bosnia itself to medium-term projects focusing on mental health, family medicine, and rehabilitation of medical facilities. With long-term reconstruction now under way, and many other development-oriented organizations in place, MSF decided to end its work in the country.

| A family medicine program, which trained 50 doctors and 71 nurses in Doboj, Tuzla, and eastern Republika Srpska, was turned over to local health workers in July 2001. MSF had also been providing short-term primary care to the Roma (gypsy) population in Sarajevo. A program of psychological support for people suffering from post-traumatic stress disorder (PTSD) and training of mental health professionals in Gorazde finished in late 2000.

| The end of MSF's service in Bosnia was punctuated by a return to a painful episode in Bosnia's past, the wartime overthrow of the safe haven Srebrenica in 1995 and subsequent deportation and massacre of thousands of Muslims. MSF, present in the enclave at the time of the massacre, called in July 2000 for a French parliamentary inquiry into the circumstances of Srebrenica's fall. See box on this page for more information on the parliamentary inquiry.

Srebrenica, five years later

MSF pushes for a French parliamentary inquiry into the fall of the enclave

| In 1993, MSF began providing medical and material assistance to the people of Srebrenica, a besieged enclave in eastern Bosnia that had officially been placed under the protection of the United Nations during the war in the former Yugoslavia. A promise had been made that the people of this "safe zone" would not be abandoned, and it was partly this guarantee that prompted many people to remain rather than flee the threat of the surrounding Bosnian Serb forces.

| However, despite its status as a "safe zone," Srebrenica fell to the Bosnian Serbs on July 11, 1995. Despite the promise of protection, and despite the repeated demand for NATO airstrikes made by the Dutch contingent of UNPROFOR (UN Protection Force) on the ground, the civilian population was not defended. The result was the deportation of 40,000 people and the execution of about 7,000 others.

| The MSF team could only look on helplessly as the sick and the injured were isolated from the rest of the population, as men were separated from women. People were taken in convoys to unknown destinations, while the UN forces failed to act. Several dozen sick and injured people under MSF's care – "evacuated" from the enclave by the Bosnian Serbs "under Dutch escort" – were taken from their buses and executed by Serb forces. Twenty-two members of MSF's local staff were also executed.

| In July 2000, MSF began a public campaign calling for a Commission of Inquiry to be set up at the French parliament, to establish the extent to which the political and military actions of France were responsible for the paralysis of the UN and NATO during the attack on Srebrenica. France had had a major decision-making role at the time of the Srebrenica massacres, with two French generals in charge of the UN contingents on the ground. It was France that had introduced the very concept of a "safe zone" at the UN Security Council.

| MSF's demand for a parliamentary inquiry took advantage of momentum created with the publication of a UN report on the tragedy of Srebrenica. The report acknowledged UN errors and asked member states that had been involved to look into their own actions to help clarify the events.

| In December 2000, the Defence and the Foreign Affairs Committees of the National Assembly jointly agreed to set up a Commission of Inquiry, whose findings are expected in fall 2001.

| MSF hopes the inquiry will draw specific lessons for the future, in order to prevent the deployment of soldiers who are powerless in the face of criminal policies against a civilian population. Even as military crisis management and intervention seem to be clearly on the rise, MSF demands that protection of civilians be at the heart of peacekeeping operations.

| For more on the work of the Commission of Inquiry and the analysis of MSF, see www.paris.msf.org/srebrenica.

Bulgaria

Training generalist doctors helps fill gap

- International staff: 2
- National staff: 13



© Didier Seguí/MSF

MSF works to build this well near a school in Vitanovac, Serbia. The well provides water for the school and a center for refugees nearby.

The people of Bulgaria have been struggling to cope with the dramatic changes that have swept their country over the last decade. Poverty is one of the steepest byproducts of the transition from a planned to a market economy engendered by the fall of the communist regime in 1989, and the health of the population has also suffered.

MSF has been working in Bulgaria since 1997, in activities that now have a dual focus. In the town of Targovichte, MSF offers medical and social aid. Training of generalist doctors helps fill a gap left by the previous system, which cultivated primarily specialist physicians. MSF has helped establish a training program, through which 49 local doctors have now been trained. Drugs are donated to the hospital. In Malcho Malchev, the Roma (gypsy) district of Targovichte, MSF provides basic care, and works to improve water and sanitation.

The other arm of the MSF program is in Sofia, the capital, where activities aimed at stemming the spread of sexually transmitted diseases (STDs) have been underway since early 2000. An STD clinic within the University of Sofia sees more than 160 patients a month. The program emphasizes quality treatment and works to show how treatment protocols can remain effective and affordable and preserve patient anonymity.

Romania and Moldova

Lessening the stigma of homelessness

- International staff: 2
- National staff: 13

There are some 9,000 people in Bucharest, Romania's capital, without homes. Most of them lack access to basic medical care and there is minimal government medical and social aid available to them.

Assisting the homeless

Since 1997, MSF has offered medical care to homeless people and works to define the level of care the Romanian government should provide. Due to the lack of shelters, MSF encourages local medical authorities to examine and treat homeless people in hospitals that were previously unaffordable. MSF provides primary medical and social aid at a drop-in center for the homeless. Casa Ioanna, a local aid agency, operates a 60-bed night shelter, and MSF contributes by doing follow-up medical assessments.

Aside from providing medical aid, MSF works to promote a favorable public perception of the homeless, to help create a broader awareness of the issue and the reasons for homelessness in Romanian society.

Moldova

In neighboring Moldova, MSF is in the early stages of collaboration with the Ministry of Health to improve primary health care. The focus is primarily on community-based mental health and mother and child health care in Ungheni province. MSF supports family clinics and related health posts and trains professionals working in family medicine.

MSF has been active in Romania since 1990 and Moldova since late 2000.

Yugoslavia

Programs support unsettled populations

- International staff: 25
- National staff: 153

Long-awaited change came to the Federal Republic of Yugoslavia in October 2000, when Slobodan Milosevic was swept from power by a popular uprising, and Vojislav Kostunica was elected president. Yet despite these events, instability has lingered, and pressing needs remain.

MSF continued to aid some of the 700,000 displaced people in Serbia, the larger of the two republics that make up Yugoslavia (the other is Montenegro). In Vranje and in the capital, Belgrade, MSF upgraded sanitation facilities at several collective centers housing internally displaced people (IDPs). MSF has provided plastic sheeting and blankets in 35 centers and coordinated visits of social workers and psychologists when warranted. Similar work is carried out in the Kraljevo/Kragujevac area, where MSF serves a population of 100,000 IDPs.

In the Presevo valley, in the south near the Macedonian border, MSF continues to assist ethnic Albanians returning from that country. MSF also donated surgical equipment to a hospital, helped expand the emergency ward from four to ten beds, and launched a mine awareness campaign.

MSF closely monitored events in Macedonia in early 2001, when Albanian separatists attacked the town of Tetovo, prompting the displacement of thousands of people toward Skopje. MSF finally determined that medical intervention was unwarranted at that time, but continued to watch the situation closely.

Kosovo presence scaled down

Kosovo remains under the civil administration of the United Nations. Despite ongoing instability and periodic violence against one or another of the ethnic communities living in Kosovo, needs have increasingly become related to longer-term development. Because of this, and in order to prompt the UN administration and fledgling civilian institutions to take up responsibility for monitoring health and ensuring quality care, MSF has scaled down its work in the province. In spring 2001, MSF mobile clinics were phased out, and water and sanitation programs were closed. MSF continues its work in Pejë/Pec, where psychologists have been treating women, children, and teenagers for post-traumatic stress disorder (PTSD) since 1999. MSF has also trained general practitioners in the recognition and referral of people with PTSD. MSF began working in Yugoslavia in 1991, and in Kosovo in 1993.

Russia | Progress in Russia offset by setbacks in the north Caucasus

- International staff: 39
- National staff: 274



Despite the ongoing difficulties of working in Russia, MSF AIDS, tuberculosis (TB), and homeless programs showed positive results over the last year. This was in sharp contrast to setbacks experienced in work in Chechnya, and in the north Caucasus in general.

Chechnya, Ingushetia, and Dagestan

The kidnapping of an MSF volunteer in the Russian republic of Chechnya in January 2001 exemplified the difficulties of bringing humanitarian aid to an area where violence is a daily occurrence and independent humanitarian action is not respected. The volunteer was released unharmed after several weeks, but MSF work in Chechnya itself was suspended. Programs continue in Ingushetia and Dagestan, where hundreds of thousands of displaced people live in sometimes appalling conditions. MSF has also assisted Chechen refugees in Georgia (see page 63). While not reestablishing a permanent expatriate presence, MSF was nevertheless able to return to Chechnya itself in June 2001 to help rebuild the 45-bed maternity ward at the central hospital in Gudermes, Chechnya's second-largest city.

Despite the illusion of normalization and statements about "reconstruction" put forward by Russian authorities, and the ongoing rhetoric that a political solution must be found for Chechnya, low-level war and a campaign of fear and terror continue. In November 2000, MSF gave its testimony at the Council of Europe and at the time issued a report called "The Politics of Terror." This report underscored the ongoing climate of fear in Chechnya and the consequences of the war on the lives of ordinary people (see the following pages for excerpts of the report).

MSF work continues to address medical and structural needs stemming from the conflict and population flows. Regular donations of drugs and medical materials have been made to 25 health facilities in Chechnya; to 22 health facilities in Ingushetia, burdened by the influx of more than 140,000 displaced people; and to health posts and small hospitals in Dagestan, near the Chechen border. MSF doctors and nurses provide medical care to thousands of displaced people living in host families and collective centers in the Ingush district of Malgobeck, and in collective centers located in and near the Ingush capital, Nazran, and in the Dagestan city of Kazhaviurt. MSF has also distributed basic relief items to people in all these areas and carried out construction and repair work to improve the sanitary and living conditions of the displaced.

MSF programs elsewhere in Russia

The situation in other parts of Russia was more encouraging. By late 2000, the government had approved the concept of "harm reduction" for intravenous drugs users and the need for preventive health measures in the Russian prison system. "Harm reduction" programs promote safer behavior among intravenous drug users and have been an important part of MSF's HIV/AIDS prevention programs in Russia since 1996. Direct outreach in Moscow and the training of health workers from 60 other cities were key parts of this program.

MSF also offered training on HIV/AIDS prevention strategies to inmates and prison staff in seven pilot penal institutions, and conducted the third nationwide mass media campaign to promote sexual health and condom use. Given the scope of the AIDS epidemic in Russia, MSF promoted the creation of a new NGO, AIDS Foundation East-West (AFEW), that would focus exclusively on this problem. Many of the AIDS programs run by MSF in Russia will be handed over to AFEW, while some projects will be handed over to other local counterparts.

Duma recognizes the need to address homelessness

Over four million homeless people throughout Russia are excluded from public services. After years of letters, meetings, and negotiations with health officials, government representatives, and parliamentarians, MSF was invited to speak at a deputy session of the Duma (parliament) in Moscow. The Duma finally voted to create municipal health and social centers for the homeless in Moscow. In the meantime, MSF continues to fill a gap by providing more than 500 medical and social consultations every week for Moscow's more than 100,000 homeless.

Pilot program expands from prisons to civil society

In Russian prisons, about one in every ten inmates is infected with TB. MSF's anti-TB pilot program within the prison system of Kemerovo, Siberia ensures that all active TB cases are quickly detected, isolated, and treated using the "DOTS" (Directly Observed Treatment Short Course) method. MSF has cured more than 4,000 patients since the program began in 1996.

Plans to begin treating 150 prisoners with multi-drug resistant TB are under negotiation. At the same time, MSF is working toward expanding the DOTS program beyond Kemerovo's prison walls and into the civil sector.

MSF also assisted residents of the Siberian town of Lensk during floods in late May 2001.

Ukraine | Treatment cuts HIV transmission to babies

- International staff: 6
- National staff: 26

Natasha Ivanova hangs laundry in the apartment she shares with her mother in Odessa, Ukraine. Natasha, an HIV-positive intravenous drug user, recently lost her five-month-old baby girl to AIDS. "My mother is the only one who has not rejected me," she says.



© John Ranard

The number of HIV/AIDS cases in Ukraine, estimated at 300,000, is higher than in any other CIS country. To help stave off the spread of the epidemic, MSF's activities focus on care and support for people who have contracted the virus, as well as on HIV/AIDS prevention among the general population.

Care and support for AIDS patients

In the southern cities of Odessa, Mykolayiv, and Simferopol, MSF is using single doses of the antiretroviral drug Nevirapine to reduce HIV transmission rates from pregnant mothers to babies by up to 50%. The organization also provides essential drugs to treat and prevent opportunistic infections and to ease suffering among HIV/AIDS patients, and will soon treat infants with antiretroviral therapy. Besides medical care, MSF offers counseling and psychosocial support to patients, their partners, and their family members. In addition, it advocates for change nationwide so that people with HIV/AIDS can have access to medicines they need.

Raising awareness and countering stigma

People living with HIV/AIDS in Ukraine are often fired from their jobs; obliged to leave their homes; and rejected by friends, family, and even medical workers who refuse to treat them. With the understanding that ignorance breeds fear and discrimination, MSF ran mass media campaigns (through TV and radio ads, leaflets, posters, the internet) to inform the general public about the facts of HIV/AIDS. It also supported four regional information centers which raise awareness about HIV/AIDS among health care professionals, NGOs, high-risk groups, and the wider population. To specifically target injecting drug users, MSF provided support and training for Ukrainian NGOs carrying out needle-exchange and other "harm reduction" programs. In the spring of 2001, the information programs described above were handed over to "AIDS Foundation East-West," a new public health NGO specialized in HIV/AIDS prevention.

MSF has been working in Ukraine since 1999.



Grozny, the capital of Chechnya, is already a shell as people flee in December 1999. Since that time, a climate of terror has transformed this Russian republic into a vast ghetto, where civilians are suspect and freedom of movement is denied.

© Eddy van Wessel

During the day it's more or less quiet here, but at night it's terrifying. There is a post on the main road right above the village. They get drunk and shoot all night. Just last week two armored vehicles came into the village at night. My husband ran out of the house and hid. They were screaming: 'Kill him! Kill him!' They were shooting right into our house. How can I live here with my children?

Resident of Prigorodnoe, 43 years old

Even though I'm not working now, people still come to my home. Especially at night, if there's a pregnancy with complications, they come and see me because they can't get to the hospital. I do what I can, but sometimes nothing can be done (...). Just recently, in early September, there was a woman whom I couldn't save.

Obstetrician, Urus Martan District

We are getting an average of 15 severely ill patients every day. I would say that about one-third of these should be hospitalized. But we can't do this. We just don't have the necessary conditions here. We don't have the beds. We don't have the rooms. We don't even have any toilets. It's almost the end of October and we don't have any heat...

Doctor, Grozny

In November 2000, MSF was invited to speak before the Council of Europe to bear witness to events in Chechnya. At the time, MSF issued "The Politics of Terror," a report based on the organization's work in Chechnya and witness accounts gathered by MSF teams between August and November 2000. The following is taken from the report, which can be found in full at www.msf.org.

The Politics of Terror

"The war in Chechnya is not over. More than a year after the federal troops first intervened, bombs, mines, and bullets continue to kill civilians. Despite the illusion of normalization upheld by the Russian authorities, and the resignation of the international community, the violence against civilians is ongoing.

| The massive bombing campaign has given way to a state of terror, perpetrating acts designed to humiliate civilians: arbitrary executions and mopping-up operations, arrests and disappearance, extortion. The people of Chechnya are today exposed to the worst kind of violence. Chechen civilians, deprived of any kind of protection or recourse, are trapped in a confrontation with soldiers whose impunity gives them free rein to act as they please. The Russian forces have transformed Chechnya into a vast ghetto, where every civilian is a suspect, and freedom of movement is denied.

The consequences of war and a climate of terror on civilian lives

| Chechnya's hospitals report a constant stream of civilian casualties resulting from gunfire and artillery, from aerial attacks and mines. War injuries are still the leading cause of death in most of the hospitals. In September and October, almost half of the hundreds of war wounded were women, children, or the elderly. Villagers live in constant fear of indiscriminate gunfire.

| The witness accounts gathered recently by MSF teams describe indiscriminate shootings, arbitrary arrests, summary executions, beatings, etc. which the people of Chechnya are subjected to daily. Abuses such as these are most often committed by Russian soldiers during the "zachistka" (police sweeps) aimed at rooting out "terrorists."

| "Zachistka" can occur at any moment, and often lead to massive arrests. No one is exempt from these arrests, though they mainly affect young men, who are suspected of being fighters. Some of those taken are tortured, as witnessed by doctors who have treated them in hospitals.

'It's impossible to live here. They arrest people all over the place – for no reason. For young men, it's dangerous to be anywhere on the street. They pick them up and take them to army headquarters. They beat them.'
-Doctor, Urus Martans district

'I examined the body myself. The scalp had been completely removed like a cap cut all the way around his skull. We never found the scalp. Three fingers had also been cut off with what looked like a pair of shears. This was done when he was alive. You can tell by the extent of the bleeding from the wounds.'
- Doctor, Grozny

Obstacles to health care

| Ten hospitals in the republic were completely destroyed during the bombings between late 1999 and mid-2000. Many other health structures suffered extensive damages. Only one maternity hospital is still functioning in the capital. Moreover, the hospitals lack the resources to take care of the wounded.

| In May [2000] the Russian government paid one or two months' wages to the medical staff, for the first time in five years. Since then, they have received no money. Even the hospitals in Stari Atagi and Grozny, which have been inside Russian-controlled zones for months, are still suffering from a severe shortage of medicines and medical equipment.

| Persons who need to be operated on must travel long distances and pass through numerous military checkpoints. Accounts gathered by MSF relate similar incidents at army checkpoints: sick or the wounded needing emergency care, or pregnant women suffering from complications, are forbidden to pass the checkpoints. As a result, the wounded die from lack of care.

'After dark it's impossible to move around – even for the medical staff or to get patients to the hospital. Just the other day a local elder was shot. For over two hours we couldn't get him to the hospital. It was only early evening when he was shot, but we needed to negotiate with the command post and the checkpoints. When we finally arrived, we couldn't save him.'
- Doctor, Grozny

Conclusion

| The war in Chechnya continues. Civilians are victims of massive acts of aggression and are subjected to a policy of terror. These acts of violence against civilians in Chechnya and the violations of their basic rights have not given rise to any opposition on the part of member states of the Council of Europe. Médecins Sans Frontières calls on these states to raise the suffering of Chechnya with the relevant international bodies – in particular the European Court of Human Rights and the United Nations Security Council – so that they take on their roles and responsibilities."



© Stephan Vanfleteren



A man holds his baby at the Shayday camp for displaced people in Herat province, Afghanistan. MSF runs a clinic and supplementary feeding center in the camp.

Azerbaijan

After ten years, MSF ends work in Azerbaijan

- International staff: 6
- National staff: 45



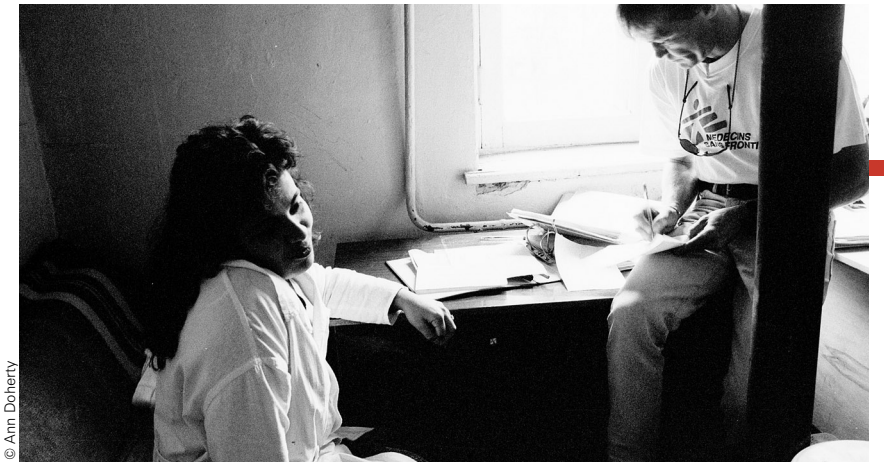
After ten years of providing care for the people of Azerbaijan, MSF has completed its missions in the country. Past programs included reproductive health programs, the rehabilitation of public health structures, and medical aid for some of the estimated 570,000 people displaced as a result of the country's war with Armenia. More recently, an immunization program and a project on sexually transmitted diseases came to their scheduled ends in December 2000 and January 2001 respectively. The distribution of drugs to four small clinics in Sumgayit ended in February 2001, and MSF donated the remaining 500 kg of medicine to ensure the needs of long-term patients are met. Regional reproductive health programs in Imishli, Fizuli, and Saatli were concluded in early 2001, and MSF left the country at the end of March. Before leaving Azerbaijan, MSF worked to transfer its programs to organizations more oriented toward long-term development.

MSF had been active in Azerbaijan since 1990.

Armenia and Nagorno-Karabakh

First MSF patient cured of multi-drug resistant tuberculosis

- International staff: 21
- National staff: 71



© Ann Doherty

A patient at the tuberculosis hospital in Nagorno-Karabakh gets a visit from an MSF doctor.

Over the last few years, MSF work in Armenia and Nagorno-Karabakh (an autonomous republic in Azerbaijan that is home to many Armenians) has focused on improving the living conditions of mental health patients, offering psychological and medical support to institutionalized children, treating tuberculosis (TB), and improving reproductive health.

First MDR-TB patient cured

June 2001 marked the first cure of a patient treated for multi-drug resistant TB (MDR-TB) in MSF's TB program in Nagorno-Karabakh. For patients suffering from the non-resistant form of TB, patient care and staff training at the Stepanakert TB clinic has boosted the cure rate to 82%. MSF also screens for the disease at the Stepanakert Psychiatric Hospital and the prison in Souchi.

Through August 2000, MSF worked to refurbish the Stepanakert Psychiatric Hospital and trained local nurses, teachers, and school directors to care for and recognize outpatient mental health disorders.

Sevan psychiatric program draws to a close

In summer 2001, MSF withdrew from the Sevan Psychiatric Hospital in northern Armenia, after three years of work. MSF rehabilitated the facilities, trained staff, and introduced recreational activities in an effort to improve living conditions and reduce the hospitalization period for the hospital's 406 patients. MSF expects to begin a new mental health project in Armenia, this time with a focus on outpatient care.

In the province of Tavush, MSF offers women of reproductive age access to family planning and information on contraception. This project will be handed over to the public health authorities in December 2001.

In Yerevan, the Armenian capital, MSF has added direct outreach to children living in the streets to its ongoing program of medical and psychosocial care for young people placed in the Vardashan Institute, a facility for children in difficulty.

MSF has been active in Armenia since 1988 and in Nagorno-Karabakh since 1989.

Georgia

Chronic crisis is the backdrop to aid

- International staff: 18
- National staff: 74



© Ann Doherty

Young boys strike a pose at the Vardashan Institute, in Yerevan, Armenia, home to over 100 boys and girls in difficulty. MSF provides medical and psycho-social support.

Georgia continues to endure profound economic and political crisis. The latent conflicts with the self-proclaimed republics of Abkhazia and South Ossetia, whose independence Georgia refuses to recognize, the arrival of Chechen refugees in the Pankisi Valley, a blockade on the Abkhazia-Russia border, and the consequences of the recent fighting have all produced instability and hampered development.

Combating tuberculosis

Tuberculosis (TB) is a large health threat. The Directly Observed Treatment Short Course (DOTS) strategy was introduced at Sukhumi Hospital, and at several outpatient sites. During the year 2000, 216 patients were treated. MSF is working to reduce the transmission of TB by detecting at least 70% of cases. Systematic testing and treatment will be introduced at the Sukhumi prison, and MSF also expects to set up a treatment program for people with multi-drug resistant TB.

Medical care for the most vulnerable

MSF regularly supplies 38 hospitals, polyclinics, and health centers with medicines and medical equipment. A health center in Sukhumi continues to offer free health care to around 3,000 of the country's most destitute people. At the same time, a network of 12 social workers interviews people throughout Abkhazia to identify the most vulnerable population groups and refer people to health facilities, where they receive free, quality care.

Aid for Chechen refugees

In March 2001, MSF's emergency assistance program in the Pankisi Valley for refugees from Chechnya closed. A total of 15,288 children had been vaccinated against diphtheria, tetanus, polio, or measles. Occupational therapy was given to 125 children who were suffering from post-traumatic stress disorder as a result of the war. MSF teams also referred more than 300 refugees to Georgian hospitals for specialized care. MSF continues to provide medical care for 76 war-wounded at Tbilisi Hospital.

MSF has been present in Georgia since 1993.

Kazakhstan | National tuberculosis protocol transformed

- International staff: 8
- National staff: 30

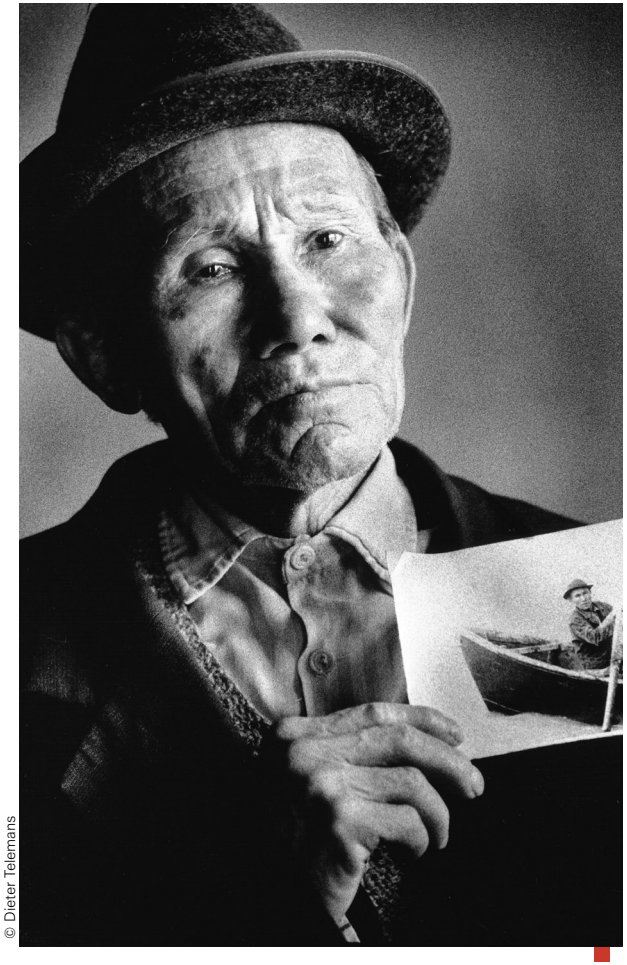
After achieving independence in 1991, Kazakhstan, like many of the former Soviet republics, has suffered from economic crisis and the difficulty of wholesale economic, political, and social transformation. Public services such as health care are struggling.

Since beginning work in the country in 1996, MSF has focused on the treatment of tuberculosis (TB), a disease on the increase partly due to poverty and lack of medicines. A pilot TB control and treatment program began in 1996 in the city of Akshy, near the capital Almaty, and in 1998 in the southern districts of Baidabeck and Ordabassy.

The programs have used a multifaceted approach to detecting and treating the disease and have promoted the DOTS (Directly Observed Treatment Short Course) protocol. In addition to treating patients directly and furnishing medicines, MSF has worked to improve laboratory techniques and train medical personnel.

Beyond the hospital world of the TB patient, MSF seeks to support patients' families during what can be a long and difficult hospitalization. However, improving social support for the poorest, especially ex-prisoners, is difficult because of the lack of government financial support.

In June 2001, the pilot project in Akshy ended after DOTS was adopted as Kazakhstan's national TB control protocol. The project in the south continues, and MSF hopes to extend treatment to people with multi-drug resistant TB.



© Dieter Telemans

Ainaev Musa, of Muynak, Uzbekistan, holds a photograph of himself in a rowboat on the Aral Sea. He caught his first fish there when he was 13. "In the end," he says, "there were no more fish to catch." The sea level has dropped 50% since 1960, exposing contaminated dust. MSF is conducting research into the link between these harsh conditions and the health problems of people in the Aral Sea area.

Kyrgyzstan | "Coffee breaks" provide information to sex workers

- International staff: 4
- National staff: 33

Against the backdrop of Kyrgyzstan's ongoing economic crisis and bouts of political unrest, the situation of marginalized people continues to deteriorate. The provision of medicines to hospitals is becoming increasingly difficult. Since 1997, the MSF mission has focused on the resurgence of sexually transmitted diseases (STDs), and on the emergence of AIDS, mainly in the areas of Osh and Batkent.

Better health care for prostitutes

Over the course of the year, MSF implemented a medical referral system for women prostitutes, who had previously either had no access at all to health care or were obliged to pay dearly to obtain quality care. Information sessions for the women, called "coffee breaks," continue at the MSF information center. Physicians from Kyrgyzstani hospitals also attend the sessions.

Over the last year, the team also reduced the number of medical facilities (clinics or doctors' surgeries) it supports, in an effort to develop a more effective partnership with Kyrgyzstani gynecologists and dermatovenereologists. Under that partnership, all parties attend consultations, and discuss and share diagnoses. MSF provides the medicines for treating patients.

New protocol for treating gonorrhea

Over the last year, a survey carried out with the Fournier Institute and the Kyrgyzstani Ministry of Health resulted in a change in the protocol for the treatment of gonorrhea. MSF is now trying to encourage physicians to adopt the new protocol.

MSF has been working in Kyrgyzstan since 1996.

Uzbekistan and Turkmenistan | "DOTS" for two million

- International staff: 23
- National staff: 110



The former Soviet Union, in an effort to become self-sufficient in cotton, diverted tributaries of the Aral Sea for massive irrigation of cotton fields in the Aral Sea area. The result has been environmental devastation: since 1960, the sea level has dropped 50%. Residents of Uzbekistan and Turkmenistan are paying the price, as winds whip tons of contaminated dust from the dry seabed into the air, leading to respiratory infections, diarrheal diseases, and some of the highest rates of tuberculosis in the former Soviet Union. MSF currently runs 12 programs in the two countries focusing on prevention and treatment of TB and other diseases, and conducts research into the effects of the environmental catastrophe on the health of people in the Aral Sea area. MSF began work in the region in 1997.

Combating tuberculosis

Tuberculosis has reached epidemic levels in Uzbekistan and Turkmenistan. By early 2001, MSF's Directly Observed Treatment Short Course (DOTS) program for treating TB was in full swing. "DOTS for All" targets over two million people in the two countries. MSF administers drugs to TB patients, trains local medical staff, and works for some improvements in water and sanitation. There is hope that this program can be handed over to the Ministry of Health within the next few years.

Operational research

A thin layer of sea salt now covers much of the ground surrounding the Aral Sea. Giant dust clouds spring from dry riverbeds, and salinity of ground water is cause for alarm. An MSF research program looking into the connection between these harsh conditions and the health problems of local residents is ongoing.

A health education project in the Ferghana Valley has been underway since 2000.

Tajikistan | Aid to health system in shambles

- International staff: 16
- National staff: 154

The break-up of the Soviet Union and the civil war and economic collapse that followed have left Tajikistan in a fragile situation. Today the health care system is in shambles; the country depends heavily on foreign aid, and ethnic tensions still surface despite a 1997 peace agreement.

MSF works in the Karategin valley, a region excluded from government support and health care service in part because it is a historical stronghold of Islamic opposition. MSF regularly distributes essential drugs to 174 basic health posts in six districts of the valley, and trains health care workers in managing prevalent diseases and collecting health data. MSF runs a reproductive health program in the valley to decrease morbidity during births and improve knowledge of sexually transmitted diseases.

In collaboration with the Ministry of Health and a local mental health organization, MSF has been improving the living conditions and treatment of patients in 17 psychiatric institutions by distributing essential drugs, food and non-food items, rehabilitating health facilities, and training hospital personnel. In the capital, Dushanbe, MSF initiated a community-based mental health program. It involves training counselors to work with people traumatized by the horrors of civil war or suffering from stress brought on by continued lawlessness and everyday insecurity.

In the southern city of Khorog, MSF refurbished the hospital's infectious diseases ward and water system, and worked to improve treatment of infectious diseases. Lab workers were trained to focus on four main diseases: malaria, typhoid, brucellosis, and shigellosis. MSF continues to donate medicines to the hospital. The Khorog mission is also used as a base for programs in Afghanistan, where MSF stays on alert for emergency situations such as refugee influxes, epidemics, and natural disasters.

MSF has been working in Tajikistan since 1991.

Afghanistan | Civil war and drought compound immense humanitarian needs

- International staff: 75
- National staff: 705

Civil war and severe drought have continued to drain the life out of Afghanistan over the last year. By late spring 2001, the number of people taking refuge in neighboring countries had been pushed to 3.5 million, and displaced people inside the country numbered at least 700,000.

People living near the front line live the consequences of war, while people living under the Taleban, the group that controls much of the country, are confronted daily with totalitarian methods of maintaining order: curfew in the cities, harsh punishments for petty crimes, restrictions on the movement, education and employment of women, and large-scale persecution endured by many Afghans, especially members of religious minorities. The Taleban has not taken responsibility for ensuring a basic health care system. MSF, working in Afghanistan since 1980, continues to meet pressing medical needs of many of the most vulnerable Afghans, with a special focus on women and children in some programs.

This text covers the MSF presence in Afghanistan through August 2001. For more information on current activities, go to www.msf.org. What was clear then, and is clear now, is that the humanitarian needs are immense, and that MSF can bring health assistance to people whose needs are being neglected. (Continued on page 68).



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Zira Gul (two years old, at left) and her sister Haqiqa, five, need medical attention: Zira Gul suffers from diarrhea and is becoming dehydrated, while Haqiqa's face has been damaged by leishmaniasis, a parasitic disease spread by sandflies. The nearest doctor is days away by donkey over a mountain pass. Their village is in the region of Shar-I-Buzurgh, which was hit by an earthquake three years ago and has since suffered from three years of drought. "There is nothing left to eat in the house," says their mother.

Afghan refugees struggle for the last items during a distribution of food at the Jalozai refugee camp near Peshawar, Pakistan, in June 2001.



© Robert Knoth

Afghanistan | Civil war and drought compound immense humanitarian needs

(Continued from page 66)

Drought and displacement

After two years of minimal rains, by summer 2000 Afghanistan was gripped by the worst drought in 30 years. Many people were forced to seek food and help in cities or camps, joining others already displaced by war. In addition to setting up nutritional surveillance systems, MSF opened therapeutic and supplementary feeding centers for displaced people and area residents in hard-hit Herat, Badghis, and Kandahar provinces in the west and south, with additional programs in Balkh, Faryab, and Baghlan provinces in the north.

By December 2000, as the effects of the drought deepened, 50% of the international aid pledged during the year had failed to materialize. At the time, MSF called on the international community to fulfill its humanitarian responsibility toward the country.

As of May 2001, the situation was far from improving, as the effects of the drought intensified and fighting resumed in the north, causing many more people to flee their homes.

Ongoing projects

In Kabul, the capital, MSF began working in a 52-bed hospital in late spring 2001 and continues to work in three other clinics. In Ghazni, MSF supports a provincial hospital and a clinic with an 80-bed tuberculosis (TB) treatment center. In the isolated region of Hazarajat, MSF works in three clinics.

MSF supports an infectious diseases ward at Mirwais hospital in Kandahar. In Herat province, the focus is on mother and child care, health education, nurse training, and mental health programs at the village level, and on pediatric care at Herat hospital.

In northern Afghanistan, 18 MSF-supported clinics in several provinces provide 40,000 consultations a month. MSF mobile clinics also provide health care at numerous IDP camps in the area, and water and sanitation activities where needed. In the front-line town of Taloqan, MSF works in the hospital. In the isolated Panjshir Valley, under opposition control, MSF cares for IDPs and residents in two hospitals and several clinics and tent clinics. In the Badakhshan and Takhar regions, also under the opposition, MSF has been working since September 2000 in several IDP camps. MSF works at the hospital in Faizabad and in clinics in nearby Baharak, Eskashen, and Zebok. In late December 2000, MSF opened a delivery room in Iskashim for complicated births.



Afghan refugees abroad

Since 1996, MSF has cared for Afghans seeking refuge in Iran. In September 2000, MSF also began working in two camps for Afghan refugees near Peshawar, Pakistan. In the Jalozai camp, approximately 45,000 people live in deplorable conditions in a camp that is treeless, waterless, overcrowded, and incredibly cold in winter. Until only recently, people living in the camp were not even screened, and thus had no possibility of being granted refugee status. Some were deported. MSF welcomes the onset of the screening at Jalozai but is concerned about the voluntary repatriation encouraged by the process, because the situation in Afghanistan remains unstable and insecure. There is still no screening of refugees in the New Shamshatoo camp, where MSF is also working.

Iran | MSF exits repatriation program

- International staff: 6
- National staff: 56

Iran is still home to more than two million refugees, including 500,000 Iraqis and 1.5 million Afghans, most of whom live in urban areas. In the atmosphere of economic crisis that pervades Iranian society, refugees are more and more openly regarded as, at best, economic migrants and, at worst, criminals. In recent years, the Iranian authorities have considerably tightened policies regarding refugee admissions and Afghans' right to asylum. The activities of MSF in Iran are centered on providing medical assistance to these refugees.

Problematic repatriation

In 1999, an estimated 100,000 Afghans were escorted by force back to the frontier. In light of the Iranian government's resolve to deal with the immigration problem in this arbitrary and brutal fashion, the United Nations High Commissioner for Refugees (UNHCR) launched a joint repatriation program in 2000. MSF participated in that program by providing medical services. By the year's end, 134,000 people had been repatriated, and almost 70,000 people had been granted temporary asylum. Yet conditions governing this asylum were not transparent, and the arrests and deportations continued. The repatriation project's implementation was also far from satisfactory. Ultimately, deteriorating living conditions in Afghanistan and the inability to guarantee acceptable medical conditions for repatriated Afghans forced MSF to suspend its participation in the project.

In Gulshar, MSF continues to provide consultations, home visits, mobile clinics and social services through a clinic run by the Iranian Ministry of Health. Gulshar has a population of around 80,000, including 40,000 Afghans. MSF reaches people living in precarious situations, especially new arrivals. For more information and to read accounts of some refugees, see the Iran file at www.msf.org.

A new mission has been opened in Teheran, and there are also plans to operate in the provinces of Khorasan and Sistan-Baluchistan. These programs will also focus on vulnerable communities of Afghan refugees.

MSF began work in Iran in 1995.

CENTRAL ASIA

© Christine Marcilly/MSF

A refugee from Afghanistan seeks aid at an MSF clinic in Mashad, Iran.

India | Earthquake prompts massive response

- International staff: 26
- National staff: 14

On January 26, 2001, an earthquake measuring 7.9 on the Richter scale hit the northwestern Indian state of Gujarat. The earthquake occurred only a week after another major earthquake halfway around the globe in El Salvador. MSF, already present in India with projects in Mumbai and the state of Jammu and Kashmir, dispatched additional staff and relief supplies to the country, and a two-month emergency intervention began. MSF flew in 18 volunteers and sent nearly 50 aid flights in the first month of intervention, with efforts focused on caring for survivors and providing relief items such as clean water, blankets, and tents. See box on page 80 for more on MSF aid to earthquake victims in India, El Salvador, and Peru, struck by an earthquake in June.

Mental health

In the state of Jammu and Kashmir, the health problems addressed by MSF result not from nature, but from man. The region is disputed by India and Pakistan and has long been the site of conflict. Years of strife and social upheaval have left a legacy of depression, post-traumatic stress disorders, and social problems such as domestic violence and substance abuse. Health services have crumbled. MSF established a presence in the area in 2000, with financial and technical aid to the Voluntary Health Association, an Indian NGO working to improve primary care in isolated areas of the Kashmir valley. This work has now been extended to training and support of local mental health counselors.

Tuberculosis

In the city of Mumbai, MSF works within the Revised National Tuberculosis Control Program, which is based on the Directly Observed Treatment Short Course (DOTS) strategy. MSF's pilot project targets about 600,000 people in the southern part of the city. The program focuses on raising the level of microscopy, improving patient care, and involving the private sector in the national control program. MSF holds training workshops in communication and counseling for district medical staff. Regular patient follow-up and counseling is done through local NGOs; outreach activities include sponsoring street plays and producing newsletters and information leaflets.

The earthquake wasn't the only natural disaster in India that prompted an MSF response over the last year. In October 2000, MSF mobile clinics assisted people in flooded and isolated villages in the state of West Bengal. MSF is also planning to study the resistance of malaria strains common in the state of Assam. MSF began work in India in 1999.

Pigeons take flight amid buildings fallen to earth in the northwest Indian town of Bhauchau, the epicenter of the earthquake that took 20,000 lives in January 2001.

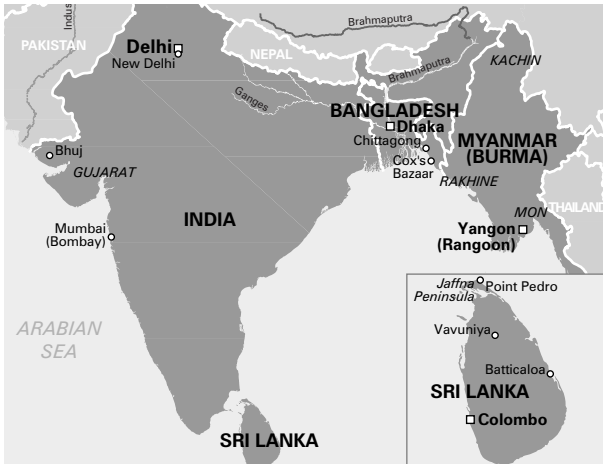


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Bangladesh

Primary care reaches troubled areas

- International staff: 11
- National staff: 163



In a country with some of the poorest, most densely packed and environmentally challenged citizens on the planet, MSF is working with those who are most marginalized by political and social pressures.

The most recent project, started at the end of 1999, is in the troubled Chittagong Hill Tracts, an isolated and conflict-ridden area where Bengali inhabitants and the original tribal population do not have access to government health care services. MSF is providing primary health care to a target group of around 50,000 people. The services, run through two local clinics, include basic diagnosis and treatment with laboratory testing, mother and child health care and family planning, immunization, health education, and the provision of clean water through well-drilling programs.

A longer-term project in Cox's Bazaar addresses the needs of refugees from Myanmar, whose status remains unresolved. Since 1992, MSF has been providing medical aid and sanitation services and helping to ensure that the rights of the refugees are respected. The project now concentrates on the health of mothers and children under ten.

Because of Bangladesh's history of floods and cyclones, MSF remains prepared to respond to natural disasters if requested.

Sri Lanka

Medical and surgical care amid war

- International staff: 43
- National staff: 178

MSF's work in Sri Lanka is dominated by aid to victims of the country's civil war, which has taken the lives of over 60,000 people and displaced about a million others over the last fifteen years. Although a relative calming of the fighting has permitted the return of some displaced people to their homes, wounded civilians and combatants continue to flock to medical facilities.

Surgical care

MSF surgical intervention takes place in Point Pedro (on the Jaffna Peninsula), Vavuniya, Mallavi, and Batticaloa. MSF supports hospital surgical units in the four locations, where, in 2000, over 11,000 people underwent surgery. In Batticaloa, the burn unit was refurbished. In Mallavi, support also extends to the hospital's pediatric, gynecology, and obstetrics departments.

Other assistance

Near the town of Madhu, MSF provides aid to displaced people in two camps, with a special focus on antenatal care, and refers people to hospitals in Vavuniya and Mallavi as necessary. Mobile teams in these areas reach villages isolated by the shifting front lines. In Vavuniya, MSF has also helped set up community-based psychosocial services for displaced people and residents. Elsewhere, in Puthukkudiyiruppu, MSF supports the public health system, with special attention to mothers and children.

An MSF project in Murankan, which included hospital care and mobile clinics, finished in December 2000. At this time, an easing of the conflict in this area allowed Sri Lankan personnel to return to the hospital.

On the Jaffna Peninsula, MSF aids some of the area's 150,000 displaced people by monitoring the nutrition situation of the population and carrying out epidemic surveillance. MSF works to inform and coordinate relevant local actors. In addition, two pediatricians offer consultations at the Jaffna Teaching Hospital, where MSF also supplies medicines and medical material for the pediatrics department. Emphasis there and in the surrounding district is on care for children and pregnant women.

MSF began work in Sri Lanka in 1986.

Myanmar (Burma)

Fighting disease in a closed country

- International staff: 18
- National staff: 39

Despite losing multi-party elections a decade ago, the military rulers of Myanmar (Burma) refused to relinquish power, a move that has largely isolated the regime from the international community and left the civilian population in difficulty. The government spends about US$.12 per person each year on health care, and international aid is limited. In this context, malaria, AIDS, and tuberculosis (TB) remain huge public health problems.

Malaria strains are resistant to standard treatments

Malaria is the main cause of illness and death in Burma. Last year MSF treated over 100,000 people suffering from malaria in Rakhine, Kachin, and Mon states and Thaninthary district.

The strains of malaria prevalent in much of Burma have some of the highest rates of resistance in the world to standard treatments such as chloroquine and Fansidar®. The only effective drugs are combinations using artemisinine derivatives, but they are relatively expensive at about US$2 – $3 a patient. MSF is working to find an affordable source for the drugs and is pushing for such treatment to be adopted as the national protocol. Because resistance is so widespread in Burma, MSF treats all patients with an artesunate/mefloquine combination.

AIDS is a growing concern

MSF is working against the growing threat of AIDS in Burma through education activities for the general public, condom distribution, and treatment of sexually transmitted diseases (STDs). At eight STD clinics in Yangon (Rangoon), the capital, and in Rakhine and Kachin, MSF treats high-risk groups, including prostitutes and their customers. For prostitutes unable to reach the clinics, MSF makes monthly visits to brothels and provides STD treatment on the spot.

A rise in TB has gone hand in hand with the AIDS pandemic. MSF diagnoses and treats TB in Kachin State. MSF is also working to reduce the threat of diarrheal diseases, including cholera, through door-to-door hygiene education and a water chlorination program.

MSF has been working Burma since 1992.

Laos

New MSF project focuses on AIDS treatment

- International staff: 10
- National staff: 42



In March 2001, the Laotian government adopted an ambitious program to try to shed the country of its status as one of the world's least developed countries by the year 2020. The plan focuses on four areas: education, agriculture, infrastructure, and health. Right now, the principal causes of mortality in the country are malaria, respiratory infections, diarrhea, and epidemics of diseases such as dengue and measles. As in other countries in the region, HIV/AIDS is an ever-growing threat, although levels of infection are officially quite low.

In mid-2001, MSF launched an AIDS program in Savannakhet, the Laotian province with the highest declared rate of HIV infection. At the main hospital, MSF treats opportunistic infections common in those with AIDS and supplies medicines and medical material. Staff training is an important part of the program. MSF hopes to establish an HIV/AIDS reference and resource center – the country's first – and will study the possibility of starting antiretroviral treatment for some patients. MSF has been working in Laos since 1990. Recent programs supporting district health care in several provinces have drawn to a close in the last few years, the last projects coming to end in the Bokeo province in late 2000 and Champassak province in early 2001.

East Timor

MSF becomes key player in Baukau district

- International staff: 11
- National staff: 70

The situation in East Timor has stabilized over the last year, as people slowly returned to their homes after the violence and upheaval of independence in fall 1999. The United Nations is now acting as temporary administrator of the country; efforts to rebuild are slowly taking shape, especially in the capital, Dili.

During the second half of 2000, MSF signed an agreement to implement a district health plan in the Baukau district in the north. At the hospital and in health posts throughout the district, MSF provides basic health services and tuberculosis treatment, trains staff, rebuilds health facilities, and monitors for disease outbreaks. The Baukau hospital is one of only three health structures in the country with surgical facilities; as such, MSF provides surgery coverage to about a quarter of the entire population of East Timor.

Difficulty in hiring permanent East Timorese staff has hampered the full implementation of the district health plan. With only 20 doctors in the whole country, the human resources are just not available. Recruiting has also been slowed by the need to put into place a countrywide health system. A cumbersome tender process that is centrally managed by the interim ministry of health and the World Bank has also slowed things down, and has raised questions about how NGOs can remain independent under such a centralized sub-contracting system.

In early 2001, MSF handed over supervision of the Dili Transit Center for returning refugees to another NGO. Some 90,000 East Timorese are still refugees in the Indonesian province of West Timor, cut off from humanitarian aid (see Indonesia, next page). MSF is following this situation closely, and remains ready to respond to an influx of refugees or other emergencies.

MSF has been working in East Timor since May 1999.

Thailand

Drug therapy and home care help AIDS patients

- International staff: 15
- National staff: 80

MSF's work in Thailand focuses largely on relieving the suffering of some of the 750,000 people living with AIDS by tackling the issues of access to medicine and sustainable care.

MSF's successful campaign for local production of generic antiretroviral drugs (ARVs), run in collaboration with a network of Thai NGOs, provided direct benefits to the Thai population in spring 2001. Triple therapy ARV treatment began for ten home care AIDS patients and 30 in the hospital in Surin in May.

In the Bangkruai area, MSF provides ARV drugs to 40 patients; it is hoped this program will expand to 250 patients. MSF is committed to the project for at least five years to ensure quality and continuity of care. In Bangkok, MSF makes regular home care visits to another 70 people, 20 of whom also receive antiretrovirals.

MSF is also campaigning for access to drugs to treat opportunistic infections and has run a series of training sessions for Bangkok pharmacists.

These projects are complemented by the ongoing work of MSF in offering technical assistance, training, and support to community hospitals, health stations, and local NGOs in the Ban Laem and Panom Thuan districts.

Caring for refugees

MSF assists Karen refugees from Burma in camps near the border towns of Mae Sot and Ratchaburi, and the Mons refugee community in Sangklaburi. Teams provide basic medical care, prenatal consultations, and vaccinations.

Since 1999, MSF opened a health center for tuberculosis patients in Mae Sot. The program targets illegal migrant workers. Teams treat patients in the health center, at home or in the places where they work.

MSF has been in Thailand since 1983.

Indonesia

Caring for vulnerable people in a turbulent archipelago

- International staff: 39
- National staff: 239

Vulnerable populations abound in Indonesia, with over one million people displaced within the country due to political instability and religious and ethnic violence. Access to these people is hampered by insecurity and logistical constraints.

Public health is further affected by disease outbreaks, inconsistent access to clean water, and the isolation of many areas.

West Timor

About 90,000 East Timorese are still refugees in the Indonesian province of West Timor. The frontier with East Timor remains closed. Most humanitarian actors withdrew from West Timor after the murder of three UN workers at the hands of militia in September 2000; much of the province is still under militia control and access by aid organizations and international agencies is difficult.

MSF, which had been providing care for 15,000 East Timorese refugees in the Tuapukan refugee camp just outside of port city of Kupang, temporarily halted this project in September 2000. However, MSF continued work begun in 1998 to prevent HIV and sexually transmitted diseases (STDs) at a drop-in center for sex workers in Kupang. In June 2001, this project was turned over to a local NGO. MSF restarted its work with refugees in March 2001 in the Naen refugee camp (with 2,200 inhabitants) in north-central West Timor and in May 2001 in the Kupang refugee camps. Since August 2001, MSF has also been assisting 2,300 refugees in the Olbinose refugee camp, a few hours drive northwest of the Naen camp.

The Moluccas

MSF continues to provide primary health care and sanitation for over 50,000 displaced people around Ambon and the nearby island of Buru, and in several camps for displaced people in Manado, Bacan, and Ternate. An MSF team is also working to improve surgical care in Ambon through training of medical personnel.

In April 2001, an immunization campaign in isolated areas of Halmahera Island took shape as a basic primary health care project. Mobile clinics now provide care to people near Loloda, a town on the island's northwest coast.

A baby with AIDS lies with its mother at Sihanouk Hospital in Phnom Penh, where MSF runs a 60-bed AIDS ward.



© Roger Job

Aceh

An MSF program training health care providers in emergency response in Aceh province was cut short in March 2001, when insecurity forced the evacuation of the MSF team. Trainings were later carried out for some Aceh health workers in the town of Medan, in Sumatra Utara province. MSF also worked with about 20,000 displaced people in the areas of Pidie, Aceh Timur, and Aceh Utara.

West Kalimantan and Irian Jaya

Since 1999, MSF has fought skin disease and diarrhea among a group of 17,000 displaced Madurese sheltering in various public facilities in the city of Pontianak. In Irian Jaya, an MSF program supporting community health workers continues, now focusing on training for epidemiological surveillance in remote areas. MSF is also working on an emergency preparedness project at the provincial level.

Sulawesi

A mental health program in Buton, which focused on counseling people and training mental health professionals to deal with post-traumatic stress disorders, was handed over to local authorities in June 2001.

Cambodia

MSF begins direct AIDS treatment

- International staff: 39
- National staff: 154

Cambodia's public health system remains quite weak despite a marked increase in the state budget for health and the greatest political stability in three decades. The divide between rich and poor is growing, with many rural people facing limited access to health care and a high burden of infectious diseases.

Fighting infectious disease

In a welcome new development, MSF is at last able to ease the suffering of some of Cambodia's 169,000 AIDS victims with the introduction of antiretroviral treatment. Since July 2001, the drugs have been administered for free at Sihanouk Hospital in Phnom Penh, where MSF runs a 60-bed ward for AIDS patients. It is hoped that 20 patients can be integrated into the program each month; MSF has committed to the project for at least five years in order to ensure regular and permanent treatment.

HIV awareness and prevention programs target specific groups such as young people, sex workers, and their clients through STD clinics in the areas of Siem Reap, Sisophon, and Poipet. The Svay Pak clinic in Phnom Penh, which provides health services and education for sex workers, is being handed over to local management. MSF has obtained its objective of improving AIDS care at Battambang Provincial Hospital.

The decline in malaria continues with the number of cases seen in Anlong Veng, Trapeang Prasat, and Sotnikum hospitals only a fraction of those in 1999 and 2000. Nevertheless, MSF remains prepared for outbreaks of disease and natural disasters. A pilot home care DOTS (Directly Observed Treatment Short Course) program to treat tuberculosis set up in the Phnom Penh area in 1997 drew to a close in fall 2001.

Developing sustainable health care

Since its arrival in Cambodia 11 years ago, MSF has concentrated on building and strengthening health facilities in marginalized areas. Most recently this has involved close collaboration with the Ministry of Health in implementing the Health Financing Scheme or "New Deal" in the areas of Takeo, Sotnikum, and now the former front-line area of Thmar Pouk. The results are encouraging, with activity in Thmar Pouk increased three-fold from last year.

MSF also assists hospitals by providing medical supplies, training, and some management support.

China

Grim prospects for health care in rural China

- International staff: 57
- National staff: 125

The "socialist market economy" that has taken root in China has had strong repercussions on health in rural communities. The cost of medical care has skyrocketed, insurance coverage has plummeted, and many skilled medical workers have fled rural areas for more lucrative work in the cities. Few rural families can afford even basic medical care. MSF focuses its attention on largely rural areas in western China, fighting infectious diseases such as AIDS and tuberculosis, offering medical attention to those families that cannot afford it, and providing cleaner drinking water in some areas.

Infectious disease

Difficulties in the health sector are compounded by fear and denial of some sectors of society and certain diseases, such as HIV/AIDS. Estimates of the number of HIV/AIDS cases vary; poor surveillance means that official estimates of 600,000 cases or other estimates of around a million may be too low. Sometimes local officials take pains to conceal the problem, or fail to look into it. However, encouraging signs at the national level include a revised national policy, and some committed officials and activists who are trying to tackle the problem.

In Liangshan prefecture in Sichuan province, MSF reaches out to high-risk groups such as migrants, drug users, and prostitutes in detention centers, detoxification centers, and karaoke bars. Workshops educate health care workers and the general public about the epidemic. MSF has renovated several clinics and laboratories, trained health staff, and provided drugs for treating sexually transmitted diseases (STDs). A smaller, similar project runs in the Kunming area of Yunnan province.

In Nujiang prefecture in Yunnan, MSF has set up a tuberculosis (TB) control program. MSF trains local health staff in the Directly Observed Treatment Short Course (DOTS) protocol for TB treatment. In addition, MSF provides TB medicines and treats people living in remote mountain villages. In Guangxi province, MSF also treats TB and trains health workers. In the same area, general medical aid is given to indigent people. In Xichou county in Yunnan, a hygiene and water and sanitation program targets infectious diseases.



© Henk Braam

Asan swallows some of the pills she takes to treat her tuberculosis (TB). Asan lives in a small village in southern China and receives TB medicine from MSF.

In Shaanxi province, over 200 street children were given food, shelter, medical attention, and education until this program was shut down in late 2000 because of difficulties with Chinese partners. MSF later relaunched the project in cooperation with regional authorities.

Tibet

MSF has worked since 1993 to combat Kashin Beck Disease (KBD), or Big Bone Disease, in Tibet autonomous region. The disease, whose cause is not well understood, progressively attacks the joints, reducing mobility and causing pain. After several years working to alleviate pain through physiotherapy, MSF began research and preventive activities in 1997, reaching 22 villages. Seventeen other villages also benefit from prevention work, while 50 community clinics still provide physiotherapy. In early 2001, a general water supply program was extended within Tibet, and another water program was set up in Kashgar prefecture in the Xinjiang Uighur autonomous region, where bacteria and chemicals have long contaminated the water supply.

Aid to refugees from North Korea

Since its departure from North Korea in late 1998 because of lack of access to the population and lack of independence to carry out its programs, MSF has tried to assist North Korean refugees coming into China. In August 2001, MSF expressed its alarm when refugees inside China near the frontier were forcibly repatriated to North Korea. MSF asked the Chinese authorities if it could assist the refugees. By early September 2001, it was still not clear whether the request would be granted. Although work in North Korea itself has been impossible since late 1998, MSF continues to monitor the nutritional crisis in that country.

During the course of the last year, MSF also responded to numerous emergencies in China in and around its ongoing program sites, including floods, village fires, and measles epidemics.

MSF has been working in China since 1988.

Papua New Guinea

Doctor and midwife support hospital's renewal

- International staff: 3
- National staff: 10



After ten years of civil war on the island of Bougainville, one of the islands that make up Papua New Guinea, a ceasefire between government troops and the rebel Bougainville People's Army was established in 1998. Shortly after, MSF arrived in the southern town of Buin, to help turn the local hospital into a referral center for the area's estimated 80,000 people.

Medical care in rural areas

Two MSF volunteers (a physician and a midwife) provide medical services at the hospital, which has very few qualified health staff. The team trains nurses. The volunteers also work together with the hospital administration to develop the financial and human resources the hospital needs to be able to provide quality health care. MSF also supplies some medicines.

Even though the hospital has not yet regained the level of operations it had before the war, MSF has helped increase people's confidence in a health system shattered by the conflict. Because the hospital is less and less dependent on outside assistance, MSF plans to leave Buin at the end of 2001, when a doctor from Bougainville is expected be appointed to the hospital.

MSF began work in Papua New Guinea in 1998.

Philippines

MSF assists displaced in the south

- International staff: 9
- National staff: 61

In early 2001, a popular uprising on the streets of the capital city Manila brought a change in power to the Philippines. However, this shift in the capital did little to alleviate the political and social turbulence among the country's poor majority and in the south, where the government has been struggling to quell the independence aspirations of separatist groups.

Aid in areas exhausted by strife

Although Mindanao province has long been the site of clashes between the government army and rebel groups, early 2000 saw the government army launch an all-out attack on the rebel Moro Independence Liberation Front. Nearly 800,000 people were subsequently displaced from their homes. In July 2000, MSF began assisting displaced people in the Cotabato area of Mindanao. Aid includes supplying medicines, constructing shelters and setting up water and sanitation services. Mobile clinics are regularly sent to centers for the displaced.

In neighboring Sulu province, itself exhausted by civil conflict, MSF began aiding community pharmacies in rural health posts in 1997. After the establishment of a basic drug supply and cost recovery system, the pharmacy network is now autonomous.

Street children in Manila

Two projects assisting Manila street children continue. One team runs a mobile unit that provides examinations and dispenses drugs free of charge; the other team is working to make Filipino society more accepting of street children. In addition to providing direct aid to the children, MSF helps key actors (such as health workers, police officers and prison guards) understand the kinds of problems faced by street children. Lobbying local governments and agencies to improve treatment and living conditions of these young people is an important part of MSF's work.

MSF has a separate project to improve water quality and sanitation in the slum area of Malabon, north of the capital.

MSF has been working in the Philippines since 1984.

Mongolia

Devastating winter hits herders

- International staff: 5
- National staff: 15



© Sam Faulkner

In rural western Mongolia, a health worker checks the size of this girl's upper arm to see whether she is malnourished.

Mongolian herders were hit hard in early 2001 by the second consecutive "dzud," or exceptionally cold and dry winter. Many heads of livestock, a dietary staple, were lost due to lack of grazing grounds, with adverse effects on the nutrition of the population. MSF, which began working in Mongolia in 1999, responded to this crisis even as it wound up its two-year program of education on HIV/AIDS.

The Dzud

MSF supported some 30,000 people in the Bayan Olgiy province after much of their livestock died due to the "dzud." MSF purchased 321 metric tons of wheat flour to distribute to struggling families. Feldchers (medical personnel with status between doctor and nurse) were affected by the winter as well. Traveling through the rough terrain became impossible with the deaths of their horses. MSF bought 33 horses to allow feldchers to continue their work. This program lasted for a few months in early 2001.

HIV/AIDS

The devastation of AIDS has not yet reached Mongolia, but the rise of syphilis and gonorrhea has raised concerns that sexually transmitted diseases (STDs) are a threat. MSF helped set up information centers in the capitol of Ulan Bator to provide information on HIV/AIDS and other STDs to health professionals. MSF also trained 12 doctors and over 200 health care workers from across Mongolia on pre- and post-HIV counseling. In addition, MSF implemented two countrywide mass media campaigns on safe sex, targeting Mongolian youth. All program activities were turned over to national counterparts.



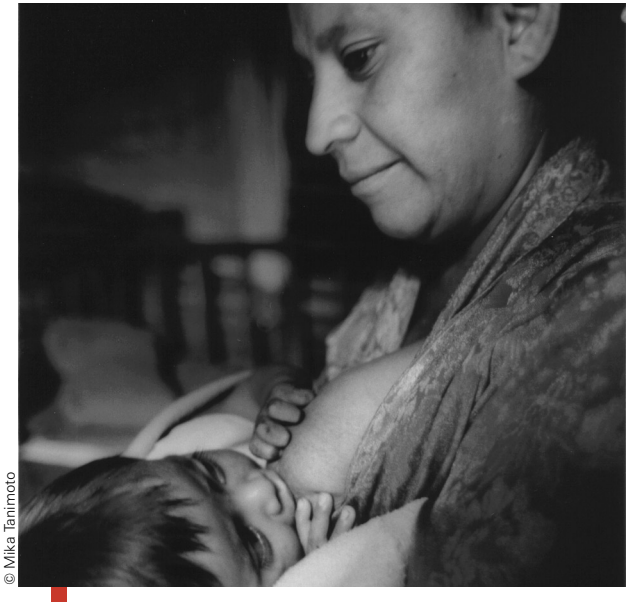
© Kadir van Lohuizen



Women enter an MSF trachoma clinic in Chiapas, Mexico.

Guatemala | Approach to AIDS unites advocacy and action

- International staff: 22
- National staff: 106



© Mika Tanimoto

A woman feeds her baby in the Guatemala slum of Lomas de Santa Faz.

Over 60% of Guatemalans live in rural areas, often in poverty and with difficult access to basic health care. Poor people in urban areas are no less vulnerable. MSF work benefits marginalized people in both rural and urban settings, with special focus on the growing threat of AIDS.

AIDS care and prevention

Advocacy has joined direct patient care as the backbone of MSF's AIDS-related work in Guatemala. As part of the organization's Access to Essential Medicines Campaign, MSF recently advised the Guatemalan government on the definition of an AIDS law and an Industrial Property law, which covers drug patents.

At Roosevelt Hospital in Guatemala City, the capital, MSF has begun antiretroviral treatment for 70 AIDS patients and treats opportunistic infections in about 400 people. In Cohatepeque, in Quetzaltenango department, MSF supports the "Proyecto Vida" treatment center, running external consultations and donating drugs for 250 AIDS patients.

In Hospicio San Jose, just outside Guatemala City, MSF is in charge of treating and caring for AIDS patients. The team offers consultations as well as antiretroviral treatment for children and adults. A similar program at Hospicio Marco Antonio in Guatemala City ended in late 2000.

Prevention of HIV/AIDS is also important. For schools and health care centers in Cohatepeque and Guatemala City, the MSF team has produced self-learning guides, organized workshops for local medical staff, and run public awareness activities.

Vulnerable populations

In April 2001, MSF began a medical and legal program to assist undocumented people migrating north through Guatemala from Central and South America. In San Marcos department, near the Mexican border, MSF works with a local NGO that offers medical and legal aid to transmigrants, both those on their way to Mexico as well as some of the 300 people who are returned by the Mexican authorities each day.

In an effort to reduce mother and child mortality rates, MSF runs rural primary health care programs in Frontera, Izabal province, and Champerico, in the southeast. Work in Frontera is expected to end by the end of 2001.

At Tzite Clinic in Guatemala City, adolescents living on the street are offered medical aid and social and psychological support. MSF also runs the therapeutic creche "Casa del Patojo" in the slum of Lomas de Santa Faz. Children receive medical assistance, and they and their families receive psychological support.

MSF also works in ten marginal settlements of Guatemala City to reduce the risk of epidemic outbreaks, floods, and landslides.

Haiti | Comprehensive aid to Communal Health Units

- International staff: 14
- National staff: 17



Access to health care in Haiti is impeded by lack of money and geographic proximity, especially in rural areas. Coupled with low vaccination coverage, malnutrition, and lack of access to water and sanitation services, this results in high rates of respiratory infections, diarrhea, and other communicable diseases. MSF assists local health authorities with the implementation of Community Health Units (CHUs), a system of organizing health care that was introduced as part of an overall decentralization of the country's health care system begun in 1996.

Since 1996, MSF has worked to launch the Communal Health Unit covering the communes of Saint-Marc, Desdunes, and Grande Saline. Key goals include improving management of the CHU, improving maternal care at all levels, and ensuring emergency surgical care. The CHU includes a hospital and 18 health centers and covers 200,000 people. In 2000, MSF helped refurbish these health facilities.

MSF also supports the CHU of Verrettes, which covers the communes of Petite Rivière, Verettes, and de Chapelle. MSF focuses on the health center and five dispensaries in Petite Rivière, which has a population of 145,000. MSF supervises medical staff and has refurbished some of the dispensaries.

In response to the country's high maternal mortality rate, MSF work in both CHUs puts special emphasis on maternal care for women of childbearing age.

Honduras | MSF fights dengue fever, Chagas disease, and AIDS

- International staff: 30
- National staff: 137

Honduras is slowly recovering from the passage of Hurricane Mitch in 1998. The health needs of the people remain great, especially for the country's poor and in rural areas, where there is difficult access to drinking water, sanitation facilities, and electricity. Chagas disease, a rare and often fatal illness, is endemic in parts of the country. Honduras is also home to about 70% of all AIDS cases registered in Central America.

Dengue fever strikes the capital

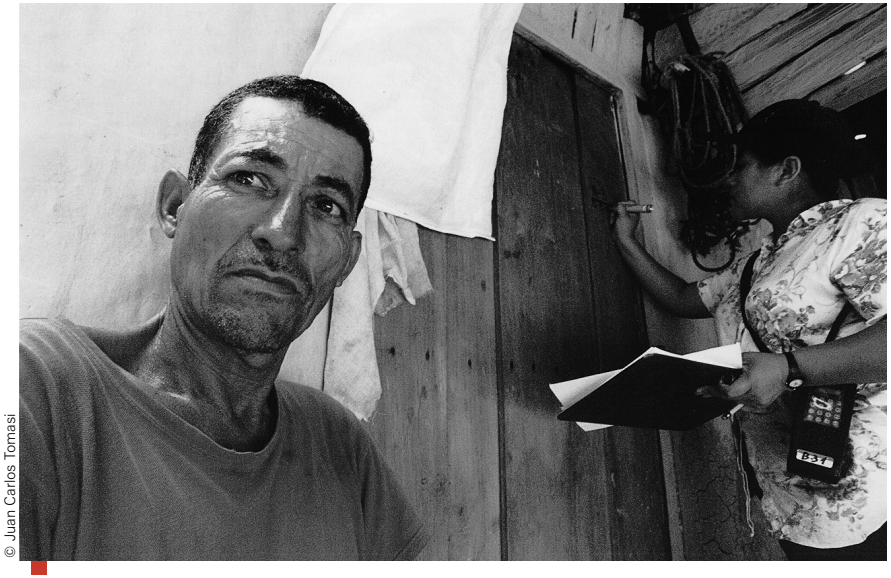
An epidemic of dengue fever broke out in September 2000, with most cases registered in Tegucigalpa. MSF teams worked with health center staff on case management and vector control, and helped educate people to prevent the spread of the disease. A separate urban health care program serving 40,000 people in Tegucigalpa's El Carrizal neighborhood ended in late 2000.

In an effort to tackle the problem of AIDS and sexually transmitted diseases (STDs), MSF runs programs in Tegucigalpa, the capital, and in La Ceiba, a town on the Caribbean coast. Teams work to improve the case management and treatment skills of local staff, and drug donations ensure treatment of opportunistic infections and STDs. In La Ceiba, MSF also has a school-based education project for teenagers and parents in collaboration with a local NGO.

Rural health care

Chagas disease, a rare parasitic ailment transmitted by small bugs, is endemic in the mountainous regions of central Honduras. MSF programs address treatment and prevention: screening and treatment are carried out primarily among children, and fumigation is accomplished by mobile brigades who go from house to house in high-risk areas, checking for fleas and spraying insecticide.

In the towns of Yoro and Olanchito in north-central Honduras, primary care programs focus on women and on children under five. MSF teams train local health staff, give logistical support to government vaccination activities, and help local medical staff improve analysis of nutritional and epidemiological data. As part of the program MSF has refurbished or built a number of health facilities and worked to improve water and sanitation systems.



© Juan Carlos Tomasi

A woman marks this house near Yoro, in central Honduras, after it has been sprayed to eradicate the small bugs that spread Chagas disease.

MSF recently opened a new health care and psychological support program among the Garifuna people on the Caribbean coast. Another project to increase food security in Choluteca will be turned over to an NGO more specialized in this area.

MSF teams in Honduras supported teams in El Salvador, following the two earthquakes, with human resources and 30 tons of relief material.

MSF first intervened in Honduras in 1974.

Mexico | Programs reach areas of isolation and neglect

- International staff: 6
- National staff: 39

MSF work in Mexico focuses on indigenous people who live in isolated regions, and have little or no access to basic health care.

In March 2000, MSF was granted access to the isolated state of Chiapas, where neglect and poverty have fomented a rebellion led by the area's indigenous people that has endured since 1994. The initial primary health care project in the region of Los Altos has now been extended to the regions of Zona Norte, Las Cañadas, and La Selva – all isolated, mountainous areas and part of the so-called "conflict area." Much of MSF's work takes place in self-declared autonomous communities, where rebels have not let the Ministry of Health operate for more than seven years.

Mobile medical teams deliver basic care and train community health workers and traditional birth attendants. In Los Altos, MSF also performs eye surgery on patients with trachoma, a blinding disease endemic in the area.

A two-year pilot program in Mixteca, in the southern state of Oaxaca, was handed over to the Mexican Ministry of Health at the end of 2000. This program of medical aid and training served some 17,000 indigenous people scattered over 60 communities.

A recent exploratory mission in the southeastern part of the state of Guerrero is likely to result in a program focused on health care for mothers and children.

MSF first worked in Mexico in 1994 and has had a continuous presence since 1997.

Earthquake: El Salvador, India, and Peru

MSF responds to physical and psychological needs in all three countries

On January 13, 2001, a major earthquake struck El Salvador. Two weeks later, a massive quake leveled entire villages in the Indian state of Gujarat. A few days after this, the earth moved again in El Salvador. In June, an earthquake rocked southern Peru. With ongoing programs in all three countries before the disasters, MSF responded in each case with massive emergency aid, including medical care, supply of relief items, and psychological support.

El Salvador

After the first quake hit the western coast of El Salvador, MSF volunteers in El Salvador, Nicaragua, Costa Rica, Honduras, Guatemala, and Colombia made their way to the region of the disaster. Within seven days, there were more than 53 MSF aid workers on the ground, a number that swelled to 85 after the second earthquake.

Initially, MSF trained its efforts on the two main hospitals in San Salvador, both of them damaged. MSF provided medicine and medical supplies. In rural areas most affected by the tremors, MSF provided medical care, including first aid, surgery, and psychosocial attention. Tents and sanitation services were provided for those left homeless.

India

In India, the area near the epicenter – the city of Bhuj in the northeastern state of Gujarat – had suffered massive damage and casualties, and villages to the north and east were almost entirely destroyed. More than 20,000 people lost their lives in the January 26 quake.

The initial priority was medical care for survivors. Because most health care facilities had collapsed, MSF set up mobile medical teams to assist the population. The greatest need, however, was tents to shelter entire families from the cold weather. MSF undertook a massive fly-in of relief items, bringing in 20,000 tents and 1,000 tons of supplies including clean water, blankets, plastic sheeting, and sanitation equipment. Nearly 20 volunteers took part in the relief operation.

MSF orchestrated daily distributions by truck, organizing with local leaders and sometimes with families themselves, ultimately assisting over 100,000 people.

Peru

On June 23, an earthquake hit Peru. Relief efforts focused on impoverished rural areas in the south, most severely affected by the earthquake. A steady stream of aftershocks kept people living in fear, while cold weather compounded the risk of health problems. At the height of the emergency, 16 volunteers helped provide medical care, shelter, and basic relief.

Psychological support is essential

The earthquakes in El Salvador, India, and Peru prompted comprehensive psychological aid to the affected populations, in addition to medical and relief assistance.

In Bhuj, the extensive number of casualties meant that almost every family had experienced a personal loss. An increase in anxiety, depression, and anger was quickly detected among the survivors. MSF trained local nurses, teachers, and social workers to help trauma victims cope with the emotional effects of the quake.

Far away in El Salvador, people were experiencing the same loss and its emotional fallout. Near San Salvador, the capital, over 10,000 people displaced by the quake gathered in El Cafetalon, a sports center. A team of five MSF psychologists and one psychiatrist offered daily consultations, in the immediate aftermath of the quake reaching more than 100 adults and 300 children each day. Trauma was so widespread after the country's second earthquake that MSF broadcast messages on radio stations to educate people about the symptoms of traumatic stress and ways to help them cope.



© Bruno De Cock

Children in Moquegua, Peru, are absorbed in drawing a picture that explains to other children what an earthquake is like. This activity is part of MSF's psychological support program for people affected by the earthquake.

In Peru's Camana province, a seaside area affected not just by the quake but by a tsunami (tidal wave) that immediately followed it, MSF ran workshops in a camp for the displaced to raise awareness of the symptoms of psychological trauma. Psychologists provided consultations and also assisted their Peruvian counterparts. Non-traditional approaches to psychological support were also used, for example identifying camp residents' individual skills, such as bread making or carpentry, and encouraging them to use their abilities to help their neighbors.

For more on ongoing MSF programs in the three countries, see Activity Report entries on El Salvador (opposite page), India (page 70), and Peru (page 85).

El Salvador

Earthquakes and dengue fever

- International staff: 38
- National staff: 76



Several emergencies hit El Salvador over the last year. From June to December 2000 there were epidemics of dengue fever and gastroenteritis due to rotavirus. Then, in January and February 2001, two earthquakes struck the country, killing over 1,200 people and wounding 8,500 others, and disrupted the functioning of at least 25% of the country's health care structures and its already poor water and sanitation facilities.

Emergency earthquake response

When the first earthquake hit, MSF teams, already working in El Salvador, launched an emergency program to assist the victims in the most affected and isolated areas. Medical brigades assisted displaced people living in El Cafetalon and Polideportivo camps and in Comasagua, Armenia, Juayua, San Agustín, and San Ildefonso. MSF also provided surgical care, supplied medicine and medical equipment, and helped repair damaged infrastructure in hospitals in San Miguel, Usulutan, and Rosales and in the maternity hospital in San Salvador, the capital. After the second earthquake, MSF extended activities to the departments of Cuscatlán, La Paz, and San Vicente. See box (opposite) for more on MSF emergency intervention following earthquakes in El Salvador, India, and Peru.



© Chris de Bode

An elderly couple gazes at an earthquake's destruction.

Dengue fever

The nationwide dengue fever epidemic resulted in 16,000 cases of classic dengue, 409 cases of haemorrhagic dengue, and 32 deaths. To reduce morbidity and mortality rates, MSF ran a case management and vector control program in the departments of San Vicente, La Paz, and Sonsonate.

Since November 1998, in the aftermath of Hurricane Mitch, MSF has worked to reduce the instance of waterborne disease through construction or renovation of 2,000 latrines, 600 wells, and four water distribution systems and health and hygiene education in Ahuachapan, Sonsonate, La Paz, and San Vicente. This program was expected to end in April 2001 but was extended when over 30% of the infrastructure built was damaged or destroyed by the earthquakes.

Preventing HIV/AIDS transmission to babies

After a delay caused by the earthquakes, MSF began an HIV/AIDS program in San Salvador. MSF supplies drugs and trains medical staff in an effort to reduce mother-to-child transmission of the HIV virus at the city's main maternity hospital and 11 area health centers; as of late summer 2001, over 20 mothers and babies were under treatment. MSF also promotes condom use and health education in sex establishments.

MSF worked in El Salvador from 1983 to 1992, during the civil war, and returned at the end of 1998 in response to Hurricane Mitch.

Nicaragua

Women receive care and compassion

- International staff: 11
- National staff: 50

MSF work in Nicaragua is centered on marginalized people without adequate access to the country's health system: the poor in rural and urban areas (especially women and children), people with AIDS, and children living on the streets.

In Quilali, in Nueva Segovia, a reproductive health care project encompasses "Casa Materna" – a clinic where pregnant women from remote areas can come and deliver their babies – and six health posts. MSF trains traditional birth attendants and promotes family planning. Recent construction of surgery facilities means that Caesarean and at-risk births can now be attended properly. At a special welcome desk at the Casa Materna, abused women and children can file complaints against domestic violence, and receive information and guidance.

In January 2001, a maternal and reproductive health program began in Ciudad Sandino, an urban area on the outskirts of Managua. Working out of several health posts and private clinics, MSF provides pre- and postnatal care, family planning, and training for medical staff. Information campaigns and other activities target at-risk groups in an effort to prevent sexually transmitted diseases (STDs) and unwanted pregnancies. In the same area, MSF has run a sanitation program since the passage of Hurricane Mitch in late 1998.

Fighting AIDS

In the city of Bluefields and on Corn Island, MSF is working to reduce transmission of STDs and HIV and improve the quality of life of AIDS patients. In December 2000, MSF opened a center in Bluefields for HIV diagnosis, information, counseling, and medical care.

Over the last year, a post-Hurricane Mitch water and sanitation program in Ocotal and Quilali was extended to new settlements of displaced people. The project will draw to a close in 2001. A three-year medical and psychological program for street children in Managua finished in March 2001.

Colombia | MSF aids people trapped by civil war

- International staff: 25
- National staff: 110



An Aponte Indian child shows signs of skin disease after government spraying of area crops, part of the effort to eradicate coca and poppy plants. This community was sprayed twice in 2000.

© Kadir van Lohuizen/Agence VU

| Peace talks between the government and guerrilla groups have failed to protect the civilian population from Colombia's ongoing civil war and the accompanying violations of fundamental rights by all armed groups. People have been left in an extremely vulnerable situation, especially in the countryside, where massacres, kidnappings, extortion, and roadblocks are an everyday fact of life. Health care centers have been destroyed or lack the medical staff, drugs, and material necessary to offer adequate care. The exodus of displaced people continues toward urban areas, where they are also confronted with violence.

| The climate of insecurity was brought home to MSF in July 2000, when an MSF volunteer was kidnapped in the department of Choco. The volunteer was released unharmed and unconditionally in January 2001, but MSF projects in that area were suspended indefinitely. MSF continues its other programs assisting vulnerable people in rural and urban areas.

"Expulsion zones"

| Violence affects the countryside in a particularly crude manner, generating high numbers of displaced people. Nearly two million people have been pushed from their homes since 1985, with over 300,000 people displaced in 2000 alone, according to a Colombian human rights group (CODHES). MSF works with displaced people and residents in some of the most affected areas, or "expulsion zones," primarily the Magdalena Medio region and the departments of Cordoba, Sucre, and Bolivar in the north and Caqueta and Putumayo in the south.

| In these areas, mobile clinics reach isolated villages. Teams treat recurring ailments, including acute diarrhoeal diseases and respiratory infections, malaria, and skin diseases. Preventive activities include vaccinations, nutritional surveillance, prenatal care, reproductive health, and prevention of malaria and dengue fever. MSF also works to improve water and sanitation facilities.

Urban areas

| Many of the displaced people gravitate to urban areas, settling on the outskirts and creating so-called "invasion slums." These marginalized urban areas lack basic services. In Bogota and Florencia, the capital of Caqueta, MSF runs two primary health projects for displaced and vulnerable populations. Teams provide medical assistance, with a special emphasis on preventive care, vaccination, and mother and child health care. MSF also works to improve sanitation facilities and access to clean water.

| Since July 2000, MSF has run a social-medical program in Bogota for sex workers and their families in collaboration with the Education and Work Foundation, a local NGO. Activities include medical consultations, drug donations, and the set-up of a creche for the children of women assisted by this program.

| In Cali, MSF runs a rehabilitation and violence prevention program in the district of Aguablanca. The team assists victims of violence and their families, providing physical and psycho-social rehabilitation services. A sexual and reproductive health project for young people in Cali was turned over to the municipal health authorities in late 2000. Two MSF workers continue to do follow-up for women with high-risk pregnancies.

| MSF teams also run small-scale emergency interventions due to floods, epidemics, or displacements. In May 2001, MSF ran a vector control and epidemiological surveillance program and distributed mosquito nets in the Pacific department of Nariño, which was badly affected by a malaria epidemic. Following a request from Cali officials, MSF supported a diptheria vaccination campaign in Aguablanca between November 2000 and April 2001.

| MSF has had a continuous presence in Colombia since its first intervention in 1985 to assist people in Armero, following the eruption of the Nevado del Ruiz volcano.

| To learn more about MSF in Colombia, see "Colombia: The human face of conflict," a photo essay which begins on page 11.

Ecuador

Basic care in turbulent border area

- International staff: 6
- National staff: 9



The Ecuadorian-Colombian border, where transient populations, people displaced from the fighting in Colombia, and local indigenous communities mix, is the focus of MSF's work in Ecuador. With the aim of improving access to health care for the area's excluded and displaced people, MSF runs a primary health care program in Sucumbios province in Ecuador and the Putumayo department in Colombia.

MSF makes a circuit of several hundred kilometers to assist 43 communities scattered along the Putumayo River and the surrounding area, on both sides of the border. Activities include training local medical staff in management, maintenance, and control of the cold chain, supporting the creation of community pharmacies, rehabilitating and equipping health structures, and helping the provincial health authorities manage epidemiological data.

In the area around Lago Agrio, in Sucumbios, in February 2001 MSF offered basic care and drinkable water to 2,700 people who had fled Colombia's Putumayo department.

In the first half of 2001, an exploratory mission was carried out in the slums of the southwestern city of Guayaquil to evaluate needs and the potential for an MSF intervention.

MSF has been working in Ecuador since 1995.

Panama

Health center opens in Kankintu

- International staff: 6
- National staff: 16

The northern, mountainous department of Bocas del Toro is the base for an MSF project to improve access to health care for indigenous people of the Ngöbe-Bugle ethnic group. About 20,000 people live in the area where MSF works. Since 1998, MSF has been working in close collaboration with the Ministry of Health to extend the care network in the area.

A new health center in the village of Kankintu was completed in early 2001 and from this base the team trains, supervises, and supports local medical staff and traditional birth attendants working here and at two other health posts, also built by MSF. Mother and child health care is an important aspect of the program.

With the help of local health committees, MSF vaccinates residents and donates medicines. In order to improve detection and treatment of certain diseases, such as tuberculosis and leishmaniasis, MSF has installed a small laboratory in the health center in Kankintu.

MSF has been working in Panama since 1992.

A Colombian man pulls up dead plants from his mountainside field. This area was sprayed in an effort to eradicate suspected coca and poppy plants.



© Kadir van Lohuizen/Agence VU

Bolivia | Diverse activities foster health education

- International staff: 6
- National staff: 8



© Scott Streble

The MSF team comforts a woman in Brazil.

| On the outskirts of the Bolivian capital, La Paz, densely populated Ciudad de El Alto counts around half a million inhabitants. In late 2000, MSF launched a program to strengthen mother and child care in districts 5 and 6 of El Alto, which together make up the largest pocket of poverty in the country. In July 2001, a new holistic health center for women opened. It offers family planning services as well as a forum for women to express their health care needs. Counseling on domestic violence and psychological matters is also available.

| Since 1999, MSF has been running a primary health care program in Chimoré, a rural community in central Bolivia. The goal is to improve basic health care and sanitary conditions for the area's mix of settlers, indigenous people, and seasonal workers who come to harvest coca, bananas, and pineapples. MSF built a new health care center next to Chimoré's old delapidated structure, and refurbished area health posts and water and sanitation facilities.

| Education is a big part of work in Chimoré. In schools, the emphasis is on health and hygiene, while maternal education stresses nutrition, mother and child care, and sexual education. A daily radio program informs the population about services available through their national health care coverage and takes up such topics as nutrition, hygiene, vaccination, and reproductive health.

| In late January 2001, floods affected around 5,000 people in Viacha, 45km from Ciudad de El Alto. MSF donated blankets, medicines, and medical material and installed ten water tanks.

| MSF has been working in Bolivia since 1987.

Brazil | Local communities take on MSF projects

- International staff: 13
- National staff: 76

| MSF has been active in Brazil since 1991, addressing the health needs of excluded people in Rio and indigenous communities in the Amazon basin. These marginalized groups often have little or no access to basic health care.

Access to basic health care in Rio

| In Costa Barros, an area in northern Rio de Janeiro, MSF has worked since 1998 to improve access to quality health care. The team hopes to consolidate family health services and encourage community participation in running the clinic. An AIDS prevention project covering 11 communities in northern Rio, most within the Costa Barros area, phased out in March 2001.

| MSF continues medical care for people living on the streets in Rio, and has supported the creation of a solidarity network to assist this population. A second phase of the project will target the high prevalence of sexually transmitted diseases (STDs) among people living on the streets.

| In fall 2001, MSF transferred to local doctors the responsibility for "Médicos Solidários," a network of over 100 physicians and 35 social institutions offering free consultations for excluded populations.

Indigenous health

| After six years of challenges and successes, in December 2000 MSF ceased its medical aid project among the indigenous people of the Javari Valley, in the Amazon, turning it over to an indigenous NGO. MSF had created a network of indigenous health workers and microscopists to identify and treat key diseases threatening this population. A similar project in Medio Solimões, with an emphasis on training and supervising community health workers, will be turned over to local organizations by early 2002.

| MSF is closely monitoring the government's implementation of Special Indigenous Health Care Districts, set up in October 1999, and is undertaking a review of health and humanitarian needs in the Amazon region.

Peru

Curative program targets painful parasitic disease

- International staff: 10
- National staff: 59



Communicable diseases remain the leading causes of morbidity and mortality in Peru, especially among children. The incidence of malaria, dengue fever, and leishmaniasis is increasing, and HIV/AIDS is a constant concern. For the last several years MSF has been focusing on AIDS-related projects in Lima. This year, MSF began a program to screen for and treat leishmaniasis, a painful disease that affects predominantly poor, isolated people in rural areas and developing countries. When an earthquake struck the country in June 2001, MSF provided medical care and other relief in the severely affected rural areas in the south. For more on aid after earthquakes in Peru, El Salvador, and India, see page 80.

Fighting a neglected disease in rural Peru

In March 2001, MSF launched a new curative program for people with leishmaniasis in San Martin de Pangoa, in the province of Satipo. In this region, numerous isolated villages are scattered in tropical forest, inhabited by indigenous people as well as migrants. As more and more trees are cut to make way for cultivation, people are increasingly exposed to the tiny fly that transmits this parasitic disease. Even though the Ministry of Health has established a leishmaniasis program, the area is so isolated that it is hard to effectively respond to the disease – which, in the forms found in Satipo, can destroy mucous membranes in the nose, mouth or throat (mucocutaneous leishmaniasis) or produce skin ulcers on exposed parts of the body (cutaneous leishmaniasis). The new MSF program screens and treats patients, and works to improve the diagnostic capacity of local medical staff.



© Bruno De Cock

Children play volleyball near their tent camp on the site of what used to be a fisherman's village in Camana, Peru. In June 2001, the earthquake and subsequent tidal wave destroyed the village.

AIDS care and prevention

In Lima, the capital, MSF runs a program to reduce transmission of sexually transmitted diseases (STDs) and HIV/AIDS and improve access and quality of care for patients with these ailments. In addition to basic care and staff training, public education is very important. MSF teams work with health promoters and youth educators to raise awareness of preventive measures, through public events such as AIDS fairs. In 2001, MSF also helped local organizations in the cities of Cuzco, Ayacucho, and Iquitos adapt and use activities like the AIDS fair. MSF continued its HIV/AIDS prevention and care program in Lima's Lurigancho prison.

In Villa El Salvador, a district of Lima, MSF runs a prevention and care module for children and adolescents on sexual and reproductive health.

Primary health care projects in the departments of Junin, in the Amazon region, and Huancavelica, in the Andean region, were transferred to the Ministry of Health (MOH) in August 2000. A primary care program for indigenous and mestizo people in the Amazon districts of Masisea and Iparia was handed over to the MOH in June 2001.

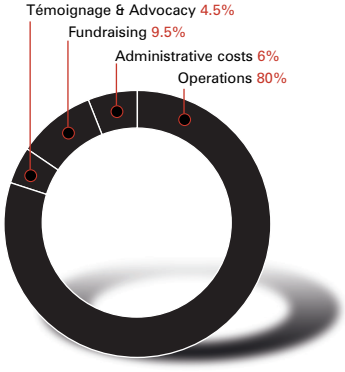
MSF began work in Peru in 1985.

Facts and Figures

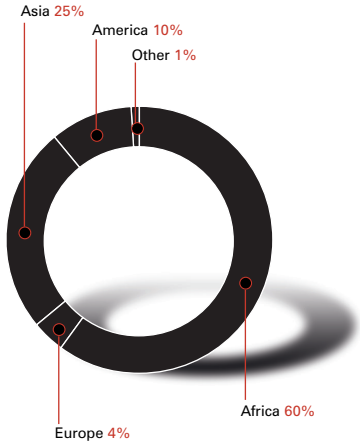
Médecins Sans Frontières is a private, non-profit, international organization. It is made up of 18 national sections in Australia, Austria, Belgium, Canada, Denmark, France, Germany, Holland, Hong Kong Special Administrative Region of China, Italy, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland, the United Kingdom, the United States, and an international office in Brussels. Each section of MSF publishes annual, audited financial statements according to its national legislation and auditing rules. Based on these national statements, the figures presented here provide an estimate of MSF's finances on an international level. The consolidated international figures have not been audited. The figures are for the 2000 calendar year; the Activity Report itself covers the period July 2000 through August 2001. All amounts are in millions of Euros.

How was the money spent?

Total Expenditure: 314

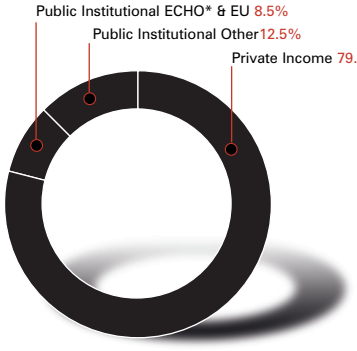


Project expenses per continent



Income

Total Income: 322

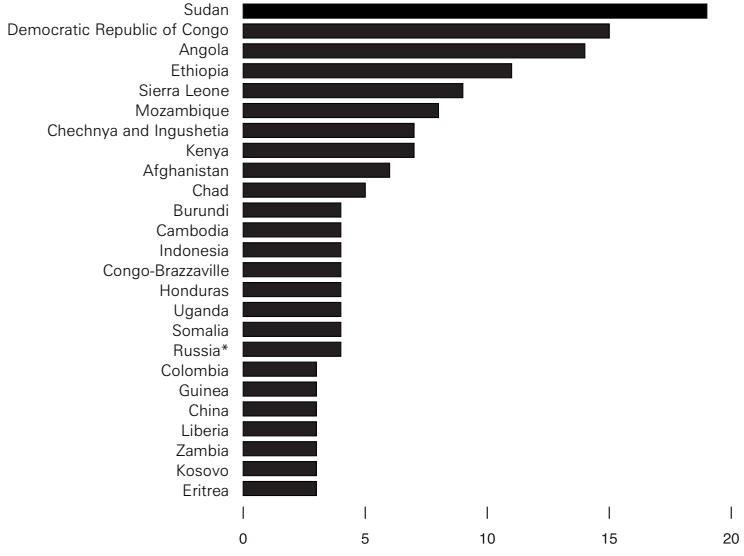


As part of our effort to guarantee our independence and strengthen our link with society, we have been striving to increase our level of private income. In 2000, 79% of MSF's income came from private sources. Over 2.5 million private funders and individuals worldwide helped make this possible.

Additional institutional donors include, among others, the governments of Belgium, Luxembourg, the Netherlands, the United Kingdom, Norway, the United States, and Sweden, as well as the United Nations.

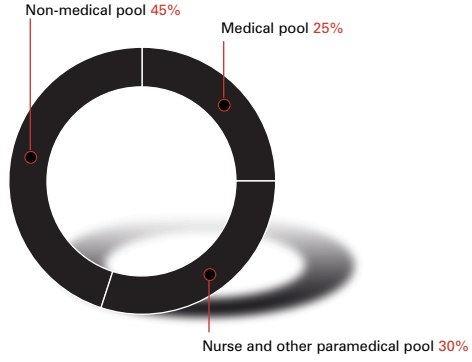
*European Community Humanitarian Office

Where was the money spent?



*Excluding Chechnya and Ingushetia

Aid workers in the field



International Departures: 2,989

Total Fieldposts 1,567
MSF national staff:13,100

Contact MSF

Australia

Médecins Sans Frontières
Street address: Suite C, Level 1, 263 Broadway | Glebe NSW 2037 | Australia
Postal address: P.O. BOX 847 | Broadway NSW 2007 | Australia
Tel: 61 (2) 9552 4933 | Fax: 61 (2) 9552 6539
E-mail: office@sydney.msf.org | Website: www.msf.org.au
Pr: Dr. Fiona Terry | GD: David Curtis

Austria

Ärzte Ohne Grenzen
Josefstädter Strasse, 19 | P.O. Box 53 | A-1082 Vienna | Austria
Tel: 43 (1) 409 7276 | Fax: 43 (1) 409 7276-40
E-mail: office@msf.at | Website: www.msf.at
Pr: Dr. Clemens Vlasich | GD: Ingrid Kircher

Belgium

Médecins Sans Frontières / Artsen Zonder Grenzen
rue Dupré 94 / Dupréstraat 94 | 1090 Brussels | Belgium
Tel: 32 (2) 474 7474 | Fax: 32 (2) 474 7575
E-mail: info@msf.be or info@azg.be | Website: www.msf.be
Pr: Dr. Barbara Kerstiens | GD: Dr. Tine Dusauchoit

Canada

Médecins Sans Frontières / Doctors Without Borders
720 Spadina Avenue, Suite 402 | Toronto, Ontario | M5S 2T9 | Canada
Tel: 1 (416) 964 0619 | Fax: 1 (416) 963 8707
E-mail: msfcan@msf.ca | Website: www.msf.ca
Pr: Dr. Leslie Shanks | GD: David Morley

Denmark

Laeger Uden Graenser
Bernstorffsvej 20 | 2900 Hellerup | Denmark
Tel: 45 (39) 62 63 01 | Fax: 45 (39) 62 61 04
E-mail: info@sf.dk | Website: www.msf.dk
Pr: Dr. Soren Brix Christensen | GD: Philip Clarke

France

Médecins Sans Frontières
8 rue Saint Sabin | 75544 Paris Cedex 11 | France
Tel: 33 (1) 40 21 29 29 | Fax: 33 (1) 48 06 68 68
E-mail: office@paris.msf.org | Website: www.paris.msf.org
Pr: Dr. Jean-Hervé Bradol | GD: Dr. Karim Laouabdia

Germany

Ärzte Ohne Grenzen
Am Köllnischen Park 1 | 10179 Berlin | Germany
Tel: 49 (30) 22 33 77 00 | Fax: 49 (30) 22 33 77 88
E-mail: office@berlin.msf.org | Website: www.aerzte-ohne-grenzen.de
Pr: Dr. Gundula Graack | GD: Dr. Ulrike von Pilar

Holland

Artsen Zonder Grenzen
Max Euweplein 40 P.O. Box 10014 | 1001 EA Amsterdam | The Netherlands
Tel: 31 (20) 520 87 00 | Fax: 31 (20) 620 51 70 / 72
E-mail: office@amsterdam.msf.org | Website: www.artsenzondergrenzen.nl
Pr: Dr. Lisette Luyckx | GD: Austen Davis

Hong Kong Special Administrative Region of China

Médecins Sans Frontières
Shop 5B Laichikok Bay Garden | 272 Lai King Hill Road Kowloon | Hong Kong
Tel: 8522 338 8277 | Fax: 8522 304 6081
E-mail: msf_hk@pacific.net.hk | Website: www.msf.org.hk
Pr: Joseph Pianpiano | GD: Olivier Bonnet

Italy

Medici Senza Frontiere
Via Volturno 58 | 00185 Rome | Italy
Tel: 39 (0) 644 86 921 | Fax: 39 (0) 644 86 9220
E-mail: msf@msf.it | Website: www.msf.it
Pr: Dr. Stefania Dente | GD: Nicoletta Dentico

Japan

Médecins Sans Frontières
Takadanobaba 3-28-1 | Shinjuku-ku | Tokyo 169-0075 | Japan
Tel: 81 (3) 3366 8571 / 72 | Fax: 81 (3) 3366 8573
E-mail: msf@japan.msf.org | Website: www.japan.msf.org
Pr: Saeko Terada | GD: Dominique Leguillier

Luxembourg

Médecins Sans Frontières
70, rue de Gasperich | L-1617 Luxembourg
Tel: 352 33 25 15 | Fax: 352 33 51 33
E-mail: office-lu@msf.org | Website: www.msf.lu
Pr: Dr. Romain Poos | GD: Laure Echilley

Norway

Leger Uten Grenser
Raadhusgata 30 A | O151 | Oslo Norway
Tel: 47 23 31 66 00 | Fax: 47 22 33 45 51
E-mail: epost@leger-uten-grenser.no | Website: www.leger-uten-grenser.no
Pr: Dr. Morten Rostrup | GD: Arnulf Torbjornsen

Spain

Médicos Sin Fronteras
Nou de la Rambla 26 | 08001 Barcelona | Spain
Tel: 34 (93) 304 61 00 | Fax: 34 (93) 304 61 02
E-mail: oficina@barcelona.msf.org | Website: www.msf.es
Pr: Dr. Miguel-Angel Perez | GD: Eric Stobbaerts

Sweden

Läkare Utan Gränser
Högbergsgatan 59 B | Box 4262 | SE - 102 66 Stockholm | Sweden
Tel: 46 (8) 55 60 98 00 | Fax: 46 (8) 55 60 98 01
E-mail : office-sto@stockholm.msf.org | Website: www.stockholm.msf.org
Pr: Dr. Ann Lindstrand | GD: Anna Bertmar

Switzerland

Médecins Sans Frontières / Ärtze Ohne Grenzen
Street address: 12, rue du Lac | 1207 Geneva | Switzerland
Postal address: Case Postale 6090 | 1211 Geneva 6 | Switzerland
Tel: 41 (22) 849 84 84 | Fax: 41 (22) 849 84 88
E-mail: office@geneva.msf.org | Website: www.msf.ch
Pr: Dr. Olivier Dechevrens | GD: Thomas Linde

UK

Médecins Sans Frontières
124-132 Clerkenwell Road | London EC1R 5DJ | UK
Tel: 44 (20) 7713 5600 | Fax: 44 (20) 7713 5004
E-mail: office@london.msf.org | Website: www.uk.msf.org
Pr: Dr. Greg McAnulty | GD: Jean-Michel Piedagnel

USA

Doctors Without Borders
6 East 39th Street, 8th Floor | New York, NY 10016 | USA
Tel: 1 (212) 679 6800 | Fax: 1 (212) 679 7016
E-mail: doctors@newyork.msf.org | Website: www.doctorswithoutborders.org
Pr: Dr. Anamaria Bulatovic | GD: Nicolas de Torrente

OTHER OFFICES

Médecins Sans Frontières International

rue de la Tourelle 39 | 1040 Brussels | Belgium
Tel: 32 (2) 280 1881 | Fax: 32 (2) 280 0173
E-mail: office-intnl@bi.msf.org | Website: www.msf.org
Secretary General: Rafa Vilasanjuan
President of the International Council: Dr. Morten Rostrup

UN Liaison Office - Geneva

Robert Muller, UN Liaison Officer
12, rue du Lac | Case Postale 6090 | 1211 Geneva 6 | Switzerland
Tel: 41 (22) 849 8400 | Fax: 41 (22) 849 8404
E-mail: msf-international-gva@geneva.msf.org

UN Liaison Office - New York

Catherine Dumait-Harper, UN Liaison Officer
6 East 39th Street, 8th Floor | New York, NY 10016 | USA
Tel: 1 (212) 655 3777 or 1 (212) 679 6800 | Fax: 1 (212) 679 7016
E-mail: catherine_harper@newyork.msf.org

Médecins Sans Frontières - United Arab Emirates

Abu Dhabi Head Office | P.O. Box 47226 | Abu Dhabi | UAE
Tel: 971 (2) 6317 645 | Fax: 971 (2) 6215 059
E-mail: msfuae@emirates.net.ae | Website: www.msfuae.org

Pr = President
GD = General Director

About this publication

Editor: Anastasia M. Warpinski

Production assistants: Marc Schakal and Sophie Capelle

Contributors: Samantha Bolton, Françoise Bouchet-Saulnier, Martyn Broughton, Fabien Dubuet, Amaia Esparza, Gazelle Gaignaire, Petter Hveem, Michael Loua, Polly Markandya, Alison Marschner, David Morley, Petrana Nowill, Liesbeth Schockaert, Charles Schultz

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Dutch edition
Translation: UVA Vertalers
Coordination and editing: Celine The and Jan Brigou

French edition
Translation: Emmanuel Pons/Translate 4 U
Editing: Anne Decortis and Dominique Desroschers

Italian edition
Translation: Elena Mazza-Fournier
Coordination and editing: Francesca Pispisa

Spanish edition
Translation: Pilar Petit
Editing: Eulalia Sanabria
Coordination: Amanda Sans

Additional translation
Andrew Long and Translate 4 U

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