



MSF **ACTIVITY REPORT** 2001-2002

The Médecins Sans Frontières Charter

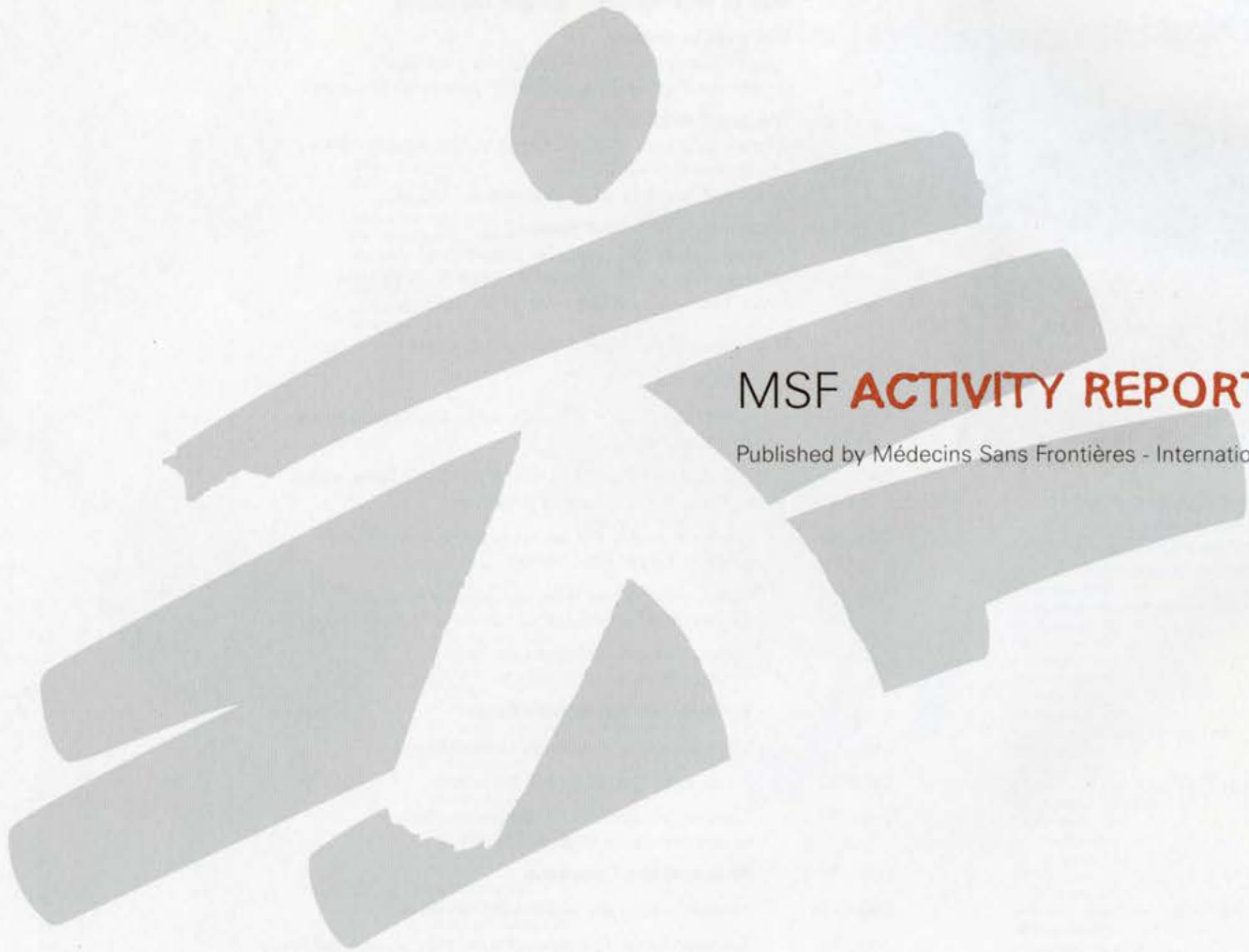
Médecins Sans Frontières is a private international association. The association is made up mainly of doctors and health sector workers and is also open to all other professions which might help in achieving its aims. All of its members agree to honor the following principles:

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

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

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

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



MSF **ACTIVITY REPORT** 2001-2002

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Marc has AIDS. Without the life-prolonging antiretroviral treatment he receives at an orphanage in Nairobi, he would not survive. He was abandoned in the street when his mother died. Kenya, April 2001.

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The Year in Review



■ Sar-i Pul camp, Afghanistan, December 2001, where MSF has assisted displaced Afghans through a medical clinic and feeding center, and by providing drinking water. The number of Afghans forced to leave their homes because of lack of food continues to grow.

© Tim Driven

| The advent of the "war on terrorism" has generated a perception among some that the world changed fundamentally on September 11th 2001. But, for MSF and humanitarian action, the biggest challenge this new conflict has presented is an old, all too familiar one – that of remaining independent from political concerns to assure that civilians in need receive humanitarian help regardless of any other will. Political manipulation of humanitarian aid – from all sides – is as relevant in this "war against terror" as the wars we are more familiar with in Sudan, Angola and elsewhere.

| Humanitarian action is a response to suffering, based on need alone, but the effective delivery of humanitarian aid is often obstructed for political and economic reasons. Over the last year MSF has been struggling to defend the independence of humanitarian aid, to ensure that the requirements of survival and dignity take priority.

| In April 2002, MSF criticised the warring parties in Sudan for the appalling numbers of civilian deaths from disease and violence in the Western Upper Nile region. During 14 years' experience in the country we had been witness to how all parties to the conflict use violence against civilians – including rape, murder and assault – while denying them access to humanitarian aid. Six months later, MSF extended operations in southern Sudan to fight a deadly outbreak of kala azar (visceral leishmaniasis) that was threatening thousands of lives. The people there are exhausted by decades of war and extremely vulnerable to this disease due to insecurity, malnutrition and poor access to health care.

| In Afghanistan, the principle of humanitarian aid was used by Western governments to gain support for military action. MSF teams that had been providing humanitarian aid in Afghanistan since 1979 were forced to leave Taliban-held areas for several months after September 11th 2001 due to increased insecurity (although our local staff members were able to keep programs running in many

MSF feeding center, Kitshanga, Nord-Kivu, Democratic Republic of Congo, October 2001. Sixteen million Congolese have critical food needs.

parts of the country). The US-led coalition began bombing a month after our expulsion, dropping food together with bombs as part of a "military-humanitarian" response. But this was to win favor in the West and to blunt resentment in Afghanistan, not to address the needs of the starving people. MSF denounced this act as damaging to the work of humanitarian aid agencies by confusing military and humanitarian objectives. Food aid must be appropriate and targeted to reach the most vulnerable, not scattered from the sky indiscriminately. A year later, though the needs are still huge, food is scarce and insecurity prevents the delivery of aid to many parts of the country, while international help falls far short of the promises.

International humanitarian law was created to protect and assist non-combatants in times of war and crisis. Yet, despite being invoked rhetorically by all sides, respect for its basic provisions is under threat. The political logic of today's "war on terrorism" seems to imply that because the "terrorists" do not, by definition, respect international conventions, anti-terrorist operations may therefore have a freer hand. The struggle to uphold humanitarian law suffers as a result, with disastrous consequences for the protection and assistance of civilian populations.

In the name of fighting terrorism, violations of international humanitarian law are increasingly being condoned. The limited attempts to restrain Israel's operations, which closed off the Jenin refugee camp for two weeks in April 2002, were rebuffed by the mantra "this is an anti-terrorist operation."

The global fight against terrorism has muted any international criticism of the abusive military operations conducted by Russian forces in Chechnya – a place of "total war" where any sense of responsibility to the citizens has been entirely obliterated by both sides, leaving no room for humanitarian aid.



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This particular concern was further demonstrated with the kidnapping of Arjan Erkel, MSF's head of operations in Dagestan, on August 12th 2002. By year-end, we had still heard no news. We have repeatedly urged the Russian authorities to maximize their efforts to solve the case and to secure Arjan's safe release. Kidnappings of staff of non-governmental organizations around the same time demonstrate the risks civilians and relief workers run in this conflict-ridden region.

The heightened vulnerability of people in many of the places where MSF works was further highlighted by a United Nations High Commissioner for Refugees report at the beginning of the year detailing the problem of sexual

exploitation, including violence, by aid staff of refugees in West Africa. Even though the claims made could not be substantiated, the issue is an extremely important concern for MSF, as it shows that refugees continue to be exposed to violence and exploitation. Our operational teams have been reviewing all training and disciplinary policies. But efforts to protect refugees from exposure to sexual violence and exploitation must go far beyond such actions and consider the increasing political disregard for refugee rights, and the erosion of the protection mandate.

The nutritional crisis in Angola this year is one of the clearest examples of why using aid to help a political cause hurts those in need of that aid. The country's 27-year



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Chipindo feeding center, Angola, May 2002. Chipindo was isolated first because of the war and then because of heavy rains. Between November 2001 and March 2002, famine and disease caused the death of some 4,000 children under the age of six in this area.

civil war, in which civilians were targeted and abused by both sides, finally ended with a ceasefire in April 2002, and regions that had been cut off from humanitarian aid for over three years became accessible, revealing tens of thousands of starving people. We began one of our largest emergency relief operations ever, with 190 international volunteers and 2,000 national staff working around the clock in scores of feeding centers to try to save as many lives as possible.

But, despite high mortality and malnutrition rates, the aid effort was insufficient. While the responsibility for protecting and meeting the needs of the Angolan people lies

first and foremost with the Angolan government, blame does not escape the international organizations, all of which were slow to respond in the first months of the crisis. Operations of many aid organizations were hindered by lengthy coordination with the United Nations, which was negotiating terms with the Angolan government with one overriding concern: maintaining the new peace. Meanwhile, thousands of people were dying of hunger. Humanitarian action became subservient to political calculations.

International news coverage of Angola, one of the worst food crises in the new millennium, was scant, and recent appeals for aid for that and other neglected crises such as Sudan or West Africa have been woefully under-funded. Clearly, the focus and priorities are elsewhere. The level of political commitment to global deprivation remains crassly insufficient, particularly in comparison with the push towards heightened military engagement and spending. The September 11th attacks immediately mobilized billions of dollars, as well as political, governmental and military resources, and public opinion. Meanwhile, resources to help the 14 million or so people who die yearly of infectious diseases are lamentably absent. Where is the coalition against infectious diseases? When will there be a massive push for a convincing solution to malaria, the number-one killer of children in Africa?

Effective new medicines to treat neglected diseases such as sleeping sickness, leishmaniasis and Chagas are lacking. These diseases primarily affect the poor and are ignored by both the public and private sector: from a purely profit-driven perspective, it is not an "attractive investment" to develop drugs for diseases affecting people without financial resources, and no public sector is presently filling that gap. To stimulate a response to the increasing need for effective medicines to treat such neglected diseases, MSF is working with partners to establish a Drugs for Neglected



Moyes, 18, from Sudan, is one of half a million people affected by sleeping sickness, predominantly in sub-Saharan Africa. Leaning against his father under a mango tree, he tries to lift his hand to brush a fly from his face. Like a slow motion film, his hand takes forever to reach his face. He has been treated several times without being cured. The drugs available to treat this painful disease are archaic, toxic or difficult to administer.

© Serge Sibert/Cosmos

Diseases initiative (DNDi), a not-for-profit drug development capacity in the public sector. MSF's aim in initiating DNDi is to push for change in the way medicines are developed – according to health needs, not profit prospects – and urge governments to take up their responsibilities to ensure that effective medicines are available to all.

More must also be done to make sure that existing medicines are used effectively and are accessible to all who need them. The funds, the resources and the political will worldwide are all still inadequate. Almost 6 million people who are ill with AIDS today are still not receiving the life-prolonging medicines they need. They will die in the next few years, while tens of millions infected with the virus will soon share their fate. Our HIV/AIDS programs have expanded significantly over the last year. We now treat people with

antiretroviral drugs in 11 countries and will continue to increase the numbers of our AIDS care programs. Over 2,000 patients currently benefit from antiretroviral treatment through our programs, with thousands more planned to benefit in the coming year. Clearly, our medical programs still only reach a fraction of those who need treatment, but our advocacy efforts help ensure that these limited programs serve as a provocation for those who are capable of and responsible for responding to the pandemic on a much larger scale. Our experience adds to the evidence that treating AIDS in resource-poor settings – once considered unviable – is possible even in remote rural areas. We are committed to expanding antiretroviral treatment in our projects, and will continue to advocate for access to treatment as a central part of AIDS prevention and care programs.

Furthermore, we cannot accept that millions of people continue to die of curable diseases like tuberculosis and malaria. In spite of many promises and proclamations, our medical teams on the ground have seen no change in the current situation. Global political engagement in the fight against infectious diseases still amounts to little more than indifference.

The humanitarian imperative requires responding to this shocking range of suffering according to needs, and meeting those needs adequately and effectively. In many places around the world, MSF is only able to meet the medical needs of marginalized, persecuted people because of our independence from political powers. We are able to do this thanks to the millions of individuals who support us worldwide and who, in doing so, have made the choice to support these principles. We will continue vigorously to protect the principle of independent humanitarian aid. At the same time, we call on all governments to exercise their fundamental responsibilities to protect the health, well-being and basic freedoms of their own citizens. The temporary nature of humanitarian work means that MSF intervention can never be part of the permanent solution. But our work can act as a reminder and a rebuke for those who are responsible for finding lasting solutions.

Rafael Vilasanjuan,
MSF Secretary General

Dr. Morten Rostrup,
President, MSF International
Council

The Good Medicine

Why are millions of malaria victims in Africa going without a treatment that works?

By Anastasia Warpinski

| Imagine a five-year-old girl in a small village in sub-Saharan Africa. A hand on her clammy forehead reveals a fever. Then she begins to shake – and perhaps vomits up her breakfast. The girl's head is hurting, and she is getting weaker. She can't move her small arms. She starts to cough. She can't eat.

| Her mother takes her to the health post later that day, and the doctor makes a diagnosis: malaria. The parasites are in her. She gets chloroquine to take for three days.

| This happens to her maybe six times a year. Six times a year! Unfortunately, there is a good chance that the medicine she receives does not even work. Yet drugs do exist that can effectively combat malaria today – the scandal is that, in many places, they are not being used.

| The most effective malaria treatment today is artemisinin-containing combination therapy (ACT), which MSF has been pushing to introduce in the countries where the old medicines – standard treatments such as chloroquine and sulfadoxine-pyrimethamine (SP) – no longer work. Derived from the sweet wormwood plant, artemisinins have cured fevers in China for two thousand years, and for the last 30 years they have been used to treat malaria, primarily in Asia, where malaria strains have been resistant to standard treatments for many years now. They have proven effective against *Plasmodium falciparum*, the deadliest of the four malaria parasites, especially when used in combination with another antimalarial (ACT). Artemisinins are five to ten times more effective than other drugs and have very few side-effects. To date, there has been no evidence that resistance has developed to artemisinins. When

administered early, they have been shown to substantially reduce the transmission and hence the incidence of malaria, at least in Thailand and South Africa.

| But, in Africa, ACT is just not being used (apart from in South Africa). Getting ACT to the people who need it most is not merely a question of showing that it works and then offering it to patients. It is a matter of money, policy and protocols. Organizations committed to fighting malaria have failed to advocate effectively; governments faced with policy choices have wavered; and international donors have held back money that could save thousands of lives.

| Meanwhile, millions of people are still threatened by malaria, a disease that was once the object of global eradication dreams.

| Malaria is spread by mosquitoes. An insect infected with a malaria parasite bites a human, transferring the parasite to the person's bloodstream, where it multiplies and can cause illness or death. When this person is bitten by another mosquito, the parasite travels from human back to insect, and the cycle continues.

| To stop this chain, in the 1950s the World Health Organization (WHO) embarked on the ambitious Global Eradication of Malaria Program, seeking to wipe out malaria completely, everywhere. Armies of scientists and others fanned out to countries where the disease was endemic, implementing eradication plans on a grand scale, spraying the chemical DDT to kill hungry hordes of mosquitoes. All this firepower effectively tamed malaria in temperate regions and cowed it into submission in

many subtropical areas. Yet by 1967 the WHO realized that eradicating malaria was impossible, and by 1972 the program was declared dead.

| For people in the United States, Europe and other areas where malaria has been more or less eliminated, the malaria "problem" has been reduced to getting prophylactic pills prior to a vacation in the tropics. But for the 40% of the world's people who live in malaria-endemic areas, the disease remains a daily, deadly threat. It strikes 300 to 500 million people each year, with 90% of cases in sub-Saharan Africa. Since the early 1980s, an estimated 40 million people worldwide, most of them children under five, have died of malaria. Those who survive multiple bouts with malaria can experience retarded physical and mental development, poor educational performance and greater vulnerability to other diseases.

| After the era of eradication, the focus in malaria-endemic regions turned to treatment, made possible with cheap drugs such as chloroquine and SP. Yet the widespread and indiscriminate use of these treatments eventually fostered the development of strains of the parasite that were resistant to the chemical knockout punch, and in recent years the disease has roared back with a vengeance.

| The experts were so alarmed that in 1998 the WHO and various other United Nations agencies launched the Roll Back Malaria Campaign, hoping to cut the world's malaria burden in half by 2010. Prevention efforts increased, with campaigns to promote insecticide-impregnated bednets and indoor spraying of DDT.



Mother with her malaria-stricken child, Karusi, Burundi, February 2001. The 2000-2001 malaria epidemic alone produced 3 million malaria cases among Burundi's 6.5 million people.

Camp residents gather for a lesson in malaria prevention, Harugali camp, Bundibugyo, Uganda, August 2001. Malaria is one of the major health problems in Bundibugyo, where 80% of the people are displaced.



© MSF

But the recognition that current treatment regimens were failing has lagged behind, and it is here that governments and international actors are at a critical point. Drug resistance – occurring through spontaneous genetic mutations in the parasite which are exacerbated by use and overuse of ineffective drugs – is leading to treatment failure and causing rising rates of mortality, particularly among children.

In some MSF projects in Africa, resistance levels show how much standard treatments are failing. In Bandundu, Democratic Republic of Congo, resistance to chloroquine is 78-85%; in Maheba, Zambia, it is 50%; in Mbarara, Uganda, it is 87%; and the list goes on.

Nowhere has the problem of resistance been more evident than in Burundi, seized in 2000-2001 by an unrelenting malaria epidemic that produced around 3 million cases among the country's 6.5 million people. MSF treated over a million cases during the epidemic, often having to use drugs that did not work.

As realization set in that chloroquine – then the country's protocol (standard for treatment) for first-line treatment of simple malaria – was not working (in areas

where MSF was active, resistance to chloroquine ranged from 63-87%; resistance to SP, the second-line drug, was 32-56%), MSF tried to change to ACT. With neither the funds nor the political will to make the change, the Burundi government resisted, opting instead for an interim protocol, chloroquine and SP combination therapy, and later SP monotherapy.

MSF, prevented from using ACT, introduced it illegally (though publicly). The government then suspended MSF's malaria-related programs, and as of September 2002 MSF was still not able to use ACT in Burundi, though other work continued. In July 2002, an expert panel recommended changing the national protocol to ACT, and the government

agreed to begin implementing it by July 2003. Ironically, artemisinin derivatives have been and remain available in private pharmacies in Burundi for people who can pay.

Money, policy and protocols

In addition to trying to introduce ACT into all its projects where people are sick with malaria, MSF is also fighting to make better malaria treatments a priority at the international level, by advocating policy and protocol changes and pushing for funding. Yet, despite evidence of its effectiveness, and the many lives at stake, implementation of ACT has been delayed by meager health budgets, lack of international support and lack of political will.

ACT is much more expensive than chloroquine or SP. Combinations that do not contain artemisinin derivatives cost about US\$0.25 for each adult dose; those with the potent remedy cost US\$1.30, while the brand-name ACT, Coartem®, is about US\$2.40 per dose. In a report released in February 2002 ("Changing National Malaria Treatment Protocols in Africa: What is the Cost and Who Will Pay?"), MSF showed that for Burundi, Kenya, Rwanda, Tanzania and Uganda – countries where resistance to chloroquine and SP is particularly high – the extra cost of changing to ACT instead of to a non-ACT combination would be US\$19 million in total. This is just not affordable for these countries. To make the switch, they need international help.

The money must come from somewhere

The funding for effective treatment for the hundreds of millions of people with malaria in sub-Saharan Africa must come from international donors. However, although malaria has recently been highlighted internationally as one of three priority diseases that need to be tackled, the cash and concrete action needed to reduce malaria deaths have not materialized and public initiatives (eg, the Global Fund to Fight AIDS, Tuberculosis and Malaria) have failed to secure the required funds.

Despite the growing consensus among experts that ACT is the malaria treatment of choice, and the WHO's recent acknowledgement that ACT is the most effective malaria treatment in many places, the United States Agency for International Development and the British Department for International Development, influential international donors, have failed to support quick implementation of ACT

in Africa. These agencies have remained silent in the face of direct pleas from African countries for financial assistance to implement ACT and are supporting continued use of ineffective medicines.

US officials have said that the drugs have not been sufficiently tested on babies, and that in any case at least one of the first-line drugs, SP, could still be used for several years. MSF has demanded that the US offer evidence to support its strategy of SP monotherapy even in cases of known resistance to the drug.

Cost is also cited as a problem. It is true that ACT costs more than current malaria treatments. But ACT works where the others do not. Another argument put forth against ACT is that the treatment is too long and complex to ensure patient compliance. SP is a one-dose treatment but chloroquine, the standard for more than 40 years, is taken for three days – and so is ACT. There is currently no evidence that malaria patients in Africa will not comply with ACT treatment regimens.

Prospects

MSF is ramping up use of ACT in field projects where it is appropriate, with ACT offered in 12 countries as of September 2002. MSF is also continuing to pressure governments and international bodies to do the right thing. But once ACT is more firmly established, there will still be much work to do – making treatments easier to administer and take, developing appropriate drugs for very young infants, and getting new drugs into the development pipeline. The clock is ticking on all these fronts. In the meantime, people who should – and could – be receiving good treatment are slipping away, one fever at a time.



Artemisinin-based combination therapy medicines on sale in a Burundi pharmacy, mid-2002. Even though MSF was forbidden to prescribe them, these effective anti-malarials were available throughout the 2000-2001 malaria epidemic for people who could pay.



An MSF doctor treats a severely malnourished child at a therapeutic feeding center, Bailundo, Angola, August 2002. The military strategies of government armed forces and UNITA rebels toward Angolan civilians have caused widespread devastation and a serious famine situation. Aid organizations did not gain access to large portions of the country until a ceasefire was declared in April 2002.

Morocco | Life and health on the street

- International staff: 6
- National staff: 15



The focus of MSF's work in Morocco has been to bring direct care, preventive advice and psychosocial care to the people who are least likely to find it anywhere else. They are often people of the street: sex workers, homeless children and the urban destitute. The other target group has been pregnant women, both because of the country's high maternal mortality rate and because single mothers can be shunned and excluded from regular healthcare provision. MSF also brings health aid to candidates for clandestine migration.

In Casablanca, MSF has been working since August 2001 on the problem of healthcare access, education and prevention. The beneficiaries of this project are women, especially single mothers, sex workers and young domestic servants.

In the capital Rabat, MSF handed over the labor and delivery unit it had helped build to the Ministry of Health in June 2002. That marked the completion of a project which had focused on mother-and-child health in the neighborhood of Mers el Kheir, providing health education for women in this poor community.

On the northern coast of Morocco in Tangier and the Spanish enclave of Ceuta, MSF has been working with street children, sub-Saharan migrants and sex workers (see page 55 for more on the Ceuta program). The geographical situation of Tangier – it is only 14km away from the Spanish coast – makes the city a key jumping-off point for migration.

Algeria | Emergency response to floods

- International staff: 4
- National staff: 9

MSF's presence in Algeria since 1998 has had a significant emergency response component. That was usually interpreted as a need to be ready for health problems emerging from the continuing civil war. What happened in November 2001 was a natural catastrophe: a flood that ripped through the capital Algiers and surrounding areas, killing hundreds of people, mainly in the poorest districts. MSF responded with additional medical staff, supplies and sanitation skills.

Working in Algiers and the province of Chlef, MSF provided logistical help for mobile teams conducting clinics for the victims. MSF distributed emergency medical kits as well as plastic sheeting, water bladders and jerry cans. Teams also constructed latrines and restored wells.

In March 2002, MSF withdrew from its AIDS prevention and reproductive health education projects in Algeria but continued to stand ready to respond to victims of violence. The complex tensions in the region of Kabylie led to an exploratory mission in Bejaia and Tizi-Ouzou in July 2001. The team established contact with the doctors and surgeons on the front line of the continuing violence.

MSF formally closed its mission in Algeria in March 2002, although future needs will be monitored closely.

Mauritania

Second clinic serves women and children

- International staff: 6
- National staff: 12

MSF projects in Mauritania are centered on mother-and-child health. MSF works in the shantytowns around the capital Nouakchott, where thousands of people have difficulty getting basic health care. In summer 2002, MSF opened a new reproductive health clinic in the southern region of Guidimaka.

In Selibaby, the capital of Guidimaka, it is estimated that less than 17% of women can get the health care they need. Many pregnant women die of infections and hemorrhages, and infant mortality in the region is 18 per 1,000 live births. A new MSF pilot project strives to provide much-needed care to women and babies, and as part of that initiative, a clinic was opened in mid-2002. Supported by an MSF midwife, public doctors, nurses and midwives are working to improve care for mothers and children, prevent and treat sexually transmitted diseases, and provide community education on reproductive health.

MSF continues to support a health center in the shantytown of Bouhdida, on the outskirts of Nouakchott. This project targets women and children and serves approximately 10,000 people. About 500 consultations are given each month. Since the clinic's opening in 2001, over 200 babies have been born there.

After surveys showed that the rate of acute malnutrition declined significantly in the capital, MSF planned to close a nutritional program in Saada, another Nouakchott neighborhood, by late 2002. Preventive nutritional activities in Bouhdida were reinforced.

MSF has been in Mauritania since 1994.

Mali

Generic drug now available to treat trachoma

- International staff: 5
- National staff: 40

In early 2002, a generic treatment for the eye disease trachoma became available in Mali for the first time. This important step in the fight against blindness was made possible through cooperation between the MSF team in the field, Malian health authorities and the MSF Campaign for Access to Essential Medicines.

MSF has played an active role in the treatment and prevention of the debilitating disease trachoma, which is the second leading cause of blindness in Mali. Trachoma is spread through contact with infected secretions from the eyes, and work in previous years has focused on prevention.

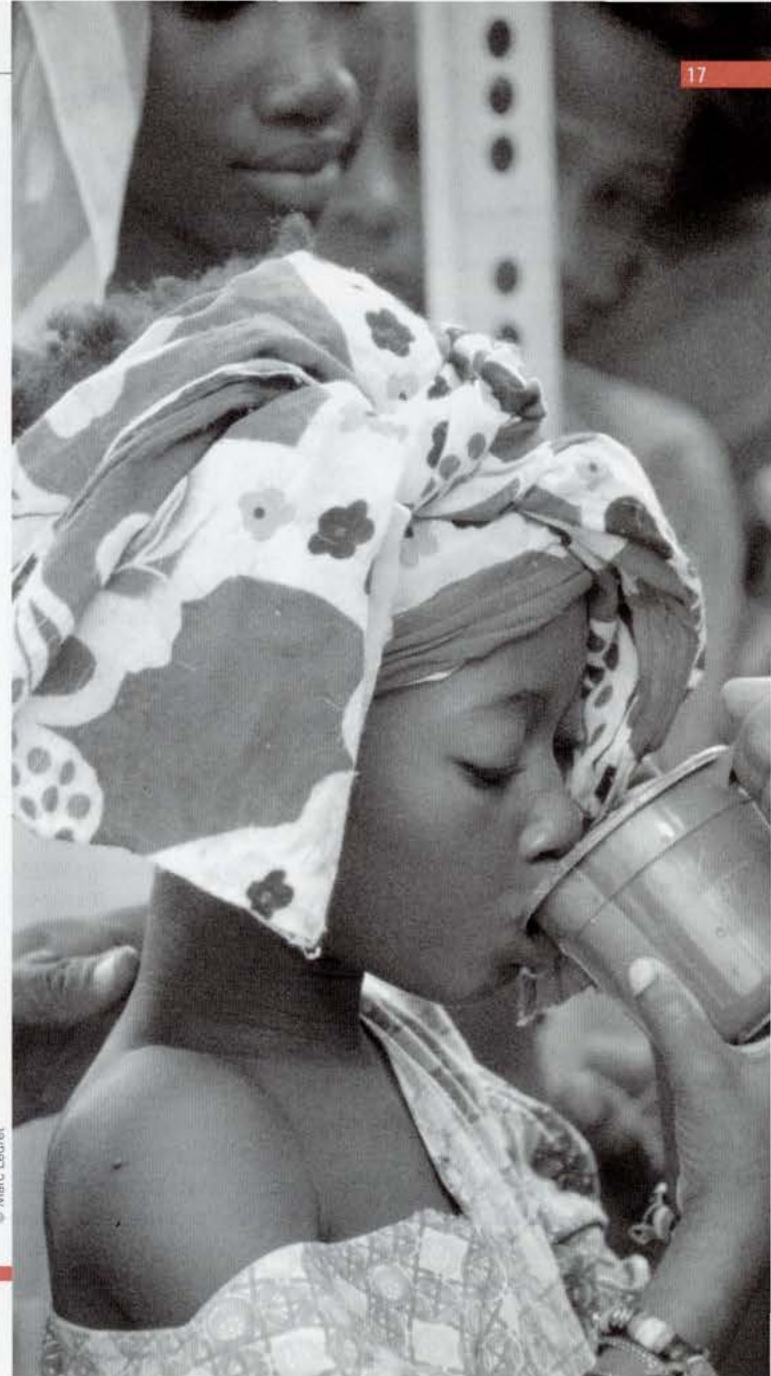
Recently, however, MSF has redirected its policy toward immediate, widespread treatment. Because locally available medicines have traditionally been prohibitively expensive, MSF has begun to import from India a high quality, generic version of the drug azithromycin in cooperation with local health officials. Distribution is being done in Bankassa, in the region of Mopti, and covers a population of 230,000. The mass distribution and accompanying assessment is being organized by Epicentre, an epidemiological research center closely affiliated with MSF.

Primary care projects continue in Ansongo, where the population of 100,000 is mainly nomadic. In the region of Gao, MSF supports a nursing school which provides health staff for Gao, Tombouctou and Kidal in northern Mali. In the southwestern area of Sélingue, MSF continues to work toward autonomy for Kangara hospital.

MSF has been active in Mali since 1983.

Young trachoma patient being treated with azithromycin in Mopti, Mali. MSF was able to scale up treatment of this debilitating eye disease in 2002 after Malian health authorities gave it the green light to import a generic version of the drug.

© Marc Ledret



Burkina Faso | One million petition for greater access to medicines

- International staff: 6
- National staff: 30



MSF's medical work in Burkina Faso added a distinctly grassroots flavor in early 2002, with a campaign to soften strict new rules that effectively limit access to essential drugs. At the same time, a previously uncommon strain of meningitis swept the country.

MSF's Campaign for Access to Essential Medicines intensified in Burkina Faso in early 2002. In January, the Bangui Agreement came into force in the country, one of 16 West African signatories. This trade and regulatory agreement holds countries to stringent rules regarding imports and generic manufacturing of drugs. This effectively limits the countries' ability to make full use of the provisions in the World Trade Organization's TRIPS agreement which enable access to key medicines. MSF helped mobilize an advocacy network dedicated to obtaining a review and eventual softening of the Bangui Agreement. As part of this effort, grassroots petitions addressed to the country's president and prime minister garnered over one million signatures

before being presented in July 2002. For more on the relation between trade-related intellectual property rights and access to medicines, see page 19.

In spring 2002, meningitis again ravaged Burkina Faso, part of Africa's "meningitis belt." The country experienced the first large-scale outbreak ever recorded of W135, a rare strain of the disease. While mass vaccination is key to containing most meningitis epidemics, for the outbreak of W135 MSF and other actors had to concentrate on treatment, because the only effective vaccine is virtually unavailable in Africa and only minimally available in Europe and America. Epicentre, an epidemiological research center associated with MSF, has studied the Burkina Faso outbreak in an effort to develop strategies for fighting W135 in the coming years.

Over the last year, MSF began work with some of Burkina Faso's many HIV/AIDS sufferers. In November 2001, a clinic offering free and anonymous testing as well as treatment of AIDS-related infections opened in the capital Ouagadougou. Treatment to prevent HIV transmission from mothers to babies is expected to begin by October 2002.

Meanwhile, a project providing medical and psychosocial care to street children continued in Ouagadougou. Public education over the last year included production of *The Street is No Paradise*, a film which was shown on national television and in provincial cinemas. MSF also continued its support of the Sindou health district in the southwest.

MSF has been active in Burkina Faso since 1995.



■ Moment during the filming of *The Street is No Paradise*, a collaboration between MSF and Burkinabe film director Guy-Désiré Yaméogo to raise awareness of the plight of homeless children in Ouagadougou, Burkina Faso, 2001.

© Denis Blangere

Benin | AIDS work begins in crossroads city

- International staff: 3
- National staff: 15

Buruli ulcer, a debilitating disease that destroys skin and bone tissue, continues to afflict people in Benin. Since 1997, MSF has worked to raise awareness about the disease, provide training for surgical intervention and support research into possible new therapies. In response to the growing problem of HIV/AIDS, a disease that is highly stigmatized in Benin and ignored by government and health officials, MSF launched a new HIV/AIDS program mid-2002.

The new HIV/AIDS program began in mid-2002 in Dogbo, a crossroads city in southwest Benin. Activities include hospital care, treatment of opportunistic infections, voluntary testing and counseling, and prevention of mother-to-child transmission of HIV.

MSF continues to support the Buruli ulcer treatment center in Mono, working closely with local health professionals to diagnose and treat the disease. Surgical intervention remains the only form of treatment, and disabilities are often the result of late detection. MSF strives to raise awareness about Buruli ulcer through a variety of means, including educational radio campaigns. In 2001, more than 126 new cases were detected and 416 surgeries were performed, including 130 skin transplants.

In late 2001, an MSF team assisted in Parakou, where contamination in a local pond used for drawing water caused a cholera outbreak.

MSF has been in Benin since 1997.

The Doha Declaration is designed to empower developing nations to widen access to essential medicines. But translating the intent into actuality remains a pressing challenge.

Words into Action: What the Doha Declaration means for public health

"The question is now, how do we make it effective? How do we make it deliver the medicines to the people? How do we avoid this Declaration ending up as a dead letter?"

Ambassador B.G. Chidyausiku, Zimbabwe, on the Doha Declaration

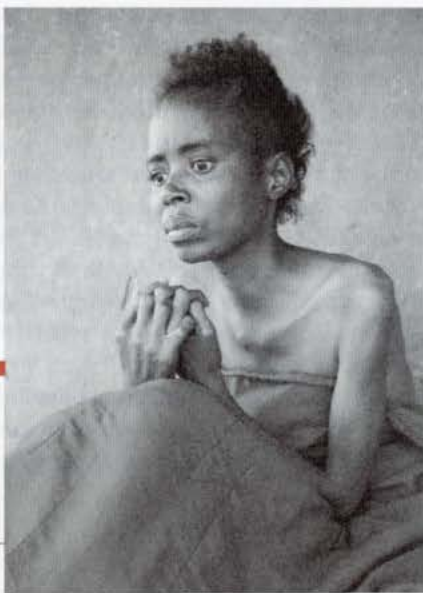
In November 2001 at the World Trade Organization Ministerial Conference in Doha, Qatar, WTO Members passed the groundbreaking "Declaration on the TRIPS (Trade-related aspects of intellectual property rights) Agreement and Public Health." For the first time, the Declaration sent a clear political message that TRIPS "can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular to promote access to medicines for all." Among other measures, the Declaration affirmed the right of countries to use compulsory licenses and to determine the grounds on which to grant them. It also gave

least-developed nations a ten-year extension from 2006 until at least 2016 to institute patents on pharmaceuticals. Both of these provisions can help countries to secure more affordable essential medicines through generic competition.

Since the Doha meeting, MSF and other concerned actors have been working to translate this political message into action, and ultimately, into better access to medicines for patients on the ground. An important step will be to ensure that countries take advantage of the Declaration as they develop national legislation regarding patents and medicines. Recognizing the vital role that international technical assistance plays in this process, MSF and other NGOs convened a conference in March 2002 to examine the best ways to implement Doha, and specifically, to consider how the World Intellectual Property Organization (WIPO) has and has not promoted health concerns through its technical assistance programs.

As the United Nations body charged with developing intellectual property systems worldwide, WIPO is in a critical position to determine whether the Doha Declaration benefits developing countries, or whether it becomes a useless piece of paper. MSF's experiences in West Africa and Cambodia have raised concerns that WIPO is not helping countries to maximize their options to protect access to medicines; rather, some countries receiving WIPO advice have instituted more stringent protections on intellectual property than is required or advisable in light of pressing health needs.

Many legal and political hurdles remain before the world's poorest patients see any benefits from Doha; thus, public pressure exerted by MSF and others will be necessary to hold responsible actors, including WIPO, the WTO, and Member governments, accountable. Such sustained scrutiny will be required to translate the political victories won at Doha into tangible improvements in people's lives.



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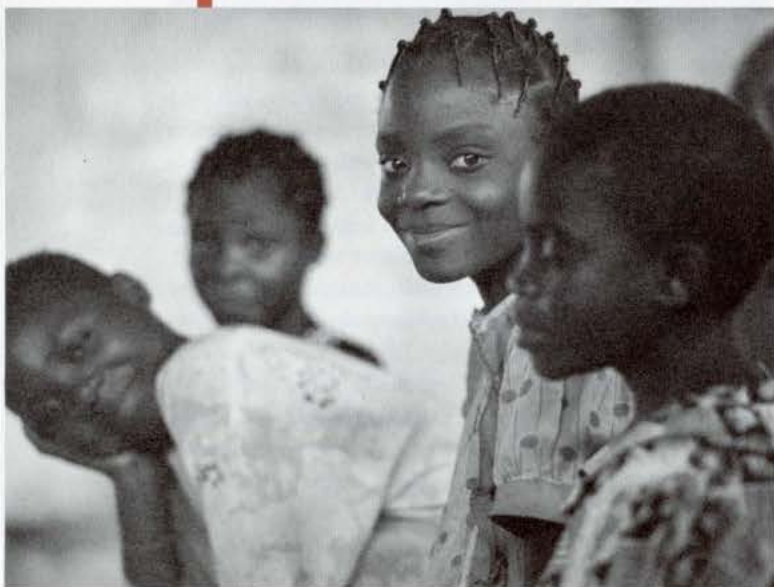
Niger "Plumpy nuts" save children's lives

- International staff: 7
- National staff: 60

In this poor country where 20% of children under three are chronically malnourished, hospitals rarely provide adequate medical treatment for severely malnourished children – a major factor behind one of the world's highest infant mortality rates.

During vaccinations of over a million people as part of MSF's emergency response to meningitis and measles epidemics in April 2001, standard MUAC (mid-upper-arm circumference) measurements among children under five

Children attending an MSF malaria clinic at Foropa, Bayelsa state, Nigeria, September 2001. Malaria is the main killer of children under five in Nigeria.



© Renca Bohle



showed an alarming rate of nutritional deficiency. This was due mainly to the effects of three years of drought and failed harvests, and the debilitating measles epidemic. MSF opened a therapeutic feeding center in Dakoro in July 2001 and supported the existing one at the Maradi hospital, in the two regions worst affected. When over 800 children were admitted to the Maradi feeding center in three weeks, MSF doubled its capacity. A total of 5,000 children were treated for severe malnutrition during the emergency and the 300-bed center at the Maradi hospital continues to respond to the ever-present needs.

In September 2001, MSF began an innovative program adapted to the needs of patients who are mostly poor and from rural areas. After a reduced phase of hospitalization, mothers bring their children for weekly checkups at which they receive a week's ration of an enriched food supplement known as "plumpy nuts." A pilot scheme to produce plumpy nuts locally starts in August 2002.

MSF has responded to food and epidemic emergencies in Niger since 1985.

Nigeria Effective malaria treatment still out of reach

- International staff: 16
- National staff: 80

The neglect of the Nigerian health care system has left the population vulnerable to medical crises and epidemics. MSF focuses its work on treating malaria, the main killer of children under five in Nigeria, and expects to launch an HIV/AIDS program in the near future.

MSF's malaria program continues in Bayelsa state in the Niger Delta. Accurate diagnosis and effective treatment are the goals of this project, but successful treatment is increasingly hampered by high levels of parasite resistance to the most commonly used medicines, chloroquine and sulfadoxine-pyrimethamine (SP). In Southern Ijaw, in Bayelsa, MSF resistance studies involving these front-line malaria treatments have shown 40% resistance to chloroquine and 45% resistance to SP; an amodiaquine resistance study was ongoing in mid-2002. Other effective options exist, including treatment with combination therapy using artemisinin derivatives; however, as of July 2002, the Bayelsa state Ministry of Health had not yet granted MSF permission to introduce the therapy. MSF is campaigning for the introduction of the most appropriate treatments for malaria, the number-one killer of children on the continent (see page 10).

Attempts to reach female sex workers in Lagos state with a new HIV/AIDS project were unsuccessful in late 2001, leading to a reevaluation of HIV-related needs. Plans are underway for a project focusing on HIV-positive patients who are also suffering from tuberculosis.

MSF has been working in Nigeria since 1999.

Côte d'Ivoire

Prison health care and nutrition

- International staff: 6
- National staff: 30

In Côte d'Ivoire, MSF has continued to focus on conditions and basic health care in Abidjan's largest prison, the Maison d'Arrêt et de Correction d'Abidjan.

In June 2001, MSF denounced the detention conditions in a juvenile observation unit, submitting a report showing that 60% of the health problems experienced by the under-age detainees were due to excessive confinement. Two significant responses have been the ending of constant cell confinement for minors and a reduction in the number of them detained (down from an average of 150 to 60 in six months). MSF has also initiated a social work program to re-establish family links for some minors as a further way to reduce detention times.

For adult detainees, MSF has continued its nutritional program, which benefits some 300 people with no food resources other than the inadequate prison rations. It also submitted a report on misappropriated food aid to the authorities in the hope of improving its delivery to the prisoners. On the medical front, MSF has continued to work closely with staff in the prison infirmary on increasing access to and the quality of health care for the detainees, with a focus on diagnosis.

From September to November 2001, MSF provided technical support and medical supplies to treatment centers during a cholera epidemic in Abidjan and the Khorogho region in the north.

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

Liberia

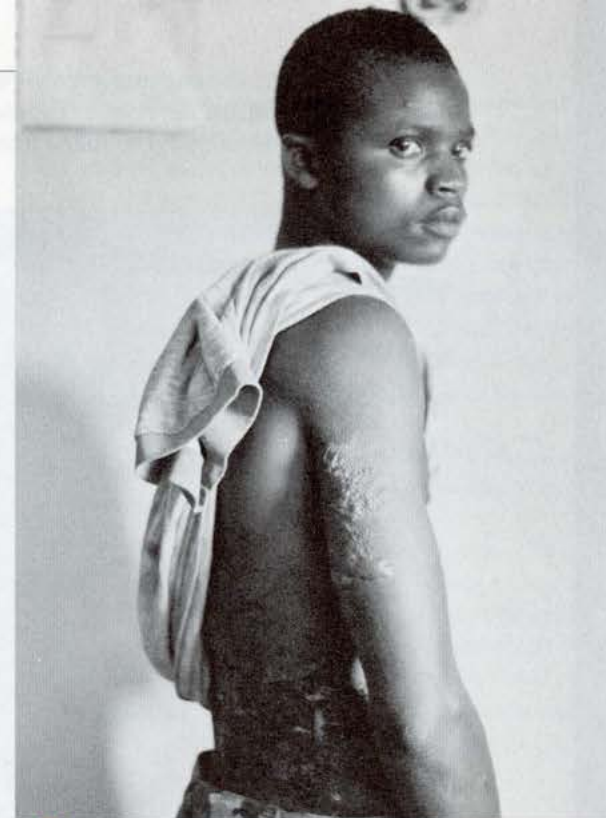
Assisting people displaced by conflict

- International staff: 24
- National staff: 197

Since early 2001, the people of Liberia have experienced increased instability because of fighting both within and beyond the country's borders. Waves of displaced Liberians have flowed southeast towards the capital Monrovia or east towards Côte d'Ivoire. Others have sought shelter in Sierra Leone, only to turn back to Liberia and become displaced in their own country. MSF has spoken out at the United Nations Security Council, most recently in May 2002, condemning the lack of protection for civilians. MSF also issued a report on the humanitarian situation in the conflict-scarred region, "Populations Affected by War in the Mano River Region of West Africa: Issues of Protection." (See page 22 for excerpts from the report.)

In Liberia, MSF's work has followed the displaced themselves. Fighting in Lofa county in the northwest and along the border with Sierra Leone throughout 2001 sparked an exodus of people in search of safety in Bong and Grand Cape Mount counties. Insecurity and military harassment as well as lack of food often pushed people to travel through dangerous areas. MSF assisted the displaced where possible, and denounced the violence inflicted upon them by the civilian and military authorities. Fighting intensified in December 2001, spreading south to Montserrado and Margibi counties in the spring. By mid-2002, a third of the country had been drawn into the conflict, and MSF was providing medical aid in an ever-shifting network of camps and temporary settlements in Bong and Margibi, and on the outskirts of Monrovia.

Other programs focus on daily health needs in Monrovia and the southeastern town of Harper. In the capital, MSF works at Redemption Hospital and four local clinics, where nearly 17,000 people a month seek consultations, and cares for 130 people a month at a cholera treatment center. Since early 2002, it has also supported two clinics on Bushrod Island providing basic health care for some of the area's 50,000 people, many



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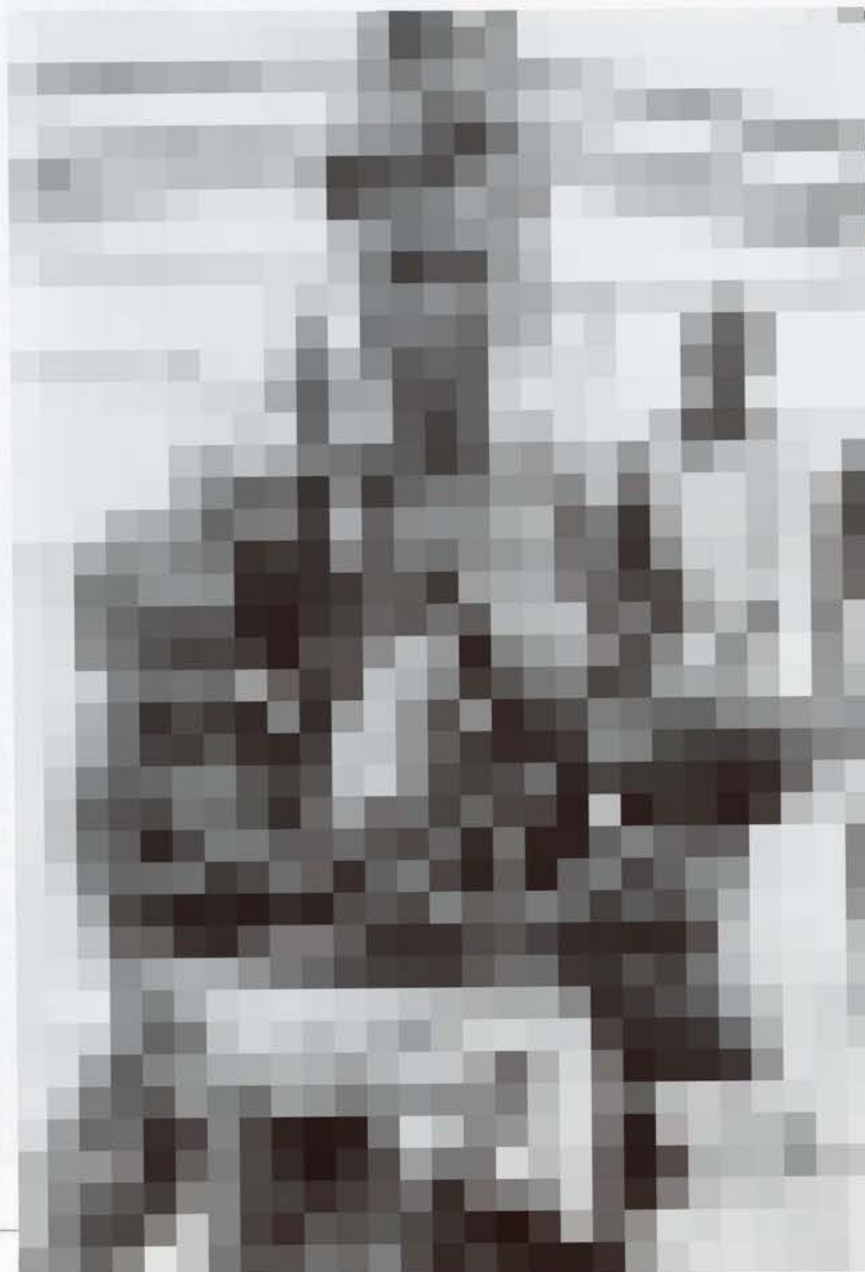
Displaced Liberian being treated by MSF for burns at the Logan clinic on Bushrod Island, Monrovia. "Rebel" soldiers attacked his home in Grand Cape Mount county, burning him with boiling water. He managed to escape and made his way to the capital on foot, as many other Liberians displaced by the conflict are doing.

of them displaced. In Harper, MSF has supported the government hospital and several health posts since 1997.

Malaria is endemic in Liberia. After a July 2001 study showed high levels of resistance in Harper to the standard treatments chloroquine and sulfadoxine-pyrimethamine, MSF introduced a new treatment protocol in April 2002 based on artemisinin derivatives with amodiaquine. MSF is pushing for the introduction of artemisinin-containing combination therapy in many areas in Africa (see page 10).

MSF has been working in Liberia since 1990.

Concerned about the ongoing precarious situation of refugees and internally displaced persons in Sierra Leone, Liberia and Guinea, MSF released the report "Populations Affected by War in the Mano River Region of West Africa: Issues of Protection," in May 2002. The following is taken from the report, which is available in full on www.msf.org



Kouankan refugee
camp, Nzérékoré,
Guinea, July 2002.

© Fabrice Cottat

Today, West Africa remains an intricately linked and complicated context, both politically as well as in terms of the humanitarian situation. While the war has been declared officially over in Sierra Leone and the biggest United Nations peacekeeping force in the world today (UNAMSIL) has been deployed throughout the country, the conflict in Liberia is gaining momentum. New waves of Liberian refugees are moving into Sierra Leone, Côte d'Ivoire and Guinea looking for safety. Thousands of others are being displaced again and again inside of Liberia. Tens of thousands of Sierra Leoneans are going back to their homes, either from neighboring Liberia and Guinea, or from the internally displaced camps within Sierra Leone. Hundreds of thousands of people are moving in the sub-region at the same time, often through the same towns and the same camps.

Many questions are being raised about the manner in which these movements are taking place. Do these people, who have been fleeing conflicts for over ten years, have a chance to decide for themselves if they are ready to return to their homes? Are the necessary conditions in place for these movements to take place in a humane and adequate way, according to international standards? Who is responsible for ensuring the protection of these people in such a politically charged environment? The human aspect of this conflict, the rights of the people to protection and humanitarian assistance, seems to have been lost in the political shuffle.

Sierra Leone

In advance of the elections and subsequent withdrawal of UNAMSIL, displaced Sierra Leoneans were sent back to their regions of origin by the UN and the government of Sierra Leone resettlement programs. It is difficult to consider this a resettlement program in anything but name. Driven by national and international political agendas and rife with problems, this process has been poorly planned, badly organized and ineffectively implemented. For the majority of the people returning to their homes today in Sierra Leone, they are going back to nothing. Their houses have been burned to the ground and entire villages destroyed. There is often no safe drinking water available, no medical facilities, no schools and no jobs.

Liberia

Since 2000, the war has greatly destabilized Lofa county, and more recently has made steady progress in Grand Cape Mount, Bomi and Bong counties, causing people to flee in front of the advancing hostilities. The voyage that has brought them to IDP camps has taken months, and in some cases years. Many people have passed through a series of camps, always just one step in front of the fighting.

Many families have been attacked by several different groups during the past year, and these attacks not only involved abductions but also rapes, killings and burning people alive in their homes. Many families have had great difficulty escaping. The final driving force for people to risk passing through such dangerous areas seems to be lack of food.

Even after they reach a camp, the assistance and protection the people can expect varies, depending on which camp they go to. For those who reach the camps close to Monrovia and close to the offices of humanitarian organizations, there are many assistance programs. But [in other places] you will almost never see any NGO or UN presence.

The problems discussed in this report are not new to people who work in the humanitarian world. In fact they are depressingly common, especially in the complicated Mano River region.

In Sierra Leone, the international community is injecting huge amounts of money, but it is going primarily to the military part of the peace process. Military operations on this scale are not only extremely important, but also very expensive, and very important to be seen as being successful. But will their success be measured against human suffering and the denial of human dignity?

In Liberia, the issues of protection are even more life-threatening. Civilians have been running from one camp to the next for years now, still with the international community hiding from their faces and their stories of horror behind a thinly veiled game of terminology. How long will political issues continue to overshadow the humanitarian needs of the people?

The war in this sub-region does not seem to be going away. As long as the violence continues the people will remain in need of humanitarian assistance and protection. The

needs which we see today, and that we know will be there tomorrow, will not go away.

"My mother doesn't want me to tell you what happened to me. But I want to tell you, and I want people to know what happened to us. I left my village, in Kailahun District, in 1993 when we were attacked. I was raped and my brother was killed. We fled into the surrounding bush while the attack continued [for three days]. Finally, we decided to cross into Guinea. We saw that there was no food for us in Guinea either. My husband and I decided to go back and try to get food. We turned back into Sierra Leone and went to our village. We were there for two days when the RUF attacked again."

Hannah, 25, a returnee, Kailahun,
Sierra Leone – April 9th 2002.

"They told us to be in the repatriation program we had to first go and register in another camp in the north of Guinea and pay our own transport. But we had no money, so we decided to return to Sierra Leone on foot. It took us two days because of our heavy load. As [we] were not registered we have no right to any aid. In Kailahun we have installed ourselves in this house with another family. There are 27 of us who sleep in three rooms."

Returnee woman, 25, Kailahun,
Sierra Leone – April 26th 2002.

"Sometimes fighters would come and round up people out of the bush camps and take them to Kolahun. This was either to work for them (washing clothes, carrying supplies, cooking) or to just go and sit down with them. The fighters do not like to live alone and they told us that the civilians are their protection from the enemy."

We decided to leave three weeks ago because things were quiet. Also, there is no food. We have been living on bush yams and mangos because the fighters took all our rice, and life is getting too difficult. Look at my children [three are malnourished; one of them severely]. Even outside of town, the fighters can take anything from you, even the clothes you are wearing."

Liberian refugee woman, Tekoulu transit camp,
Guéckédou, Guinea – March 17th 2002.

"I want to go home but I have a lot of questions and a lot of frustration. My place is burned down. Who will help me to get tools and material to rebuild it? I do not want to go home until after elections to see if the peace stays. I also do not want to go back to an empty village. I am old and do not want to be alone."

Sierra Leonean refugee woman, age approximately 65,
Boreah camp, Guinea – March 1st 2002.



A family of refugees returns home to find their village devastated by the war, Kailahun, Sierra Leone, April 2002. The question of how or where West Africa's returnees will find the resources to rebuild their lives seems to have been relegated to the sidelines.

© David Saverio/Agence VU

Guinea Care for refugees in a volatile region

- International staff: 34
- National staff: 325



MSF began work in Guinea in 1984 with programs focusing on the pressing health needs of Guineans: disease and malnutrition are rife in this corner of West Africa. Since 1990, MSF has also been operating medical assistance programs for refugees from Liberia and Sierra Leone.

Armed conflict in Sierra Leone and Liberia has ravaged this fragile region. In May 2002, MSF issued the report "Populations Affected by War in the Mano River Region of West Africa: Issues of Protection," which condemns the lack of protection and humanitarian assistance afforded the region's refugees and internally displaced persons. (See page 22 for excerpts from the report.)

Guinea is now home to an estimated 190,000 refugees, and existing local health services cannot cope with the added pressure of a large refugee population. Although the United Nations High Commissioner for Refugees organized the repatriation of many thousands of Sierra Leoneans over the last year, the bulk of them remain inside Guinea.

MSF activities in Guinea remain strongly focused on providing medical screenings, primary health care and water and sanitation services for refugees and for resident Guineans in refugee areas. Around 55,000 refugees are installed in three camps near Albadaria and Dabola. MSF runs two health posts in Boreah camp, and provides clean water for both Telikoro and Boreah camps. MSF also cares for several thousand Sierra Leonean refugees in Sembakounya camp near Dabola.

In April 2002 a new project running four mobile health clinics began in and around Macenta, a town of 25,000 that continues to receive a daily stream of new refugees. Since mid-2001, MSF has also aided around 6,000 Liberian refugees in Nonah transit camp near Yomou in Nzérékoré region and through six mobile clinics along the border. MSF also supports a health post in Tekoulu refugee transit camp and 13 public health centers for Guineans living in the remote Parrot's Beak border area of Guéckédou prefecture.

On the road between Kissidougou and the capital Conakry, MSF runs two transit camps for Sierra Leonean refugees who have fled from southern Guinea and want to return to their country by boat.

In addition, MSF provides medical care and psychosocial support for street children in Conakry, and supports a local NGO that runs three health centers.

In rural Konkouré and Kégnéko prefectures, MSF has been training traditional birth attendants since mid-2000.

MSF has fought tuberculosis (TB) in Guinea since 1988. Working with the national TB program, MSF's TB projects now cover 2 million people in Conakry and the prefectures of Mali, Koubia, Tougué and Dalaba.



© Fabrice Cortat

One of 50 Liberian refugees waiting to be transported to a refugee camp, Dieke village, Nzérékoré, Guinea, July 2002. Insufficient camp resources mean some refugees have to wait for months for a place or transport.

Sierra Leone | Restoring healthcare services after civil war

- International staff: 60
- National staff: 500

After a decade of horrific civil war, Sierra Leone is moving toward stability. The peace process culminated in May 2002 with a relatively calm election, and a 17,000-strong United Nations force is now deployed throughout the country. Yet regional instability continues, with renewed war in neighboring Liberia sending Liberians across the border to Sierra Leone; at the same time, thousands of Sierra Leoneans are returning home from Guinea in precarious conditions and with insufficient aid.

In May 2002, MSF issued the report "Populations Affected by War in the Mano River Region: Issues of Protection," which condemns the United Nations and government-run resettlement programs in Sierra Leone as "poorly planned, badly organized and ineffectively implemented, [resulting] in a process that more closely resembles eviction than resettlement." (See page 22 for excerpts from the report.)

The civil war had prevented MSF's constant presence in unstable regions. With the demobilization and disarmament, however, MSF extended assistance to neglected areas, helping restore healthcare services to districts formerly controlled by the Revolutionary United Front (RUF). MSF rehabilitated and supports the district hospitals in Makeni and Magburaka – the RUF heartland – and provides crucial assistance to 12 clinics. The hospital in Magburaka provides the only facilities for emergency surgery in the northern districts. MSF also runs a therapeutic feeding center (TFC) and clinic in Port Loko, and supports a hospital and six clinics in Kambia district.

In the southern towns of Moyamba and Kenema, MSF offers primary health care through eight health units and pediatric services in hospitals and clinics. A mental health project for internally displaced persons (IDPs) and returnees in Kenema ended in June 2002, after the sudden resettlement organized by the government and the United Nations emptied the IDP camps. In Kailahun, MSF runs a TFC and a 50-bed inpatient facility.

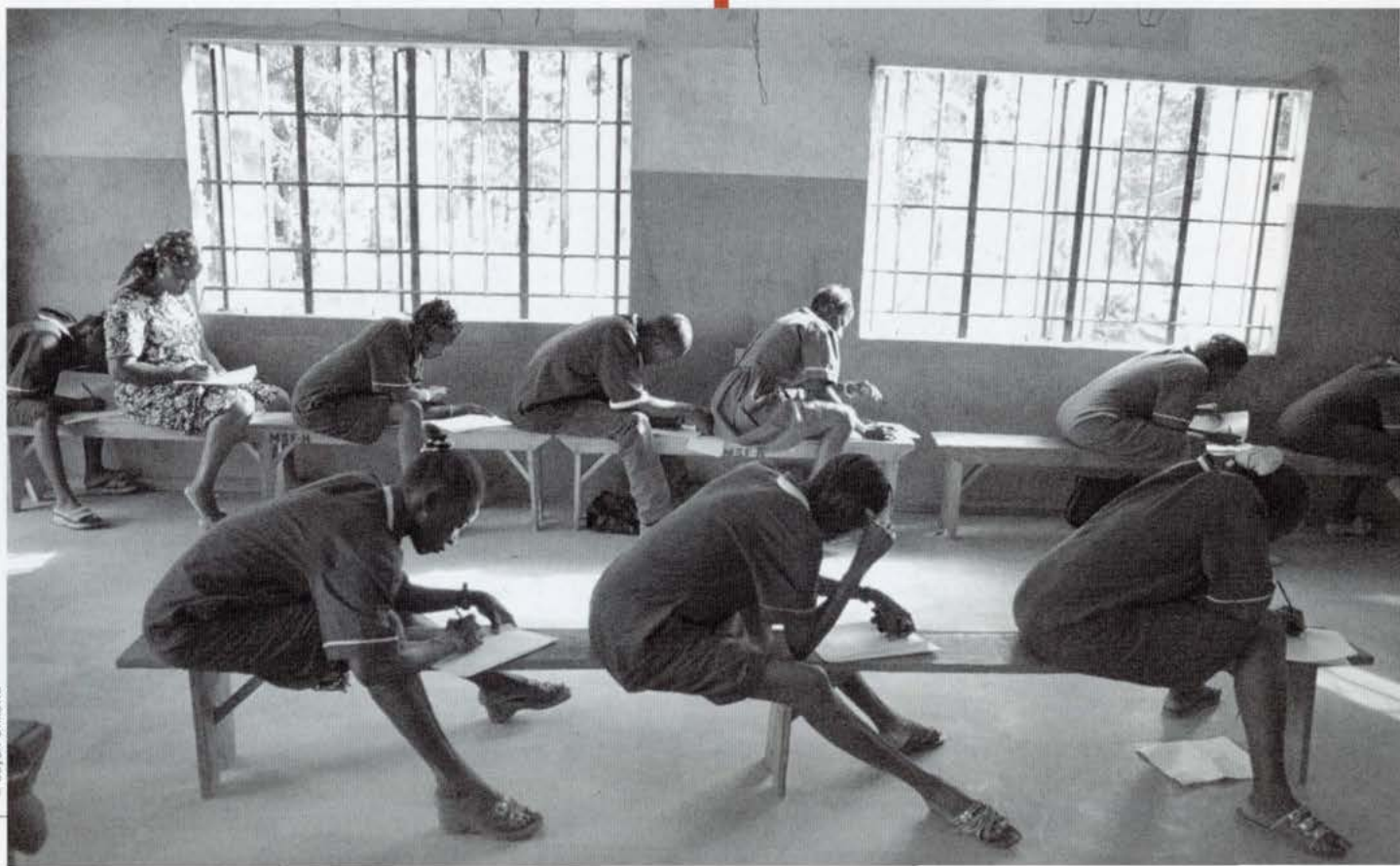
MSF supports health services in six refugee camps near Pujehun and Bo, as well a 435-bed hospital in Bo, a hospital in Kono district, and a hospital and ten clinics in Koinadugu district.

In December 2001, MSF ended its surgery program in the capital Freetown; counseling and pain control for war wounded ended in June 2002. Local doctors continue to do surgery,

with MSF giving follow-up support for pain management. In March 2002, MSF passed control of two small hospitals in Freetown to the Ministry of Health.

MSF first worked in Sierra Leone in 1986.

Sitting medical exams, Sierra Leone, February 2002. Rebuilding the healthcare infrastructure is a major task ahead for this country as it emerges from a decade of civil war.

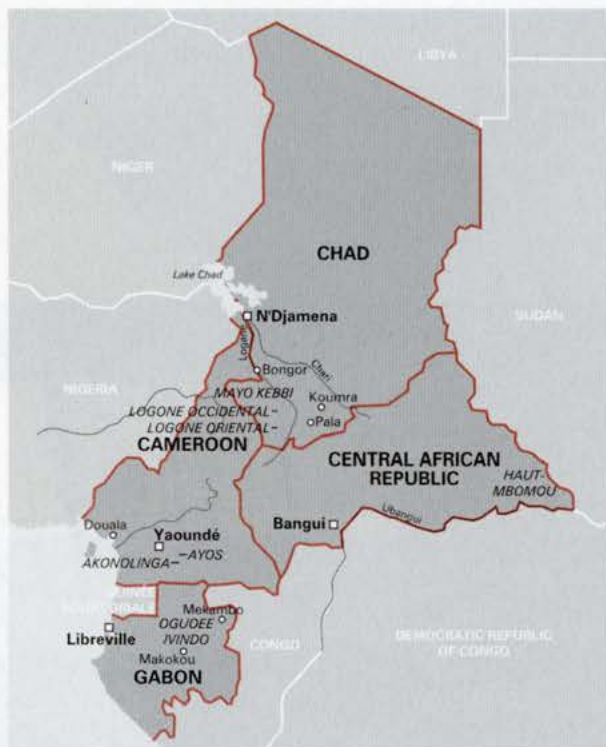


© Sayuri Ohkawa

Central African Republic

Launch of sleeping sickness program

- International staff: 11
- National staff: 25



| The landlocked and sparsely populated Central African Republic experienced an attempted coup in May 2001 and continues to suffer both political and economic instability. Access to health care is becoming ever more restricted in this country that already has one of the highest maternal mortality rates in the world and is ranked third in declared cases of sleeping sickness.

| In October 2001, MSF started a sleeping sickness program in Haut-Mbomou prefecture in the southeast of the country, one of the areas worst hit by this re-emerging disease that hits mainly rural populations already affected by malaria and meningitis. Sleeping sickness is a parasitic infection transmitted by the tsetse fly that causes irreversible neurological damage and is lethal if untreated. MSF provides treatment and trains local staff. While constrained to use the toxic and sometimes deadly arsenic-derivative melarsoprol as standard treatment, MSF gained authorization to introduce the newer, less toxic drug eflornithine on a pilot basis for advanced cases.

| MSF is running a maternal health program in the capital Bangui, covering pre- and postnatal care, vaccinations, family planning, resource management and training for local staff in three maternity wards in the city.

| Central African Republic is also host to refugees from the Democratic Republic of Congo and Sudan, who receive barely any health assistance because of the precarious state of the country's infrastructure. MSF carried out an exploratory mission in May 2002 to evaluate the situation of Sudanese refugees settled in isolated border areas with no access to health services, and provided them with basic medical care, water and sanitation services, and non-food supplies.

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

Cameroon

Widening access to AIDS treatment

- International staff: 8
- National staff: 18

| Drastic cuts in Cameroon's health budget and the introduction of cost recovery at a time of falling incomes has led to a decline in the quality and use of medical services, and a corresponding deterioration in public health.

| Over 860,000 or 11.8% of Cameroon's adults live with HIV/AIDS. In January 2001, it became the first country in Africa where MSF introduced antiretroviral (ARV) treatment for people with limited resources. By the end of July 2002, 102 people in the capital Yaoundé were receiving free ARV treatment through this program. MSF also provides medical follow-up to 40 patients receiving ARV treatment through another channel; trains local doctors and health personnel; and has helped the government and health authorities to find a cheaper, non-patented source for ARV drugs (India).

| A second HIV/AIDS program was set up in Douala in August 2001. MSF runs testing, counseling and prevention activities in the outpatient departments of two hospitals, and provides drugs against opportunistic infections to low-income patients. The team averages 600 consultations per month.

| In October 2001, MSF and partner organizations identified over 400 cases of Buruli ulcer, a severely deforming mycobacterial infection that manifests itself in swellings and skin lesions, in the central districts of Ayos and Akonolinga. At least 200 of those infected need surgery; more than half of them are children under 15. MSF is starting a treatment and information program to fight this often disabling disease in September 2002.

| MSF began working in Cameroon in 2000.

Chad | Tackling cholera and meningitis epidemics

- International staff: 17
- National staff: 200

MSF has been working in Chad for more than 20 years, supporting primary health structures, providing nutritional aid and fighting epidemics. While the country continues to struggle with annual outbreaks of cholera and meningitis, MSF has been able to implement a process of gradual disengagement from its work at the district health level.

Provision of basic health care continues in the prefectures of Mayo Kebbi and Logone Oriental, and in the district of Koumra. Consistent training of young people has enabled MSF to continue its policy in Chad of transferring responsibility to local medical staff. By early 2002, support in the Mayo Kebbi region had been reduced to Bongor and Pala, the largest and most populous districts.

Beginning in July 2001, Chad was once again faced with epidemic levels of disease. A cholera epidemic started in the capital N'Djamena. MSF intervened through the installation of cholera treatment centers for the more than 5,000 registered cases. At the same time, flooding was reported in the region of Logone Occidental, and MSF responded to the increase in malaria and diarrheal diseases.

Epidemic levels of meningitis were reached by March 2002. Mass vaccination of the population is the only way to halt a meningitis epidemic and nearly 80,000 people were vaccinated in Chad in early 2002. MSF is monitoring an emerging strain of meningitis (W135), which was the cause of a large-scale outbreak in Burkina Faso in spring 2002 (see page 18). Currently, the vaccine for W135 is virtually unavailable in Africa.

Gabon | Ebola response frustrated

- International staff (December 2001 to February 2002): 6

The lethal Ebola virus surfaced in Ogooue Ivindo province in northeast Gabon in December 2001. MSF sent six specialists and medicines, protective gear and sanitary equipment to Mekambo and Makokou as part of an immediate international response coordinated by the World Health Organization (WHO). However, hostility from local communities unused to the Western scientific approach to medicine, combined with bureaucratic constraints imposed by

the WHO and Gabonese authorities, prevented MSF from making full use of its expertise in treating and containing Ebola. The team reluctantly withdrew in mid-February 2002.

Another MSF team continued its intervention in the remote tropical forest area of Mbomo and Kellé, across the border in Congo, until the outbreak was contained there in March 2002.

MSF does not currently work in Gabon.



Two generations of women in this family have AIDS but no access to treatment as yet. The grandmother does not know her daughter and granddaughter are infected. Social stigma remains an additional burden for many people coping with HIV/AIDS. Cameroon, May 2002.

© Juan Carlos Tornasi

Uganda | Fight against malaria and HIV/AIDS gathers pace

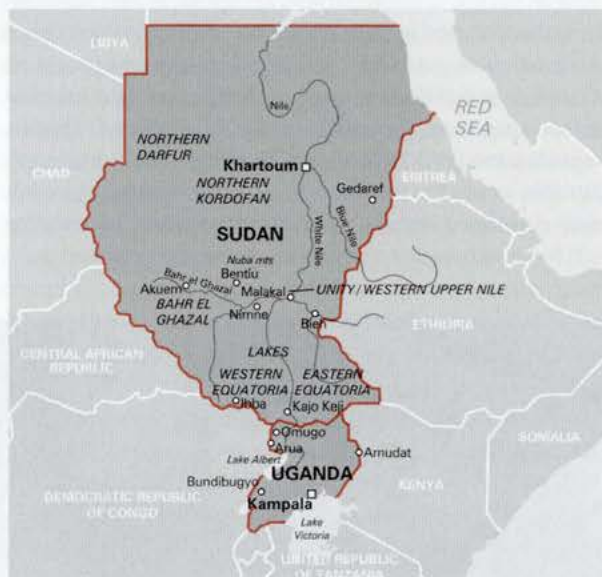
- International staff: 30
- National staff: 159

MSF's work in Uganda has increasingly focused on diseases such as malaria, AIDS and kala azar (visceral leishmaniasis), while work to combat sleeping sickness has wound down after 16 years. MSF continues primary and maternal medical care to residents and displaced people in some areas.

The Bundibugyo area, where MSF has been working since 1999, is home to about 150,000 people, 120,000 of whom are displaced people living in about 60 camps. MSF's work in an area hospital and through a mobile clinic reaching the displaced has shown malaria to be the main reason for hospitalizations and consultations. MSF is assessing resistance to malaria drugs and is working to implement adequate treatment protocols in the district. (See page 10 for more on MSF's push to improve malaria treatment in Africa.)

Over the last year, MSF has begun offering direct anti-retroviral (ARV) treatment to AIDS sufferers in a number of developing countries, including Uganda. By July 2002, MSF's HIV/AIDS program at the hospital in Arua had started providing ARV treatment (see page 89 for more on the introduction of ARV treatment in MSF projects around the world). MSF has already been using ARV drugs at the same hospital since July 2000 to help prevent mother-to-child transmission of HIV. The building of an HIV/AIDS clinic, which will make possible separate care and counseling facilities, is under way. The temporary clinic in the hospital has about 350 regular patients.

MSF is completing its 16-year intervention to fight sleeping sickness in northern Uganda in September 2002. Since 1986, the MSF program has treated over 17,000 people; trained local medical staff at a variety of levels; and met its goal of reducing the prevalence of the disease. Moreover,



after several years of pushing for the introduction of eflo-rithine to treat advanced cases, MSF gained authorization to implement this newer, less toxic treatment in Omugo health center at the end of May 2002.

In Amudat, in eastern Uganda, MSF continues to screen for and treat kala azar, a deadly parasitic disease endemic in the area. About 30 patients, many crossing the border from Kenya, are treated each month. In the same area, MSF manages a health center that provides 800 outpatient consultations per month, with 120 beds for inpatient care.

MSF began working in Uganda in 1982.

Sudan | Improving treatment of sleeping sickness and malaria amid civil war

- International staff: 93
- National staff: 1,293

Over the past two decades, civil war and famine in Sudan have led to the loss of 1.5 million lives and the displacement of millions more. The effects of the war have been devastating: violence, malnutrition and disease, and disruption of local economies and services. Areas of particular concern are in the conflict zones: Kordofan, Unity/Western Upper Nile, Blue Nile and the Nuba mountains. Humanitarian access to these areas is difficult if not impossible. Drought in Northern Darfur and Northern Kordofan has also led to significant population displacements.

MSF has been working in Sudan since the 1970s in activities largely responding to the ongoing civil war. Current activities include mother-and-child health care, surgical intervention, nutrition support at feeding centers, vaccinations, primary health care, water supply, hospital support and programs to fight diseases such as sleeping sickness, tuberculosis (TB), river blindness and kala azar (visceral leishmaniasis). MSF projects are located across the country: from Khartoum and Gedaref in the north and Bahr el Ghazal in the west, to the Lakes Region and Western and Eastern Equatoria in the south.

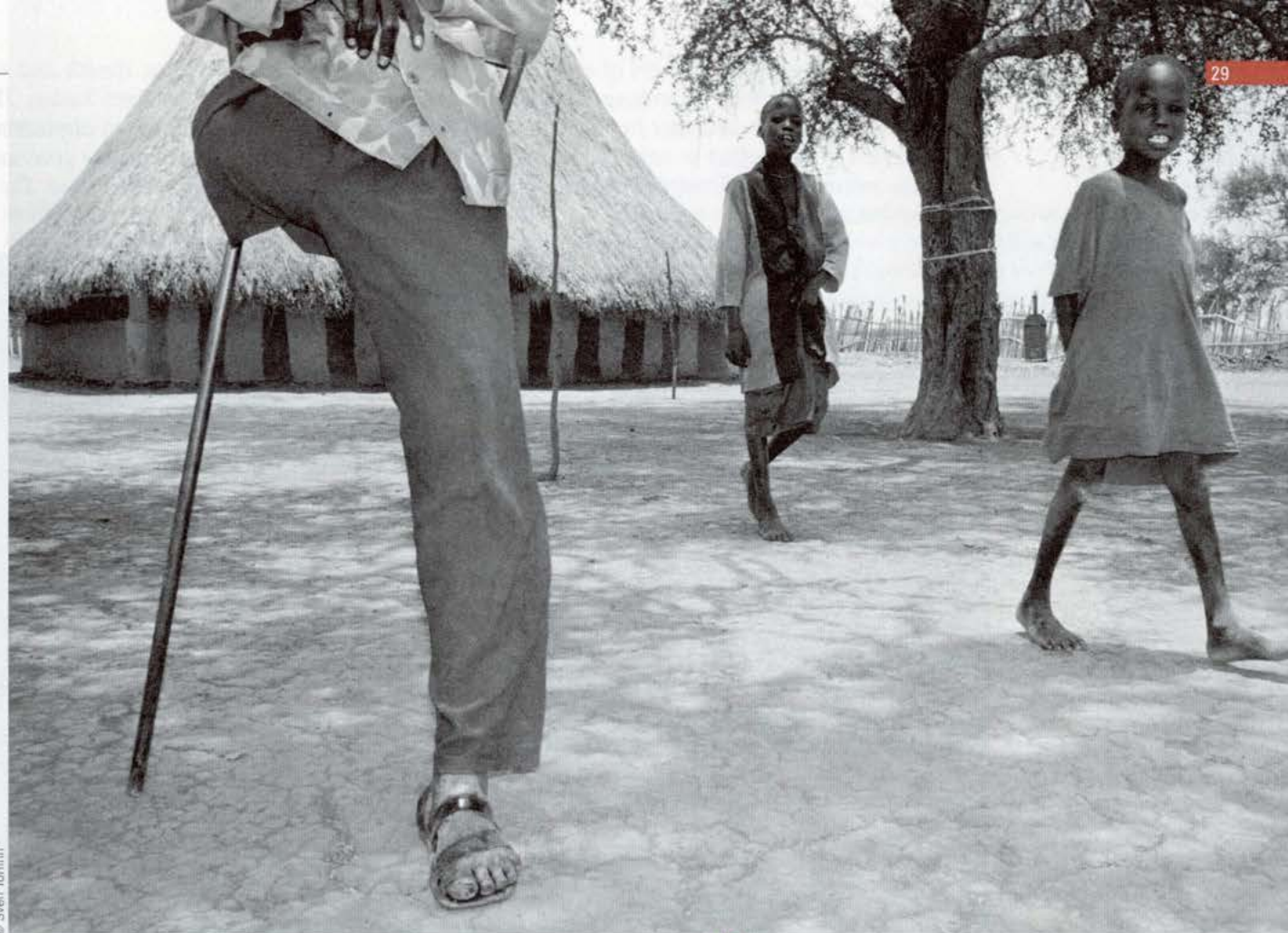
Western Upper Nile

In April 2002, MSF brought attention to the miserable conditions of civilians in Western Upper Nile in the report "Violence, Health and Access to Aid in Unity State/Western Upper Nile, Sudan." MSF provides aid in several locations in the disputed province, offering basic health care, inpatient and outpatient care, therapeutic feeding, and tuberculosis and kala azar treatment. Based on 14 years of work in Western Upper Nile, the report shows that repeated displacement and continued fighting, coupled with lack of access to health care and humanitarian aid, are slowly killing off the region's people. (See page 30 for excerpts from the report.)

Disruption of aid activities – only one element of the fatal consequences of Sudan's long-running conflict on Sudanese civilians – is all too common in Sudan. In an attack on the village of Nimne in Western Upper Nile in February 2002, an MSF compound was looted. Days later a local MSF health worker was killed when three bombs were dropped on the village. MSF was forced to suspend its program in Nimne. A health clinic in Bieh also suffered disruption following a helicopter gunship attack. In March, another MSF team in the area was evacuated due to shooting. The attack on Nimne came in the same days that government planes bombed Akuem in the southern state of Bahr el Ghazal, where MSF runs a primary healthcare program and a feeding center.

New treatment achieving positive results

Until September 2001 MSF teams had to treat patients suffering from second-stage sleeping sickness, a tropical disease endemic in southern Sudan, with the toxic and sometimes deadly arsenic-derivative melarsoprol, because no other drug was available. After years of lobbying by the World Health Organization and MSF a much safer drug, eflornithine, has now become available. MSF's first program to document the effects of eflornithine in the field, the Ibba sleeping sickness project in Western Equatoria, is showing positive results. The number of patients seeking treatment has tripled in recent months and drug-related fatalities are now rare. MSF also treats the disease in Kajo Keji, in Eastern Equatoria. Also in Kajo Keji, an MSF study showed that area malaria strains were resistant to common malaria treatments; in June 2002, MSF introduced artemisinin-based combination therapy (ACT), allowing for better treatment of malaria cases. (See page 10 for more on the fight for better malaria treatments in Africa.)



© Sven Torfinn

In March 2002, after years of donating drugs and medical material, MSF established a health center and eight health units in Nagorba in the Nuba mountains. For the past ten years the government had refused to allow humanitarian access to the region.

In December 2001, after a year of trying to get access to the area, MSF began a kala azar program in Malakal, in Western Upper Nile, with pediatrics and tuberculosis support planned to begin by mid-2002.

Amputee, Thonyor, near Ler, Western Upper Nile, Sudan, April 2002. Violence against civilians has been a common war tactic of all parties in the conflict in southern Sudan.

In northern Sudan, MSF phased out clinics in three camps for displaced people on the outskirts of Khartoum and in a hospital in Meiram, because other health facilities were available and the needs no longer acute. MSF continues to support a therapeutic feeding center in Mayo camp.

In April 2002, drawing on 14 years of experience in Sudan, MSF released "Violence, Health and Access to Aid in Unity State/Western Upper Nile, Sudan," a report detailing the effects of prolonged conflict on the people of this part of southern Sudan. The collection of testimonies and analysis reveals a civilian population subjected to atrocities from all sides and ravaged by a vicious circle of forced displacement, malnutrition and spiraling disease, particularly since the escalation of the conflict in 1997. During this period, the fighting between the Sudanese government (assisted by militias) and opposition groups has swept across the entire region of central Western Upper Nile, with few villages escaping destruction. The following is taken from the report, which can be found in full at www.msf.org



People in southern Sudan sleep outside under mosquito nets when they have them. The looting of bednets by soldiers of all parties leaves civilians vulnerable to malarial mosquitoes and the sandflies that transmit kala azar (visceral leishmaniasis) – a disease that has spread rapidly since it was introduced to the area by soldiers or people migrating after the war broke out in 1983. Thonyor, near Ler, Western Upper Nile, April 2002.

Padeah village, near Ler: a June 2000 survey by MSF found that 75% of Padeah's families had been displaced and 93.4% had lost cattle in the 1999 fighting. The global malnutrition rate was 28.6% and the severe malnutrition rate was 8.7%. The high malnutrition rates were related to the fact that people had been unable to cultivate in 1999 due to their displacement, had lost their cattle, had received no relief food and were forced to await the new harvest in 2000.

Fighting forced Nyageai, a woman in her early 30s, to leave her village in July 2000. She and the other women in her compound were beaten by the soldiers and they fled into the bush. They returned to find their tukuls [huts] burned and their cattle stolen. Some of the girls from the village had been taken by the troops and "used as wives." She and her children spent two days and nights walking through the bush to Bentiu. There they received some relief items and stayed for six months but left because there were "too many people in Bentiu" and children of breastfeeding age were dying. [Many months of forced migration later] sitting in a small shelter north of Nimne, Nyageai says: "We have no hope when we are sitting in this place. We have no hope where help will come from. We have no hope."

Since the resumption of the civil war in Sudan in 1983, life in Western Upper Nile has been a struggle for survival. For civilians, the war has brought little but misery, particularly since the escalation of the conflict in 1997. Repeated food shortages, displacement and epidemics have been commonplace. Military and militia groups on all sides of the conflict have increasingly targeted civilians and their property. The health consequences of the war are enormous.

Displacement, food insecurity and malnutrition

Displacement has been a common feature of the conflict in Western Upper Nile, and increasingly, the displacement is permanent, leaving communities in areas where they may have little access to land or cattle and are unfamiliar with the terrain.

The link between the conflict, food security and malnutrition is clearly demonstrated in the example of

Kala azar

Changes in lifestyle produced by the conflict – the displacement, increased malnutrition, cattle raiding and violence – have permitted diseases of various kinds to proliferate in Western Upper Nile. Over 100,000 people are known to have died from one war-related disease alone – kala azar (visceral leishmaniasis).

"When we arrived in Ler – I cannot describe it. Everyone was naked and hungry. I walked to Duar and everyone was dead. All the villages along the way were empty. Except for a few people, everyone had died."

Wouter Kok, MSF nurse in Ler in 1988,
interviewed in March 2002.

By April 2002, MSF had treated over 20,000 cases of kala azar in Western Upper Nile. As long as the war continues and serious preventive measures and sandfly control are not implemented, treatment of those who access health centers is the only means of reducing mortality.

Veronica, a woman in her 40s, lost four siblings to kala azar in the late 1980s. Of her six children, three died of kala azar or other diseases. Of three remaining children, one is infected with the disease. She brought this child to MSF's treatment center in Nimne, where the girl received the painful daily injections of the medicine from MSF staff and recovered.

Targeting of civilians

Mortality and injuries as a result of violence from military and militia factions are perhaps the most obvious effect of the conflict, but data is incomplete, given that many civilian victims of violence do not reach health centers. From MSF's own records, it is clear that each year dozens of people have been medically evacuated due to war injuries such as gunshot wounds. Killings of civilians, even young children, appear to be commonplace.

In January 2002, Nyakuon, a 14-year-old girl was walking from Dablual to Padeah to attend a wedding with her 16-year-old friend

Nyatek. On the way they ran into a Government of Sudan patrol. Nyatek was raped by a soldier. Nyakuon resisted the rape and was shot in the chest by one of the soldiers. She was brought to a nearby MSF clinic where she was given first aid and then evacuated to Lokichoggio for surgery.

In March 2001, Majak, a man in his late 40s, walked to Lake No to do some fishing. Early the next morning he heard the sound of bombing and shooting and started walking back to his village. As he walked he saw fire and smoke rising and realized the villages were burning. He hid from the troops in the forest, walking on to Bol under cover of darkness. In Bol, he found a devastated village. One person had survived the day's massacre: a young mentally handicapped boy had been spared by the soldiers. He found 30 people in a luak [cattle barn], all dead, two of them young women who had been brutally mutilated.

Constraints on access to humanitarian relief

Relief operations in the context of conflict are not uncomplicated. The problems associated with emergency relief in Sudan and other chronic conflicts include diversion of aid to the military, manipulation of aid, lack of accountability and associated human rights violations. Constraints include denied access – when for instance humanitarian agencies are refused permission to enter an area and provide services – and access limited by security constraints such as active fighting.

"We walked over an open grave, past burned huts – everything was burned to the ground. Many people had tropical ulcers – huge wounds – because they had no clean water and nothing to put on the wounds. In most places you will have a piece of cloth to put on the wound, but there they didn't even have cloth to put on the wounds."

Jill Seaman, MSF doctor, on a first [1991] visit to northern Paranou, a district where high insecurity and flight bans hinder humanitarian access and the combination of violence, displacement and lack of medical services has resulted in one of the worst situations MSF has ever witnessed.

Conclusion

MSF urges the Government of Sudan, the Sudan People's Liberation Movement/Army, and associated militia groups, to provide protection to medical personnel and medical facilities in accordance with international humanitarian law.

MSF calls on all of the warring parties to respect their obligations to protect civilians.

MSF demands full and unhindered humanitarian access to areas where permission has been denied and where civilians are in need of assistance.

The total mortality from violence, disease and hunger in Western Upper Nile will never be known. The conflict has affected the lives of thousands. Each individual has a story. What is clear is that the war in Western Upper Nile is inexorably killing off the people of the area.

"When the war started, it was soldiers fighting each other. Then the soldiers turned on the community and started taking the cattle. We, the citizens, are suffering between the two forces. We don't know why the soldiers have turned against the community."

Diu, from Rupnygai

"When they [Government of Sudan troops] capture people, if they are young women they rape them. If they are old, they take them to Pariang [Government of Sudan-held town]. If very young children, they knife them and throw them inside the tukuls [huts]."

Arup, from Awet, Panarou

Kenya | Antiretrovirals prolong life in Homa Bay

- International staff: 39
- National staff: 224

The AIDS epidemic continues its disastrous assault in Kenya. About 2.3 million Kenyans live with the disease, and an estimated 500 people die daily from AIDS-related infections. In addition to providing medical care – and now antiretroviral (ARV) treatment – for people with AIDS, MSF is pushing for accessible treatment options for AIDS and other diseases. Although some positive steps have been taken, the crisis is far from receiving adequate government response.

In late 2001, MSF began ARV treatment at the hospital in Homa Bay in Nyanza province, where about 35% of the adult population is infected with HIV. Around 240 will be under treatment by fall 2002. This project shows the effectiveness of ARV treatment in rural and resource-poor settings, and is one of several MSF ARV programs around the world (see page 89). MSF also trains medical staff and works to improve treatment of opportunistic infections in AIDS patients. One of the most common such infections is tuberculosis (TB), and in the Homa Bay hospital and 27 local health centers MSF works with Kenya's national TB program to treat 1,500 patients and improve TB diagnosis and follow-up.

In Busia, in Western province, MSF carries out HIV/AIDS testing, treatment and home-based care, as well as TB treatment. MSF has also embarked on an extensive grass-roots effort, eliciting the support of parents, village elders, religious leaders and others to encourage prevention of HIV/AIDS through the formation of school-based anti-AIDS clubs.

AIDS prevention, testing, care and training are also the focus at Mbagathi hospital in the capital Nairobi and in the city's slums of Kibera, Dandora and Mathare. In these

Local MSF volunteers use music and dance to increase HIV/AIDS awareness among fellow residents in the Kibera slum area of Nairobi, Kenya, October 2001.



© Dieter Telemans

Somalia | Medical aid to civilians worn down by war

- International staff: 19
- National staff: 298



areas, health workers provide both primary health care and AIDS-related care to thousands of people each month.

MSF has been assisting refugees in Kenya for many years. In May 2002, when several thousand Somalis fled fighting in southern Somalia for refuge near Mandera, MSF reopened one of its area feeding centers. With the Somalis confined to a dangerous area near the border, MSF asked the authorities to move them to safer areas.

In eastern Kenya, near Dadaab, MSF provides medical care and nutritional support to Somali refugees in three camps. Around 300 patients are also treated for TB. In March 2002, MSF began to train local staff and treat and diagnose the deadly parasitic disease kala azar (visceral leishmaniasis), which has recently surfaced in the area.

MSF has been working in Kenya since 1987.

In early 2002, the "war on terrorism" briefly focused international attention on Somalia as a potential harbor for terrorists. Little mention was made of the country's real problems: a long-running civil war, an inexistent or poorly functioning health system, treatable diseases that kill thousands and, for women, a very high chance of dying in pregnancy or childbirth. While providing medical aid in various parts of the country, MSF is urging international actors to take notice of the desperate situation in which many Somalis live.

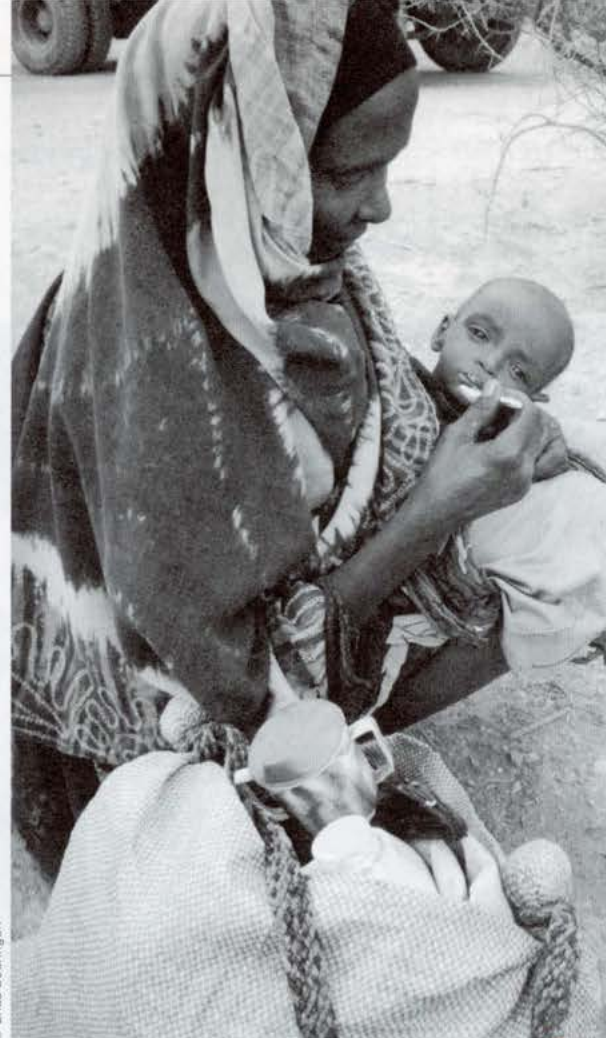
MSF restarted its programs in the capital Mogadishu in May 2002, over a year after seizure of several staff members (later released) forced suspension of the projects there. At mid-year, fighting was continuing in and around the city. MSF offers consultations in outpatient clinics and mother-and-child health care programs. A cholera treatment camp has also been set up to cope with periodic outbreaks.

Fighting in southern Somalia in May 2002 forced 10,000 Somalis to seek refuge in neighboring Kenya, and MSF teams there were able to assist them. MSF voiced concern about pressure being exerted by Kenyan authorities on refugees to return to Somalia despite the continued fighting.

In Hudur, the capital of the Bakool region, MSF runs a tuberculosis ward and therapeutic feeding center, as well as primary care and kala azar (visceral leishmaniasis) projects. In summer 2002, a health post opened in the Rabdhure district, also in Bakool. Coordination of a separate kala azar project in the south was handed over to Health Net International in April 2002.

In Middle Shabelle, in Giowhar and Aden Yabal, MSF responds to disease outbreaks and provides health care via health centers, a network of mother-and-child health care programs and vaccination campaigns. MSF also supports a 60-bed hospital in the city of Galkaayo and three health centers in rural areas, and cares for wounded civilians when fighting breaks out.

In January 2002, after a meningitis outbreak, MSF sent a team to Hargeisa in Somaliland for a vaccination campaign,



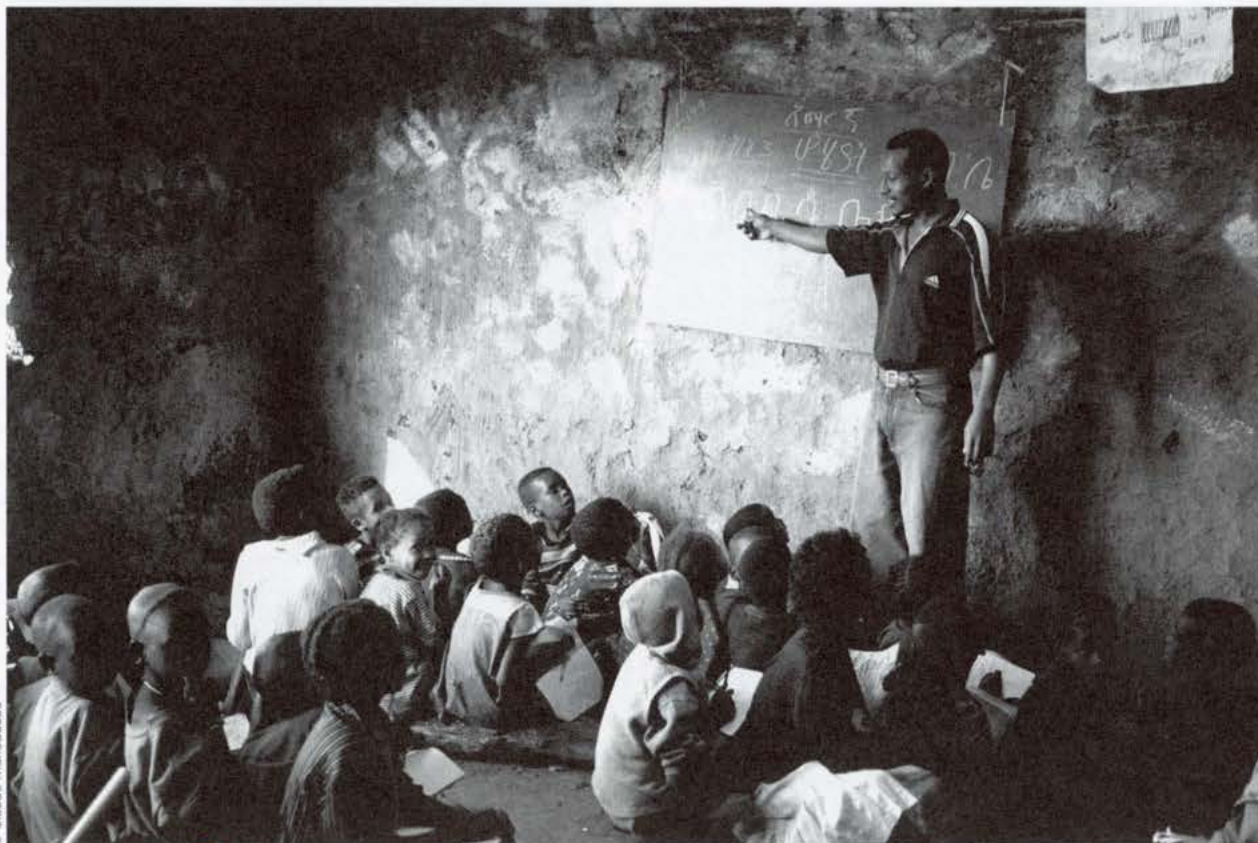
Mother feeding her baby at an MSF food distribution point in Rabdhure, Bakool region, Somalia, September 2002.

reaching 190,000 people. In Bossaso, in Puntland, MSF established a cholera treatment camp in April 2002 when an epidemic hit the city, and treated 1,100 patients in seven weeks. Fighting in the area in May caused international volunteers to evacuate for a week.

MSF has been active in Somalia since 1991.

Ethiopia | TB programs and meningitis vaccinations reach millions

- International staff: 45
- National staff: 427



© Claude Mahoudesou

Guro school, Salamago, Ethiopia, November 2002. An MSF primary healthcare team visits this Dimi village, which is more than a day's walk from the nearest clinic, for three to four days every month.

Ethiopians continue to be affected by endemic diseases such as tuberculosis (TB), HIV/AIDS and meningitis, chronic malnutrition, as well as lingering tension on the country's border with Eritrea. At the same time, deteriorating socio-economic conditions make health care virtually inaccessible for the most vulnerable people. Against this backdrop, MSF works to diagnose, treat and prevent TB, HIV/AIDS and meningitis, while work on kala azar (visceral leishmaniasis), a deadly parasitic disease endemic in several areas of the country, has ended. The closure of this and other projects has made room for new initiatives, including efforts to establish a long-term program targeting chronic malnutrition. MSF also responds to nutritional emergencies as they arise.

Tuberculosis

Ethiopia has one of the highest instances of TB cases in the world. A TB treatment program begun in Somali National



State in 1996 expanded in 2002 to several additional health centers and clinics; the entire program now covers about 2 million people. In 2001, 2,000 people received treatment and over 100 health workers were trained in managing TB and leprosy, another mycobacterial disease. MSF works closely with an Ethiopian NGO specializing in mother-and-child care and development to ensure that displaced people being treated in MSF's TB program have food and shelter.

Since early 2001, MSF has worked in Galaha to treat TB among the primarily nomadic Afar people. About 400 people are under treatment there at any one time. MSF hopes to construct a permanent TB treatment center in the region. MSF's newest tuberculosis effort began in January 2001 in Sekota, where TB and nutrition are the primary concerns.

Meningitis

Ethiopia is at one end of the "meningitis belt" that stretches across sub-Saharan Africa to Senegal and is regularly hit by outbreaks of this potentially fatal infection of the brain membrane. In spring 2002, as the disease once again reached epidemic levels, MSF carried out mass vaccination campaigns in Tigray region and the zones of Kefa, North Gondar, Sidama and South Omo. Approximately 1.2 million people were vaccinated.

AIDS/STDs

Since early 2001, MSF has focused on diagnosis and prevention of sexually transmitted diseases (STDs) and HIV/AIDS among vulnerable people. Work is centered on the northern town of Humera, in 14 clinics in Tigray region and in another 22 clinics in the capital Addis Ababa, where prostitutes are also offered peer education in reproductive health and family planning.

Kala azar

From 1997 through mid-2002, MSF was deeply involved in diagnosis and treatment of kala azar in several areas of Ethiopia. From 1997 through fall 2001, MSF treated more than 2,500 people in the Humera area. In early 2002, a progressive increase in the number of people admitted to the hospital prompted MSF to give additional support to active case finding and referral. This project was turned over to the Ministry of Health in May. MSF continues to supply drugs to the Humera hospital for treatment of the disease.

Basic care and water/sanitation

In November 2001, MSF began providing basic health care to people living in the conflict-prone area of Arero/Udeth, in

Oromiya region. Since late 2000, MSF has been helping build wells and latrines in Adfer. An additional water and sanitation project is ongoing in Sekota.

Changing needs prompted MSF to phase out several of its projects in Ethiopia over the last year. A hospital support project in Woldiya closed in December 2001, as did a surgery project in Dubti. In March 2002, MSF finished work in the town of Mankush as it became clear that the target population of Sudanese refugees was becoming more integrated into the local community or transferred to a new camp. A primary care project among the Bodi, Dimi and Mursi people in Salamago is expected to end in December 2002.

MSF has been working in Ethiopia since 1984.



Dimi families walk for up to half a day to attend this monthly MSF clinic for primary and prenatal care at Guro, a small village in Salamago, Ethiopia, November 2002.

Burundi Pushing for effective malaria treatment

- International staff: 59
- National staff: 652



Despite entering a transition period in November 2001, Burundi continues to be a country in conflict. Civilians are the losers in the wake of regular rebel attacks and subsequent government retaliation, as well as incursions of armed groups from neighboring countries. In many areas, MSF medical care is focused on meeting needs directly or indirectly created by the fighting. Other needs are also gallingly apparent: the need for effective malaria treatment and the need for access to basic health care.

Malaria is not being treated correctly

Malaria, which kills 1-2 million people a year, most of them children in Africa, is endemic in Burundi. In an epidemic lasting from late 2000 through summer 2001 over 3 million cases occurred among a total population of 6.5 million. The magnitude of the epidemic was due in part to the ineffectiveness of the first-line drugs (chloroquine and sulfadoxine-pyrimethamine, or SP), which became evident in various resistance studies.

MSF treated around a million cases during the epidemic. Realizing that many patients were resistant to the drugs with which it was treating them, an ethically untenable position, MSF pushed for Burundi's national protocol to adopt combination therapy including artemisinin derivatives (ACT), an effective treatment recommended by most experts. When MSF started using ACT (illegally, though publicly) in certain projects, the government suspended MSF malaria-related work in these sites. After much pressure and negotiation, in July 2002, the government finally agreed to introduce a new protocol using ACT by July 2003. While continuing to lobby for ACT to be introduced earlier, MSF is encouraging the use of quinine, effective but far from ideal, as the treatment of choice until its adop-

Karinzi health center waiting area, Burundi, July 2002.



© Lella Kramis

tion. Further information on the need to introduce more effective malaria drugs in Africa, and the Burundi case in particular, can be found on page 10.

Medical and nutritional assistance

MSF continues to provide medical aid through several hospitals and numerous health centers in the provinces of Bujumbura (Mairie and Rural), Cankuzo, Karuzi, Ruyigi,

United Republic of Tanzania | Focus on communicable diseases

- International staff: 14
- National staff: 76

Makamba and Kayanza. When MSF malaria activities were suspended, work in the health centers in Kayanza ceased, but MSF continued to perform surgery in the hospital there until withdrawing in July 2002. Mobile clinics in Makamba serve some of that area's 100,000 people displaced by fighting.

After a major nutritional crisis in 2001, MSF is continuing to run supplementary and therapeutic feeding centers in Cankuso and Karuzi provinces, and in Bujumbura Mairie. In Cankuso, the therapeutic feeding center has been integrated into the local hospital, and MSF is looking for a local partner to take over the supplementary feeding centers. MSF teams perform emergency surgery at hospitals in Kayanza (until July 2002), Makamba, Kinyinya and Ruyigi, and in a center for war-wounded in the Bujumbura neighborhood of Kamenge. The latter also has a mental health component.

MSF is increasingly worried about the limited access to health care for most of the population, particularly the poorest groups. With a US\$3-4 million health budget, the government's failure to sustain the public health system has prompted a move to decentralize health services and require a higher fee structure for consultations and medicines at public health facilities. In some provinces, this has already resulted in a 60-80% drop in the number of consultations. MSF is keeping a close eye on this evolution and its effects on the most vulnerable people.

MSF's work in United Republic of Tanzania focuses on communicable diseases such as cholera and malaria. The medical teams work closely with local health facilities to prepare for and respond to disease outbreaks, supervising pharmacies and training local health workers. Related activities include advocating for effective malaria medicines and a change in protocol at the national level; and expanding access to clean water to prevent cholera and other diarrheal diseases.

In January 2002, MSF responded to an outbreak of cholera in Zanzibar, treating 585 patients, and provided support to fight smaller outbreaks in several other parts of the country, including Kigoma, Pwani, Lindi and Mtwara.

Education and community awareness are an important aspect of MSF's work in Tanzania. As part of the program in Kigoma, MSF works with local singing, dancing and drama groups to spread information about malaria, and prepares public service messages for radio broadcast.

In addition to providing safe sources of water, MSF uses a participatory approach to raise community awareness about health and sanitation. To prevent the spread of cholera, it distributed health posters to villages targeted in the cholera preparedness project. New districts have been identified for the next phase of the program, where health workers will be trained in cholera management.

MSF also continues to support a program focused on mother-and-child health in Mtwara, including rehabilitation of 33 health facilities.

MSF has been working in United Republic of Tanzania since 1993.

Paracheck® rapid test for malaria, Kigoma, Burundi, July 2002.



© Leila Kramis

Congo

MSF supports rape survivors but is denied access to conflict zones

- International staff: 47
- National staff: 253



The cumulative effects of consecutive wars continue to be felt in Congo. In April 2002, fighting shattered a fragile calm in the southeast. In addition to responding to this emergency, MSF continued to aid victims of sexual violence in the capital Brazzaville, treat sleeping sickness patients in Gamboma and attend to basic health needs in several other areas.

The renewed fighting between government troops and rebel militia in the Pool region in the southeast prompted MSF to send a team to Kinkala to evaluate and respond to the needs of a large group of people displaced by the fighting. MSF helped reestablish the local medical team after finding a hospital with no patients, no equipment and no medical staff. As of summer 2002, MSF's repeated requests for access

to areas in greater difficulty were still being denied.

In spring 2002, a legal component was added to MSF medical work in treating and supporting victims of sexual violence at Makelekele hospital in Brazzaville. MSF now advises women from the time they file a complaint through to the end of the legal process.

By mid-2002, the MSF sleeping sickness project in the Gamboma region had screened nearly 26,000 patients since its start a year earlier. Out of the approximately 950 people who tested positive, 900 have been treated. MSF works closely with the country's national sleeping sickness program on staff training as well as direct treatment.

In late 2001 and early 2002, MSF withdrew from clinics in Mindouli, Sibiti and Njoundou as the needs in those areas



Elisabeth Zakitoka, a displaced seven-year-old, does her homework while minding her brothers, Shabunda, Sud-Kivu, Democratic Republic of Congo, October 2001. Four out of ten Congolese children are not in school; and 400,000 displaced children in the country have no access to education.

changed. Activities in Bétou continued, with hospital capacity expanded to cover emergency surgery, outpatient consultations, and mother-and-child care.

From January to March 2002, MSF helped to contain an outbreak of Ebola in Mbomo and Kéllé in the northwest (see page 27). It also helped with basic health care and measles vaccinations for internally displaced people in Brazzaville following renewed fighting in some parts of the town in mid-June 2002.

MSF first worked in Congo in 1997.

Rwanda

First program reducing transmission of HIV/AIDS to babies

- International staff: 8
- National staff: 90

Eight years after the genocide, Rwanda remains a poor, over-populated country desperately short of qualified medical staff. Fortunately, there have been signs it may disengage from the conflict in neighboring Democratic Republic of Congo. Meanwhile, urgent health problems such as AIDS, which affects over 11% of those aged 15 to 49, clamor for response.

In April 2002, MSF opened the first program in Rwanda to offer voluntary counseling, testing and prevention activities to reduce mother-to-child transmission of HIV/AIDS, as well as treating AIDS-related infections. Operating from a Kigali health center, the new program complements MSF's ongoing AIDS awareness work in primary schools in Kigali and Cyangugu.

MSF continues to train local counselors in directing group therapy for survivors of the 1994 genocide. Mostly women, the participants struggle to heal from the trauma of losing relatives, being raped and, in many cases, contracting HIV/AIDS as a result. Some 250 women were taking part in summer 2002.

In late summer 2001, an MSF surgical team performed over 140 operations in Ruhengeri hospital after increased fighting in the northwest. Many of the wounded were child soldiers. Other emergency responses included aid to survivors of the Mount Nyiragongo eruption in January 2002 and floods in Bweyeye region near Bugarama in Cyangugu province in May 2002.

MSF is setting up a project to prevent cholera by improving the supply of drinking water from Lake Kivu. Support to Bushenge health district in Cyangugu ended in early 2002.

MSF has worked in Rwanda since 1991.

Democratic Republic of Congo

Giving voice to untold human suffering

- International staff: 84
- National staff: 814

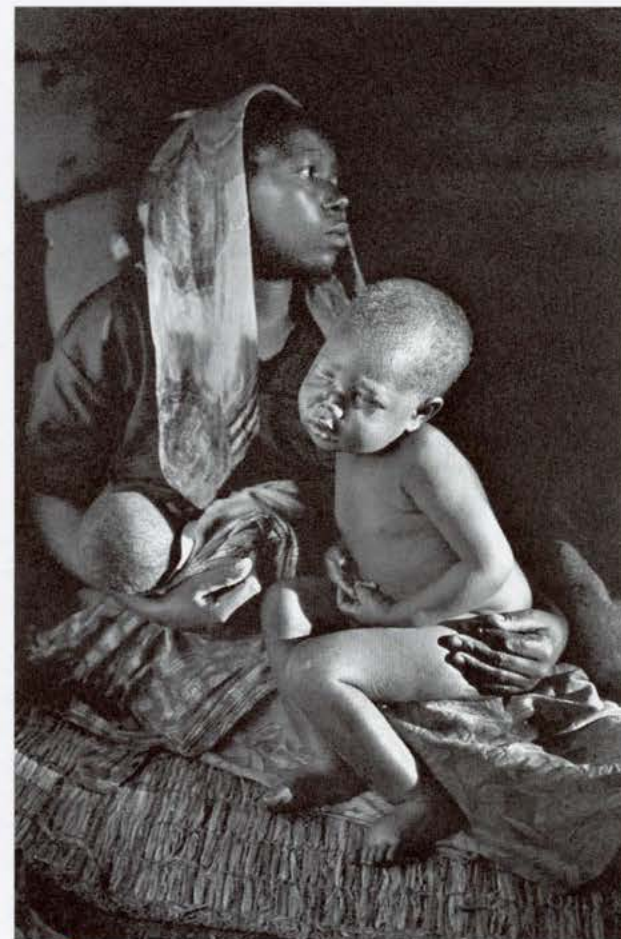
"The war catches up with us ... we are forced to flee to Zambia. Three months in Zambia, three months a nightmare. Three of my sons are hospitalized with cholera. I lose my first son, Paul, a boy of eleven, on May 31 1999 at 12:05. I take the rest of my children, who have barely escaped death, nearly corpses, and take to the road for Pweto [DRC]. Angry? Yes. Mad? Yes – but against whom? Fight? But against whom and with what weapons?"

Francois K.M., Katanga province

Years of conflict in Democratic Republic of Congo (DRC) have led to one of the most devastating human crises of our era, with millions of deaths and displacements of people linked directly or indirectly to the conflicts. Yet the continued suffering of countless Congolese goes largely overlooked. For this reason, MSF, active in the country (formerly called Zaire) since 1981, has issued several reports and collections of personal accounts of Congolese civilians in an attempt to bring to light the dire health emergency caused by years of war. The following pages give excerpts from the MSF book *Quiet, We're Dying* in which a number of Congolese describe what their lives have been like in their own words. Another collection, *The War was Following Me: Ten Years of Conflict, Violence and Chaos in the Eastern DRC*, is available online at www.msf.org.

Despite a series of peace talks aimed at ending the war, conditions have continued to deteriorate for much of the civilian population. Millions have been forced from their homes by fighting: around 2.3 million inside the country and nearly 350,000 in neighboring countries. Since 1998, the deaths of over 3.5 million Congolese can be attributed to the conflict. The country's infrastructure has effectively collapsed and very few people have access to decent health care, due not only to the lack of medicines and health staff, and transportation problems, but also to the widespread poverty.

(continued on page 41)



This mother walked for a day to carry her two very sick children to an MSF feeding center, Kitshanga, Nord-Kivu province, Democratic Republic of Congo, October 2001. Congolese walk up to 50km to reach the center and often have to evacuate because of ethnic violence.

© Chris Keulen

AFRICA

Displacement, murder, rape and other violence, coupled with malnutrition, disease and the breakdown of the public health infrastructure: the hardship and suffering inflicted on the civilian population of the Democratic Republic of Congo as a result of their country's ongoing conflict is overwhelming. Yet to date their struggle to survive has been a silent one, under-reported and neglected by the international community. In order that their voices may be heard, MSF published two collections of personal stories by Congolese civilians in 2002. The stories below are taken from one of these: *R D Congo: Silence, On Meurt – Témoignages* [D R Congo: Quiet, We're Dying – Witness Accounts]. A second collection, *The War Was Following Me: Ten Years of Conflict, Violence and Chaos in the Eastern DRC*, which documents the experiences of MSF national staff as well as patients, is available online at www.msf.org

Isidore B., a nurse, recounts how, given its isolation and the insecure environment, the health center where she works, which has just been looted, has decided to transfer its patients to another hospital. As many patients cannot afford the combined costs of transport, nursing and food, they have resigned themselves to remaining behind (Equateur province).

| "Our health center is supported by MSF, but we are facing security problems and there are transport difficulties in delivering medicines to us from the health zone. Because of the insecurity, we are no longer supervised by our medical officer who last visited us in May 2000. And we ran out of medicines in April 2001.

| Before the second war, we were also receiving medicines and medical equipment from some members of a Catholic religious order. One of the nuns worked here as a surgeon until May 1999, but everybody has left since the beginning of the rebellion.

| Quite a number of surgical cases arrive here and we refer them to Basankusu. But many families are unable to afford the cost of traveling there: Basankusu is three days away by dugout canoe. Neither can they afford the cost of living near the hospital while the patient is being treated. Of those who do set out, we know that some die on the way because of the distance and the difficulties involved.

| We normally receive about 1,000 new cases each month. I know that there are many more sick people in this area, but they stay home because they cannot afford treatment or because they are ashamed [to reveal their destitution]. We also take in-patients, but there have been no beds, no doors and no windows since everything was looted by passing soldiers in July 1999. We have no money to pay for repairs."

A. Ambuga, a widow, has lost three of her five children to dysentery and malnutrition (Equateur province).

| "We were living in a small village, hunting and working in the fields. One day, my husband, not knowing that Basankusu had already been occupied by the rebels, went hunting just where FRC

soldiers [Congolese army] were hiding and taking up defensive positions. They arrested him and threw him into a hole [prison], where he was kept for a day with nothing to drink or eat. Nobody in the village knew what had happened to him and we began to get worried. We decided to go and look for him making lots of noise on gongs, tam-tams and trumpets so that he would hear the instruments and find us. In fact, we met him about 15km from the village because it was God's will that the soldiers let him go.

| Two days later, the village was surrounded by the same soldiers and my husband was again arrested and accused of scouting for the rebels. For that reason, he was locked up in our house and burnt alive. As all our belongings burned along with him and the whole village was in a panic, I took my five children and went into the forest where we remained for one month and five days.

| I gathered what I could in the forest to feed my family. But the bad living conditions brought on an outbreak of malaria in my oldest child. Two of the other children then got diarrhea at the same time and they both died. Like their father, they had to be buried with no burial cloth and no coffin. Terrified, I continued my journey with my three remaining children. One could walk, but I had to carry the two others. We rested for four days in the first village we came to when we got out of the forest and then we reached Bokakata. Nobody helped us during that difficult period.

| In Bokakata, the church gave us some manioc, fish and a cooking pot, as well as clothes, for we were almost naked when we came out of the forest. Two weeks later, all three children showed signs of malnutrition (edema and hair discoloration). My whole body was covered with scabies and mycoses [fungal infection], and I also had bowel problems, but there was no possibility of going to hospital.

| I am unable to do anything but to watch my children and give them the same diet as everyone else. Last week, one of them died because of the malnutrition and the two others are not well at all. I'm afraid I may end up as the only living member of the family, but my future lies in the hands of God."

"The health situation in the Democratic Republic of Congo has become so serious that considerable human, material and financial resources would have to be mobilized in order to return to just about acceptable mortality and morbidity rates. Despite their constant efforts, aid workers in the DRC are left feeling powerless, forced to watch a humanitarian disaster silently taking place on an unprecedented scale."

Dr. Françoise Saive and Jean-Marc Biquet, MSF-Belgium

Césarie, displaced by the fighting, lost six of her eight children to malnutrition during the war (Nord-Kivu province).

| "I have been displaced since 1993, when the interethnic war broke out in the region and we had to flee. As malaria is endemic in the first town we reached, we had to move on after six months. Now, I am living here, but still in an unsafe environment with frequent attacks by the Interhamwe. The last attack was three months ago when they burned our houses. All my belongings have been looted several times.

| Because of the attacks, we are often forced to flee into the forest where we build shelters with tarpaulins and branches. We stay there waiting for the situation to improve. You never know how long it might last: a few hours, a few days.

| I am living here with my husband and my two children. I have already lost six children through malnutrition. It is a real problem in my village, but people don't admit it. They think the children's condition is due to something else, witchcraft, for example. However, I think that the malnutrition one of the children is suffering from now is due to a malarial infection that we could not afford to treat."

(continued from page 39)

MSF maintains medical aid programs in both government and rebel-held territory in the face of wave after wave of bitter fighting. MSF teams work daily with victims of violence, people suffering from malnutrition and diseases such as measles, diarrhea, cholera and meningitis, and also deal with occasional outbreaks of polio, Marburg disease and bubonic plague.

Life is especially precarious for those forced from their homes by the fighting. Conditions are most severe in eastern Congo, where rebel forces and other armed groups remain highly active. Unfortunately, continued offensives by armed groups make it extremely hard to reach affected civilians, who

have often fled deep in the bush where there is high insecurity and access is extremely difficult. MSF teams use all possible means to reach them, traveling through the jungle by motor-bike and canoe when necessary. The condition of the people is shocking: lack of food and health care, and extreme violence, including rape, continue to cause misery and loss of life on an unprecedented scale. MSF cares for displaced people in Kitenge (Katanga province) and Kitshanga (Nord-Kivu province); work in Sicotra IDP camp outside Kinshasa was turned over to an Italian NGO in March 2002.

MSF's support for health posts and hospitals in two dozen health zones also benefits the displaced, as well as local resi-

dents. In some areas, MSF provides the only medical service available. In Nord-Kivu, MSF is also running two therapeutic feeding centers and seven supplementary feeding centers.

Epidemics thrive in this environment of insecurity and collapsed health systems, and much of MSF's work in the DRC revolves around emergency preparedness and response with teams and stocks prepositioned in key locations throughout the country. In November and December 2001, MSF, in collaboration with the Ministry of Health and another NGO, responded to a meningitis outbreak around the eastern city of Bukavu with treatment and vaccinations. MSF teams worked on both sides of the front line in Katanga province when yet another cholera epidemic broke out in October 2001. By late August 2002, MSF had treated over 14,000 cases.

HIV/AIDS is a problem in Congo to which little attention has generally been paid. MSF runs a pilot program in Bukavu, providing voluntary testing and counseling, and treatment of sexually transmitted diseases (STDs) and opportunistic infections. Since 1995, similar programs have been in place in 22 health centers in the capital Kinshasa, 20 in Katanga province and 15 in Equateur province. Over the next year, MSF hopes to expand the Bukavu and Kinshasa programs to include antiretroviral treatment.

International media attention turned to DRC on January 17, 2002 when Mount Nyiragongo volcano erupted, destroying almost a fifth of the heavily populated town of Goma. MSF, already present there, participated in the response by providing clean water to people fleeing into nearby Rwanda. As they returned, MSF undertook a measles vaccination campaign for 87,000 children to prevent an outbreak in this already weakened population. MSF continues to monitor the region for signs of cholera, measles and meningitis.



Women and children returning home after a ten-hour day of strenuous agricultural work in the jungle and fields, Kitshanga, Nord-Kivu province, Democratic Republic of Congo, October 2001. Leaving the village is dangerous as they risk ambush and attack by rebel soldiers hiding in the bush.

Zambia | Assisting war refugees

- International staff: 16
- National staff: 183

MSF programs in Zambia focus primarily on refugees, who have arrived by the thousands from neighboring countries, particularly Angola. Some refugees from Angola returned home after the country's February 2002 ceasefire.

Angolans predominate in Maheba refugee camp near Solwezi, established in 1971. Together with local actors, MSF has been supporting health clinics and nutrition programs at Maheba since 2000, concentrating on those who have arrived since 1998. In January 2002, MSF began providing tuberculosis treatment; by early summer, 20 patients were being treated.

MSF also fights malaria in Maheba, and is documenting the efficacy and compliance rate for artemisinin-based combination therapy. In April 2002, the "Global Fund to Fight AIDS, Tuberculosis, and Malaria" announced it would grant money to Zambia to use artemisins (for more on efforts to improve malaria treatment see page 10).

Following the stabilization of the public health situation there in early 2002, MSF handed over activities in a refugee camp in Kala, northern Zambia, home to 25,000 refugees from Democratic Republic of Congo. In the west, MSF also handed over work in Nangweshi camp, home to 10,000 Angolan refugees, and now assists them at their point of entry into Zambia.

Integrated HIV/AIDS care continues in the northern district of Nchelenge, including voluntary testing and counseling, home-based care, advocacy and education. These activities are being expanded to reach refugees.

MSF has been in Zambia since 1999.

Chipindo feeding center, Angola, May 2002. Chipindo was isolated first because of the war and then because of heavy rains. Between November 2001 and March 2002, famine and disease caused the death of some 4,000 children under the age of six in this area.



Angola | Devastating nutritional emergency revealed as war ends

- International staff: 190
- National staff: 2,000

"We may sleep more soundly ... but we're dying of hunger."

Alfredo, displaced person in Bunjei

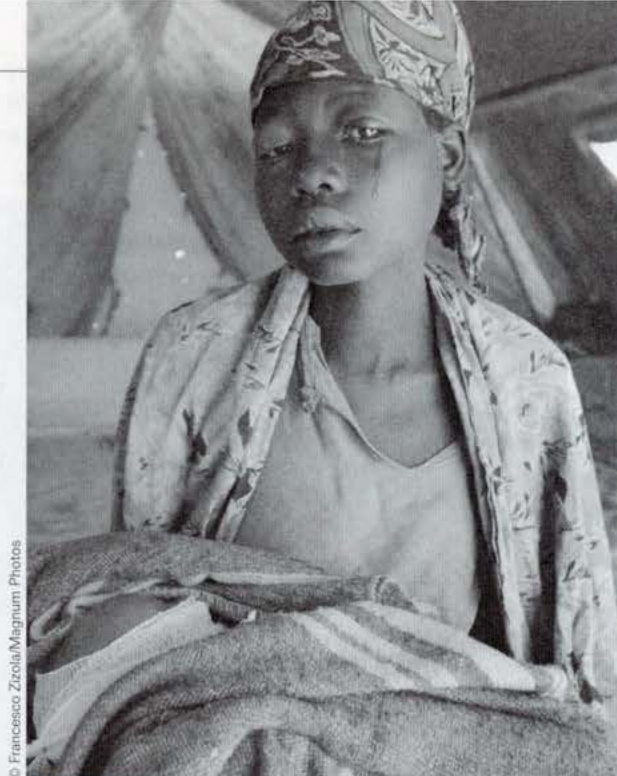
After 27 years of civil war, peace seemed finally to come to Angola in early 2002. The death of long-time rebel leader Jonas Savimbi in February paved the way for a ceasefire and subsequent peace agreement between the government and the União Nacional para a Independência Total de Angola (UNITA) rebels.

With the unexpected peace, however, a veil began to lift on hitherto inaccessible areas, revealing a devastating landscape peopled with hundreds of thousands of civilians who had been scorned and manipulated by both sides and deprived of humanitarian assistance for over three years. People emerged from these previously inaccessible "grey areas" – UNITA territory or inaccessible government regions, where control had been contested and fluid, and humanitarian assistance prevented – starving, shrunk, burying their children one by one.

The human catastrophe was compounded by the slowness of the Angolan government, the United Nations and many aid agencies and organizations to respond to the horrifying conditions when they began to become apparent. MSF, already working in eleven of the country's 18 provinces, saw immediate increases in the numbers of children admitted to its feeding centers, and began working around the clock to increase capacity and try to gain access to previously unreachable areas. After urgent calls for widespread action failed, MSF condemned the Angolan government and international responses as "shamefully slow and shockingly insufficient" and urged that more be done to prevent the deaths of thousands of people.

The starvation did not begin in spring 2002. Fighting in Angola's civil war resumed in November 1998 after an aborted peace agreement, and this new phase quickly became one of the cruelest periods in an already cruel conflict. Civilians caught in contested areas were specifically targeted and made hostages to the strategies of war. They were turned into slaves, forced to fight; their villages were burned along with their crops; they were taken by warring parties and used as "resources" to help win the war. They were subjected to systematic violence. Many were displaced from their homes time and again, either fleeing on the own or forced by the warring parties. Some reached provincial capitals; others spent long years in the bush or captive in military encampments. MSF estimates that up to 500,000 people were trapped in the "grey areas."

Access of humanitarian aid workers to the areas where



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■ *Susana Bimbi cries over the body of her dead son, Mauricio. They arrived at the MSF therapeutic feeding center in Kuito, Angola, the day before, but it was too late to save her baby. June 2002.*

this was all happening was denied from November 1998 until March 2002.

In November 2000 and again in November 2001, MSF had issued reports detailing conditions in Angola, based on testimonies of people in camps for the displaced and hospitals where MSF was working. And in early March, before the consequences of Savimbi's death began to be felt, MSF had gone before the United Nations Security Council to condemn to the "politicization of access" to people in need and the devastating health consequences of forced displacement of civilians.

Rapid assessments conducted by MSF revealed mortality rates well above emergency levels in most places evaluated. As of summer 2002, an in-depth evaluation of the situation in several areas was underway by Epicentre, MSF's epidemiological research center.

As the scope of the nutritional crisis was revealed, MSF stepped up operations, rapidly increasing the number of

feeding centers for both severe and moderate cases. Often it was a race to set up facilities to accept the truckloads of sick and starving children who were arriving from the bush (see excerpts of one MSF volunteer's diary, page 44). By July 2002, MSF was providing therapeutic (for severe cases) or supplementary nutritional treatment to 14,000 children at any one time in 44 feeding centers spread across 11 provinces. The relief operation became MSF's largest mission worldwide during 2002.

MSF continued to discover pockets of severe malnutrition throughout summer 2002. And while admissions to some facilities had begun to drop, MSF remained concerned about the situation in regions that, despite the peace agreement, had remained inaccessible to MSF and other organizations because of bad roads, lack of bridges, landmines. MSF was also worried that displaced people might be rushed back to their places of origin without the return being entirely voluntary, and without facilities and safety being verified.

Ongoing MSF activities already underway prior to the emergency work of spring and summer 2002 include running primary health care services for displaced people in camps and within several provincial capitals and towns, supporting hospitals and other health facilities, and treating the malnourished. MSF also provides care for sleeping sickness and tuberculosis patients, and has worked to improve surgery and maternity care in several provincial hospitals. These medical activities targeted both residents and displaced people, and were ongoing in the provinces of Bengo, Bie, Cuando Cubango, Huambo, Huila, Lunda Sul, Malange, Moxico, Uíge and Zaire, and the capital Luanda. During the nutritional crisis, work was expanded to previously inaccessible areas of these provinces and also to the province of Lunda Norte.

MSF has been working in Angola since 1983.

A humanitarian crisis of enormous proportions followed the ceasefire between Angolan rebel group UNITA (União Nacional para a Independência Total de Angola) and government forces in spring 2002. At locations across the country, hundreds of thousands of displaced people began to emerge from the bush where they had been trapped by the conflict, starving and isolated from health care. The following is drawn from a personal diary kept by Els Adams, MSF Project Coordinator in Malange, Angola.

Monday, May 20th

Not a very good start to the day. Alice, the critically ill ten-year-old girl who was brought in by her father yesterday, has died.

The father had walked through the bush for four days with Alice on his back. She was in an advanced stage of malnutrition, her whole body swollen with edema. Last night he looked at Marjan, one of our nurses, and pleaded, "Please do everything to save Alice. She's all I have left."

From his rags he pulled out a photo of his family – a young, healthy woman and six radiant children in their Sunday best. His wife and five of the children had already lost their lives.

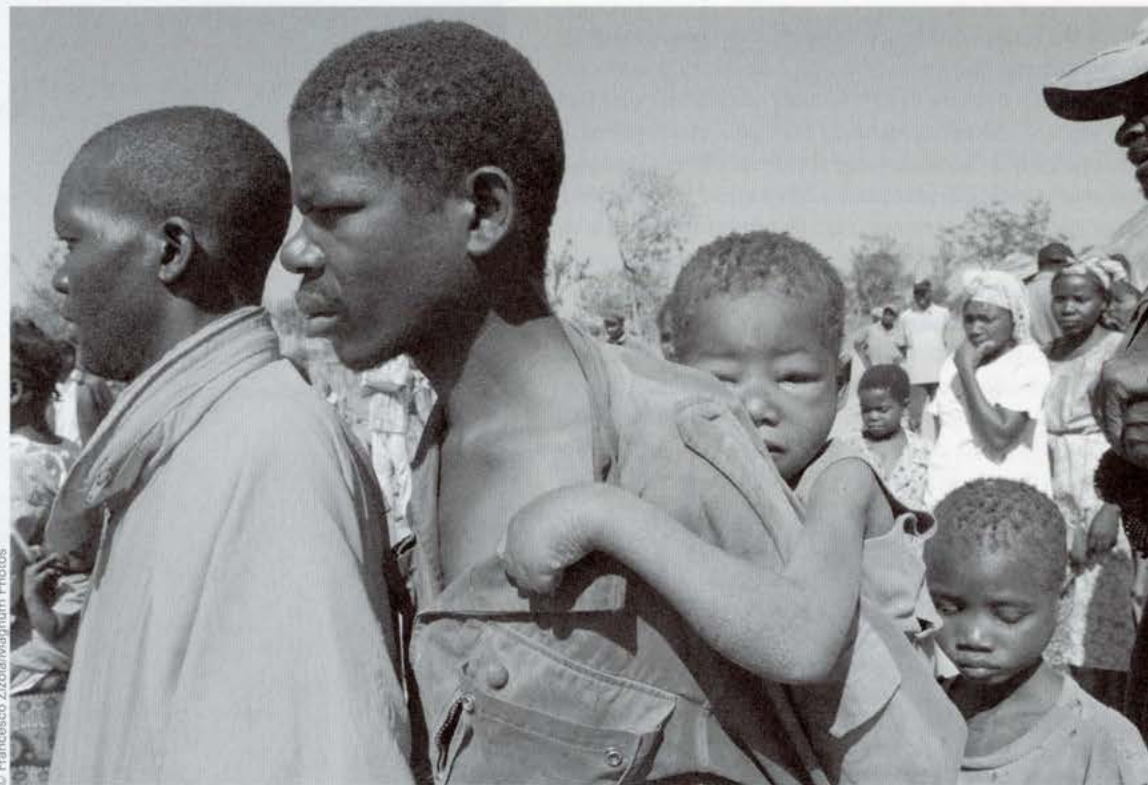
This morning Marjan and I are devastated when we hear that Alice hasn't made it.

Now that rebel leader Jonas Savimbi is dead and the peace process has started, more and more people are emerging from UNITA army bases in the bush. Our feeding center is being swamped with severely malnourished children.

I notice Marjan is looking tired.

Tuesday, May 21st

A sleepless night. I can feel the effects of the increased workload. Our feeding center is becoming overcrowded. I've been communicating to the MSF headquarters in Luanda the need for another feeding center. Fortunately, they give me the go-ahead today and Luis, my Angolan logistician, and I start looking for suitable premises. We find an old warehouse, strike a deal with the owner and start planning the preparations. We reckon we need around three days.



Wednesday, May 22nd

In the middle of the widespread euphoria about the peace process, we are starting to realize what went on in the bush during the years of war. The demobilization of the UNITA troops is part of the peace process. They are being concentrated with their families in special areas. There are two demobilization camps in Malange province. None of the aid organizations have been allowed in so far.

Ex-soldier carrying a severely malnourished child whose body is swollen with edema, UNITA demobilization camp, Gamba, Bie province, Angola, June 2002.

Child suffering from severe malnutrition, MSF intensive care center, Caala, Angola, May 2002.



© Sebastião Salgado/Amazonas Images

| At 3pm I receive a radio message asking me to go to the hospital right away. It sounds urgent, so I jump into the car. At the entrance to the feeding center I find a large group of seriously malnourished children, often with a mother who looks just as bad.

| We have to open the new center right away. The whole team, including the national staff, works throughout the evening. I am sure all of us collapse totally exhausted into bed, plagued by dreams full of malnourished children. But we have our new feeding center and I am proud of my team.

Thursday, May 23rd

| Nobody slept well. Everybody is shaken by the stories and the suffering. Again it is confirmed that just as many people are still in the bush, and in an even worse state. Help will come too late for them. And again, it transpires that almost all the mothers we speak to have recently lost one or more children.

| One woman tells me she lost four children in the month of April. Her two remaining children are in bad shape and I doubt if they will make it. Another woman buried her eighth and last child a few days ago. There are just no words for the suffering of these people.

Friday, May 24th

| Getting access to the demobilization camps becomes more and more of a priority. But this could be awkward, as they are in military territory. However, when I am invited

to a meeting [with commanders from both sides] at the military headquarters, we get the green light at all levels. The UN is as yet refusing to enter the demobilization camps because the national government has not submitted a formal request for aid.

| I drop by the feeding center this afternoon. I see children, whose eyes only a few days ago were closed by edema, starting to look around again. We can't save them all, but most of them will change gradually from sad, apathetic, sick children into lively and happy ones. I am sure this is what is giving the team such energy.

Saturday, May 25th

| At 9am we leave for the demobilization zone, about 50km away, driving past the burnt-out remains of trucks. Only a few

months ago it was impossible to drive here because of the risk of mines and ambushes. We are officially welcomed [to the demobilization camps] by a delegation who say they are in desperate need of our help. Children are dying every day. The army sends food for the troops but no one cares for the women and children.

| The children are waiting in a long row. I can't believe my eyes – so many children, each one in a worse state than the next. Our lorry filled to overflowing, we radio ahead that we are on our way, so the team is ready to take charge of the children. The new feeding center is already filling up.

| Tonight I tune in to Radio Netherlands. I hear reports of political wrangling surrounding the upcoming elections and a general sense of dissatisfaction in the Netherlands. Sometimes home seems very far away.

Zimbabwe | AIDS emergency declared

- International staff: 4
- National staff: 10

The impact of the HIV/AIDS pandemic in Zimbabwe is overwhelming, with 2 million (or one-in-three) adults infected. In May 2002, the government declared a national emergency and became the first country to override patent protection on brand-name drugs to allow use of generic versions to treat AIDS, in line with the Doha Declaration (see page 19). MSF fully supports this action to secure more affordable antiretrovirals.

Since late 2001, MSF has working to implement a program targeting mother-to-child transmission of HIV in Bulawayo, the country's second largest city.

Ongoing tensions in rural areas forced MSF to suspend its HIV/AIDS program at the Inyathi hospital in Bubi district in Matebeland North province in September 2001.

With a food security crisis looming, MSF began training local staff in therapeutic and supplementary feeding in Tsholotsho in Matabeleland North in July 2002.

MSF first worked in Zimbabwe in the 1980s.



South Africa | Generics widen access to AIDS treatment

- International staff: 6
- National staff: 12

"We today invite you to visit Khayelitsha and meet with us, so that you can hear firsthand from us, people taking antiretroviral therapy, that these medicines are not poisonous and that they help"

From an open letter to President Mbeki from AIDS patients on antiretroviral therapy in Khayelitsha, February 2002

An estimated 5 million South Africans now live with HIV/AIDS. National policy has focused on prevention; and antiretroviral (ARV) medicines, which can prolong and improve quality of life for AIDS patients, have been prohibitively expensive.

Already treating patients with brand-name ARVs since May 2001 in its HIV/AIDS program in Khayelitsha township, in Western Cape province, MSF began to import generic ARVs from Brazil in late 2001. Switching to generics meant the program budget could meet the cost of treatment for twice as many people as anticipated. By early summer 2002, 170 patients were receiving ARVs. Patient compliance is good and the survival rate has been 90%, even though most patients were at an advanced stage of the illness when entering treatment.

In a dramatic policy shift, in April 2002 the South African government announced it would immediately begin to supply ARVs (which it had previously characterized as "toxic") as post-exposure prophylaxis for rape survivors in public health facilities. The government also promised to start treatment to prevent mother-to-child transmission of HIV (MTCT) in all public health facilities by the end of 2002. MSF is closely monitoring this to see if the government delivers on its promises.

Thanks to a pilot MTCT program at Khayelitsha, MSF estimates it has already prevented several hundred babies from being born with HIV. In addition, up to 1,500 HIV-positive people seek consultations for HIV-related infections each month in MSF's three clinics.

MSF began HIV/AIDS work in South Africa in 1999.

Madagascar | Support to street children and juvenile detainees

- International staff: 5
- National staff: 55

Madagascar plunged into political and economic crisis after disputed presidential elections in December 2001, worsening already tough living conditions for many Malagasies. Against this background, MSF continued its work with children in difficulty.

In the capital Antananarivo, MSF moved two medical and social support centers for street children into independent premises in Andravoa-hangy and Anosibé districts, and re-opened a third one in Isotry district. Each center has a multidisciplinary team composed of a doctor, nurse, social worker and youth leader. Two legal advisers also work with MSF to document the children's medical, social and legal histories, including records of any abuse against them, and to ensure their civil status is recognized. More than 2,500 street children now receive regular medical and social follow-up through the program. Some of them are referred on to a network of doctors providing free medical care under MSF supervision.

MSF also works with children held in three juvenile detention centers and a prison. The main focus this year was on improving the sanitary conditions. A court ruling in late 2001 gave an encouraging signal that the law would uphold juvenile detainees' rights to safety and protection.

The medical program for street children in Antsirabe was handed over to local actors in December 2001. Food aid reserves from a nutritional program in place since the 2000 cyclones was shared out to malnourished families when the program closed in mid-2001.

MSF first worked in Madagascar in 1987.

Malawi | HIV/AIDS programs overcome cultural taboos

- International staff: 13
- National staff: 94

"Sure, the treatment is difficult, and it's a long way to the hospital. It takes me three hours on foot to get there, every week. But it's better than dying."

Fred, 42, a farmer, on getting antiretroviral treatment

As a result of the AIDS epidemic, life expectancy in Malawi has fallen to 41 years. Since 1990, MSF has provided integrated HIV/AIDS care, including voluntary counseling and testing, programs to prevent mother-to-child transmission of the virus, treatment of opportunistic infections, and education. In summer 2001, MSF began treatment with antiretroviral (ARV) medicines (see page 89 for more on MSF's ARV projects around the world).

Pilot antiretroviral program

MSF launched a pilot antiretroviral treatment program in the rural district of Chiradzulu in August 2001. By June 2002, over 140 people were receiving these life-extending medicines. Together with the local community, MSF has created an admissions committee to participate in decisions regarding access to the program. By fall 2002, 70 new patients are to be included in the program each month. The program will also be extended to children.

An integrated approach to HIV/AIDS in Thyolo

Home-based AIDS care continues in the southern district of Thyolo, where MSF has an integrated, multi-sector program that includes education and prevention in high-risk groups and treatment of related diseases. MSF treats approximately 300 tuberculosis patients per year in Malawi and over 75% are also HIV-positive.

In March 2002, MSF expanded the program in Thyolo to include prevention of mother-to-child transmission of HIV. This program provided prenatal counseling for more than 800 women in its first month, with 90% accepting voluntary testing for HIV, an extraordinary number in a country where HIV/AIDS is not discussed openly.

Cholera epidemic

Beginning in November 2001, MSF also responded to a cholera epidemic that swept Malawi. Under control by March 2002, the epidemic resulted in over 20,000 cases. MSF is also monitoring the nutritional situation in Malawi.

The first MSF project in Malawi took place in 1986.



© Sebastian Charles

Mozambique | Reducing transmission of HIV/AIDS to babies

- International staff: 24
- National staff: 181

The HIV/AIDS epidemic has devastated this southern African country, where over a million or 13% of adults aged 15 to 49 are HIV-positive. In 1999, the government designed a national strategic plan to fight the disease. However, three years later, few of the plan's ambitious intentions have been realized. MSF projects in Mozambique are focused essentially on the AIDS crisis.

Through clinics, hospitals and home visits, MSF provides comprehensive HIV/AIDS care in Maputo, Niassa and Tete provinces. Services include voluntary testing and counseling, treatment of opportunistic infections, and education and prevention. By mid-2002, MSF had begun using antiretrovirals to prevent mother-to-child transmission of the virus in Maputo and Tete; and was looking at expanding their use for wider indications.

In Niassa, MSF work is centered on voluntary counseling and testing for AIDS as well as detection and treatment of AIDS-related infections in the provincial hospital in Lichinga. In the capital Maputo similar activities are carried out in several health centers. In February 2002, MSF opened a new HIV day clinic in the hospital in Tete town.

Cholera continues to be a problem in Mozambique, and MSF is helping improve water and sanitation facilities in Maputo, Zambezia and Niassa provinces. A cholera alert and response system, which includes 14 cholera treatment centers, was recently established. In January 2002, MSF provided care during a cholera epidemic in Tete province.

MSF first worked in Mozambique in 1984.

■ AIDS patient following antiretroviral treatment through MSF's HIV/AIDS program at Khayelitsha township in South Africa, January 2001. Treatment is helping to extend and improve the quality of her life. The "Did I take my dose today?" calendar reminds her to stick to the schedule for taking the drugs.





Palestinian woman and child leaving the Abraham Mosque under the gaze of an Israeli soldier in Hebron's H2 zone, December 2001. The zone has been under Israeli military authority since the 1993 Oslo Accords. Life is always very tense for its 40,000 Palestinian residents, who are subjected to repeated curfews.

Yemen | Free medicines for Aden's poorest

- International staff: 8
- National staff: 30



The financially driven reform of the national healthcare system, begun in 1997, has failed to improve access to quality medical care in Yemen, one of the poorest countries in the Middle East. The emphasis on cost-recovery (through charging patients for medicines) prevents many Yemenis from seeking the medical care they need. Trained medical staff and essential medicines remain in short supply.

MSF works with local authorities in Aden Governorate to improve primary medical care within the framework of the healthcare reforms. From 1997 to October 2001, it supported 12 healthcare facilities in this southern region. After completing program objectives in seven of them, MSF rechanneled its efforts to support one polyclinic and four dispensaries in the semi-rural suburb of Little Aden, on the outskirts of the city. Working with local medical staff to improve the quality of consultations, nursing care, and maternal and infant follow-up is a major part of MSF's work at these five facilities.

Since late 2000, MSF has run a pilot scheme exempting destitute and very poor people from paying for medicines in Aden's main polyclinics. It eventually hopes to hand this program over to the Ministry of Health.

MSF has been present in Yemen since 1987.

Palestinian territories | Open wound

- International staff: 10
- National staff: 22

The cycle of disproportionate use of force by the Israeli army and indiscriminate suicide bombings by Palestinians abruptly escalated in early 2002, devastating civilians on both sides. Palestinian cities have been repeatedly occupied, leaving many neighborhoods in ruins and severely limiting people's access to clinics and hospitals. Daily life for many Palestinians has become intolerable. Repeated humiliation, military assaults and restrictions on movement have demoralized and terrorized people living in constant threat of violence. In September 2002, MSF published "Palestinian Chronicles: Trapped by War," a group of articles and testimonies detailing the deteriorating conditions and suffering of Palestinian civilians in Hebron and the Gaza Strip since the Al-Aqsa intifada (or uprising) began in September 2000 (see page 52 for excerpts).

In spring 2002, MSF adapted its ongoing projects to the crisis. Lack of access had become the most serious obstacle to medical care. Curfews and roadblocks made it increasingly difficult to travel, and many hospitals and clinics began to face shortages of medicines and vaccines. Medical workers were prevented from reaching their workplaces and patients were unable or too fearful to leave their homes to seek treatment. MSF teams assisted in the delivery of essential medical supplies and in many cases helped bring patients to health facilities when there was no other way.

In one instance, an MSF team waited for five hours before being allowed to enter the village of Yatta to pick up wounded civilians. After finally picking up the two boys who had been shot, the MSF vehicle was stopped again and the wounded were carried out of the car and searched. In other incidents, Israeli tanks have destroyed ambulances and targeted Palestinian health facilities. MSF has spoken



■ MSF home visit with a family living 500m from the Dabboya settlement in the occupied Old City, Hebron, June 2001. Originally a mechanic, the father has been reduced to working as a juice vendor despite a ban by the Palestinian city police, who accuse the pushcart vendors of disrupting traffic. Financial worries add to the psychological strain of life under occupation.

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out through numerous press releases about these serious obstructions of medical activities and has condemned the increasing attacks against medical providers as a violation of international law.

| In April 2002, MSF was able to enter the district of Jenin, which had been cut off during the month-long occupation by the Israeli army. MSF provided medicine and medical material to a public hospital there, and assisted Palestinian health workers with the transport of medicine and vaccines in Jenin, Tulkarm and Nablus.

| A large part of MSF's work in Hebron and the Gaza strip, ongoing even before the escalation of the crisis in spring 2002, has been to provide medical, psychological and social assistance to people living close to Israeli settlements, army installations and checkpoints, where they are subjected daily to machine-gun fire and restrictions on movement and often have tanks parked outside their door. Doctors and psychologists visit families in their homes, providing treatment and referrals.

| MSF also aids Bedouins in the region of Yatta and in several villages in the district of Hebron.

| MSF has been working with Palestinian civilians since 1988.

In September 2002, MSF released the "Palestinian Chronicles: Trapped by War," a collection of articles and diary entries documenting the plight of Palestinian civilians trapped by conflict in Hebron and the Gaza Strip, and whose suffering is generally unknown. Written by MSF doctors and psychologists, the *Palestinian Chronicles* chart the psychological consequences of living under the continual threat of violence. The following excerpts are taken from the sections "Put to the test" by Dr. Jean-Hervé Bradol, President, MSF-France and "Palestinian interior." The *Palestinian Chronicles* are available in full at www.msf.org

| Houses razed to the ground, ravaged strawberry fields, olive trees torn from the ground, blocked roads with figures moving like shadows, watchtowers, assault tanks, small military fortresses made of concrete. Gaza is like a vast open-air detention center, watched from land, sea and air.

Sinister Dialogue of the Deaf

| In the West Bank, too, the Palestinians are hemmed in. They cannot travel to Israel and it is extremely difficult to move from one town to another. The hundreds of civilians killed since the beginning of this phase of the conflict offer confirmation that, as the desire to separate grows stronger, each side sees less of the other, and the death toll climbs higher.

| In Israel, every daily act is accompanied by the fear of being the victim of an attack or of losing a close relative. At any moment, terror can wreak havoc upon day-to-day life.

| It is like some sinister dialogue of the deaf, where a good reason is always found to justify the death of people who share no responsibility for the clashes.

| The invitation to join one side or the other is accompanied by an obligation to collude with criminal forms of violence. Two examples of this are the deadly attacks against Israeli civilians and – less spectacular but ultimately more lethal – the Israeli army's shooting of Palestinian civilians. If humanitarian action is to be effective, it must detach itself from political positions that seek to manipulate people's various origins, their spiritual beliefs and their suffering; that invite people to deny the humanity of the adversary; and that reduce an entire people to a single figure: whether terrorist or settler.

An order created by the violence

| Usually it is the relief that MSF provides to the wounded, to the starving, and to exiles living in conditions of desperate poverty that occupies our teams in countries at war. Here, displaced people and refugees make up the majority of a people that has lived in exile for decades. They have had time to learn how to care for their wounded and their sick and to establish a public health policy.

Palestinian man and child, three days after the liberation of Jenin in April 2002. This is the site of their family home, which was destroyed during the month-long occupation of Jenin by the Israeli army.



© Philippe Conté

Palestinian interior: Life in Gaza and Hebron, November 2000-October 2001

They receive considerable help from abroad. On the Israeli side, the resources are there to care for wounded soldiers and bring assistance to civilians who are victims of attacks. A permanent order created by the violence.

Palestinians in these districts must face constant grief, physical and psychological injury, and arrests, and live in a state of growing destitution caused by the economic blockade. These are the people with whom we work in the Gaza Strip and Hebron. We bring medical, psychological and social assistance to their homes, which have been transformed by the fighting into a frontline.

Humanitarian resistance

MSF has been working in the Palestinian territories for nearly ten years. Every day, our doctors and psychologists witness the profound trauma suffered by the Palestinian people. Even if MSF's presence in this crisis is not as great as it is in Angola, Chechnya or Afghanistan, that does not mean that the suffering of the Palestinian people is any less intense. Assistance to those affected by armed conflict is never a matter of simply providing food and shelter or healing bodies: only the key players involved can determine what can be tolerated, in terms of offense to human dignity.

As it attempts to seal off the population of the West Bank, the Israeli government is also trying to pressure humanitarian organizations to become the social workers of an oppressive system designed to imprison an entire people. The Palestinian people's capacity has been sorely tried. Now it is the independence of foreign aid workers that will be put to the test.

Cut in half – Beit Hanoun, April 2001

Beit Hanoun is a region in the northern Gaza Strip at the Israeli frontier. Last night, bombings followed mortar fire. The *haji*, the leader of the family, comes to meet us. His hands tremble and his voice catches. He tells us about the night he's just experienced. With each explosion, the house seemed to leap from its foundations and then fall back down. He hasn't slept. This morning, he learned that a youth from the district was literally cut in half by a missile. He keeps repeating, "Cut in half."

Thinking about bullets – Tufah, March 2001

Hania, 14, had been in front of her house when she was suddenly racked by pain. Her sister asked what happened and saw Hania bleeding. The two girls ran to an ambulance nearby. Hania still has a bullet in her back. She thinks the Israeli soldiers might be able to find her, wherever she is.

What about the children? – Netzarim, November 2000

We returned to Al Muragah and met a woman in her forties who was visibly exhausted and troubled by persistent anxiety. She no longer sleeps and eats very little. Her expression is sorrowful and her exhaustion shows. "What will happen to the children if I die?"

Like an enormous earthquake – Tufah, April 2001

A man is erecting a tent on a pile of rubble. He explains how the bulldozers came to his house. The tanks were firing constantly. Hidden in a bedroom with his children, he saw the engine attack the front rooms. He tells us that the children were crying as the machine headed toward the neighbor's house. I ask him why he is raising his tent on the ruins, exposed to the gunfire. "Where will I go?" he answers.

Netzarim, November 2000

[There is a] sentence that people, especially the elderly, repeat often: "They are going to kill us, we are all going to die."

Patients also voice the hope that we will bear witness to what we see and hear: "Do people where you live really know what we're going through?"

Hebron, March 2001

I visit the home of a nine-year-old child who is unable to sleep, cries out for his mother at night and has become agitated. His mother doesn't know how to calm him. Her house is occupied and Israeli soldiers are stationed on her roof.

"In the beginning we were terrorized and we couldn't sleep. The soldiers leave their mess behind, they urinate in front of our windows. It was never like this before, even during the [first] intifada [1987-93]. They fire heavily now, whenever they want, just like that, to play games, for nothing. We don't know what's going to happen."

Hebron, March 2001

We conduct a visit in Abu Sneina district, located on a hillside facing the Qiryat Arb'a settlement, which was rocked several days ago by violent bombing and strafing. Bullets and missiles woke the family in the middle of the night, breaking windows, tearing through walls. They were all pinned to the bedroom floor, terrorized and waiting to die. A 12-year-old was wounded in the head and lost a lot of blood. The child himself removed the metal fragment from the wound. They couldn't call an ambulance. Crying, her legs shaking, the mother had to give first aid. The other children sobbed next to her, clinging tightly to her.

Gaza Strip, July 2001

We meet with a family whose roof has become a permanent base for Israeli soldiers.

"The soldiers have done everything to make us leave but I'm still here," the father says, proudly. "This is my home. But they've stolen my life and my dignity."

Italy | Focused support for female asylum seekers

- Paid staff: 11

| In Italy, MSF works to assist immigrants and asylum seekers, many of whose situations have worsened since the establishment of the new government in 2001. Budget cuts have left several associations without the means to open new reception centers or sheltered accommodation. More worrying still is the adoption of restrictive legislation empowering regional authorities to expel asylum seekers immediately and without access to legal defense.

| MSF began assisting refugees, asylum seekers and undocumented immigrants in Brindisi in November 1999, and opened a reception center for them there in February 2001. Originally for both sexes, the center now focuses exclusively on support to vulnerable female foreigners. The deci-

sion to change its mission was taken because 85% of the people taken in since it opened were women, many of them escapees from prostitution networks. MSF has also reached an agreement with the Brindisi health authorities for public health centers and hospitals to provide health care to all the users of the MSF facility.

| MSF is starting a medical program for refugees and asylum seekers arriving at Lampedusa island, 200km south of Sicily, in September 2002.

| In Rome, MSF is currently reorienting its program, with the aim of improving health dispensary access for vulnerable foreigners.

Belgium | Health centers running at full capacity

- Paid staff: 16
- Volunteers: 30

| MSF's ongoing projects in Belgium are designed to increase access to health care, whether the barriers to this are administrative, cultural, psychological or financial.

| Over the past year, some 3,100 disadvantaged people, asylum seekers and refugees have sought medical help at MSF "Access to Healthcare" centers in the capital Brussels, Liège and Antwerp. Running at full capacity, the Brussels and Antwerp centers have been forced to limit the number of consultations per session.

| The program was created in 1991 to provide medical support for destitute or homeless Belgians. However, 92.5% of the people now attending the centers are recently arrived asylum seekers and migrants without legal status.

| Many need psychological support to overcome trauma experienced in their home countries or due to their uncertain residency status in Belgium. MSF provides diagnosis and treatment by doctors, complemented by a social orientation to enable patients to seek further treatment autonomously and by initial psychological counseling for those who need it most. Translators help to provide this in the patients' mother tongue where possible, with Russian and Arabic most in demand.

| Since 1998, project "Mporé" has provided psychological support for survivors of the 1994 Rwandan genocide living in Belgium. The project became part of a new non-profit organization, "Ulysse," in late 2001.

| MSF's "Elisa" center in Brussels, which opened in 1988, offers free, anonymous HIV-screening with counseling.

| MSF began working in Belgium in 1987.

Despairing asylum seeker, Belgium. Many refugees and asylum seekers need psychological support to overcome trauma experienced in their home countries or due to uncertain residency status in their country of refuge.



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France | Assisting the young and marginalized

■ Paid staff: 34

| Access to health care remains a central issue for MSF's work in France. Current programs in Paris, Lille and Marseilles provide medical care and social support for underprivileged young people, immigrants and drug addicts.

| In Paris and Lille, MSF assists young people living in marginalized communities or on the street. MSF refers patients who are most at risk to their refuges in Lille and at Clausmatt in Ribeauvillé, Alsace.

| In l'Etang de Berre, on the outskirts of Marseilles, MSF provides medical care and social protection to children and adolescents from immigrant families living in near isolation far from the city center, without transport facilities or social structures. To better meet their needs, MSF is developing a telephone interpreting service to ensure accurate communication of technical information between non-French speakers and medical and social workers.

| In September 2001, MSF launched an orientation program in Marseilles to raise foreigners' awareness of their entitlements to health care and social rights.

| MSF's work with drug addicts continues in several districts of Paris. Those who seek treatment receive not only medical and social care, but are provided with sterile injection materials in a "steribox." These are also on sale in pharmacies and in vending machines.

| MSF continues to be active on a wide range of legal issues, from the French government's methods of dealing with asylum applications to a push for new European-wide legislation on the rights of sick people arriving in Europe from abroad.

| MSF has run programs in France since 1986.

Luxembourg | Integrated approach to drug addiction

■ Paid staff: 4

| Luxembourg's reputation as a small but prosperous country conceals many of the psychosocial and relational problems, such as drug addiction, commonly found in Western societies where traditional values are changing.

| MSF, in cooperation with other NGOs and state agencies, has run a support program, "MSF – Solidarité Jeunes," for under-age drug abusers since 1997. The psychologists working in the program offer support to these young people and their families and communities based on the premise that drug abuse among young people often is a reaction to deeper personal, family or social problems.

| Emphasis is also placed on efficient collaboration with all institutions and authorities who work with young people, such as schools, foster homes, legal authorities, psychosocial and family services. The key objective is to coordinate the work of the different services involved so as to approach the problem of drug abuse in a holistic way.

| The program has expanded considerably since it was launched, with the team providing psychological and therapeutic care to 195 young people in 2001. Other work includes providing support to psychosocial workers and educators, and organizing training sessions and conferences to enhance professional skills and promote a "common culture" of case management.

| Expanding work in schools and strengthening collaboration with the judiciary and youth services were also important emphases this year.

Spain | Denouncing refugee detention conditions

■ Paid staff: 27
■ Volunteers: 15

| MSF's programs in Spain try to aid vulnerable people with little access to health care, including undocumented immigrants and drug addicts.

| Two programs in Barcelona and Madrid – including a mobile primary care and needle exchange outreach project for drug addicts in Barcelona, and psychological support and tuberculosis (TB) treatment for immigrants in Madrid – were completed and evaluated in early 2002. Several new programs are set to begin in late 2002, including public health follow-up to the TB project and research on future needs in Madrid, and a new intervention in Ceuta, a Spanish department on the north coast of Morocco (see page 16). MSF has been studying the situation of unaccompanied, undocumented children in need of protection in Ceuta.

| Some of society's most vulnerable continue to be those without legal status. In January 2002, MSF drew attention to the plight of detainees at Fuerteventura airport in the Canary Islands, where undocumented immigrants, most from Africa, were being held. Around 500 people were living in less than 2,000m² with only two showers and three toilets. With no ventilation, minimal water and sanitation facilities and inadequate medical care, the old airport was clearly unsuitable even as temporary housing. MSF denounced the situation and called on the authorities to find an appropriate solution. By May 2002, some female detainees had been moved to a new detention center, but many people remain.

| MSF has carried out programs in Spain since 1994.

Having been the only international aid organization to witness the 1995 Srebrenica massacre, MSF has repeatedly called for independent and thorough inquiries into the tragedy. In 2001, MSF presented testimony at the French Parliamentary Hearing into the Srebrenica tragedy. In April of 2002, MSF submitted "Srebrenica: Questions for the Future" to the Netherlands Institute for War Documentation (NIOD) asking that the institute's independent inquiry into the events clarify key questions. Excerpts from the report are below. The full document can be found on www.msf.org.

On July 11th 1995, the east Bosnian city of Srebrenica fell into the hands of the Bosnian-Serb army. This resulted in a mass exodus from the enclave; approximately 7,000 men have since been killed or are missing.

The people of Srebrenica lived in a "safe area" as labelled by the United Nations. They were convinced that those same UN forces that carried the word "protection" in their name would protect them: UNPROFOR (United Nations Protection Force). The UNPROFOR battalion in Srebrenica at the time of the fall was the Dutch battalion, Dutchbat.

As the only international aid organization with international staff in Srebrenica at that time, MSF witnessed the panic and fear of death amongst the population dur-

ing the fall of the enclave and the days that followed. MSF witnessed the international community's failure to act, which resulted in the deaths of many thousands of people. The fact of our presence bearing witness to events provides us with the responsibility to demand total disclosure of the facts.

The international community and the Dutch parliament must never again allow people in conflict situations to be deluded by a false sense of security; they must never again allow their soldiers and humanitarian aid workers to be placed in such an untenable position; they must put the lessons from "Srebrenica" into practice to promote real protection of civilians and prevent crimes against humanity.



The international community failed to defend Srebrenica's civilians from deportation or execution by the Bosnian-Serb army in 1995 despite the enclave's status as a "safe zone."



Roma children at play in Faculteta suburb, Sofia, Bulgaria, April 2002.

Bulgaria | Stemming spread of STDs and HIV/AIDS

- International staff: 3
- National staff: 25

Bulgaria's healthcare system is in transition. General practitioners are now paid according to a managed care model, and most hospitals are being transformed into commercial companies. Because of the economic situation, access to care is difficult for many people, particularly for the poor and ethnic minorities.

MSF started work in Bulgaria with the distribution of drugs in hospitals during the economic crisis in 1997. MSF then decided to focus on sexually transmitted diseases (STDs) because it noticed a tendency to prescribe unnecessarily high quantities of drugs due to outdated treatment protocols from the Soviet era.

In the capital Sofia, MSF treats patients with STDs and carries out HIV/AIDS prevention and counseling. Emphasis is on raising community awareness of STDs and HIV/AIDS. For better outreach towards at-risk groups, a mobile unit is being set up in addition to the existing clinic.

In 2002, a research program involving 400 women with vaginal discharge is being used to confirm STD treatment protocols that put less strain on the patient (fewer exams, shorter hospitalization) than those traditionally used. The protocols will later be promoted at the national level.

In the town of Targoviste, MSF runs a primary healthcare program for the marginalized Roma and Turkish minority peoples. In mid-2002 a similar project began in the Sofia suburb Faculteta, home to 80,000 Roma.

MSF has been working in Bulgaria since 1997.

Romania

MSF welcomes medical insurance for homeless

- International staff: 1
- National staff: 25

New social legislation paving the way for homeless people to obtain free medical insurance came into force in Romania in January 2002. Supported by MSF, this step marks a milestone in a five-year effort to improve medical care and access to services for the country's many homeless people, particularly those in the capital Bucharest.

Since 1997, MSF has provided medical and social aid at a drop-in center for the homeless as well as medical follow-up at a night shelter in Bucharest. In recent years, the program also included a strong lobbying component on behalf of these often-ignored people.

Following the introduction of the new legislation in January, MSF has turned its attention to monitoring how the new law is implemented. MSF is encouraging the creation of new services for the homeless via government social departments, and helping homeless people to access these services as they become available. There is also an ongoing effort to find general practitioners who are willing to add homeless people to their patient lists. At the same time, MSF is continuing medical support to the drop-in center and night shelter.

Attempts to develop a primary healthcare program in neighboring Moldova have been discontinued for the present.

MSF has been working in Romania since 1990.

Ukraine

Pushing for generic drugs to treat AIDS

- International staff: 4
- National staff: 28

In May 2002, MSF criticized an agreement between the Ukrainian government and four pharmaceutical companies to discount antiretroviral (ARV) medicines. Under the accord, brand-name AIDS treatment, although less expensive than before, will continue to be six times more costly than generic medicines. MSF, together with an Ukrainian NGO, has called on the government to allow generic ARV drugs in the country, where an estimated 250,000 people are living with HIV/AIDS.

MSF provides HIV/AIDS support for mothers and children in Odessa, Mikolayiv and Simferopol, where HIV incidence is the highest in the country. Preventing HIV transmission between mothers and children is a priority, and more than 300 mother-child pairs were involved in the program by July 2002. Transmission rates have dropped from 30% to 13% since the project's inception in November 2000.

In April 2002, MSF started treating HIV-positive babies at high risk of developing full-blown AIDS with ARV therapy to help them fight the disease. MSF will widen ARV treatment if generic drugs are registered.

Peer support is an important part of the MSF program. HIV-positive mothers, some with infected babies, provide counseling for women in the clinics before and after HIV testing.

MSF also supports the AIDS hospital in Odessa by providing antibiotics and other medicines.

For World AIDS Day 2001 (1 December), MSF held a photo exhibition in the capital Kiev in collaboration with the NGO "AIDS Foundation East-West."

MSF has been in Ukraine since 1999.

Yugoslavia

Short-term emergencies and long-term trauma

- International staff: 7
- National staff: 40

Although Serbia is now benefiting from more financial aid and debt cancellation in return for greater cooperation with the United Nations International Criminal Tribunal, the economy is far from recovery and over half the population lives either on or below the poverty threshold.

Some 30,000 out of the 700,000 refugees and internally displaced people in Yugoslavia live in very poor conditions in collective centers. MSF has been helping the most vulnerable such families in Pcinja district to find private accommodation and access social services.

In April 2002, MSF provided emergency disinfectants and hygiene kits for some 1,500 households in Petrovac following flooding in Pomoravlje county. An earthquake in southern Kosovo in the same month also led to emergency intervention. The MSF team paid special attention to the mental health of quake victims already suffering from war-related trauma. This resulted in a booklet aimed at relieving stress related to the aftermath of the earthquake and preparing people mentally for new tremors and/or quakes.

Mental health among Kosovars was also the focus of a program running from June 1999 to February 2002 in Pejë/Pec. This provided consultations for people suffering from post-traumatic stress in villages badly affected by war. Attendees were mainly children, teenagers and women – with cultural barriers preventing female rape victims and men in general from seeking help.

MSF has worked in Yugoslavia since 1991 and in Kosovo since 1993.



The "fight against terrorism" continues in Chechnya. In January 2001, MSF released a report about the Russian authorities' neglect of Chechen civilians in Chechnya and neighboring republics. The following is taken from the report, which can be found in full at www.msf.org

Since the resumption of war in Chechnya in 1999, MSF has repeatedly denounced the conduct of Russian and pro-Russian forces toward Chechen civilians. Testimonies gathered by MSF staff working in Chechnya and neighboring Ingushetia and Georgia have illustrated the arbitrary and violent nature of treatment meted out to civilians in Chechnya as a result of the "fight against terrorism" being waged by the Russian authorities.

Conditions in Chechnya: An open air prison

The violence of the conflict, the Russian repression and the assimilation of civilians with the actions of the rebel groups make every civilian a potential victim. Men from 15 to 50 years of age are the most threatened, and the random violence and risks to which they are exposed often oblige them to flee or join ranks with the soldiers. Far from improving, this situation has continued to deteriorate. Since September 2001, the resumption of bombing, rocket fire, and the danger of stray bullets have forced many Chechens to spend most of their time seeking safety in their cellars, like rats. In Chechnya, horror is a part of daily life.

Last year, Russia officially and publicly invited aid organizations to assist with the reconstruction of Chechnya, presenting their request to MSF in March 2001. Since that time, however, the prevailing climate of insecurity coupled with the unreasonable pressures exerted on NGO independence by Resolution 22 has made access to Chechnya more and more difficult and hazardous.

Aminat, age 23 – Logobaz, Nazran

She is six months pregnant:

"I have been here for a week and I'm sick! There were terrible bombings on Argun on October 8th and 9th, so I came here. I couldn't stand it there anymore, my husband was taken in



© Alexander Givadelov

a cleansing operation seven months ago, he had no papers, and I haven't heard from him since."

Ingushetia: The "invisible" displaced Chechens

MSF is extremely aware and concerned about the inability of aid organizations to handle the needs of the tens of thousands of newly arrived displaced Chechens in Ingushetia, many of whom are living in *kompaknikis* or squats, with little or no assistance. The deplorable conditions for displaced Chechens in Ingushetia, their inability to get registered and receive assistance, and the threats and pressure on them to return to Chechnya may also deter people in need of safety and assistance from seeking refuge there.

Khouzimat, age 101 – Sleptsovskaya

She lives in the corner of a barn at Bogatyr:

"I haven't gotten anything for three months. Fortunately, the neighbors bring me a dish of food at night. And I bake bread outside."

These displaced Chechen children live in a collective occupying a disused restaurant, Malgobek, Ingushetia, November 2001. They may have a roof over their heads but the trauma of war and displacement runs deep.

Ingushetia: A strategy of minimal assistance to the displaced

The inadequate level of "assistance," according to the Russian President's Representative for Human Rights in Chechnya, Vladimir Kalamonov, is the result of an administrative game of tag. MSF remains skeptical that simple bureaucratic and organizational problems are the real cause of the delay in providing assistance to the displaced Chechens.

During 2001 the Russian authorities increased the direct pressure on the displaced Chechens in Ingushetia to go home by publishing false reports about the amounts of aid offered in Chechnya.

Russian Federation | "Total war" in Chechnya and ten years for homeless program

- International staff: 39
- National staff: 309



In the new political context of the "international war on terrorism", Russian operations in Chechnya are seen in a more tolerant light by sections of the international community. Three years of the Russian army's "anti-terrorist" operations have taken their toll: people remaining in this conflict-scarred republic continue to live with daily terror and violence. The last year has also failed to bring about better conditions for the hundreds of thousands of Chechens seeking refuge in neighboring republics. MSF continued to provide medical assistance to Chechens in the north Caucasus region and speak out against the inhumane living conditions of the displaced. Elsewhere in the Russian Federation, MSF projects have focused on tuberculosis (TB), the homeless and, until recently, HIV/AIDS.

MSF denounced the Russian and pro-Russian authorities' strategy of denying assistance to persons displaced by the war in Chechnya in a report published in January 2002 (see opposite page). In May 2002, Ingush and Chechen authorities signed an accord providing for repatriation of Chechens sheltering in Ingushetia. MSF decried the ensuing campaign of forced repatriation and demanded that any return to Chechnya must be voluntary and undertaken with safe conditions at their destination – which do not exist today. Chechnya today can in no way be called secure.

Despite security constraints in many areas, MSF continues to give essential drugs and medical material to over 30 hospitals and clinics in Chechnya, 30 in Ingushetia and 10 in Dagestan, while MSF mobile clinics offer basic health care and gynecological consultations to displaced persons living in collective centers, camps and villages in these three republics. The maternity ward and operating theater of a hospital in Gudermes, Chechnya was refurbished. MSF also distributed items to needy families before winter, built small houses, and replaced 400 old and worn-out tents in Ingush camps. To address the huge psychological scars of war, MSF began mental health consultations in the Chechen district of Achkhoy-Martan and a program of psychosocial assistance in the Dagestan city of Khazaviurt.

TB program reaches civil society

MSF's program to combat TB has grown to cover the entire penal system of the Kemerovo region of Siberia. Over the past five years, MSF has detected, isolated and cured more than 5,000 incarcerated persons with active TB. The impact of MSF's intervention is now visible: the inci-

dence of TB in Kemerovo's prison system has been cut by more than 50%, and mortality has decreased sevenfold.

While waiting to start treating multi-drug resistant TB in 150 prisoners, MSF responded to the rising epidemic among local civilians by expanding its program to the civil sector. In November 2001, working with local authorities and other NGOs, MSF launched a pilot project in one urban and one rural district of Kemerovo. The project provides a practical model for the authorities to curb the epidemic among civilians.

Center for homeless becomes reality

A municipal center in Moscow for medical and social assistance to the homeless, which MSF campaigned for, should open its doors by the end of 2002. In the meantime, MSF continues to provide 500 medical and social consultations to homeless people each week. In May 2002, to mark the tenth anniversary of its program for the homeless, MSF organized a series of public events in Moscow to raise solidarity and political will to solve the problem.

AIDS work handed over

A new NGO, "AIDS Foundation East-West," created in December 2001 by a former MSF team, has taken on MSF's HIV/AIDS prevention work in the Russian Federation. MSF continued some financial support to the new organization.



A black and white photograph showing a woman riding a bicycle on a dirt road. She is carrying a person on a stretcher on the back of the bike. The landscape is rural and mountainous, with some trees and a small building in the background. The road is unpaved and appears to be in a remote area.

Meymaneh, Faryab province, northern Afghanistan, December 2001. The woman on the stretcher is in critical condition following a difficult home birth. Her family is carrying her to the nearest MSF clinic, a walk of several hours. Many Afghans have little or no access to health care because the places they live in are too remote.

Armenia and Nagorno-Karabakh

Tackling TB and STDs

International staff: 16
National staff: 97

MSF programs target mental health issues, sexually transmitted diseases (STDs) and tuberculosis (TB) in Armenia and the autonomous territory of Nagorno-Karabakh in Azerbaijan. Sovereignty of the enclave remains contested, though a ceasefire has held since 1994.

In Stepanakert, MSF works with health authorities to combat TB using the DOTS (Directly Observed Treatment Short-course) strategy, as well as training staff and providing public information. Some 533 patients have been included in the program since 1997, 52 of them needing adapted therapy for drug resistant TB. With an 80% cure rate for patients finishing DOTS and only 11% defaulting, the program is evolving positively and MSF will hand it over to the health authorities at the end of 2002.

In Yerevan, MSF has run a combined medical, psychological and social care program since 1997 for young people placed in the Vardashan Institute. The team also provides outreach to high-risk children and their families in the city.

In late 2001, MSF began outpatient support for people with mental disorders in Sevan, and opened a day center there in June 2002 for therapeutic and community integration activities.

In Tavush province, MSF runs an STD/HIV program targeting sex workers and the general community in Bagratashen. In May 2002, MSF opened a counseling and information center with a women's group in Berd, as part of a joint project on family planning and STD/HIV prevention.

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

Georgia

Card-based programs increase access to health care

International staff: 15
National staff: 110

Political and economic insecurity continues to beset Georgia. Against this background, MSF works to increase access to health care for society's most vulnerable in the capital Tbilisi, Akhmeta and the separatist republic of Abkhazia, where it also combats the high incidence of tuberculosis (TB).

MSF and the International Committee of the Red Cross have identified 18,000 people in Abkhazia as vulnerable and without access to health care. These people have been given cards entitling them to free medical treatment from selected doctors at a number of hospitals. MSF provides the doctors

Givi, 37, hopes not to infect his 13-year-old daughter with TB, for which he is being treated at the Gulripchi TB hospital in Abkhazia. He was transferred there from prison after a visiting TB specialist found him in agony, vomiting blood on his straw mattress and weighing only 30kg. Despite manifesting symptoms of TB, a highly infectious disease, he was still sharing a cell with nine other inmates.



Kazakhstan TB continues to ravage population

- International staff: 8
- National staff: 29



with medical supplies, equipment and financial support. An MSF doctor-and-nurse team also provides home care in Sukhumi, Abkhazia's capital, for those unable to travel.

A similar card-based program is underway in Varketili, one of Tbilisi's poorest suburbs. MSF opened a clinic there in January 2002 to care for 10,000 people identified as vulnerable, many of them internally displaced people or refugees.

MSF diagnoses and treats TB in Sukhumi at the Gurilipchi hospital, several outpatient clinics and the prison using the DOTS (Directly Observed Treatment Short-course) strategy. Some 219 new patients started treatment in the year ending March 2002. A specialized program for multi-drug resistant TB began in mid-2001, with 15 patients included so far.

In Akhmeta, MSF supports surgery for refugees and disadvantaged local people by providing medicines and medical equipment.

MSF has been active in Georgia since 1993.

Public health has suffered in Kazakhstan since it gained independence in 1991. Tuberculosis (TB) was declared a national disaster in 1998. Many cases are resistant to conventional treatment.

Since 1998, MSF has been working with local health authorities to implement the DOTS (Directly Observed Treatment Short-course) TB strategy in the districts of Baidibek and Ordobassy in the South Kazakhstan region.

MSF does case-finding, treats patients at two 80-bed TB facilities in Karaspan and Mombulak, trains staff and supports two laboratories. It also does health education and rehabilitates TB facilities. Its current program will close at the end of 2002, having implemented all planned activities.

MSF has been working in Kazakhstan since 1996.

Uzbekistan and Turkmenistan DOTS in 30 districts

- International staff: 20
- National staff: 110

Despite some international attention to the environmental disaster of the shrinking Aral Sea, the health of the people living in nearby areas of Uzbekistan and Turkmenistan remains neglected. MSF is focusing medical activities on the high incidence of tuberculosis (TB); and continues to research links between the degraded environment and human health.

MSF has implemented the DOTS (Directly Observed Treatment Short-course) strategy to fight TB in a total of 30 districts in the autonomous republic of Karakalpakstan and Khorezm in Uzbekistan, and Dashoguz in Turkmenistan. Over 13,000 patients have registered since 1997. Patient compliance is good and treatment success rates average 70-76%. High levels of multi-drug resistant TB (MDR-TB) are a main reason for treatment failure. MSF is preparing a pilot program to treat MDR-TB in the coming year. It is also rehabilitating a 600-bed TB facility in Nukus.

Another project in Karakalpakstan, handed over to the Ministry of Health in March 2002, trained more than 500 health workers in the prevention and management of respiratory infections and diarrheal diseases in children under five.

In the Ferghana Valley, MSF provides health education through traditional social structures called *makhallas*.

Ashgabat in Turkmenistan was an important staging point for MSF when it was forced to leave Afghanistan in late 2001, and is still used for logistical support (for more on MSF and Afghanistan, see page 67).

MSF has been in Uzbekistan since 1997 and in Turkmenistan since 1999.

Tajikistan | Activities wind down as needs change

- International staff: 10
- National staff: 93

Since the 1992-97 civil war and collapse of the Soviet Union, health reforms have been slow in Tajikistan and the old top-down Soviet-style system endures. With security improving, the needs of the population changing and development agencies beginning activities in the country, MSF is preparing to end its medical intervention by the end of 2003.

MSF continues to support primary health care in the isolated Rasht/Karategin Valley by distributing essential medicines, training health staff and assisting responses to disease outbreaks – a program begun in 1998. It also runs a reproductive health program to improve maternal care through collaboration with local midwives, doctors and nurses.

MSF has been working to improve conditions for psychiatric patients in Tajikistan since 1997. By the end of 2001, more than 1,000 patients were directly benefiting from this program, which will be phased out in late 2002.

In the capital Dushanbe, MSF has been implementing community-based mental health care for people suffering from post-war trauma and related stress (for more information on MSF and mental health, see page 75). MSF will hand this program over to the city health authorities by 2003.

Dushanbe was an important base for emergency planning and operational support when MSF teams were forced to leave Afghanistan in September 2001 (see page 67). MSF programs in Khorog were closed down due to the events in Afghanistan.

MSF began working in Tajikistan in 1991.

Kyrgyzstan | Conclusion of successful STD program

- International staff: 5
- National staff: 34

MSF became aware of a widespread resurgence of sexually transmitted diseases (STDs) in the troubled republic of Kyrgyzstan when responding to a typhoid epidemic in 1996.

This led to a program for syphilis prevention, diagnosis and treatment in Osh region from 1997. MSF improved screening quality and was instrumental in introducing a new national treatment protocol, backed by training for lab staff and specialist doctors, and supplies of medicines. Patients do not now have to be hospitalized to receive treatment.

MSF also set up an STD information center in the town of Osh targeting the general population and groups at risk; and developed a program to treat and refer previously excluded sex workers and their children. Two local NGOs were enabled to take these over when MSF withdrew from Kyrgyzstan in December 2001.



■ An MSF nurse with a baby selected for inclusion in a nutritional survey, Gumbolok, Tajikistan, November 2001.

■ Baby being weighed as part of nutritional survey, Rogun, Tajikistan, November 2001.





*Displaced woman sweeping at
Meymaneh camp, Faryab province,
northern Afghanistan, December 2001.
Thin fabric and plastic sheeting
is the only shelter available for the
1,100 families living in the camp.*

Islamic Republic of Iran | New project assists vulnerable refugees

- International staff: 8
- National staff (Afghan and Iranian): 89

The Islamic Republic of Iran (Iran) is host to some 2.5 million Afghan and 200,000 Iraqi refugees: the largest refugee population in the world. Treated at best as economic migrants and at worst as drug traffickers, every pressure is being put on the Afghans to return home, particularly since the fall of the Taliban in late 2001.

MSF assists Afghan refugees in the border provinces of Khorasan and Sistan-va-Baluchestan, the latter being Iran's least developed region and the main entry point for the refugees.

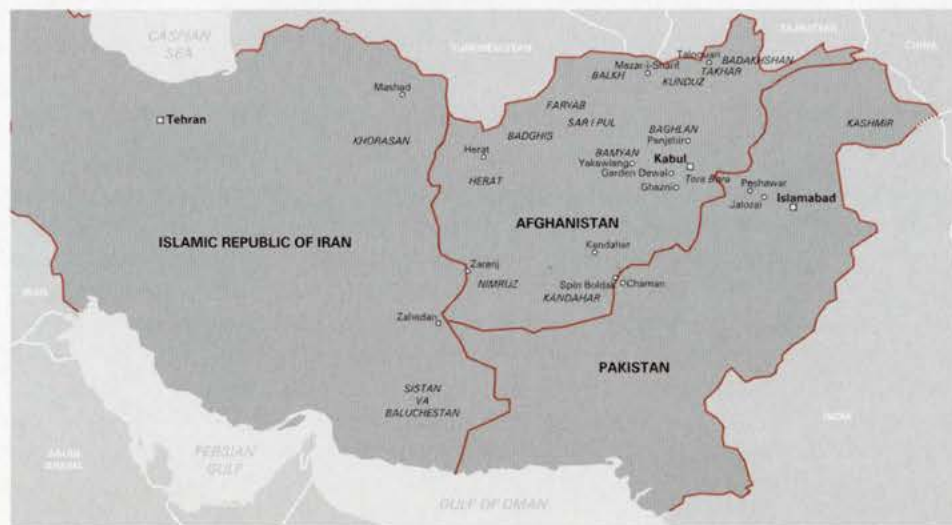
In October 2001, MSF opened a new project in a mainly Afghan-populated section of Zahedan. Medical care is provided through a clinic, mobile clinics and a home-visit program. Both here and in the older program in Mashad, the focus is on improving refugee access to medical care (3,000 consultations are given monthly in each place). Food aid and basic necessities

are also provided for the most vulnerable families in the harsh winter months.

The number of Afghans seeking refuge in Iran rose sharply with the late 2001 bombing campaign. The Iranian government responded by closing its border and setting up the Makaki and Mile 46 camps to "house" some 11,000 of the would-be refugees in Nimruz province, just inside Afghan territory. MSF supported the Iranian Red Crescent's efforts by providing medical care until the camps' closure in May 2002, reopening the Zaranj hospital (30 beds and 3,000 consultations per month) and referring the most serious cases to Iranian hospitals, as well as providing nutritional care, clean water and sanitation.

MSF has also been active in bearing witness to the treatment of Afghan refugees in Iran and in making public appeals for the authorities to remove obstacles to aid operations.

MSF has worked in Iran since 1995.



Pakistan | Supporting the displaced in border zones

- International staff: 44
- National staff: 120

MSF has worked with Afghan refugees in Pakistan since 2000. The late 2001 bombing campaign in Afghanistan pushed the number of refugees already fleeing the civil war and persistent drought to over 2.2 million in Pakistan alone.

MSF teams helped care for the new refugees in camps near Peshawar and Chaman, as well as continuing work in the existing camp at Jalojai. As the camps quickly filled to capacity, plans were made to move 70,000 refugees to new sites dangerously close to the border with Afghanistan. MSF decried the decision, calling on the United Nations High Commissioner for Refugees to select more appropriate sites.

More than 1,200 Afghan families were repatriated by April 2002 while others continued fleeing to Pakistan. The only border crossing point between the two countries, near Chaman, opened intermittently and was again closed in February 2002. By mid-2002, an estimated 60,000 people were trapped at Spin Boldak and the "Chaman waiting area," just inside the Afghan border. MSF teams support these displaced Afghans and a further 60,000 who reached the Chaman refugee camps with basic health care, water and sanitation projects, and advocacy activities.

The camp at Jalojai, where Afghan refugees had lived for years in deplorable conditions, was closed in February 2002. MSF teams saw over 50,000 patients, conducted a mass vaccination of children and built more than 1,200 latrines between late 2000 and the camp's closure.

In February 2002, as the conflict between India and Pakistan over the disputed region of Kashmir intensified, MSF provided care to displaced people on both sides of the border. MSF completed its activities in Pakistani-administered Kashmir in June 2002.

Afghanistan | War aggravates chronic humanitarian crisis

- International staff: 134
- National staff: 906

When terrorist attacks in the United States focused the world's attention on Afghanistan in fall 2001, the situation in the country had already reached crisis point. Decades of civil war, five years of oppressive Taliban rule and three years of drought had forced millions from their homes in search of safety and food. During the months following the September 11th attacks, many more fled from the retaliatory military action taken by the US-led coalition, and from fighting within the country. Vital humanitarian assistance, the only source of food and medical care for thousands, was cut off when Taliban forces compelled all international aid organizations to leave the country. Borders were closed, trapping civilians inside Afghanistan. The coalition dropped food packages as well as bombs – a propaganda move that was not only ineffective in meeting the needs of hungry people but also a dangerous fusion of military and humanitarian agendas.

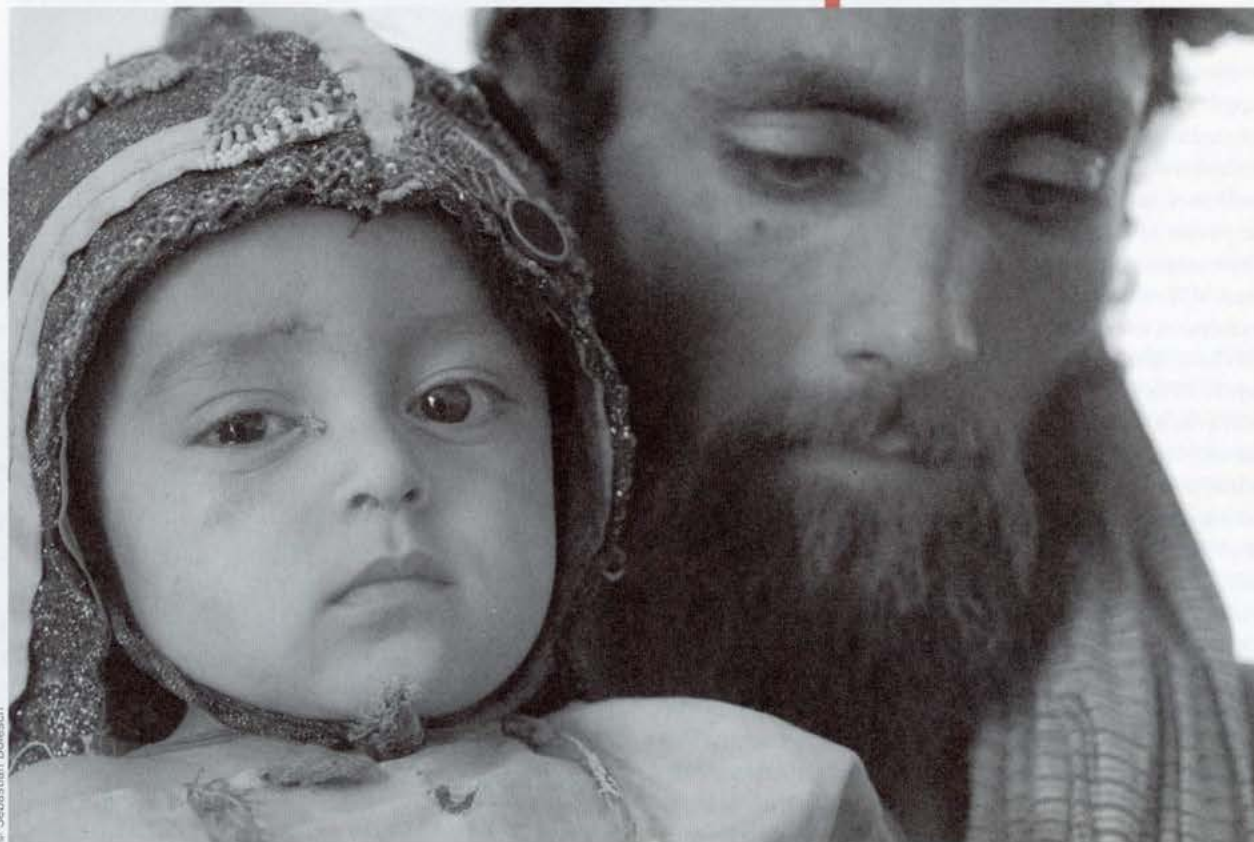
Eventually the Taliban was driven from power. However, by July 2002, as a new government tried to establish itself in Afghanistan, the situation for most people remained precarious. Access to areas in the south was limited, dangerous or impossible. Malnutrition remained ever-present. Refugees were returning from neighboring countries even though the war was not yet over. And access to health care for most Afghans remained extremely limited.

The events of the last year illustrate the vulnerable position of civilians in conflict situations and the dangers of letting political objectives, and not the needs of the people, shape the aid that is given.

MSF has worked in Afghanistan since 1980, and medical aid programs were underway in 13 of the country's 32 provinces when the events of September 11th took place. In early 2001,

having witnessed growing numbers of people displaced as a result of the civil war and the ongoing drought, MSF urged the international community to act. By summer 2001, everything was pointing to a worsening humanitarian situation in the country. The events from September onward only intensified this dire situation.

Displaced Afghan father and baby, Zhare Dasht (Yellow Desert) camp, near Kandahar, Afghanistan, September 2002. The camp was set up to "house" 60,000 of the displaced Afghans stuck at the Pakistan-Afghan border.



© Sebastian Bolech

In conflicts, MSF relies on its neutrality to ensure the safety of its workers, but it soon became clear that anyone perceived as a "Westerner" could be in danger. With US-led military action imminent, MSF project leaders were informed by the Taliban that they should leave the country. By September 14th international volunteers had been evacuated from Taliban-held areas.

MSF activities, however, continued. International staff remained in the Northern Alliance-held areas, and MSF national staff throughout the country adapted to the crisis. They continued most programs in the Taliban-held areas, even as the conflict escalated around them.

From outside Afghanistan, MSF tried to negotiate reentry. Communication with local teams was difficult, and crucial supplies were cut off due to the fighting and the closure of international borders. Hospitals and clinics began to run low on food and essential medicines. MSF responded by shipping medicines, medical material and other relief items to strategic points in Pakistan, Tajikistan, Turkmenistan and Iran, where ongoing projects facilitated the emergency preparations. MSF met with Taliban representatives but was denied permission to return.

US and British forces began bombing Afghanistan on October 7th. At the same time, they began dropping food rations as part of a "bread and bombs" military campaign. Not only were the few thousand daily rations dropped insufficient to feed the millions of hungry people, but they were also the same color as cluster bombs being used in the offensive. These cluster bombs will be an enduring legacy of the conflict. Furthermore, through its 30 years of experience in delivering aid, MSF has learned that untargeted and unmonitored aid, particularly food aid, rarely reaches those who need it most, and this was the case in Afghanistan.

MSF strongly condemned this mix of military and humanitarian action as dangerous, ineffective and detrimental to future humanitarian aid. As long as humanitarian workers are recognized as neutral, they are safe to work in conflict areas. Once aid is linked to military action, humanitarian

organizations become targets: future attempts to provide aid are suspect and new barriers exist between the most vulnerable and the international aid organizations trying to reach them. (See the Year in Review on page 6 and the essay on page 70, for more on MSF's concerns about linking military and humanitarian action.)

International borders remained closed – Afghans able to reach the border were often trapped inside, denied the right to flee. Thousands waited for assistance near the border with Iran, digging holes to protect themselves from the sandstorms and the freezing cold. Others were trapped near

the Pakistan border. MSF called on the international community to find an immediate solution for those who could neither flee to another country nor be reached inside Afghanistan by international organizations.

MSF distribution point for blankets and basic necessities, Yakawlang, Afghanistan, January 2002.



© Juan Carlos Tornasi

Mazlakh camp near Herat, western Afghanistan, September 2002. The camp hosts around 160,000 Afghans fleeing drought and insecurity. An MSF nutritional survey conducted at the camp shows a severe increase in malnutrition among camp residents.

© Sebastien Bolesch



As the Taliban regime crumbled, MSF teams were finally able to return – first to Kabul on November 13th, then to Herat, Mazari-Sharif, Taloqan and other places in the following days and weeks. Many operations had been looted during the fighting, resulting in the loss of radio equipment, trucks and other supplies. As military strikes continued in parts of the country, MSF teams evaluated immediate needs and returned to supporting clinics, hospitals and camps for displaced people, building on existing programs and adding projects to meet new needs.

The consequences of the military operations on civilians as well as the critical health situation continued to be of concern. In December 2001, MSF transported civilians who had been wounded in the bombing of Tora Bora, and spoke out against the high number of civilian casualties. Half the country was still inaccessible in February 2002, and access to people in need continues to be a serious problem. A nutritional crisis in northern Afghanistan had become critical, and by March 2002 MSF had more than 4,000 children in emergency feeding centers.

By July 2002, about a million Afghan refugees had been repatriated from Pakistan and 150,000 from Iran; the conditions of their return have varied from area to area, depending on the security situation and the international assistance pro-

vided. MSF is monitoring the return and reinstallation of Afghans from points in Afghanistan, Iran and Pakistan, and in many project areas providing returnees with basic health care assistance.

Even as the new regime tries to establish itself and bring brighter prospects to a country so long at war, the situation in Afghanistan remains fragile. Conflict continues, especially in rural areas, and MSF teams work with isolated communities that have no access to health care and little food to survive the winter. In some places, the people have retreated into caves in the mountains. MSF also works in camps for people who have been displaced, vaccinating against infectious diseases and providing emergency medical care. Natural disasters, such as the series of earthquakes that struck the country in the first half of 2002, continue to take a heavy toll (MSF assisted people affected by the tremors).

Many projects specifically address the needs of women and children who would otherwise have no access to health care. Feeding centers continue to receive malnourished children.

As of July 2002, MSF was running medical and nutritional aid programs in many parts of Afghanistan, with support to hospitals, clinics, health posts, and therapeutic and supplementary feeding centers in cities and villages in the provinces of Badakhshan, Badghis, Bamyan, Faryab, Herat, Ghazni, Kabul, Kandahar and Takhar, as well as the cities and regions of Garden Dewal, Karai Valley in Faryab province, the Panjshir Valley/Shamali Plain and Yakawlang. Projects were ongoing with internally displaced people in Balkh, Baghlan, Herat, Kandahar and Kunduz provinces, while nutritional aid in Nimruz and Sari Pul provinces came to an end in May 2002. MSF also continued its work with Afghan refugees in Pakistan and Iran (see page 66).

Same aims, different means?

Why promoting “coherence” in military and humanitarian goals is a disservice to civilians in need

By Austen Davis, General Director, MSF-Holland

Humanitarian actors seek to serve the suffering and the needy, and cry out for political actors to stop causing misery and death and address the causes of suffering. Humanitarian action demands the development of a more just and humane society. Over the past decade, the West has increased belief in the utility of military intervention to impose peace and alter the balance of power as a means for development of a more just and humane society, locally and globally. (Think of NATO in Bosnia and Kosovo, the US-led coalitions in Afghanistan and the Persian Gulf, and the US in Somalia.) But sharing similar goals – and thinking about humanitarian and military action as “coherent” aspects of the same effort – disguises fundamental differences in the capacities, roles and responsibilities of government and humanitarian actors. They must not be confused.

Should we go to war?

Humanitarian action does not cast a vote on the “justness” of war – but reacts to its dehumanizing consequences. Humanitarian actors believe that, regardless of political context, civilians on all sides in a conflict should be helped when they are in extreme pain or at risk of death. Need is the only qualifying factor. In a world where origin and identity are political statements that often put people on one “side” or another, how else can we try and sustain a value for humanity?

Changing solutions

Humanitarian agencies frequently work in war and conflict zones. War is complex, irrational, destructive and regressive, and obviously not a means to develop a just society. The more wars you work in, the more you are confronted

with the same analysis: war is complicated; violence is irrational and ultimately unproductive. In every war you hear “there is no military solution to this conflict.” For years we have been told that the wars of Sudan, Angola, the Democratic Republic of Congo, Liberia, Sri Lanka, Afghanistan, Colombia, Kashmir and Israel/Palestine cannot be won militarily.

However, the West increasingly sends military forces into conflicts, sending the signal that there are military solutions to societal problems. One reason put forward by Western leaders for the shift is that the new wars waged by the West are “humanitarian” wars, fought by democratic governments with the collaboration of aid agencies to ensure a just and humane outcome.

Working for peace and justice

Under the new militarism, the West claims to intervene for the “good of the world” and for civilians in the affected country. Humanitarian assistance is supposed to be a natural ally to this new military interventionism. After all, don’t we have a common goal – a world in which all people live in peace, security and relative prosperity? So, shouldn’t humanitarian aid agencies work with Western military forces to secure peace, law and order, and sow the seeds for a more positive future? Our answer is no. While such an alliance in the name of common goals may be useful for governments, it is deadly to the humanitarian mission, and a betrayal of the people who should be served by the aid agencies.

Are aid agencies effective political allies?

The means by which we construct peace and security are deeply political processes. For Afghanistan to attain peace, it is not enough simply to overthrow the Taliban and

offer a large aid package as long as everyone “behaves.” There is a complex process of competition being played out as former warlords vie for prestige and power. The new government being formed is not just an expression of the popular will, but reflects alliances with external states (the US, Russia, Iran, Pakistan) and the balance of military force.

Humanitarian assistance is not a natural partner in this process. We do not have access to backroom bargaining – nor should we. We have neither the skills nor capacities to define the true path for positive social progress and construction of a balanced and just post-war state.

What we do have is the responsibility to care for the dying while crisis remains in the country and to report on the suffering we face. This suffering is an indicator of political failure in this complex process – and we demand redress. We are one important voice – with one important concern, in a critical, complex and messy process. To do this we must be independent from the political process.

Following the humanitarian imperative

Yet this independence is not easy to maintain. In order to mount humanitarian operations, agencies must have money. Most humanitarian funding is provided to NGOs by governments. This year in Afghanistan, a lot of money was made available to aid agencies. Agencies rapidly responded by drawing up three-, five- or even ten-year development plans in a matter of weeks after massive political change. But how could they know the challenges and the future? Aid agencies have been conscripted to manage the peace, and their development plans have become blueprints for the situation in Afghanistan.

| The most important task is to define policy and keep the money flowing – and that means following the plan. Reality becomes an inconvenient obstruction to the willingly blind. The reality in Afghanistan – inaccessible people, banditry, robberies, rape, killings and assassinations, new refugee flows – continues to be ignored or buried. There is very little discussion of how to ensure immediate and essential humanitarian action. Instead, the agenda was defined through political will for the establishment of a modern liberal state, and exercised through the obedient and hungry bureaucratic imperative of the global aid agencies.

| One might ask: So what, if it works? But it doesn't – because such a process generates false expectations, and false solutions. It is only now that the abstract falseness of the process and the hard realities of Afghan political life are being recognized – but not yet faced. We cannot create peace in the image of aid agencies. Military decisiveness coupled with an obedient aid community is not enough to meet the complex political challenges of a state in crisis.

(continued on page 73)

© Fernand Domange/GRIP



*Soldiers with Rwandan children,
Rwanda, 1994.*



MSF team crossing into the village of Yatta after a five-hour wait for authorization to collect two teenagers who had been shot in the legs. The convoy was stopped on the way back before the team could get the wounded boys to Hebron hospital, and the boys were searched at gunpoint.

Becoming partisan

Multiple examples over the last decade and a half show just how much the attempt to portray coherent military and humanitarian goals has undercut the humanitarian mission. Under the new spirit of Western military interventionism, humanitarian agencies have been encouraged to come in on the tails of the military. Military leaders have already requested that NGOs prepare a "massive deployment of staff and materials" to the region, to be ready to go into Iraq. No wonder humanitarian agencies are increasingly seen as partisan. In Angola, the rebel opposition group UNITA refused aid agencies access to people under its control because it saw aid workers as part of Western support mechanisms to the enemy. The Serbian authorities refused access by aid agencies to Kosovo while NATO was bombing. Western aid agencies withdrew from assisting refugees in West Timor after militia leaders targeted humanitarian workers who they perceived as pro-East Timorese secession. The northern Sudanese authorities regularly deny access to aid agencies trying to work in southern Sudan as part of their political strategy to confront Western power. Saddam Hussein tightly restricts humanitarian access to people in Iraq, despite arguing that sanctions are killing women and children. Opponents to the vision of justice and progress held by the West (and there are many) will see humanitarian action as part of the Western package and therefore part of the opposition. The essential message of humanitarianism is then lost – there is room for cultural, social and political diversity – but we must remember, when we disagree, that we are all human beings and we all bleed when cut.

"Smart" aid

This year aid agencies also tried to consolidate the political role of aid in the reconstruction of a newly peaceful Angola. After decades of conflict, the end of war offers great

hopes for the future. But massive immediate problems remain: a huge proportion of the population displaced and hungry; a shattered economy; no commercial infrastructure; total absence of educated and healthy workers; landmines that litter the land; and no accountability of government to the people. There is a widely shared belief that aid should not continue to be a substitute for the responsibilities of the Angolan government, which has shamefully neglected the well-being of its own citizens during this brutal war (a view MSF shares). With the end of conflict, the aid agencies acted quickly to consolidate their influence, standing together to maximize their leverage for framework agreements from the government on respective roles in the post-war period. But this was at a moment when huge numbers of people were starving to death. MSF refused to become involved in the political jockeying and instead increased aid to affected civilians. Withholding critical humanitarian action at a moment when it is known the government does not have the capacity to act is to sentence those people to certain death. The idea that "smart" aid can be used to promote good governance overruled the instinct to go and feed desperately hungry women and children. Aid agencies cannot encourage a government's responsibility to its own people by displaying callousness and lack of concern themselves. What kind of humanitarian action is it that no longer represents that basic impulse so well understood by the average member of the public – not political, not complex, simply humane?

Doing what you can

It often seems that focusing on helping people in the middle of conflict does not address the causes of the crisis. It is demoralizing to heal the wounded and see them back in the clinics six weeks later. We all want to see peace and justice. But how to get it? Directing or withholding humanitarian relief has little impact on the ability of a regime to

hold on to power – but it does serve to undermine the non-partisan character of humanitarian assistance the world over. So politicians think humanitarian aid is part of Western action, and champion it or refuse it. And aid workers become convinced they have the power to design aid programs to further political progress. This achieves little political progress and obscures the responsibility of political actors for that progress. It also runs the risk of losing something very precious. The real importance of humanitarian assistance is to save lives in the heart of crisis, and to demonstrate that caring for people is so important, even in the midst of crisis. Only such a realization can make the pursuit of a future tolerant peace viable.

We are not politicians, but people who morally respond to the needs of ordinary human beings. When humanitarian action becomes incorporated into the political contest, it becomes prey to the political calculation of profit and loss on each side. Whether we support or reject the value of Western intervention in this or that country has no bearing on whether humanitarian action should be incorporated. Humanitarian action that goes hand in hand with Western military intervention will continue to be rejected by opponents to the West and humanitarian assistance will only be given to people living under the political authority of allies of the West. This type of humanitarian assistance is nothing but a civilian quartermaster. It presents no moral challenge to the destruction of war – it does not argue for restraint in conduct of war – it is partisan and merely fuels the capacity for conflict.

India Projects intensify in disputed border region

- International staff: 17
- National staff: 51



As the conflict between India and Pakistan over Kashmir continues, MSF is addressing a wide range of needs in Jammu and Kashmir for people traumatized by the ongoing violence.

In Srinagar, MSF assists the integration of mental health care into the existing healthcare system by training and supervising Ministry of Health staff and volunteers from a local NGO. It is also working to raise awareness and to establish a referral network between outlying villages and Srinagar Psychiatric Hospital for severe or complicated cases.

The health of displaced people along the line of control separating Indian and Pakistani Kashmir is of particular concern. MSF was able to gain access to camps around Jammu and Rajouri in June 2002; and is starting a water and sanitation program in Jammu in August 2002.



© MSF-Mumbai

Professional street performers sponsored by MSF raise TB awareness in Mumbai, where MSF is supporting the implementation of treatment in a zone of 1.5 million people.

Elsewhere in India, MSF works to improve diagnosis and treatment of malaria and tuberculosis (TB), and to bring primary care to people with limited access to health facilities.

In Mumbai, MSF is helping health authorities implement a TB strategy based on DOTS (Directly Observed Treatment Short-course) in a zone of 1.5 million people. The MSF team medically follows up some 300 patients a month, and works to improve laboratory services and create community support structures for TB patients.

In Assam, MSF mobile malaria clinics promote early diagnosis, prompt treatment, education and prevention in Nalbari district. MSF recently gained permission to access camps for displaced people in Kokrajhar.

MSF has been in India since 1999.

Mental health care within MSF activities

In any MSF medical project, in any part of the world, there is always a psychological component to the work, if only in the personal interaction between doctor and patient, the ability to listen and the chance to be heard. People living in unstable political situations or living through a natural disaster suffer severe trauma. No one would deny the psychological impact of living with disease, poverty or in conflict settings.

MSF considers that psychological programs are not only an essential response to human suffering, but part of an integrated approach to medical care. In March 2002, it sponsored an international symposium on "Trauma, treatment and culture," drawing some 600 humanitarian and healthcare practitioners to Paris to discuss this issue, share experiences of successful projects and debate how best to provide psychological support across different cultures.

In Angola, women carry their starving children for days, trying to reach help. Many walk into feeding centers with their last surviving child in their arms. MSF teams fight to save thousands of malnourished children, but the needs are immense and many die. There is no time to listen to the stories of suffering, to offer more than emergency care, but there is no denying the look on each woman's face as she cradles her child in the feeding tents. At night there is weeping.

Bunjei camp, Angola, 2002

In a house that sits across from an Israeli settlement, an MSF psychologist offers crayons and paper to children while listening to their mother. She tells the story of the night her 12-year-old son was wounded and she fought to stop the bleeding, the smaller children clinging to her legs in terror. While they talk, the two-year-old makes heavy marks on the paper and the sound of bullets, "tar, tar, tar," while the five-year-old colors a red spot, over and over.

Abu Sneina district, Hebron, West Bank, 2002

From counseling to psychosocial support

In some places MSF has developed projects that specifically seek to provide mental health care. In the West Bank and Gaza Strip, for example, MSF teams visit Palestinians in their homes, counseling people trapped in the ongoing conflict, where stress and trauma create a complicated mix of physical and psychological reactions. In Rwanda, MSF works with women survivors of the 1994 genocide, many of whom continue to suffer trauma associated with rape and torture eight years on.

In other settings, MSF has developed programs with a broader approach, focusing less on individual counseling and more on an integrated mix of social, psychological, legal and medical activities. Examples of multidisciplinary "psychosocial" programs can be found in Guatemala, Guinea and the Philippines, where MSF works with street children. Building trust is central to these psychosocial pro-



Patients waiting for a consultation, Srinagar Psychiatric Hospital, India, January 2002. The ongoing conflict over Kashmir is a major source of anxiety and trauma.

grams, which strive to reintegrate homeless children into existing social structures and to support their transition in various ways.

Limits and capacity

Every MSF project has limits. There is always a struggle to identify the most urgent needs and the best way to respond to medical emergencies with finite resources. In what situations should mental health care become a priority? Should every project have an element of psychological care? When MSF responds to massive famine and displacement (as in Angola and Afghanistan) should including mental health care even be considered?

For MSF, the question is not whether mental health care should be a part of our missions or not, but rather how and when to focus on mental health.

Sri Lanka Health needs remain high even as war abates

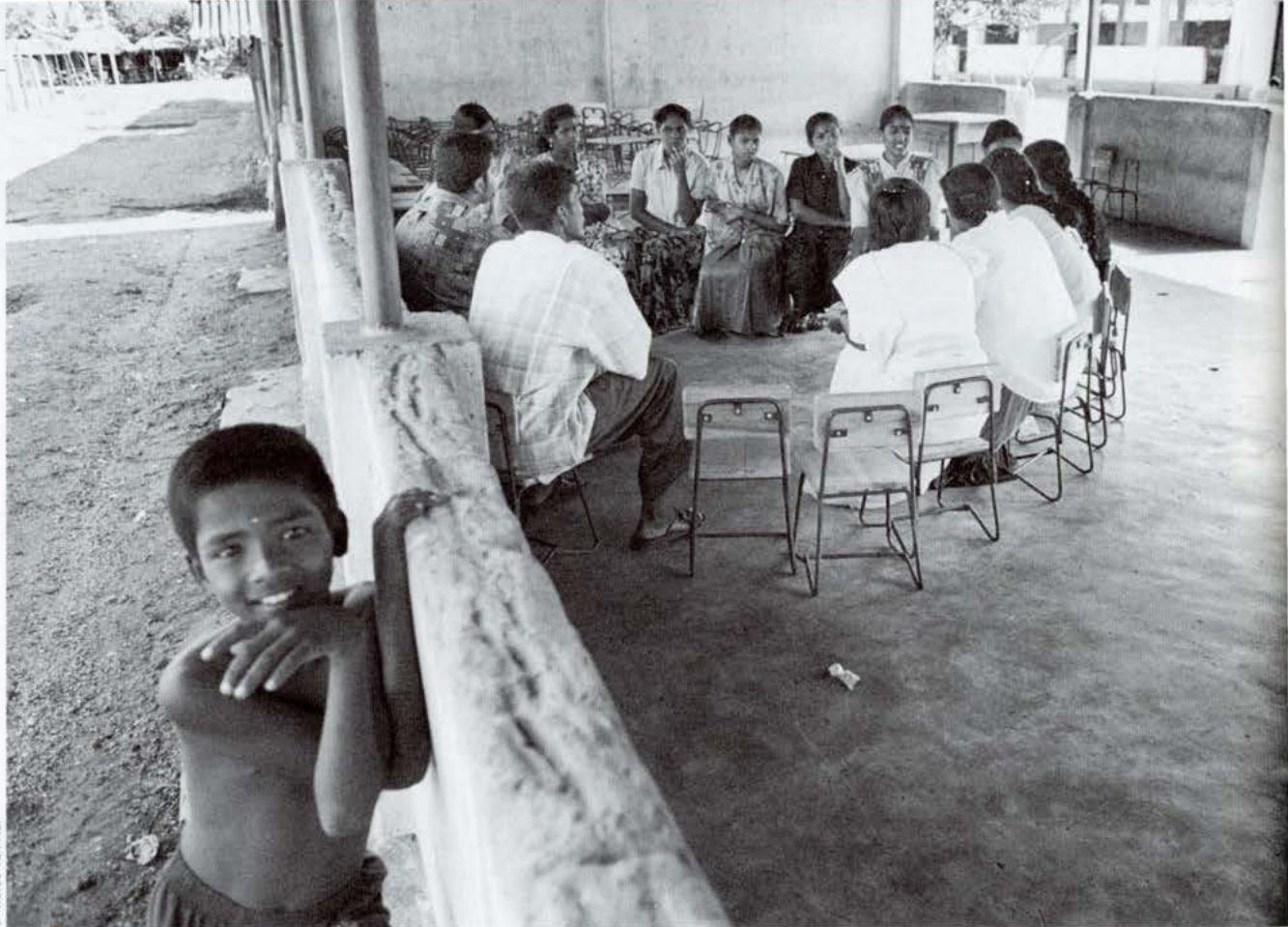
- International staff: 46
- National staff: 178

The signing of a ceasefire between the government and the rebel Tamil Tigers in February 2002, and the scheduled start of peace talks, have raised hopes that Sri Lanka's civil war may finally be over. An embargo on materials being sent to the north – including medicines – has been lifted; the main road into the Jaffna peninsula has been reopened; and those displaced by the war have started returning to their homes. Nevertheless, after nearly 20 years of war, health needs remain high and health staff are lacking. MSF continues to provide medical assistance, with a strong focus on people displaced by the war. It has eight projects ongoing, principally in the north and northeast.

In Vavuniya, in addition to providing surgery facilities, MSF helped establish protocols for the disposal of medical and other waste. In 2001, MSF surveyed the psychosocial problems present in camps for the internally displaced and found very high levels of trauma. Many people had seen acts of war or the deaths of friends and family; many had been displaced repeatedly. MSF now provides counseling and psycho-educational support in the camps.

In Mallavi, Point Pedro on the Jaffna peninsula and Batticaloa, MSF surgeons work in public hospitals. Each month, MSF teams carry out an average of 60 major surgeries in Batticaloa, 30% of which are emergencies; 132 major surgeries in Mallavi, 65% of them emergencies; and 45 major surgeries in Point Pedro, 50% of them emergencies. MSF also offers basic care to people in outlying war-affected areas near these cities and towns, and monitors the health needs of about 6,000 internally displaced people in Jaffna.

mother-and-child health care is an important part of many MSF projects in Sri Lanka. In Puttukkudiyiruppu, MSF trains community health staff in prenatal and well-baby



© Marco van Hal

Group discussion with residents and community health workers, MSF psychosocial care program, Poonthoddam transit camp, Sri Lanka, May 2002. Lack of privacy is a major cause of tension in the camp: families get less than a square meter to live in, with plastic sheeting or rice sacks the only partitioning between the "homes." Poonthoddam was built as a transit camp but around 10,000 internally displaced Sri Lankans have ended up living here for years.

clinics and emergency obstetrical and gynecological care in the hospital. At Jaffna Teaching Hospital, each month 650 children are admitted to the pediatric ward, where two MSF pediatricians work. In Point Pedro, three MSF doctors provide gynecological and obstetrical care and surgery. MSF began working in Sri Lanka in 1986.

Myanmar (Burma) | Effective drugs beat malaria

- International staff: 24
- National staff: 454

The military government of Myanmar (Burma)'s spending on health care remains very low, resulting in a shortage of facilities, staff and medical supplies. Communicable and infectious diseases continue to take their toll on the population.

Fighting malaria

MSF runs several major programs targeting malaria, the number-one cause of death in the country. The world's most resistant strains of malaria are found along the border with Thailand. Due to the high resistance of these strains to traditional anti-malarial drugs, MSF exclusively uses artemisinin-based combination therapy in Myanmar. These medicines are fast-acting and potent, and to date no resistance to them has been reported (see page 10).

MSF malaria teams work closely with local health structures, and hard-to-reach communities are accessed through

a network of mobile clinics. In addition to treating the disease, the teams are involved in training local health workers and raising community awareness of malaria transmission and prevention. MSF's malaria programs currently span Tanintharyi division and the states of Kachin, Mon, Rakhine and Shan. The program in Tanintharyi's Dawei district was extended to Myeik (Mergui) district in January 2002. Programs in the other areas also continue to expand, and MSF will treat over 100,000 patients for malaria in 2002.

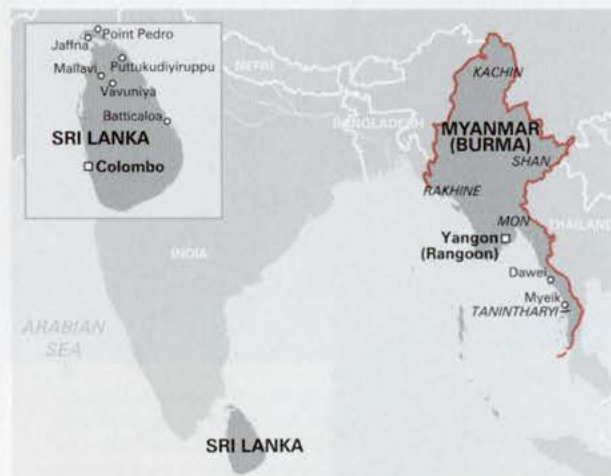
Assisting marginalized groups

MSF tries to address the HIV/AIDS epidemic in Myanmar through condom promotion and treatment of sexually transmitted diseases (STDs) among sex workers. People living with HIV/AIDS in Myanmar are often discriminated against and have little access to health services. MSF supports multiple clinics where care is provided for people living with HIV/AIDS and also provides home-based care in Kachin, Shan and the capital Yangon (Rangoon). MSF is preparing to implement the first antiretroviral treatment in the country in December 2002.

A new program launched in Shan state in October 2001 includes STD and HIV/AIDS prevention, treatment and advocacy, as well as treatment for malaria and tuberculosis.

2002 marks the tenth anniversary of the flight of the mainly Muslim Rohingya refugees from Myanmar to Bangladesh. MSF assists Rohingyas in Bangladesh (see page 78) and in Myanmar itself. In Rakhine state, where Rohingyas are denied citizenship, MSF provides primary health care at the village level, as well as malaria diagnostics and treatment, supporting a network of 22 clinics throughout the region.

MSF has worked in Myanmar since 1992.



Malaria prevention and treatment in rural Myanmar: an MSF mobile team member carries microscopy equipment and medical supplies to a remote village in Rakhine state, December 2001.

© Olivier Bonnet

Fearing repatriation to Myanmar, a country that denies them citizenship, and without offers for third-country resettlement, 21,600 Rohingya refugees endure malnutrition, confinement, abuse and neglect in Bangladesh, their country of refuge. In March 2002, MSF published a report calling for solutions that protect the Rohingyas and respect their dignity and rights. Following is a summary of the report, "Ten Years for the Rohingya Refugees in Bangladesh: Past, Present and Future," which can be found, together with personal testimonies from some of the refugees, at www.msf.org

"I was born in Burma, but the Burmese government says I don't belong there. I grew up in Bangladesh, but the Bangladesh government says I cannot stay here. As a Rohingya, I feel I am caught between a crocodile and a snake."

19-year-old male refugee. Nayapara camp

| Discrimination, violence, religious intolerance and forced labor practices by the authorities in Myanmar (Burma) triggered an exodus of more than 250,000 Rohingya people from Rakhine (Arakan) state in Myanmar to Bangladesh between mid-1991 and early 1992. Since 1992, approximately 232,000 of the refugees have been returned to Myanmar under a repatriation program supervised by the United Nations High Commissioner for Refugees (UNHCR). Today, more than 21,600 of them remain in two camps south of Cox's Bazaar.

| In 1992, the Bangladeshi government welcomed the refugees and settled them in 20 camps with the notion that their stay was short-term. Now, ten years later, the Rohingyas continue to live in temporary, emergency-like conditions that are substandard and unhealthy. Prohibited from leaving the camp freely, the refugees remain confined to overcrowded, tight spaces, with insufficient water, inadequate shelter and few educational opportunities. They are not allowed to work or farm, nor are they provided sufficient food to feed their families. As a result, 58% of the refugee children and 53% of the adults were suffering from chronic malnutrition at the end of 2001.

| Throughout their decade of exile, the Rohingyas have confronted waves of aggression and coercion in their land of refuge. Many have been sent back to Myanmar against their will, in violation of the

principle of voluntary repatriation. While incidents of forced repatriation have declined in recent years, violence and intimidation by camp officials persist.

| Although refugees have three possible solutions to their situation – repatriation, integration in the host country and resettlement in a third country – the Rohingya refugees do not seem to be given a choice. The UNHCR promotes repatriation as the most optimal solution, contending that the security situation in Rakhine state is stable and conducive to their safe return. But human rights reports, witness accounts and testimonies from newly arriving Rohingyas state that the situation has not improved. As a result, many refugees are unwilling to repatriate.

The Bangladeshi government does not support local integration of the remaining refugees, and the international community has not yet expressed an interest in resettling them in "third" countries.

| Unwanted in their land of birth, and no longer welcomed in their land of refuge, the Rohingya refugees face an uncertain future. Until a political breakthrough is achieved, intermediate and long-term solutions must be sought for those refugees unwilling to return to Myanmar. The living conditions of the refugees and the safety and security in the camps need to be improved. The refugees need to be viewed not as a burden or "residual caseload," but as human beings, with hopes, voices and rights.



© Pictet Wiggers

Rohingya refugee family at Nayapara camp. Jalil, the young boy sitting in his mother's lap, suffers from malaria.

Bangladesh | Programs continue in conflict zone and refugee camp

- International staff: 12
- National staff: 106



© Herman Smitskamp

Caught between a crocodile and a snake: this Rohingya refugee and his family face an uncertain future, denied citizenship in their country of origin and no longer welcome in their country of refuge.



"Government of Burma says, 'This is not your land.' Government of Bangladesh says, 'This is not your land.' So I ask you; I ask UNHCR; I ask Bangladesh and Burma to please tell me, where do I belong? Where is my home? Where can I go? I do not want to be a refugee anymore. I just want to live in peace."

50-year-old male refugee, Kutupalong camp

| The year 2002 marks the tenth anniversary of the flight of some 250,000 Rohingya refugees from Myanmar to Bangladesh. Though many have been repatriated, more than 20,000 continue to live in refugee camps, where MSF works to meet their medical needs. In April 2002, MSF issued a report on the unacceptable conditions in the camps and organized a conference in Dhaka to discuss possible solutions (see opposite page).

| Malnutrition is a persistent problem for the Rohingya refugees at Nayapara camp in Cox's Bazaar. MSF provides nutritional monitoring, and supplementary and therapeutic feeding for women and children under ten, who make up more than 60% of the refugee population. Other services include in- and outpatient care, reproductive health care, and health and hygiene education. MSF also trains refugees as volunteer health workers.

| Since 1999, MSF has run two primary healthcare clinics with a laboratory in Khagrachari district in the conflict-ridden Chittagong Hill Tracts, where health care is basically non-existent. The clinics treat common diseases and offer vaccinations, reproductive health care, and health and hygiene education.

| Malaria is a major health concern in this part of the country. The malaria drugs in use do not seem to be effective, but alternative treatment is not allowed. MSF is negotiating with the health authorities for permission to do a sensitivity study to prove the effectiveness of the newer treatments currently advocated by international experts. (See page 10 for more on the push for better malaria treatments.)

| MSF has been in Bangladesh since 1992.

Cambodia | Expanding frontline treatments for malaria and AIDS

- International staff: 28
- National staff: 177

| When MSF first arrived in Cambodia in 1989, health care was practically non-existent, particularly in the rural areas. Over the years MSF has played a pivotal role in the restructuring of the country's health system, building and strengthening facilities in marginalized areas. Now, only two health districts, Sotnikum and Thmar Pouk, are still supervised by MSF and even Thmar Pouk is preparing for handover. MSF will nevertheless maintain a presence in Cambodia, running a selection of small, pilot projects of high medical value, looking at ways to help the most vulnerable.

Malaria

| One of the most innovative projects is aimed at research into effective malaria treatments in Anlong Veng and Sotnikum. Set up in response to a malaria epidemic in 1999, the project introduced combination therapy (artesunate and mefloquine) to combat drug resistance that has rendered old drugs ineffective and proven so fatal. The government soon adopted the more effective combination therapy in its national protocols. More recently MSF is considering an operational trial of a new combination drug called Artekin (which combines the drugs artemisinin and piperazine); this combination therapy is cheaper and has fewer side-effects. The success could have significance beyond Cambodia, helping to improve access to effective and affordable malaria treatment in other countries as well. MSF is working with malaria specialists to gather the scientific data needed to develop a comprehensive treatment protocol (see page 10 for more on efforts to improve malaria treatment).

HIV/AIDS

| MSF's pilot program to administer antiretroviral (ARV) therapy to AIDS patients for free, introduced in July 2001 at Norodom Sihanouk Hospital in Phnom Penh, had over 115 patients by mid-2002. MSF is the only NGO treating AIDS patients with triple therapy in a public health facility in Cambodia, a country where most of the money for HIV/AIDS goes essentially to prevention programs.

| The Chronic Disease Clinic in Siem Reap, an MSF initiative which opened in April 2002, is hoping to benefit from the experiences at Norodom Sihanouk Hospital and at MSF's ARV programs in Thailand and eventually introduce antiretrovirals. MSF is currently treating AIDS patients for related infections and also focusing on other chronic diseases for which there is very limited treatment in Cambodia, such as diabetes, hypertension and arthritis.



Lao People's Democratic Republic | MSF sets up first HIV/AIDS referral service

- International staff: 4
- National staff: 19

| Health standards are dreadfully low in the Lao People's Democratic Republic (Laos). The public health system has been poorly maintained and is inaccessible to a large percentage of the population. The HIV/AIDS infection rate is increasing even though the number of people infected is lower than in neighboring countries. With HIV testing only available in 12 out of 18 provinces, official statistics are almost certainly unrepresentative of the real infection rate. MSF estimates that at least 4,000 of the country's people now live with HIV/AIDS.

| Since June 2001, MSF has focused on establishing the country's first referral service for HIV/AIDS in the southern province of Savannakhet, the province with the highest number of HIV cases in the country and a population of 766,000. The team supports the provincial hospital in providing palliative care for HIV-infected patients and by supplying medicines. One of the program's goals is to strengthen the referral service and consultations for people suffering from AIDS-related opportunistic infections. It also provides training and technical assistance for local doctors and nurses. Furthermore, MSF runs home-based care for people living with HIV/AIDS.

| MSF has worked in the Lao People's Democratic Republic since 1990.

Thailand | Treating AIDS in many settings

- International staff: 19
- National staff: 623

Coping with the AIDS epidemic is a main focus of MSF's work in Thailand. Additional programs concentrate on tuberculosis (TB) and primary care for refugees and displaced people along the country's border with Myanmar (see page 77).

For several years, MSF and local partners have campaigned to decrease the price of antiretroviral (ARV) drugs that could prolong the life of some of the country's 670,000-plus people infected with HIV/AIDS. The prices have dropped and, as of July 2002, MSF is treating 470 AIDS patients – including 50 children – with ARV drugs in home and hospital settings at several locations in Thailand.

In Bangkok, home-based and community care are cornerstones of MSF's approach to bringing AIDS care and treatment to people neglected by Thailand's social system. In Rayong, a program including ARV treatment responds specifically to the needs of infected children. MSF has evaluated the educational and psychological needs of children living with HIV/AIDS and is working to develop child-friendly tools to help them take their medicines correctly. MSF also provides AIDS care and ARV treatment in Surin province and in the district hospitals of Bang Kruai, Ban Laem and Kuchinarai. Training local medical staff and treating AIDS-related opportunistic infections are an integral part of the programs.

In December 2001, MSF began to diagnose and treat HIV/AIDS and related infections in Maela refugee camp near Mae Sot, home to 37,000 mainly Karen refugees from Myanmar. MSF provides ARV treatment to a handful of patients there, as well as treatment to prevent mother-to-child transmission of HIV (MTCT). MSF also provides counseling in the MTCT context in Surin.



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This AIDS patient does not have access to treatment. The disease has left him paralyzed on one side. His wife stays with him day and night, feeding him, massaging him, changing his urinary catheter, helping him move. He can no longer talk and only communicates with his eyes. Norodom Sihanouk Hospital, Phnom Penh, Cambodia, October 2002.

A nationwide campaign, "AIDS Can Be Treated", launched by MSF and local NGOs in late 2000, is helping dispel misconceptions many health workers have about HIV/AIDS. With government plans to scale up ARV treatment by the end of 2002, campaign staff are now training people living with HIV/AIDS to be counselors in care centers run by the health authorities. People in precarious economic and social situations are also affected by TB. In Maela camp, MSF

is treating some 120 refugees for TB, including several suffering from multi-drug resistant TB. Illegal migrant workers in the area are also treated.

MSF also provides basic health care at two clinics in Maela camp and Tham Hin camp near Ratchaburi, home to 8,500 Karen refugees. In Sangklaburi, an MSF clinic primarily treats displaced Mon people.

MSF has been working in Thailand since 1983.

Timor-Leste (East Timor)

MSF projects turned over to government

- International staff: 15
- National staff: 55

As part of the move towards full independence, East Timorese health authorities made a decision in September 2001 regarding the withdrawal of funding for international health NGOs that resulted in most such organizations leaving the country. As a privately funded organization, MSF was able to continue work until January 2002, when its ongoing projects were transferred to the Ministry of Health.

From July 2001 to January 2002, MSF involvement in Timor-Leste (East Timor) focused on the northern district of Baucau, where it had been helping to set up a transitional health system since early 1999. As part of this program, MSF provided surgical services and tuberculosis treatment to a population of more than 200,000, supporting five health centers, one health post and five mobile clinics. It also rehabilitated many health structures and provided training to local staff.

MSF began its medical intervention in what is now Timor-Leste in May 1999, three months before the vote for independence from Indonesia, and continued through the post-conflict transitional period.



Indonesia

Go-ahead for first comprehensive AIDS program

- International staff: 30
- National staff: 254

Over 1.26 million Indonesians remain internally displaced as a result of government-encouraged "transmigration," and ethnic and religious differences. A sharp rise in urban poverty, and isolation and the departure of health staff from insecure rural areas leave many excluded from health care.

While repatriation of war-displaced East Timorese seems to be increasing, tens of thousands remain in West Timor. Over half of the 60,000 present in July 2001 in seven camps in Kefa and Kupang assisted by MSF remained in July 2002. In April 2002, MSF set up a program in camps in Belu district mainly focusing on vaccination.

MSF began work in West Kalimantan in 1999 after horrific ethnic violence forced thousands of Madurese transmigrants into makeshift urban camps in Pontianak and Singkawang. When the last camp in Pontianak closed in August 2002, MSF decided to end the project.

MSF continues to provide medical, water and sanitation aid in 15 locations to internally displaced persons (IDPs) and local people affected by civil strife in Ambon and the outlying Maluku (Moluccas) islands. Two boats are used as mobile clinics to reach the islands, mainly Seram and Buru. An emergency preparedness plan was set up in order to react to any eventuality. Support to IDPs and local civilians in North Maluku and in IDP camps in Sulawesi ended in August 2001 as the situation had stabilized.

In January 2001, MSF started a new medical program for sex workers and other vulnerable groups excluded from health care in Jakarta. Mobile clinics in two prostitution zones treat sexually transmitted diseases (STDs) and provide general health care.

MSF is reinforcing local capacity to monitor and respond to epidemics and other emergencies in Jayawijaya, West Papua (Irian Jaya). Merauke in this province is to be site of the country's first comprehensive AIDS program, given official approval in May 2002.

Indonesia remains volatile and numerous population groups are vulnerable. MSF continues epidemiological surveillance for early detection of disease outbreaks and remains ready to bring aid to civilians affected by future violence.

MSF has worked in Indonesia since 1997.

Philippines

Reintegrating Manila's street children

- International staff: 10
- National staff: 75

MSF's work in the Philippines this year has continued to address health problems related to poverty and civil strife.

In the capital Manila, MSF provides a comprehensive package of medical, psychosocial and legal services aimed at facilitating the reintegration of street children into Filipino society. In addition, a separate mobile medical team is now concentrating on street children in District V, one of Manila's six districts and the heart of the city. The team's work is complemented by a child-friendly center in the Paco area of the district and a pilot project offering social support to the families of street children and the communities where they live.

The southern island of Mindanao has long been the site of clashes between the government army and rebel groups. MSF began assisting people displaced internally by fighting in Maguindanao and North Cotabato in 2000. Following the cessation of hostilities in March 2001, the number of people displaced fell from 800,000 in July 2000 to less than 20,000 in March 2002. In light of the improved situation, MSF was able to close its mobile clinics in March and to stop supplying medicines in May.

In neighboring Sulu province, the site of intense civil conflict, MSF continues to provide financial support to a pharmacy cooperative set up in 1997.

A project to improve water quality and sanitation in the slum area of Malabon, north of Manila, drew to a close in spring 2002.

MSF has been working in the Philippines since 1984.

China Targeting assistance to rural populations

- Staff: 37
- Volunteers: 120

The gulf between the riches of China's east coast cities and the abject poverty of its rural regions continues to widen, with a disastrous effect on health care. Many medical professionals have left rural areas; the poorest people cannot pay for the health care they need. MSF continues to provide basic care and tuberculosis (TB) treatment to some of the most vulnerable people.

In Guangxi province, MSF focuses on quality and access to care for Miao, Dong and Yao minority people in Danian and Gongdong. A health economist has worked to increase MSF understanding of how the local health system functions, its cost and its acceptance by the local people. This has led to more targeted training and better follow-up of a network of village doctors. MSF has also begun training midwives in Gongdong. Treating TB is an important part of MSF work in Guangxi. From 1999 to mid-2002, around 200 patients were treated.

In Shaanxi province, MSF provides medical care and social support for 45-50 children at a public welcome center in the city of Baoji. Transferred from detention after being picked up on the streets, these children – mostly boys aged from 4 to 17 – also receive food and educational assistance. An integrated water supply and hygiene promotion program initiated in early 2001 continues to improve public health in poor villages in Kashgar prefecture in Xinjiang Uighur Autonomous Region. MSF is now looking at ways to become involved in AIDS prevention, care and treatment both here and in Henan province.

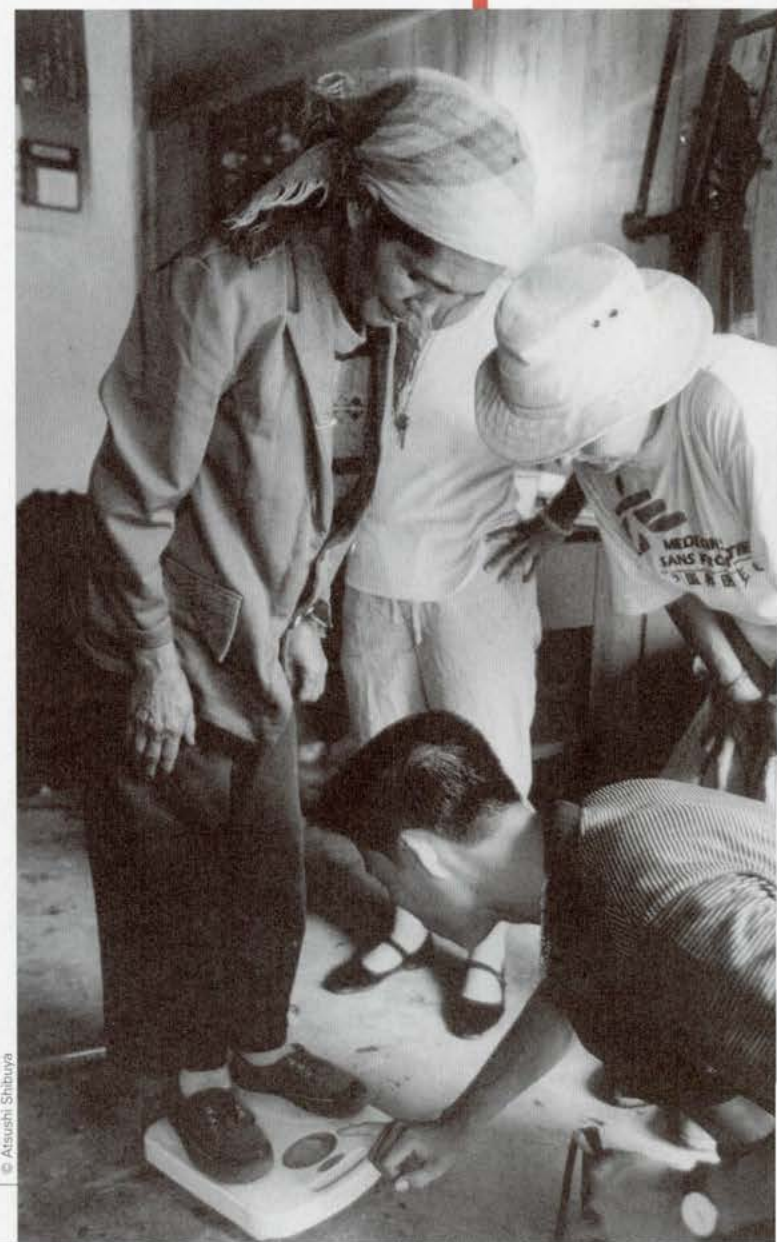
MSF is phasing out some projects after reevaluating its work in several regions. Since 1993, MSF has attempted several basic care projects in Tibet Autonomous Region and has also helped Tibetans affected by Kashin-Beck or Big Bone disease, a painful progressive joint disease. However, it has found it impossible to work either within the collapsing public medical system, or independently, and stay close to people in need. MSF has thus decided to end its existing projects in Tibet by the end of 2002.

A TB program in Nujiang prefecture of Yunnan province closed in June 2002. MSF was only able to achieve a 50-60% cure rate (the target was 85%) after treating 355 patients since 1999. Work to increase AIDS awareness and promote prevention among high-risk groups in Liangshan prefecture of Sichuan province and in Yunnan province also ended in summer 2002.

MSF was forced to cease work in North Korea in 1998 because of lack of access to people in need and lack of independence to carry out its programs. MSF continues to decry the abysmal conditions and state of famine within North Korea and the disappearance and manipulation of food aid given by donor countries. MSF is also supporting North Korean refugees in China through a local network of assistance. In a statement before the US Congress in May 2002, MSF urged the Chinese government and the United Nations High Commissioner for Refugees to ensure protection and assistance for North Korean refugees in China.

MSF has been working in China since 1988.

Weighing a tuberculosis patient in a remote mountain village to calculate the exact treatment dosage for her bodyweight. Nujiang, Yunnan, China, June 2001.





Patricia has AIDS but no access to treatment. By March 2002, she had been on the waiting list for antiretroviral therapy for 11 months. She lives in Guatepeque, Guatemala, with her son and her disabled sister.



Mexico | Work with indigenous people extended to Guerrero

- International staff: 8
- National staff: 60

| Immersed in a low-intensity war, as in the state of Chiapas, or repressed (in the state of Guerrero), indigenous communities often lack access to basic health care. They are stigmatized by society. MSF offers medical care to indigenous people in both these areas and tackles neglected but treatable diseases, such as trachoma, which inflict a heavy economic and social toll.

| In Chiapas, MSF provides basic health care in more than 25 indigenous communities, investigates and responds to acute health needs in the region, and raises awareness about the plight of indigenous people. A trachoma control campaign includes active case finding, corrective surgery, training Ministry of Health staff, and inter-institutional coordination and advocacy. Part of MSF's role is to provide basic health services in a way indigenous communities feel secure using, until minimal confidence in the Ministry of Health can be restored. MSF has plans to operate in the region at least until the armed conflict between the Zapatista National Liberation Army, paramilitary groups, and the Mexican government is settled.

| In April 2002, a new project was opened in the isolated region of La Montaña in Guerrero, to reduce morbidity and mortality rates among the area's indigenous people, particularly women of childbearing age and children under five. MSF work includes consultations, vaccinations, epidemiological surveillance, training traditional birth attendants, and providing health education.

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

El Salvador | MSF enters HIV/AIDS fray with treatment and advocacy

- International staff: 6
- National staff: 25

"The health staff told me that I could not breastfeed but should give artificial milk. That's OK but where am I going to get it? How will I pay for it? Who is going to help me? I cannot sit by and watch my baby being hungry."

Blanca Lidia, an HIV-positive mother six months pregnant with her second child, San Salvador, November 2001

| In November 2001 the government passed the "Law on the Prevention and Control of Infection caused by HIV," which stipulates mandatory testing of employees and patients (at the doctor's request) as well as criminal charges for people who transmit the virus, including breastfeeding mothers with no access to replacement milk. From its vantage point of treating HIV-positive pregnant women, MSF sees this law as opening the door to discrimination against people living with the virus.

| With an alliance of local NGOs, MSF is calling for review and withdrawal of several articles in the new AIDS law, and is trying to raise awareness of the law among international organizations dealing with HIV/AIDS. MSF is also advocating for Salvadorans' access to antiretroviral (ARV) treatment.

Cutting HIV transmission to babies

| MSF's direct work to prevent mother-to-child transmission of the disease is now in its second year. Over 80 mothers and 90 babies had been treated by May 2002 in two mother-and-child hospitals and 12 health posts in the capital San Salvador. Seven or eight babies and mothers are brought into the program each month. In addition to providing ARVs for mothers and babies, MSF provides replacement feeding for babies of mothers with HIV.

| The MSF team also carries out, with national counterparts, prenatal consultations, voluntary testing for HIV, pre- and post-test counseling, and nutritional education.

| In tandem, a condom marketing effort uses sexual health education and condom distribution in 150 bars throughout the country to try and prevent HIV transmission between sex workers and their clients. MSF also advocates for improved quality and access to medical assistance for sex workers.

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



Haiti Improving maternal and reproductive care

- International staff: 13
- National staff: 52



Chiapas, Mexico, 2001. Tzotzil Indians Diego Lopez Gomez, 83, and Maria Santes Torres, 82, live in Yokwitz, a remote community without electricity – though Coca-Cola is available.

Haiti is the poorest country in the Western Hemisphere and has the worst health indicators in the region. There is low vaccination coverage, malnutrition and lack of access to water and sanitation services; people suffer from high rates of respiratory infections, diarrhea and other communicable diseases. Since 1996, MSF has assisted in the implementation of Community Health Units (CHUs), a health care structure introduced as part of the decentralization of the country's health care system begun in 1996. Given Haiti's high maternal mortality rate, a key focus of MSF's work is maternal and reproductive care.

MSF helped launch the CHU covering the communes of Saint-Marc, Desdunes and Grande Saline, which includes a hospital and 18 health centers and covers 200,000 people. Key goals include improving management of the CHU, increasing the level of maternal care at all levels, and ensuring emergency surgery. At Saint Nicolas Hospital in Saint-Marc, MSF trains medical staff in basic surgery and anesthesia techniques for high-risk births.

Since 2001, MSF has worked in the CHU of Verrettes, which covers the communes of Petite Rivière, Verettes and Deschapelles. Again, in the hope of reducing the maternal mortality rate, MSF tries to improve the quality of care and the management and facilities of a health center and two dispensaries in Petite Rivière, where some 2,900 people seek medical care each month.

MSF has been working in Haiti since 1992.

Guatemala

Care for society's "undesirables" including people with AIDS

- International staff: 22
- National staff: 74



AIDS patient Marlene is following antiretroviral treatment through MSF's program at Roosevelt Hospital in Guatemala City. Treatment is helping to extend and improve the quality of her life. Here she collects her next prescription from the pharmacist. March 2002.



© Juan Carlos Torreal

Economic, social and political deterioration in Guatemala in recent years has favored an increase in human rights violations and general insecurity, with society's "undesirables" – poor people, migrants, street children – at particular risk. With about 40% of the population having no access to basic health services, MSF focuses its attention on some of the most vulnerable, including people affected by HIV/AIDS.

In the capital Guatemala City, the Tzite Clinic continues to provide medical and psychological assistance to street children and young people. In Lomas de Santa Faz, one of the city's slums, MSF is in charge of the therapeutic crèche "Casa del Patojo," where children at high risk of ending up in the street, as well as their parents, receive medical assistance and psychological support.

MSF's primary health care program in Champerico, on

the Pacific coast, is focused on improving access to mother-and-child health care through consultations, vaccination and the training of local medical staff. A similar program in Río Dulce, Izabal department, ended as planned in February 2002, after three years.

Antiretroviral treatment

The fight against HIV/AIDS has gained force in Guatemala over the last several years. At several sites around the country, MSF runs integral HIV/AIDS care programs, which include antiretroviral (ARV) treatment for some 150 patients. ARV treatment began in 2001 at Roosevelt Hospital and at an MSF clinic in Guatemala City, and in April 2002 at the clinic of Proyecto Vida, in Coatepeque. The teams also treat opportunistic infections associated with HIV/AIDS, train local medical staff, and offer regular external consulta-

tions, including voluntary counseling and testing. Some patients receive palliative care and ARV follow-up through home visits. (For more on MSF's ARV treatment programs in resource-poor settings, see opposite page.) In addition to its hands-on medical work, MSF also helped organize Central America's Regional AIDS Congress in Guatemala City in November 2001.

The first phase of a project to reduce vulnerability to natural disasters in marginalized areas of Guatemala City ended in February 2002; a second phase focusing on three new neighborhoods began in May 2002.

Guatemala has become a key route for undocumented migration to the United States. Through December 2001, MSF provided medical and legal support for people in transit in San Marcos department.

MSF has worked in Guatemala since 1982.

Treatment starts now: Increasing access to HIV/AIDS treatment in resource-poor countries

Doctor examining an AIDS patient to determine whether he is a suitable candidate for antiretroviral treatment, Roosevelt Hospital, Guatemala City, March 2002.

| There is no cure for HIV/AIDS, which now affects 40 million people worldwide. Antiretroviral (ARV) medicines used in combination, however, help extend and improve quality of life for people living with the disease. But only a very small number of the 36 million people living with HIV/AIDS in developing countries have access to these essential drugs. The drugs are available in industrialized countries at high prices that have till now made them an unaffordable luxury for resource-poor countries for whom prevention was long seen as the only "cost-effective" way to curb the pandemic.

| MSF now runs HIV/AIDS programs in almost 30 countries (including testing, counseling, prevention, palliative care and treatment for opportunistic infections). Refusing to choose between prevention and treatment, and in line with our successful campaign (as part of the Access to Drugs Campaign) to reduce the price of ARVs, MSF began offering them in some projects in 2001. In November 2002, about 2,300 people in Cambodia, Cameroon, Guatemala, Kenya, Malawi, South Africa, Uganda, Ukraine, Honduras and Thailand were receiving them and the number is increasing steadily. We also work to prevent pregnant mother-to-child transmission (MTCT) of HIV in South Africa, Ukraine, Honduras and El Salvador.

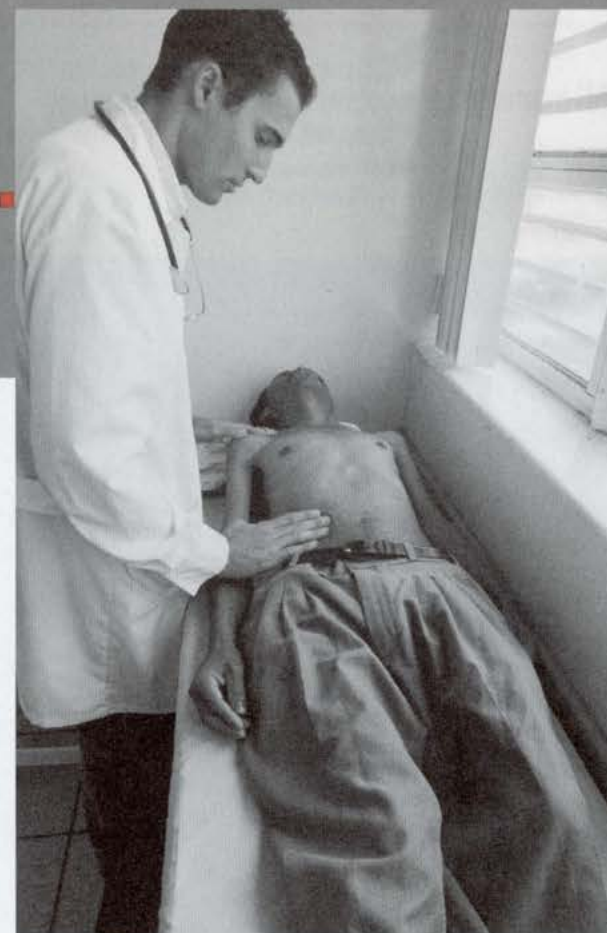
| MSF offers ARVs free of charge using the most affordable combinations of drugs available, a mixture of brand-name products and generics. In Khayelitsha, South Africa, the government has authorized the use of Brazilian generics, thus allowing us to treat three times the number of patients for the same cost.

| MSF selects patients for treatment after consultations to determine their suitability. If the white cell count is below a certain level, there are clinical signs of the disease and patients can comply with the drug regimen, they qualify for treatment. But with limited resources, difficult choices have to be made.

| Initial results after six months of ARV treatment are extremely encouraging: patients gained an average of 5kg and the cell counts improved significantly, with the virus undetectable in over 90% of cases. Clearly, patients in developing countries comply with treatment as rigorously as those in Europe and North America, removing another argument against ARV treatment in such settings.

| MSF trains and works with local health staff. We also try to dispel the stigma surrounding AIDS in most countries, such as Malawi where as many as one in ten people are HIV-infected, yet society is in collective denial. However, attitudes change with the availability of treatment, information and counseling, leading people to use protection and prevent further transmission. Hurdles have to be faced when treating HIV/AIDS patients in resource-poor settings, but MSF is helping to show these can be overcome when individuals and communities are involved in planning and implementing projects.

| If ARVs in developing countries are to be given nationally, patient follow-up must be adapted, simpler monitoring tests developed and resistance risks monitored, all of which MSF is engaged in. We also advocate, with local activist groups, for cheaper, more available ARVs and greater international funding. With 3 million deaths and 5 million new HIV/AIDS cases in 2001, widespread access is essential.



© Juan Carlos Tomasi

Mary, 32, walks eight hours for her weekly appointment at Chiradzulu hospital, Malawi, but has no complaints. "I found out I was HIV-positive in July 2000. I was doubly affected because it turned out my daughter was positive as well. I knew I was going to die, so I started selling my things and stopped working." In August 2001, when the Malawi government registered several ARV drugs, MSF began offering treatment to some patients in Chiradzulu hospital, including Mary. A month later, her hope returned: "I feel stronger, and I can start my business again and look for work on a farm to have a steady income." A year on from the interview, Mary is taking her ARVs regularly and training to be a community AIDS counselor. Her six-year-old daughter is also being followed up as a potential candidate for treatment.

Nicaragua

Coping mechanisms for victims of domestic and sexual violence

- International staff: 9
- National staff: 50

Women in particular suffer from Nicaragua's high level of sexual and domestic violence, and MSF's work continues to address this problem. Reducing maternal and perinatal morbidity and mortality has been the focus of MSF activities in Ciudad Sandino, near the capital Managua, and in rural Quilali, in Nueva Segovia department.

Work in Ciudad Sandino, based in several public health centers and alternative clinics, was expanded in 2002 to put even greater emphasis on coping with the health consequences of sexual and domestic violence. In Quilali, MSF supports the Casa Materna, where women can deliver their babies, as well as a women's center where abused women can file complaints stemming from domestic violence. Over 250 complaints were filed between July 2001 and May 2002. An operating room at an area health center was completed in mid-2002 and should improve access to delivery facilities for the rural population. Direct work in Quilali will finish by the end of 2002, with financial support to Casa Materna continuing into 2004.

From April 1999 through September 2002, MSF was engaged in HIV/AIDS and sexually transmitted disease prevention work in Bluefields and nearby Corn Island. All MSF activities here, including an AIDS information, testing, and counseling center established by MSF, were turned over to local organizations in September.

MSF first intervened in Nicaragua in 1972.

Honduras

Push to widen AIDS treatment

- International staff: 14
- National staff: 54

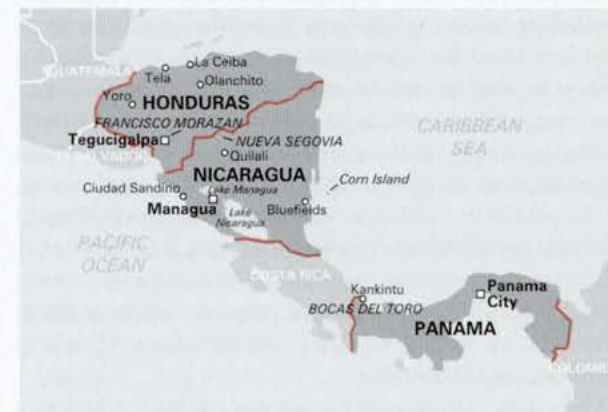
Honduras is home to about 60% of all people with HIV/AIDS in Central America. Despite this, as of mid-summer 2002, antiretroviral drugs (ARVs), which can prolong life, were virtually unavailable. The government, however, was taking some promising steps that would make the first ARVs available in public health facilities by the end of the summer. With a handful of people under ARV treatment, MSF is advocating at the national level to make treatment a reality for more Hondurans, and in its hands-on medical work continues to improve the quality of life and chances of survival of people living with AIDS. Other MSF work focuses on fighting Chagas disease, an endemic parasitic disease, and improving mother-and-child health care in rural Honduras, as well as responding to natural disasters and disease outbreaks.

In August 2001, MSF opened an AIDS clinic in Tela, a city on the Atlantic coast, to serve the area's 130,000 people as well as five nearby indigenous Garifuna communities. MSF offers voluntary counseling and testing; sixty HIV tests are carried out monthly, with over 20% of tests coming back positive. Those who test positive can get treatment for opportunistic infections as well as psychosocial support. About 120 home visits are also carried out each month in collaboration with local organizations. MSF began offering ARVs at the clinic in spring 2002, and around ten patients were under treatment by July 2002. A separate HIV/AIDS project focusing on prevention and care in the capital Tegucigalpa and in the city of La Ceiba, ended in January 2002.

For the last several years, MSF has been fighting Chagas disease in poor, isolated areas in central Honduras. While work in Montaña de la Flor in Francisco Morazan department ended in December 2001 after treatment of the last infected patients identified by MSF, teams continue to diagnose and treat the disease in the Yoro area, although vector control activities ended there in late 2001.

In Yoro and Olanchito, MSF continues its mother-and-child health care program. MSF also aided victims of Hurricane Michelle in October 2001.

MSF first intervened in Honduras in 1974.



Panama | Work with the Ngöbe-Bugle people handed over

- International staff: 5
- National staff: 12

In remote rural areas of Panama, the health care network is very limited; indigenous people have been particularly affected. In November 1998, the administrative autonomy of indigenous territories, or Comarca, was officially recognized. This has improved indigenous people's access to health care. From 1998 through 2001, MSF ran a primary care project in the Rio Cricamola valley, in Boca del Toro province's isolated northern district of Kankintu, inhabited by about 250,000 people of the Ngöbe-Bugle ethnic group.

MSF worked closely with the health authorities to extend the health care network in the area. MSF trained local medical staff, community health promoters, and traditional birth attendants, donated drugs, improved water and sanitation, and carried out vaccination campaigns. MSF re-equipped and expanded Kankintu's health center and built three new health posts in nearby villages. MSF also installed a small laboratory to detect diseases such as leishmaniasis and tuberculosis.

In December 2001, MSF handed the project over to Kankintu's Comarca to ensure the continuation of activities. In support of the traditional culture of the Ngöbe-Bugle and as a complement to the health care network in Kankintu district, MSF continues financial support through 2002 of Medescal, a local organization promoting traditional herbal medicine. Medescal is setting up collective botanical gardens, and encourages botanical research and the scientific validation of the therapeutic impact of herbal medicine.

MSF began work in Panama in 1992.



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These blood samples were taken to test for Chagas disease, a parasitic disease endemic in Honduras. The Chagas parasite is not transmitted by breastfeeding, but can be passed on through blood and from mother to child during pregnancy. June 2001.

Colombia | Assisting civilian victims of increasing violence

- International staff: 30
- National staff: 110

The humanitarian situation in Colombia remains critical. Civil war, forced displacement, assassinations and kidnappings of civilians, and escalating urban violence, coupled with widespread poverty, have worn through the country's social fabric. Moreover, the armed conflict has intensified since peace talks between the government and the Revolutionary Armed Forces of Colombia (FARC) broke down in February 2002.

The two million people displaced by conflict since 1985 are one measure of the human toll. These are often society's most vulnerable – subsistence farmers, women, children and ethnic minorities – and their health is seriously affected. There are high morbidity and mortality rates from communicable diseases (such as diarrheal diseases and respiratory infections) as well as high levels of chronic malnutrition. MSF continues to assist people affected by the violence, in both rural and urban settings.

Taking primary care to rural communities

Following the breakdown of peace talks, MSF organized mobile medical teams to provide primary health care to displaced people and residents in rural areas of San Vicente del Caguán, a formerly demilitarized area retaken by the government in February 2002. The abrupt power shift left health posts unattended, hospital medical brigades suspended and people afraid to risk traveling to seek medical care. MSF's intervention was expected to last about six months but has been extended until the end of 2002 at least.

In other rural areas, periodic forays by medical teams continue to be one of the only chances for people to see a doctor. In Magdalena Medio region and in the departments of Córdoba, Sucre, Bolívar, Caquetá and Tolima, MSF medical teams offer basic care to communities isolated by the conflict or with difficult access to health facilities. Activities include vaccinations, nutritional follow-up, prenatal checkups, fam-

ily planning, mental health care, prevention of diseases such as malaria and dengue fever, and improving water and sanitation facilities. A new primary healthcare program and malaria control project started in May 2002 in El Charco, in Narino department.

To tackle the measles epidemic in the Sierra Nevada de Santa Marta in Magdalena department, two MSF teams collaborated with local health authorities to vaccinate 5,000 people in March 2002.

Medical support for IDPs and victims of violence

Most of Colombia's displaced end up in slums known as *invasiones*, perched on the edges of big urban centers and lacking any infrastructure or services. MSF runs primary healthcare



© Antonio da Silva

■ The rehabilitation team helps a gunshot victim from his wheelchair into an MSF van, Aguablanca district, Cali, Colombia, October 2002.



An MSF bacteriologist examines blood samples from a malaria patient, Pichiguay, Colombia, May 2001.

Ecuador | New sexual and reproductive health program

■ International staff: 10
■ National staff: 20

| The introduction of the dollar as market currency in 2000 has significantly reduced the ability of Ecuador's poorest to afford adequate health care. MSF has begun working with some of these marginalized people in the city of Guayaquil. It also brings basic care to Ecuadorian communities along the Putumayo river and to Colombians fleeing conflict in their own country.

| In May 2002, MSF opened a new program focusing on sexual and reproductive health in Flor de Bastion, a slum of about 43,000 people on the outskirts of Guayaquil. The program was set up in response to needs expressed by the community, where the misery of poverty and unemployment is aggravated by high teenage pregnancy rates, juvenile and domestic violence, and the absence of community health programs or water and sanitation infrastructure. Activities, carried out through the area's three health units, include pre- and postnatal care, family planning and the prevention and treatment of sexually transmitted diseases.

| The primary health care project along the Putumayo river, which forms a natural border with Colombia, continues to provide health care to excluded and displaced people, for the most part in rural communities. Mobile MSF teams train local medical staff in the management and conservation of medicines and vaccines, support community pharmacies, and equip and refurbish health facilities. A primary care program supporting 45,000 people in Susufinde drew to a close at the end of 2001.

| MSF has been working in Ecuador since 1995.

projects emphasizing prevention, mother-and-child health care, and vaccinations in the slums of Soacha, just south of Bogotá, and Florencia, the capital of Caquetá department. Water and sanitation activities were phased out in November 2001, and MSF expects to turn over its Soacha clinics to the local hospital in late 2002.

| In Cali's impoverished Aguablanca district, MSF runs a physical and psychological rehabilitation and prevention program for victims of urban violence – most of whom have suffered injuries, such as paralysis, as a result of gun violence – and their families.

| A one-year medical and social program assisting sex workers and their families in Bogotá finished in July 2001.

Speaking out for the displaced

| During the second half of 2001, MSF carried out research on both access to health care and forced displacement in Colombia. The resulting report was submitted to the presidency of the European Union in May 2002 to highlight the magnitude of the humanitarian crisis and the need to increase pressure on the Colombian government to assume responsibility for the plight of its displaced people.

| MSF has worked in Colombia since 1985.

Bolivia | Primary care reaches women and children

- International staff: 9
- National staff: 29

Basic health care is out of reach for many Bolivians, and access to treatment for some diseases almost impossible. MSF provides primary care in rural and urban areas. It is also preparing to treat Chagas disease, an often fatal parasitic disease.

MSF continues its primary health care program in Chimore in Cochabamba department, where the coca eradication policy has led to frequent violations of human rights. In collaboration with the local health center, the team supports primary care programs and runs education activities on hygiene, nutrition, mother-and-child health care and reproductive health. The project includes water and sanitation work to improve hygiene conditions in schools.

In impoverished El Alto, a city of about a million inhabitants on the outskirts of the capital La Paz, MSF efforts to strengthen mother-and-child health care are slowly taking shape. After extensive local administrative delays, MSF is now helping rebuild the Los Andes Hospital.

To help contain a yellow fever epidemic that hit the country in early 2002, MSF participated in a massive vaccination campaign in March, reaching 80% of the population in Chimore municipality.

In late 2002, MSF plans to begin activities to diagnose and treat Chagas disease in O'Connor province, Tarija department, one of the areas where it is most prevalent. Chagas disease is transmitted by triatomine insect bites and blood transfusions. It is endemic in Latin America and affects about 30% of Bolivians.

MSF has worked in Bolivia since 1987.



© Serge Sibert/Cosmos

An MSF nurse examines an Ashaninka baby for manta blanca sandfly bites and signs of leishmaniasis. The nurse has been working with MSF for more than five years; he speaks the Ashaninka's language and is familiar with their customs and traditional medicine. Peru, 2001.

Brazil Helping Rio's down and out

- International staff: 2
- National staff: 21

Nearly one-third of Rio de Janeiro's 10 million people live in extreme poverty in the city's *favelas* (slums), or on the streets and under viaducts. For the last five years, MSF has been tackling some of the health problems common to people living in these precarious conditions.

From 1998 to late 2001, MSF ran a combined medical and social program in the impoverished and violence-prone Costa Barros favela in northern Rio. The clinic and related family health program focused on improving health care for mothers and children, and preventing and treating communicable diseases. It was turned over to a local NGO in October 2001.

MSF is continuing its combined medical and social program aimed at improving the health of some of the thousands of people living on the streets in downtown Rio de Janeiro. An accompanying information campaign is aimed at sensitizing the broader public to the plight of the homeless.

After over a decade bringing health assistance to indigenous people in Brazil's Amazon region, MSF handed over its equipment and educational materials to local actors in February 2002.

Brazil supplies antiretroviral (ARV) treatment free of charge to all Brazilians with AIDS, thanks to generic drugs produced by the federal public pharmaceutical laboratory Far-Manguinhos. MSF has signed a collaborative agreement with the health authorities that includes the use of Brazilian drugs in some of MSF's ARV projects; and began using them in South Africa in January 2002 (see page 46).

MSF has been working in Brazil since 1991.

Peruvian Mauro, 48, walks two hours every day to an MSF health center for injections to treat his leishmaniasis ulcers. The shape of the ulcer on his elbow is recorded on tracing paper so that its development can be observed. The ulcer hinders him at work; another is eating away at the inside of his nose. His legs show scars from earlier ulcers for which he was treated three years ago. Exposed daily to the bites of the infecting manta blanca sandfly, he has not seen the end of the disease. Peru, 2001.

Peru Push for generic leishmaniasis drug

- International staff: 9
- National staff: 45



© Serge Siret/Cosmos

Quality health care is still not assured for people living in Peru's isolated rural areas and urban slums. In woodland areas, diagnosis and treatment of diseases such as leishmaniasis is difficult and expensive; while lack of means and precarious social conditions in urban areas often impede access to care. MSF provides care to people in both settings.

Since early 2001, MSF has diagnosed and treated cutaneous and mucocutaneous leishmaniasis, a parasitic disease of the skin and mucous membranes transmitted by *manta blanca* sandfly bites, in San Martin de Pangoa, Satipo province. Some 250 patients were treated in the year ending July 2002. MSF does active case searching, treatment and follow-up, and trains local medical staff. Through its Access to Essential Medicines Campaign, MSF is also working with the Peruvian authorities to introduce generic sodium stibogluconate, an effective and affordable treatment for this disease.

MSF is working in four districts of the capital Lima to improve access and quality of care for people with HIV/AIDS and to promote prevention of this and other sexually transmitted diseases (STDs). At Maria Auxiliadora Hospital, the team offers outpatient consultations and trains local medical workers in counseling and integral care for AIDS patients. Activities include home visits, counseling and treatment of opportunistic infections. A second HIV/AIDS and STD prevention and care program is run in Lurigancho prison, Lima's largest and most overcrowded jail. MSF's Access to Essential Medicines Campaign is also working with the Peruvian network "Colectivo por la Vida" to increase access to affordable antiretroviral medicines.

After working for five years to address sexual and reproductive health, child abuse and violence in the Lima slum Villa El Salvador, MSF transferred its project to the Ministry of Health in March 2002. A new MSF program started working with some of the poorest neighborhoods in July 2002 to support children and adolescent victims of violence and sexual abuse.

MSF has been present in Peru since the end of 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 and the United States, and an international office in Brussels.

Each section of MSF publishes annual, audited financial statements according to its national accounting policies, legislation and auditing rules. Copies of these may be requested from the individual sections (see page 98).

Based on these audited national statements, the figures presented here provide an estimate of MSF's finances on an international level. These combined international figures have not been audited and are therefore not certified. The figures are for the 2001 calendar year; the Activity Report itself covers the period July 2001 to August 2002. All amounts are in millions of euros.

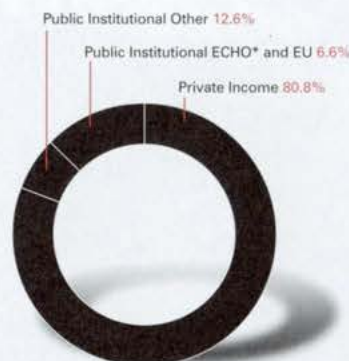


© Juan Carlos Tomasi

■ Measles vaccination campaign, Yakawlang, Afghanistan, January 2002. MSF international and national staff work hand in hand in all MSF projects around the world.

Income

Total Income: 340.4

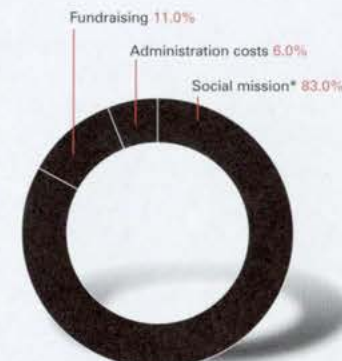


Private Income	275.1	80.8%
Public Institutional ECHO* and EU	22.3	6.6%
Public Institutional Other	43.0	12.6%
Total Income	340.4	100.0%

*European Community Humanitarian Office

How was the money spent?

Total expenditure: 333.8



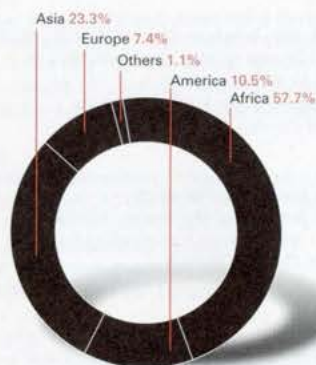
Social mission (Operations + Témoignage and advocacy)	277.1	83.0%
Operations	259.5	77.7%
Témoignage and advocacy	17.6	5.3%
Fundraising	36.8	11.0%
Administrative costs	19.9	6.0%
Total expenditure	333.8	100.0%

Income

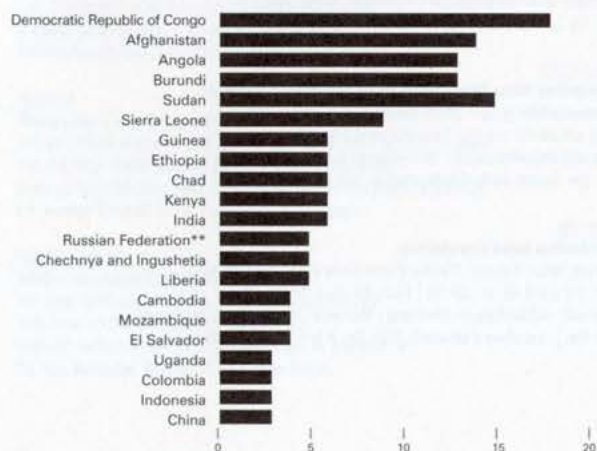
As part of our effort to guarantee our independence and strengthen our link with society, we have been striving to increase our level of private income. In 2001, 81% of MSF's income came from private sources. Over 2.5 million private funders and individuals worldwide helped make this possible.

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

Project expenses per continent



Where was the money spent?*



* Expenditure over 3 million euros

**Excluding Chechnya and Ingushetia

Year-end financial position

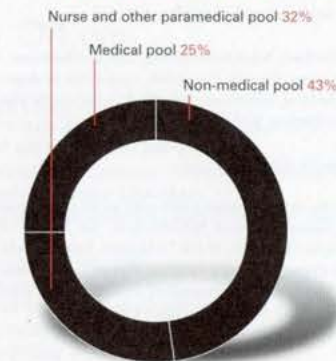
		Total assets: 241
Long-term assets		25
Current assets		56
Cash and equivalent		160
Total assets		241
Liabilities		45
Unrestricted net assets	187	
Restricted net assets	9	
Net assets		196
Total net assets + liabilities		241

Year-end financial position

Restricted net assets may be either unspent donor-designated funds, which will be strictly spent by MSF in accordance with the donors' desires (eg, on specific countries or types of interventions) as needs arise; or they may be capital funds, where the assets are required to be invested, or retained for future use, rather than expended. Unrestricted net assets are unspent donor non-designated funds expendable at the discretion of MSF's trustees in furtherance of our social mission.

MSF's net assets have been built up over the years by surpluses of income over expenses. As of end of 2001, their available part (the unrestricted net assets) represents 6.7 months of activity. The purpose of maintaining net assets is to meet the following needs: future major humanitarian emergencies for which the obtainable funding is insufficient, and/or a sudden drop of private and/or public institutional funding, and the sustainability of long-term programs (eg, antiretroviral treatment for people living with HIV/AIDS), as well as the pre-financing of operations to be funded by upcoming public funding campaigns and/or by public institutional funding.

Aid workers in the field



	Total	
International departures (full year):	2 895	100%
- Medical pool	727	25%
- Nurse and other paramedical pool	933	32%
- Non-medical pool	1 235	43%
First time departures (full year):	984	*34%
Other HR statistics (average)	14 925	
- Fieldposts	1 605	
- National staff	13 320	

*of the international departures

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