



ACTIVITY REPORT

NOBEL PEACE PRIZE 1999

1999 - 2000



ACTIVITY REPORT 1999-2000

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COVER

Holding their intake papers, people await treatment by MSF at the stadium in Dili, East Timor in October 1999. A violent backlash to the area's August independence referendum had caused hundreds of thousands of people to flee their homes. These people were returning to Dili after hiding in the hills.

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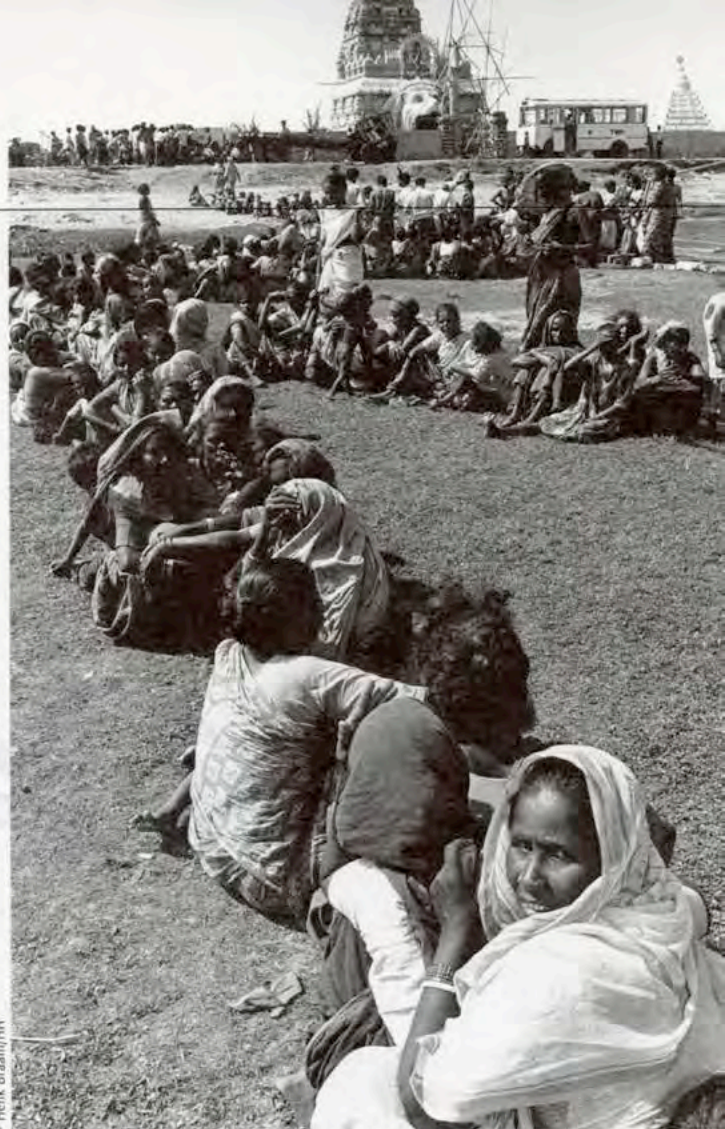
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People wait for food and drink near a temple in Paradip, in India's state of Orissa, after the region was hit by a massive cyclone in October 1999. MSF responded to the disaster with medical care and other aid.

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The Year in Review

In many ways, this has been a normal year for MSF, with the sudden demands of emergencies like the floods in Mozambique, the earthquake in Turkey, and war in Eritrea. There was also the daily persistence of our ongoing work caring for psychiatric patients in Tajikistan, treating TB sufferers in Russia, feeding children in Angola, training birth attendants in Peru, helping AIDS patients in Cambodia. All of this is part of our mission of bringing medical aid and speaking out. We do this in over 80 countries around the world.

But for us it was also an exceptional year, with the award of the Nobel Peace Prize bringing both increased attention and support to our action. When introducing MSF at the Nobel Awards, the chairman of the Nobel Committee explained that "the essential points for Médecins Sans Frontières are to reach those in need of help as quickly as possible, and to maintain impartiality. They demand freedom

close to the ideal of independence from political forces, of impartiality in conflicts, when the success of humanitarianism has led to an invasion of its sphere by political, military and economic interests? Today, humanitarianism carries so much emotional and historical weight that it has become a target for manipulation, a smokescreen to conceal entirely self-interested motives. In addition, the "humanitarian" label is selectively employed. These trends have been obvious in the past year in the very different levels of international response to crises in Kosovo and East Timor, for example, when compared to several places in Africa.

In Kosovo, NATO governments gave a humanitarian label to the war to generate public support for military intervention. They supplied vast resources to humanitarian activities, apparently for the same reason. A number of these "humanitarian actions" were provided through NGOs from

MSF REFUSES TO WAIT FOR THE APPROVAL OF ALL PARTIES BEFORE ACTING. IT INSISTS ON THE RIGHT TO SPEAK OUT IN THE FACE OF HUMAN RIGHTS VIOLATIONS. PUTTING POPULATIONS IN DANGER FIRST, ABOVE POLITICAL CONSIDERATIONS, IS ENGRAINED AS CORE TO OUR MISSION – AND IN THIS MSF HAS HELPED SHAPE THE HUMANITARIAN MOVEMENT WORLDWIDE.

to carry out their medical mandate, and to decide for themselves whom to help according to purely humanitarian criteria. What is more, they insist on making violations known. In addition to helping, in other words, they also seek to draw attention to the causes of humanitarian catastrophes. To alleviate distress one must also get to its roots."

This acknowledgement goes to all our teams, who on a daily basis struggle to bring a sense of humanity to abnormal situations, by listening to people and caring for them, trying to restore their dignity. This is medical, and this is personal. It is done by every MSF volunteer with every person suffering, regardless of his origin or beliefs. It is an expression of hope and fraternity with another human being.

When MSF began, it changed the nature of humanitarian action. It refused to wait for the approval of all parties before acting. It insisted on the right to speak out in the face of human rights violations. Putting populations in danger first, above political considerations, is engrained as core to our mission – and in this MSF has helped shape the humanitarian movement worldwide.

But how can MSF stay

their own countries, which further blurred the line between independent humanitarian actors and the parties to the conflict. MSF was so concerned about this deliberate confusion of military and humanitarian labels that we refused all funds from NATO countries for our work related to the conflict. MSF insisted that the armed forces involved in the conflict be removed from the refugee camps to avoid endangering the people seeking shelter.

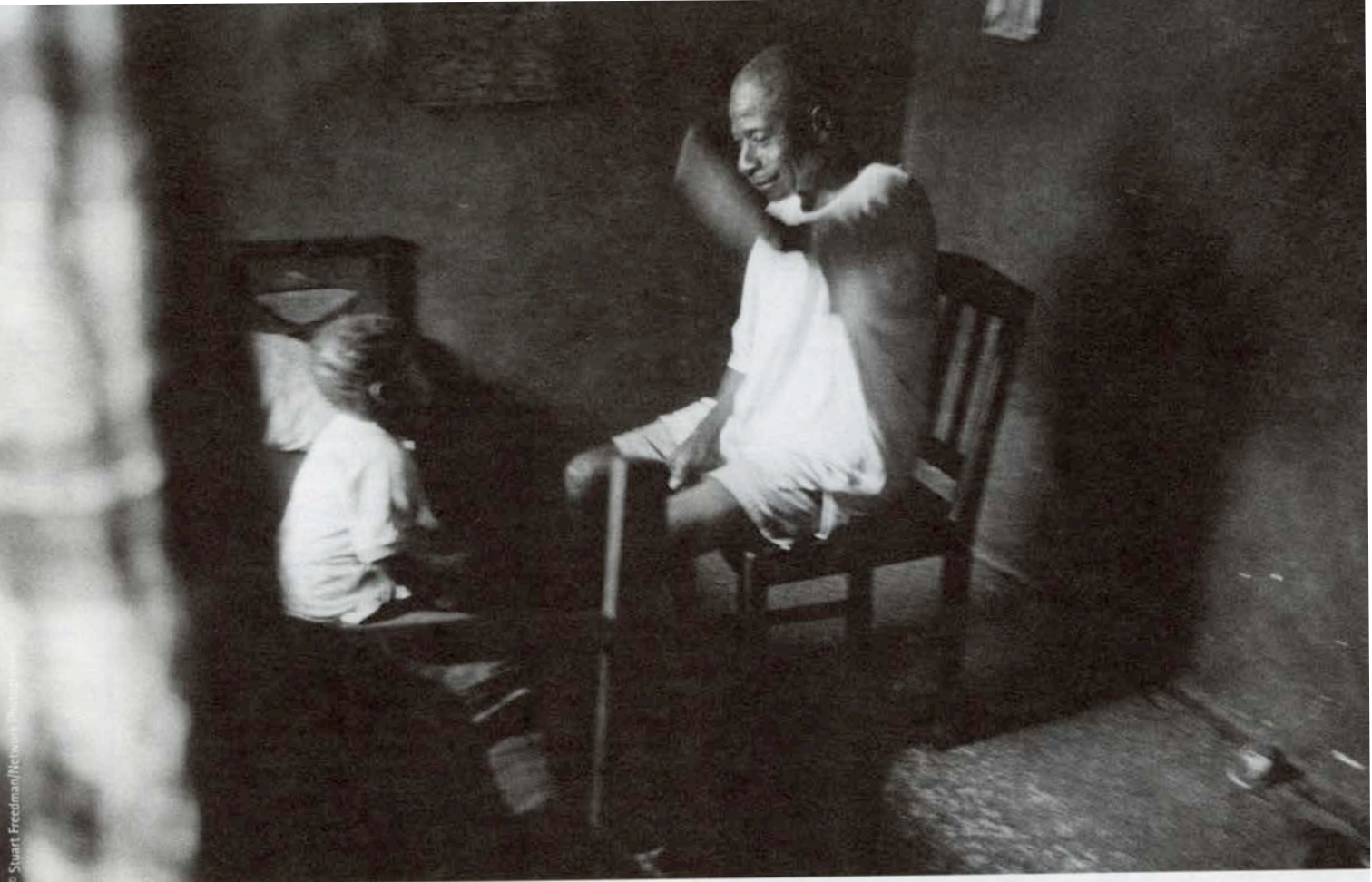
A lot of international resources also went to the UN intervention in East Timor (in the wake of violence following the area's positive referendum on independence from Indonesia), for both peacekeeping and humanitarian action. At the same time, in West Timor (which remained part of Indonesia), large numbers of people were regrouped and abandoned without protection or help. We question the different responses offered in the face of the same need.

Progressing down the scale of international concern and response, the picture gets worse. When the Russian government indiscriminately and disproportionately bombed civilians in Chechnya, the idea of "morally-based intervention," justified in Kosovo on humanitarian grounds, no longer seemed to apply. This contributed to the fact that humanitarian organizations were denied access – despite our protests – to people who were most in need of help.

At the bottom of the scale, Africa seemed to be totally abandoned. Poorly equipped and supported peacekeeping operations in Sierra Leone and the Democratic Republic of Congo are in stark contrast to the well-equipped peacekeepers in Kosovo, a vivid illustration of the lack of interest in Africa. So often, when Africa is concerned, it is easy for the outside world to sit back and push the idea of a "regional approach" – let West Africa take care of West Africa.



A mother holds her young child at an MSF therapeutic feeding center in Karusi, Burundi.



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COMPARED TO EAST TIMOR AND KOSOVO, THE DIRE STATE OF AFFAIRS IN MANY PLACES IN AFRICA ELICITED LITTLE EFFECTIVE HUMANITARIAN ACTION OR POLITICAL INTEREST FROM THE INTERNATIONAL COMMUNITY.



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Forgotten or even unknown conflicts and horrors in Congo-Brazzaville, Angola and Burundi show how easy it is for the world to turn its back. Compared to East Timor and Kosovo, the dire state of affairs in many places in Africa elicited little effective humanitarian action or political interest from the international community. It was sometimes hard for our volunteers to see any international relief at work in these places, much less any genuine concern for the protection of civilians.

The objectives of a conflict too often take precedence over the protection of populations. Governments often push their territorial, political or economic goals through armed conflict and expect international relief organizations to care for the civilians. This may happen directly or indirectly, but it always happens knowingly. It always provokes the outrageous consequences of violence, famine or epidemic disease. This was the case in Ethiopia, Eritrea and Burundi.

Even more disturbingly, external states are actively participating in internal conflicts in a number of countries, ignoring the interests of civilian populations. Who cares for Congolese civilians in the Democratic Republic of Congo when Rwanda and Uganda are occupying part of the country, or when Zimbabwe and Angola are active in the conflict? The same could be said for other countries in Africa, like Angola and Sierra Leone.

This adds to the sense that humanitarian action is often

This lack of access to lifesaving medicines is a result of increasing resistance of diseases to old drugs, unacceptably high prices of the drugs which are available (often still under patent), and lack of research into new medicines. Poor people have a need, but they are not a viable market. In a globalized world, they are of no interest to economic actors.

Traditionally, MSF has spoken out to bring international attention to abuses within a country's borders, hoping to bring pressure on a government to effect change. The injustice of the lack of medicines can only be fought at the international level. We have to address not only the responsibility of the state (as we have done many times in the past, in the case of conflict or injustice) but the often unclear responsibilities of different companies, actors and states. We advocate for a better balance between the interests of peoples' health and the financial interests of multinational companies.

We are pushing for solutions to the fundamental problem of ensuring access to medicines for all. We have increased our medical programs accordingly and simultaneously launched a campaign to improve access to essential drugs for poor people. This is a new ambition for MSF.

During the last year, together with allied organizations, we helped raise awareness of this problem, questioning political leaders and public opinion.

Public leaders have subsequently addressed this question,



WE DO NOT ACCEPT THAT PEOPLE CANNOT AFFORD LIFESAVING MEDICINES, THAT THEY GET INEFFECTIVE 40-YEAR-OLD DRUGS, OR THAT RESEARCH AND DRUG DEVELOPMENT IS NOT CONSIDERED A PRIORITY FOR POOR PEOPLE'S ILLNESSES. WE SIMPLY WANT TO BE ABLE TO TREAT PATIENTS WITH AFFORDABLE DRUGS THAT WORK.

confronted with seemingly intractable conflicts, such as those in Angola, Sudan, Afghanistan and Colombia. In these cases, ensuring protection of civilians, very often displaced, remains a challenge for us. This is especially true for vulnerable people and people who are totally disregarded, like children, women or the elderly. These are not "interesting" groups for those in power.

We have faced similar difficulties for years now, and they have not stopped us from trying to bring some normality to inhuman situations. We know the limits of what we can achieve. We can often only mitigate the effects of violence on people who are far from media attention, although we also try to raise awareness of what is happening. Our responsibility is simply to do more – all that we can – for them.

One way we are trying to do more is in the fight against disease. There is a dramatic difference between how diseases affect the poor, and in how they affect the rich. This is often simply a matter of access to medicines.

Nearly two billion people – the world's poorest – lack access to effective drugs to treat certain diseases (e.g. AIDS, tuberculosis (TB), malaria, sleeping sickness and kala azar) that kill more people than do wars. The consequences for a country's economy and society and the well-being of its people are devastating.

at the World Trade Organization meeting in Seattle and in other important international settings. The international media has brought attention to these issues. However, this is not enough, and we must achieve more by increasing the pressure, with a view to reducing drastically the price of some essential drugs, through generic and local production. Research for priority diseases must also be relaunched; slowly we are starting to see some movement in this area.

We are initiating actions to make existing drugs available for patients with sleeping sickness or resistant TB, by pooling purchases, in order to show that it is feasible to treat such diseases. We are also pushing to ensure that relevant authorities manage both the continuation and widening of this action. Ensuring access to essential medicines is a long process whose effects are not going to be seen within one year. It needs continuous political commitment and public resources.

We are doctors. We do not accept that people cannot afford lifesaving medicines, that they get ineffective 40-year-old drugs, or that research and drug development is not considered a priority for poor people's illnesses. We simply want to be able to treat patients with affordable drugs that work. These drugs must be seen as common public goods. This is our vision and practice of our common human dignity and fraternity. We hope we will get your support in this new ambition and challenge. ■

*Dr Jean-Marie Kindermans
Secretary General*

* A man whose arm was brutally amputated shares a light moment with his granddaughter in Sierra Leone. Many adults – and children – have been subject to forced amputations at the hands of the those vying for control of the country.

* A woman stricken with sleeping sickness lies in the grass outside a clinic in Ibba, Sudan. Sixty million people in sub-Saharan Africa are at risk for the disease, but treatment still relies on archaic, toxic or expensive drugs.



Grozny, the Chechen capital, is reduced to a shell after the Russian bombardment in 1995. The destruction was repeated in 1999.

BETWEEN HUMANITARIAN LAW AND PRINCIPLES

The principles and practices of “rebellious humanitarianism” by Françoise Bouchet-Saulnier

Françoise Bouchet-Saulnier is Director of Research at the Médecins Sans Frontières Foundation, and author of the Dictionnaire pratique du droit humanitaire (Éditions La Découverte, 2nd edition, 2000).

Without a doubt, the 1990s saw a renewed focus on law and humanitarian principles in the official language of the United Nations and national governments, and in the language of NGOs. We should not be surprised by this, nor should we try to pretend that it represents a moral victory for law and principles. Reference to the law is always strongest precisely at those moments when respect for the rules disappears. We had to wait until the cruelty of ethnic cleansing had reached its logical conclusion in the former Yugoslavia, and until genocide had run its full course in Rwanda, before talk of law and justice replaced talk of realpolitik and the political and humanitarian cover provided for these crimes by international agencies. These massacres shattered the illusion of an all-powerful humanitarianism, underlining the limitations of humanitarian action in certain situations and raising questions about how endangered populations should be protected.

Caught between the requirements of peacekeeping, human rights and humanitarian law, how are NGOs to make use of the law without sacrificing their freedom of operation, and without giving in to legalistic hypocrisy or outright pragmatism?

Humanitarian action and human rights

A number of initiatives emerged after the disasters in Rwanda and the former Yugoslavia, reflecting a desire to improve the quality and standards of humanitarian action. These initiatives also affirmed the importance of making respect for human rights an integral part of humanitarian action and basing that action on principles, in order to limit the acts of violence committed against people. This desire was embodied in projects such as “Sphere” (an international initiative working to establish technical standards for humanitarian action) and the use of humanitarian mediators. It is reflected in the codes of conduct drawn up by a number of countries with a view to standardizing practices of various humanitarian actors. It also reflected in UN-implemented strategic frameworks – efforts to make humanitarian action part of a broader project that includes the restoration of peace, respect for human rights, and economic reconstruction.

This tendency to adopt a more global approach is an

attempt to group humanitarian action together with peacekeeping, the restoration of democracy, and human rights. It is a comforting approach, because it obscures the relatively modest impact of humanitarian action in situations of conflict or crisis, by integrating it within a grander design of conflict resolution and the restoration of peace. It is also more comfortable for humanitarian organizations themselves, because it places the limited action of each organization into a broader framework. For example, humanitarian organizations that witness massive crimes need only convey the information to human rights organizations, thereby avoiding the difficult choice between denunciation (at the risk of expulsion) and silence (at the risk of complicity).

However, this kind of approach blurs the nature of each organization’s responsibility. Public statements made by humanitarian NGOs address not only violations of human rights, but also (and more importantly) the quality of relief actions, and the obstacles placed in their way. This discreet cooperation between humanitarian and human rights organizations is not necessarily synonymous with security. Indeed, in a context in which human rights are an element of international diplomacy, giving confidential information to human rights groups might be regarded by the authorities as clandestine, suspicious and subversive. Passing on information this way hardly ensures the safety of humanitarian staff working in the field. Moreover, it may make protection of the populations concerned subject to the specific agenda of human rights diplomacy.

Coordination of activities increases the ability of an organization to put pressure on the warring parties. With this approach, however, relief operations become a pawn in a power game that is perilous for humanitarianism. By participating in this process, humanitarian organizations become prey to the weaknesses and failures of the entire system. If, for example, it becomes impossible to maintain peace, humanitarian organizations lose their neutral status in the eyes of whichever warring party has rejected the peace. As a result, people living in the territories controlled by such parties are deprived of all relief activity. In Sierra Leone, Afghanistan and Angola, for example, this approach – which was supported by the UN – did not lead to an increased respect for humanitarian principles on the part of the warring parties. On the contrary, it served to justify the fact that part of the population was deprived of the humanitarian relief



offered by the official international community.

Thus, a genuine conditionality of humanitarian aid has gradually taken hold, in the name of peace and human rights. However, although the practice of conditionality may take refuge behind these noble objectives, it in fact violates the only absolute principle of humanitarian action: impartiality. This principle dictates that humanitarian aid obey no other imperative than that of the needs of people, and it provides the foundation for humanitarian organizations' right to access conflict areas. And yet, must we be reminded that once the door of conditionality has been opened, we no longer have any way of monitoring how it is being abused for the purposes of other, less humanist agendas? Paradoxically, the most serious consequence of this approach becomes the subordination of humanitarian aid to non-humanitarian objectives. In this context, it is important that we stop believing in the fantasy of a humanitarian community comprising United Nations organizations, humanitarian relief agencies, human rights groups, and certain democratic, developed countries deemed to be virtuous.

The strength of humanitarian action resides not in the power of a group brought together in the name of the defense of human rights or peace. Instead, it lies in the relevance of the humanitarian action itself, and in the independence in the face of power that makes the humanitarian presence in the field acceptable to warring parties. This independence is reflected in respect for the operational principles governing the practical side of conducting relief actions. We must therefore go beyond the comforting notion of a humanitarian

are charged with upholding them. The conventions accord no specific rights to NGOs. Human rights allow for acts of denunciation, but they do not constitute a frame of reference for humanitarian relief operations. Humanitarian law, on the other hand, is concerned with periods of armed conflict. It is enshrined in four conventions signed in Geneva in 1949 and in two additional protocols of 1977. These laws set out specific rules regarding protection and assistance to precise categories of vulnerable people (civilians, the sick and wounded, and those deprived of freedom) in situations of armed international or internal conflict. The laws also define the rights conferred upon the ICRC and impartial humanitarian organizations to provide humanitarian assistance to endangered populations independently of governments and warring parties.

Some NGOs see the law only as a source of constraint and limitation. Yet it is thanks to the specific provisions of humanitarian law that NGOs are able to claim independence in their actions with respect to governments; demand access to victims; assert control over the distribution of relief; enter a country's territory without prior consent in order to bring medical relief to the wounded and the sick; and identify and denounce war crimes and crimes against humanity.

Humanitarian law does not, therefore, limit the concrete action of NGOs. On the contrary, it ensures that offers of relief made by independent and impartial humanitarian organizations may not be considered interference in a country's internal affairs. It also gives such organizations the responsibility to formulate and propose all initiatives required to ensure the protection of endangered populations.

IT IS THANKS TO THE SPECIFIC PROVISIONS OF HUMANITARIAN LAW THAT NGOS ARE ABLE TO CLAIM INDEPENDENCE.

community. Humanitarian action is not enough to guarantee respect for human rights and may not be used as a bargaining chip to secure respect for human rights in a certain country. We must accept that simply referring to human rights is not an adequate or appropriate way of guaranteeing the quality of humanitarian action.

Humanitarian law and human rights

In order to strengthen the quality of humanitarian action, it is important to specify that, beyond human rights in general, there exist more precise commitments and rights for which humanitarian organizations are more particularly responsible.

Human rights conventions state general principles for the treatment of individuals by governments. These rights are often limited in periods of conflict, and it is governments that

Lastly, humanitarian law stipulates that no sanctions may be imposed on those who have practiced medical activities in an ethical manner, regardless of the circumstances.

Humanitarian law therefore goes far beyond general principles. It provides minimum rights that help guarantee the survival of vulnerable people in situations of danger. It traces the limits between human rights violations and crimes against humanity. It authorizes and regulates relief action and gives responsibility for such action to independent organizations. In the conventions mentioned above, states explicitly recognize specific rights of and entrust certain responsibilities to NGOs. Impartial humanitarian organizations are responsible for verifying the overall situation of endangered populations and ensuring that they receive aid. The organizations implement relief operations aimed at protecting such people from the various threats posed by the conflict.

The responsibility of humanitarian NGOs is directed more toward negotiating the concrete conditions governing their aid actions than toward denouncing violations of law or justice after the fact. The humanitarian code of conduct recently devised for NGOs in Sierra Leone, for example, affirmed the commitment of NGOs to improving respect for human rights. This makes little sense, however, since quite obviously they are not the ones committing the violations. Humanitarian responsibility should not be confused with the monitoring of human rights violations. Nor should humanitarian responsibility be delegated to human rights organizations. Improving humanitarian action requires strengthening the framework and principles which are in its area of responsibility.



Clémence K. calls her daughter, conceived when she was raped during the Rwandan genocide, Umumararungu, or "the one who cures my loneliness." This image is part of the MSF exhibit "The Wounds of Silence," featuring portraits and testimonies of survivors and perpetrators of the genocide in Rwanda.

Responsibility and humanitarian principles

The responsibility of humanitarian organizations is directly related to their role as actors who are present during situations of violence. They are responsible for negotiating relief conditions with the warring parties, in accordance with the protection offered to victims of conflicts under humanitarian law. They are charged with bearing witness to the obstacles encountered while fulfilling their mission to assist and protect populations. They are also responsible for denouncing situations in which the presence of relief organizations has been diverted from its objective, or in which that presence is used to endanger the population that it is supposed to be protecting. These are particularly grave situations, because the humanitarian presence is being used against the interests of the people.

Médecins Sans Frontières has experienced various situations in which humanitarian organizations were used as a way to locate and attack places where groups of vulnerable people had taken shelter. This happened, for example, with the Rwandan refugees in the Shabunda region of eastern Zaire in 1996. In other instances, aid distribution has been used to bring together people who were subsequently attacked, pulled away from the group, or forcibly displaced. Relief organizations have in some cases been authorized to provide aid merely in order to give a semblance of normalcy to situations where – despite the assistance provided – populations have been subject to acts of violence and abuse.

In a situation of this kind, it is important that humanitarian organizations be able to evaluate the real

Rebellious humanitarianism

By awarding the Nobel Peace Prize to the “rebellious humanitarianism” of Médecins Sans Frontières, the Nobel Committee chose to reward the sometimes controversial choices made by MSF, which sees acting and speaking as two inseparable elements of providing relief to endangered people.

Médecins Sans Frontières does not see itself as a cog in the machinery of international solidarity, responding to medical needs like some eager hired hand summoned to deal with the failures of states or of global privatization. MSF sees in these medical needs often deliberate choices to exclude certain populations, or symptoms of the dysfunction of societies in general and of international society in particular. In cases such as these, material relief is simply not enough. Indeed, by providing such relief, organizations often run the risk of giving a semblance of normalcy to situations of extreme violence. In some cases, authorities allow relief operations only in order to more effectively conceal their hostile intentions toward certain populations. They may also intentionally create the suffering and deprivations of such people, in order to attract and more effectively divert the aid provided for them.

In such situations, humanitarian organizations react in various ways. Some believe that they have no responsibility – and no capacity – to influence the political, military or economic context or any potential manipulation and corruption of their actions. They regard themselves as accountable only for their presence and the quality of their intended relief operations. Others, however, believe that relief

PUBLIC STATEMENTS BY HUMANITARIAN ORGANIZATIONS CONSTITUTE, IN EXTREME CIRCUMSTANCES, A GUARANTEE OF THE QUALITY OF THEIR ACTION AND AN ACT OF PROTECTION FOR ENDANGERED POPULATIONS.

nature and effectiveness of their action. Many NGOs are still at a very early stage when it comes to assuming such responsibilities. They mostly limit themselves to generalized debates on the moral dilemmas surrounding humanitarian work, without being willing to accept the risk of denouncing these abuses or abstaining from relief action.

Clearly, the concept of humanitarian responsibility goes beyond simply denouncing human rights abuses. Humanitarian responsibility is also a concept that does not fit in easily with the complex mechanisms of complementarity and international coordination.

organizations have operational responsibility, reflected in their ability to negotiate, make public statements, and, perhaps, even suspend their relief activities. This responsibility is an essential counterweight to the significant political, military and economic constraints imposed upon their actions.

Lastly, MSF is a member of the youngest generation of humanitarian organizations. Created after the Second World War, it is among those organizations questioning the role of humanitarianism with regard to genocide. It refuses to accept that silence is a precondition for its operational freedom. Indeed, for MSF, public statements are a rarely used but indispensable tool that enable NGOs to assume their responsibilities as relief actors. Public statements represent an essential and legitimate aspect of humanitarian action, which in certain circumstances must call into question the dogma of operational freedom at all costs. This attitude was reaffirmed in the words of MSF upon the award of the Nobel Peace Prize: “We don’t know whether words save lives, but we know for sure that silence kills.” Public statements express the part of humanitarian responsibility that cannot be delegated to other organizations.

Contrary to the general view, public statements by humanitarian organizations constitute, in extreme circumstances, a guarantee of the quality of their action and an act of protection for endangered populations. They shatter the relationship of passive complicity that is created between the executioner and relief personnel. However, such statements must focus on the quality of humanitarian space rather than respect for human rights. They derive not from general moral or legal considerations, but from the knowledge that there is an operational responsibility that is specific to humanitarian organizations. ■



■ A hospital in Grozny is hit hard during the bombing of the city in December 1999.



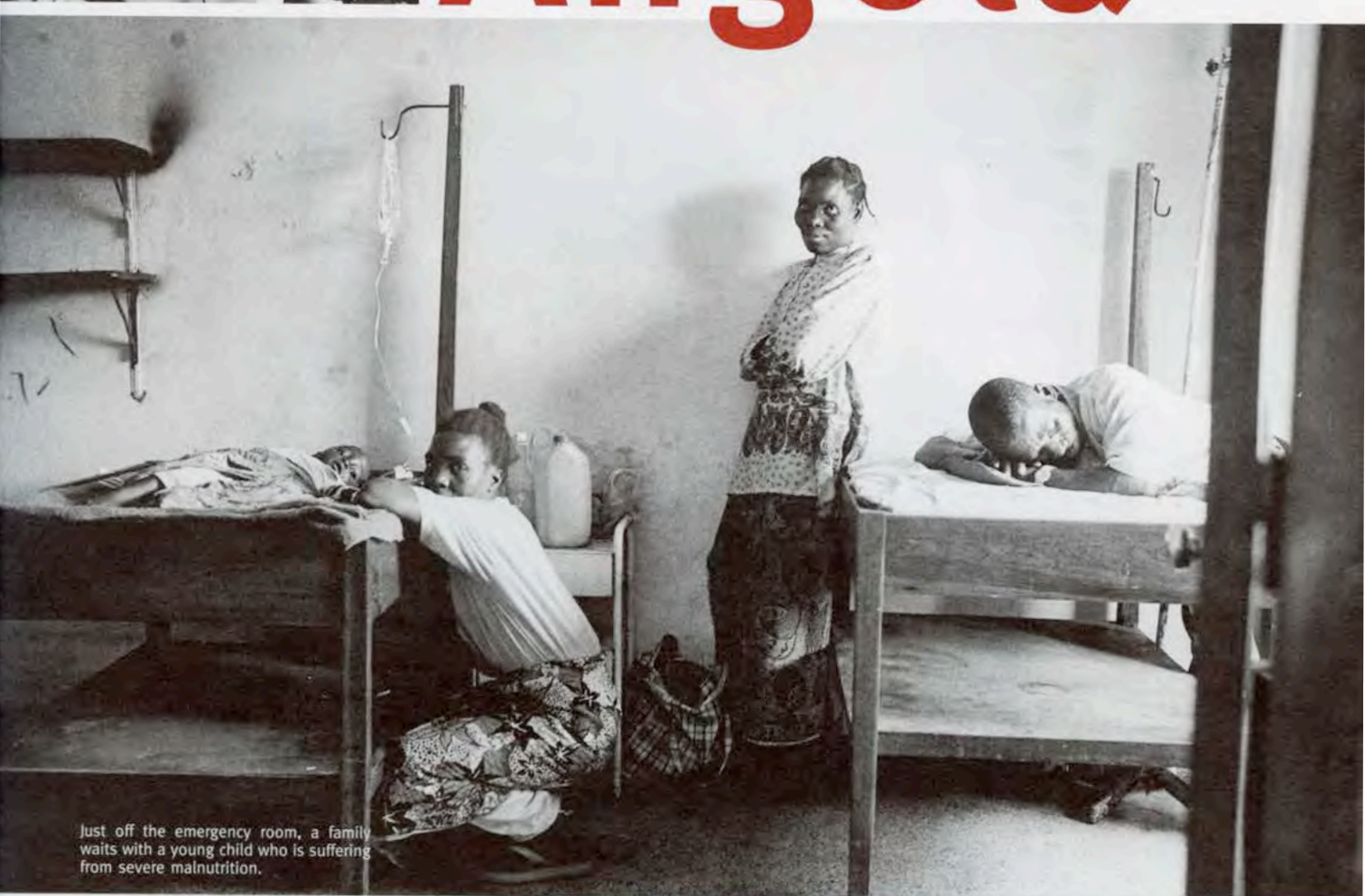
Alberto João

Alberto, 54, has worked with MSF as a driver for seven years, and he also helps translate for the international volunteers. He is married to Thérèse (called "Nene"), and they have six children. All my children go to school, it's free for everybody, and we can also say that the right to health care is free. Otherwise everything is brought in from the capital and is really expensive – two times more expensive than Luanda! Nobody knows anything about the future of the war, but for us it's become a normal situation, today we can say that it's relatively calm – but of course we hope that the war will pass. We are really tired from this war, and it's impossible to know our future with this war, and we can't begin any long-term projects with the war, everything is from day to day. But one important thing to say is that we never get used to death, it lies in wait for us, we live very close to it, but when death takes one of us, the pain is always just as strong, and we won't ever be able to forget it.

Photographs by ALAIN KAZINIERAKIS

photo essay

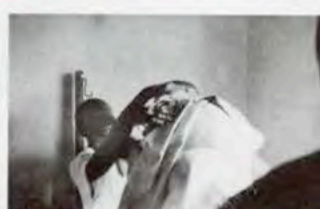
Luena, Angola



Just off the emergency room, a family waits with a young child who is suffering from severe malnutrition.

Luena, Angola is in the heart of a country at war. Although this year marks Angola's 25th anniversary of independence, the Angolan people have hardly known peace. A decades-long civil war rages on. Since 1983, MSF has been working in many parts of the country, treating people suffering from chronic malnutrition, malaria, sleeping sickness, preventable diseases such as measles and polio, and injuries caused by land mines and war. These photos are a window onto the daily reality of the country, as seen through the lives and activities of those who work alongside MSF volunteers in Luena, a city like many others in this war-torn country.

→ The team can do nothing more for this baby boy, who is pronounced dead from malnutrition, complicated by a suspected case of meningitis. His mother flees the room in anguish, while the baby is tenderly wrapped in a cloth so his father can carry him home.



Sylvia Mariza

Sylvia, 24, is the assistant medical administrator. She is originally from Luena, and comes from a family of 12 children. She lives in a small one-room apartment, with her son, Omar. Every four months a cargo arrives in Luena with stock for the pharmacy. Sylvia is responsible for checking and organizing the supplies. *My father is Portuguese, my mother Angolan. I would love to visit Portugal, but I've never been because there isn't enough money. I would prefer to live in the province of Huila, in Lusango, where I have family. It's also very beautiful! If I live in Luena, it's because of work.*



↑ As her mother gently holds her up, a nurse cleans this little girl's burn wound as Peter Rosseel, a Belgian anesthiologist visiting the mission, looks on.

↓ In the busy emergency room, nurse César Daniel examines a patient, while Anja Weggheleire, a Belgian doctor also filling in as head of mission, responds to an urgent call.

URGENT CARE



Manuel Calunya

Manuel, 31, is married with three children. A native of Luena, he is the financial administrator of the mission. He has been working for MSF for a year, and before that he was with the United Nations High Commissioner for Refugees (UNHCR). For Manuel, working with MSF is a chance to express himself, give an opinion, take part in different decisions related to the mission, and be useful in his own society, in Luena. Manuel hopes to take classes in order to evolve in his work, which he considers essential.



César Daniel

César, 24, a pediatric nurse at the hospital, was born in Luena and has lived here all his life. He is married with two small children. César took an MSF medical techniques class last year, and now he does periodic shifts in the emergency room, where he sees all kinds of patients, including this young land mine victim (lower right). The MSF class is still offered. Trainees, already nurses, have nine hours of class a week for several months and work in the emergency room with experienced staff, including César (center).





Augusto "Charles" Chambi

Charles, 39, is the mission's assistant logistician. In 1984, he left Luacano, about 200km from Luena, near the border with the Democratic Republic of Congo. He came to Luena with his wife and his first two children. His father was killed in the war. Now he has seven children, and his mother and two of his brothers also live with him.

Charles has been working for MSF for six years. He began as a mason's aid, then became a mason. After that, he worked as the stock manager, and finally became the assistant logistician. His job takes him to all corners of the mission (clockwise, from lower left): putting up protective netting in the burn room, unloading stock at the main MSF warehouse, and delivering water to the nutrition center.

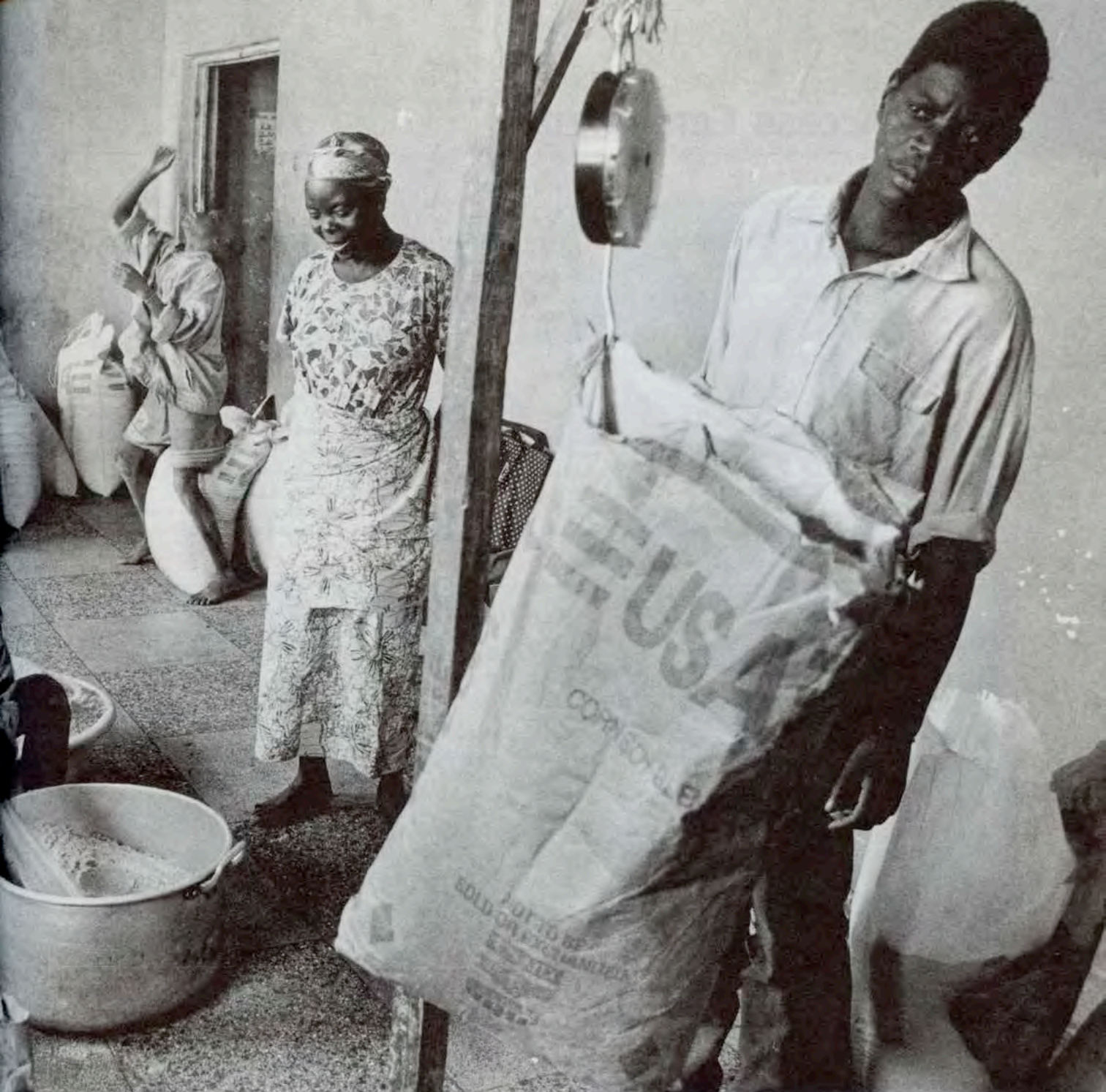
It's necessary to provide for the basic needs of the entire family, which we manage by sometimes selling wood or coal. Agriculture is very difficult, since we no longer have access to the countryside because of the mines and the war.



↓ Accompanied by her sister, a young girl gets her weight checked.

↓ Big dreams meet Angolan reality: A young boy at risk for malnutrition waits for his checkup at the nutrition center, while his father tries to sort out an administrative problem.





↑ Time seems to stop, if only for a moment, during the daily food preparation at the nutrition center.

VITAL AID

Domingos Figueira Lopes

Domingos, 39, is married and has five children. He was born in the province of Malange and came to Luena to work as a nurse in the hospital, where he's been for 18 years. Domingos is responsible for new arrivals at the therapeutic feeding center, which takes in severely malnourished children (lower right). He examines and receives the children, and cares for them and follows their progress as they become stronger. Children stay at the therapeutic feeding center anywhere from a few days to several weeks, depending on their degree of malnutrition. They are then moved to another room (the supplementary feeding center), where they stay only during the day and return in the evenings to their families. Thirty-five percent of Angolan children under five are malnourished, and over one million Angolans receive international food aid.



The Access Campaign

MSF launched the Campaign for Access to Essential Medicines in 1999, in response to field experience showing that lifesaving medicines were not available or affordable to people in the countries where we work.

This lack of access to essential medicines has several causes. First, research into diseases that are the most common killers in poor countries (such as tuberculosis and malaria) has ground to a halt. The lack of profit in selling drugs for diseases that primarily affect the poor has led companies to abandon production of lifesaving medicines, and to focus on the more lucrative markets for conditions such as heart disease, obesity and impotence.

In addition, medicines are subject to the same intellectual property protection as other kinds of innovations, even though "protecting" a medical invention often means that it is not available to people in need. The MSF campaign is pushing for a balance between public and private interests. It calls on drug companies, governments and international bodies to create sustainable policies for ensuring the availability of affordable drugs for the diseases that afflict many of the world's poorest

people. The campaign is fighting for research into and development of drugs to treat neglected diseases, and for safeguards regarding essential medicines to be built into international trade rules. Public involvement is absolutely necessary. The development and supply of lifesaving medicines should not be left solely to market forces.

Over the last year, the work of the campaign has begun to bear fruit. In Thailand, a key AIDS drug was finally made available at an affordable cost (see main article). An urgently needed new supply of an African sleeping sickness medicine "abandoned" by its manufacturer was finally made available to patients, with MSF and WHO working to identify a long-term producer (see box). And, finally, political leaders are beginning to ask their own questions about the place of medicines in the global economic order. Through collaboration with a wide network of international and local NGOs and other organizations, MSF has succeeded in getting the issue of access to essential medicines onto the international agenda.

NEGLECTED DISEASE, ORPHANED DRUG

Human African Trypanosomiasis (sleeping sickness), virtually unknown in the industrialized world, wreaks havoc on its victims. The parasitic disease is caused by the bite of an infected tsetse fly. In its advanced stages, the parasite invades the central nervous system, causing sleep disturbances, mental confusion and convulsions. Next comes a permanent state of lethargy, followed by irreversible coma and death. Every year, over 300,000 Africans are diagnosed with this painful, deadly disease.

Melarsoprol, an arsenic derivative, is the only drug widely available to treat the advanced stages of sleeping sickness. Treatment with this drug is brutal – like injecting arsenic, some say. Between three and ten percent of those treated with the drug, developed 70 years ago, are killed by it. And resistance to melarsoprol is growing. In the MSF sleeping sickness program in Uganda, 25% of the patients are resistant to the drug.

Unfortunately, the production of eflornithine (DFMO), the

second-line drug used to treat advanced sleeping sickness, was abandoned six years ago.

DFMO was produced by a large multinational company which finally stopped production because of the drug's low profitability. After negotiating with MSF and the World Health Organization (WHO), at the end of last year the company agreed to process one last batch of medicine from their remaining stock, enough for 10,000 vials. The drug was released in May 2000 and supplies are expected to last 18 months. Meanwhile, the license to produce DFMO was transferred to WHO.

MSF is leading the search for a manufacturer to produce the drug long-term. To reduce commercial risk, MSF and WHO, with the support of funders, are ready to guarantee the purchase of a significant supply. Of the 25 pharmaceutical companies that expressed an interest, six have been identified as potential new producers. Although a producer has not yet been selected, it

AFFORDABLE AIDS DRUGS IN THAILAND: The fight for ddi

Over the last year, MSF has been part of an unfolding story in Thailand which pitted MSF, local NGOs and activists against the Thai government and an international pharmaceutical giant. At stake were cheaper drugs and more widespread treatment for some of Thailand's one million people who suffer from HIV/AIDS.

Antiretroviral therapy (or combination therapy, use of a combination of drugs to attack the HIV virus directly) has reduced illness and death and improved the quality of life for people living with HIV/AIDS in developed countries. However, for those of the world's 34 million HIV-infected people who live in developing countries, these drugs might as well not exist. Their high cost puts them beyond the reach of the vast majority of people in poor countries.

In Thailand, fewer than 5% of HIV/AIDS patients currently have access to antiretroviral therapy. For most Thais living with the disease, ddi, an important AIDS drug used in standard combination therapy, was just too expensive. The price of the brand-name drug, at US\$136 per month, is higher than the typical monthly wage of a Thai office worker, which is only US\$120 per month. A generic version of the drug (interchangeable with the brand-name product but manufactured without a license from the company that developed the drug after the expiration of the

patent) would be much more affordable.

DDI was developed by a US government research institute, the National Institutes of Health (NIH). The NIH then licensed it to the pharmaceutical company Bristol-Myers Squibb, with the condition that it would be fairly priced. However, despite repeated requests by MSF, the NIH has been unwilling to enforce the fair pricing clause of the license agreement.

In Thailand, other AIDS drugs were already being produced at reasonable prices: Generic AZT is sold at 1/5 the price of the brand-name drug, and generic fluconazole, used for treating the common opportunistic infection cryptococcal meningitis, is sold at 1/14 the price of the brand-name drug. The Thai government's Generic Pharmaceutical Organization (GPO), which produces a number of high-quality generic drugs, was on the point of producing ddi when Bristol-Myers Squibb secured a patent in Thailand, blocking the GPO.

Attempts to get the Thai government to use a compulsory license – a provision of the Trade Related Aspects of Intellectual Property Rights (TRIPS) part of the WTO which permits generic production of a patented drug if a government considers it to be in the health interest of the country – failed, initially because of worries about US trade

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MSF is committed to fighting this market-oriented mentality, which ultimately treats health and well-being as a commodity. The campaign is calling for research and development of drugs to treat the neglected diseases that strike the world's poor.



**ACCESS
ESSENTIAL
MEDICINE**

Neglected Diseases

Médecins Sans Frontières has dedicated its Nobel Peace Prize money to fighting neglected diseases. Diseases such as tuberculosis, malaria, sleeping sickness and leishmaniasis are called "neglected" for many reasons. Affordable treatment is not available. There is not enough new research into the diseases and the drugs to fight them. And there is a lack of political and economic incentive to search for solutions, because the "consumers" of medicines for these illnesses are overwhelmingly poor. However, these diseases continue to shape the reality of many of the world's poorest people.

Leishmaniasis

Leishmaniasis is a widespread group of parasitic diseases, transmitted by the bite of an infected sandfly. In humans, leishmaniasis presents itself in four forms. Visceral Leishmaniasis (VL), also known as kala azar, is the most severe form of the disease. Untreated, the mortality rate is almost 100%. It is characterized by irregular bouts of fever, substantial weight loss, swelling of the spleen and liver, and anemia. Mucocutaneous Leishmaniasis (MCL) produces lesions which can destroy mucous membranes in the nose, mouth and throat cavities. Cutaneous Leishmaniasis (CL) and Diffuse Cutaneous Leishmaniasis (DCL) can produce large numbers of skin ulcers on exposed parts of the body, causing serious disability and leaving the patient permanently scarred.

Leishmaniasis is now endemic in 88 countries in Africa, Asia, Europe, North America and South America, with 350 million people at risk. The World Health Organization (WHO) estimates that there are 12 million people infected with the disease worldwide, with those in poor and remote areas being particularly vulnerable. Ninety percent of VL cases are found in five developing countries: Bangladesh, India, Nepal, Sudan and Brazil.

Leishmaniasis/HIV co-infection is emerging as an extremely serious, new disease. Most people who are bitten by infected sandflies do not develop the disease. However, among people with suppressed immune systems, cases quickly evolve into severe leishmaniasis. In addition, VL accelerates the onset of AIDS, and HIV spurs the spread of VL.

Since 1993, Leishmania-endemic regions have expanded significantly, due to factors related mostly to development. Massive rural-urban migration, agro-industrial projects (which bring non-immune urban dwellers into endemic rural areas), and man-made projects with environmental impact (such as dams and irrigation systems) have contributed to the spread of the disease.

Malaria

Malaria is a public health problem in about 90 countries, home to 40% of the world's population. There are between 300 and 500 million cases per year, and estimates of the number of deaths range from one to three million. The great majority of victims are children. More than any other illness, malaria is a disease of the poor and vulnerable.

This tropical parasitic disease is transmitted by Anopheles mosquitoes. Symptoms include fever, shivering, joint pain, headache, repeated vomiting, generalized convulsions and coma. Early diagnosis and immediate treatment are key to fighting malaria.

Although the geographic area affected by malaria has shrunk over the last 50 years, control is becoming increasingly difficult. Preventive measures (including use of mosquito nets, insect repellents and environmental management) are not always easy to implement. Activities such as road building, mining, logging and agricultural and irrigation projects – especially in "frontier" areas like the Amazon and Southeast Asia – contribute to the increasing risk of the disease. The disintegration of health services, armed conflict and the mass movement of people also contribute to the spread of the disease.

Malaria is a curable disease for which a limited number of drugs are available. Increasing resistance to these drugs, however, means that the cost of treating malaria continues to rise.

Sleeping Sickness

Human African Trypanosomiasis, or sleeping sickness, is caused by the bite of a tsetse fly carrying the trypanosome parasite. Tsetse flies are found in sub-Saharan Africa, near water sources and in forested areas.

During the early stages of the disease, people often present a range of symptoms including fever, general weakness, an aching sensation, headaches and itchiness. Swollen lymph glands are a common early sign.

At the advanced stage, the parasite invades the central nervous system. The patient suffers neurological disorders such as sleep disturbances, mental confusion and convulsions. Untreated, the patient falls into a permanent state of lethargy, followed by an irreversible coma and death.

Sixty million people in 36 sub-Saharan countries live under daily threat of the disease, but only four million of them have access to diagnosis and treatment. The World Health Organization (WHO) estimates that up to 500,000 people may have the disease. Sleeping sickness strikes the poorest and most isolated communities in the poorest countries in the world.

Treatment relies on expensive drugs developed decades ago. Melarsoprol, a key arsenic-derived drug for treating advanced stages of the disease, results in death in three to ten percent of patients.

Tuberculosis

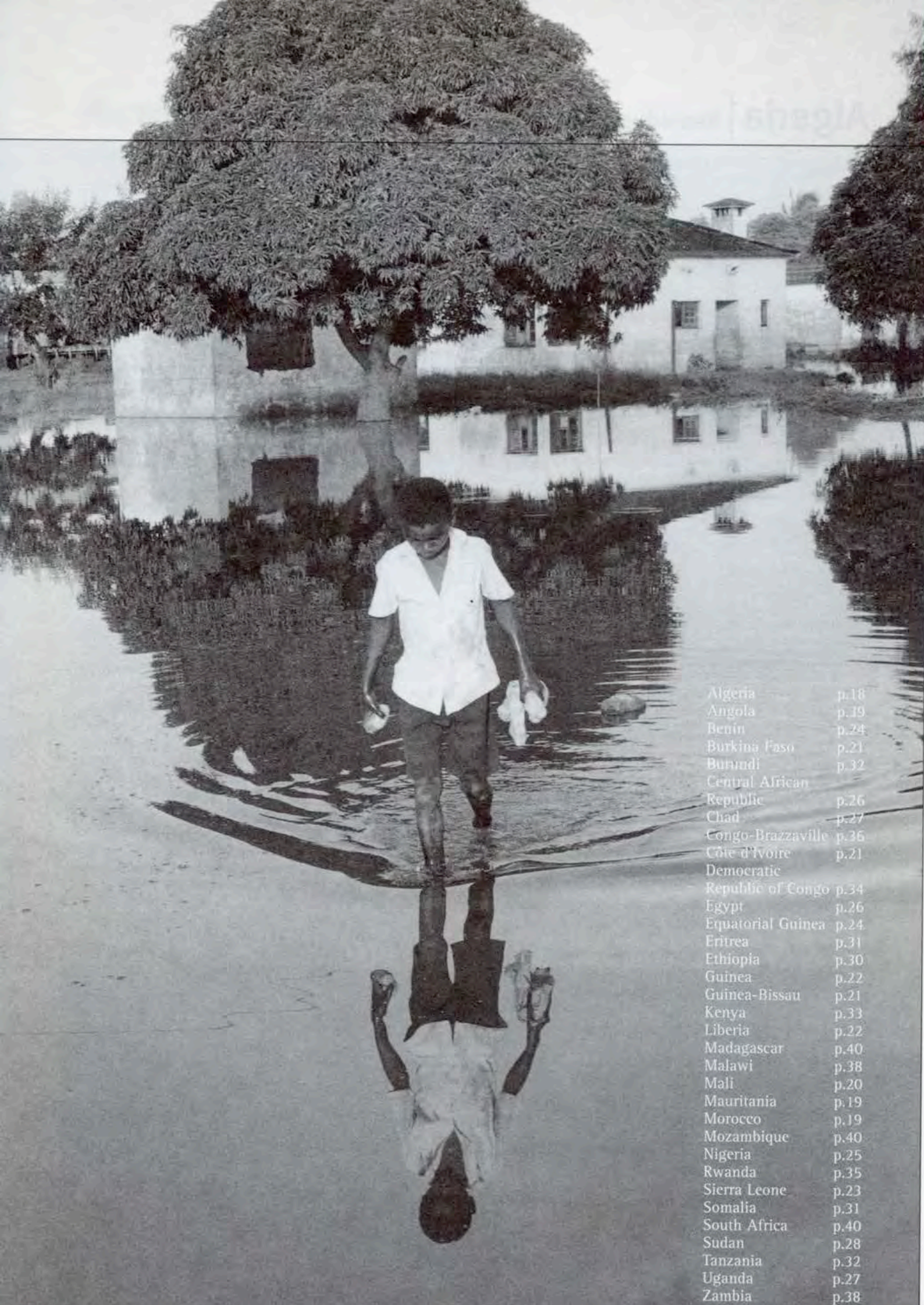
Tuberculosis (TB) kills two million people each year. This infectious disease is caused by mycobacterium tuberculosis, estimated by the World Health Organization (WHO) to infect about one-third of the world's population. About five to ten percent of those infected will become sick or contagious at some point during their lives.

TB occurs most frequently in the lungs, the principal site of infection. Symptoms include a prolonged cough, coughing up blood, chest pain, a change in overall health, and a moderate fever at night. Coughing, sneezing, talking or spitting pass the bacilli into the air, where they can remain for hours and be inhaled by others.

People with a weak immune system are most at risk for TB, which explains why the rapid spread of HIV has accelerated the spread of TB. TB accounts for about 15% of AIDS deaths worldwide.

The most effective way to treat the disease is by using a combination of drugs for six to eight months, under direct supervision by trained health professionals. Known as DOTS (Directly Observed Treatment Short Course), the treatment is recommended by WHO. The emergence of drug-resistant strains of TB (including multi-drug resistant TB, or MDR TB) has resulted from incomplete or improper treatment. While drug-resistant TB is treatable, it requires up to two years of chemotherapy that is prohibitively expensive. The cost of drugs for treatment of simple TB is US\$40. For MDR TB treatment, this rises to \$8,000 (in Siberia) and \$20,000 (in Western countries).





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A survivor of the floods wades through Chokwe, Mozambique, after torrential rains in southern Africa caused devastating floods in February and March 2000. The natural disaster prompted a massive response from MSF, which rescued people, set up cholera treatment centers, and distributed food, medicine and drinkable water in Chokwe and other areas.

Algeria | Reproductive health for the young and marginalized

- ▶ International staff: 5
- ▶ National staff: 11

Over the last few years, a move toward openness in Algerian society and the increasing number of women getting higher-level education have meant that many Algerians, particularly young people and women, are faced with new social contexts and a new sense of freedom. At the same time, education about reproductive matters and access to family planning services are limited in this traditionally conservative, Muslim society. The result is an increase in unplanned pregnancies and STD/HIV rates among the young. Médecins Sans Frontières has been working with both private and official agencies to address these sensitive health matters.

Focus on reproductive health

A new family planning program is aimed at improving access to reproductive health care services and AIDS education in Blida, a renowned university city about 50km south of Algiers. The program is slated to run for three years. It targets young people on three campuses and in two marginalized areas of the city, 19 June and Bananiers. The goal is to increase accurate knowledge and use of family planning methods, decrease the number of unwanted pregnancies and promote AIDS awareness among the young. Partners on the project include university administrators, municipal authorities and the Ministry of Health Department of Prevention. MSF has also been working with the Ministry of Health since June 2000 to organize a global AIDS prevention and education campaign targeting university campuses around the country.



A training program for mental health professionals in Algiers, which included the introduction of new therapy techniques and the setting up of a professional support group, has moved into a new phase. This new effort is a

MSF WORKS WITH PRIVATE AND OFFICIAL AGENCIES TO ADDRESS SENSITIVE HEALTH MATTERS.

A transition year for MSF

The last year has been a transition time for MSF in Algeria, with the phasing out or closure of some of its original programs. The Partnership Program, a networking and professional exchange project facilitated by MSF, came to a close in May 2000. Over a two-year period, 39 Algerian health institutions and organizations gained valuable contacts with their counterparts in Belgium and France. Workshops were held on a variety of topics in all three countries.

networking project for mental health professionals and community leaders in Tipassah, a small town near Algiers.

Work introducing new methodologies to prevent the institutionalization of abandoned children in public institutions and children's homes was also phased out, after the successful opening of a new children's home.

MSF has been working in Algeria since 1998.



- ▶ International staff: 3
- ▶ National staff: 6

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In this traditionally Muslim country, where many women are reluctant to go to a male doctor, the high maternal mortality rate – 228 per 100,000 live births – is an area of key concern for MSF. In July 1999, the organization began working in Mers El Kheir, a district of Rabat, on activities to improve women's health. MSF helps manage the area's health center and is currently assessing the condition of labor and delivery facilities available to the population.

In Souk es Sebti, a neighborhood of Mers El Kheir, a multipurpose center was constructed in 1999 by MSF and

Women and their children get vaccinations at this MSF clinic in the Mers el Kheir district of Rabat, the Moroccan capital (above and lower left).

ENDA, an African NGO. Women and children have access to health education, literacy training and skills workshops. MSF is also working to raise awareness of mother-and-child health issues among the people and is planning to build a delivery room in the neighborhood's clinic.

MSF has been working in Morocco since 1997.

Mauritania

A new clinic in the capital will offer a variety of services

- ▶ International staff: 8
- ▶ National staff: 6

Since 1996, MSF has supported primary health care services in the Toujounine district of the capital, Nouakchott. However, after realizing that there was little chance of influencing the overall quality of care given at the health centers, MSF began to change the focus of its work in the city.

The organization constructed a clinic, which now belongs to the regional health directorate. The health center – which has examination rooms, a delivery room, and a pharmacy – will offer primary care, family planning, gynecological services, and curative and preventive care. As of August 2000, the clinic had not yet opened because the water and electricity connection had not yet been secured by the regional health authorities.

In the meantime, MSF carried out an extensive assessment to better understand the needs of the area's residents, and their expectations for the health center. The

clinic will be managed partly by the community, along with the Ministry of Health.

Throughout 1999, MSF also worked to assess the nutritional status of children under five and improve the vaccination rate in the isolated central Mauritanian region of Tagant. The largely nomadic population in the area has little access to health care and is subject to periodic famines. MSF vaccinated 80% of the area's very young children (under one year old) against childhood diseases and vaccinated pregnant women against tetanus. The organization also worked to improve the cold chain (the method used to keep vaccines at the appropriate temperature from source to vaccination point). In addition, in the hospital of Tidjikdja MSF helped put in place procedures and training to reduce infant mortality due to malnutrition. At the end of 1999, MSF completed this nutritional-vaccination project in the region.

Mali | Young nurses go against the tide

► International staff: 7
► National staff: 45



© Alain Kazimierakis

In March 2000, five students began their nursing studies at the nursing school in Gao, a small city along the Niger River in north-central Mali. This would be nothing unusual in most countries. Yet here these student nurses are among a very small number of health practitioners going against a general "brain-drain" south. This movement to work and live in the more developed south has left poorer northerners with even less access to adequate health care than their southern compatriots. And the need for adequate access to care is urgent in Mali, one of the poorest countries in the world: 70% of the population lives below the poverty line, and only 1% of rural inhabitants and 16% of city-dwellers have access to drinkable water.

The nursing students in Gao have been given scholarships by MSF, and they are being mentored by an expatriate nurse. After they graduate, they are committed to spending five years working in the north, in the Circle (District) of Ansongo. The area is home to about 400,000 people, a quarter of whom are nomadic or semi-nomadic. In addition to supporting the nursing school and nursing students, MSF runs a wider district health program in Ansongo, working to promote a health system that corresponds to the special circumstances of the area's nomadic people.

Promoting healthy eyes

In summer 1999, MSF launched a program focusing on ocular health in central Mali, in the region of Mopti. The area has a high rate of eye diseases such as trachoma; MSF estimates that 75% of the cases could be avoided by simple measures, including better hygiene. The goal is to integrate a basic approach to eye health into the area's primary care structure.

Local health workers have been trained to intervene and to educate local communities about eye diseases, and to raise awareness of basic hygiene techniques. At the international level, MSF is pushing for better access to one of the key trachoma drugs, azithromycin, prohibitively expensive for most Malians (see the ACCESS Campaign, page 14).

Other projects

MSF supports four health centers in Selingué, in the Circle of Yanfolilia. In addition, MSF is working in the city of Kangari to improve overall management and performance of the district hospital. Employees have been asked to sign new contracts outlining specific responsibilities as well as consequences for failing to carry out these duties. This somewhat radical approach invites greater involvement on the part of the employees in the management of the hospital and a greater investment in welcoming patients and giving good care.

Mali is regularly hit by epidemics, notably yellow fever, meningitis, cholera and measles. MSF worked from 1997 through early 2000 to revise the national epidemic response plan, develop a written guidebook for managing outbreaks and monitor the country's epidemic surveillance system.

MSF first intervened in Mali in 1984.

In the region of Mopti, in Mali, a man is examined for trachoma (right). Above, a nurse working with MSF performs a trachoma operation on a young boy in the village of Berembe. An MSF program in the region targets trachoma, cataracts and vitamin deficiency – all causes of blindness.



© Alain Kazimierakis

Guinea-Bissau

MSF helps put in place a cholera preparedness plan

- International staff: 14
- National staff: 34

Responding to a 1998 internal conflict that shook the country, in late 1998 and early 1999 MSF carried out post-emergency intervention in Safim, Cacheu, Bafatá, Gabú and Oio provinces. The goal was to reduce morbidity and mortality rates among the area's internally displaced people. The project was completed in June 1999. MSF also carried out a massive meningitis vaccination campaign between February and April 1999, vaccinating 1,400,000 people throughout the country.

MSF then turned its attention to more longer-term, post-emergency work in cholera preparedness. From July through September 1999, MSF worked with the Ministry of Health to develop a cholera preparedness plan for the entire country. Contingency plans were drawn up for different regions, and MSF trained both clinical staff and managers in seminars held during the summer.

Following the successful completion of the cholera project, MSF closed its mission in the country.

Côte d'Ivoire

Dramatic improvement in the country's largest prison

- International staff: 5
- National staff: 10

MSF concentrates its work in Côte D'Ivoire on a medical and hygiene program at the country's largest prison, the MACA (the Abidjan Detention and Correction Center). Located in the capital, the prison was built for 1,500 prisoners but holds 3,500.

Since MSF arrived in 1997, sanitary conditions at the prison have improved greatly. The mortality rate is now one-tenth of what it was. Before, prisoners had to pay for drinkable water, and there were no showers, latrines or morgue. Now, water is free, the buildings have been disinfected, and the sanitary facilities have been renovated. Based on this work, the authorities have given MSF permission to train and supervise the prison's medical staff.

MSF is renovating the 30-bed infirmary, which has about 100 consultations a day. Every prisoner now has an

initial medical exam and has an administrative and medical file. Writing medical reports documenting mistreatment has resulted in a dramatic decrease in police brutality against the detainees. Because prison rations are only 500 calories a day, MSF provides food to isolated prisoners, those without families, and those coming from backgrounds of extreme poverty. The organization recently began working with women and young people in the prison.

MSF's earliest work in the country was with Liberian refugees, located on the banks of the Cavally River, which marks the border between Côte D'Ivoire and Liberia. By 1999, only 60,000 of the 350,000 Liberian refugees remained, and MSF was able to turn these activities over to other organizations.

Burkina Faso

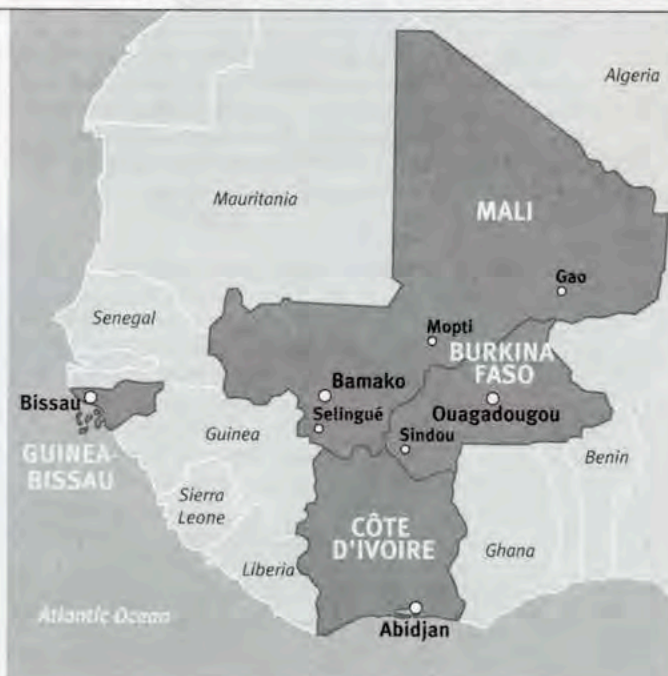
An anthropological survey helps assess health needs

- International staff: 4
- National staff: 25

MSF recently began work in the health district of Sindou, in southwest Burkina Faso near the border with Côte d'Ivoire. During the first part of 2000, the team conducted an anthropological study to assess people's attitudes toward their health system, in order to discover how and why they seek health care. Ultimately, the results of the survey will shape the support services that MSF offers in this area of 110,000 people.

In addition to its project in Sindou, MSF is continuing its work with street children in the capital, Ouagadougou. Since 1998, the team has provided health services to young people living in the streets, sometimes reaching them in the evening in places where they meet to spend the night. MSF is trying to increase their awareness of AIDS, hygiene and children's rights. The organization is also trying to sensitize people who play an important part of the daily lives of the street children: police, town dwellers and social assistance groups. MSF engages in advocacy at the national level.

MSF has been working in Burkina Faso since 1995.



Guinea | Minimal government in a turbulent region

- International staff: 12
- National staff: 252

Guinea has been a refuge for over a decade to those fleeing violent conflicts in neighboring Sierra Leone and Liberia. Guinea itself has not been immune to turmoil and has experienced the economic fallout of the region's conflicts. The country's health system suffers from poverty, shortages of supplies and a lack of management.

Working in six refugee camps, MSF helps about 75,000 Sierra Leonean and Liberian refugees. After a fragile peace accord was brokered in Sierra Leone in mid-1999, the UNHCR encouraged repatriation of some of the refugees – a move which MSF vigorously opposed because it wasn't clear whether the refugees wanted to go home, nor whether they would be safe. The renewal of civil war in Sierra Leone this spring put a stop to that plan. MSF medical and water and sanitation assistance in the camps continues.

An urban initiative takes shape in Conakry

In spring 2000, MSF started an urban health program in the capital, Conakry, whose main goal is to support a local NGO, FMG (Fraternité Médicale Guinée). This project, undertaken with the Belgian organization Songes, is designed to build FMG's capacity to implement sustainable urban health care projects. MSF is also looking at working with some of the city's street children.

Songes is focusing on improving FMG's structure and organization. MSF, on the other hand, is concentrating its work in one of the several clinics that FMG runs in the city. The emphasis is on promoting good hygiene and cleanliness, providing medicine, developing treatment protocols and encouraging community participation in running the health center. Ideally, work in the clinic will be adopted by FMG and transferred to the organization's other clinics in Conakry.



Fighting measles and tuberculosis

In March and April 2000, MSF vaccinated over 200,000 children in Conakry for measles. MSF also has a tuberculosis (TB) program in the city and has been working in the areas of Mamou and Labé to improve TB treatment. The organization is preparing an extension of the TB program to the entire "Moyenne Guinée" region.

MSF first intervened in Guinea in 1984.

Liberia | Sharp reminders of the country's instability

- International staff: 10
- National staff: 300

Situated in a region shaken by tension and violence, and virtually outcast by the international community, Liberia is limping along in the wake of seven years of civil war and three years of unstable peace. The war left most of the country's infrastructure – including the health system – in ruins. MSF works in Monrovia, Maryland county (in the southeast) and Lofa county (in the northeast).

Security incidents prompt evacuations

The entire region of Lofa, home to many displaced Liberians and refugees from neighboring Sierra Leone, is gripped by chronic instability and insecurity. The kidnapping of two MSF volunteers in August 1999 was a sharp reminder of this. The volunteers (kidnapped with other aid workers near Kolahun) were released unharmed, and MSF evacuated its staff in the area. In January 2000, the organization was able to return. However, in summer 2000, clashes between factions of the Liberian army and the kidnapping of an MSF driver again forced the evacuation of the Kolahun mission, where MSF gives medical care at a small hospital and three local clinics. There are no Liberian doctors and no other aid agencies in the area.

A shortage of doctors

In the capital, Monrovia, MSF supports four clinics and one hospital, working closely with Liberian staff. The clinics have about 13,000 consultations per month, reflecting the dire need for medical services in this city of 750,000 people. In the entire country, in fact, there are only 100 Liberian doctors, with over 80 of them concentrated in the capital.

MSF works in the main hospital in Maryland county, in the town of Harper. MSF is renovating the hospital building and looking at improving access to and the quality of care. Key medical problems include advanced respiratory infections, tuberculosis and malaria.

Work at another hospital in the small town of Tubmanburg ceased at the end of May, though MSF will supply drugs through the end of 2000. After determining that the Ministry of Health lacked the resources to manage the hospital, MSF turned over the administration of the facility to the hospital staff. MSF also fulfilled its goals at the health centers in Salala (Bong county) and Kakata (Upper Margibi county), but continues to pay staff salaries.

Sierra Leone

Traumatized civilians are rocked by renewed violence

- ▶ International staff: 50
- ▶ National staff: 318

In mid-1999, peace accords seemingly put an end to Sierra Leone's eight-year civil war, and it appeared that peace in Sierra Leone was, if not at hand, at least a step closer.

The situation in other parts of the country has remained relatively stable. In the southern province, MSF continues to support three hospitals and 28 clinics in Pujehun, Bo and

FOR MSF, THE SITUATION IN SIERRA LEONE IS AN EXAMPLE OF ALL THAT CAN BE AGGRESSIVE TO A CIVILIAN POPULATION.

However, by July 2000, what MSF had feared had come to pass: government forces (the Sierra Leone Army) and rebel forces (the Revolutionary United Front) had begun fighting again, and the peace agreement crumbled like dust. Traumatized civilians were subject anew to bombings, attacks, forced amputations, rapes and abductions. Many, especially those in the rebel-held northern province, fled their homes in fear of the rebels and bombing by government forces. For MSF, the current situation in Sierra Leone is a grim example of all that can be aggressive to a civilian population.

Even without the factional violence shaking the country, the health of the population was far from assured. The health system has progressively deteriorated: staff are ill-paid and poorly trained, the logistical network is weak and the vaccination rate is low. The country is subject to periodic outbreaks of epidemics, notably cholera, measles and shigellosis (bloody diarrhea).

Before the fighting started up again in May 2000, MSF had been working in the capital, Freetown, the southern and eastern provinces, and several towns in the northern province. Even in the absence of outright war, insecurity had remained high. In December, an MSF vaccination project in the northern town of Kailahun was suspended after the MSF team was taken hostage for ten days.

Many programs are suspended in the north

This spring's renewed fighting forced the evacuation of most programs in the northern province. In the district of Kambia, MSF provided basic health care at 11 clinics. The organization also ran a feeding program for children under five and an inpatient dispensary in Kambia town. The fighting in May forced the closure of these programs. In Makeni, MSF provided basic care at six clinics and several dispensaries. This program, too, was forced to close when the security situation deteriorated.

In Bombali and Tonkolili districts of the northern province, MSF had to suspend a measles vaccination campaign. Despite the vaccination of 100,000 children, many more were left unvaccinated.

MSF continues to work in the northern area of Kabala, providing basic health care at a hospital and six clinics.

Bonthe. In Moyamba, MSF works in five clinics and supports a pediatric ward and nutrition program for children under five. In Mile 91, a town 50km southwest of Makeni, MSF works in two clinics for newly displaced people from the Makeni area. In the eastern province, MSF has a primary health care project in Kenema, a fairly inaccessible area.

The psychological scars of conflict

The latest fighting in Sierra Leone has severely disrupted the lives and physical health of many civilians. It has also weighed heavily on their mental well-being. For the last several years, MSF has been working to understand and address the populations' mental trauma, a devastating consequence of years of violence.

In 1999, MSF undertook a survey of Freetown's residents and displaced people. Of the 245 people interviewed, the survey revealed that almost everyone had been exposed to conflict, including attacks on villages, explosion of mines, aerial bombing, the burning of property and the destruction of houses. Over 40% of the respondents reported having been abducted.

MSF has trained local aid workers in psycho-social health care and has a mental health program in Freetown. MSF also assists a local NGO that works with female victims of sexual abuse in Freetown and Kenema.

Freetown

MSF continues to provide surgical care for war victims at Connaught Hospital, general surgery and medical care at two other Freetown hospitals, and basic care at an area clinic. The capital is home to several camps for displaced people and victims of the war; MSF is actively supporting one such camp, Murray Town, home to many civilian victims of forced amputations, and has worked in others.

MSF first intervened in Sierra Leone in the wake of a 1986 cholera epidemic.

At a ferry checkpoint in Lungi, Sierra Leone in June 2000, a UN soldier searches a woman on her way to Freetown.



Benin | Fighting Buruli ulcer

- International staff: 2
- National staff: 15

Since 1997, MSF has been working to treat Buruli ulcer in Benin, where about 2,300 cases have been recorded since 1989. The program, which involves screening, treatment and training in surgical procedures, is now moving into a second phase.

Buruli ulcer is a bacterial infection caused by *Mycobacterium ulcerans*, from the same family of bacteria that causes tuberculosis and leprosy. Found primarily in tropical and subtropical humid environments, the disease causes skin swelling, destroys tissue, and suppresses the immune system, sometimes destroying massive areas of skin and bone. Thus far, the only way to treat Buruli ulcer is through difficult and costly surgery to remove affected areas, with the possible use of skin grafts. The first phase of

the MSF program emphasized treating the disease itself and training health professionals in curative and diagnostic techniques.

The focus is now turning to education of the community in early detection of the disease. People are encouraged to come in early when they notice signs of the ulcer, in order to reduce the time they spend in the hospital (and away from work) and minimize aftereffects caused by large skin excisions. MSF is also trying to better understand local attitudes toward Buruli ulcer, in order to help dispel myths surrounding it – again with the aim of encouraging early detection and treatment. MSF is cooperating with the Institute for Tropical Medicine in Antwerp, Belgium, on research to discover the exact cause of the disease.

Equatorial Guinea | MSF withdraws from the country

- International staff: 3
- National staff: 16

MSF closed its mission in Equatorial Guinea in October 1999, following systematic administrative difficulties and the government's abrogation of agreements that had ensured MSF's ability to act independently. MSF had been working in the country for about ten years.

Prior to its departure, MSF was working in the district of Bata, providing health care to mothers and children from both rural and urban areas. In addition to giving direct care, MSF ran vaccination programs, improved water quality and constructed latrines.

Another program – providing health education in schools – was arbitrarily cut short by the Ministry of Health.

MSF is now lobbying European governments and multinational corporations which have close cooperation with Equatorial Guinea, in an effort to improve the human rights situation in the country.



An MSF boat equipped with a laboratory and malaria medicine heads toward a remote cluster of villages on the Niger Delta, in Nigeria.

© Kadir van Lohuizen/Agence VU

► International staff: 15
► National staff: 38



© Kadir van Lohuizen/Agence VU

Although Nigeria is slowly coming to political life after the death in 1998 of military leader Sani Abacha and the election in 1999 of a new democratic government, many Nigerians continue to live in poverty, untouched by the country's vast wealth. They are distrustful of giant multinational oil companies that continue to exploit the country's abundant oil resources. Tension among various ethnic and religious groups continues to erupt in violence. MSF, whose roots reach back to the country's 1967-1970 civil war, has had ongoing programs in the country since 1996. There is an emergency response program in Kano, in the north, and a new malaria program in the Niger Delta.

Malaria

In the low, watery Niger Delta, malaria is endemic. Access to screening and care is minimal, and people must often travel several days by canoe to reach a health post. Malaria is the main cause of illness and death in Bayelsa State, an area of the Delta with about 1.5 million inhabitants. The disease is estimated to be the number one killer of children under five.

After assessing nearly 30 health posts in Bayelsa in spring 2000, MSF, members of the local communities, local health workers and the State Ministry of Health met to select the villages where the malaria program would be launched. Work in eight village clusters began in June.

The MSF team spends up to two and a half weeks in each cluster. Part of the team works in the health center of the central village; the others take a malaria boat, fitted with lab equipment and medicine, to villages that are more

MSF doctors examine a patient in the village of Oporoma, on the Niger Delta, in Nigeria.

understand how the Ijaw people – the main ethnic group in the region – seek health care.

MSF is also working with the Federal Medical Center in the state capital Yenagoa on protocols for laboratory work related to the malaria project. An MSF lab technician trained a group of village lab workers earlier this year. These technicians, in turn, are putting in place advanced screening techniques in the village health posts which are part of the MSF project.

Emergency preparedness

MSF runs an emergency preparedness program based in the northern city of Kano, which has a population of around 1.6 million. Concentrating on 19 health centers and hospitals, the organization supports surveillance of four epidemic diseases – cholera, measles, meningitis and yellow fever – in the city's main hospitals and clinics.

In the event of an epidemic, MSF intervenes in cooperation with the Ministry of Health in case management, epidemiology and disease control. In 1999, MSF treated 9,000 cases of cholera and 550 cases of post-measles complication. Over 2,000 community health workers were trained in cholera prevention and hygiene.

As part of the program, MSF has sponsored training sessions for local health workers. Initially, participants met to share information on traditional beliefs, personal and

AS PART OF THE MALARIA PROJECT, A MEDICAL ANTHROPOLOGIST AND THREE LOCAL FIELD INVESTIGATORS CARRIED OUT AN IN-DEPTH SURVEY OF THE POPULATION. WHO DO PEOPLE TURN TO WHEN THEY ARE SICK? WHAT MEDICINES DO THEY USE? HOW FAR DO THEY HAVE TO TRAVEL TO REACH CARE? THE ANSWERS HAVE BEEN ILLUMINATING.

than a half day's paddling away from the health center. They do malaria smears and treat patients. Health workers in the villages are trained in diagnosing and treating malaria, and in educating local people about the disease.

As part of the malaria project, a medical anthropologist, working with three local field investigators, carried out an in-depth survey of the population. Who do people turn to when they are sick? What medicines do they use? How far do they have to travel to reach care? The answers have been illuminating. It seems that many people who suffer from malaria go first to a masseur to have their painful muscles treated. If that doesn't help, people may seek out a traditional healer, who works with herbs, or a spiritual healer. The results of the survey are being used to

environmental hygiene, nutrition and health-seeking behavior. Based on this, MSF worked with the State Ministry of Health/HECTIC (Health Education Communication Training Information Center) to develop ten different health education kits covering topics such as a measles, malaria, female genital cutting and nutrition. The kits are used during the organizational training sessions.

MSF also aids victims of violence in emergency situations, a growing problem in Nigeria. In late 1999, MSF treated over 500 villagers in Bayelsa State after their village had been blockaded and set on fire.

An urban health care program in Lagos was handed over to the local government and UNICEF in early 2000.

Egypt

Care for some of Cairo's many street children

- ▶ International staff: 2
- ▶ National staff: 8

Cairo, like many big cities, has seen an explosion in the number of children living on its streets. They are often subject to mistreatment and lack access to education and health care.

In 1997, MSF began working with its Egyptian partner organization EASS (Egyptian Association for Societal Safety) to offer health care and education to some of the city's street children at the Omraneyya drop-in center. While MSF provided medical consultations, EASS offered social support and also sent teams into the streets to make contact with the children, do health education and let the children know about the center.

In September 1999, because of registration difficulties vis-à-vis the Egyptian government, MSF handed the project in its entirety over to EASS.



Central African Republic

Promoting healthy motherhood

- ▶ International staff: 8
- ▶ National staff: 11

Alarmed by the high maternal mortality rate in the Central African Republic (948 deaths for every 100,000 mothers), in May 1999 MSF began work in three maternity wards in the capital, Bangui. In addition to constructing and rehabilitating maternity wards and operating rooms, MSF has worked to educate the population on institutional prenatal care, deliveries and postnatal care, train health workers and improve the performance of the local health management committee. MSF has also donated medicine, equipment and ambulances. The three maternity wards together see about 850 deliveries a month.

MSF has also responded to a growing refugee crisis in the country. Fleeing civil war in their own country, two

separate waves of several thousand refugees from the Democratic Republic of Congo fled to the CAR. In early 1999, and again from July 1999 onward, MSF provided health care at the Port Amont refugee camp. Teams provided drinkable water, constructed latrines and carried out a vaccination campaign. The refugees were repatriated in October 1999.

Meningitis was reported in northern CAR in February 2000. Working with Ministry of Health staff, MSF teams administered vaccinations and treatment in three of the country's five health regions through May 2000.

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



People are vaccinated for meningitis in the Central African Republic. The MSF vaccination campaign covered the areas of Paoua, Bocaranga, Kelle and Borodoul and lasted from March to May 2000.

Chad | A slow transition from substitution to support

- ▶ International staff: 28
- ▶ National staff: 230

Years of chronic instability and continuous civil strife have left Chad one of the least developed countries in the world. The medical system is one of the world's poorest; it is estimated that only 30% of the population has access to health services. And, despite some improvement in the health infrastructure in recent years, Chad still has a serious lack of qualified health professionals.

Active in Chad since 1981, MSF has been working to improve the quality of health care, and to support Chadian professionals as they take on the responsibilities of running public health services.

Basic support for several health districts

The foundation of MSF's work in Chad is the support of several operational health districts in the prefectures of Mayo-Kebbi, Logone Oriental, Logone Occidental, Tandjilé and Moyen-Chari. The organization also supplied six metric tons of emergency cholera kits along with treatment education to health workers in Mayo-Kebbi and Logone Oriental to help these areas cope with seasonal cholera outbreaks.

care for patients in the district hospitals. They train public and community health care workers. MSF has also introduced cost recovery programs to help make some of the health care services self-sustaining.

Responding to emergencies

In addition to its long-term work in the health districts, over the last year MSF has also responded to several emergencies in Chad, the largest of which was a massive meningitis outbreak that hit the country in January 2000. MSF teams mobilized to vaccinate over one million people in Mayo-Kebbi, Logone Oriental, Logone Occidental, Tandjilé and Moyen-Chari. The organization also supplied six metric tons of emergency cholera kits along with treatment education to health workers in Mayo-Kebbi and Logone Oriental to help these areas cope with seasonal cholera outbreaks.

As Chad slowly rebuilds its human and medical resources, MSF will continue moving from a substitution role to one of technical support.

Uganda | Fighting neglected diseases

- ▶ International staff: 31
- ▶ National staff: 265

MSF has been engaged in a long-term effort to combat Human African Trypanosomiasis (sleeping sickness) in Uganda. In 13 years of work in the district of Moyo and seven in Ajumani, both in the West Nile region, MSF has treated 16,000 patients for the disease. MSF supervises activities, carries out epidemiological surveys and supplies medicines in both areas. A similar project has been underway in the district of Arua since 1995. From bases in northern Uganda, MSF has also sent mobile teams door-to-door to treat sleeping sickness in southern Sudan, in Maridi county, but this work has been suspended because of insecurity in the area.

At the Amudat Health Center in Pokot county, near the Kenyan border, MSF provides care for the largely nomadic Pokot population. The area has a high rate of kala azar, a parasitic disease affecting the immune system. MSF considers both kala azar and sleeping sickness to be neglected diseases, and is working through the Access to Essential Medicines Campaign to increase accessibility to treatment (see page 14).

MSF also supports several Ugandan NGOs which fight AIDS, and expects to put an increasing emphasis on fighting this disease in its work with the Pokot people. A key goal of a pilot mother and child health care project recently launched in Arua is to reduce the mother-to-child HIV transmission rate.

The unstable Bundibugyo region, in western Uganda near the border with the Democratic Republic of Congo, is home to over 100,000 displaced people. In Bundi Hospital and in Nyauka camp, MSF worked in a pediatric clinic, responded to cholera epidemics, carried out vaccinations,

distributed basic hygiene material and provided drinkable water. In late 1999, a new focus was placed on fighting malaria. Unfortunately, high insecurity in the region prompted the evacuation of MSF teams on several occasions, but in April 2000 the organization was able to return on a permanent basis.

In April and May 2000, MSF responded to the needs of displaced people fleeing inter-ethnic fighting in eastern Uganda. For about 7,000 displaced people in the district of Katakwi, MSF distributed cooking materials, water containers and tools for constructing latrines, and carried out measles vaccinations.

MSF has been working in Uganda since 1983.



© Tom Stoddart/IFPG

A woman at the MSF sleeping sickness clinic in Omugo, Uganda is injected with melarsoprol, one of the drugs used to treat the advanced stages of the disease. The drug is arsenic-based and kills 3 - 10% of those who take it.

Sudan

Humanitarian aid in the balance

- International staff: 78
- National staff: 1200

Sudan has been embroiled in civil war since 1955. Despite a ceasefire in the early 1970s, the war – with roots in the economic, religious and social differences between the country's north and south – has continued. This has been devastating for the Sudanese people, and challenging for the humanitarian community trying to provide them with relief.

In late 1999 and early 2000, the rebel Sudanese People's Liberation Movement (SPLM), which controls most of the southern part of the country, pushed for a memorandum of understanding (MOU) to be signed by its humanitarian wing (the Sudan Relief and Rehabilitation Association) and NGOs. All NGOs were expected to sign, whether or not they were part of the UN aid umbrella Operation Lifeline Sudan (or OLS, in place as an aid coordinating mechanism since 1989). The agreement was thought to be a possible step toward more SPLM control over NGO projects, which put all NGOs working in SPLM-held territories in a difficult dilemma: either sign the agreement by the March 1st deadline and open the door to this possibility, or do not sign and be expelled.

Some NGOs working in SPLM-held territory decided against signing and were forced to evacuate their missions. Most MSF teams signed, in order to remain operational in the area to respond quickly to medical or nutritional needs. This decision allowed MSF to stay close to the population as long as possible – continuing to struggle for access to the people but prepared to leave should access or a means of working be denied.

Because of the specific situation and the SPLM's local control, one MSF team determined that they would no longer be able to carry out their work under the MOU. As a result, they decided not to sign and left southern Sudan, at least temporarily.

In another development, the sole remaining MSF team working within Operation Lifeline Sudan withdrew in August 2000, after judging that the OLS had lost its capacity to negotiate unconditional access for humanitarian aid.

MSF has continued to call on all parties to protect civilians throughout the country. In the province of Equatoria, in the south, repeated government bombing of civilian populations – and the hospital where MSF works – forced MSF to protest publicly in February 2000.

Projects seek to help civilians in north and south

Against this struggle to maintain access to the population and a humanitarian space in which to work, MSF continues to bring direct medical care to people on all sides of the conflict.

MSF projects are scattered all over southern Sudan: from Bahr el Ghazal, the Lakes Region and Western Equatoria, to the Upper Nile, Eastern Equatoria and Jonglei. Its missions in the south are varied – nutrition support at feeding centers, primary care, water supply, hygiene promotion, vaccinations, mother and child health care, and surgical intervention. MSF also works at the civilian hospital in the government-held garrison town of Wau.

Long-term projects in the north are just as diverse. Near Khartoum, MSF provides primary care and feeding programs at three camps for displaced people. In Meiram, a clinic treats both the displaced and the area's residents, providing vaccinations, general consultations, and prenatal care. During the rainy season, MSF distributes protein rations to needy residents and displaced people.

→ This little girl cries out in pain as her finger is pricked by a Sudanese nurse at a mobile clinic in southern Sudan. The blood sample will be tested for sleeping sickness.



© Remco Böhle/MSF-Holland



Responding to Crises

The organization also responds to crises as they occur. For instance, the town of Akobo, on the Ethiopian border, experienced particularly high rates of meningitis in early 2000. MSF responded quickly with patient care, vaccinations and epidemiological surveillance. Immediately after the meningitis outbreak came sudden and severe nutritional problems in Akobo. MSF's emergency teams were mobilized again, this time for therapeutic and supplementary feedings and measles vaccinations.

Crises occurred in the north as well: The month of May saw tens of thousands of Eritrean refugees flee the war between Ethiopia and Eritrea, which resumed in May 2000. Refugees arrived en masse in and around Kassala, on the Eritrean border, and MSF was quick to respond to the crisis.

Intensification of the fighting in summer 2000 prompted MSF to temporarily evacuate some of its staff from the region of Bahr el Ghazal.

Ongoing fight against disease

MSF projects fighting kala azar, sleeping sickness, and malaria have reached thousands of people at risk for or

suffering from these diseases. Kala azar clinics in Qasaab and Um El Kher help combat this potentially fatal illness. Spread by the sandfly, the disease leads to an enlarged spleen, internal bleeding and eventually death. However, through analyses done at MSF's labs in Qasaab and Um El Kher, kala azar can be diagnosed quickly and treated in time.

MSF began a new sleeping sickness program in Kajo Keji county in early 2000. The disease is treatable, but the treatment itself can be lethal: Between three and ten percent of those treated with Melarsoprol, used during the later stages of sleeping sickness, die from the medicine and not the disease.

In Meiram, MSF is putting a special emphasis on fighting malaria, endemic in many parts of Sudan and a particular problem in this area.

Malnutrition

Getting enough to eat is a struggle for many Sudanese. Many MSF programs have an ongoing nutrition component. Therapeutic and supplementary feeding centers are sometimes set up for just a few months to address periodic food shortages or peaks in chronic malnutrition.

MSF has been working in Sudan since the late 1970s.



Ethiopia | Food crisis and war

- ▶ International staff: 50
- ▶ National staff: 617

The Horn of Africa was in the limelight in early 2000, with hunger tightening its grip on this region often affected by drought. Ethiopia has been badly hit by the current three-year drought. War with Eritrea to the north and civil war in the Ogaden region have also taken their toll.

Food crisis

In September 1999, MSF found that severe and moderate malnutrition rates in Konso Special Wereda, an area southwest of the capital, Addis Ababa, warranted immediate intervention. A supplementary feeding program for 9,000 pregnant and lactating women and children under five began in October 1999.

Further east, meanwhile, the situation became steadily worse. The people of the Ogaden region are nomadic and depend almost entirely on their livestock in an area which is naturally arid, flat, dusty and hot. The Ogadenis have coping mechanisms to cross the "hunger gap", but this year it was not enough – there was no food, no grass and no water for the livestock, and the harvest had failed. In early February 2000 a team went into Gode, Ogaden, to review the needs and operational possibilities. However, a security incident further north, during which an MSF driver was killed and a volunteer seriously injured, led to the immediate evacuation of



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↑ A severely malnourished child is treated and comforted at an MSF feeding center in Denan, Ethiopia, in May 2000.

all staff in the region. The team was shuttled in and out of Gode afterwards, despite the security risks, to carry out measles vaccinations, vitamin A distribution and a basic nutritional study. Because of the insecurity, MSF's activities in Ogaden were delayed.

In March, the UN World Food Program and the Ethiopian authorities stated that about eight million Ethiopians were at risk of famine. Appeals to the international community went out. As

THE OGADENI PEOPLE USUALLY HAVE COPING MECHANISMS TO CROSS THE "HUNGER GAP," BUT THIS YEAR IT WAS NOT ENOUGH. THERE WAS NO FOOD, NO GRASS, AND NO WATER FOR THE LIVESTOCK, AND THE HARVEST HAD FAILED.

media reports became more and more alarmist, MSF sent a team back into Gode to collect accurate data and look at the possibilities of intervention. MSF found that, while the threat of widespread famine wasn't high, there were pockets of severe malnutrition that posed great danger to certain nomadic people.

Soon after, MSF set up feeding centers in Denan for about 1,000 children, as well as water and hygiene facilities for the centers and a nearby camp for displaced people. Tuberculosis cases in Gode were diagnosed and treated and another team went to Gudis and Imi to examine the needs of the nomadic people there. The rains, which finally came in May, ironically caused flooding in Ogaden, making food distribution difficult and cutting off access to Gudis and Imi. MSF eventually opened therapeutic and supplementary feeding centers and a small consultation clinic in the area. In the Arero region, the organization began a nutrition



program for young children. In late spring, MSF also set up emergency feeding programs in Wag Hamra and Welayita.

Wide-ranging programs throughout the country

Aside from responding to crises, MSF has a wide range of other projects in Ethiopia. In Addis Ababa, MSF works in all 19 health centers to prevent HIV and STDs, and provides health information and services to a target group of about 15,000 women involved in prostitution.

In Somali state, MSF has a water rehabilitation program and an STD/HIV prevention project. Further north, in the Tigray region, MSF's surgery projects at Mekele and Adigrat hospitals reach a population with no other access to surgical care. The organization also works to prevent and treat HIV/AIDS and kala azar (a fatal parasitic disease transmitted by the sandfly) in northwestern Tigray. In addition, MSF provides medical support and water and sanitation services to nearly 100,000 people displaced by war in the area. There is another long-term kala azar project in Konso Special Wereda, where the disease is endemic.

MSF also supports Dubti hospital in the Afar region, and there are plans to begin a tuberculosis (TB) program for nomads in the area in late 2000. A five-year surgery training

program at Woldya hospital, in North Wollo, finished in 1999. MSF opened an intensive care unit at the hospital.

In the tiny village of Menza, near the Sudanese border, MSF had a basic care and nutrition program until insecurity forced its closure at the end of 1999; a similar program continues just over the border in the Sudanese village of Menkush. In nearby Bambudei, a health care program reaches about 5,000 Sudanese who have fled the conflict in their country. In addition, in January 2000, MSF began a water and sanitation and hygiene education program for 10,000 Sudanese refugees in Dyma.

In the southern part of the country, in the South Omo Zone, MSF has a primary care program that reaches the Mursi people. A water and sanitation project in Wag Hamra is scheduled to finish in 2000, while an assessment for a possible medical program in the same area is underway. MSF has been working in Ethiopia since 1985.

- ▶ International staff: 22
- ▶ National staff: 54

MSF opened its first mission in Eritrea in April 2000, in response to the growing risk of hunger and renewed conflict between Eritrea and its southern neighbor and former ally, Ethiopia. The mission was originally designed to extend health care to around 50,000 people in six displacement camps in the Debub zone, just south of the capital, Asmara.

In May, however, the war between Eritrea and Ethiopia resumed, leading to tens of thousands of casualties on both sides. Eritrean civilians in particular were caught in the cross-fire, and as the front moved further north a refugee

stream began flowing both northwest within Eritrea and west into Sudan. In response to the conflict, MSF provided war surgery in the town of Massawa in the north, and medical relief in camps for displaced people (in the May-Habar, Kari-Bossa, Ghinda, Salina, Alba, Obali and Agraa camps). By midsummer, many refugees who had fled to neighboring Sudan had returned to Eritrea, but large numbers of people remained in the camps, unable to return home.

MSF continues to work in camps in the Debub zone, the Northern Red Sea zone, and in Gash Barka.

Somalia

Small signs of government in a fractured country

- ▶ International staff: 12
- ▶ National staff: 30



A patient receives treatment from Somali staff at the Mudug Regional Hospital in Galkaayo, where MSF works side by side with local health workers.

Somalia has been mired in civil war since the Siad Barre regime collapsed in 1991. While the central and southern regions of Somalia are still seen as lawless and chaotic by the West, the northern regions of Puntland and Somaliland have succeeded in establishing a halting peace and, more importantly, a system of governance – without international help or intervention.

MSF insists on impartiality

The country's clan system, the social hierarchy of elders, businessmen and warlords and the fallout from the conflict between Ethiopia and Eritrea make working in Somalia extremely difficult. Yet MSF has maintained its presence throughout the country for a decade now, always insisting on impartiality. The organization works in many areas of Somalia and deals with all contexts: from the relative stability of Galkaayo in Puntland to the besieged and troubled Kismaayo in the south.

In Galkaayo, MSF is working together with the local community to refurbish, equip and help out at Mudug Regional Hospital, where teams also train staff and do emergency preparedness work. Further southeast, in Middle Shabelle, MSF runs primary health programs with outpatient dispensaries, mother and child health clinics, mobile vaccination teams and emergency monitoring and response. In Mogadishu, MSF has set up an early warning system for epidemics and has been responsible for a cholera treatment center in North Mogadishu since 1994.

"The incidence of diarrhea [a key symptom of cholera] tends to rise every November, with confirmed outbreaks starting around January," says André LeSage, MSF Head of Mission until April 2000. "Part of the problem is that, while oral rehydration salts are effective in treating early-stage

cholera, Somali common sense dictates that the only effective treatment is ringer lactate (isotonic solution administered intravenously), which is only used when there are no other alternatives. Having an IV plugged into your arm is more impressive than drinking the rehydration salts, so they think it must be more effective. But it also means a delay in treatment."

The realities of working in a conflict

In the southern city of Kismaayo, the realities of working as an NGO in a conflict area are brought home. MSF works in the hospital, providing in- and outpatient care, health care for tuberculosis (TB) patients and surgical care for the war-wounded. However, the mission had to be temporarily evacuated several times due to insecurity. MSF left Kismaayo in June 1999 and returned for several monitoring and assessment visits in the fall and winter of that year. After an unexpectedly strong appeal from Somalis in the area (women's groups, the Regional Health Board Committee, and some of the warlords themselves) and renewed guarantees of security, the team was finally able to go back in February 2000.

The war has also led to problems accessing populations in other areas notorious for their insecurity. The drought which plagued the entire Horn also led to problems in the western regions of Somalia bordering Ethiopia: Gedo, Bay, Bakool, and Hiran. Despite the security risks, MSF sent an exploratory mission to the Bay and Bakool regions to assess the nutritional and medical needs there. Because the people of this area are nomadic, it was even more difficult to reach the populations in distress.

The exploration led to an outpatient dispensary with 20 hospital beds and a mother and child health care center in Hudur, near the Ethiopian border, with vaccination campaigns planned for the surrounding villages.

MSF has been working in Somalia since 1991.

Burundi | Population forced into policy of regroupment

- International staff: 35
- National staff: 390

Burundi, a tiny country wedged between the Democratic Republic of Congo (DRC), Rwanda and Tanzania, has been trapped in civil war since 1993. Tanzanian-based peace talks, mediated by former South African President Nelson Mandela, have resulted in an agreement signed by most – but not all – of the parties involved. And those that did sign expressed

the population, and the strong sense that the conditions of the forced regroupment deprived people of their most basic human rights led MSF to believe that its presence was merely lending credence to the government's policy and was in opposition to the principles of the MSF charter. As a result, MSF suspended its activities in the camps in November 1999, but remained

MSF BELIEVED THAT ITS PRESENCE IN THE REGROUPMENT CAMPS WAS MERELY LENDING CREDENCE TO THE GOVERNMENT'S POLICY. AS A RESULT, MSF SUSPENDED ITS ACTIVITIES IN THE CAMPS.

reservations on the clauses covering, among other things, electoral process, transitional government, and percentage of Hutus to be integrated into the army. The peace accords have not provided solutions acceptable to all parties, on many of the major areas of contention. It remains to be seen if they will result in true peace for the people of Burundi.

MSF has been present in Burundi since 1992, providing basic health care, nutrition programs, surgical services and epidemiological intervention in an effort to help the traumatized population.

Insecurity has punctuated MSF's work in this country. Throughout summer and early fall 1999, there was a sharp increase in violence, culminating in the killing of two UN representatives in October. Around the same time, the government forced 350,000 civilians in Bujumbura Rural province into 50 regroupment camps around the capital, Bujumbura.

After the regroupment, MSF began bringing emergency relief – medical care, clean water and latrines – to 54,000 people in three camps. But the lack of free and independent access to the camps, the lack of security, the manipulation of

ready to intervene in the event of epidemics. The organization has since responded to two cholera outbreaks. MSF also maintains a presence in the province supporting seven health centers. The regroupment camps were finally dismantled in July and August, one of the conditions of the peace talks.

MSF has several other projects in the country. In May 2000, a surgical project in Makamba had to be evacuated following attacks and looting in the town during which the MSF house was also targeted. Besides performing surgery (primarily on the war-wounded), MSF supervised five health centers, provided medicine and material to 16 others, and ran one therapeutic and five supplementary feeding centers. As of mid-summer, the team had not yet been able to return, but instead began surgical work in Rutovu, about 80km away. In Kayanza, MSF works in the city's hospital and supervises and supplies medicine for five health centers. MSF also runs therapeutic feeding centers and supports health structures in central Bujumbura. In Karusi and Cancuzo, the organization supports hospitals and clinics and also runs nutrition programs.

Tanzania | Primary care in Mtwara and Kigoma

- International staff: 15
- National staff: 87

Half of Tanzania's 32 million people live below the poverty line, and life expectancy in the country is only 50 years. Child mortality rates are also sobering: 144 deaths for every 1000 children under five. Against this backdrop, MSF is working to aid the Tanzanian health care system, which is in a state of deterioration because of the poor economy, infrastructure problems and a shortage of medical professionals.

MSF runs primary health care projects in the districts of Mtwara and Kigoma. The goal is to improve the quality of and access to basic health services. The Mtwara project reaches some 200,000 inhabitants, while in Kigoma (an area strongly affected by the country's many refugees) some 227,000 Tanzanians benefit.

Fighting malaria and cholera

Malaria is the number one killer in Tanzania. Since 1998 – when MSF intervened in a malaria epidemic in the Kagera region – the organization has pushed for effective treatment of this illness. Partly at MSF's urging, the Ministry of Health (MOH) recently abandoned chloroquine, which has a high resistance rate in Tanzania, in favor of another, less resistant first-line treatment for malaria.

Since January 2000, MSF has been working to improve the Tanzanian health system's capacity to deal with the country's constant cholera outbreaks. This cholera preparedness project – known as CHOPIN – is based in Dar-es-Salaam and involves surveillance and data collection, training of front-line health staff, reinforcement of emergency

stocks and raising community awareness. The program is based in the MOH and targets the general population.

Refugees continue to flow into the country

There are now an estimated 500,000 refugees in Tanzania, the reluctant host to thousands of refugees for several decades now. People have streamed across the border from Rwanda, Burundi and the Democratic Republic of Congo (DRC) into the Kigoma and Kagera regions in western Tanzania, looking for respite and safety from the wars back home. The Kigoma camps are strained to capacity, putting a heavy burden on the finances of the Tanzanian government.

The last MSF intervention in a refugee camp in Tanzania was carried out in a transit camp for DRC refugees and ended in December 1998. MSF continues to provide technical assistance for NGOs working in the camps and collaborate with UNHCR on contingency plans for new refugees and disease outbreaks.

Other work

Until December 1999, MSF worked in the district hospital in Kasulu, training management and health personnel, rehabilitating health structures and improving the health information system.

In cooperation with the Ministry of Home Affairs, MSF is currently evaluating possibilities for a health project in some of the country's penitentiaries, where detainees are particularly susceptible to communicable illnesses.

Kenya | Grappling with AIDS

- ▶ International staff: 41
- ▶ National staff: 750

Kenya's HIV/AIDS statistics are frightening: one in fourteen Kenyans has the disease, and in the capital, Nairobi, this rate jumps to one in seven. It is spreading fast, especially because HIV is still difficult to discuss and few people are willing to take a test. In Kenya, those with AIDS are often treated like outcasts.

"People die fast here, with less dignity than if they died from other diseases," says Dr. Christopher Ouma, who works for MSF at Mbagathi Hospital in Nairobi, which receives many patients from the slum areas where MSF works. "People know what AIDS is. And what it means. Most patients here have just been abandoned." MSF has AIDS projects in the capital, Nairobi, and in Busia and Homa Bay.

Improving the quality of life for those with AIDS

MSF's work with AIDS patients in Nairobi is intended to improve the quality of their lives. Teams train health workers and organize comprehensive care in patients' homes (in the slum areas of Dandora and Kibera), Mbagathi Hospital and several health centers. MSF offers psychological support and social assistance, which sometimes means paying rent or school fees for family members of those with AIDS. The organization also works within Ministry of Health structures, providing training and supervision and supplying drugs.

In June 2000, MSF started an HIV/AIDS program in the district of Busia in the Western Province. The project focuses on reducing HIV transmission, home-based care for AIDS patients and work with local groups to develop income-generating activities.

Further south, on the banks of Lake Victoria, MSF has run an AIDS/tuberculosis (TB) program at Homa Bay Hospital since 1996. Homa Bay boasts HIV rates of 35% among young women alone – and 60% of those are estimated to have tuberculosis, the biggest AIDS-related killer. Many women come to the harbor to sell sex for food to willing fishermen. HIV spreads quickly in this environment, as does the TB which often accompanies it. MSF cares for TB patients at Homa Bay Hospital and also works at hospitals and clinics in Marindi, Pala and God Kojowe, areas of Homa Bay.

Disease, drought and refugees

HIV is not the only problem Kenya faces. In summer 2000, MSF launched a project to fight the disease kala azar in the Dadaab area of Kenya. Malaria is also a recurring problem, especially in and around Kisumu. This year MSF set up an emergency preparedness program in Kisii, which includes systematic malaria testing, treatment and epidemiological analysis.

Northern and eastern Kenya were badly affected by the hunger crisis that touched the Horn of Africa in late 1999 and early 2000. MSF responded with supplementary food distributions in Turkana. Further east, in Mandera and Dadaab, MSF provides health care and nutrition programs for Somali refugees who have fled their country's civil war.

Urban health care

MSF has urban primary health care projects in the Nairobi slum areas of Matharé, Kibera and Dandora. The programs encompass basic access to care, primary care and dispensaries, and involve cooperation with local community organizations. Programs in Matharé and Dandora have an additional emphasis on HIV/AIDS prevention and treatment.

Organizing for access to medicine

In June 2000, government officials and civil representatives from Kenya, Uganda, Tanzania and Ethiopia, and participants from 17 other countries met in Nairobi to discuss the problem of adequate access to medicines in East Africa. This conference, organized by MSF, is part of the organization's Access to Essential Medicines Campaign, launched in 1999. MSF has set up a coordination office for the campaign in Nairobi.



© Dieter Telemans

→ Mike Munuhu (far right) and his three half brothers sit at home in their two-room shack in the slums of Nairobi, Kenya. The youngest boy, David, has TB and is HIV-positive. Their mother, asleep in the adjoining room, is too sick with AIDS to work but receives regular home-care visits from MSF. To support the family, Mike gets up at five every morning to collect plastic bottles at the dump, earning 20 Kenyan shillings (US\$0.27) a day.



Democratic Republic of Congo [DRC]

Complex emergency, human catastrophe

- International staff: 36
- National staff: 450

The Democratic Republic of Congo is ground zero of what has been called an "African world war." Nearly 20 armed groups – both Congolese and foreign – are vying for political advantage or economic gain. Attempts to curb the war, through peace accords signed in Lusaka, Zambia, have been desperately inadequate, as has the small United Nations force meant to keep the "peace." The intractable war comes on the heels of decades of misrule and the misappropriation of the country's vast natural wealth.

Impoverished despite their country's riches, forgotten by international actors who could possibly offer help, the Congolese people are living out an overwhelming catastrophe.

Congo's infrastructure and health system are in ruins. Of the 300 health districts in the country, 79 are more than 100km from their referral hospital. The lack of government funds and foreign aid means that 100 districts are left without any outside funding. Human resources fare no better: the country's 50 million people have only 2,000 Congolese doctors to serve them. Life expectancy is 45 years, and one in four children will die before they reach the age of five. Large parts of the country are inaccessible to humanitarian assistance.



IMPOVERISHED DESPITE THEIR COUNTRY'S RICHES, FORGOTTEN BY INTERNATIONAL ACTORS WHO COULD POSSIBLY OFFER HELP, THE CONGOLESE PEOPLE ARE LIVING OUT AN OVERWHELMING HUMANITARIAN CATASTROPHE.

Against this backdrop, MSF provides medical relief in several provinces, working in government-held areas as well as territory controlled by rebels. Teams work side by side with Congolese health professionals, in a climate of urgency and insecurity.

Controllable diseases are spreading

The disintegration of the health system and the ongoing ravages of war have encouraged an explosion of disease in the country. Continual outbreaks of meningitis, cholera, shigellosis (bloody diarrhea) and measles are coupled with periodic outbreaks of diseases such as polio, Marburg disease, and the plague – nearly eradicated in the West – and the mounting scourge of AIDS and African sleeping sickness.

In order to respond quickly to disease outbreaks, MSF has helped set up a national emergency response team, made up of Congolese doctors, in Kinshasa. There are similar teams in Lubumbashi, Mbandaka, Kisangani, Goma and Bukavu.

MSF runs a program combating sleeping sickness in several health zones in Equateur province. A similar program in Bas Congo was suspended because of security concerns.

To help stem the spread of AIDS, MSF opened a health clinic in Matonge, an area of Kinshasa, to attend to prostitutes with sexually transmitted diseases (STDs). The center treats about 20,000 people a year. In Katanga province in the southeast, an HIV/AIDS program covers five rural health zones. A pilot STD/HIV program, targeting prostitutes and other at-risk people, is scheduled to begin in Bukavu in late 2000.

Basic health care in several provinces

In Orientale province, in early summer 2000, fighting erupted between Ugandan and Rwandan forces near the Congolese city of Kisangani. MSF teams, which run primary care, nutrition and mental health programs in the city, were forced to take cover, emerging only six days after the peak of the fighting. After responding to the immediate needs of the stricken population, the organization resumed its regular programs. MSF currently has 16 feeding centers in the area, feeding over 2,500 malnourished children. MSF also supplies medicine to 13 health zones in the province.

In Katanga province, MSF works in 38 health centers and five hospitals spread over five health zones, covering a population of about 700,000. In Equateur province, the organization works in eight health zones that reach over one million people. In Bas Congo, MSF works in two health zones. In all of these provinces, MSF teams supervise health workers, provide drugs, training and logistical help, and often help pay staff salaries. MSF is also present at several health centers in Kinshasa.

In June 1999, insecurity forced the halt of work at hospitals in Zongo and Libenge, in Equateur province. In early 2000, work in the Shabunda area of South Kivu province and in Bunia, in Orientale province was suspended, also because of insecurity. Primary care and water and sanitation projects continue in other parts of South Kivu and in North Kivu.

A young boy's eyes are fixed on the special high-calorie milk being poured at an MSF feeding center in Kisangani, in eastern Congo. Civil war in the country threatens many people with malnutrition.



© Remco Bohle/MSF-Holland



Care for refugees and the displaced

Congo is both country of origin and place of refuge for many refugees. At least 200,000 Congolese have sought refuge in neighboring countries. At the same time, a vicious civil war in Angola has caused people from that country to flee to Congo. And it is estimated that over one million Congolese are displaced within the country.

In the Kilueka refugee camp for Angolan refugees in Bas Congo, MSF offers basic health care and ensures the supply of clean water, and also works within the region's health system. In April 2000, in Sicotra on the outskirts of Kinshasa, MSF launched a program to care for internally displaced Congolese arriving from Equateur and Orientale provinces, and for refugees returning from Sudan and the Central African Republic.

In many of its programs in the provinces, MSF cares for internally displaced people as well as local residents.

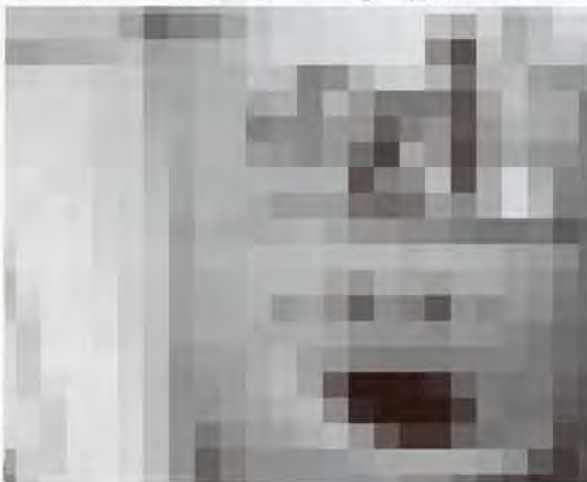
Waging public information campaigns in Congo and abroad

Given the dire state of the Congolese health system and the worsening situation in the country, lobbying and public awareness campaigns outside of the country are increasingly important. In summer 2000, MSF sponsored an exhibit of photographs by Belgian photographer Roger Job, entitled 'Santé d'Etat, Etat de Santé' (The Poor Health of the Health System).

In an effort to make itself better known among the people and the authorities, MSF has also been reaching out to the Congolese. The organization puts out periodic press releases, organizes television and radio stories and publishes a small newsletter destined for the general public.

Médecins Sans Frontières, active in Congo since 1985, is one of the few aid organizations still working in the country.

Minutes after a birth, this delivery room at Bolenge Hospital in Equateur Province, Congo, becomes a silent testament to the decay of the country's health facilities. These images appeared in the MSF photo exhibit "Congo 2000: The Poor Health of the Health System."



Rwanda Tentative steps toward recovery

- International staff: 10
- National staff: 85

Rwanda's health system and its medical personnel were devastated by the mass inter-ethnic killings of 1994, in which one million Rwandans died. MSF is now participating in the country's nascent reconstruction by supporting a health district and responding to emergencies.

There have been recent reforms in the health sector, including some decentralization and the partial institution of a cost recovery system, and even the growth of health insurance. Yet in an impoverished country with fewer than 200 doctors, many people are at risk of being left without adequate access to medical care or the means to pay for it.

The primary MSF activity in Rwanda is the support of the Bushenge health district in Cyangugu Province, in southwestern Rwanda. MSF has been working there since 1997. The health district includes a hospital and nine associated health centers; the services reach about 190,000 people. Working with the Ministry of Health, MSF trains medical staff in malaria and sexually transmitted disease (STD) treatment and prevention and prenatal care. MSF also supplies the district with medicine and helps supervise local health care workers.

In addition to its work with the hospital and health centers, the MSF team intervened in several emergencies over the last year: From January through August 1999, MSF ran two therapeutic feeding centers for severely malnourished children in Ruhengeri province. Teams have also responded to cholera epidemics in Ruhengeri and Cyangugu provinces.

In late 1999, MSF was able to turn over one of its projects, support of the Kabutare health district, to another NGO more focused on long-term development. MSF also wound down work in two refugee camps located near Cyangugu and Kibogora, where refugees from Burundi and Congo had been living after fleeing violence in the own countries. Many of these refugees returned home, and others moved away from the camps.

One of MSF's priorities in Rwanda is increasing its dialogue with the Rwandan people by implementing new projects in partnership with civil society. Possibilities for future projects include psychological and mental health work and AIDS prevention and treatment. At the same time, MSF continues to raise awareness in Europe of the trauma the country has suffered, through a travelling photo exhibit commemorating the genocide (see photo, page 7).

Congo-Brazzaville

Civilians suffer from a hidden war

- International staff: 26
- National staff: 35

The people of Congo-Brazzaville have been deeply affected by a civil war largely hidden from the outside world. MSF put the war on its list of top ten underreported conflicts of 1999, and teams working there are committed to

At one point, more than a quarter of the country's population was estimated to be on the move, without shelter, food or medical help. The humanitarian consequences of the fighting, destruction and subsequent

IN THE HOPE OF FINALLY ALERTING THE WORLD TO THE UNDERREPORTED EMERGENCY PLAGUING THE COUNTRY, MSF PUBLISHED "STORY OF A HIDDEN WAR," WHICH EXPOSES THE VIOLENCE DONE TO THE CIVILIAN POPULATION.

drawing attention to the violence inflicted on the civilian population. The organization's work in the country constitutes one of its biggest emergency programs.

Raging off and on since 1997, the war has led to the destruction of many public facilities, including health centers, dams, electrical sources and bridges. Almost all essential services – including health care – have collapsed, and access by NGOs to much of the south was cut off.

A terrifying road into the forest – and back again

Fighting between government forces and militia ("Cobras") and the rebel militia ("Ninjas" and "Cocoye") broke out anew in December 1998. In a desperate bid to flee the fighting in the capital, Brazzaville, many thousands of people fled into the forests south of the city. There they were frequently victims of violent acts, deprived of food and cut off from all humanitarian aid.

flows of people have been predictably devastating.

The current MSF presence in Congo-Brazzaville dates to February 1999, when the organization was confronted with the arrival of many thousands of shocked people who had lost everything and were in a desperate state of health.

The MSF mission first took charge of cholera cases in northern Brazzaville, where many displaced people had fled. April 1999, the organization began supplementing the medical services provided by Makelekele Hospital in the areas of emergency treatment, pediatric care and nutrition.

To cope with the nutritional emergency, MSF set up four therapeutic feeding centers (TFCs) in Brazzaville to care for children suffering from severe malnutrition. During the second half of 1999, MSF volunteers cared for more than 8,000 severely malnourished children.

By May 1999, many who had fled began making their way back to Brazzaville. By February 2000, more than 250,000 people had returned. During the greatest wave of the return of the population, MSF teams worked in the





"Sports Center," the "Station" and Nganga Lingolo, a city suburb that was a key transit point for returning people. Returnees gathered in these areas, where they underwent medical checks. MSF assessed their nutritional health and directed the sick to a hospital or a nutrition center.

Witnesses to the horrors of war

In the hope of finally alerting the world to the underreported emergency plaguing the country, in October 1999 MSF published a document entitled "Story of a Hidden War," which uses firsthand accounts and medical information to expose the violence done to the civilian population.

MSF collected testimonies from some of the victims, who were subject to gross human rights violations and deplorable living conditions while they hid in the forest or tried to make their way home. A nine-year-old boy named Cedric recalls: "We were going back to Brazzaville when we came across soldiers very early in the morning. I heard shots, my daddy fell to the ground, my aunt too, and I felt a bad pain in my foot." A 19-year-old girl told MSF: "A group of us came out of the forest. When we reached the military roadblock at Makana, the men were separated from the women. In the queue, they chose me and put me in a room. When I tried to escape they fired shots at my feet. Luckily they didn't hit me. Five men raped me."

Through its work at Makelekele hospital, between May and December 1999 MSF counted 1,600 women who had been raped. After long negotiations with the health authorities (in a country where abortion is illegal and the official HIV rate more than 7%), MSF was able to put into place a program to care for women who had been raped, with a focus on STD and AIDS prevention.

"Normalization" in some areas

In late 1999, the security situation had slightly improved, and MSF was able to begin medical and nutrition work in the region of Pool, which surrounds the capital. Programs also began in Kinkala, and a few months later in nearby Mindouli. In March 2000, MSF began medical and nutritional work at the hospital in the town of Sibiti, on the way from Brazzaville to Pointe Noire on the west coast.

Also in the spring, MSF launched a basic curative and preventive health care program in the northern part of Niari region, controlled by the opposition. MSF hopes to reestablish basic health care for 60,000 people in the area, which had previously been cut off from the rest of the country by three years of war and inaccessible for security reasons.



In downtown Brazzaville, a building destroyed by machine gun fire during ferocious fighting that swept the city in late 1998 looms over one small sign of renewal: a worker putting fresh paint on a Chinese restaurant sign.

The waiting room at this MSF-supported hospital in Mindouli, Congo-Brazzaville is filled to capacity.

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Zambia

Caring for refugees and the displaced

AFRICA

© Marco van Hal

- ▶ International staff: 16
- ▶ National staff: 6



© Marco van Hal

Throughout much of the last year, MSF assisted some of the nearly 200,000 refugees fleeing to Zambia, primarily from Angola. Refugees also came from the Democratic Republic of Congo, Rwanda and Burundi.

Beginning in October 1999, a wave of Angolan refugees arrived in the Zambia's Western and Northwestern provinces. Several thousand were eventually brought to a refugee camp in Kalabo, where MSF provided full emergency public health services through July 2000. At that time, the camp was closed and the remaining refugees moved by long boat to a new site at Mayukwayukwa, where MSF had set up an emergency water supply system.

The influx in the northwest was followed in January by the surprise arrival of up to 15,000 Angolan refugees in southwestern Zambia. For two months beginning in February 2000, MSF provided health care, water and basic materials for the refugees and vaccinated all children between six months and 15 years for measles, before the transfer of the refugees to a camp in Nangweshi. At the Nangweshi camp,

Women and children carry baskets of water near the Mayukwayukwa refugee camp in western Zambia (left), while an additional tent is set up near the camp (right).

MSF has a feeding center and provides 24-hour health services. The organization is also putting in a water pipeline.

In Maheba, in northwest Zambia, MSF has begun providing health care, water and basic necessities to some of the area's 40,000 Angolan refugees. In August 2000 MSF helped open a camp for Congolese refugees, also in the north, when fighting in Congo intensified near the border. MSF provides emergency public health services for about 10,000 refugees.

Through August 2000, MSF cared for 6,000 displaced Zambians along the east bank of the Zambeze River, in Chavuma. In addition to carrying out vaccinations, the organization set up mobile clinics for villages in areas where the displaced were living.

Malawi

One of the highest HIV/AIDS rates in the world

- ▶ International staff: 17
- ▶ National staff: 75

Malawi has been stricken by AIDS. Estimates put the HIV infection rate among 15-49 year-olds at over 15%, and in the overall population at 7%. A large majority of hospital beds are filled with people suffering from AIDS-related illnesses and complications.

MSF works in Thyolo, Mwanza and Chiradzulu districts to try and stem the spread of disease through both prevention and treatment. In the district hospitals, teams work to care for patients, improve universal precautions and sterilization procedures and train staff.

Patient counseling is becoming an increasing priority. In Thyolo, special emphasis is placed on testing, counseling and treating people with tuberculosis, an opportunistic infection common in those with HIV.

AIDS prevention activities are aimed at young people, local leaders, healers and prisoners. MSF has also opened centers for free and anonymous HIV/AIDS testing in all three districts.

MSF takes part in Malawi's National Technical Committee for the Control of the AIDS epidemic.

MSF has been active in Malawi since 1986.

Angola

A people trapped in civil war

- International staff: 77
- National staff: 400

Angola's decades-long, on-again, off-again civil war has had a devastating effect on the health and well-being of the population. Fighting between government forces and UNITA (União Nacional para Independência Total de Angola) rebels, which began in 1975, has left the country with entire regions that are abandoned, countless mined roads, and a virtually nonexistent health system. The people suffer from chronic malnutrition, sleeping sickness, malaria, preventable diseases such as measles and polio, and injuries caused by land mines and war. Up to a quarter of the country's 12 million people have been displaced during the course of the conflict. And, despite the country's natural wealth (from oil and diamonds), 60% of the population lives below the poverty line.

A peace agreement was signed in 1994, but the war flared up again in 1998. Control of the country remains divided between UNITA and the government (the MPLA, or Movimento Popular de Libertação de Angola). Vast parts of the territory remain hidden behind a curtain of war and silence, inaccessible even to aid agencies such as MSF. The people of Angola have been living in this state of chronic emergency for over 25 years.



ANGOLANS SUFFER FROM CHRONIC MALNUTRITION, SLEEPING SICKNESS, MALARIA, PREVENTABLE DISEASES SUCH AS MEASLES AND POLIO, AND INJURIES CAUSED BY LAND MINES AND WAR. THE PEOPLE OF ANGOLA, 60% OF WHOM LIVE IN POVERTY, HAVE BEEN EXISTING IN THIS STATE OF CHRONIC EMERGENCY FOR OVER 25 YEARS.

The Angolan public health system has all but disintegrated. MSF provides support to several hospitals and health clinics, and works to screen for and treat diseases such as sleeping sickness and pellagra. The organization has focused much of its work on treating and feeding many thousands of internally displaced persons (IDPs) and residents.

The combat against malnutrition

Widespread malnutrition has been one of the most vicious consequences of the Angolan war. MSF runs feeding programs in the cities of Huambo, Kaala, Kuito, Luena, Huíge, Malange and Cangandala. A large part of the territory is accessible only by air.

From late 1998 on, renewed fighting between the government and UNITA forced MSF to suspend operations in Kuito and, later, Malange. The situation eased slightly in early 1999, and programs in Kuito were reopened, but it was only in late summer that MSF was able to return to Malange.

The government renewed its offensive against the rebels in September 1999, and the number of IDPs increased dramatically in some areas. This put additional pressure on the food supply, as people fled the fighting for regions already facing food shortages. Fighting in some areas eased in spring 2000, but large parts of the country remain inaccessible.

Many of MSF's nutrition programs have been ongoing for a year or more. Others are new, reflecting the continual pressure on the population. Responding to an alarming increase in malnutrition in Malange province in summer 1999, MSF opened eight therapeutic feeding centers. In early 2000, the nutritional situation improved, and the project was scaled down to three. The feeding program in Huambo opened in September 1999, and another in Huíge in February 2000. Later that spring, the organization opened a small feeding program in the town of Cangandala.

In Kaala, where MSF had previously provided only emergency care, more permanent programs were launched in January 2000. These include four nutrition centers and drug procurement and support for all services in Kaala hospital. Until early this year, MSF supported nutrition programs run by the local health authorities in Benguela, Angola's second largest city.

Sleeping sickness and other diseases

Malnutrition is not the only health problem facing Angolans. MSF runs sleeping sickness programs in the towns of N'Dalatando and Golungo Alto. The organization screens for sleeping sickness with a mobile lab and supports in- and outpatient care at the hospital in N'Dalatando. As part of its hospital-based and nutrition work, MSF also treats pellagra, a rare vitamin B deficiency disease.

In October 1999, MSF brought to a close its support of the tuberculosis center at the Catholic hospital in Cubal.

Basic health services

The backbone of MSF's work in Angola is its support of various hospitals and health centers in several provinces. Teams often function as the primary staff at the hospitals in Kuito and Luena. In Kamaciú, MSF opened a small health center and is assisting with the rehabilitation of some of the medical infrastructure. In Menongué, MSF supports three health posts and the hospital. Three local medical professionals work for MSF in the municipal hospital in M'banza Congo. In October 1999, an MSF project supporting three health centers in Cazenga, a slum area of Luanda, was successfully handed over to the Ministry of Health after a ten-year intervention.

MSF has been working in Angola since 1983.

South Africa

Working to prevent mother-to-child transmission of HIV

- ▶ International staff: 5
- ▶ National staff: 10

In mid-1999, an MSF mission focused on AIDS in South Africa was still a vision in the heads of a few people in Brussels and Geneva. A year later, MSF supports a mother-to-child transmission (MTCT) prevention program and has created three clinics where HIV-positive people receive care and support. MSF has also begun a high-profile campaign for access to medications to treat HIV.

MSF monitors, evaluates and provides technical assistance to the MTCT program in Khayelitsha, a township outside Cape Town where one in five women at prenatal clinics test positive for HIV. The site was selected largely because it was the only government-supported MTCT program in the country. The program has been successful: High proportions of women accept counseling and testing, and eventually take AZT to reduce the risk of transmitting HIV to their children.

MSF began infectious diseases clinics in the primary health care centers adjacent to the maternity units, for mothers, their partners and the broader community. Initial response has been overwhelmingly positive, with hundreds of women being seen in the clinics' first months. Although medical care is now limited to treating opportunistic infections, use of antiretrovirals (drugs that attack HIV directly) is foreseen in early 2001.

Working with local NGOs such as the Treatment Action Campaign, the South Africa team has advised the Minister of Health on a drug donation offer and addressed parliament on the issue of access to medicines, all in an effort to improve access to care for people with HIV. During the International AIDS conference in Durban, 1000 people listened to speakers from around the world at an MSF-organized satellite meeting.

Mozambique

Epic floods

- ▶ International staff: 16
- ▶ National staff: 105

Mozambique will remember 2000 as the year of the floods. Torrential rains began in early February, affecting the whole of southern Africa, and the rivers flowing eastwards into the drainage basin of Mozambique soon burst their banks to flood the provinces of Gaza, Sofala and Inhambane. Severe tropical storms from the Indian Ocean hit the country soon after, causing a new wave of flooding in late February. South Africa then opened its floodgates, unleashing the third wave of flooding to wash over Mozambique.

An estimated one million Mozambiquans were directly affected by the floods, 300,000 of whom were made homeless. MSF, which has a permanent presence in the country, was quick to conduct rescue operations, set up cholera treatment centers, distribute tons of emergency food, potable water, shelter and

medicines, clean wells, and help with body retrieval.

Other MSF projects in Mozambique include work in a slum area near Maputo City to improve community health through better water management. In Niassa province, in the north, MSF has trained 400 community health workers to spread information on AIDS, cholera and other health concerns. The projects in Maputo and Niassa will be turned over to local health authorities by early 2001. MSF continues to support the Mutarara health district, with an increasing focus on HIV/AIDS prevention and treatment.

In 1999, MSF helped work out an emergency preparedness plan for cholera, which included vaccinations in the province of Tete. This plan was put into action when a cholera epidemic hit Gaza province in spring 2000.

Madagascar

Cholera strikes for the first time in recent history

- ▶ International staff: 11
- ▶ National staff: 76

In early 1999, Madagascar was struck by cholera for the first time in the island's recent history. MSF worked quickly to treat the outbreak, which began in the north, and to get basic information on cholera to the island's population. MSF trained health workers in the province of Mahajanga and distributed medicine and equipment.

At the time of the outbreak, MSF began an emergency cholera preparedness program in the western province of Toliary, which hadn't yet been hit. When the epidemic reached Toliary at the end of 1999, the authorities prevented MSF from carrying out preventive and curative work within the health system. MSF teams withdrew from the province to protest what was seen as government inaction in the face of the epidemic.

MSF also responded to health crises caused by several cyclones and tropical storms that struck the island in early 2000.

Ongoing MSF work in the country concentrates on about 6,000 street children in Antananarivo, the capital, and Antsirabe, the second largest city. A network of volunteer doctors, pharmacists and dentists also offers over 6,500 consultations a year to young people on the streets. Seventy young people receive psychological care. In Antananarivo, teams tour the city two nights a week, providing aid.

MSF intervenes in both cities on behalf of young people (and, in Antsirabe, also on behalf of women) who have been institutionalized or placed in detention. The goal is to provide both preventive and curative care. Permanent medical files are created for patients. MSF also monitors the status of those in the judicial system and works with the judicial authorities to accelerate the processing of these cases.





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Small children in the Christian village of Jezinne in southern Lebanon dance for their parents. They are involved in an MSF mental health project to help them cope with the stress of living in a conflict area.

Yemen

Reaching out to the poorest and most isolated

- ▶ International staff: 13
- ▶ National staff: 20

Yemen has experienced relative stability since elections in 1997. Yet even the somewhat stable situation hasn't permitted the state to turn its attention fully to the public health sector. Problems of access to health care remain, especially for the country's poorest and most isolated people.

In the mountainous northern region of Al Hazm, MSF has been working since 1997 to improve the overall quality of health care. In the Yemenite culture, doctors rarely touch those who come in for a consultation, and the patients do not even get undressed. One of the goals of the five-year program is to better understand the needs and the expectations of the area's 82,000 people. The lack of qualified health workers means that MSF often has a substitution role. A special emphasis on mother and child care is the natural response to a high maternal mortality rate of about 1,400 deaths for every 100,000 mothers.

In Aden, MSF works to rehabilitate health facilities and improve the quality of nursing care, and to train those engaged in mother and child care. To improve the medicine supply system and help establish a sustainable cost recovery structure, a health economist began work in 1999. This vast project to involve the population in the cost recovery system is scheduled to last five years. It encompasses an entire health district in Aden, including 12 clinics and all dispensaries, and reaches about 370,000 people.

MSF continues to supply medicine and offer technical support to the health district of Dhi Sufal, in northwestern Yemen.

MSF has been working in the country since 1991.



The Palestinian Authority

▶ National staff: 14

▶ International staff: 8

Palestinians living under the Palestinian Authority have seen little improvement in their living conditions since the signing of the Oslo Accords in 1993. Restrictions on movement imposed by Israel continue, and rights violations by the Palestinian government are a regular occurrence. As political leaders pursue a difficult peace, this climate of tension and violence continues to take its toll on the population.

A weakened mother-child bond takes its toll on children

Malnutrition among young Palestinian children is often linked not to lack of food, but to a weakened emotional link between mothers and their children – one result of the difficulty and stress in the mothers' daily lives. The consequences for the children can be

MALNUTRITION AMONG YOUNG PALESTINIAN CHILDREN IS OFTEN LINKED TO A WEAKENED EMOTIONAL LINK BETWEEN MOTHERS AND THEIR CHILDREN, A RESULT OF THE STRESS AND DIFFICULTY OF DAILY LIFE.

devastating and include mental and physical problems, and death. Since 1996, MSF psychologists have been working to help reestablish the mother-child bond, and to train local health professionals in caring for mothers and their children. The program, based in Hebron, has followed more than 350 women since its inception. A Palestinian psychologist is now in charge of the project.

In six centers located in the main cities of the West Bank, MSF has also given psychological care to ex-detainees who suffer from psychological disorders as a result of detention in Israeli prisons. MSF intends to transfer both programs in Hebron to local organizations before the end of 2000, while launching a psychological support project for mothers and children in Gaza.

In Hebron, support for primary care

MSF also works within the Hebron health district to improve access to primary care, rehabilitate clinics, improve the health information system, and train community health workers. In the Yatta region, in the southern part of this district, MSF has begun a pilot program to improve the quality of health services available to the population, including the Bedouins living in the Nakab desert.

In response to a measles outbreak in May 1999, the organization offered logistical and technical support to the Hebron and Ramallah health authorities. This effort, together with a tetanus vaccination campaign in August 1999, has helped MSF gain access to an even broader part of the Palestinian population.

Lebanon | Addressing the psychological scars of conflict

- International staff: 10
- National staff: 6

The people of southern Lebanon had been living in the midst of a continuing conflict between Lebanese armed groups and Israel, until Israeli troops and the Israel-supported South Lebanon Army made a hasty withdrawal from southern Lebanon in May 2000.

MSF continues to bring psychological relief to Lebanese living near the villages of Nebatiye and Jezzine in the south. The organization has trained Lebanese volunteers and social assistants working for the Ministry of Social Affairs in how to recognize stress and trauma, and provide psycho-social care and education. MSF is now working to help the authorities set up their own psycho-social programs in Hasbaye, Chebaa and Bint Jbeil. Through May 2000, MSF also gave first aid training to Lebanese Red Cross volunteers working on the front line.

The Israeli evacuation of southern Lebanon in May 2000 did little to change the plight of the country's estimated 350,000 Palestinian refugees. Long denied basic rights by

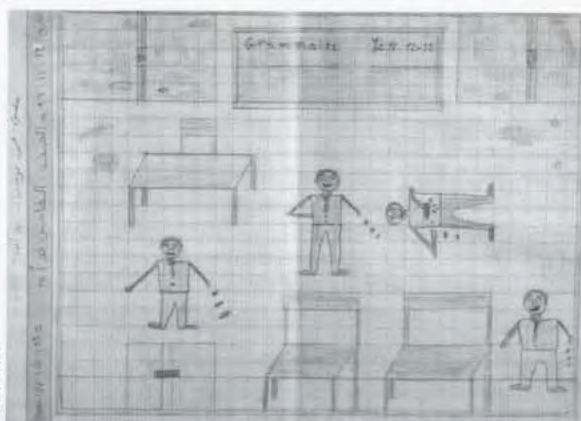
the Lebanese government, most refugees have passed years in overcrowded refugee camps. Many of them have had difficulties getting access to medical care.

Through April 2000, MSF worked at the Ain-El-Hilweh refugee camp, bringing medical aid to those who had fallen through the cracks. It was easy to get overlooked in the desperately overcrowded camp, which houses 62,000 people living on one square kilometer. For people too poor or immobile to use the UN dispensary, MSF was able to make house visits. The organization also helped those who were excluded from the UNRWA (the UN Relief and Works Agency for Palestinian Refugees) health program to access that system. MSF finished up its work at Ain-El-Hilweh after all the refugees had become integrated in either the UNRWA or Red Crescent health systems.

MSF also worked in the pediatric hospital in Saida through April 2000, when the pediatric service was turned over to the Palestinian Red Crescent society.

Lebanese women in the Muslim village of Nebatiye in southern Lebanon participate in a workshop as part of MSF's mental health program in the region (below). At right, a child's drawing is a response to the violence that is part of everyday life.

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Belgium

Free consultations for those who lack access to care

- National staff: 12
- Volunteers: 20

Refugees and others without papers – primarily from Kosovo, Eastern Europe and Africa – continued to seek MSF's services in Belgium over the last year.

In 1999, more than 2,600 people sought help in Antwerp, Brussels, Verviers and Liège, where MSF has small consultation clinics for people who are excluded from the country's health system. There was a rise in the number of young people and children who sought help, with a total of 7,500 consultations in all.

Another project, "Mpore," began in 1999. Using group therapy and individual sessions, a Rwandan psychologist works with refugees traumatized by the Rwandan genocide of 1994. Many institutions (such as the school system) and parents who are worried about young Rwandans have turned to the "Mpore" project for help.

In the capital, Brussels, MSF offers free and anonymous testing for HIV, with psychological help and follow-up.

Luxembourg

Creating a network of support for young drug abusers

- National staff: 5

Since 1997, MSF has worked throughout Luxembourg with young people who abuse mind-altering drugs. Starting from the premise that drug abuse may be a reaction to deeper family, personal, or social problems, MSF seeks to offer support to young people by working with two key partners who helped found the program: the foundation Jugend-an Drogenhëllef and the organization Jongenheem. However, instead of seeing itself as one more social service, the team identifies and links various Luxembourgish institutions and services. Institutions that work directly with

young people – the school system, the judicial system, and home and family services – can request help from MSF when dealing with those involved in substance abuse. Several MSF psychologists then work directly with young people, their parents, and the teams in the institutions. MSF has treated nearly 220 young people since the program began. Even though it receives referrals from the justice department, MSF remains completely independent of the judicial system.

France

Focus on the most vulnerable people

- Volunteer staff: 30
- Volunteer helpers: 20

The work of MSF in France has considerably changed with the introduction of the new "Couverture Maladie Universelle" or "CMU" (universal medical coverage). This new legislation facilitates access to medical care for six million potential patients who live in precarious situations. Following the application of this law, the mission now focuses on the most vulnerable groups of the population.

Positive results for the CMU

In 1999, MSF worked on the CMU bill in order to underline the difficulties certain groups of people have in accessing health care, and to prompt a public debate on the orientation of the project – in particular denouncing the possible risk of the privatization of medical care for the poor. More than 25 propositions submitted by MSF were included in the new legislation, and MSF helped elaborate the texts regarding its application. Since it came into force on January 1st 2000, a data collection system has been set up in each "Solidarité-France" center to observe and monitor the application of the new legislation. For the moment the results have been positive. The most serious flaw is the lack of both information for health professionals and access to health care for certain vulnerable groups.

MSF has been working in Marseilles for ten years, but given that the CMU now accelerates access to health care, it will reduce the medical side of this center's activities.

In the region of Etang de Berre, a new mission will aid foreign families living in public housing. A social-medical center has opened in Marignane to facilitate access to medical care for children over six years old and young people in difficulty.

Helping those in distress

MSF continues to focus on more specific populations to improve their access to health care. The program to reduce risks for drug users has been strengthened in liaison with pharmacies which have accepted the installation of eight Distriboboxes (sterile injection material distributors) in six districts of Paris. They have also agreed to sell 20,000 prevention kits. This approach to drug users and marginalized young people – set up in 1995 by mobile "street teams" – has considerably changed the waiting rooms in the Paris social-medical center, which now sees youths that live in ever more precarious circumstances. The program "Enfants-Jeunesse" in Lille now also has mobile "street teams." Almost 1,000 consultations and 700 social services appointments have been given at the center.

The activities of the social-legal unit have been diversified as the team now assists asylum seekers in precarious situations. In July 1999 it intervened to help Kosovar refugees in France.

Spain | Meeting the needs of the “fourth world” population

► National staff: 45

Many people in Spain, and in particular a vulnerable, excluded often immigrant population, do not make use of the country's General Social Service, which covers basic necessities such as health care. Since 1994, MSF has been working to improve the access to health care and social services of this “fourth world” population.

4th World Barcelona

MSF has a socio-medical dispensary for Barcelona's marginalized population next to the main MSF office in the city. The focus is on increasing access to the existing health network. In addition to providing medical care at the dispensary, MSF raises awareness of HIV/AIDS and offers general health information. In an area of the city frequented by heroin addicts, MSF mobile clinics exchange needles with drug users and offer basic care. Teams also visit parts of the city where homeless people live, to talk to them, encourage them to visit the clinic if necessary, and help them learn how to access existing health and social services.

To better understand the social, health, educational and housing rights of disadvantaged people in Barcelona, MSF is conducting a legal review of relevant national and regional laws. This work is focused initially on the laws regarding creating a space for drug users to inject heroine safely, because a plan to create such a space was refused by the authorities after extensive pressure from people in the surrounding neighborhood.

4th World Madrid

In April 2000, MSF began work in Madrid. The program is twofold. Medical work is done through the Madrid-area tuberculosis control (TBC) program. The legal/social part of the program focuses on immigrants and asylum seekers, who often live in difficult conditions because of their lack of papers.

MSF works to detect and treat tuberculosis, with special priority given to often undocumented immigrants. People receive information on administrative and judiciary procedures necessary for legalizing their stay in Spain. MSF also guides immigrants and asylum seekers to various general services, such as social and health services, educational and cultural services, professional training and career guidance.

The project has recently begun offering psychological assistance to those in need, who often suffer from depression, anxiety, alcoholism, drug addiction, and stress. These problems have a variety of causes: difficulty adapting



to Spain, distance from families, limited networks of social support, unemployment, or physical or psychological mistreatment undergone prior to arrival in Spain.

Public debate

To open a public dialogue about the problems faced by the “fourth world” population in Spain, MSF is interested in participating in civic platforms supporting immigrants, cooperating with human rights organizations, campaigning to change public opinion, and denouncing Spanish government actions which violate the rights of asylum seekers and other immigrants.



► Intravenous drug users exchange needles and receive basic care from MSF health workers who travel daily to Can Tunis, a depressed area on the outskirts of Barcelona.

Italy | New focus on refugees and asylum seekers

► International staff: 1
► National staff: 4

In October 1999, MSF opened an office in Brindisi, Italy, to monitor the condition of the many refugees fleeing across the Adriatic to that part of Italy as a result of the Kosovo war or other unrest in the Balkans. During summer 2000, MSF was able to visit a number of refugee camps in the Puglia, Calabria and Trieste regions. These visits were the groundwork for a possible future program for improving the protection status of asylum seekers in Italy (and in Europe in general), and increasing access to health care for this vulnerable population.

In Rome, beginning in January 2000, MSF has helped several hundred people coming from South America, the Balkans, Eastern Europe and North Africa get access to

health care. Under Italian law, all those residing in the country, legally or illegally, are entitled to health care, but many illegal immigrants are afraid to seek help. MSF helps some of them register with the health services through a system guaranteeing their anonymity.

A program aimed at a large Roma (Gypsy) community living in camps outside of Rome – where flimsy housing and the lack of water, electricity, latrines and health care put the population at risk for disease – was turned over to the public health authorities in December 1999, after over three years of MSF intervention. MSF provided medical care, water and sanitation support, and social and legal assistance to about 1,500 people.

Yugoslavia | Care for people fleeing Kosovo

► International staff: 7
► National staff: 23

In the wake of the war in Kosovo and the consequent entrance of KFOR (the NATO-led international military force) and the UCK (Kosovo Liberation Army) into the region, many thousands of people fled the area because they were threatened, feared violence, or had experienced direct attacks – and felt that they were not being protected. They fled Kosovo for other parts of Serbia, the largest republic in the Federal Republic of Yugoslavia. Others fled to Montenegro, the country's other republic.

Most of those fleeing were Serbs, with a significant number of Roma (Gypsies), and some Goranci, Muslim and other non-Albanian populations. The several hundred thousand people flooding into Serbia increased pressure on an infrastructure and economy already severely damaged by sanctions, mismanagement and war – and overloaded by more than half a million refugees from the Bosnian and Croatian wars in the early 1990s.

Beginning in July 1999, MSF began to help meet the needs of these displaced people, with a focus on those housed in community buildings, such as schools, which had been converted to shelters. MSF distributed basic relief items, such as hygiene materials, extra food, clothes, shoes, baby diapers, milk and school items. This program centered on the Belgrade area and Kraljevo and Kragujevac, the two towns with the highest concentration of displaced people.

After this initial phase of work, in December 1999 MSF started a project in central Serbia and, soon after, in southern Serbia near the Kosovo border. The focus is on displaced people living in both collective buildings and private homes. In close collaboration with the local authorities, MSF ensures that these people have decent shelter, heating, water, sanitation and hygiene conditions. MSF also plans to work in both areas to revitalize local health facilities and supply diagnostic material.

MSF began working in Yugoslavia in 1991.

Kosovo The physical and psychological consequences of war

► National staff: 152

► International staff: 55

Summer 1999 saw the beginning of the post-war period in Kosovo. With peace in June, hundreds of thousands of refugees who had sheltered in Albania, Macedonia and Montenegro returned en masse. MSF, which had an extensive presence in Kosovo prior to the war but withdrew when the bombing started, was also quick to come back, setting up medical aid points, rehabilitating health facilities, and providing mental health care to traumatized people. It soon became clear that, despite the peace agreement between NATO and Yugoslavia, tensions throughout the province remained high – especially in areas containing a substantial minority of either Kosovar Albanians, Kosovar Serbs, or Roma (Gypsies).

Hoping for a sense of security with the presence of KFOR (the NATO-led military force charged with keeping the peace in Kosovo), many Kosovars from all ethnic groups have instead felt a growing insecurity. The interim civilian administration set up by the UN was also slow to get off the ground and often vague in its provisions for responsibilities like policing, adding to the sense of unease. In addition to providing medical aid and psychological support to people from all ethnic groups, MSF has worked over the last year to gather first-person accounts of inter-ethnic abuse and violence. MSF continues to call for increased protection for all Kosovars. In August 2000, the organization ceased activities in several minority enclaves in the north, as an act of protest and to draw attention to the deteriorating security situation for minority groups and vulnerable civilians in general.

Meanwhile, MSF is offering aid to those in need in much of Kosovo. Since MSF re-entered the region in June 1999, it has been working in different areas: Pejë/Pec (geographic names are given in

Albanian and Serbian). Istog/Istok, Prizren, Gjakova/Djakovica, Skenderaj/Srbica, Vushtri/Vucitrn, Gjilan/Gnjilane, Mitrovica and in many small villages, reaching a total population of 750,000 people. Activities have been many and varied. Direct medical care is given at

HOPING FOR A SENSE OF SECURITY WITH THE PRESENCE OF KFOR, MANY KOSOVARS FROM ALL ETHNIC GROUPS HAVE INSTEAD FELT A GROWING INSECURITY.

hospitals, through mobile clinics or in small community "ambulantes," or clinics. Major hospitals in Prizren, Mitrovica, Pejë/Pec and Gjakova/Djakovica have received either ongoing or short-term MSF support.

Because of the mental trauma of the war and the high incidence of post-traumatic stress disorders (PTSDs), psychological care and training have been an important part

of the work. Numerous mental health programs are currently in place in Kosovo, and include the support and training of Kosovar mental health professionals in dealing with PTSDs.

In a place devastated by both civic violence and bombing, the reconstruction of infrastructure necessary for good health and good sanitation is critical. MSF gave technical advice and provided materials to help rebuild 800 roofs. In the aftermath of the war, access to clean water was impeded by dirty wells, sometimes containing human or animal cadavers. MSF worked with many communities to

clean thousands of wells. Rehabilitation of several hospitals and many health clinics has also been an important part of MSF's work.

From the onset of the war through September 1999, the organization also ran a clinic at the Cegrane refugee camp in Macedonia, home to 43,000 refugees at the peak of the crisis. MSF began working in Kosovo in 1993.

Bosnia and Hercegovina

Coping with the effects of turmoil in the Balkans

- ▶ International staff: 6
- ▶ National staff: 38

The 1999 war in Kosovo caused a wave of refugees to flee to neighboring Bosnia. From summer 1999 through March 2000, MSF provided medical care in several camps for Kosovar refugees.

In January 2000, two small health posts were opened for the Roma (Gypsy) population in Sarajevo, many of whom had fled from Serbia and Kosovo during the war. The clinics are located in Buca Potok and Vraca, two hilly areas above Sarajevo where many Roma live.

Not just the recent war but the Bosnian war (1992-1995) has left its mark on the country, not least on the mental health of its inhabitants. From 1996 through July 2000, MSF helped people in the town of Gorazde who were

suffering from post-traumatic stress disorders (PTSDs). MSF set up a mental health center and trained Bosnian mental health professionals. The program is to be turned over to the local authorities by the end of 2000.

In eastern Republika Srpska, a medicine distribution program begun in 1995 came to an end in late 1999, when responsibility for the drug supply was turned over to the government. MSF is continuing to monitor the medicine supply situation in the region.

In Tuzla and Pale, in September 2000, MSF finished a training program for doctors and nurses specializing in family medicine. In October, a third and final family medicine training cycle will begin in Doboj.

Albania

MSF mission draws to a close

- ▶ International staff: 4
- ▶ National staff: 10

Most Albanians have limited access to health care because of poor medical infrastructure, ineffective use of medical resources and shortages of equipment and drugs. The health system has suffered from decades of inefficient administration and lack of funds.

However, political stabilization in the country is opening the door to private investment and bilateral aid aimed at long-term development. After evaluating its role, MSF has decided to close its mission by the end of 2000.

MSF has worked in Albania since 1998, and when refugees flooded the country during the Kosovo war in spring 1999, the organization also did emergency work in numerous camps. By the end of the summer of 1999, most of the hundreds of thousands of Kosovar refugees had returned home, and MSF's emergency intervention drew to a close.

MSF continued a water and sanitation project in the Korce District in southeastern Albania, and support for the regional hospital in Fier and a polyclinic in Vlora, in the south near the Adriatic Sea. Work in Fier and Vlora focused on repairing infrastructure, procuring medical equipment, and providing medical training, and was completed in spring 2000. The water and sanitation program will finish in the fall.

Elections in the Balkans in fall 2000 are a critical step toward democracy and peace in the region. MSF is monitoring the situation and is involved in emergency preparedness planning.



« This Roma (Gypsy) family crowds into a corrugated tin shack in Skopje, Macedonia after fleeing Kosovo in fear in July 1999.

Russia

Concern for Chechen civilians

- ▶ International staff: 37
- ▶ National staff: 250

Over the last year, MSF has focused on responding to the outbreak of war between Russian forces and rebels in the Russian republic of Chechnya (see box). MSF decried the Russian government's indiscriminate bombing of Chechen civilians during the conflict and the lack of international response to the crisis. MSF's work elsewhere in the Russian Federation continues to target three key problems: the spread of HIV/AIDS, the medical and social exclusion of a rapidly growing homeless population, and the tuberculosis (TB) epidemic in Siberian prisons.

Attacking HIV/AIDS on many fronts

Russia now ranks among those countries with the fastest increase of HIV infection, the 50,000 registered cases indicating (according to WHO estimates) up to 500,000 infections in total. HIV/AIDS programs, based in Moscow, are run in collaboration with Russian health authorities and national NGOs. Begun in 1996, they are designed to be models for preventive health programs nationwide.

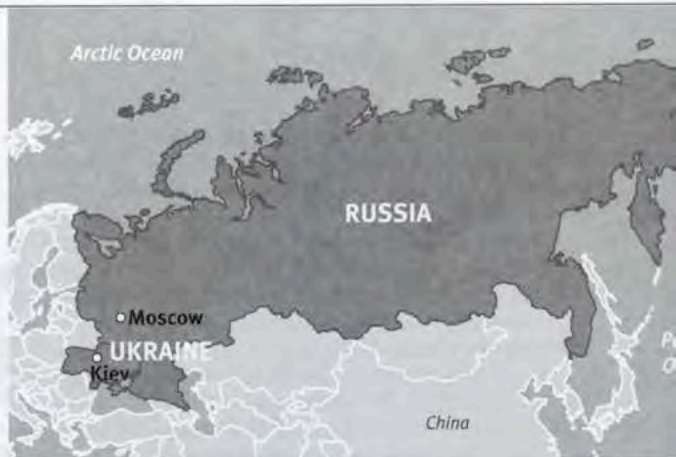
MSF activities include mass-media campaigns to raise awareness of the disease, the dissemination of HIV/AIDS information (through research, counseling, training, seminars, an information hotline and a library) and a "harm reduction" initiative targeted at the country's growing ranks of intravenous drug users, who make up 80 % of those registered with HIV. As part of this initiative, all 35 current needle exchange projects in Russia receive technical assistance and training from MSF.

To address HIV in the Russian penitentiary system, MSF began a three-year pilot program in July 1999. In collaboration with the Russian Ministry of Justice, preventive health measures are being implemented in six prisons throughout the country. MSF trains medical staff, inmates and prison guards in HIV prevention and distributes condoms and bleach to prisoners.

Russia's four million homeless

When MSF began working with Moscow's homeless in 1992, the official number for this marginalized population was 30,000. Today there are 100,000 homeless people in the capital, and four million throughout the country. MSF hopes to offer a model for socio-medical assistance that can be handed over to the Russian government and reproduced on a larger scale. This was done successfully with a similar MSF program in St. Petersburg, which was handed over to the government in 1999.

MSF carries out more than 500 medical and social consultations per week, which include basic medical care,



vaccinations and referrals to city hospitals. Teams lobby the Russian authorities and also help the homeless wanting to reintegrate into society to solve legal problems, replace official documents, seek jobs and find places where food and clothes are donated. Educating the general public about homelessness (through documentaries, posters, and mass-media campaigns) is also an important part of the work.

Siberian prisons carry a sentence of ill health

Penal detention in Russia often carries with it an extra-judicial sentence of ill health. Malnutrition and massive overcrowding have made Russia's prisons a breeding ground for TB. MSF uses the DOTS (Directly Observed Treatment Short Course) method to treat all prisoners in the Kemerovo region who have active (contagious) TB. MSF treats patients, trains staff on the implementation of DOTS and supplies laboratory equipment, materials and quality drugs to detect and treat TB. The program now covers the entire prison system in Kemerovo, including the pre-trial detention centers (SIZOs), where work began in February 2000.

MSF also addresses the problem of resistance to TB drugs (including multi-drug resistance, or MDR TB) by conducting research and ensuring the early detection and isolation of MDR TB patients. More broadly, MSF is setting up a system to supply MDR TB projects worldwide with quality drugs, after having negotiated significant reductions in drug prices.

Although the TB cure rate has risen and now hovers around 70%, further progress has been slowed by several factors, including the large number of MDR TB patients and high turnover rates in the prisons. And, not least, there has been no improvement in the underlying living conditions of most prisoners.

▲ Inmates of Prison Colony #5 in Penza, Russia do a group exercise as they learn how to educate their fellow prisoners on preventing HIV through reducing risk associated with intravenous drug use. The workshop is part of a three-day MSF training course.



Ukraine

The highest number of AIDS cases in the former Soviet Union

- ▶ International staff: 2
- ▶ National staff: 15

The number of Ukrainians with HIV has climbed from 50 new registered cases in 1995 to almost 40,000 four years later. Current estimates put the number of infected people at 250,000 – the highest number in the former Soviet Union.

This skyrocketing problem prompted MSF to launch an HIV/AIDS prevention and treatment program in the country in October 1999. The project has four main components: preventing HIV among intravenous drug users, a mass media campaign, information centers, and preventing mother-to-child transmission of the disease.

Intravenous drug use

With the deteriorating economic situation in Ukraine, intravenous drug use – responsible for an estimated 80% of HIV infections in the country – has become very popular with young people, especially young men 18 to 25 years old.

Ukrainian NGOs targeting these young drug users operate in 18 cities around the country, offering preventive services that have proven to be effective, such as needle exchange and education about health risks. Where possible, they offer basic medical and psychological care. Together with the Renaissance Foundation (part of the Soros Fund), MSF is helping these NGOs increase the quality of their programs.

Getting information on AIDS to those who need it most

Four Ukrainian NGOs will help get badly needed information on HIV/AIDS to health professionals who are often still afraid to care for someone with the disease. MSF and the Russian organization AIDS Infoshare provide

training and practical experience to the Ukrainian NGOs, through developing skills such as management and bookkeeping, and the design and printing of educational materials.

MSF research in three major Ukrainian cities shows that HIV/AIDS is poorly understood, and that lack of knowledge is at the root of unnecessary fear. The organization is planning a mass media campaign to reduce prejudice toward people with AIDS and educate people on issues such as how the disease is transmitted.

Pilot projects target mother-to-child transmission

More and more children are being born to mothers with HIV. Hoping to identify preventive solutions that are affordable for Ukraine, in June 2000 MSF began pilot projects in Odessa, Nikolayev, and Simferopol, the three cities hardest hit by the epidemic. Medical evidence supports a drug that can reduce mother-to-child transmission of HIV by 50%, and, at US\$5, this is affordable in Ukraine. Twenty mother-child pairs have been treated with the medicine, and early results have moved another city to reproduce the program using local funds. The program will begin home care for HIV/AIDS sufferers and their families, with training starting in 2001.

Working with Ukrainian doctors, MSF is expanding its efforts to find affordable ways to treat opportunistic infections, in a country where the treatment for HIV/AIDS-related illness is limited for purely economic reasons.

MSF has been working in Ukraine since 1999.

"The people of Chechnya, today and for more than three months, are enduring indiscriminate bombing by the Russian army....I appeal here today to his excellency the Ambassador of Russia and through him, to President Yeltsin, to stop the bombing of defenseless civilians in Chechnya." MSF made this appeal when it accepted the Nobel Peace Prize in December 1999, and went on to lobby European and international institutions to speak out and act on behalf of the Chechen people. MSF decried the fact that countries so quick to intervene during the crisis in Kosovo failed even to recognize the war in Chechnya and the suffering of the Chechen people.

In August 1999, conflict between Russian forces and Chechen rebels exploded, bringing destruction upon the Chechen capital, Grozny, and forcing hundreds of thousands of people to flee their homes. Many health facilities were damaged and access to others cut off by insecurity. Poor living conditions, overcrowded shelters and lack of hygiene have resulted in a high instance of skin diseases and gastro-intestinal infections, especially among children. The health and well-being of the population is in a precarious state. MSF works in Chechnya and in the neighboring Russian republics of Ingushetia and Dagestan. The organization relies extensively on local health professionals, backed up by coordination teams in Moscow and in the field.

Ingushetia

The majority of the more than 250,000 people who fled Chechnya poured into Ingushetia. MSF has distributed relief items, such as blankets and hygiene kits, to the displaced. The organization has also supplied local hospitals and

clinics with medicine and medical equipment, to help the Ingush health system cope with the burden created by the influx of internally displaced people (IDPs).

Since late spring 2000, two mobile clinics in northwestern Ingushetia have been treating skin diseases, respiratory infections, diarrhea and STDs, and providing psycho-social support. A gynecologist and a social nurse offer consultations to women. MSF also works at the main hospital in Nazran, the Ingush capital, to ensure that seriously ill IDPs are treated even if they are unable to pay.

Dagestan

In Dagestan, MSF distributes basic medical kits to health posts, clinics and hospitals damaged by fighting. Many of the area's displaced people were either uprooted from their homes within Dagestan during the first phase of the conflict, or came later from Chechnya.

Chechnya

In February 2000, MSF began distributing medicines and medical equipment throughout Chechnya. In spite of the ravages of two wars, and years without payment of salaries or new equipment, many hospitals and clinics continue to function. MSF is helping to restart the health system, providing doctors with the tools and supplies they need. MSF has done light repairs on 12 damaged health facilities and has rehabilitated surgical facilities in two of Chechnya's key hospitals. MSF began working directly with five hospitals in Grozny in March 2000 and in the city's maternity hospital in August.

Romania | Helping the homeless

- International staff: 1
- National staff: 10

Romania's uneven transition from a planned to a market economy has caused many Romanians to fall through the cracks, unable to afford basic necessities. Many of these people are homeless and lack access to medical care.

MSF focuses its work in Romania on the needs of homeless people in Bucharest, who number some 9,000. There is still no network of medical and social assistance for the homeless. So, in September 1999, MSF sponsored a seminar for 25 delegates from city and federal agencies, as well as NGOs, to raise awareness of the problems facing the homeless and coordinate activities of the participating organizations.

The results were positive. The government agreed to look into the problem of documentation (needed for services such as health care) for homeless people. The city council said it would pay for food offered at a food distribution point, with MSF providing logistical support. In addition, the national Ministry of Labor and Social Protection began developing a program to support handicapped homeless people.

The advocacy stance of MSF is rooted in its work with the homeless on the streets of Bucharest. Medical and social assistance is provided at a drop-in center, and MSF collaborates with a local aid agency, Casa Ioanna, which runs a night shelter. Together the programs reach about 1,500 people.



In addition to its work with the homeless, through June 2000 MSF financed several projects run by other groups. MSF funded a program to aid some of Bucharest's many street children through a mobile medical bus clinic that makes nightly rounds. MSF also supported work to prevent child abandonment in Bucharest, as well as a project to help children and families touched by the AIDS virus in Giurgiu, a town near the Bulgarian border.

MSF has been working in Romania since 1990.

Bulgaria | Fighting sexually transmitted diseases

- International staff: 2
- National staff: 5

Much of MSF's work in Bulgaria has targeted the dramatic rise in cases of sexually transmitted diseases (STDs) and HIV the country has experienced over the last decade.

In February 2000, the organization opened an STD clinic within the University of Sofia. A pilot program for managing STD cases according to international standards, the project promotes patient confidentiality, counseling, and partner tracing. The clinic has had about 100 consultations a month, and MSF expects the number of people served to grow as information on the clinic reaches more people.

In Bulgaria, prevailing STD treatment protocols have often been long and costly. In 1999, by leveraging its position distributing penicillin to a dozen hospitals country-

wide, MSF successfully pressured the Ministry of Public Health to adopt new protocols promoting syphilis treatment on an outpatient rather than inpatient basis. The drug distribution program itself was phased out over the last year.

In addition to its work in Sofia, in fall 1999 MSF set up a small clinic in the northern Bulgarian town of Targoviche to serve the Roma (Gypsy) population. Social ostracism has caused many Roma to lack confidence in the official health system. The clinic offers consultations and social support and distributes basic items such as soap, sugar, beans and cooking oil to a community of about 5,000 people.

MSF has been working in Bulgaria since 1997.

Turkey | Earthquakes hit western Turkey

- International staff: 25

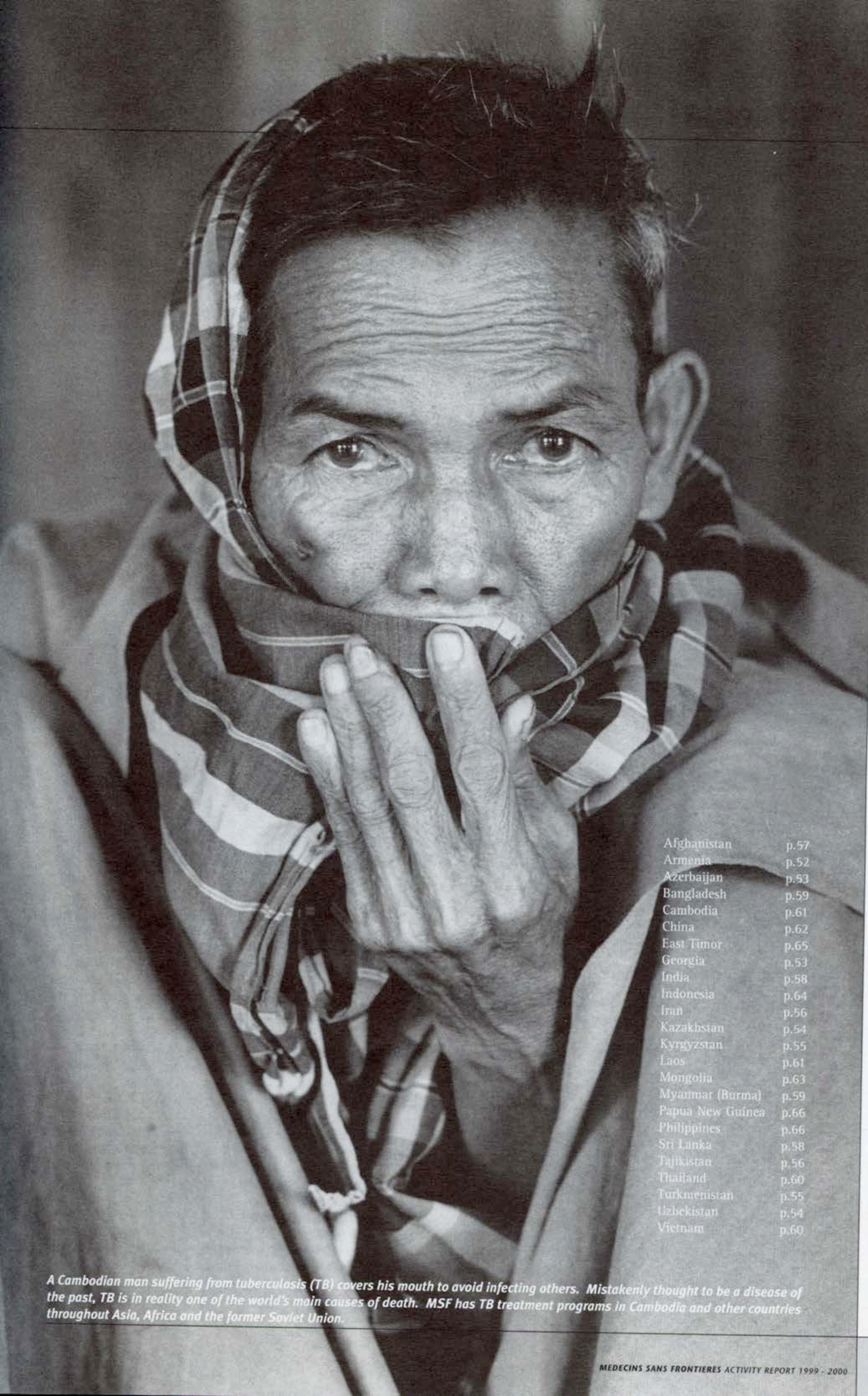
A massive earthquake struck Turkey in the early hours of August 17th, 1999, devastating much of densely populated, industrialized western Turkey. The quake, which measured 7.4 on the Richter scale, took over 17,000 lives and injured many thousands more. In the immediate aftermath of the disaster, MSF set up and staffed five small clinics in Izmit and Gölcük, two cities near the epicenter, to address the basic medical needs of earthquake victims.

Working closely with a Turkish NGO, the organization also set up ten water bladders (able to provide water for 1,500 people each) and distributed plastic sheeting for thousands of

families. Teams of nephrology specialists brought five dialysis machines to the Marmara University Hospital in Istanbul, to treat the acute kidney failure that often occurs when limbs are crushed. MSF also offered psychological assistance for people suffering from post-traumatic stress disorder.

In November, a second major earthquake hit, with the epicenter in Duzce. In the town of Kaynasli, MSF set up several health posts and worked to ensure adequate water and sanitation.

MSF worked in Turkey from August through September 1999 and again in November and December.



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A Cambodian man suffering from tuberculosis (TB) covers his mouth to avoid infecting others. Mistakenly thought to be a disease of the past, TB is in reality one of the world's main causes of death. MSF has TB treatment programs in Cambodia and other countries throughout Asia, Africa and the former Soviet Union.

Armenia | Reaching out to troubled youth

- ▶ International staff (including Nagorno-Karabakh): 23
- ▶ National staff (including Nagorno-Karabakh): 95

In Yerevan, the capital, MSF works with young people who have fallen by the wayside, either living in the streets or pulled into the institutional or prison systems. Teams have helped to improve the living conditions, food, and hygiene of children institutionalized in the Vardashan Institute. The focus is on helping these young people rebuild family ties and get better access to education and training. MSF also coordinates teams that go into the streets and seek children out, to identify problems before young people enter the institutional or prison system. The organization hopes to turn this project over to local actors.

Family planning in the rural Tavush region

In northeastern Armenia, in the Tavush region near the border with Azerbaijan, MSF helps implement the Ministry of Health's (MOH) national reproductive health plan. MSF assists a network of 55 government hospitals, polyclinics, dispensaries and health posts. Teams work to improve maternal care through safer deliveries, postnatal

consultations, and by offering health education. Midwives work with their counterparts in the local community to reinforce the role of the local midwife as a key information and health care provider. Leaflets, posters and occasional drama productions educate the public about family planning.

Improving life for psychiatric patients

In the psychiatric hospital in Sevan, MSF works to avoid or reduce patient hospitalization, prevent relapses and stabilize patients' conditions. In addition to improving basic living conditions at the hospital (such as food and hygiene), MSF encourages activities like drawing, dancing and sports to help improve the atmosphere and the quality of life. Promoting contact between patients and their families, preparing patients for their release, and collaborating with other institutions and organizations are all part of the psycho-social approach to mental health care that is at the center of MSF's work in Sevan.

MSF has been working in Armenia since 1989, when the country was hit by a devastating earthquake.

At a psychiatric hospital in the mountains near Sevan, Armenia, patients dance to traditional Armenian music, played by a fellow patient. As part of its mental health program, MSF has introduced activities such as dancing and art to help improve daily life in the institution.



© Ann Dorothy

Nagorno-Karabakh

Nagorno-Karabakh, a predominantly ethnically Armenian enclave within Azerbaijan, seceded from Azerbaijan in 1994. The self-proclaimed republic, whose economy is essentially at a standstill, remains contested territory.

Tuberculosis

MSF has been running an anti-tuberculosis (TB) program in Nagorno-Karabakh since 1997, screening and treating patients at the central TB clinic of Stepanakert. MSF provides drugs, food supplements, and hygiene materials to the patients, and trains health staff in DOTS. The cure rate for patients under treatment has risen to 80%. MSF seeks out patients who have difficulty reaching the clinic or can't pay for hospitalization, in an effort to help them get treatment.

MSF's activities have expanded beyond the central TB clinic. MSF screens patients for TB at the Stepanakert Psychiatric Hospital. Teams also visit regional polyclinics, to check that patients who have returned to the regions from the Stepanakert clinic receive the necessary follow-up treatment and drugs. At the prison in the town of Souchi, MSF educates prisoners about TB and trains the staff. The organization also provides TB training and education to staff and military personnel at the Armenian military barracks.

Last year, MSF began a pilot program to treat people with multi-drug resistant TB (MDR TB), which no longer responds to common anti-TB drugs. MSF constructed a new building within the Stepanakert TB clinic to isolate these infectious patients. The high cost of MDR TB drugs means that only a few patients can be treated.

Mental health

To address the high incidence of post-traumatic stress disorders among the population (partly a result of the conflict over the republic), MSF set up a referral system for people suffering from these and other psychological problems. Patients are referred to doctors who have received additional training from MSF, and to psychological centers and psychiatric institutions that receive technical assistance – all in an effort to humanize the treatment of mental health patients. To help reinforce the enclave's mental health care facilities, MSF rehabilitated and added an outpatient ward to the Stepanakert Psychiatric Hospital.

Water and sanitation

From early 1999 through summer 2000, MSF helped improve hygiene, water and sanitation facilities in 14 villages throughout Nagorno-Karabakh.

Georgia

Providing aid in a climate of insecurity

- International staff: 5
- National staff: 51

Insecurity has been a constant in Georgia over the last year. In June 1999, due to a deteriorating security situation, MSF left South Ossetia, where it had been running a tuberculosis (TB) program in Tshkinvali. MSF continues to supply the city's central TB clinic and 15 hospitals with drugs, and the MSF medical team based in Tbilisi, the capital, monitors consumption. Unfortunately, South Ossetia remains an isolated enclave and the public health services lack the means to fully pursue the anti-TB program.

In Abkhazia, MSF continues to work in the central TB hospital in Sukhumi, treating patients using the DOTS strategy. This program has expanded to include five regional polyclinics where patients receive follow-up treatment.

For about 3,000 mainly isolated and older patients, MSF offers basic health care at the Pushkin Center, an MSF health center in Sukhumi. People come to the center every day for social as well as medical attention. Although currently under the direction of MSF, it is hoped that it will eventually be reintegrated into the Abkhazian health system. In addition to its work at the Pushkin Center, MSF distributes essential drugs to 38 hospitals, clinics and healthposts throughout Abkhazia.

Chechen refugees seek shelter in Georgia

Up to 10,000 Chechens fleeing the war had sought refuge in neighboring Georgia last fall. From the onset of the influx until the closing of the border by Georgian authorities in December 1999, MSF gave emergency assistance to refugees at the Zinvali border crossing.



Most of the refugees then regrouped in the Pankishi Valley, where their needs have been met by the ICRC, the UNHCR, the Red Cross Federation and MSF. MSF set up a system to refer patients with serious injuries to hospitals in Akhmeta, Telavi and Tbilisi. The organization also runs a mental health program for children ages 6 to 12.

Insecurity prompted MSF's withdrawal from the Pankishi Valley, after three workers from the International Red Cross (ICRC) were kidnapped. They were eventually released, and the MSF program continued, led by a local team.

MSF has been working in Georgia since 1993.

Azerbaijan

Caring for impoverished residents and displaced people

- International staff: 5
- National staff: 51

Azerbaijan may be sitting on a potential oil bonanza, but riches from this valuable resource have not flowed down to the people. Nearly 70% of the population lives in poverty.

MSF works with the country's most vulnerable people: some of Azerbaijan's 600,000 internally displaced persons (IDPs) and a large number of residents who also suffer from poverty and the lack of government resources. The IDPs are Azerbaijanis who fled the predominantly ethnically Armenian enclave of Nagorno-Karabakh (see box). Though most of the IDPs do not live in camps, they are not "at home." Though the residents are "at home," they suffer from poverty and severe economic dislocation. The IDPs and residents share an impoverished state and a lack of access to affordable, quality health care.

Cost recovery system to improve health care services

Over the past four years, MSF has provided free care at four health centers in the ex-industrial city of Sumgayit. However, the slow pace of change in the health sector and the entrenched poverty of the local population have combined to prevent quality care from being truly self-sustaining. Against this backdrop, MSF is testing a pilot cost recovery program in two health centers where the organization already works. Patients will be charged a small fee for family-oriented and primary health care. The development of a partial cost recovery system should in turn strengthen and improve the health care services. MSF will

continue, however, to offer free care at a clinic in Saragaya, a mixed IDP and resident community just outside Sumgayit. This clinic is the only health facility in the area.

Health education is an important part of MSF's work in Azerbaijan. In the wake of a scabies epidemic last year, MSF began an education program teaching hygiene measures to at-risk groups. This drew to a close in May 2000. In July, a new nine-month program began. It focuses on educating the people near the two pilot clinics in subjects they are interested in, ranging from reproductive physiology, family planning, STDs, pregnancy and care of newborns.

In southwestern Azerbaijan, a focus on reproductive care

In southwestern Azerbaijan, MSF also works in the Imishli, Saatli and Fizuli regions. The population of the three regions is about 270,000 people, a quarter of whom are IDPs. The program includes reproductive health training and supervision of midwives and gynecologists, support for the immunization programs, supply of drugs and equipment to maternity wards and STD treatment. MSF also helped define a national protocol for STD management and will train all doctors in Saatli and Imishli on the new protocol.

This year, MSF is ending emergency activities such as free drug distribution to public health facilities and support of a small health center. A laboratory training program ended in July 2000, after training lab technicians from two regional reference hospitals and two STD clinics.

Kazakhstan | Fighting tuberculosis

- ▶ International staff: 6
- ▶ National staff: 21

Tuberculosis (TB) is one of the biggest health problems in Kazakhstan, where 18,500 cases were declared in 1998 (out of a total population of 16 million). Since beginning work in Kazakhstan in 1996, MSF has been helping to fight TB in several provinces.

A successful pilot project in the southern area of Baidibek, begun in January 1998, demonstrated the effectiveness of the DOTS (Directly Observed Treatment Short Course) TB treatment method. In July 1999, the project was extended to encompass the Ordobassy area, also in the south. In both places, MSF introduced and implemented DOTS as the TB treatment of choice and rehabilitated facilities and equipment in TB clinics. Training nurses and other health workers in TB diagnosis and treatment is key to the program.

Tuberculosis control is also a focus in Almaty province and in the regions of Illy and Balkash. In the regional polyclinics, MSF identifies new TB cases, provides drugs, and ensures that there is adequate follow-up treatment for patients after they have first been treated in the larger clinics. MSF uses posters, leaflets, drama and children's doll play to educate people about the disease. MSF also goes to meetings at the national TB institute and hopes to help establish a regional training center in Shimkent.

Kazakhstan is the place of refuge for about 12,000 Chechens who fled their homes during the recent conflict. MSF is evaluating how it might assist this vulnerable group.

MSF has been working in Kazakhstan since 1996.

Uzbekistan | Environmental disaster on a colossal scale

- ▶ International staff: 18
- ▶ National staff: 69

The Aral Sea, once the fourth largest inland body of water in the world, has shrunk by 50% since 1960. Massive cotton irrigation has diverted much of the water from the rivers that feed the Sea, exposing 38,000 square kilometers of the former seabed. Each year, wind whips 45 million metric tons of salty and contaminated dust into the air, contributing to health problems such as respiratory infections, tuberculosis, anemia, kidney diseases, diarrhea and cancer. This massive environmental disaster affects about five million people.

MSF established a presence in the Aral Sea area in July 1997, and is still the only international medical aid organization in the region. The medical program, based in the Karakalpakstan region near the Aral Sea, is focused on tuberculosis (TB) control and treatment, and on the prevention of respiratory infections and diarrheal diseases.

DOTS is used to fight ravages of TB

To combat TB, MSF uses the DOTS protocol (Directly Observed Treatment Short Course), recommended by the World Health Organization (WHO). DOTS is a comprehensive public health strategy used around the world to detect and cure TB patients. Detection of infectious cases by laboratory microscopy, direct observation by health care professionals

and the stages of DOTS treatment at a regional training center established in February 2000 in Nukus. MSF has another basic training program for health workers on acute respiratory infections and the control of diarrheal diseases, the leading causes of children's morbidity and mortality. In addition, MSF offers logistical support, fundamental to the success of DOTS. The organization also works closely with the Ministry of Health to gather and analyze epidemiological data on infectious diseases.

Research program explores link between environment and health

Besides delivering medical assistance, MSF has launched a research program that focuses on the relationship between environmental degradation and public health in the Aral Sea area. In 1999, a research agenda was developed based of interviews with 50 specialists and a survey of 1,000 people from Karakalpakstan about the impact of the environment on their health. In June 2000, a study was launched on the links between dust deposit and composition and respiratory diseases in children. Other current studies include one on the links between water salinity, hypertension and kidney diseases, as well as pesticide contamination of the food chain. The goal of the research program is to provide

EACH YEAR, WIND WHIPS 45 MILLION METRIC TONS OF SALTY AND CONTAMINATED DUST FROM THE EXPOSED ARAL SEA SEABED INTO THE AIR, CONTRIBUTING TO HEALTH PROBLEMS SUCH AS RESPIRATORY INFECTIONS, TUBERCULOSIS, ANEMIA, KIDNEY DISEASES, DIARRHEA AND CANCER. THIS MASSIVE ENVIRONMENTAL DISASTER AFFECTS MILLIONS OF PEOPLE.

of patients taking their medicine, as well as an uninterrupted drug supply are key to the strategy.

Begun with pilot projects in the districts of Muynak and Kungrad, DOTS treatment was expanded to the city of Nukus in February 2000, and to Khorezm, in the northwest, in August 2000 – all in close collaboration with the Ministry of Health. In July 2000, 780 patients were following the DOTS treatment in those three areas. The ultimate goal – known as the "DOTS for ALL" strategy – is to cover the entire region of Karakalpakstan.

MSF trains Aral Sea-area health workers in TB diagnosis

scientific evidence for MSF's advocacy campaign, provide policymakers with reliable environmental health data and, ultimately, improve the health of the local people.

Following a health education needs assessment in the Ferghana Valley, MSF has begun a new project aimed at improving the health information capacity of the local communities through traditional social structures known as *makhallas*. In May 2000, MSF established an office in Ferghana city from which pilot *makhallas* within the Namangan, Andijan and Ferghana regions will be identified.

Turkmenistan | “DOTS for ALL” to fight tuberculosis

- International staff: 4
- National staff: 20

MSF's work in Turkmenistan is twofold. A traditional medical support program combats the spread of tuberculosis (TB) in the northern part of the country as part of MSF's Aral Sea program (see Uzbekistan). MSF also has a regional logistics office in the Turkmen capital, Ashgabat, to serve the needs of MSF missions in Central Asia and Afghanistan.

Fighting TB

The medical program focuses on controlling and treating TB using the DOTS (Directly Observed Treatment Short Course) method. In August 1999, the program was launched in Kunya-Urgench in the northern region of Dashoguz, which has the highest rate of TB in the country. A few months later, another pilot project began in Turkmenbashi. Both are carried out in collaboration with health authorities at all levels.

By July 2000, 367 patients had been registered in the DOTS program in Kunya-Urgench, with 93% achieving an early positive response to the treatment. The 336 patients registered in Turkmenbashi had a positive response rate of 86%.

Based on these results, the authorities agreed to extend the DOTS strategy to Dashoguz city. In July, health workers closely involved with DOTS treatment received training in the city's central TB hospital. Thirty-five doctors were trained. Seven were trained as trainers, with responsibility for supervising DOTS in their respective districts. In addition, 118 nurses and seven lab technicians received training, through tailor-made teaching materials such as videos and practical exercises. This was followed by the official opening of the city's “DOTS for ALL” program in Dashoguz at the end of July.

Around the same time, the Ministry of Health and MSF signed an agreement to expand the DOTS strategy to the entire Dashoguz region.

A regional logistics office for Central Asia

The MSF office in Ashgabat also plays the role of regional logistics office. Its main purpose is to serve the freight and practical needs of various MSF missions in Central Asia and neighboring Afghanistan. By July 2000, 87 tons of drugs and equipment had been dispatched from Ashgabat to the field.



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Children play in a rusted out ship in Muynak, which used to be on the Aral Sea. Today the shore is 100 kilometers away, and pesticide-contaminated dust from the former seabed exacerbates health problems such as TB.

Kyrgyzstan | Improving detection and treatment of STDs

- International staff: 4
- National staff: 26

MSF started working in Kyrgyzstan 1996, during an outbreak of typhoid fever. However, the growing incidence of sexually transmitted diseases (STDs), coupled with the collapse of the health system, soon prompted a focus on STD/HIV prevention and treatment.

In 1998, MSF opened the “Rainbow Center,” an STD/AIDS information center in Osh, and began to target high risk groups. The “Sex Workers Outreach Project” (SWOP) was launched in late 1998 and focuses on outreach visits. The team also organizes education seminars (called “coffee breaks”) for sex workers once a month in the MSF office.

In addition, MSF has trained sex workers as educators. Initially charged with giving condoms to their peers and informing them about MSF, the educators also work on “mini-projects” such as increasing awareness of STDs among taxi

and trucks drivers. Members of a support group accompany women to public clinics to get tested and treated for STDs.

The medical part of the program includes STD screening and treatment at 29 hospitals, clinics and laboratories in the Osh area. MSF supplies drugs and trains gynecologists and dermo-venereologists. The organization has introduced a new syphilis test for area health facilities, designed to improve diagnosis and reduce patient hospitalization. MSF also worked with the Ministry of Health and the World Health Organization on a study of the resistance to antibiotics of gonorrhea, another painful STD.

Given the instability in the region and the frequent fighting between armed groups (particularly on the border with Tajikistan), MSF is closely watching the security situation in the country.

Iran | Care for Afghan refugees

- International staff: 4
- National staff: 51

Since 1995, MSF has been aiding Afghan refugees fleeing civil war in their own country for shelter in Iran. In the city of Mashad, in northeastern Iran, MSF offers preventive and curative care to about 50,000 Afghan refugees through a clinic in the neighborhood of Gulshahr.

According to the Iranian government, more than 3,000 refugees enter Iran each week. In April 2000, the UN High Commissioner for Refugees and the Iranian authorities signed an agreement for the voluntary repatriation of Afghan refugees. MSF agreed to provide medical care within this process. Within a six-month period, 100,000 repatriations are supposed to take place. However, Afghanistan is still a country at war, and there are worries about food security and drought.

MSF is closely monitoring this situation, especially with regard to the protection of refugees who are repatriated. There is particular concern for the most vulnerable, including ethnic and religious minorities and women.

MSF volunteers often speak out about the discrimination faced by Afghan refugees in Iran, and about the hardships they encounter during forced repatriation.



Tajikistan | Vast improvement in living conditions for mental health patients

- International staff: 16
- National staff: 140

The legacy of civil war and economic collapse in this poorest of the former Soviet Central Asian states has given MSF the challenge of rehabilitating the country's mental hospitals and sustaining critical health services in some of the most isolated areas.

A better life for psychiatric patients

The past year has seen MSF's relief program in Tajikistan's psychiatric institutions nearing completion. When it was started in 1997, mental patients were dying in large numbers from hypothermia, malnutrition and infections. MSF has put in heating, showers, toilets and new kitchens in 17 institutions scattered throughout the country. Patients are supplied with food, clothing and medicine. Training programs for nursing staff and the encouragement of new professional standards have also been part of the work. When the last of the restored institutions was handed back to the Ministry of Health in March 2000, the survival prospects of the people living there had been transformed.

The need of the broader society for mental health support is being addressed in a community project now underway in the capital, Dushanbe. A team of counselors is being trained to work with people traumatized by the horrors of the civil war of the mid-nineties or suffering from stress brought on by the continued lawlessness and insecurity of everyday life. When MSF did a mental health assessment in 1999, the symptoms of depression, hopelessness, anxiety and increased drug use were readily identifiable. The 15 counselors and five trainers in the capital will be the core of a service that will be extended by the Ministry of Health across the country. A companion public education effort attempts to break down fears and taboos about mental health.

Care in isolated regions

Another group of people that MSF has identified as being particularly at risk are those living in the central Karategin Valley. Since the civil war, the valley has been a stronghold of armed opposition forces – and as a consequence gets limited health resources from the state system. MSF distributes medicines, trains health workers in rational drug use and is now establishing a network of mother and child health workers among the valley communities. Because the ongoing war in Afghanistan and political instability in other neighboring states threatens Tajikistan's own precarious semi-peace, MSF has been working on emergency preparedness and strengthening local health structures.

Similarly, the province of Pamir is geographically and politically isolated from the rest of the country and is largely dependent on humanitarian aid. Since 1999, MSF has given technical support to the infectious diseases department at the hospital in Khorog and has worked to improve the quality of the laboratory. MSF has also set up a system for the weekly supply of the pharmacy.

A key aim of work in Khorog is to strengthen the local capacity to treat infectious diseases. MSF will work with the authorities to put in place a surveillance system for epidemics and will help create a cold chain, provide medicine and equipment, and monitor nursing care.

Khorog also serves as a base for MSF programs in Badakhshan and the Panjshir Valley in Afghanistan.

MSF has been working in Tajikistan since 1991.

An MSF convoy passes by a charred tank in northern Afghanistan, a reminder of the country's past – and present – conflict. The convoy was bringing medicine to the town of Taloqan in January 2000, but was turned back at a Taliban checkpoint.

- International staff: 68
- National staff: 406

Afghanistan has been in conflict for over two decades. Guerrilla warfare under a brutal Soviet occupation, civil war that quickly filled the vacuum after the Russian departure, and totalitarian rule of the victorious Taliban which now controls the vast majority of the country: The health of the Afghan people has been aggrieved by each of these stages of the country's recent history.

Médecins Sans Frontières has worked in Afghanistan since 1980, on all sides of the various front lines. Aid to women, men and children in hospitals, clinics and health posts throughout the country has taken many forms over the years, but has almost always been carried out in conditions of insecurity and quickly changing circumstances.

Maintaining an independent humanitarian presence

MSF is committed to carrying out an independent humanitarian mission in the face of pressure from both the Taliban government, which seeks to place broad restrictions on aid work in the country, and international organizations such as the UN, which has sought to be an umbrella contact between international NGOs and the Afghan government. MSF is, above all, dedicated to maintaining its contact with the Afghan people.

MSF IS COMMITTED TO CARRYING OUT AN INDEPENDENT HUMANITARIAN MISSION IN AFGHANISTAN.

Of special concern are the problems experienced by Afghan women with regard to their access to health care: In the Taliban's Islamic state, women are severely restricted in employment, movement outside of the home and in where they can go to receive medical attention. For this reason, MSF seeks to give women access to both primary and specialized care.

The conflict intensifies

By mid-summer 2000, both civil war and drought were weighing heavily on the Afghan people. The conflict had intensified, with the Taliban (government) forces taking territory formerly held by the Northern Alliance, the group of opposition forces that has held part of northeastern Afghanistan for the last several years. When the fighting reached Taloqan, in Takhar province in the north, MSF was forced to evacuate its volunteers, who later rejoined some of the many thousands of people fleeing the advancing front line. Mobile clinics were set up in the areas of Keshem and Dashti Qala to treat the displaced.

By the end of the summer MSF was also closely monitoring the effect of a drought on people in Faryab province in the north, relying on a network of 19 clinics in five northern provinces to detect signs of cholera, a possible

consequence of the drought. The drought is the worst to hit the country in 30 years.

MSF works in three health clinics and two hospitals in the Panjshir Valley, long a stronghold of opposition forces. The area is frequently touched by fighting (it was the object of a renewed government offensive in 1999), and is also home to many displaced people. Both the displaced and residents in this isolated region have limited access to health care. MSF provides primary care and responds to emergencies.

In the province of Badakhshan, also held by the opposition, MSF works in the hospital in Faizabad and supports primary health clinics in Baharak, Ishkashim and Zebok.

Work in Taliban-controlled areas

Kabul, the once-cosmopolitan Afghan capital, is usually first hit by government restrictions that affect the well-being of the population and, often, MSF's ability to provide health care. MSF teams were expelled from Kabul in July 1998. Work in the capital resumed in May 1999, in the poor areas of Dashte Barchi and slightly later in Khair Khana. Working in clinics in both areas maintains MSF's contact with the city's inhabitants.

MSF has a wide variety of programs in government-controlled areas. In Ghazni, a city about 125km southwest of

Kabul, MSF supports the provincial hospital, works to fight tuberculosis and runs a nutrition program. In Sarab and Garden Dewal, both in the Hazarajat region, clinics provide basic care. In Oruzgan province, MSF concentrates on developing local capacity to manage infectious diseases and epidemics.

In the western province of Herat, teams focus on primary care. A midwife visits several towns in the province, meeting with traditional birth attendants, health educators, and community health workers to try and improve care for women and children. MSF works with local midwives to improve care of mothers, in an effort to reduce the high maternal mortality rate of 1,700 deaths for every 100,000 births. MSF also works in the pediatric ward of Herat hospital. At the Herat nursing school, MSF recently launched a project to train health workers in recognizing and managing mental health problems.

Another program focusing on primary health care for women and children has been underway in Badghis province since April 1999. In addition to providing primary care, MSF has also been working on emergency preparedness in Kandahar province, and will be doing a tuberculosis assessment there as a basis for possible future intervention.



India | Epic floods engulf the state of Orissa

► International staff: 17
► National staff: 16

In the aftermath of the vicious cyclone that swept through the Indian state of Orissa in November 1999, a woman in Jagatsingpur stands in front of her destroyed house, while the only doctor at a small hospital in Jambu (opposite page) treats a patient.

MSF work in India over the last year was marked by devastating floods. A cyclone that struck India's Orissa state in October 1999 left at least 10,000 people dead, and many thousands more without shelter, food or medical facilities. To prevent the spread of disease, MSF set up a surveillance and early warning system, later maintained in cooperation with the Orissa Health Service and Epicentre. MSF also provided medical care, water and sanitation facilities and shelter to some of the victims.

Fighting tuberculosis in crowded Mumbai

Since 1998, MSF has been part of the struggle against tuberculosis (TB) in Mumbai (Bombay), where 9,000 people die of the disease each year. In this densely populated city, home to 15 million people, TB poses a special threat if left undetected or untreated. MSF works with the local health authorities as a technical advisor and implementing partner for a pilot project using the DOTS (Directly Observed Treatment Short Course) method, which requires direct

supervision of patients while they take their medicine. Work (including upgrading laboratories, training health workers and sensitizing the private health sector) focuses on an area of about 570,000 people at the southern tip of the city.

Improving mental health in Jammu and Kashmir

In summer 2000, MSF began financing a community health project conducted by the Voluntary Health Association (VHA) in the Indian state of Jammu and Kashmir. MSF also began to support a mental health program in the region, where decades of violence have taken a toll on the psychological well-being of the population. The project, which will train grassroots counselors and general practitioners and work to increase the coping skills of the population, will also be carried out in cooperation with the VHA.

MSF hopes to begin a malaria program in Assam in late 2000.

Sri Lanka | Civilians are the victims of a long civil war

► International staff: 51
► National staff: 230

The 17-year war between the Sinhalese government and the northern rebel Tamil army in Sri Lanka is one of the world's most bitter conflicts. The toll on the civilian population has been devastating. Since 1986, MSF has been providing medical assistance to civilians caught in the fighting.

Many Sri Lankans have difficulty reaching medical care, either because of a lack of trained personnel in the north, or because of the danger in crossing the shifting front line. High-altitude bombing by the Sri Lankan forces frequently results in civilian casualties, a situation compounded by difficulty transporting drugs and medical material to facilities in Tamil-held areas.

The Jaffna Peninsula in the north has been the scene of some of the heaviest fighting. In spring 2000, the conflict intensified, and the government restricted the flow of medicines to the region, an act which MSF protested vigorously.

MSF supports pediatric services at the Jaffna Teaching Hospital and provides midwives, nurses and anesthetists to reinforce local medical personnel. A mobile clinic cares for residents outside the main town. At Point Pedro, on the far northern tip of the peninsula, MSF restarted work at the main hospital in January 2000 after an absence of almost three years. Three MSF doctors and a nurse reinforce the sole Sri Lankan doctor.

Below the Jaffna Peninsula, MSF teams are scattered throughout the north. In Mallavi, MSF runs the pediatric, obstetrics and surgical departments in the town's hospital. In Puthukkudiyiruppu, MSF focuses on mother and child health, providing clinical support to midwives. An MSF mission in Madhu caring for the displaced had wound down in June 1999; however, a fresh military offensive in November caused 17,000 people to seek refuge anew in the town. MSF restarted work in the hospital and also set up mobile clinics.

In Vavuniya, MSF gives surgical support to the hospital. In December 1999, the MSF team operated on 64 wounded civilians here after four rockets hit a church in nearby Madhu, where several thousand refugees were sheltering. Also in Vavuniya, MSF began a mental health program in August 2000 to address the psycho-social needs of people suffering from war-related trauma.

In Murunkan, MSF works side by side with Sri Lankan health workers in the hospital and also runs mobile clinics. In the eastern town of Batticaloa, MSF renovated the surgical unit of the hospital and repaired the roof and walls. Mobile clinics also provide health care to people living in the surrounding area.

Bangladesh

Work begins in the Chittagong Hill Tracts

- International staff: 31
- National staff: 192

In August 2000, floods struck Bangladesh, leaving over half a million people homeless. Based in the capital, Dhaka, MSF watched for possible disease outbreaks through its Natural Disaster Preparedness program, set up in the wake of the floods that hit the country in 1998. Although the Bengali government seemed to have most of the needs covered, MSF stood ready to intervene if requested.

MSF also has several long-term projects in the country. In December 1999, MSF opened two clinics in the Chittagong Hill Tracts, a hilly region in southeastern Bangladesh, and also started outreach and water and sanitation programs. The one hundred thousand or so people who live in the area are Bengali and various tribal populations. MSF is the first aid organization to have permission to work in the region, where unkept promises of autonomy for the tribal people have resulted in off-and-on low-level conflict. Access to health care, especially for the non-Bengali population, is limited. The MSF clinics have about 1,200 consultations each month. Major health problems in the region include malaria, respiratory infections, skin diseases and diarrhea.

For several years, MSF has been working in Cox's Bazaar in southeastern Bangladesh with Rohingya refugees from Myanmar (Burma), just across the Naf River which forms the border between the two countries. MSF provides medical care to some of refugees, who now number about 13,000, and also monitors ongoing repatriation of the refugees to see whether it is occurring on a voluntary basis.

Further south, an MSF primary health care program based in seaside villages near Cox's Bazaar drew to a close in December 1999. Clinics in the villages of Shamlapur and Sonarpara served the area's 25,000 people. MSF also trained village doctors to prescribe medicine and run local pharmacies. Both clinics were turned over to the community.

MSF began work in Bangladesh in 1997.



© Henk Braam/MSF

Myanmar [Burma]

Treating thousands of malaria patients

- International staff: 31
- National staff: 192

MSF work in Myanmar (Burma) concentrates on key health problems including malaria, tuberculosis (TB) and sexually transmitted diseases (STDs), including HIV/AIDS.

The fight against malaria

Almost 60% of the country's 28 million people live in areas of moderate or high risk for malaria. MSF works in the states of Kachin, Rakhine and Tenasserim, where high levels of resistance to the most commonly used malaria medicines make treating the disease particularly difficult. In Kachin and Rakhine, MSF operates mobile malaria clinics and supports national field labs for testing and treatment of the disease, treating about 50,000 malaria patients a year – the vast majority of them children under 15 or pregnant women.

In northern Rakhine, MSF also runs a primary health care program which trains, monitors, and equips traditional birth attendants and community health workers. MSF does TB diagnosis and treatment in southeastern Kachin.

In July 2000, MSF received permission to begin a new malaria program in the southern state of Tenasserim. MSF's

malaria program in this area, which covers a population of about 250,000 people, will introduce new diagnosis methods and treatments, initially through work in three public health posts, a district hospital and a private hospital. MSF will work closely with the World Health Organization's Roll Back Malaria initiative.

HIV/AIDS prevention

HIV/AIDS prevention and education is a priority for MSF throughout Myanmar. Preventive education activities are implemented in Kachin, Rakhine and in the capital, Yangon (Rangoon). MSF also runs three STD clinics in the jade mine area of western Kachin.

In Yangon, MSF works to improve the health of 250,000 people living in two new townships. Teams provide reproductive health services, operate therapeutic feeding centers for children under five and provide water and sanitation services.

MSF has been working in Burma since 1992.

Thailand | Cooperating with local groups to fight AIDS

- ▶ International staff: 19
- ▶ National staff: 10

The HIV epidemic in Thailand is entering a new phase, as many of the people infected during its explosive start now fall ill. The increasing numbers of sick and needy people, coupled with poverty brought on by the country's economic crisis, mean further hardship and suffering for those living with AIDS in Thailand.

Working with the community to fight AIDS

In an attempt to alleviate some of this suffering, MSF has joined with local groups to fight for improved standards of treatment and care for people with HIV and AIDS. Collaboration with Thai organizations is very important. MSF works closely with a local NGO in community hospitals in Kantchanaburi and Petchburi provinces. In Bangkok, the capital, MSF is working with local organizations on a multifaceted project called Bangkok Plus, aimed at improving health and psycho-social care for low-income families affected by HIV/AIDS.

Also in Bangkok, a team of MSF nurses supports four AIDS hospices and visits AIDS patients in their homes in urban slum areas. Nearly 200 patients received home care in through this project in 1999. Home-based care is central to work in the eastern province of Surin as well, where MSF is also working to prevent mother-to-child transmission of the

disease. In Surin, in the central provinces and in Bangkok, MSF continues to train health care staff in community hospitals and health posts.

As part of its international Campaign for Access to Essential Medicines, MSF is working closely at the local and international level to make antiretroviral therapy (treatment with a combination of drugs) more widely available to Thailand's AIDS sufferers (see page 14).

Care for Karen and Mons refugees

On the Burmese border, MSF gives medical assistance to Karen refugees in camps near the town of Mae Sot, and in Ratchaburi, further south. MSF also gives medical aid to the Mons refugee community in Sangklaburi. The refugees live in a precarious situation: Guerrilla activity in the border region is common, and much of the frontier is mined. At the same time, in an effort to control migration, the Thai government has restricted the refugees' movement, limiting their ability to be self-sufficient. MSF provides medical care, trains health workers and monitors epidemics of cholera and malaria, endemic in the region. In Mae Sot, MSF also treats tuberculosis among migrant workers.

MSF has been working in Thailand since 1983.

Vietnam | Permanent MSF presence comes to an end

- ▶ International staff : 8
- ▶ National staff : 30

The Vietnamese government is reducing its investment in public health services and encouraging the private sector to get involved in providing health care. As a result, poor rural people and ethnic minorities have little access to quality care, even though the country has experienced an overall improvement in living standards over the past ten years. Despite the great need to fill this "health care gap," MSF felt that conditions were not right for it to continue to bring added value through its work in the country. As a consequence, the organization closed its mission in September 2000, after ten years of work.

MSF completed a dengue prevention project in the southern province of Ca Mau, and an assistance program for typhoon victims in the central province of Quang Nam. Then, in November 1999, a storm caused severe flooding that killed livestock, left many thousands of people homeless and destroyed much of the local health infrastructure. In response, MSF delivered medical kits to hundreds of clinics in 14 districts and repaired damaged health centers.

MSF's long-term work in Vietnam targeted vulnerable and excluded people, including AIDS sufferers, drug users, women and adolescents who were victims of sexual exploitation, migrants and ethnic minorities. An STD/AIDS control project in the southeastern city of Nha Trang recently drew to a close. The MSF clinic in the city center had provided more than 45,000 consultations over five years.



Another project in Can Tho province ended in March 2000. Based in a hospital and three health centers, MSF sought to improve health care for women, and also focused on STD cases and AIDS prevention. In a country that takes a very repressive stance towards AIDS, MSF used information campaigns to try and break down taboos associated with the disease.

- International staff: 11
- National staff: 45

With the economy still suffering the effects of the regional economic crisis, the budget for health and education has been reduced to 3.6% of GDP. Only 30% of the population has access to health care. Given minimal state resources and the privatization of the private health sector, MSF has focused on support for the Laotian public health service.

Assistance in the provinces

Three technical assistance projects have been aimed at revitalizing the health services in the southern provinces of Champassac and Sekong and in the northern province of Bokeo. The goal has been to improve access to health care and the quality of the medical services, and to ensure that minority groups and the poor are not excluded.

In December 1999, MSF handed over to the local authorities a project that had run for ten years in the Champassac district of Champassac province. MSF supplied medical equipment and rehabilitated the district health structures, and trained health workers in the specialties offered by the reference hospital serving the southern part of the province. A cost recovery system – key to ensuring access to health care in a country with a weak public health service and rapidly growing private sector – is now in place. A new pharmacy will be completed in late 2000, as should reconstruction work on health facilities elsewhere in the province.

In Bokeo, where programs will come to an end in fall 2000, MSF has improved water supply and sanitation, and promoted domestic hygiene and health education – all carried out through a network of volunteer health workers trained and supported by the MSF field team. Most recently, a health center was opened in Pak Tha district.

Sekong, an isolated mountain province

MSF also works in Sekong, a mountainous area where many of the minority communities are several days' walk away from a health center and the monsoon season isolates the province for six months of the year. The organization made improvements at the provincial hospital and two smaller hospitals in Kalum and Dakchung, and organized training sessions related to hygiene and good prescription practices for health personnel. MSF also did several vaccination campaigns. Results from an MSF study on resistance to standard malaria drugs were handed to the authorities, with a view to improving treatment protocols.

The growing problem of AIDS

As growing economic contacts with neighbouring Thailand push the spread of STD and HIV/AIDS, an MSF team has been conducting evaluations and training hospital personnel who work with people suffering from these diseases. MSF has been working in Laos since 1990.

- International staff : 43
- National staff : 271

Cambodia is slowly recovering from its recent history of invasion and genocide (1974-79), which killed around two million people. Although the political situation seems to have stabilized after the unrest of the late 1990s, reforms and transparency in the administration are still badly needed. Cambodians face growing exclusion, a poor national health system and a high burden of infectious diseases, mainly HIV, tuberculosis (TB) and malaria.

In Cambodia for ten years, MSF works closely with the Ministry of Health in the districts of Stung, Sotnikum, Bakan, Stung Treng and Thmar Pouk. In the remote former front-line areas of Nong Chan and Anlong Veng (where the conflict ended in 1998), MSF set up three health centers. In the provincial prison of Banteay Meanchey in Sisophon, MSF has set up a basic health care system.

At the hospital in Sotnikum, an innovative pilot program contracts employees to make them accountable for their work and the hospital's performance, all to encourage a decentralized system of management.

Training is essential in a society that has seen a whole generation of health workers wiped out. In Phnom Penh, the capital, MSF runs a basic surgery training program for doctors and nurses working in district health centers which have operating facilities. After ten years, a laboratory technician training program in the city recently closed.

The highest HIV rate in Southeast Asia

Cambodia has the highest HIV prevalence in Southeast Asia (3.5%). In the Norodom Sihanouk hospital in Phnom Penh, MSF runs a 60-bed ward for AIDS patients, which functions as a national referral center. MSF plans to introduce antiretroviral drugs for those patients in the year 2001. An HIV consultation service is in place in the provincial hospital of Battambang.



© Jan Banning

◀ In an effort to stop the spread of AIDS, a community health worker trained by MSF explains condom use to villagers in Samroung, in northern Cambodia.

MSF has three STD/HIV/AIDS awareness and prevention programs targeting primarily sex workers. Four STD (sexually transmitted disease) clinics have been set up in Svay Pak, Siem Reap, Sisophon and Poipet – areas with a high concentration of prostitutes.

The scourge of TB

TB is still rampant in Cambodia, with 539 new cases a year for every 100,000 people. In addition to treatment provided in the district hospitals, a home care DOTS (Directly Observed Treatment Short Course) program was set up in 1997 Phnom Penh. In 1999, the cure rate for patients in this program was 87.3%.

Malaria remains the first health problem in many remote areas, with multi-resistant strains in the west. MSF is starting a new project in Anlong Veng and Sotnikum to strengthen malaria diagnosis and treatment at the community level.

China | The socialist market economy takes a toll on public health

► International staff: 57
► National staff: 125

The liberalization of China's economy has given the country one of the fastest-growing economies in the world. But public health has deteriorated since the introduction of the "socialist market economy."

Many families, especially those in poor rural areas, can no longer afford even the most basic medical care. The result is a large-scale migration of health care providers to urban areas, where people can afford their services. The consequence for rural communities is clear: a rapid deterioration of the quality and availability of medical care.

Economic crisis hits medicine

The commercialization of the health system means that many people, and especially the poorest, are left without basic medical care. Because their income often comes directly from the services they provide, health workers in China increasingly prescribe drugs and treatments that are inappropriate or expensive in order to boost their income. As a result, because preventive medicine is not very lucrative, it is often neglected. The expanding economy, combined with this laissez-faire style of health care, has had an enormous

PUBLIC HEALTH IN CHINA HAS DETERIORATED SINCE THE INTRODUCTION OF THE "SOCIALIST MARKET ECONOMY."

impact on the care being provided throughout the country.

MSF is active primarily in Yunnan, Sichuan, and Shaanxi provinces and in the Guangxi and Tibet autonomous regions. The organization has long-term projects for improving basic health care, fighting tuberculosis (TB), venereal diseases and Kashin Beck Disease (KBD), improving water and sanitation and providing information on HIV/AIDS. MSF also advises local governments on disaster response.

In Danian and Gongdong, in Guangxi Autonomous Region, MSF supports official health structures medically and financially. Teams also exchange ideas with their Chinese colleagues on treatment choices and the functioning of the health system. In Shaanxi, MSF welcomes about 50 street children at a small center in Baoji, offering them shelter, food, medical care and schooling.

Basic care is also given in mountainous Qinghai province, in the town of Jiqu. MSF is working on a complete renovation of the town's clinic and also offers basic medical care.

In Yunnan, MSF has been improving the water supply in several areas, with a focus on improving water quality rather than quantity. Hygiene education is an important part of the project, as is consultation with villagers.

Infectious diseases are epidemic

Infectious diseases such as TB, hepatitis and HIV/AIDS are on the rise throughout China. It is estimated that one million Chinese will have HIV by the end of 2000. However, because the AIDS epidemic is underplayed by the government, accurate figures are not available.

At the end of 1999, MSF started an HIV/AIDS awareness program in several counties in Yunnan province, which has one of the highest numbers of HIV-infected people. In the southern Sichuan province, a similar project has been underway since September 1999. In both programs, MSF works closely with the authorities to reach health care workers and people at risk of infection. Public information campaigns, often the only legal way to talk about condom use in the country, are an important part of MSF's work. In Sichuan, MSF is working to set up clinics to treat sexually transmitted diseases (STDs). This has included renovating laboratories training lab staff in diagnostic techniques.

TB is also a growing problem in China. In Yunnan province, MSF trains health staff in DOTS (Directly Observed Treatment Short Course) TB treatment, which calls for



patients to be directly supervised while taking their medication. MSF set up laboratories for testing and monitoring TB. The organization provides all the drugs and monitors every step of the DOTS treatment. MSF also

monitors the factories producing the TB medicine.

In addition, a public information campaign targets the Lisu, Dulong, Tibetan, Nu and Bai ethnic minorities, who live in a remote mountain valley with a high rate of TB, a poor infrastructure and a low level of health services.

In 2000, TB programs were set up in both Danian and Gongdong. Village doctors have been trained to follow up with TB patients once they have left the hospital.

Tibet

Over three million people in Asia suffer from Kashin Beck Disease (KBD), also known as Big Bone Disease. MSF research and medical activities in Tibet are focused on this illness, which progressively affects the joints, decreasing mobility and causing pain. The disease has no clear cause but is related to four factors: a toxin from a fungus on crops; a deficiency in iodine; a deficiency in selenium and certain vitamins; and a lack of hygiene and good drinking water. As part of its attempt to learn more about the disease, MSF is trying out various prevention measures on a sample of 1,055 children in 24 villages.

Prevention of the disease involves supplying iodine, selenium and vitamins C and E, as well as improving the quality and storage of basic food supplies such as grain.

MSF tries to ensure both access to clean drinking water and community education in hygiene. In Lhasa, Shigatse and Lokhas prefectures, 164 clean rural drinking sources were developed between 1993 and 1999. MSF is now evaluating how the systems are actually being used. Part of this assessment looks at local knowledge, attitudes and practices related to water and hygiene. The results of the study will guide future water projects in Tibet.

In Kashgar prefecture, 80 hand pumps will be installed in two of the poorest counties, in small, remote communities of less than 200 inhabitants. The project promotes community participation and is linked to health and hygiene education.

Physical therapy programs, in place since 1997, reach those suffering from KBD and help alleviate pain. MSF has also equipped Confucius Hospital in Lhasa and trained lab workers in KBD-related techniques. Physical therapy courses have been introduced to the curriculum of local medical schools, and health workers have been trained in KBD control.

MSF is looking at expanding the current KBD program to Chamdo prefecture in eastern Tibet.

MSF has been working in China since 1988.



MEDECINS SANS FRONTIERES
无国界医生组织

无国界医生组织怒江肺结核病援助项目

★ 此项目旨在帮助得病的人，这种病叫肺结核病，得肺结核病的人将得到免费的治疗与诊断。
项目由无国界医生组织，一个国际性人道主义医疗组织，和怒江卫生局共同开展。



什么是结核病？

肺结核病是一种病菌引起的传染病。通常这种病菌跑到你的肺里，这就引起了疾病。

症状是什么？

通常的表现是连续咳三周以上，痰中有血（肺部较深的痰液），可能还会夜间出汗，胸口痛，消瘦和容易疲劳等症状。

结核病菌是怎样使人致病的？

结核病菌能在你的肺部长期生存，你可能感觉不到。当病菌数量增加后，会对你的肺部造成损坏，肺部损坏后会使你致病。

如何得上结核病的？

结核病是传染性的，这种病可以从一个人传给另一个人。因为这种病可以通过空气传播。一个得病的人，可以在咳嗽的时候把病菌传给旁边的人，当健康的人吸入这个病人呼出的空气后，就会得病。因为此时病菌进入了健康人的肺里。



停止传播肺结核病——保护他人。

如果自己觉得可能患有结核病，该怎么办？

如果你自己或你的家人出现上面提到的一些症状，你或你的家人就应该去看乡村医生。乡村医生会问你们是哪不舒服。医生还会给你三个药盒，教你在什么时候吐以及怎么吐。你应应深呼吸一口气后吐出的痰，并要吐到痰盒中。

是如何诊断为结核病的？

最好的办法是取一些痰样，然后放在显微镜下观察。如果发现结核病菌，则证明是结核病。

免费
诊断



免费治疗

使用DOTS能够战胜
结核病。



DOTS 是怎么回事？

DOTS是短程督导化疗的简称。这是世界卫生组织推荐的方法。结核病人要在督导员的指导下服药。短程的意思是结核病能在六个月内治好。病人在家就能接受治疗。而在以前，治疗期要达到十八个月。在中国其它地方，DOTS已被广泛应用，而且取得了良好的效果。规范DOTS方法在福贡与贡山都能取得成功。

让我们一起努力消灭

在福贡与贡山的结核病

请与随访站联系咨询详细情况。

This MSF poster, which presents simple TB prevention measures, is used for public education in Yunnan province, China.

© MSF-Holland Myanmar

Mongolia

Mass-media campaign encourages safe sex

- International staff: 3
- National staff: 10

With only two reported HIV cases so far, Mongolia is one of the few countries not heavily affected by HIV/AIDS. However, a 1999 survey of 15-25 year-olds has showed that, despite a very high awareness of the disease (98%), there is little use of contraceptives.

The Mongolian health authorities and UNAIDS/Mongolia asked MSF to set up an AIDS program in the country. Because the above survey had also revealed that Mongolians find it extremely difficult to discuss sexual health issues and are embarrassed to buy condoms, in December 1999 MSF and the Ministry of Health launched Mongolia's first-ever mass media campaign to promote safe sex and condom use.

The campaign ran for six months. A post-campaign evaluation showed that 75% of the respondents had seen the campaign and 97% thought the information was important for people of their age. A new campaign is scheduled for late 2000.

An information center with up-to-date information for health professionals and relevant organizations will be handed over the National AIDS Foundation this year. Twelve Mongolian trainers have been trained in counseling people before and after an HIV test. Mongolian trainers successfully trained 88 health workers from all parts of the country.

MSF has been working in Mongolia since March 1999.

Indonesia

Waves of displaced people spread over archipelago

- ▶ International staff: 37
- ▶ National staff: 164

MSF work in Indonesia over the last year was marked by the independence struggle and ensuing violence in East Timor (see opposite page), as well as religious, ethnic and economic conflict elsewhere in this archipelago nation. MSF provides emergency care for displaced people and others affected by violence throughout the country, and also runs longer-term projects designed to improve access to care for some of Indonesia's many poor and isolated inhabitants. MSF has also responded to several natural disasters, providing relief to earthquake victims in Bangi and Bankuku.

Litany of conflicts

Conflicts are many in this vast country, home to over 200 million people. Religious strife between warring Christians and Muslims in the Moluccan islands has caused thousands of deaths and sparked massive population flows. In Kalimantan, the Dayaks and the Malay have fought the Madurese in an ethnic conflict with economic roots. In Aceh, the Free Aceh Movement has called for independence and is fighting the government. In Papua, which has received large numbers of displaced people from other parts of Indonesia, calls for independence are intensifying. And people fleeing the violence in the wake of the East Timor referendum sought refuge in West Timor.

Following a series of exploratory missions throughout 1999 to evaluate the condition of IDPs and area health care facilities, MSF started projects in or near the cities of Pontianak (Kalimantan), Manado and Buton (Sulawesi), Banda Aceh (Aceh), Kupang (West Timor) and Ternate (North Moluccas), and on the island of Bali for people fleeing religious conflict in Lombok.

Moluccas

This conflict continues to spread, encompassing more and more islands and causing a great movement of people. Over 100,000 internally displaced persons (IDPs) have stayed in the Moluccas, often in IDP camps, and tens of thousands more have fled the area for the Sulawesi island group to the west. It is not likely that these people will be resettled in the immediate future. MSF has clearly stated its concern over the deteriorating conditions in the Moluccas.

Since March 1999, MSF has been active in Ambon, one of the islands in the Moluccan group, providing help to nearly 50,000 displaced in more than 100 camps in both Christian and Muslim areas. In February 2000, assistance was extended to the North Moluccas, focusing on displaced people and area residents near Ternate.

MSF teams initially organized temporary shelters, set up waste disposal systems, provided water supplies and washing products and distributed information on health and hygiene. This was later complemented by direct health care for displaced people and area inhabitants, replenishment of drug supplies and training of local health workers. Long-term health facilities receive, when possible, drugs, trauma care equipment and the means to monitor diseases and deaths.

MSF also has long-term medical programs in the Moluccas. In the Halmahera Islands, 70,000 children have been vaccinated against measles. In the southern part of the province, where access to the population is particularly difficult, a mobile clinic provides medical care.

West Timor

Since September 1999, MSF has been active at IDP camps in the southern Betun, Atambua, Kefa and Kupang areas of West Timor, still home to about 100,000 refugees from East Timor. Militias exert control over many refugee camps, raising concern about the protection of refugees. Nearly one year after the referendum, continuing tension reached a peak with the deaths of several UN aid workers at the hands of pro-Indonesia militia in early September.

West Kalimantan and Aceh

In Pontianak and Singkawang, 13,000 Madurese live in eight IDP camps. MSF provides safe water and sanitation, and has set up an early warning system to monitor for disease. Educating people about safe hygiene is an important aspect of this work. Similar activities are carried out for some 20,000 IDPs in several districts of Aceh province. MSF also pushes for humane treatment of IDPs by the authorities.

Mental health

Many people who have survived Indonesia's recent violence and subsequent waves of displacement have been afflicted by post-traumatic stress disorders. In southeast Sulawesi, in BauBau, MSF is training community health workers to identify people – many of whom have fled the violence in the Moluccas – who might be suffering from mental trauma. The organization has also trained health center staff in counseling. MSF is considering running a similar mental health program in Aceh in 2001.

Highland Irian Jaya

In a remote highlands area in the district of Jayawijaya, indigenous people are particularly at risk for disease, especially malaria. Since 1998, MSF has supported local health centers with medicine and training and has renovated health facilities. In 2000, MSF has focused on infectious disease control in the area and has also turned its attention to training community health workers, midwives and traditional birth attendants to work in some of the area's many small villages. This work is based on an ongoing medical-anthropological study begun by MSF in 1998.

Fighting AIDS and other infectious diseases

As in other southeast Asian countries, AIDS is a growing problem in Indonesia. In Kupang City, in Nusa Tenggara Timor province, an STD (sexually transmitted disease) program reaches prostitutes, port laborers, fishermen, taxi and bus drivers, students and prisoners. In collaboration with the Ministry of Health and local NGOs, MSF works in area clinics on STD training and treatment and conducts education outreach activities for the general public.

In Jakarta, the capital, MSF is developing a comprehensive disaster management and response program in close cooperation with the authorities.

MSF has been active in Indonesia since 1995.

East Timor | Independence

- ▶ International staff: 57
- ▶ National staff: 136

East Timor dominated Indonesian affairs throughout 1999, when the East Timorese voted overwhelmingly for independence.

MSF initially entered East Timor in 1999, in advance of the August independence referendum, and began training health workers in first aid and emergency preparedness. This work was underway in Baucau, Liquica and in what would become the capital of the new country, Dili.

The referendum offered a choice between autonomy and independence, and the people of East Timor chose the latter. The backlash by the Indonesian government in the wake of the vote brought the immediate forced removal of MSF – and all other humanitarian actors – from the country. Violence perpetrated by government forces and pro-Indonesia militia left thousands dead and hundreds of thousands of people in flight. In September, the United Nations sent an Australian-led force to East Timor to both protect the local population and restore order. Independence was achieved.

Return to a devastated, but independent country

MSF remained in Darwin, Australia, returning to East Timor on September 20th. Formal independence was recognized October 1st. However, by this time the country was faced with untold destruction and a massive displaced population. Few communities escaped the devastation of cities, towns and villages. These conditions set the tone for both the close of 1999 and the activities that would dominate 2000.

The return of refugees was often poorly coordinated, leaving MSF staff at reception points hard-pressed to provide comprehensive services. Matters were further complicated by the lack of local authorities to assist in dealing with the local population.

The immediate concern was to treat the people for illnesses related to displacement and exposure and reestablish health centers in key areas. MSF has focused its activities in five areas – Dili, Liquica, Baucau, Viqueque and Bobonaro – providing general medical care, measles immunization, distributing non-food items, and assisting refugees returning from West Timor. The organization has also monitored human rights violations.

The Baucau, Bobonaro, Liquica and Viqueque hospitals were quickly restored, along with numerous health centers in these areas, providing a series of locations where returning people could receive treatment. The facilities are supplied by MSF to ensure a sufficient quantity of drugs and medical materials for the local people.

By the beginning of August, 168,000 refugees had been repatriated. However, 100,000 East Timorese are still located in West Timor, either unable or too frightened to come home.

Stability returns

Assessing the health conditions of the refugees has remained a key MSF objective, both at the time of return and in the ensuing several months. Curative and preventive health care was provided, and children between six months and 15 years of age were immunized against measles. At most sites, MSF now offers both primary and secondary care, helps with uncomplicated deliveries and surgery, and has health education activities. Equally important is the collection and analysis of epidemiological data.

With the passing of the emergency situation and the first signs of stability, MSF has begun to dedicate more staff and time to establishing a longer-term health care system and upgrading the skills of local partners.



▶ A young boy awaits treatment from MSF at the stadium in Dili, the capital of East Timor, in October 1999. He and his family fled into the hills after the August referendum on independence. When they returned they were checked and treated by MSF.

Philippines | Shrinking social budget hits the poorest

- International staff: 10
- National staff: 42

The Philippine government's policy of shifting social responsibilities from the national to the local governments has reduced the federal social services budget from US\$40 million in 1998 to just US\$25 million in 2000. However, local governments now entrusted with basic social services, including health care, lack the funding and human resources to handle the demand.

People living on the streets in the capital, Manila – including more than 75,000 young people – are particularly affected by the budget cuts. Many survive by selling cigarettes or flowers, begging, stealing or prostitution. Since the first MSF street children program began in 1992, MSF has worked toward the reintegration of these children by offering medical, social and legal assistance.

MSF provides medical care, vaccinations and health education in clinics, the Molave Youth Home, Tulay ng Kabataan and Sampaloc Bible Church or out on the streets in places where children gather. In some areas of the city, medical care is directly provided by MSF. The team also goes to detention centers for drug users to identify those most in need of help. Children in jail are also visited by MSF teams, who monitor their health and welfare and also offer legal assistance.

Paradise Village

Paradise Village, an ironically named shantytown in the swampy outskirts of Manila, is home to 15,000 people. The area is continually flooded by typhoons, monsoons and high tides. MSF has improved drainage facilities and basic access to the slum area and has offered health education to residents. A similar project will get underway in fall 2000 in nearby People's Village.

→ An MSF worker speaks with a young boy in the Caloocan cemetery, on the outskirts of Manila. It takes time to build confidence between health workers and children living on the streets before being able to offer them medical, social or legal aid.

IDPs in Mindanao

Fighting between the Philippine government and rebels in the Mindanao region in the south has caused over 10% of the area's five million people to flee their homes. In June 2000, MSF began to bring aid to about 40,000 people displaced by fighting in the Cotabato area. This program is part of MSF's emergency response efforts, which have also included help for people displaced by the eruption of the Mayon volcano that spring.

In Sulu province, a group of islands on the extreme south of the Philippines, MSF has worked since 1997 to develop cooperative pharmacies. MSF supplies drugs to 14 rural health units to supplement those provided by the Ministry of Health. This project has helped make necessary drugs – sold in city pharmacies at four times the price – available to the poor in the region, where many health units do not even have a pharmacy. Despite the success of the program, instability throughout the region has prohibited the expansion of the project.



Papua New Guinea | In Bougainville, turning the Buin health center into a rural reference hospital

- International staff : 8
- National staff : 3

Following a civil war that lasted nearly a decade, MSF managed to gain access to Papua New Guinea in 1998. Ten years of war had left the country's health facilities in need of extensive rehabilitation. MSF works in the Buin health center, in the southern part of Bougainville, one of the islands that make up Papua New Guinea.

The focus has been on improving health care for area's 70,000 people. The organization has rehabilitated the health facilities in order to help the health center become a reference hospital for the region. The team has also started training activities to raise standards of medical care, with a particular focus on nurses. New training courses will also focus on hygiene. MSF supplies drugs and medical equipment to various health facilities in the district.

MSF provides direct medical care at the health center, and has seen a rise in the number of monthly consultations. The center now has about 50 births each month, and the number of hospitalized patients averages 15.

Through organizing direct medical care both in the hospital and throughout the district of Buin, MSF hopes to improve the entire network of care available to the rural population.

MSF first intervened in Papua New Guinea in 1998.





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A whole world is reflected in the eyes of this young Yanomami girl in the Roraima area of the Amazon, in Brazil. She was photographed for an MSF-sponsored photo exhibit designed to educate the Brazilian public about the country's indigenous population. MSF works with indigenous people, who often have unique health concerns, in many countries in Latin America.

Mexico

Basic health care for indigenous people

- ▶ International staff: 4
- ▶ National staff: 55

Since early 1999, MSF has been working in the state of Oaxaca, helping the Ministry of Health (MOH) reinforce primary health care services that had not been widely available in some marginalized indigenous communities. At the core of MSF's work is an underlying respect for cultural health supports such as traditional medicine, traditional birthing attendants and women's groups. The idea is to empower communities by fostering active participation in the health system – an approach that differs from the more top-down method used by the government in some indigenous areas. Around 17,000 indigenous people in 60 communities benefit from this pilot project, scheduled to be handed over to the MOH by January 2001.

In the state of Chiapas, MSF works in ten indigenous communities in the Altos, the mountainous area of Chiapas that was the birthplace of the EZLN (Zapatista) rebellion in 1994. Indigenous people there have little or no access to basic health care due to the ongoing low-intensity armed conflict between the government and the Zapatistas, and because of a largely inadequate public health system. In areas where MSF works, in which indigenous people make up about 70% of the population, there are only four doctors for every 100,000 people.

AT THE CORE OF MSF'S WORK IS A RESPECT FOR CULTURAL HEALTH SUPPORTS SUCH AS TRADITIONAL MEDICINE, TRADITIONAL BIRTHING ATTENDANTS AND WOMEN'S GROUPS. THE IDEA IS TO EMPOWER COMMUNITIES.

With the goal of reducing the risks of humanitarian or health crises in the area, MSF provides primary health care services (including a small trachoma treatment program), and maintains a visible presence. The organization is raising awareness of the health plight of indigenous people and is building up a rapid response capacity to intervene in case of



natural or man-made disasters, such as epidemics or an extension of conflict.

MSF continues to look at other health and humanitarian needs in southeastern Mexico. The organization first worked in the country in 1994 and has had a continuous presence since 1997.

El Salvador

Continuing post-Mitch rehabilitation

- ▶ International staff: 5
- ▶ National staff: 20



MSF has been assisting vulnerable people in El Salvador ever since Hurricane Mitch struck Central America in late 1998. When the first phase of emergency relief work came to an end in early 1999, MSF began longer-term initiatives for improving sanitation and access to clean water.

The western departments of Ahuachapán, Sonsonate, La Paz and San Vicente are susceptible to floods. MSF has started a program to reduce waterborne diseases, improve understanding of health issues and increase emergency preparedness at the community level. In addition to providing materials for constructing water and sanitation facilities, MSF trains communities in how to use the facilities (poster above) and – very important in this flood-prone area – how to use

them in case of flooding. Health education focuses on water treatment, hygiene and preparing for floods. This program will finish in April 2001.

Another key area of activity is cholera preparedness. In the wake of a post-hurricane cholera outbreak in early 1999, MSF set up special cholera wards in three hospitals in the capital San Salvador. These facilities can be easily used again in the event of another major outbreak. Because clean, potable water is scarce, particularly in rural areas, MSF helped install equipment for producing chlorine solution used to purify water. Teams also trained Ministry of Health staff in water quality control.

MSF is considering launching a program to work on preventing mother-to-child HIV/AIDS transmission.

Médecins Sans Frontières first intervened in El Salvador in the early 1980s, during the height of the country's armed conflict.

- International staff: 21
- National staff: 35

Most Guatemalans have limited access to health care because they lack means or live in rural areas where health care services are minimal. MSF works in both urban and rural settings to treat and prevent AIDS, improve primary health care and address the health care needs of the vulnerable and excluded.

Attacking the problem of AIDS

MSF works with children, young people and adults to raise awareness of AIDS, a growing problem in this country of 11 million people. In both Guatemala City and Quetzaltenango, the second largest city, MSF has developed self-study AIDS prevention guides for schools and has undertaken public information and awareness campaigns. The organization trains local health workers in universal precautions and an approach to STDs that emphasizes patient confidentiality, counseling and partner tracing. MSF also provides nursing care and pharmacy management in two private hospices, the Marco Antonio hospice in Guatemala City and the San Jose hospice just outside the city.

In Coatepeque, in Quetzaltenango province, MSF offers medical support and supplies drugs to an AIDS outpatient clinic. Teams also work with local medical staff on HIV/AIDS case management and opportunistic disease treatment protocols. MSF is helping to create a reference network of HIV/AIDS specialists. Through the ACCESS campaign (see page 14), the organization is pushing for lower-cost drugs for AIDS sufferers.

"Prevention activities are aimed at the general public, but we also work with specific high risk groups such as sex workers," explains Olaf Valverde, one of the MSF coordinators in the country. "At the same time, MSF is making a big effort to improve diagnosis and treatment of AIDS patients."

Caring for street children

The country's gross inequality in income distribution (5% of the population owns 85% of the wealth) has meant that many people – and in particular many young people – have fallen through the cracks. In Guatemala City, MSF worked with street children aged 14–24 at "Rescate" (Rescue), a day center established in 1997 with the local NGO Casa Alianza. In Rescate, the team provided medical care – about 200 consultations per month – and psychological assistance.

Although the need to redefine the project meant that "Rescate" was closed earlier this year, MSF will continue to provide medical and psychological care through a new health center, which opened in June. Adolescents will be the focus, with special attention given to young mothers and their children. MSF is also working to set up a reference network of medical specialists and social workers to extend the range of care available and the network of support. In addition, teams will go into the streets to identify those young people who need help.

To prevent children from ending up on the street in the first place, in 1997 MSF started a medical and psychological support program for children and families in Lomas de Santa Faz, a slum area of Guatemala City. The MSF team makes home visits to try and strengthen relationships between

mothers and children. In addition, around 40 children attend the "Casa del Patojo" (Children's House), a medical day center set up in 1999. Children here receive both psychological support and medical attention for at least three months.

People in Lomas de Santa Faz also requested help setting up a community day care center for children who need a place to stay while their parents work, or who no longer meet the medical and psychological criteria of "Casa del Patojo" but need a place to stay during the day. This center will open in late 2000.

Primary health care

MSF also runs several primary health care programs, one in the rural region of Izabal in eastern Guatemala, and another in Champerico, on the Pacific Ocean. In Izabal, the team works in the town of Frontera to improve preventive and curative services and the management of the health district. This project serves about 30,000 people. In early 2000, MSF launched a similar program in Champerico, where the last decade has seen a sharp increase in poverty due in part to the closure of the port and the railway. Another primary care program in Barillas, in Huehuetenango province, was phased out in February 2000.

In summer 2000, MSF finished the emergency sanitation and disease-control work it began in late 1998 in the aftermath of Hurricane Mitch.

MSF has been working in Guatemala since 1986.



A young girl peers over her shoulder in Lomas de Santa Faz, a slum area of Guatemala City. MSF gives medical and psychological aid to area children and their families. The photographer was the winner of a photojournalist contest sponsored by the Japanese office of MSF.

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Honduras

Fighting disease

- International staff: 34
- National staff: 30

Poverty, rural isolation and the devastation of Hurricane Mitch in 1998 have all taken their toll on the health of the people of Honduras, the second poorest country in Central America after Nicaragua. MSF works on post-emergency projects, primary health care and prevention and treatment of sexually transmitted diseases (STDs) and AIDS. The organization also treats and works to prevent Chagas disease, a rare and often fatal illness that is endemic in some parts of the country.

Chagas disease

Over the last year, MSF has launched several new programs targeting South American Trypanosomiasis, or Chagas disease, which affects about 300,000 poor and isolated Hondurans – about 5% of the country's six million people. MSF coordinates its work with the Ministry of Health's (MOH) National Chagas Program. Projects in Montaña de la Flor and Yoro treat Chagas patients and work to eradicate or reduce the key vectors carrying the parasite, the small insects *rhodnius prolixus* and *triatoma dimidiata*.

The earlier the infection is detected, the more effective the treatment, so MSF concentrates on children. The Yoro project helps children under five. In Montaña de la Flor, treatment for children under 13 is being tested. Patients take one or two pills of Benznidazol a day for two months.

CHAGAS DISEASE AFFECTS ABOUT 300,000 POOR AND ISOLATED HONDURANS – 5% OF THE COUNTRY'S POPULATION.

"The problem is that communities are very scattered and some are very far away from health centers," says Manuel Duce, a field coordinator for the program. "So people are being trained in each community to supply patients with the drug, under the supervision of medical staff."

Both Benznidazol and Nifurtimox, the other key Chagas drug, are difficult to come by: The former is no longer available in the country and the latter is no longer produced. MSF bought the remaining stock of 750,000 tablets of Nifurtimox to use in Honduras as a second-line drug for children under 13 who have strong side effects when treated with Benznidazol. The drug is also used in clinical trials to treat Human African Trypanosomiasis (sleeping sickness).

On the level of prevention, MSF-organized teams visit communities to check for insects in walls, straw roofs or dirt tracks. This is followed by fumigation of homes and external areas with insecticide. A community surveillance system then watches for the possible return of insects.

After Hurricane Mitch

MSF has entered a new phase of its post-emergency work, focusing on long-term efforts to decrease malnutrition. In the southern province of Choluteca, MSF trained local doctors and nurses and linked them with village volunteer networks to improve early detection and treatment of children with chronic malnutrition. Protocols put in place in Choluteca have become the foundation for nationwide procedures. Now MSF is focusing on improving the local diet by improving corn and bean production, creating family gardens and encouraging production of eggs to improve the quality of the daily diet of children. Other post-Mitch work rehabilitating medical facilities in Tegucigalpa and La Ceiba drew to a close in mid-2000.



AIDS and urban health care

Honduras has the highest incidence of HIV/AIDS infections and deaths in all of Central America – over 13,000 cases were confirmed by the Honduran MOH between 1986 and early 2000. In Tegucigalpa and La Ceiba, MSF has STD case management projects designed to reduce transmission of STDs and HIV among excluded people and improve care for patients. MSF donates drugs to treat opportunistic diseases and STDs. In La Ceiba, MSF has produced a self-study guide to encourage AIDS/STD prevention among 9–12 year-old children. This effort reached about 3,000 young people in 15 public schools in 1999.

MSF also supports a new health center in the Tegucigalpa slum area El Carrizal. The clinic, which opened in January 2000, serves about 40,000 people.

Other programs

In the north-central towns of Yoro and Olanchito, MSF has mother and child health care programs designed for children under five. The organization also helped build a "casa materna" next to the hospital in Yoro to host women with high-risk pregnancies and births.

A project serving some 20,000 Garifunas and Ladinos (groups living on the Atlantic coast and in the interior, respectively) closed in July 1999 because of insecurity in the region. Three Honduran doctors are carrying on the work in the five area health centers where MSF had been working.

MSF first intervened in Honduras in 1974.

Pregnant women listen attentively to a talk about healthy breast feeding at the Casa Materna in Quilali, Nicaragua. The women's clinic is supported by MSF.

- International staff: 32
- National staff: 206

Nicaragua, like many other countries in the region, has experienced intense urban migration over the last decade. About 60% of the population now lives in and around cities. This puts undue pressure on a public health system already suffering from infrastructure deterioration, a shortage of medical material and medical staff often unmotivated because of very low wages. In the overcrowded cities, many people fall through the cracks.

The capital, Managua, is home to about 30,000 children and adolescents living on the streets. MSF has a medical, psycho-social and legal assistance program that reaches about 4,000 young people, who often flee home because of ill-treatment or violence.

The goal of the program is to improve the street children's family relationships and their access to health care, facilitate social reintegration and encourage area people and institutions to treat these young people like ordinary citizens – as stipulated in Nicaragua's National Code for Children and Adolescents.

"Street children are in a very vulnerable situation," explains Chus Alonso, coordinator of the program. "They are seen as undesirable and are the victims of all kinds of abuse and violence."

MSF visits the areas of the city where street children live. A doctor, nurse, psychologist and lawyer provide health care, psychological support and legal aid both on the streets and at a recently opened drop-in center. In addition, MSF contacts any institution that has not respected the National Code.

Lobbying efforts lead to results

On several occasions, MSF has publicly denounced violence against street children. In November 1999, MSF bought advertising space in two newspapers to condemn the murder of a street child who had stolen a hat. More ad space was bought again the following January, after a security guard shot and wounded a child who was trying to steal a chair. After both of these public denunciations, the General Prosecutor contacted MSF for more information and committed himself to investigating the cases. The investigations were ongoing through summer 2000.

A focus on women's rights in Quilali

Since late 1998, MSF has been working at the Casa Materna in Quilali, a small city in northern Nicaragua. At its core a place to care for women with difficult pregnancies, MSF hopes the center will also become a base for working with the local community to promote women's rights. Beginning in April 2000, MSF began to set up a prevention and response network for women in the community. A separate "Women's Commission" – to accompany victims, push for the training of a female police officer, and rehabilitate facilities – was also launched.

Tourism and shipping increase the rate of HIV/AIDS

Although Nicaragua has one of the lowest HIV/AIDS rates in Central America, certain parts of the country have been particularly touched by the disease. In the southeastern coastal city of Bluefields and on Corn Island, in the Caribbean, adults regularly leave for work in the tourism industry or on commercial boats, a pattern that has resulted in an STD/AIDS rate much higher than the national average. MSF runs STD/AIDS prevention and awareness programs in both of these areas.

In the aftermath of Hurricane Mitch, MSF helped rehabilitate medical buildings and water and sanitation systems. This program, in the departments of Managua, Leon, Chinandega and Nueva Segovia, ended in June 2000.

MSF first intervened in Nicaragua in 1972, following an earthquake that devastated Managua.



Panama

Primary care for the Ngöbe-Bugle people

- International staff: 4
- National staff: 12

People in remote areas of Panama – and in particular the indigenous groups who make up 8% of the country's population – have very limited access to health care.

MSF works in one of these remote regions, the Rio Cricamola Valley, an area in northern Panama where people from the Ngöbe-Bugle ethnic group live.

In November 1998, the Panamanian government recognized the administrative autonomy of this area, also called the "Comarca." However, it will take a long time before the region's administrative autonomy process is complete. Only a medical sector has been created so far.

In Kankintu, the main village in the district, MSF is trying to improve the indigenous population's access to health care and integrate traditional and modern medicine. MSF trains, supervises and supports a dozen local health workers who serve about 25,000 people. Working through

health care committees, the team provides medicine, carries out vaccinations, offers nutritional aid and provides water and sanitation services. MSF also works with traditional birth attendants in the area.

MSF has rehabilitated and equipped Kankintu's clinic and has built a new health post in Coronte, a small village about a day's walk from Kankintu. The organization helps manage the health center and health post. The extension of the Kankintu clinic and construction of a health post in Quebrada Hacha, a two-day walk from Kankintu, have been planned for 2000.

In addition, MSF shares its expertise with the Ministry of Health and works to facilitate relations between the Ministry of Health's provincial secretary and the "Comarca." MSF has been working in Panama since 1992.

Cuba

MSF closes its missions on the island

- International staff: 5

In late 1999, Médecins Sans Frontières made the difficult decision to discontinue its work in Cuba. Some MSF programs in Cuba were successfully completed and handed over to the the Ministry of Health. But excessive administrative control by Cuban authorities and related problems with local supply channels made it difficult for the organization to continue running other projects independently and effectively, prompting the decision to withdraw. MSF closed its last mission in Cuba in April 2000.

While on the island, MSF focused on STD/AIDS and on water and sanitation, areas where it was able to bring added value to a health system that already had well-trained medical professionals but lacked financial resources.

Raising awareness of STD/AIDS

STD/AIDS prevention programs in Havana and Santiago de Cuba targeted young people and vulnerable groups. MSF carried out awareness campaigns, trained local health workers and encouraged condom use.

In early 2000, MSF teams and community health workers travelled through Havana and the provincial capitals for an outreach campaign called "Carrito por la vida" (Trailer for Life). Riding in a brightly painted Dutch

caravan, teams worked enthusiastically day and night distributing information and condoms to high risk people, raising awareness of HIV/AIDS and STDs and promoting universal precautions. The project was carried out in conjunction with the Ministry of Health.

Although the STD/AIDS project in Santiago de Cuba was praised by the Minister of Health and its extension to four other provinces requested, the extension proved impossible due to unacceptable conditions posed by the Cuban authorities. The Santiago project is continuing with the Cuban team which had been working with MSF since 1997.

Improving water quality

In addition to its STD/AIDS work, MSF carried out several long-term water and sanitation (WATSAN) projects on the island. The organization ran a project aimed at eliminating aedes aegypti mosquito (Dengue fever vector) breeding points in the José Martí district of Santiago de Cuba, a rainwater collection program in Rio Cauto (Granma Province), and a domestic water filter project in Baracoa (Guantanamo Province).

MSF began work in Cuba in 1993.



Costa Rica | Preparing for emergencies

The MSF Regional Office (CRO) in San José, Costa Rica, was set up in 1992. The office facilitates emergency preparation and response in Latin America and the Caribbean.

In late 1999, the CRO made an initial evaluation after floods in Mexico and again after landslides in Venezuela. But a large part of the CRO's recent work has been related to the ongoing rehabilitation after Hurricane Mitch struck Central America in late 1998. Shipments of flood equipment were sent to Honduras, Nicaragua and Guatemala in late 1999.

The CRO also works with five other organizations to maintain the Regional Center for Information and Disasters in San José. This center houses thousands of documents, technical reports and specialized magazines which are used for training and communication.

MSF has responded to about 30 emergencies in the region over the last three and a half years.



Haiti | The worst health statistics in the Western Hemisphere

- ▶ International staff: 8
- ▶ National staff: 41

MSF has been working since 1992 on several projects designed to improve health care and sanitation in Haiti, the country with the worst health indicators in the Western Hemisphere. The public health care system suffers from the country's poverty, and continuing political and social instability means that a majority of Haitians live in precarious conditions.

Improving management at the district level

This focus on maternal care follows three years of work based in the Saint-Marc health district supporting the government's transition to a new organizational structure for health services, the Community Health Unit. Through December 1999, MSF worked with the Ministry of Health to define and begin implementation of the final stage of this

CONTINUING POLITICAL AND SOCIAL INSTABILITY MEANS THAT A MAJORITY OF HAITIANS LIVE IN PRECARIOUS CONDITIONS.

Improving maternal medical care

In early 2000, MSF launched a four-year effort to fight maternal mortality, estimated by the Pan-American Health Organization to be about 457 deaths per 100,000 live births.

The MSF program is based in the commune of Saint-Marc, on the coast about 100km northwest of the capital Port-au-Prince. Expatriate and local midwives work with the people and their community leaders, traditional birth attendants and local dispensaries to improve the chain of medical care for pregnant women.

program, a management and logistics system for the whole district (including Saint-Marc and the communes of Desdunes and Grande Saline).

MSF has also provided a health management professional to help create a district-wide system for managing human and financial resources and information. The MSF team continues to train local doctors and nurses in basic emergency surgery skills. Toward the end of 2000, a similar but smaller-scale program will begin in the neighboring district of Petite Rivière.

Projects brought to a close in 1999

In disadvantaged areas of Port-au-Prince, work to construct latrines, rehabilitate dispensaries and improve access to drinkable water drew to a close in August 1999. Another program training nurses in the basics of anesthesiology in Jérémie, a town in the western part of the country, was phased out at the same time.

MSF's "Carrito por la vida" (Trailer for Life) stops at a Cuban beach to offer information on preventing sexually transmitted diseases, including AIDS.

Ecuador | Caring for people along the Putumayo River

► International staff: 9
► National staff: 16



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In Ecuador, difficult economic conditions and a move toward privatizing the health sector have pushed health care beyond the reach of many.

MSF has concentrated its work in northeast Ecuador, where the Putumayo River forms the border with Colombia. In a program that got underway in January 2000, MSF provides basic health care services for Ecuadorians largely excluded from the Ecuadorian medical system and Colombians either fleeing violence in their own country or traveling to Ecuador for economic reasons.

The MSF project has two bases, one in the town of Puerto del Carmen, on the river, and the other in Nueva Loja, a small town a few hours south. The entire area is a place the authorities are unable to reach, and where travel for the population – and access to health services – is difficult. From these towns, MSF provides care for Ecuadorians and Colombians on both sides of the border.

A 200-kilometer boat trip

Each month, the team based in Puerto del Carmen makes a 200km circuit by boat along the Putumayo River, traveling eight days northeast to Cuenbi and Puerto Asis, and another eight days to the southwest to Tres Fronteras and Puerto Leguizamo. On the Ecuadorian side of the border, MSF supports a health center, a health post and a "hogar materno," a place for women with difficult pregnancies or births. On the Colombian side of the river, MSF provides care at eight health posts. Common medical problems in the region include acute respiratory and diarrhea infections, malaria, parasitosis, and yellow fever (MSF carried out vaccinations for this disease in early 2000). The program serves about 8,000 people on the Ecuadorian side of the border and 32,000 on the Colombian side. Another 10,000 Colombians (refugees and others travelling through the region) also benefit.

The other part of the project is based in Nueva Loja and reaches about 50,000 people – primarily from the Secoya, Quichua, Suares and Cofane indigenous groups – as well as settlers. MSF supports the basic health care activities the government has set out in its national health plan but for which there are limited public resources. The organization also trains local health care staff and assists with the rehabilitation and equipment of health facilities. Early on in the project, MSF lobbied successfully for the authorities to assign a Quichua-speaking nurse to the area.

↑ Children at a preschool in Bogotá, Colombia, take their monthly dose of anti-parasite medicine. The MSF team brings the medicine during regular visits to the school.

The need for cheaper medicines

As the Ecuadorian public health system has become more decentralized, private health services and pharmacies have flourished. But the country's economic difficulties mean that most people cannot afford the expensive commercial drugs that are the mainstay of the market. In addition, health centers frequently run out of medicine. MSF is trying to make more low-cost drugs available at the pharmacies linked to the health posts it supports. The organization donated the first stock of medicine and set up a cost recovery system to help make the pharmacies self-sustaining.

MSF has been working in Ecuador since 1996.



- International staff: 36
- National staff: 90

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Wilson, paralyzed by gang violence in Cali, Colombia, tosses a ball during a rehabilitation session run by MSF.

The well-being of most Colombians has been adversely affected by one thing: violence. Colombia is one of the most violent countries in the world. Conflicting political aspirations are often expressed in deadly ways: Armed groups launch attacks on those they suspect of collaborating with the powers that be, and others use equally brutal methods to defend what they see as the country's established economic and industrial order. The government and the military seek to redress the balance through force of their own. But it is the civilians who suffer.

In conflict areas, small groups of people live in partially abandoned villages with little or no access to health care. Many health posts have no staff or lack medicine and equipment. To help these people, MSF has organized medical brigades to assist those in the isolated areas of Córdoba, Urabá, Magdalena Medio and Montes de María in northern Colombia, the area

"IDPs often don't know how the health care system works, or what their rights are. They are distressed, trying to find ways to survive in a hostile environment, and they experience a lot of difficulties getting integrated into the public health system," says one of the MSF coordinators in Colombia.

In Soacha, a suburb of Bogotá, MSF carries out health education, vaccinations and mother and child health care programs targeted at the area's many IDPs.

Urban violence touches young men

Poverty, unemployment, easy access to firearms and minimal access to education have spectacularly increased the homicide rate in Colombia – the murder rate is 77 killings for every 100,000 people.

Urban violence, and in particular fighting between gangs, has left a ghastly legacy in its wake: physically

IDPS OFTEN DON'T KNOW HOW THE HEALTH CARE SYSTEM WORKS, OR WHAT THEIR RIGHTS ARE. THEY ARE DISTRESSED, TRYING TO FIND WAYS TO SURVIVE IN A HOSTILE ENVIRONMENT AND EXPERIENCING A LOT OF DIFFICULTIES.

most hit by violence. In addition to treating common health problems (including malaria, dengue fever, pneumonia and skin problems), teams do vaccinations and work on prevention and health education. MSF also engages in advocacy. The focus is on the most vulnerable people: children, women and internally displaced persons (IDPs).

MSF recently began work in the Pacific province of Chocó. At the hospital in the town of Tadó, MSF works side by side with Colombian health workers. The treatment of malaria, mother and child care and vaccination have been identified as priorities in this region where an estimated five out of six people do not have access to adequate care, and where about 40,000 people (out of a population of 500,000) have been displaced by violence.

Caring for those who flee to the cities

Many of the country's 1.5 million IDPs flee to urban areas. They settle down in slums and mushrooming shantytowns, where they live in deplorable conditions. Basic services such as water and sanitation are very poor, and access to health care is difficult. MSF offers IDPs and other vulnerable people in the cities medical care and health education.

handicapped young people with little access to medical care. Gunshot wounds leave many boys between the ages of 15 and 21 paralyzed from spinal cord injuries. Many of the victims are paraplegic patients who require special care. They need physical and psychological rehabilitation, yet they often lack the economic resources to get the care they need.

In a community-based project in Cali, MSF works with these victims of violence and their families, through a rehabilitation program that includes medical care, physiotherapy, psychological support and social work, as well as prevention activities. There is a reference system for specialized consultations.

Another problem targeted by MSF is that of early pregnancies and sexual violence. In Agua Blanca, a neighborhood of Cali, MSF has been working since 1996 to provide pre- and postnatal medical care, family planning services, psycho-social support and counseling. Education about sexual health and the detection and treatment of STDs are also part of the program.

In little-populated rural southern Colombia, MSF makes rotating visits to small villages in the area of Solita. Teams carry out vaccinations, offer preventive and curative care and train local medical workers.

Peru | AIDS prevention and reproductive health

- ▶ International staff: 16
- ▶ National staff: 98

Young teenagers listen as their teacher explains the dangers and realities of AIDS at "Escuela Elias Aguirre" in Villa El Salvador, a poor area of Lima, Peru.

Forty-five percent of Peruvians live in poverty, many in extreme poverty. People living in urban slum areas are vulnerable to transmission of sexually transmitted diseases (STDs), HIV/AIDS and cholera outbreaks. They are affected by social and family violence and environmental deterioration. And, although Peru is more politically stable now than it was during the peak period of unrest and guerrilla warfare in the 1980s and early 1990s, current efforts to liberalize the economy have left many Peruvians either politically alienated or economically adrift.

In Lurigancho prison, a high risk of AIDS

Some of the most marginalized people inhabit the country's prisons. In April 2000, MSF launched a three-year STD/HIV/AIDS control project in overcrowded Lurigancho prison, in northern Lima. The prison, primarily a holding center for men who have been accused of common crimes, houses more than 6,600 people – 25% of the total Peruvian prison population.

The social characteristics and behavior patterns of the inmates, coupled with poor and overcrowded living conditions and lack of access to condoms, put both the prisoners and those around them at great risk for TB, STDs and HIV/AIDS. The prison's high turnover rate also makes it a catalyst for the spread of these diseases to other prisons and the prisoners' home communities.

In an attempt to reduce risky behavior, education activities emphasize prevention. For those already infected with HIV, MSF has set up a counseling service and introduced comprehensive care for HIV/AIDS patients (including adequate TB treatment). There is a self-help group for prisoners living with HIV/AIDS. In addition, MSF is training prison health staff to improve infection control procedures.

Focus on young people

In Villa El Salvador, MSF, along with the MOH and other Peruvian organisations, educates young people about reproductive health and provides prevention activities focusing on violence and abuse.

Teams provide medical, social and psychological care and support to pregnant teenagers, abused children and adolescents. The activities are carried out through the multi-disciplinary consultation service "Entre Amigos" (Among Friends), and through home visits and cooperation with teachers, community health workers, adolescents and their parents.

Care for isolated communities

MSF also works in rural Peru, far away from the country's urban centers. In remote areas of the Amazon jungle and the Andes, health care is limited. Along the Ucayali river, in the Amazon region of Pucallpa, MSF provides primary care to scattered indigenous communities in the Masisa and Iparia districts.

Two other rural primary health care projects, one in the Amazon jungle province of Satipo, and another covering the Andean provinces of Angaraes and Acobamba, were handed over to the MOH in 2000.

An extensive mission to assess health, water and sanitation needs in Belén, a district in the northern city Iquitos, was carried out in early 1999. The findings were turned over to local health officials for possible intervention. During the second half of 1999, MSF vaccinated about half a million people in and around Iquitos and in San Martin province against yellow fever.

THE BEHAVIOR PATTERNS OF THE INMATES, COUPLED WITH POOR AND OVERCROWDED LIVING CONDITIONS AND LACK OF ACCESS TO CONDOMS, PUT THE PRISONERS AND THOSE AROUND THEM AT GREAT RISK FOR TB, STDs AND HIV/AIDS.

MSF also works to control STDs and HIV/AIDS among the wider population. An estimated 40,000 – 70,000 people are living with HIV/AIDS in Peru, with a significant recent increase among 20-24 year-olds due to sexual transmission of HIV during adolescence.

MSF works in four marginalized districts of Lima: San Juan de Miraflores, Villa María del Triunfo, Villa El Salvador and Chorrillos. Part of the Ministry of Health's (MOH) national STD/HIV control program, the MSF project seeks to prevent infection (especially in adolescents and young adults) and improve care for those already infected.

MSF has held training workshops for public health personnel on subjects such as individual counseling, current approaches to STD management, and comprehensive care for people living with HIV/AIDS. MSF is also training adolescent and adult community health workers to organize STD/AIDS prevention education activities, and to detect and refer STD cases to appropriate health care services. Since November 1999, an MSF doctor specializing in infectious diseases has been working to establish an infectious diseases department, and organize comprehensive care for AIDS patients in the reference hospital María Auxiliadora in Lima.



- ▶ International staff: 6
- ▶ National staff: 29

The broader challenges facing native American and rural communities throughout Latin America are omnipresent in Bolivia. Over 50% of the population is indigenous, but people of European or mixed European-native American origin hold political and economic power. Nine out of ten rural households are poor.

Caring for a rural population

"Rural communities, especially indigenous, live in extreme poverty and have little or no access to health care and water and sanitation services," explains Reyes Otero, general coordinator of the MSF program in Bolivia.

"Indigenous people have little access to modern medicine."

The municipality of Chimoré, in the department of Cochabamba in west-central Bolivia, is home to about 15,000 people, including 3,000 Yuki and Yuracaré native Americans. Outsiders who were lured there in the early 1980s by profitable coca crops pushed the indigenous population to inaccessible spots near the Chapare and Ichilo rivers. MSF has been working to improve health care in the area since April 1999.

RURAL COMMUNITIES, ESPECIALLY INDIGENOUS, LIVE IN EXTREME POVERTY AND HAVE LITTLE OR NO ACCESS TO HEALTH CARE AND WATER AND SANITATION SERVICES.

In addition to providing drugs, medical and cold chain material and radios, MSF runs a basic health care program in collaboration with the Chimoré health center. Educational outreach covers basics such as hygiene, water, nutrition, mother and child health care and sexual education. The team recently built a new clinic in Chimoré and another in the area where the Yuracaré live. New toilets are slated for the schools, and water systems for communities that have none.

In neighboring Mizque, also in Cochabamba, MSF helped organize and manage a health care district for some 35,000 Quichua. The project was handed over to the Ministry of Health in July 2000.

Mother and child care amid urban population pressure

A new mother and child health care program will begin in fall 2000 in the municipality of El Alto, in the department of La Paz. Population pressure in the area is tremendous. The growth rate is higher than in any other Andean city. Around 70% of the district's half a million people – mostly Aymará, Quichua and Guaraní – live in poverty.

The result is a permanent social emergency. People suffer from cultural and economic exclusion. Urban planning is nonexistent, and health and education infrastructure is inadequate. Women and children are the most vulnerable: Domestic violence, high abortion and maternal mortality rates, poor pre- and postnatal medical care, malnutrition and acute diarrhea and respiratory infections abound.

The MSF program emphasizes mother and child health care, sexual and reproductive health and counseling for victims of violence. MSF also plans to create a woman's clinic to help reduce maternal morbidity-mortality rates.

MSF has been working in Bolivia since 1986.

This MSF poster urging adults to "Unite Against Child Abuse" hangs at "Entre Amigos," a center for young people and their parents in Villa El Salvador, Peru.



- ▶ International staff: 16
- ▶ National staff: 83

Eighty percent of Brazil's 165 million people live in or near a city. This intense urbanization, coupled with the vast economic divide between rich and poor, puts great pressure on the health of those on the cities' economic margins. MSF's work in Brazil is focused on the excluded urban areas of Rio de Janeiro and, at the other extreme, in isolated indigenous communities in the Brazilian Amazon.

One of MSF's newest programs involves street dwellers in Rio de Janeiro. Although the presence of people living in the street is not a new phenomenon in Rio, it is a growing one.

To better understand what living on the street can mean, MSF invited a number of homeless people to a three-day meeting last April. They presented their stories, questions and grievances to representatives of different government services involved with street people, including police, health and social workers and people in the housing department. The meeting gave important clues about how a homeless program could be designed.

Medical assistance will be the starting point for the development of a broader social reintegration program. MSF plans to host seminars for local residents, entrepreneurs, sports and religious associations, restaurants, and schools, with the aim of creating a network of support for MSF work and for the street people themselves.

Working with people on Rio's margins

MSF also works in the northern Rio district of Costa Barros, an area with a total population of about 45,000 people and a long history of poverty, violence and insecurity. The project began in September 1998. The first phase, which ran through September 1999, focused on restarting the activities of the local health center. The emphasis has now turned to education and outreach, with special attention to prevention and health promotion services rather than just medical assistance.

In June 2000, MSF phased out its support for another community development project. Local organizations received training on setting up and running associations to support a health center and other local needs. The result was the creation of an NGO devoted to

MSF INVITED HOMELESS PEOPLE TO A THREE-DAY MEETING, WHERE THEY PRESENTED THEIR STORIES, QUESTIONS AND GRIEVANCES TO GOVERNMENT REPRESENTATIVES. THE MEETING GAVE IMPORTANT CLUES ABOUT HOW A HOMELESS PROGRAM COULD BE DESIGNED.

accompanying AIDS patients, as well as several community associations. Participants continue to receive support from local funds.

MSF also helped create "Médicos Solidários" (Doctors in Solidarity), a network of 85 physicians who offer about 200 free consultations per month to the poor in Rio.

Working within the local AIDS control program, MSF has a project focusing on raising awareness of sexually transmitted diseases and increasing access to condoms.



About 20 community organizations have been trained in the development and management of AIDS-related projects.

Indigenous health

Far from the urban poverty of Rio, MSF works with indigenous people in Brazil's Amazon state, home to about 58% of the country's indigenous population. Isolation and relatively recent contact with disease-bearing people from the outside have resulted in a unique set of health problems: acute respiratory and diarrheal infections, tuberculosis, malaria, and high mother and child mortality rates.

Based in Manaus, MSF works in Atalaia do Norte (in Javari Valley District) and in Tefe (in Médio Solimões District), in collaboration with Brazilian Ministry of Health and local organizations. During five- to seven-day visits to each community, MSF trains indigenous health workers to identify and treat key diseases affecting indigenous communities. MSF has also trained staff of the Ministry of Health and the Indian National Foundation in preventive healthcare techniques for indigenous people.

In October 1999, the government created Special Indigenous Healthcare Districts (SIHD), a system geared in theory to the culture and specific needs of the indigenous population. One of MSF's priorities is to support the values

and philosophy of the original indigenous health care district concept, whose implementation has unfortunately often resulted in a replica of the regular national health care system.

As a way to raise awareness throughout Brazil of its indigenous peoples, MSF is sponsoring "Indians 2000," an exhibition of 26 photographs by Sebastião Salgado, nine panels by artist Claudio Andrade, and texts by poet Thiago de Mello (poster left). In Rio, MSF is also trying to sensitize the broader Brazilian public - with newsletters, seminars and other communication activities - to some of the problems and issues encountered in its programs.

MSF has been working in Brazil since 1991.



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The Nobel Peace Prize speech

Delivered by Dr. James Orbinski, President of the MSF International Council, in Oslo, Norway on 10 December 1999

Your Majesties, Your Highness, Members of the Norwegian Nobel Committee, Excellencies, Ladies and Gentlemen:

The people of Chechnya – and the people of Grozny – today, and for more than three months, are enduring indiscriminate bombing by the Russian army. For them, humanitarian assistance is virtually unknown. It is the sick, the old and the infirm who cannot escape Grozny. While the dignity of people in crisis is so central to the honor you give today, what you acknowledge in us is our particular response to it. I appeal here today to his excellency the Ambassador of Russia and through him, to President Yeltsin, to stop the bombing of defenseless civilians in Chechnya. If conflicts and wars are an affair of the state, violations of humanitarian law, war crimes and crimes against humanity apply to us all – as civil society, as citizens and as human beings.

Let me say immediately that the extraordinary distinction that the Nobel Committee has given Médecins Sans Frontières is one that we accept with sincere gratitude. But also with a profound discomfort in knowing that the dignity of the excluded is assaulted daily. These are the forgotten populations in danger, like the street children who struggle each grinding hour to live off the waste of those who are “included” in the social and economic order. These, too, are the illegal refugees that we work with in Europe, denied political status, and afraid to seek health care, lest this contact lead to their expulsion.

Our action is to help people in situations of crisis. And ours is not a contented action. Bringing medical aid to people in distress is an attempt to defend them against what is aggressive to them as human beings. Humanitarian action is more than simple generosity, simple charity. It aims to build spaces of normalcy in the midst of what is profoundly abnormal. More than offering material assistance, we aim to enable individuals to regain their rights and dignity as human beings. As an independent volunteer association, we are committed to bringing direct medical aid to people in need. But we act not in a vacuum, and we speak not into the wind, but with a clear intent to assist, to provoke change, or to reveal injustice. Our action and our voice are acts of indignation, a refusal to accept an active or passive assault on the other.

The honor you give us today could so easily go to so many organizations, or worthy individuals, who struggle in their own society. But clearly, you have made a choice to recognize MSF. We began formally in 1971 as a group of French doctors and journalists who decided to make themselves available to assist those in crisis. This meant sometimes a rejection of the practices of states that directly assault the dignity of people. Silence has long been confused with neutrality, and has been presented as a necessary condition for humanitarian action. From its beginning, MSF was created in opposition to this assumption. We are not sure that words can always save lives, but we know that silence can certainly kill. Over our 28 years we have been – and are today – firmly and irrevocably committed to this ethic of refusal. This is the proud genesis of our identity, and today we struggle as an imperfect movement, but strong in our volunteers and national staff, and with millions of donors who support both financially and morally the project that is MSF. This honor is shared with all who, in one way or another, have struggled and do struggle every day to make live the fragile reality that is MSF.

Humanitarianism occurs where the political has failed or is in crisis. We act not to assume political responsibility, but firstly to relieve the inhuman suffering of that failure. The act

must be free of political influence, and the political must recognize its responsibility to ensure that the humanitarian can exist.

Humanitarian action requires a framework in which to act. In conflict, this framework is international humanitarian law. It establishes rights for victims and humanitarian organizations. It fixes the responsibility of states to ensure respect of these rights, and to sanction their violation as war crimes. Today this framework is clearly dysfunctional. Access to victims of conflict is often refused. Humanitarian assistance is even used as a tool of war by belligerents. And more seriously, we are seeing the militarization of humanitarian action by the international community.

In this dysfunction, we will speak to push the political to assume its inescapable responsibility. Humanitarianism is not a tool to end war or to create peace. It is a citizens' response to political failure. It is an immediate, short-term act that cannot erase the long-term necessity of political responsibility.

And ours is an ethic of refusal. It will not allow any moral political failure or injustice to be sanitized or cleansed of its meaning. The 1992 crimes against humanity in Bosnia-Herzegovina. The 1994 genocide in Rwanda. The 1997 massacres in Zaire. The indiscriminate 1999 attacks on civilians in Chechnya. These cannot be masked by terms like “Complex Humanitarian Emergency,” or “Internal Security Crisis.” Or by any other such euphemism – as though they are some random, politically undetermined event. Language is determinant. It frames the problem and defines response. It defines, too, rights, and therefore responsibilities. It defines whether a medical or humanitarian response is adequate. And it defines whether a political response is inadequate. No one calls a rape a complex gynecologic emergency. A rape is a rape, just as a genocide is a genocide. And both are a crime. For MSF, this is the humanitarian act: to seek to relieve suffering, to seek to restore autonomy, to witness to the truth of injustice and to insist on political responsibility.

The work that MSF chooses does not occur in a vacuum, but in a social order that both includes and excludes, that both affirms and denies, and that both protects and attacks. Our daily work is a struggle, and it is intensely medical, and it is intensely personal. MSF is not a formal institution, and with any luck at all, it never will be. It is a civil society organization, and today civil society has a new global role, a new informal legitimacy that is rooted in its action and in its support from public opinion. It is also rooted in the maturity of its intent, in for example the human rights, the environmental and the humanitarian movements, and of course, the movement for equitable trade. Conflict and violence are not the only subjects of concern. We, as members of civil society, will maintain our role and our power if we remain lucid in our intent and independence.

As civil society we exist relative to the state, to its institutions and its power. We also exist relative to other non-state actors such as the private sector. Ours is not to displace the responsibility of the state. The final responsibility of the state is to include, not exclude, to balance public interests over private interests and to ensure that a just social order exists. Ours is not to allow a humanitarian alibi to mask the state responsibility to ensure justice and security. And ours is not to be co-managers of misery with the state. If civil society identifies a problem, it is not theirs to provide a solution, but it is theirs to expect that states will translate this into concrete and just solutions. Only the state has the legitimacy and power to do this.

Today, in what is now a globalizing market economy, a

growing injustice confronts us. More than 90% of all death and suffering from infectious diseases occurs in the developing world. Some of the reasons that people die from diseases like AIDS, TB, sleeping sickness and other tropical diseases are that lifesaving essential medicines are either too expensive, are not available because they are not seen as financially viable, or because there is virtually no new research and development for priority tropical diseases. This market failure is our next challenge. The challenge, however, is not ours alone. It is also for governments, International Government Institutions, the Pharmaceutical Industry and other NGOs to confront this injustice. What we as a civil society movement demand is change, not charity.

We affirm the independence of the humanitarian from the political, but this is not to polarize the "good" NGO against "bad" governments, or the "virtue" of civil society against the "vice" of political power. Such a polemic is false and dangerous. As with slavery and welfare rights, history has shown that humanitarian preoccupations born in civil society have gained influence until they reach the political agenda. But these convergences should not mask the distinctions that exist between the political and the humanitarian. Humanitarian action takes place in the short term, for limited groups and for limited objectives. This is at the same time both its strength and its limitation. The political can only be conceived in the long term, which itself is the movement of societies. Humanitarian action is by definition universal. Humanitarian responsibility has no frontiers. Wherever in the world there is manifest distress, the humanitarian, by vocation, must respond. By contrast, the political knows borders, and where crisis occurs, political response will vary because historical relations, balance of power, and the interests of one or the other must be measured. The time and space of the humanitarian are not those of the political. These vary in opposing ways, and this is another way to locate the founding principles of humanitarian action: the refusal of all forms of problem solving through sacrifice of the weak and vulnerable – no victim can be intentionally discriminated against, or neglected to the advantage of another. One life today cannot be measured by its value tomorrow: and the relief of suffering "here" cannot legitimize the abandoning of relief "over there." The limitation of means naturally must mean the making of choice, but the context and the constraints of action do not alter the fundamentals of this humanitarian vision. It is a vision that, by definition, must ignore political choices.

Today there is a confusion and inherent ambiguity in the development of so-called "military-humanitarian operations." We must reaffirm with vigor and clarity the principle of an independent civilian humanitarianism. And we must criticize those interventions called "military-humanitarian." Humanitarian action exists only to preserve life, not to eliminate it. Our weapons are our transparency, the clarity of our intentions, as much as our medicines and our surgical instruments. Our weapons cannot be fighter jets and tanks, even if sometimes we think that their use may respond to a necessity. The humanitarian is not the military, and the military is not the humanitarian. We are not the same, we cannot be seen to be the same, and we cannot be made to be the same. Concretely, this is why we refused any funding from NATO member states for our work in Kosovo. And this is why we were critical then and are critical now of the humanitarian discourse of NATO. It is also why, on the ground, we can work side by side with the presence of armed forces, but certainly not under their authority.

The debate on the "Droit d'Ingérence" – the right of state

intervention for so called humanitarian purposes – is further evidence of this ambiguity. It seeks to put at the level of the humanitarian the political question of the abuse of power, and to seek a humanitarian legitimacy for a security action through military means. When one mixes the humanitarian with the need for public security, then one inevitably tars the humanitarian with the security brush. It must be recalled that the UN Charter obliges states to intervene sometimes by force to stop threats to international peace and security. There is no need, and indeed a danger, in using a humanitarian justification for this. In Helsinki this weekend governments will sit down to establish the makings of a European army, to be available for humanitarian purposes. We appeal to governments to go no further down this path of dangerous ambiguity. But we also encourage states to seek ways to enforce public security so that international humanitarian and human rights law can be respected.

Humanitarian action comes with limitations. It cannot be a substitute for definitive political action. In Rwanda, early in the genocide, MSF spoke out to demand that genocide be stopped by the use of force. And so did the Red Cross. It was, however, a cry that met with institutional paralysis, with acquiescence to self-interest, and with a denial of political responsibility to stop a crime that was "never again" to go unchallenged. The genocide was over before the UN Operation Turquoise was launched.

I would like for a moment to acknowledge among our invited guests Chantal Ndagijimana. She lost 40 members of her family in Rwanda's genocide. Today she is a part of our team in Brussels. She survived the genocide, but like a million others, her mother and father, brothers and sisters did not. And nor did many hundreds of our national staff. I was MSF's Head of Mission in Kigali during that time. No words can describe the sheer courage with which our Rwandan staff worked. No words can describe the horror that they died in. And no words can describe the deepest sorrow that I and all in MSF will carry always.

I remember what one of my patients said to me in Kigali: "Ummera, Ummerra-sha." It is a Rwandan saying that loosely translated means "courage, courage, my friend – find and let live your courage." It was said to me in Kigali at our hospital, by a woman who was not just attacked with a machete, but her entire body rationally and systematically mutilated. Her ears had been cut off. And her face had been so carefully disfigured, that a pattern was obvious in the slashes. There were hundreds of women, children and men brought to the hospital that day, so many that we had to lay them out on the street. And in many cases, we operated on them then and there, as the gutters around the hospital literally ran red with blood. She was one among many – living an inhuman and simply indescribable suffering. We could do little more for her at that moment than stop the bleeding with a few necessary sutures. We were completely overwhelmed, and she knew that there were so many others. She knew and I knew that there were so many others. She said to me in the clearest voice I have ever heard "allez, allez... ummera, ummera-sha" – "go, go... my friend; find and let live your courage."

There are limits to humanitarianism. No doctor can stop a genocide. No humanitarian can stop ethnic cleansing, just as no humanitarian can make war. And no humanitarian can make peace. These are political responsibilities, not humanitarian imperatives. Let me say this very clearly: the humanitarian act is the most apolitical of all acts, but if its actions and its morality are taken seriously, it has the most profound of political implications. And the fight against impunity is one of these implications.

This is exactly what has been affirmed with the creation of the international criminal courts for both the Former Yugoslavia and Rwanda. It is also what has been affirmed with the adoption of statutes for an International Criminal Court. These are significant steps. But today on the 50th anniversary of the Universal Declaration of Human Rights, the court does not yet exist, and the principles have only been ratified by three states in the last year. At this rate, it will take 20 years before the court comes into being. What are we waiting for? Whatever the political costs of creating justice within the community of states, MSF can and will testify that the human costs of impunity are impossible to bear.

Only states can impose respect for humanitarian law. And that effort cannot be purely symbolic. Srebrenica was apparently a safe haven in which we – as MSF – were present. The UN was also present. The UN said it would protect. It had Blue Helmets on the ground. And the UN stood silent and present – as the people of Srebrenica were massacred.

Given the deadly attempts of UN intervention in former Yugoslavia and Rwanda, which led to the death of thousands, MSF objects to the principles of military intervention which do not stipulate clear frameworks of responsibility and transparency to ensure security. MSF does not want military forces to show that they can put up refugee tents faster than NGOs. UN military operations should be at the service of governments and policies which seek to protect the rights of victims.

If UN military operations are to protect civilian populations in the future, they must go beyond the *mea culpa* excuses of the Secretary General over Srebrenica and Rwanda. There must be a reform of peacekeeping operations in the UN. Member States of the Security Council should be held publicly accountable for the decisions that they do or do not vote for. Their right to veto should be regulated. And Member States should be bound to ensure that adequate means are made available to implement the decisions they take.

Yes, humanitarian action has limits. It also has responsibility. It is not only about rules of right conduct and technical performance. It is at first an ethic framed in a morality. The moral intention of the humanitarian act must be confronted with its actual result. And it is here where any form of moral neutrality about what is good must be rejected. A negative result that must be rejected is the use of the humanitarian in 1985 to support forced migration in Ethiopia, or the use in 1996 of the humanitarian to support a genocidal regime in the refugee camps of Goma. Abstention is sometimes necessary so that the humanitarian is not used against a population in crisis.

More recently, in North Korea, we were the first independent humanitarian organization to gain access in 1995. However, we chose to leave in the fall of 1998. Why? Because we came to the conclusion that our assistance could not be given freely and independent of political influence from the state authorities. We found that the most vulnerable were likely to remain so, as food aid is used to support a system that in the first instance creates vulnerability and starvation among millions. Our humanitarian action must be given independently, with a freedom to assess, to deliver and to monitor assistance so that the most vulnerable are assisted first. Aid must not mask the causes of suffering. And it cannot be simply an internal or foreign policy tool that creates rather than counters human suffering. If this is the case, we must confront the dilemma and consider abstention as the least of bad options. As MSF, we constantly call into question the limits and ambiguities of humanitarian action – particularly when it submits in silence to the interests of states and armed forces.

Last week, the United States Congress passed a bill authorizing direct food transfers to the rebels in South Sudan. This is a misappropriation of the meaning and intent of humanitarian assistance. It makes food a fuel of war. And it is a dereliction of a state's duty to use any and all political means to address a 17-year-long civil war that has left millions dead. Sudan's civil war today is a human misery where millions are displaced and at risk of starvation and disease; where people are bombed, robbed, looted constantly, and even enslaved, while corporate oil interests are protected; where humanitarian space is so severely restricted that it exists only in pockets; and where we and other NGOs and UN agencies struggle to bring humanitarian assistance and protection. Is food to fuel this war the only political option? Food aid or humanitarian assistance – if it is to be "humanitarian assistance" – cannot be a tool in statecraft. In this case we must denounce this kind of perfidious use of food that confuses the meaning of humanitarian assistance. If the political masks itself in one ambulance, then it is certain that the other ambulance will also be fired on. As well, if food is allowed to be used as a weapon of war then it also legitimates that populations can be starved as a weapon of war.

Independent humanitarianism is a daily struggle to assist and protect. In the vast majority of our projects it is played out away from the media spotlight, and away from the attention of the politically powerful. It is lived most deeply, most intimately in the daily grind of forgotten war and forgotten crisis. Numerous peoples of Africa literally agonize in a continent rich in natural resources and culture. Hundreds of thousands of our contemporaries are forced to leave their lands and their family to search for work, food, to educate their children and to stay alive. Men and women risk their lives to embark on clandestine journeys only to end up in a hellish immigration detention center, or barely surviving on the periphery of our so-called civilized world.

Our volunteers and staff live and work among people whose dignity is violated every day. These volunteers choose freely to use their liberty to make the world a more bearable place. Despite grand debates on world order, the act of humanitarianism comes down to one thing: individual human beings reaching out to those others who find themselves in the most difficult circumstances. And they reach out one bandage at a time, one suture at a time, one vaccination at a time. And for Médecins Sans Frontières, working in more than 80 countries, over 20 of which are in conflict, this also means telling the world of the injustice that they have seen. All this, in the hope that the cycles of violence and destruction will not continue endlessly.

As we accept this extraordinary honor, we want again to thank the Nobel Committee for its affirmation of the right to humanitarian assistance around the globe; for its affirmation of the road MSF has chosen to take, which is to exist in an ethic of refusal, to remain outspoken and to remain committed to its core principles of volunteerism, impartiality and its belief that every person must be recognized in his or her humanity. It is the volunteers and national staff who struggle each day to make these ideals a concrete reality, who have brought at least some small place of peace to those who have experienced immense suffering, and who are the living reality of MSF. Again, thank you.

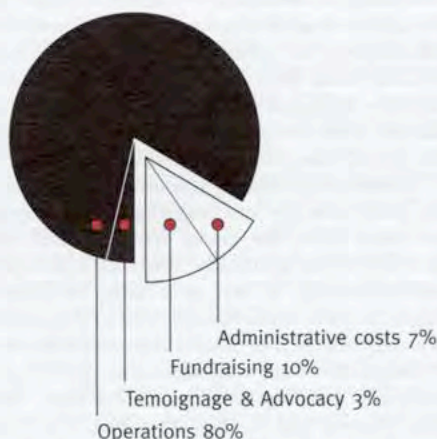
Facts and Figures

Médecins Sans Frontières is a private, nonprofit, international organization. It is made up of 18 national sections in Australia, Austria, Belgium, Canada, Denmark, France, Germany, Holland, Hong Kong, Italy, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland, the United Kingdom and the United States, and by an international office in Brussels. Each section of MSF

publishes annual, audited financial statements according to its national legislation and auditing rules. On the basis of these national statements, the figures hereby presented provide an estimate of MSF's finances on an international level. The combined figures have not been audited. The figures are for the 1999 calendar year; the Activity Report itself covers the period July 1999 through June 2000.

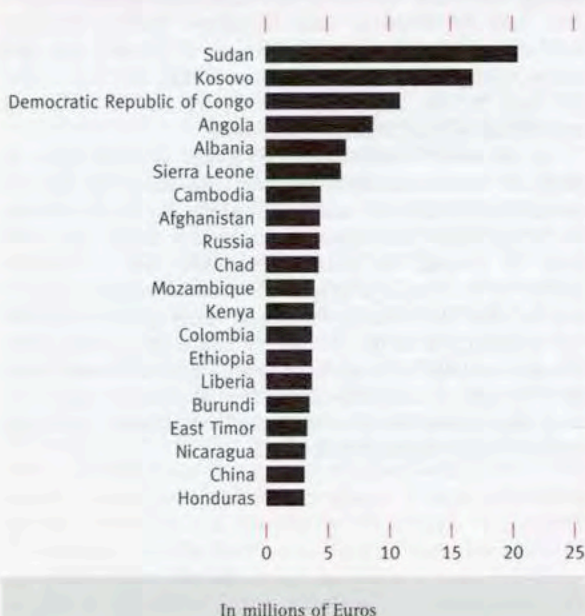
How was the money spent?

Total expenditure:
273 million Euros



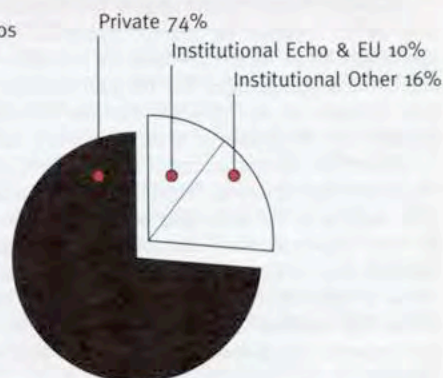
MSF's mission is to provide humanitarian assistance to populations in danger and to increase public awareness of the plight of these populations. In 1999, 83% of our expenses were directly devoted to this "social mission."

Where was the money spent?



Income

Total income:
305 million Euros

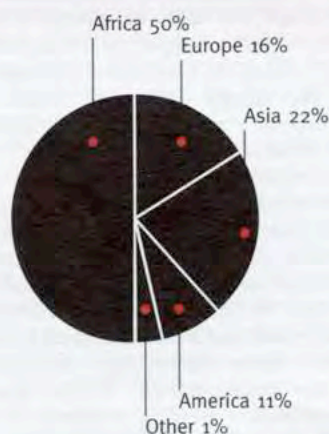


As part of our effort to guarantee our independence and strengthen our link with society, we have been striving to increase our level of private income. Thanks mainly to the support of millions of individuals, but also to the support of foundations and corporations, 74% of our income in 1999 came from private sources, as opposed to 58% in 1998.

After ECHO* and other European Union funding agencies (which make up 10% of our total income), our other main institutional funding sources include the Belgian, Dutch, Norwegian, Canadian, Swedish, UK, and US government funding agencies, the United Nations, and others.

*European Community Humanitarian Office

Project expenses per continent



Aid workers in the field in 1999

International departures: 3,090

Doctors and specialists: 24%

Nurses and other paramedical staff: 31%

Non-medical staff: 45%

Fieldposts: 1,485

National staff: 9,570

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PR = President
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AFRICA

EUROPE AND THE MIDDLE EAST

THE CAUCASUS, ASIA AND CENTRAL ASIA

THE AMERICAS





MSF MISSIONS THROUGHOUT THE WORLD / JULY 1999 - JUNE 2000

