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Médecins Sans Frontières (MSF) was founded in 1971 by a small group of doctors and journalists who believed that all people have a right to emergency relief. MSF was one of the first nongovernmental organizations to provide both urgently needed medical assistance and to publicly bear witness to the plight of the people it helps. Today MSF is an international medical humanitarian movement with branch offices in 18 countries. In 2003, MSF volunteer doctors, nurses, other medical professionals, logistical experts, water-and-sanitation engineers, and administrators departed on more than 3,400 missions and joined more than 16,000 locally hired staff to provide medical aid in nearly 80 countries. MSF was awarded the 1999 Nobel Peace Prize.

MSF Activity Report

2003/04

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The Médecins Sans Frontières Charter

Médecins Sans Frontières is a private international association.

The association is made up mainly of doctors and health sector workers and is also open to all other professions which might help in achieving its aims.

All of its members agree to honor the following principles:

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

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

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

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

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COVER PHOTO An MSF nurse holds a three-year-old girl on her knee while her assistant helps a mother feed her child at the feeding center in the Iridimi refugee camp in Chad, near the border with the Dafur region of Sudan. When the little girl first arrived in the camp, she was severely malnourished, now she has gained weight and will soon be able to leave the therapeutic feeding center's daily program.
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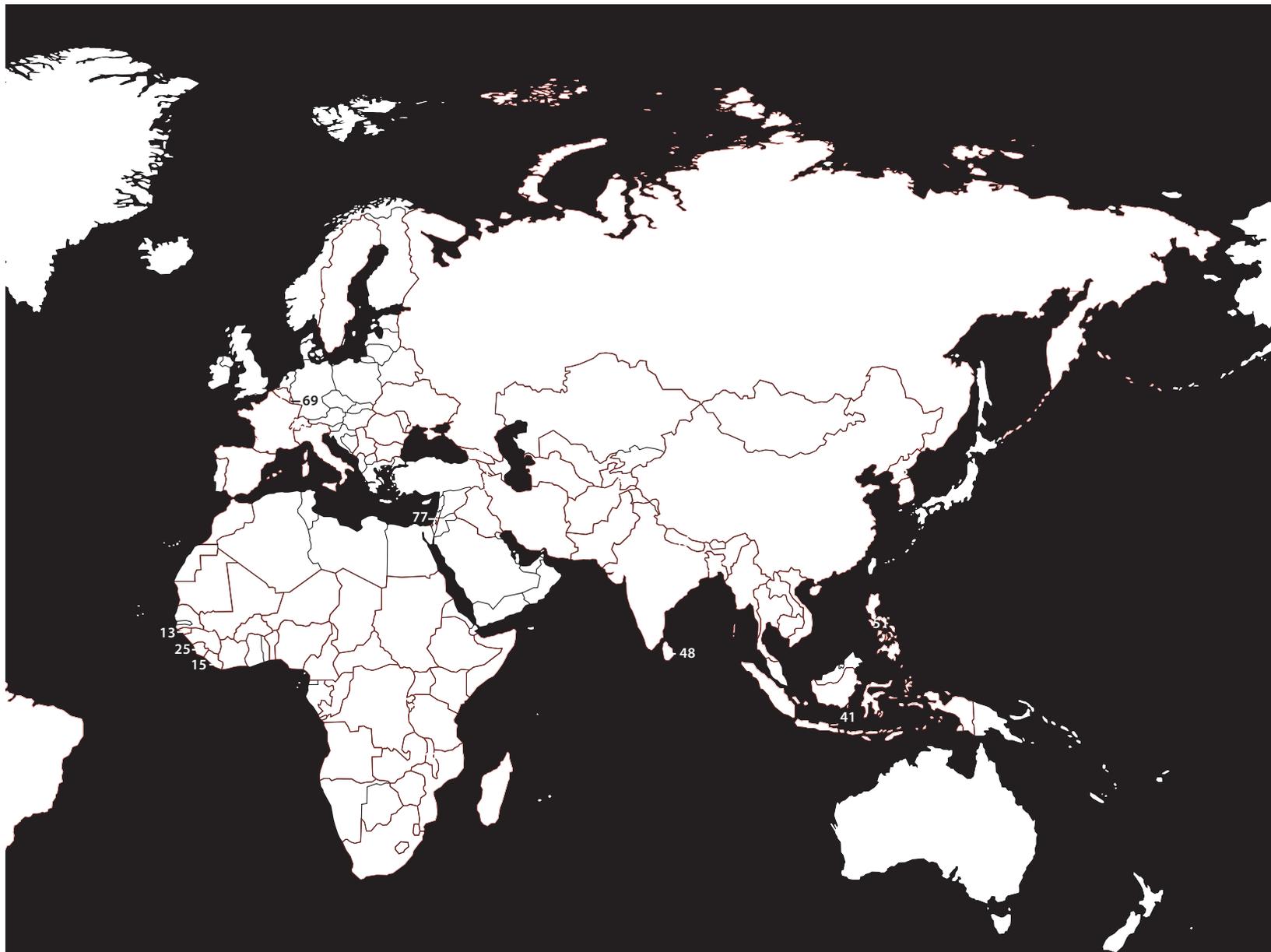
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The Year in Review

Karima, an elderly woman by Sudanese standards, sat in the rain outside an MSF clinic in western Darfur, Sudan, when MSF staff first saw her. She was sitting, exhausted, in the mud and her legs were covered with her own excrement, suffering from diarrhea and subsequent dehydration. The clinic was closed. Together, with the help of a Sudanese nurse, MSF medical volunteers took her to the nearby hospital, washed and fed her, and found a relative to look after her. She stayed at the hospital for only one night, became rehydrated and left for her own shelter the next day.

Karima's desperate situation was not unique. Millions around the world face the same suffering and feeling of abandonment. Yet she reflects the foundation on which MSF's work is based, every day, in hundreds of projects around the world. Each patient is an individual deserving care simply because they have none and need it. Every individual deserves assistance that helps restore personal dignity. Our work, whatever the context, can be simplified into thousands of these individual interactions taking place between MSF care givers and our patients. Our aim is clear. Assist those who need medical help now.

The past twelve months have been turbulent by any standard. The tragedy in Darfur, Sudan unraveled before our eyes, growing worse as the months went by. Extreme violence against civilians led to a massive displacement of more than a million people. Access to this whole population was denied and then restricted for months, with only occasional but ineffective protests from the international community as their condition deteriorated. The scant attention given to the crisis until recently was due partially to a desire not to upset the North-South Sudan peace process – effectively sacrificing a group of the country's civilians for future stability. At the time of this writing, although the humanitarian response to the crisis has improved dramatically, the presence of food and medical aid has done little to end the fear and abuse that haunt the people of Darfur.

While Darfur finally started receiving public attention by mid-2004, many other crises causing immense human suffering remained hidden from view, rarely mentioned in headlines. The forgotten war taking place in the Democratic Republic of the Congo continued to claim lives, both directly through violence and more insidiously because of displacement and disease. Increasing violence in Uganda also sent thousands on the run, but made little

impact on the outside world. MSF's independence makes it possible for us to go to these "neglected" crisis zones and help those who have been forgotten. While we cannot provide assistance to all of those who need it, our presence in nearly 80 countries provides aid for many of the most vulnerable and allows us to speak out on what we witness there.

Neutrality under attack

The murders of our five colleagues in Afghanistan's Badghis province on 2 June 2004 were a shock to the movement and to the world. The tragedy highlighted both the dedication of our national staff and volunteers and the increasingly difficult and dangerous environment in which they work. The decision to withdraw from Afghanistan was a tragic consequence of MSF becoming a target. While MSF feels a great sense of frustration and sadness at diminishing aid to people who need it desperately, there are limits to the risks the organization can accept.

The targeting of humanitarian aid workers for political gain is, unfortunately, not a new phenomenon. However, the current "war on terror" in all of its guises makes maintaining our neutral and independent position an ongoing struggle we cannot afford to lose. Within this report you will find an essay that explores the emergence of "military humanitarianism" and what it may mean for MSF and its work.

Although the entire MSF movement was relieved when volunteer Arjan Erkel was released in April 2004 after 20 months in captivity, the North Caucasus' insecurity remains a daily reality for the people of the region. Effective assistance is severely curtailed through an atmosphere of violence and intimidation, compounded by the impunity shown for attacks on humanitarian workers. The difficulties we face pale in comparison to the daily suffering of the people we try to help. Humanitarians will always be needed who will seek out and assist people in crisis, whatever the political framework of the day, regardless of the obstacles placed between them and the populations they seek to help. The ongoing struggle to reach those who most need assistance and the challenges involved in getting help to them are also discussed in this report's pages.

When people are "sacrificed"

Today there are plenty of crises and conflict zones requiring humanitarian assistance. While a few are caused by natural disasters



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or epidemics sparked by natural conditions, most are man-made. The need for humanitarian action usually arises when those in power refuse to uphold commitments they have made to protect those living within their borders or to shoulder responsibilities promised under national or international law. While action can be linked to cases of violent conflict, humanitarian action can also be called for when states allow the most vulnerable to be excluded from needed protection or care. The growing use of cost-recovery programs is an illustration of this type of problem. Related user fees require payment to obtain health care in many countries – a system that has proven exclusionary and dangerous for the most vulnerable groups. Today MSF is trying to eliminate all user fee requirements involving its own programs. Whether or not MSF should address this issue at the advocacy level is currently the subject of an internal debate within the movement. A piece in this report sets the groundwork for developing our position on it.

When civilians are not protected or are actively harmed by governments or other actors, it is the role of humanitarians first to respond to their needs but also to expose the conditions and lives of those who are sacrificed – and to remain in solidarity with these people. Such situations not only occur in Africa, Asia and Latin America. Civilians escaping from Darfur and other crisis zones have been met with harsh treatment in Europe when they tried to gain political asylum or immigrate. An article included here describes the dismal welcome awaiting many immigrants when they arrive on Europe's beaches and what MSF is doing to help them.

Urging expanded treatment

Humanitarian action is called for in silent wars as well. The death toll caused by treatable infectious diseases such as HIV/AIDS, malaria and tuberculosis (TB) remains staggering, especially in the poorest countries. During the past few years there has been a paradigm shift in the “accepted” thinking on infectious diseases. Patient treatment is becoming the focus as opposed to economic or public health mores. The World Health Organization (WHO) and many governments and donor agencies now agree with MSF that it is unethical to keep giving chloroquine to patients suffering from highly resistant strains of malaria. In the same way, it is no longer considered ethical to allow the 30 million people currently infected with HIV/AIDS to die due to lack of treatment. Before 2002, WHO and donor governments used what could be called a “public health”

approach on HIV/AIDS treatment in poor countries. They believed it was too difficult and expensive to treat people with HIV/AIDS using antiretroviral (ARV) drugs, so the focus was placed on prevention programs – essentially sentencing millions to an early death.

Civil society action during the last three years has caused the prices of ARV medications to plummet. The WHO and the US government have professed desires to treat millions of HIV-positive people and close to 500,000 people in developing countries are now getting treatment. This change is no doubt a success, but the struggle is far from over. Major obstacles are keeping effective treatment out of reach for many who need it, as another article in this report explains. Other diseases, such as TB, have not received the same strong political push to improve and expand treatment. An essay included here describes how current TB diagnostic tools and treatment fail many hard-to-treat patients, often the kind we see in our own programs, because their care is considered too difficult to provide. The Campaign for Access to Essential Medicines, which has had so much success with reducing the price of HIV/AIDS drugs, is now advocating for an urgent global approach to the lack of research and development on TB.

Whether we are working directly with patients like Karima or advocating for policy change on their behalf, principles are essential to MSF's work. Impartiality allows us to assess who are the most vulnerable, the most excluded, so that we can make practical and ethical decisions about our interventions and actions. Independence and neutrality are tools we use to enable us to gain access to these people and create the trust essential to help those who have been betrayed, attacked or neglected by others. These principles also allow us to speak out on what our teams witness in the field, perhaps helping to bring about change, but certainly raising the question, is such suffering necessary? In the end, however, our goal is simple: to treat other humans with respect when they are at their most vulnerable and to do so in a pragmatic and palpable manner.

Rowan Gillies, M.D., President, MSF International Council
Marine Buissonnière, MSF Secretary-General

In Memoriam

On 2 June 2004, five MSF colleagues were brutally murdered on a lonely strip of road between Khairkhana and Qala-i-Naw in Afghanistan's Badghis province. In this single violent episode, MSF lost five volunteers and staff members:

project coordinator **Hélène de Beir**

logistician **Pim Kwint**

physician **Egil Tynaes**

translator **Fasil Ahmad**

and **Besmillah**, the team's driver.

We mourn the deaths of all of these individuals committed to carrying out MSF's work and our deepest sympathies and support go to their families.

The murder of five of our colleagues is an unprecedented tragedy for MSF. We have never faced a loss of such magnitude in the more than three decades we have spent working in some of the world's worst conflicts.

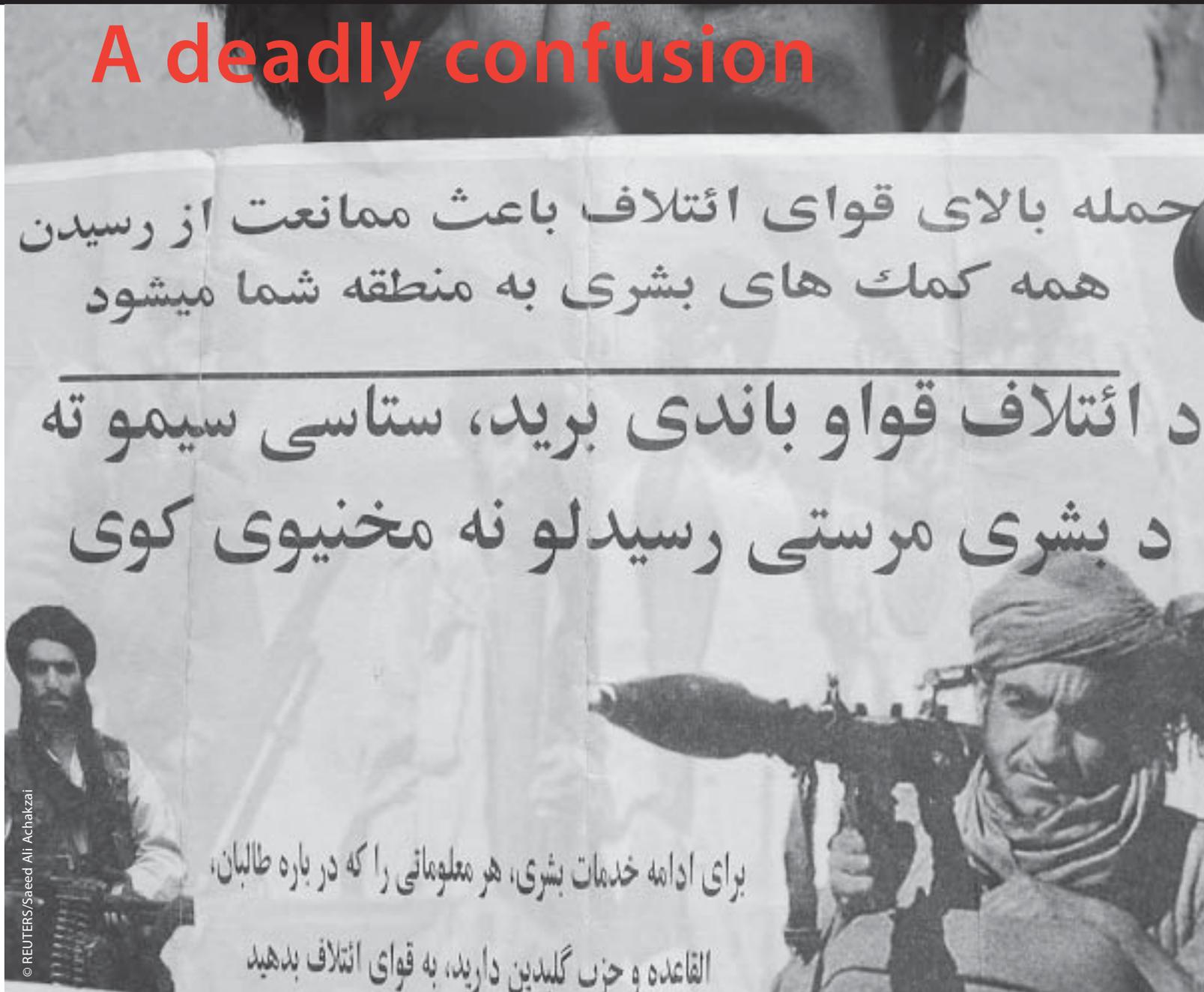
MSF seeks to assist civilians affected by conflict or struck by disaster. MSF honors the separation of aid from political motives as a founding principle. The sole aim of the organization is to provide assistance to populations in distress in the name of medical ethics and based only on their needs.

Despite the tragic loss of these dedicated staff members, MSF will continue to provide help for those most in need in countries around the world. It will also continue to speak out strongly on the plight of populations and against the violence now being targeted at humanitarian aid workers.



Military humanitarianism:

A deadly confusion



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A man holds a sign calling on local residents to help US soldiers find members of Al-Qaeda and the Taliban or risk losing humanitarian aid provided by the coalition.

On 11 June 2004, nine days after five MSF staff members were killed in Afghanistan, a Taliban spokesperson offered the following justification for their murder: "Organizations like Médecins Sans Frontières work for American interests and are therefore targets for us." As horrific as the crime is that this accusation seeks to legitimize, the statement itself is hardly surprising given the confusion that currently characterizes the symbol of humanitarianism.

Getting access to the battlefield from belligerents in order to provide impartial aid to non-combatants is a difficult and dangerous undertaking. Field armies are not comfortable with the presence of foreign actors, who are often suspected of serving the enemy's interests. Under these conditions, the safety of international aid workers, and their room to maneuver, is tied closely to the credibility of the humanitarian symbol under which they operate. That symbol says, "We refuse to take sides in this war. Our only goal is to provide aid to its victims." When all is said and done, the only protection humanitarian actors have is the clarity of their image. It must reflect their position as outsiders to the conflict and the transparency of their intentions. Both coalition forces and the majority of aid actors have seriously abused this image in Afghanistan, thus perpetuating a deadly confusion between humanitarian organizations and political-military institutions.

“We should remember the obvious: international aid workers have no enemies.”

Camouflage and cooperation

In Afghanistan, the first aspect of this confusion was caused by camouflaging psychological warfare and intelligence operations as humanitarian action. Clear-cut examples include the coalition’s “humanitarian” food drops during the first aerial strikes in 2001, its deployment of special forces in civilian dress who claim to be on a “humanitarian mission,” and threatening to suspend humanitarian aid to populations in southern Afghanistan if they refuse to provide information about the Taliban and Al-Qaeda. Winning the hearts and minds of civilian populations and encouraging them to cooperate with military forces are classic and legal military techniques according to the Geneva Conventions. On the other hand, presenting a combat tactic as a humanitarian operation blatantly violates the humanitarian symbol, just as using a Red Cross vehicle to transport weapons clandestinely alongside a patient would be.

After the defeat of the Taliban, many institutional donors required NGOs and UN agencies to help stabilize and rebuild Afghanistan. The vast majority of humanitarian actors placed themselves at the service of the UN Assistance Mission in Afghanistan (UNAMA) and of the interim government. Both of these actors receive varying degrees of support from coalition forces. NGOs and UN agencies thus abandoned the independence essential to providing independent aid and modeled their priorities on those of the new regime and its Western allies, who were still at war with the Taliban. This scenario constitutes the second element of confusion: making it impossible to distinguish between a subcontractor working on behalf of a warring party and an independent, impartial humanitarian aid actor.

Finally, the use of humanitarian rhetoric to justify going to war is another confusing element. Beyond retaliation for the 11 September attacks, the defense of human rights and international humanitarian law were presented as forceful arguments in favor of armed intervention in Afghanistan. The world was told that force and occupation were required to save an exhausted population from famine, to improve women’s access to medical care and to ease refugees’ return, among other goals. This



martial and imperial use of humanitarian rhetoric contributed significantly to blurring the image of aid organizations. If an appeal to humanitarian considerations can justify both a medical aid operation and a military campaign, doesn’t that suggest that aid workers and international troops represent two sides of the same coin? Aid actors do not, of course, have a monopoly on the words they use. However, using the semantic and legal terms that aid workers rely on for military ends obscures the image of humanitarian organizations, making it difficult to determine whether those organizations are outsiders to the conflict or the vanguard of expeditionary troops of new “just wars”.

War as a continuation of aid

It would be wrong to hold governments alone responsible for the confusion surrounding the humanitarian symbol today, as many aid actors are also confusing the situation. A liberal, universalist strain within the charitable aid movement and among human rights defense groups holds

“Armed interventions intended to assist and protect civilian populations put aid workers’ safety at risk from the moment they are deployed under the humanitarian banner.”

that war can be the continuation of humanitarian aid by other means. In the belief that the worldwide export of market democracy is the highest philanthropic calling, this movement considers any action to be “humanitarian” if it contributes to achieving that mission. Such actions include assisting and protecting “good victims” (those whose survival does not threaten the project’s success), imposing economic sanctions, dropping bombs, and invading and occupying nations “guilty of massive violations of human rights”. Consequently, organizations that take this



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“The clarity of the humanitarian symbol may not guarantee absolute security but it is, nonetheless, an essential precondition.”

mind, it is no surprise that the Taliban could believe that we “work for American interests”. More than 30 Afghan humanitarian aid workers and 9 international volunteers have been killed in recent months by forces hostile to the coalition, leading to a significant reduction in aid activities and to MSF’s withdrawal from Afghanistan after 24 years.

Let us be clear, however, that the murders of our colleagues cannot be reduced to “a terrible misunderstanding”. Forces hostile to the interim government and to the coalition intend to conduct a total war, one that accepts no compromise with the adversary, including the saving of lives as part of independent and impartial aid operations. We are not so idealistic as to think that a clear understanding of our action principles would be enough to dissuade anyone from attacking us. However, the confusion between occupation forces and humanitarian organizations undoubtedly has encouraged acts of violence against aid agencies. The clarity of the humanitarian symbol may not guarantee absolute security but it is, nonetheless, an essential precondition.

Aid workers’ safety at risk

The blurring of the humanitarian symbol and its disastrous consequences for team safety and aid activities are not limited to the Afghan theater. They may be found in most places where international forces are deployed. Those include, of course, Iraq, where many perceive – even more so than in Afghanistan – aid actors as mere auxiliaries to occupation forces. They have been targeted for bloody attacks to such an extent that there is little room for humanitarian action in Iraq. This is also the case in countries like Liberia, where the humanitarian symbol encompasses UN peacekeeping operations, including combat actions and influences operations against groups hostile to the peace process. Those groups then consider anyone who claims to be a humanitarian as a potential enemy. Whatever their legitimacy, armed interventions intended to assist and protect civilian populations put aid workers’ safety at risk from the moment they are deployed under the humanitarian banner. If a protection operation is to be serious, it necessarily involves the use of force against the enemy

“The safety of international aid workers, and their room to maneuver, is tied closely to the credibility of the humanitarian symbol under which they operate.”

and, creates a risk of non-combatant victims. How can a humanitarian organization provide aid to victims if it is equated with the “humanitarian” protection force doing the fighting? This is the danger that threatens aid organizations in Sudan today. By brandishing the threat of armed intervention in Darfur in the name of humanitarianism, the Security Council and certain Western nations are including humanitarian actors in their camp. In so doing, they are designating those actors as enemies in the eyes of Khartoum’s authorities.

We should remember the obvious: international aid workers have no enemies. The Revolutionary United Front in Sierra Leone, UNITA in Angola and the Taliban in Afghanistan are not their enemies. Neither are the Sudanese pro-government militias. These armed groups are parties to a conflict, just like a potential international intervention force. If the latter claims a humanitarian role – or worse, if it appeals to aid organizations to provide military intelligence – then humanitarian organizations’ position as outsiders to the conflict is discredited. How long until an aid worker in Sudan is killed because he or she “works for the interests of the intervention force”?

It may be good for the UN or Western powers to intervene in Sudan to assist and protect civilians in Darfur. However, that is not a question for aid actors to decide. But conducting a “just war” in the name, and with the participation, of humanitarian organizations poses a deadly threat to aid organizations and the people they assist. After the Iraqi and Afghan populations, will the Sudanese people on the wrong side of the front line become the newest victims, abandoned by humanitarian organizations forced to evacuate the country after their symbol has been militarized?

position have no objection to supporting “just wars” and serving the governments that pursue them. From this perspective, the term “humanitarian action” is only a euphemism for a colonizing mission that imposes, by force, institutions whose every feature is supposed to embody a value system believed to be universal. This interpretation has terrible ramifications for aid workers who display that same humanitarian symbol to conduct their aid missions.

Weakening the meaning of humanitarian language has had the effects we feared it would. On the Afghan political scene, international aid actors are perceived as back-up troops to the Western intervention forces – if not to the Crusaders. How can aid groups make a convincing claim that they are outsiders to the conflict when the symbol they display is used to justify an armed offensive and, subsequently, an occupation? And when it is used to consolidate the institutions of one party to the conflict and to provide cover for psychological operations? With this in

BY KENNY GLUCK, MSF DIRECTOR OF OPERATIONS,
AMSTERDAM

The struggle to reach people in need



The decision to withdraw from Afghanistan following the killings of five of our colleagues was sad and painful because it represented a rupture in a quarter century of commitment and engagement with victims of this crisis. It was jarring to lose the ability to provide health care in

a spirit of human solidarity in a place which has absorbed so much passion and dedication in the history of MSF. We are forced to ask if this foreshadows the loss everywhere – the beginning of our irrelevance as humanitarians and as a movement.

The murders in Afghanistan highlight the fundamental vulnerability of our work and remind us of the frailty of the humanitarian position. Our allegiance to a humanitarian ideal demands that we go unarmed into areas of crisis to provide assistance where it is most needed. We are not willing to turn into an armed agency of medical providers. We believe that going unarmed into an area of conflict, trying to save lives, trying to alleviate suffering, is a reaffirmation of human dignity.

The only protection we carry is hope, sometimes a naïve one – that we will be recognized as people outside of the framework of violence and therefore will not be seen as a legitimate target for it. When we talk with faction leaders about gaining access to victims and respect for the safety of aid workers, our key arguments are the content of our aid and our humanitarian identity, that is, our independence from political and military forces and agendas. However, during the last ten years, many governments have sought to rob us of this identity and undermine our argument.

More importantly, most other United Nations and private aid agencies seem to have given up on the very idea of a limited humanitarian mandate. Today even UN relief agencies uphold the notion that their assistance has to be coherent with their political strategies.

Many NGOs explicitly mix the promotion of democracy and human rights with their humanitarian agenda. In Iraq, NGOs sought to use humanitarian arguments to advance their political positions against the United States invasion of Iraq. In Afghanistan, many of the larger NGOs even called for NATO deployment throughout the country in order to improve the security situation. The promotion of a partisan military advance is a clear breach of the humanitarian ethic of neutrality. These groups freely depart from humanitarian principles but still seek to be covered by protections associated with humanitarian action. Sharing the same institutional form, their rejection of humanitarian principles erodes the protections for all and undermines the entire field of humanitarian aid.

“The survival of those abused and neglected in crisis often holds little interest for the powerful.”



Living conditions in Chechnya are inhuman after years of war and destruction. Residents are terrorized by soldiers in a daily and structural way and disappearances and executions are common.

When aid is blocked

In many countries where we work our access to populations in crisis continues to be threatened in other ways. We have seen it in Darfur. Starting in the middle of 2003, villagers in Darfur, western Sudan, have faced a violent campaign of terror, in which their villages have been burned and their livelihoods destroyed. Thousands have died and hundreds of thousands more have been forced to flee across the border into Chad or into overcrowded, makeshift camps in Darfur itself where they have sought, but never found, safety in numbers. In addition to the massacres and campaign of rape which occurred during attacks, hundreds of thousands of displaced people soon started a slow slide into malnutrition and death. In spite of the enormity of the abuse and urgent needs, it would take months before MSF could mount interventions of any scale. Although we had small teams on the ground back in November 2003, the large-scale intervention demanded by the situation would not become a reality until April and May 2004. For months, the displaced lived in destitution and misery with little aid from MSF or anyone else. MSF watched with frustration as the Sudanese government blocked volunteers' visas and cargo shipments while we were torn between the desire

“Access to people in need has always been blocked and manipulated by those who control the violence against them.”

to denounce their delay tactics and the hope that we could still negotiate our way in. It was only months later that international pressure forced the government to lower the barriers, allowing MSF and other agencies to provide some of the massive amount of assistance required.

While such situations conjure up a feeling of frustration, it would be wrong to assume that this is a new phenomenon. Access to people in need has always been blocked and manipulated by those who control the violence against them. Humanitarians have had to continuously struggle to ensure that aid is provided in a way that allows dignity and does not get turned against the very victims we seek to assist. But to be honest, it is not difficult for governments or military forces to keep us out. The humanitarian aid worker is not a powerful negotiating partner. We come to the table with no force of arms. We offer practical assistance to those in need, but the survival of those abused and neglected in crisis often holds little interest for the powerful. In the negotiation for access, we offer little else but a clear and compelling position on caring for those in need.

There are other ways in which our ability to reach people in crisis is blocked. For many years, we have been unable to provide the levels of assistance in Somalia which the crisis demands. Ravaged by 15 years of war, massive levels of malnutrition periodically plague much of the country. Armed clashes between warring militias continue to leave hundreds or even thousands of wounded who receive little or no care. In spite of the clear needs, neither MSF nor other agencies has been able to negotiate safe and secure arrangements which allow us to work fully and openly in the country. The armed groups are too fractious and numerous to allow a stable negotiation of access. The blurred lines between humanitarian assistance and the international military takeover in the early 1990s as well as the UN's use of aid to advance its military strategy has crippled the respect which humanitarians could have enjoyed as neutral and independent caregivers.

In Chechnya, where civilians have endured a brutal bombing campaign and waves of oppression, MSF and other humanitarian aid groups have likewise been forced to reduce, if not completely stop, assistance. As in Somalia, MSF has found it impossible to negotiate a protected space to work amid the intertwined mix of criminal and military endeavors in the region. More insidiously, the Russian government and some Chechen rebel groups have tolerated and even encouraged attacks on humanitarian actors. After dozens of kidnappings, assassinations and other abuses, the powers that be do not need to construct administrative obstacles to bar our entry which we can publicize and denounce. We are no longer willing to take the risk of sending our volunteers there. We want our work to be a gesture of solidarity with those who suffer in crisis, but we do not want to martyr ourselves on the suffering of others.

It is simple for totalitarian regimes to keep out humanitarians. North Korea has, for years, denied any possibility for independent humanitarian action. MSF left the country when we saw that our



An MSF health worker discusses problems with a soldier in Angola.

“The murders in Afghanistan highlight the fundamental vulnerability of our work and remind us of the frailty of the humanitarian position.”

assistance was controlled by the government which would not allow us to reach those most in need or ensure that the aid was not diverted by those in power, contributing to further oppression of the most vulnerable. Denied access to the vast misery in the country, MSF has, for years only been able to provide limited assistance to the lucky few who manage to escape its borders. Knowing the suffering of millions inside the country, the denial of the ability to provide aid to all but these few refugees, who have risked forced repatriation, imprisonment and execution, should be a constant provocation to our conscience.

Overcoming suspicion in communities

As humanitarian workers, we always seek to negotiate our presence with the armed actors that rule an area. However, the degree of respect and understanding that we generate in the communities where we work is even more crucial. Our acceptance by aid recipients and their communities keeps us safe too. In some countries, a loss of acceptance and even the demonstration of mistrust or suspicion due to changes in global political contexts are a great threat to our relations with the communities we seek to serve. In a time of Western political and economic domination, many communities find it hard to imagine that our activities represent individual action with a separate set of ethics and objectives. Instead of health care and human solidarity, they fear that we bring unwanted Western influences or carry hidden motives. While we cannot force our help on those who do not want it, we also cannot passively abandon our ambition to ignore boundaries in our increasingly polarized world.

The struggle to reach populations living in crisis is not new. Providing care to those who are abused and neglected inevitably brings humanitarian aid workers into conflict with those who conduct this violence. This is a confrontation we should not avoid. The greater tragedy would be if our daily, hands-on work with individuals and communities fails to create an understanding and tolerance that overrides the fears and suspicions generated by an increasing global divide.

No cash, no care

MSF's confrontation with cost recovery



"I was very worried and I brought my little girl to the health center in my district in the south of Bujumbura. But the nurse wouldn't see us as I didn't have any money to pay for the consultation. So I had to take my girl back home without having received any care. Then I had no choice but to borrow 2,000 francs (about euro 2) from my neighbors for the consultation. I also bought a few medicines on the black market. Every day I pay back 150 of the 250 that I earn each day from carrying bags for people. I have 100 francs left to feed my family. It's not a lot."

– Simeon, an unemployed man who brought his three-year-old daughter suffering from second-degree burns to an MSF health clinic in Burundi

© Didier Lefevre

Simeon's situation is a common one. A recent MSF survey done in 2,700 households throughout rural Burundi revealed that almost one in five people did not receive medical care the last time they were ill. The main reason for that was a lack of money. While the cost of a basic consultation might not seem excessive: approximately two to three euros, the average Burundian has to work for 12 days to earn this amount. Although theoretically the poorest patients are exempt from paying, in reality, less than one percent actually does not have to pay. The survey also found no correlation between a payment exemption and extreme vulnerability. Among those who did attend a health clinic, the vast majority had to borrow money or sell some goods to pay the medical bill, feeding the vicious circle of illness and poverty.

In Burundi, this situation is the consequence of a government edict issued two years ago that led to the liberal use of user fees in primary health care. The introduction of cost recovery was not so much a new health policy, but rather the activation of part of the planned health sector reform that had remained dormant since the 1990s.

With civil conflict ending and peace negotiations progressing, the country's emergency phase seemed to be coming to an end and donors wanted to move from relief to development aid.

As a result, people who could not obtain medical assistance for years because of insecurity are now excluded from care because of their inability to pay for it. Currently Burundi is listed as one of the world's three poorest countries. About 99 percent of its population lives on less than US\$1 per day, and a staggering 85 to 90 percent lives on less than US\$1 per week. Nevertheless, if nothing changes, health care will remain available only to those who can afford it, keeping it out of reach for almost a million people.

User fees in the real world

Today, user fees are an increasing part of the environment in which MSF works. Due to failing state funding, user fees have become the cornerstone of public health care financing in many countries. Implemented without any effective solidarity measures, they are a barrier for the patient and a major constraint for MSF. In

many places, MSF has been pressured by governments to introduce user fees, even in complex emergencies. For example, in poverty-stricken southern Sudan, user fees were introduced in 2003 as part of a US-sponsored health program. Health centers supported by MSF were forced by authorities to ask patients for money in exchange for care. The result was immediate: attendance rates plummeted. In particular, women and children stopped coming to the centers for help.

Beyond emergency situations, people also need access to effective care. Poor people are particularly vulnerable and the major part of the disease burden is concentrated among the poor. In low-income countries, the poor do not constitute a fringe part of the population – poverty affects the vast majority of the people. The exclusion caused by user fees implies that it has become increasingly difficult to reach the poor through existing health services. Besides ethical considerations, this raises questions of accountability for any agency serious about reaching its beneficiaries. Moreover, out-of-pocket expenses for health care pose a serious risk for further impoverishment. Medical expenses cause

"My wife died a few months ago. Very probably from malaria because she had a lot of fever and was also vomiting. But she never went to a health center. Because of the lack of money. I don't even have enough to feed my two children so how could I have paid the price of a consultation? I thought that she would eventually get better. That didn't happen. After four months in that state, she finally died."

– Révérien, an unemployed Burundian man, living on the outskirts of Bujumbura

poverty. How can we accept the fact that poor people in poor countries are asked to pay a greater share out-of-pocket for health care than people in high-income countries?

While some countries are implementing cost recovery systems at a rapid rate, others are dismantling them to remove barriers to care. Recent examples from countries that are working to abolish user fees show spectacular increases in attendance rates. In South Africa, for example, use of curative services doubled when fees were no longer requested. In Uganda, consultations saw a 120 percent increase in the months after fees were stopped. And interestingly, more people took advantage of preventive care including vaccinations, although they were already free. MSF has experienced similar increases when user fees were stopped in the places its teams worked. During the recent crisis in Cote d'Ivoire, attendance rates rose significantly when consultations became free, leading to commentaries that the emergency situation was improving access to health care! A similar tendency was noticed by MSF in Liberia and Sierra Leone.

However, in most countries, our teams face a great deal of resistance to the idea of free medical care, even when MSF agrees to subsidize all of the involved costs. Often the ministry of health is reluctant to give permission for MSF to provide free care, as it relies on user fees to pay functioning costs in the absence of central funding. Free essential care means higher utilization rates, which is good news from a medical point of view, but which brings higher costs with it.

Taking a stand against user fees

Over the years, MSF teams have struggled with the user fee issue as MSF had to work within or around the existing system. In some projects, attempts were made to improve cost recovery systems, focusing on rationalizing care-seeking, moving to more effective waiver systems and making better use of collected revenues. Sometimes MSF teams saw user fees as a necessary condition to be able to operate within a country. However, based on disappointing experiences and serious self-critique, MSF is now strengthening its opposition to user fees. Humanitarian assistance, by definition,

helps the most vulnerable. That help should be organized in a way that makes it as accessible as possible. With that in mind, how can MSF participate in a system that accepts exclusion from essential health care for the sake of sustainability, efficiency or other benefits for part of the population?

In 2004, MSF decided that as a humanitarian association dedicated to assisting people in times of crisis and targeting the most vulnerable, we could no longer accept or allow exclusion within our projects. Currently, MSF is in the process of implementing a policy whereby the health care we provide is free at the point of delivery in conflict contexts. The crucial issue is that people in crisis should not be forced to choose between spending scarce resources on health care or going without it. In post-conflict or stable contexts as well, MSF's starting position will be that health care in our programs should be free at the point of delivery.

Changing our position is not easy or cheap. In many countries, MSF will have to challenge state or donor agency policies that result in the exclusion of the most vulnerable. Providing free care to patients will also imply that extra financial resources are necessary, not only to compensate the loss of income from the fees, but also to face the increased demand. MSF is committed to ensure free medical care for patients in its projects. But is this enough?

MSF's confrontation with macroeconomics

In a context of deficit health budgets and pressure from international agencies such as the International Monetary Fund and the World Bank to restrain public spending, health services are doomed to focus on making ends meet instead of responding to the needs of the ill.

Does it make sense for MSF to provide free health care to its own patients, without advocating for it for vulnerable populations we don't reach? Should MSF go further and advocate for a whole new health development paradigm? One that allows sufficient public health expenditure? Probably not. Does it make sense for MSF to advocate for more effective (but also more expensive) treatment regimes like artemisinin-based

combination therapy (ACT) for malaria patients or antiretrovirals (ARVs) for HIV-positive patients, without advocating for such a new health development paradigm? Probably not. On the other hand, is it our role to become involved in this highly political debate, where so many other actors are already trying to influence the policies of the international financial institutions? Can MSF make a difference?

It could be a logical step for MSF now to promote better access to health care. Through its success in lowering prices for essential drugs in poor nations, MSF's Campaign for Access to Essential Medicines has challenged the inevitability of poor people's exclusion from life-saving drugs. However, maintaining user fees and health budget ceilings will keep even these lowered prices out of reach for large numbers of patients.

Cost recovery policies need to be changed so that lives are not sacrificed for the sake of macroeconomic theory. MSF could play a significant role in showing donor agencies, policy makers and health care providers the true, cruel consequences of their choices. By challenging their declarations of good intent, MSF could insist on transforming existing policies so that they improve people's health and lives, instead of causing further suffering. At least the choice to sacrifice thousands of people should be recognized as such and publicly debated. MSF believes a person's needs should again be central to the provision of health care, not a person's ability to pay. In this way, refusing user fees in MSF's own projects could be a first but necessary step to promote a crucial policy change.

To read more about the consequences of cost recovery programs in Burundi, download MSF's April 2004 report "Access to health care in Burundi: Results of three epidemiological surveys" at: www.msf.org.



Darfur: A disaster unfolds

Since the summer of 2003, the people of western Sudan's Darfur region have endured a campaign of violence and terror which forced many to flee from their destroyed villages in search of safety. The wave of attacks against villages throughout Darfur came after clashes between government of Sudan forces and rebels earlier this year. What started for MSF as an exploratory mission in September 2003 to assess the condition of Sudanese refugees rumored to be flooding into eastern Chad grew into a massive relief effort involving thousands of staff in Sudan and Chad within a few months.

People from Darfur have told of the scorched earth policy carried out by so-called Janjaweed militias backed by the government of Sudan. The displaced have been attacked and chased from their homes. They describe their villages being bombarded by government forces only to be attacked, burned and emptied later by groups of Janjaweed fighters. Many were killed, others were raped. Water points and crops have been destroyed and food and livestock have been looted or ruined. By August 2004, the terror and destruction caused by this group had resulted in the forced displacement of more than one million people within the Darfur region. An additional 180,000 civilians were also forced to flee to neighboring Chad despite harsh conditions there.

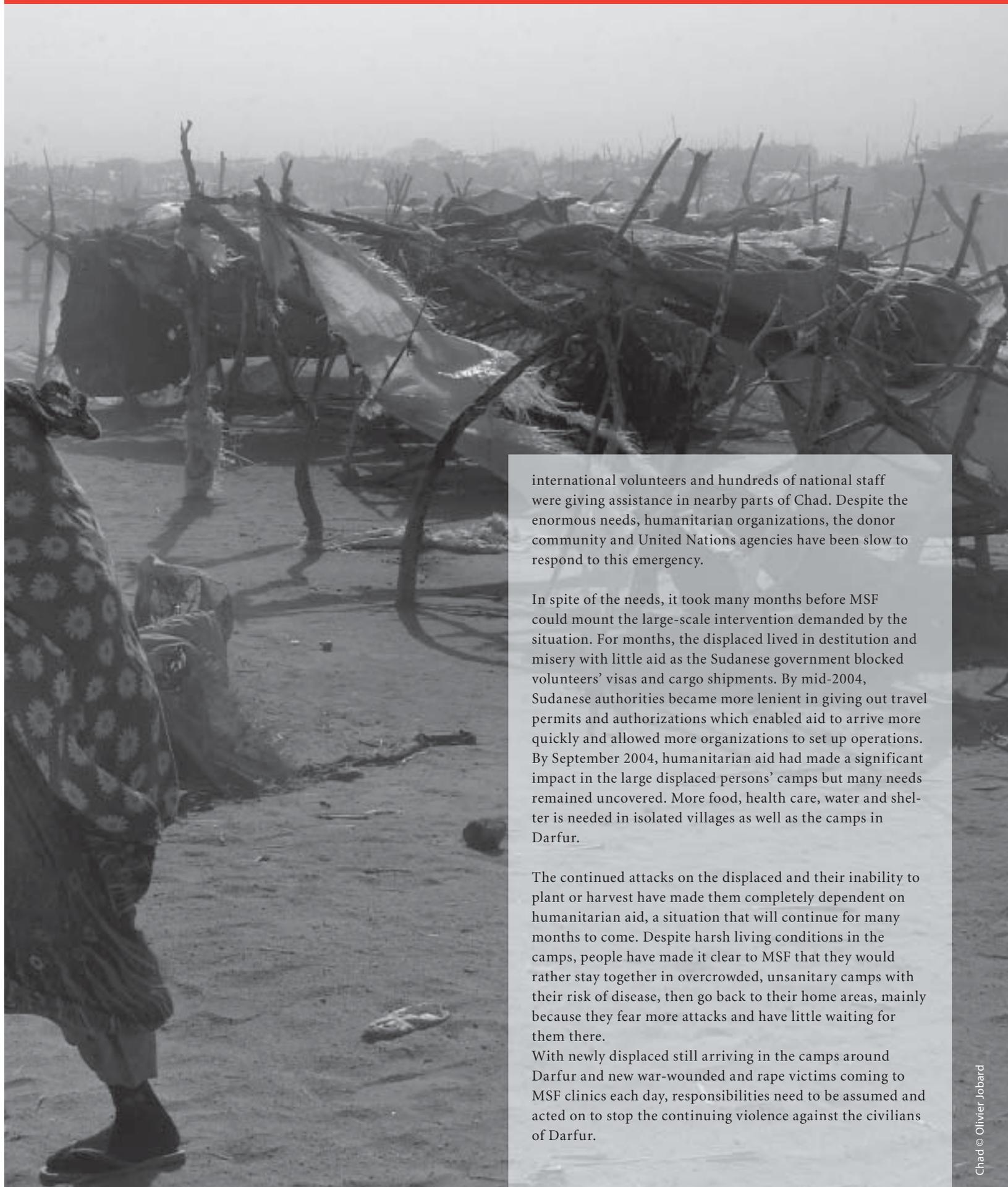
Life in makeshift shelters or displacement camps has bred its own suffering. The displaced have endured a nightmarish combination of violence, panicked flight, and deprivation, only to find more of the same in the place where they sought refuge. Sandstorms, extreme changes in temperatures and a lack of assistance have confronted those entering Chad. In Sudan, people who attempt to leave the camps, even to find firewood are often attacked or sexually assaulted. Overcrowding and insufficient access to health care have led to outbreaks of diarrheal diseases and measles. The rainy season, which began in late June and will continue until October, aggravates the health situation in the areas where people have gathered. Heavy rains promote the spread of malaria, and poor hygiene contributes to respiratory infections and diarrhea, which are the primary reasons people seek treatment at MSF's health facilities. Since June, an epidemic of hepatitis E has been rampant in Darfur and eastern Chad, proving particularly fatal for pregnant women.

In the face of this disaster, MSF launched one of its largest aid operations ever. By August 2004, approximately 200 international volunteers and 2,000 national staff members were providing health care and nutritional aid in more than 25 locations in north, west, and south Darfur. Another 35



“Our actions remain a drop in the ocean in comparison to the tremendous needs.”

– Ton Koene, Emergency Coordinator in an address before the United Nations Security Council, May 2004



international volunteers and hundreds of national staff were giving assistance in nearby parts of Chad. Despite the enormous needs, humanitarian organizations, the donor community and United Nations agencies have been slow to respond to this emergency.

In spite of the needs, it took many months before MSF could mount the large-scale intervention demanded by the situation. For months, the displaced lived in destitution and misery with little aid as the Sudanese government blocked volunteers' visas and cargo shipments. By mid-2004, Sudanese authorities became more lenient in giving out travel permits and authorizations which enabled aid to arrive more quickly and allowed more organizations to set up operations. By September 2004, humanitarian aid had made a significant impact in the large displaced persons' camps but many needs remained uncovered. More food, health care, water and shelter is needed in isolated villages as well as the camps in Darfur.

The continued attacks on the displaced and their inability to plant or harvest have made them completely dependent on humanitarian aid, a situation that will continue for many months to come. Despite harsh living conditions in the camps, people have made it clear to MSF that they would rather stay together in overcrowded, unsanitary camps with their risk of disease, then go back to their home areas, mainly because they fear more attacks and have little waiting for them there.

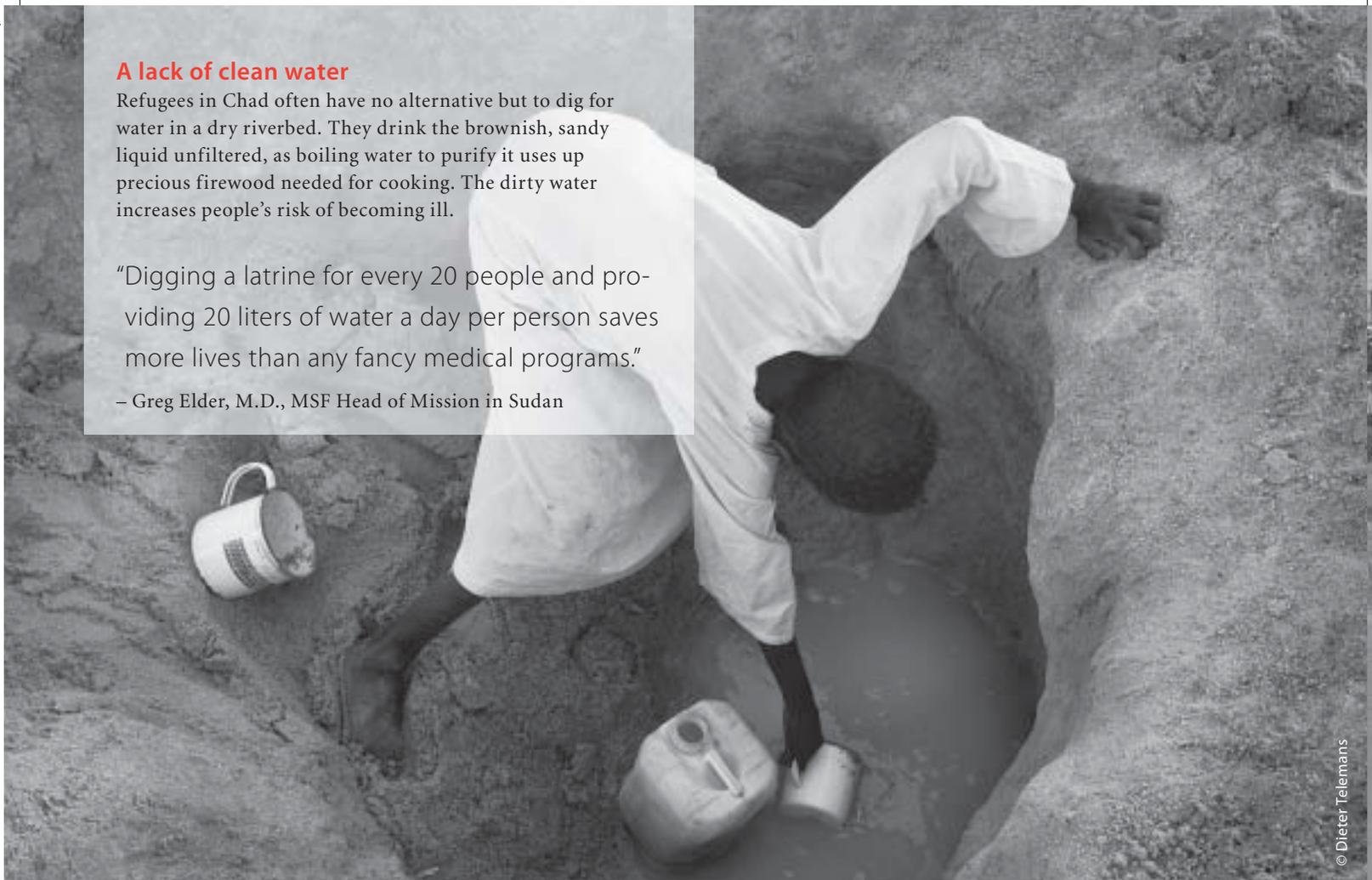
With newly displaced still arriving in the camps around Darfur and new war-wounded and rape victims coming to MSF clinics each day, responsibilities need to be assumed and acted on to stop the continuing violence against the civilians of Darfur.

A lack of clean water

Refugees in Chad often have no alternative but to dig for water in a dry riverbed. They drink the brownish, sandy liquid unfiltered, as boiling water to purify it uses up precious firewood needed for cooking. The dirty water increases people's risk of becoming ill.

"Digging a latrine for every 20 people and providing 20 liters of water a day per person saves more lives than any fancy medical programs."

– Greg Elder, M.D., MSF Head of Mission in Sudan



© Dieter Telemans

Fleeing to Chad

"In October we dug a hiding place in the earth to save us from attacks. Each time there was danger we threw ourselves into our refuge. We lived like this for three months until one day we met some inhabitants from the village of Adlkheir who were running away and they told us what was happening. We had no choice, we had to abandon everything and escape. We loaded the children and water onto our donkey and headed west. We walked at night so we wouldn't be seen."

– Alsadig, a 32-year-old male refugee who works in MSF's supplementary feeding center in Touloum, Chad.



Refugees struggle to raise a collapsed donkey after a 34-day march towards safety in Chad.

© Marcus Bleasdale/IPG

Rainy season

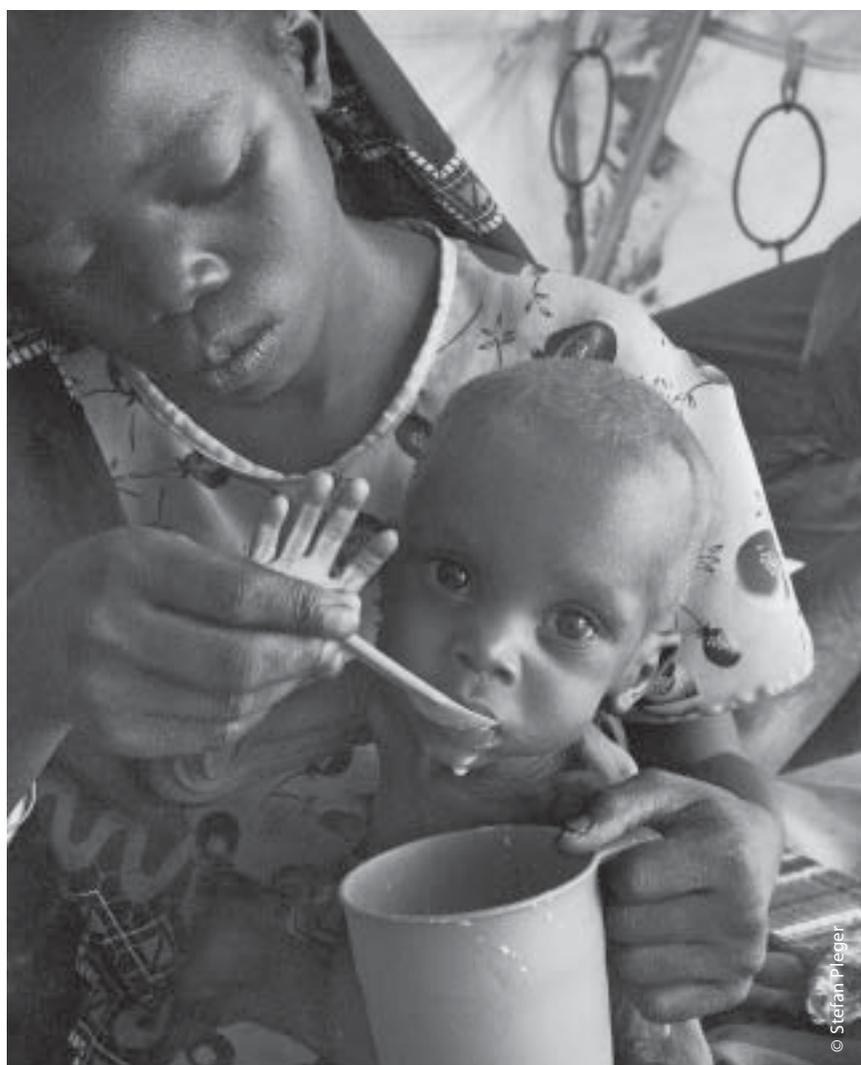
In late June, the rainy season began. In usual times the rains would be welcome for filling the dry riverbeds and watering freshly planted crops. This year, it is just one more hardship to endure. The rains exacerbate the severe health risks to people already weakened by violence and malnutrition. With only a few latrines and drastic shortages of water, many camps become ponds of stagnant sewage. Roads are impassable, further hampering already slow and irregular relief efforts.

“We have no beds and the water just rushed in. We had to stand up all night – me, my wife, my nine children.”

– Adam Abaka, 43-year-old refugee in Mornay camp, West Darfur



© Ton Koene



© Stefan Plegier

A young girl feeds her malnourished brother at MSF's therapeutic feeding center in Mornay, Sudan.

Malnutrition

According to nutrition studies conducted by MSF, there are dangerously high levels of malnutrition in some areas, especially among young children. MSF has distributed more than 300,000 survival rations in several places in western Darfur and the organization expects that an estimated 800,000 will be distributed by the end of 2004.

“I am shocked by the poor condition of some of the children. Some are definitely beyond saving – even with our intensive approach. The mothers clearly realize that there is no hope for their children.”

– John Heeneman, MSF Project Coordinator in Nyala, Darfur



Teenagers and children are routinely sent out from the camps to find drinking water and firewood for their families despite the ever-present risk of rape or assault while they travel outside camp borders.



MSF staff carry out a vaccination campaign in Guereda refugee camp on the Chad-Sudan border.

Insecurity

Violence and abuses continue to be perpetrated against the civilian population despite the international attention focused on Darfur. The people have become imprisoned in the places where they have gathered because they are surrounded by the same militias that attacked their villages and forced them to flee. Men cannot leave the camps for fear of being killed and women are often beaten or raped if they go outside the camps to search for food or firewood.

"It's unbelievable to see little 14 or 15-year-old girls on donkeys going over the hill with all their stuff for three days. They're sure to be beaten and raped, but they tell me, 'We don't have any choice.'"

– Jennifer Pahl, an MSF nurse working in the camps around El Genina Hospital in Darfur



An MSF team at Iriba Hospital in Chad examines a 12-year-old girl wounded by an explosive device she thought was a toy before it exploded.

MSF Projects
around the World
Africa



© Marcus Bleasdale/JPG

Refugees from the Darfur region of Sudan battle the elements during their journey to find safety in Chad.

Angola

Addressing a lack of care

Although Angola's long civil war has ended, the country's civilians still lack the care they need in many places. In some areas, MSF is the sole health care provider, with programs that assist those affected by a number of infectious diseases.

MSF malaria projects have demonstrated the success of artemisinin-based combination therapy (ACT), contributing to the government's decision to change the national treatment protocol to ACT by the first part of 2005. MSF is treating people with malaria at facilities in Caala. In February 2004, MSF responded to an outbreak of malaria in Matala, in Huila province, by treating more than 16,000 people. From January to May 2004, an MSF team ran a malaria-treatment center in Kuito, the capital of Bié province, which treated 4,594 children under the age of 13.

in collaboration with the Angolan Health Ministry, providing drugs and supplies, managing the laboratory and pharmacy and training staff. MSF is treating more than 600 patients in the province. In Huambo province, an MSF-built TB center in Caala was handed over to local authorities in August 2004.

MSF also provides care to many people living with HIV/AIDS. Since July 2003, the organization has provided HIV/AIDS training and education at three health care facilities and at a voluntary testing and counseling center in the town of Malanje. The project targets low-income women, returned refugees and sex workers. Activities include treatment for opportunistic infections and voluntary counseling and testing. Plans are under way to begin providing treatment with life-extending antiretroviral medications.



MSF also works with other vulnerable populations in Angola, including those living in camps for internally displaced persons and returning refugees. In April 2004, MSF spoke out about the treatment of illegal diamond miners expelled from Lunda Norte province. Some miners were held in areas without food, water or sanitation facilities for weeks, while

others were forced to walk 65 kilometers to the border of the Democratic Republic of the Congo without basic supplies.

In late 2003, MSF handed over activities at the provincial hospital in Kuito to local health authorities. In Saurimo, Lunda Sul province, MSF staff ended a project in November 2003 that had targeted displaced people. MSF completed basic health care projects in Bailundo, Huambo province, in December 2003 and in Luena, Moxico province, in March 2004.

MSF has worked in Angola since 1983.

As part of its work to improve the detection and treatment of sleeping sickness in Caxito, in Bengo province, MSF treated 817 patients and screened more than 45,000 people for this often deadly disease. In April 2004, MSF also began treating patients with sleeping sickness in Camabatela, in Kuanza Norte province. MSF carries out this work in collaboration with the Angolan Ministry of Health and other organizations.

In many parts of Angola, MSF teams treat patients with tuberculosis (TB) and strive to improve both diagnosis and treatment. In Bié province, MSF manages a TB center

Benin

Helping those with Buruli ulcer

Treating people who suffer from Buruli ulcer remains MSF's principal work in Benin. Buruli ulcer is a bacterial infection related to tuberculosis and leprosy. It causes skin swelling and suppresses the immune system. The infection destroys skin and bone tissue over a wide area of the body. To date, there is neither a medicinal treatment for the disease nor a vaccine to prevent it; surgery to relieve its effects is the only option.

In the town of Lalo, in Mono-Couffo department, MSF runs a treatment center to help those with this illness. The staff diagnose the disease, oversee surgery and help rehabilitate people disabled by it. MSF also teaches local health professionals about diagnostic and curative techniques, with particular emphasis on surgical training. At present, MSF supervises an average of 25 surgical interventions per week. Through operational research, MSF strives, with other partners, to improve care for people with this disease and raise awareness about it so that this care can be integrated into the national health system.

Although official statistics place the HIV/AIDS prevalence rate at 4.1 percent in Benin, figures differ among regions and population groups. Surveillance of women seeking prenatal care in the town of Dogbo, Mono-Couffo department, revealed a prevalence rate of 7.4 percent. Because this region has no health facility that implements HIV/AIDS-related care, MSF has opened such a program there.

The team started by providing voluntary testing, information, and medical consultations for opportunistic infections. By the end of 2003, MSF had signed an agreement to launch a treatment program using life-extending antiretroviral (ARV) therapy in this rural area. In the second half of 2004, in Dogbo, MSF will begin to treat patients with ARVs and start a program to prevent mother-to-child transmission of the disease. MSF's goal is for 300 of its patients to be taking ARVs by the end of 2004.

MSF has worked in Benin since 1997.

Burkina Faso



Helping street children

MSF helps children and youngsters living on the streets of the capital, Ouagadougou. Instead of operating from a center, the team works on the streets in close proximity to these children. Today, the program reaches around 700 children and 80 teenage girls. MSF's team carries out 40 to 60 medical consultations and various psychosocial activities each month. MSF organizes meetings with teenage girls to raise awareness about health issues related to prostitution. It has also trained local health groups to treat sexually transmitted infections and started a medical program for survivors of sexual violence.

Advocacy is a key part of MSF's work with street children. Since August 2003, the organization has held 65 information sessions on the predicament facing these young people. A total of 85,550 people living around Ouagadougou have taken part and watched the MSF movie "The Streets Are Not Paradise." Information sessions have also been held in schools and at the national police academy. The national television station has broadcast the movie twice.

In the remote town of Sindou in Leraba province, MSF advocates for improved health care by raising awareness of health issues among the residents and by supporting their demands for quality care. MSF focuses particularly on maternal and child

health care. The team provides assistance to seven regions in Sindou: Wolonkoto, Bagera, Niassogon, Negueni, Oueleni, Kangoura and Konadougou.

Burkina Faso is facing a growing AIDS epidemic. In order to help those with the illness, MSF runs a project to improve the quality and duration of life for HIV-positive people living in the health district of Pissy in Ouagadougou. Now 1,300 patients are enrolled in the program and receive medical care for opportunistic infections. A program to prevent mother-to-child transmission of the virus started in January 2003 and is now operating in two maternity centers. In April 2003, MSF started providing life-extending antiretroviral (ARV) treatment as well. By the end of 2004, MSF hopes to have 600 HIV-positive patients enrolled.

In early 2004, MSF was able to help halt a meningitis outbreak in the district of Nanoro by vaccinating 135,000 people against the less common W135 strain of meningitis.

MSF has worked in Burkina Faso since 1995.



Cameroon © Juan Carlos Tomasi

Cameroon

Caring for people with AIDS and Buruli ulcer

MSF is helping people with two health problems in Cameroon: HIV/AIDS, which affects an estimated 13 percent of the population, and Buruli ulcer, a debilitating disease.

MSF has been caring for people living with HIV/AIDS in Cameroon since December 2000. The following year, the organization began treating patients with life-extending antiretroviral (ARV) medicines. In the capital, Yaoundé, MSF runs an AIDS project that assists 1,000 people, of which 600 are receiving ARVs. Another prevention and treatment project began in the city of Douala in 2002, with ARV treatment started in early 2003. By June 2004, 736 patients were participating in that project with 198 receiving ARVs. The project staff anticipates that 400 people will be using ARVs by the end of 2004. MSF's project also focuses on counseling and helping to ease access to treatment.

In the district of Akonolinga, MSF treats people suffering from Buruli ulcer. Similar to leprosy, this disease seems to be contracted by people who come into contact with the bacteria in swamps and stagnant water. Once in the body, the bacteria destroy skin tissue and cause massive mutilations. A 2001 study done by MSF and another NGO in the districts of Ayos and Akonolinga found that more than 400 people out of every 100,000 had the disease. At present, there is no curative treatment for this disease, and surgery is the only remedy available to ease symptoms. MSF began a surgical program to treat people with Buruli ulcer in 2002 and has assisted 235 patients so far. Sixty-six people received surgery in the first half of 2004.

In February 2004, MSF responded to a cholera outbreak in the city of Douala and helped the district's health facilities in their effort to contain the disease. More than 1,700 cases were reported during the course of the outbreak. In May 2004, MSF ended its intervention.

MSF has worked in Cameroon since 2000.

Burundi

Providing care to those with none

Civilians in Burundi have lived through years of conflict – years in which infectious and parasitic diseases, especially malaria, have remained immense health problems. To meet some of the various health needs, MSF's work in Burundi is diverse.

Teams treat patients in clinics and hospitals in parts of the country where war and displacement have left civilians without health care or with little access to it. In the capital, Bujumbura, MSF treats war wounds, manages a health center and runs a medical/surgical program in a local hospital. In 2003, MSF opened a new center in Bujumbura to assist survivors of sexual violence.

The country's civil war and resulting economic crisis have left civilians with little access to care. MSF is concerned that a new cost-recovery policy, implemented nationwide, will further reduce people's ability to get needed care (see page 12). A national survey conducted by MSF during the final quarter of 2003 suggested that approximately one million of the country's six million inhabitants had no means to attain health care and three million had to use extreme measures to gain even limited access.

MSF overcame significant barriers to open a sexual violence project in Bujumbura – a city where the term "rape" does not exist in the local language. Now the clinic, opened in September 2003, sees 120-150 new cases each month. Housed in a downtown shopping area, the clinic treats gynecological wounds and helps patients to prevent being infected by HIV or other sexually transmitted infections as well as to avoid unwanted pregnancies. MSF also provides counseling services to give survivors a safe environment in which to talk about their experiences and learn how to cope with them.

In addition, MSF operates nutrition programs, prepares to respond to epidemics and treats people with infectious diseases. In Bujumbura Rural province, MSF provides basic medical care in the district of Rwibaga where the most common illnesses treated are respiratory infections, diarrheal diseases and malaria. Special attention and

support is given to the Karinzi health center, which assists an estimated 50,000 people living in an insecure area. MSF supports various health care structures by providing training, medical assistance, supervision and supplies. Since the beginning of 2004, emphasis has been placed on maternal health. A mobile MSF clinic at a camp for internally displaced persons in Kivoga provides first- and second-level medical care to approximately 10,000 people. MSF has also launched several cholera interventions, most recently in March 2004 in the district of Rubiza.

In response to a number of malaria epidemics, MSF has launched a large-scale emergency program that offers both curative and preventive care. In 2003, the team helped change the national malaria protocol to implement the use of artemisinin-based combination therapy (ACT). MSF now supports training of medical personnel and supervises implementation of the new protocol.

In June 2004, MSF began to assist thousands of people who had gathered at Burundi's border in their attempt to flee fighting in the eastern region of the Democratic Republic of the Congo. MSF teams set up two mobile clinics and opened a cholera treatment center in Cibitoke Hospital and isolation areas in two displaced persons camps. Later in August, about 150 people were killed and 105 wounded when a refugee camp in Gatumba, on the border between the two countries, was attacked by a military group who set fire to buildings where the refugees were sleeping, and used guns, machetes and hand grenades to kill others. Victims were brought to the nearby capital, where MSF treated more than 20 of the wounded and operated on eight. MSF also provided victims with psychological support at its center for the war wounded and at its health center for women in Bujumbura.

MSF has worked in Burundi since 1992.

Central African Republic

Giving emergency care

Since civil war started in the Central African Republic in 2002, MSF has focused on providing emergency medical relief to the victims. MSF staff also run a sleeping sickness project – which was halted for part of 2003 because of the conflict – in the southeastern town of Haut-Mbomou.

MSF aided civilians attempting to escape the violence by crossing into neighboring Chad. A team based just over the border carried out medical consultations and surgery while also distributing medicine and needed supplies. MSF also gave urgent medical care to those who were sexually assaulted during the conflict.

During 2003, MSF carried out a number of exploratory missions in the country. A team visited Bouzum to determine the needs of the people in the area. In Bouar, MSF carried out a measles vaccination campaign and evaluated the situation of displaced people living in the region. In Bossemptele, Bouzum, Paoua and Bocaranga, MSF distributed medicines and medical supplies and in Sibut, Paoua and Gore, a team assessed operations at local health facilities.

MSF has worked in the Central African Republic since 1997.

Children living in Nana Bakassa wait to be vaccinated against measles during an epidemic in the area.



Chad

Helping desperate refugees
In 2002-2003, Chad was the destination for waves of refugees fleeing conflict in neighboring Central African Republic. During 2003-4, Chad was again inundated with refugees, this time people fleeing atrocities in the Darfur region of western Sudan.

The exhausted, malnourished and often ill people who have been arriving in Chad have little hope of receiving the care that they need. The country has a chronic shortage of qualified staff and even many of its residents do not obtain basic health care. Treatment for tuberculosis and malaria is hard to come by, and HIV/AIDS care is practically non-existent. Epidemics including cholera, measles and meningitis often sweep through parts of the country, and food can be scarce depending on the success of harvests. Moreover, the country's medical system which includes user fees, excludes many in dire need of care for lack of ability to pay.

Malaria is the most lethal disease in Chad. In January 2004, MSF started a malaria project in Bongor district, which aims to reduce levels of illness and death in the area. MSF is also working to improve treatment by introducing a new protocol that includes artemisinin-based combination therapy (ACT). The project will include a prevention component targeting pregnant women and children under five. MSF also runs a surgical training program at Bongor Hospital.

In August 2004, more than 1,500 people were infected with cholera around the town of N'Djamena. When nearby health facilities became overwhelmed by the outbreak, MSF, in collaboration with the ministry of health, built a cholera-treatment center able to accommodate 100 patients. MSF also flew in cholera kits containing supplies and needed medicines. An MSF medical coordinator, nurse and water-and-sanitation specialist were also brought in to oversee patient care and the construction of the treatment center.

MSF has worked in Chad since 1981.



© Espen Rasmussen

Fleeing from Darfur

"I arrived here about two months and ten days ago. I came here by foot. I came here without anything. I only have my clothes that I am wearing. I asked for food from the Chad people and they gave me something but it is not enough. Here it is very difficult. There is not enough food and we are cold during the night."

– Female refugee, 45, in Birak, Chad

Since July 2003, refugees from the Darfur region of Sudan have been setting up makeshift shelters along a 600-kilometer stretch of border between Chad and Sudan. MSF teams have followed them there, starting projects to help the exhausted, hungry civilians who make it across the border. Thousands more remain trapped by violence in Darfur.

MSF set up health posts in the border towns of Tine and Birak in September 2003 to provide medical care and food. More than 10,000 medical consultations were completed by MSF staff in these two towns between September and December 2003. Although the first refugees to arrive were taken in by the local communities, their numbers soon ballooned, exhausting the region's resources. Since December 2003, thousands of refugees have been arriving each month in eastern Chad. By the end of August 2004, an estimated 180,000 refugees had arrived. The conditions they face upon arrival are harsh. Most have walked for days, and when they arrive, there is no shelter or food for them. The region's extreme weather conditions only worsen the problems. Many of the refugees are in a deplorable state, with young children the most vulnerable. A large number of these families have already lost relatives during attacks on their villages.

In the first part of 2004, MSF teams launched a meningitis-vaccination campaign and immunized almost 83,000 children in the Iriba area, a coverage rate of 82 percent. An immunization campaign against measles was also conducted. An MSF team runs the hospital in the town of Adre where 30 to 60 surgical interventions are performed each month. The number of referrals to the hospital has increased since an ambulance service was started in August 2004. Admissions now average between 130 and 150 each month. A nutritional unit has been opened to treat children suffering from severe malnutrition.

In August, in Breidjing camp, where 100 to 300 people continued to arrive each day, an MSF team provided food and medical care to an estimated 42,000 refugees. Most of the patients were suffering from diarrhea, malaria, malnutrition or respiratory infections. In the northern Toulum and Iridimi refugee camps near Iriba, and in refugee areas near the towns of Tine and Birak, there were few malaria cases at first, although they began to appear with the onset of the rainy season. This region of Chad has also been hit by a hepatitis E epidemic which is plaguing Darfur, Sudan as well. By mid-August, Goz Amer camp reported 875 hepatitis E patients and 24 deaths, including 8 pregnant women, who are extremely vulnerable to the illness.

Additional MSF teams have spread out along the border area to provide prenatal services, more nutritional activities and desperately needed water. As refugees are moved by UN agencies away from border towns to safer locations deeper within Chad, MSF moves its activities to areas where new refugees are arriving.

Although a large amount of aid has now entered the country, MSF remains concerned about the health of the refugees. While MSF and other organizations have been able to provide food aid, water and health care to many, the needs are overwhelming and will continue for many months as long as the refugees remain too afraid to return to their own villages to begin farming again.

Democratic Republic of the Congo



A never ending health crisis

After years of war in the Democratic Republic of the Congo (DRC), efforts to end the conflict moved ahead in 2003-4. A transition government is now in place and elections are scheduled for June 2005. Yet the path to a lasting peace is fraught with obstacles and little has been done to alleviate the miserable conditions in which most civilians live.

Throughout the country, medical services are woefully inadequate if they exist at all, and much of the country remains in a state of emergency in terms of health. MSF continues to witness massive humanitarian needs in many of the places where it works. Since 1998, the International Rescue Committee estimates more than three million people have died as a result of the war, mainly from malnutrition and disease. Parts of the DRC continue to be inaccessible to humanitarian aid due to fighting, forcing the population to live under the specter of violence, displacement, malnutrition and disease. In reality, few civilians can get the medical care and health services they urgently need.

The eastern district of Ituri, in Orientale province, which last year became notorious for instances of mass murder, remains volatile even after European Union troops and later United Nations troops pacified parts of the region, re-establishing law and order in at least some of the main towns. In May 2004, seven armed militia groups from the embattled district signed an agreement with the government to disarm and participate in the country's transitional democracy process. However, renewed fighting broke out shortly thereafter between armed factions in Ituri, with mass pillaging and rape sending thousands of civilians on the run again.

Long-term conflict in the DRC has left people in most provinces vulnerable, and hundreds of thousands depend on external assistance for basic medical care and food. The end of active fighting between most of the belligerents has enabled MSF to travel into areas that, until recently, were too unsafe to enter. New projects have opened, and the quantity of humanitarian assistance being provided has increased. Greater stability has also made it possible for Congolese people to travel farther from

home or from their area of displacement to seek assistance.

MSF continues to provide hospital and basic health care, nutritional assistance to malnourished children, care of war-injured civilians, and psychological counseling. In many areas, the organization has been treating patients affected by outbreaks of infectious diseases such as cholera, meningitis and measles which are endemic in many parts of the DRC. MSF has launched vaccination campaigns to tackle such outbreaks, having vaccinated 500,000 children against measles in the Equateur and Orientale provinces. In these two provinces, the transportation infrastructure is appalling, and many areas can only be reached by dug-out canoe or motorbike. MSF is running basic health care clinics there, serving some 700,000 people. Some of these clinics are among the most remote in the country.

In the Equateur province and in the village of Isangi, in Orientale province, MSF is also working to combat sleeping sickness, a deadly disease that is extremely prevalent in the region. The project in Isangi includes a research component aimed at introducing more efficient drugs to treat those with the disease. In 2003-4, national health authorities agreed to allow MSF to carry out several research studies examining the efficacy of various antimalarial drugs. The results should aid MSF's efforts to advocate for the national malaria protocol to be changed to artemisinin-based combination therapy (ACT), a more effective therapy, in 2005. Teams that are treating malaria in the DRC have already introduced ACT in their projects.

Treating survivors of sexual violence

During the past year it has become increasingly clear that sexual violence, mostly against women, has been a terrifying reality for people during the years of war. MSF

is now working in several areas including Baraka, in South Kivu province (see page 25) and Bunia, in the Ituri region, to help survivors of this violence by treating their physical symptoms and providing counseling to address trauma. Hundreds of patients have received medical care and counseling from the MSF teams in Baraka, and more than 1,600 women have been treated since July 2003 in Bunia. MSF has also treated patients who have experienced sexual violence in Kinshasa and Kisangani, and the organization makes such treatment a part of the integral care it provides in North Katanga, North Kivu and Equateur. MSF hopes that a national protocol will be developed to ensure proper treatment for survivors of sexual violence.

Giving AIDS care

HIV/AIDS is beginning to take a massive toll on the DRC. There is very little data on the prevalence of the disease let alone adequate treatment for those living with it. MSF has been treating people with AIDS-related opportunistic infections, providing testing and counseling services and raising awareness about HIV prevention. The organization has developed a comprehensive program in Lubumbashi, Kisangani, Mbandaka and the nation's capital, Kinshasa, to fight sexually transmitted infections among those carrying out high-risk behavior, especially commercial sex workers. In October 2003, MSF started a treatment program using life-extending antiretroviral (ARV) medicines for severely ill AIDS patients in the eastern town of Bukavu, located in South Kivu province near the Rwandan border. MSF is the only organization providing such treatment in eastern DRC. Similar programs have been launched in Kinshasa and Lubumbashi. By the middle of 2004, 66 people were enrolled in the treatment program in Bukavu and 250 were enrolled in Kinshasa, while thousands of medical consultations were done each month.

Ongoing crisis

In late May 2004, renewed fighting broke out in Bukavu, and tension quickly spread to the surrounding regions. The upsurge of violence forced MSF temporarily to evacuate most of its staff from five project sites in the Kivu provinces, but local staff managed to keep the programs running. MSF

MSF uses all possible means to reach civilians cut off from health care because of offensives carried out by armed groups. Teams travel into the deep forests of the country using motorbikes and canoes to reach isolated villages and offer basic medical care.

provided crucial medical care to approximately 32,000 Congolese who fled to Burundi following this outbreak of violence. Displacement caused by fighting north of Bukavu prompted MSF to bring medical assistance to civilians near the town of Kalehe who had been forced to flee their homes.

In Kitenge, in the province of North Katanga, more than 40,000 people were displaced and 50 villages set ablaze in the first five months of 2004 amid fighting among various militias and government troops. Since June, displaced people have started returning to their villages, yet they have few if any resources now that their crops have been destroyed by armed groups. MSF has been working in the region since 2002 providing medical care and treating severely malnourished children. Admissions to MSF's therapeutic feeding center doubled to 200 in April 2004 with 60 percent of the children from families that had been displaced recently. Two of the health centers in which MSF works were closed due to nearby violence. One of them, in Kaloko, was looted and partially destroyed during fighting. The other, in Kileo, was reopened in March 2004. MSF is now strengthening the referral hospital in the town of Ankoro to respond to emergencies in North Katanga.

While sporadic outbreaks of extreme violence capture headlines in the media, huge swathes of the DRC exist in a constant state of catastrophe. MSF has four permanent emergency teams covering the length and breadth of the country. These staff members respond to emergencies ranging from measles and cholera outbreaks, to displacements due to violence, to nutritional crises.

The transition process in the DRC has continued to be severely tested in 2004, and there is concern that war may resume. MSF is again launching interventions to respond to the needs of the newly displaced. From east to west, needs in the DRC remain vast and while it is clear that the transition represents a step forward, it is only an early step on a long road. **MSF has worked in the DRC since 1981.**



© Jodi Bieber

Alleviating the suffering caused by sexual violence

The town of Baraka, in eastern DRC, located on the shore of Lake Tanganyika, in the province of South Kivu, has been the scene of massive suffering since the outbreak of war. Caught between rival armed groups, civilians have faced brutal killings and lootings that have forced many to flee and have created myriad hardships including illness and malnutrition.

In August 2002, during a lull in the fighting, MSF began providing hospital services in Baraka. The team was quickly confronted with another horrific dimension of war perpetrated by all warring parties – sexual violence against civilians. Hundreds of women, girls and men of all ages had been raped or subjected to other forms of sexual violence. Most did not seek medical care at the time because either there was simply no care available or they felt too ashamed or sick after the event.

The medical consequences of sexual violence are many, including transmission of HIV/AIDS and other sexually transmitted infections, unwanted pregnancy and serious complications of reproductive health. In July 2003, MSF began providing special care for survivors of sexual violence. MSF gives "morning-after" emergency contraception to prevent pregnancy and post-emergency prophylaxis (PEP), which can help prevent the possible transmission of HIV/AIDS for those who are treated within 72 hours of the rape. MSF staff members counsel survivors to address psychological and emotional trauma. Between August 2003 and April 2004, more than 500 people came to MSF for medical consultations and counseling. MSF believes that hundreds more need care but live in areas from which it is difficult to reach the MSF clinic.

"That night, I was at home with my husband and my four children. Suddenly, there was an attack on our village. My husband managed to escape, but I was eight months pregnant. I had no strength to run and my children were with me. I had to protect them and so I couldn't escape. Three armed men entered our house and tore off my clothes, as I remained naked in front of my children. They hit me with the butt of their guns and then raped me – all three of them, in front of my children. I lost consciousness. When my husband came back, he called the neighbors and they took me to the health center.... I am very afraid to have caught diseases and at night I suffer from insomnia. The baby I was carrying at the time of the rape survived, but he is always sick and has constant diarrhea. Since what happened, my husband insults me every day calling me the wife of the militiamen who raped me and sometimes he doesn't even sleep at home. I have no joy, no peace of mind anymore."

– 23-year-old woman, raped in January 2003

This material is drawn from the MSF report "I have no joy, no peace of mind: Medical, psychosocial and socio-economic consequences of sexual violence in eastern DRC" published in April 2004 by MSF-Holland.

Republic of Congo (Congo Brazzaville)



© Steve Harris

Caring for victims of war

A peace accord signed in March 2003 brought a halt to open hostilities in the country's Pool region near the capital city, Brazzaville. But the uneasy peace has not led to political progress in disarming the Ninja militia or integrating combatants back into community life. Tension remains high and MSF is one of the few organizations present in the area, which remains unstable, lawless and dangerous.

For more than two years, MSF has been responding to medical needs resulting from the area's devastation by civil war. Currently, MSF staff members work in hospitals and mobile clinics in the Pool region towns of Kinkala and Kindama providing basic health care, performing emergency surgery and treating people with malaria and tuberculosis. Between December 2003 and May 2004, MSF averaged more than 10,000 patient consultations each month in the Pool region. In 2004, MSF added mental health care activities, including counseling and community outreach, to its health care program in Kinkala. MSF team members use individual and group counseling to help civilians work through traumatic war experiences.

Since June 2003, MSF staff members have been working in the Pool's Mindouli district, operating mobile clinics that visit ten sites, vaccinating children against common diseases including measles, polio and

tuberculosis and offering medical support at the district hospital. Each month the team conducts about 3,000 medical consultations and admits 250 people to the hospital for further care.

In 2003, MSF rehabilitated the health center in the northeastern district of Bétou. This is an isolated area where many refugees from the Democratic Republic of the Congo and Central African Republic now live. The construction project enabled MSF to increase the kinds of care available in the area. Teams can now offer tuberculosis treatment, more surgical care, prenatal consultations and other medical activities. The team in Bétou also carries out vaccination campaigns and runs mobile clinics. More than 50,000 consultations were conducted in 2003. Approximately 26,000 people received outpatient consultations at the hospital and 35,000 were helped in the district health center and its mobile clinics.

Care for victims of sexual violence is another important part of MSF's activities in Brazzaville. Patients who visit Makélékélé or Talangai Hospital within 72 hours of an assault are given preventative treatment for sexually transmitted infections, a voluntary HIV test, and, if female, emergency contraception to prevent pregnancy. Pregnant women receive treatment to reduce the risk of transmitting the virus to their baby. All of these patients are encouraged to meet with an MSF psychologist to talk about their experience. Health care assistants, trained by MSF, visit the patients at home later to ensure that they are continuing their medical treatment and to encourage them to regularly consult the hospital psychologist. MSF has treated more than 600 people since the program began four years ago.

MSF also aids people suffering from sleeping sickness (African trypanosomiasis) in Nyazi, Bouenza, in the south of the country and in Mossaka, Cuvette Est, on the Congo River, some 450 kilometers north of Brazzaville. Since 2000, MSF has screened more than 250,000 people for sleeping sickness and treated more than 2,000 patients with the disease. Caused by parasites spread by tsetse flies, the disease is fatal unless treated.

MSF has worked in the Republic of Congo since 1997.

Ethiopia

Advancing treatment for deadly diseases

The past year has brought about important developments in treating people with malaria and AIDS in Ethiopia. One positive change has been the country's move toward a new, more effective protocol for treating malaria, which is endemic in the country. This policy shift came about after many months of advocacy work done by MSF and numerous national and international organizations in the midst of a severe malaria epidemic that started near the end of 2003.

In most of Africa, conventional malaria treatments such as chloroquine and sulfadoxine-pyrimethamine (SP) are no longer effective in many patients due to the increased resistance of parasites to these drugs. To counter this problem, MSF has been promoting the use of artemisinin-based combination therapy (ACT) which is derived from a centuries-old Chinese herbal medicine.

The malaria epidemic of late 2003 affected the southern Ethiopian state of Oromiya and other parts of the country. When the World Health Organization (WHO) announced that an estimated 15 million Ethiopians were at risk of contracting the disease, MSF asked the government for permission to use ACT. MSF believed that this combination therapy was vital to stopping the further spread of the epidemic. However, the government refused. It said it wanted more scientific evidence before determining whether the national treatment protocol should be changed. As a consequence, health staff from some organizations were forced to treat thousands of sick patients in the epidemic area with largely ineffective medicines, and MSF was obliged to adapt to the situation by using quinine as first-line treatment. The death toll from this outbreak was substantially higher than it was from malaria in 2001 and 2002. According to government figures, approximately 3,500 people died of malaria during the outbreak. In response to intensive advocacy conducted by MSF and others, the ministry of health announced in May 2004 that it would change the protocol by July. The government planned to introduce ACT in

August as the country's standard malaria treatment. The episode also pushed major institutions, such as the WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria to strengthen their support for ACT. While implementation was still pending in September, the change in policy enabled MSF to bring ACT drugs into the country. MSF teams are now starting to implement the new treatment in MSF projects.

A resettlement nightmare

Tension also erupted between the Ethiopian government and MSF around the government's three-year program to resettle approximately 2.2 million farmers from overcrowded, low-yield agricultural areas to underpopulated, more fertile land. The scheme is part of the government's plan to solve recurring hunger problems and increase agricultural production. However, in 2003, during the pilot phase of the program in which more than 150,000 people were moved, MSF discerned poor planning and insufficient monitoring in some settlements, leading to high levels of malnutrition and disease. In various locations there was also insufficient water to support the increased population. MSF made a decision to intervene in a number of emergency situations by providing urgently needed health care and food programs for thousands of sick and malnourished settlers in the Amhara region. It opened a therapeutic feeding center for children and adults, a supplementary feeding program and mobile "fever clinics" to detect and treat malaria as well as the disease kala azar (visceral leishmaniasis). Kala azar is a sandfly-borne disease that affects the immune system and, if left untreated, kills almost all who contract it.

In 2004, MSF urged Ethiopian authorities to evaluate the program's pilot phase to help

avoid future problems. With the resettlement program continuing and thousands of new settlers arriving, MSF fears that new health emergencies will erupt again in the most vulnerable new settlements.

Treatment for AIDS

Early 2004 also saw the start of Ethiopia's first free AIDS-treatment program using life-extending antiretroviral (ARV) medicines. In close cooperation with district health authorities and HIV/AIDS patient groups in the northern Tigray region, MSF began treating patients with ARVs in the district hospital in Humera. By mid-2004, 67 patients were receiving ARVs, and the program aims to admit 15 new patients per month. As part of the project, the MSF team provides voluntary HIV counseling and testing to the wider Humera community. It also provides medical care to approximately 500 HIV-positive people and food for patients with HIV/AIDS, kala azar or tuberculosis who require it.

Other MSF activities in Ethiopia

MSF has helped control multiple meningitis outbreaks in the Gurage and Haydia zones in the southern Oromia region and most recently in the Wag Hamra zone in the Amhara region. In Wag Hamra, MSF also provides community therapeutic feeding in an area where people experience frequent food shortages and cannot get quality health care. In June 2004, MSF opened a primary health care clinic in the Somali region of southeastern Ethiopia. Based in Cherati, the clinic covers about 75,000 people living in an area in which health facilities are scarce or not working. Finally, at the border with Sudan and Eritrea, MSF treats people with kala azar in three locations.

MSF has worked in Ethiopia since 1984.



Guinea

Helping refugees and treating infectious diseases

MSF teams have been assisting the hundreds of thousands of refugees fleeing to Guinea to escape armed conflicts in Sierra Leone, Liberia and Côte d'Ivoire. As some areas became considered more secure, MSF aided refugees returning to Sierra Leone by setting up transit camps and supplying medical screenings for them.

MSF has begun work to improve the care and treatment of Guineans living with diseases such as HIV/AIDS, tuberculosis and malaria. In the capital city of Conakry and the Moyenne Guinée region, MSF trains local doctors and health workers to manage care for tuberculosis (TB) patients. Teams are working to improve detection and treatment of the disease and raise awareness about it. MSF has also set up a database to help health workers track TB patients who stopped taking treatment and to provide follow-up care. The organization currently provides TB drugs for 4,500 patients a year and supplies 15 TB laboratories. MSF has been actively involved in Guinea's National Program for the Fight Against Tuberculosis (TB) since 1988.

In August 2003, MSF started providing care for people living with HIV/AIDS in Conakry and Guéckedou prefecture. Teams have opened free HIV testing and treatment centers. MSF offers care for opportunistic infections, provides treatment with life-extending antiretroviral (ARV) medicines and gives information on the disease. Currently, 250 patients are receiving care for opportunistic infections in Conakry and 150 obtain such care in Guéckedou. The MSF team started treating people with ARVs in July 2004 and hopes to have 200 people using ARV treatment by the end of 2004.

Malaria is one of the leading causes of illness in the country. Health authorities currently promote drug treatments which are considered ineffective in many countries due to growing resistance to them. MSF is now conducting a resistance study in Dabola using two new artemisinin-based combination therapies (ACT), more effective treatment that does not have the same problems with resistance. The study, carried out in cooperation with local health authorities, may lead to the opening of a pilot project introducing a more efficient

treatment protocol to treat those with the disease.

Since May 2003, MSF has conducted surgical activities at Macenta Hospital located near the Liberian border. MSF staff carried out more than 600 surgical interventions in 2003. In the first half of 2004, about one-third of the surgical procedures were done to alleviate gynecological and obstetrical problems. Staff also manage the water and sanitation systems for the 75-bed hospital.

In N'zérékoré prefecture, MSF cares for refugees in Lainé camp which houses more than 22,000 people and Nonah camp where 3,700 people live. MSF staff members provide basic medical and maternity care, vaccinations and therapeutic feeding for malnourished women and children. In July 2004, MSF carried out 3,894 medical consultations in Lainé camp and 1,687 consultations in Nonah camp. Though MSF stopped its medical activities at Kuankan camp in August 2003, a new influx of Liberian refugees prompted MSF to restart them in February 2004. The MSF team provides water and sanitation for approximately 6,500 camp residents. In addition, MSF runs a clinic and dispensary. MSF plans to stay in Kuankan camp as long as refugees continue to need assistance.

In August 2004, MSF closed a project that provided aid to refugees in Boreah camp in Kissidougou prefecture. Repatriation of Sierra Leone refugees in 2003 and 2004 greatly reduced the camps' populations and the need for help. Since 2001, MSF teams had provided medical consultations, fed malnourished women and children and provided water and sanitation facilities within the camp. In the same month, MSF also ended a project which entailed providing equipment and training to staff at Kissidougou Hospital to reduce HIV transmission through blood transfusions.

MSF has worked in Guinea since 1984.

Guinea Bissau

Providing help during a measles outbreak

An outbreak of measles in Bissau, the country's capital, raised alarm in the early months of 2004. The country has a national vaccination coverage rate of less than 60 percent and even below 45 percent in some regions.

Concerned about the potential for an epidemic, MSF sent a team to assess medical needs in April 2004. The team found that more than 964 measles cases had been registered in the first three months of the year. The central cold chain system was not working well and no measles vaccines were available.

MSF transported vaccines as well as logistical and medical material in cargo planes from Brussels and started an emergency vaccination campaign in early May. Targeting a population of 200,000 children between the ages of six months and 15 years old, the team ran vaccination programs in the areas of Gabu, Oio, the Bijagos islands and Bolama. Awareness activities were conducted to improve future routine vaccinations. The vaccination campaign ended in June 2004 with 89 percent of the targeted population having been vaccinated.

MSF last worked in Guinea Bissau in 1998 to assist the population in a conflict and post-conflict situation. Since then, MSF keeps in regular contact with health authorities to respond to any health emergencies that arise.

Côte d'Ivoire

© Frida Lagerholm

Giving care amid violence

In 2002-3, a violent civil war divided this once peaceful country in half and sparked a political and medical crisis that continues today.

Ongoing political unrest has kept thousands of impoverished, displaced civilians from returning to their homes, especially in the north and western regions of the country.

The violence caused hundreds of thousands of workers to abandon their farms, and hunger is a persistent problem. The conflict has severely damaged the country's health care system, which lacks personnel and medical equipment, leaving many civilians without basic care. At the same time, there has been a resurgence of epidemics and diseases in overcrowded cities and towns.

Working on both sides of the frontlines, volunteers and national staff provided urgently needed medical care and personnel for health facilities. Throughout the past year, MSF restored medical facilities that had been plundered and whose personnel had fled. Teams were based in the western towns of Man, Kouibly, Bangolo, Bin-Houyé and Danané, as well as in the city of Bouaké in central Côte d'Ivoire and in the city of Korhogo in the north of the country. At hospitals in Bouaké, Man and Danané, MSF staff members provide essential medical care including pediatrics, emergency medicine, gynecology/obstetrics and surgery for area residents. Since April 2003, MSF has run mobile clinics in villages along the northwestern border with Liberia. Projects were also begun in the western towns of Guiglo and Toulépleu to decrease malnutrition and assist people displaced by violence. MSF teams have continued to carry out thousands of medical consultations each month. In 2004,

MSF handed its project in Toulépleu over to the government.

War wounds were most prevalent in the early days of the conflict, but now most MSF patients suffer from severe malnutrition and infectious diseases, especially malaria. MSF opened a therapeutic feeding center in Man Hospital in May 2003, and admitted more than 350 children during the July 2003 peak. During the past year, MSF staff vaccinated children and provided care during outbreaks of measles, yellow fever and meningitis.

Treating inmates with TB

MSF continues to provide medical care to the more than 5,000 inmates crammed into the Maison d'Arrêt et de Correction d'Abidjan (MACA) prison in the capital city, Abidjan. In a facility designed for merely 1,500 inmates, the prison's horrendous living conditions give rise to frequent cholera epidemics and high levels of tuberculosis (TB). MSF has been conducting nearly 2,000 medical consultations there each month. During 2004, MSF extended its activities in the prison's TB ward in collaboration with the country's national TB program and also began treating people with multidrug-resistant strains of the disease. More than 200 detainees benefit from a supplemental nutrition program established by MSF in 2003.

MSF has worked in Côte d'Ivoire since 1990.

Kenya

Expanding treatment for people with AIDS

MSF's long relationship with Kenya has been focused in recent years largely on helping those living with HIV/AIDS. Today more than 2.5 million of the country's 32 million residents are living with this disease. In several locations, MSF has begun providing HIV testing and counseling services, care for patients with opportunistic infections and treatment with life-extending antiretroviral (ARV) medicines. As of August 2004, MSF staff working in the Mathare slums of Nairobi were providing care and ARV treatment to 386 people including 49 children, as well as treatment for tuberculosis (TB), a common co-infection of HIV/AIDS. In the city's Mbagathi district hospital and in the Kibera area, MSF has started treating 600 people with ARVs including 80 children. And in Homa Bay in western Kenya, MSF works in the city and in three peripheral health centers to provide ARVs to 1,565 people, including 86 children, as well as TB treatment.

In and around the rural town of Busia in western Kenya, MSF provides home-based AIDS care to more than 1,500 patients who are too weak to seek health care themselves and who lack social support. A total of 502 people, including 20 children, are participating in Busia's ARV program. In all, more than 3,000 Kenyan patients are now receiving ARVs through MSF. Based on its own experience, MSF also shares information with the government on ways to get ARV treatment to the estimated 250,000 people in Kenya who need it urgently but cannot afford it.

In April 2004, MSF responded to alarming malnutrition in the drought-stricken north of the country by starting a therapeutic feeding program in Turkana. MSF continues to monitor the nutritional situation of people living near Marsabit.

MSF has worked in Kenya since 1987.



© David Levene

Liberia

War ends, but the crisis continues

Fierce fighting between rebel and government forces on the streets of the capital, Monrovia, between June and August 2003, killed more than 2,000 people and wounded many civilians. Although the fighting has ended, the war's long-term consequences continue to cause suffering among the civilian population.

In August 2003, Liberia's president, Charles Taylor, stepped down and accepted Nigeria's offer of political asylum. Soon after, the three warring parties signed a peace agreement ushering in a transitional government and a process of military disarmament and demobilization. Yet the long years of war, the latest round since 1999, have severely damaged the social fabric of Liberian society. Families have been separated as people were forced to flee to other parts of the country or neighboring nations. Many civilians died from war wounds, malnutrition or the epidemics that plagued the weakened population. The country's infrastructure, including the health care system, is destroyed. More than 40 percent of the population lacks health care and less than 20 percent have safe drinking water and sanitation facilities. Today there are only about 30 Liberian physicians working in this country of more than three million people.

Monrovia: during and after the battle

When Monrovia was under siege in July 2003 and other health facilities were forced to close as fighting neared, MSF staff converted their living compound into an emergency surgical hospital. By September, the fighting had ceased but Monrovia remained a city of squatters living without electricity, running water, shelter, sanitation or adequate food. Every new clinic opened by MSF was immediately flooded with people seeking treatment and clean water. Days after the fighting ended, MSF



© Kadir van Lohuizen

In September 2003 MSF opened therapeutic feeding centers in the cities of Buchanan and Monrovia. The centers had hardly opened their doors when severely malnourished children started pouring in.

"Because the war has gone on for so long there are teenagers who have known nothing for the last 14 years but violence. So for them to go back to being a farmer will be very difficult – I don't know whether they will be able to cope."

– Carolyn Merry, nurse and project coordinator for MSF in Liberia

staff re-opened Redemption Hospital and converted a school into Mamba Point Hospital, both free, full-service facilities. They also restarted the 50-bed Island pediatric facility and Benson Hospital. MSF staff continued to run three cholera treatment units until they were no longer needed shortly after fighting ended. Teams also managed therapeutic feeding centers in the city, including one, still in operation, that treats severely malnourished children who also have tuberculosis. Among all of these facilities, the MSF teams were treating 1,500 to 2,000 people a day by September 2003. Later, in October, two medical clinics called Red Light and Logan were opened in the city to provide additional care to the local population. Once needs began to subside, MSF closed the Red Light clinic in April 2004 and Logan clinic in July.

The most common health problems seen were cholera, malaria, watery diarrhea, measles, sexually transmitted infections and pregnancy-related conditions. MSF introduced artemisinin-based combination therapy (ACT), the most effective malaria treatment today, to several of its clinics in Monrovia during the fighting. It also supplied more than 300,000 liters of drinking and washing water to centers for displaced people.

Devastation in rural areas

In the weeks following the battle in Monrovia, MSF assessment teams traveled beyond the capital to Grand Bassa, Grand Gedeh, Lofa, Montserrado and Nimba counties to assess health needs in parts of the country that had been cut off from humanitarian aid for months or, in some cases, even years. In the city of Buchanan

in Grand Bassa county, MSF fed malnourished children from September 2003 until the early part of 2004 when needs declined. In Bong county, international staff rejoined Liberian staff who had continued providing medical consultations and clean water to more than 70,000 displaced people despite nearby fighting. In some areas, MSF staff found people surviving amid horrendous living conditions in displacement camps and villages. Many had inadequate food, water and medical care. Malaria, respiratory infections, cholera, sexually transmitted infections and malnutrition rates were high. MSF began providing care in local hospitals and started health clinics which together carried out thousands of medical consultations each month. MSF also organized blanket feedings for more than 10,000 children.

In early October 2003, MSF began a program to treat survivors of rape and sexual violence in three displacement camps located north of Monrovia which shelter about 35,000 people. The project encourages rape survivors and their families to seek care quickly after sexual assaults in order to receive medical treatment necessary to prevent unwanted pregnancies and sexually transmitted infections, including HIV/AIDS. The team's Liberian staff works in the camps to spread the message that treatment is available and to encourage camp residents to take advantage of it. By July 2004, more than 800 people had come to MSF for treatment. All individuals who report being raped are examined and treated in the camps. Those needing extra care are referred to Redemption or Benson Hospital in Monrovia.

MSF has worked in Liberia since 1990.

Madagascar

Providing care for children and families

MSF offers medical, nutritional, social and judicial assistance for children and families in severe need in the capital city of Antananarivo. Staff seek contact, often at night, with vulnerable civilians living on the streets, in detention centers and in temporary shelters. During 2003, MSF intensified its medical activity in the Isotry, Andravohangy, and Anosibe health centers in Antananarivo. The team gives outpatient medical consultations, vaccinations, pre- and post-natal care and refers patients to Befelatanana Hospital when needed. At present, approximately 3,700 children and pregnant women are being assisted by the program. MSF staff also continue to provide health care to patients and to train staff in the therapeutic feeding center for malnourished children located in Befelatanana Hospital. MSF also gives social and legal assistance on a case-by-case basis.

Relief after a cyclone

After a cyclone hit the northeastern region of Antalaha, MSF distributed medicines, helped reconstruct roofs and supplied other materials to the affected population. When malnutrition became a serious problem in the areas surrounding the southwestern province of Morondave, which were difficult to reach due to flooding, MSF opened a therapeutic feeding center to provide urgently needed food and medical treatment to children. In June 2004, MSF started a medical-nutritional program for children and families who had been affected by the cyclone. The main objective was to reduce mortality and to prevent further illness linked to malnutrition.

MSF has worked in Madagascar since 1987.



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Malawi



© Didier Lefevre

Giving comprehensive AIDS care

The southern African nation of Malawi is one of the countries most severely affected by HIV/AIDS. One million adults and children are estimated to have HIV/AIDS, and life expectancy has fallen below 40 years of age. In this country, where most people live in rural areas and have little or no access to health care, MSF provides medical treatment including life-extending antiretroviral (ARV) therapy to people living with AIDS in the districts of Chiradzulu and Thyolo in southern Malawi. MSF also responds to nutritional emergencies and outbreaks of diseases such as cholera.

In the Thyolo district, MSF is providing health care to people living with HIV/AIDS through activities in two hospitals, ten health centers and multiple clinics and other sites. MSF works with volunteers, traditional healers and birth attendants to provide an integrated approach to HIV/AIDS prevention, care, treatment and support. Team activities include voluntary counseling and testing services, treatment for opportunistic diseases (including tuberculosis), prevention of mother-to-child transmission and home-based care. MSF staff also hold monthly mobile clinics for commercial sex workers. By the end of August 2004, about 1,250 patients were receiving treatment with ARVs.

In Chiradzulu, MSF staff carry out daily HIV clinics in the central district hospital and bimonthly clinics in 11 district health centers. MSF sees an average of 400 newly diagnosed patients per month. The MSF team also cares for hospitalized HIV/AIDS patients. By July 2004, more than 3,200 patients were taking ARVs, at the rate of 200 to 250 new patients per month. MSF also works to educate the public to fight the stigma associated with HIV/AIDS.

MSF has worked in Malawi since 1986.

Mali

Treating eye illnesses and infectious diseases

The people of Mali are confronted with chronic health emergencies that include epidemics of meningitis, cholera, measles and yellow fever. Because exclusion from health care is a large problem, the primary focus of MSF's medical programs in Mali is to provide treatment to those who most need it.

Since 1996, MSF has provided support to one hospital and three health centers in the Ansongo district of Mali's Gao region. MSF's work includes surgical training, providing essential medicines and materials, and vaccination and outreach activities. MSF also trains traditional birth attendants and supervises overall management of the health centers. In Gao district, MSF supports the Sahel Formation nursing school which prepares health staff for Mali's three northern regions: Gao, Tombouctou and Kidal.

The region of Mopti, located about 600 kilometers northeast of Bamako, has a particularly high prevalence of eye illnesses. In 2003, an MSF mobile team carried out 650 surgical operations for cataracts (400 at the mobile site and 250 at the hospital) and corrective surgery for 1,200 people with trichiasis, another damaging eye condition. More than 265,000 people received generic medicine to treat trachoma, a viral disease that can lead to blindness.

In 2003, MSF sent an emergency medical team in Mopti to address meningitis and cholera epidemics both in Mali and neighbouring Burkina Faso.

In Bougouni (Koumantou) research done by MSF's malaria program staff found severe resistance to chloroquine and fansidar, two long-time treatments for the disease. MSF plans to use the collected medical data in its efforts to convince the government to change its national malaria protocol to implement artemisinin-based combination therapy (ACT).

MSF has worked in Mali since 1992.

Mauritania

Providing care where there is none

Widespread poverty, lack of infrastructure and insufficient resources have left many of Mauritania's inhabitants without needed health care. MSF's projects seek to assist those who most need care and to reduce malnutrition. In Bouhdida, a poor neighborhood on the outskirts of the capital, Nouakchott, an MSF team runs a primary health care clinic. In the southern region of Guidimakha, MSF operates a project aimed at reducing maternal morbidity and mortality – among the country's most pressing health problems. MSF staff provide basic obstetrical services for 30 percent of the region's pregnant women. In Saada, another poverty-stricken neighborhood of Nouakchott, MSF supports a supplementary feeding center to reduce malnutrition. The results of a study begun in the Guidimakha region at the end of 2002 prompted MSF to open a therapeutic feeding center in Selibaby, the region's chief city, in the middle of 2003.

MSF is also intervening in small- and medium-scale emergencies. A team assisted the population of the Guidimakha region after heavy flooding in August 2003. It also supported the country's ministry of health during a measles vaccination campaign held in the same region.

MSF is now reducing its activities in Mauritania and plans to hand over these projects to local authorities or local NGOs by the end of 2004.

MSF has worked in Mauritania since 1994.

Mozambique

Scaling up AIDS treatment

Most MSF activities in Mozambique are focused on improving the lives of those who live with HIV/AIDS – an estimated 1.8 million of the country's approximately 19 million people. Life expectancy has already begun to be affected by the AIDS epidemic.

Since 2001, MSF has provided comprehensive care to people living with HIV/AIDS, conducted HIV education and assisted patient-support groups in Maputo. In the Chamanculo health district, MSF supports the Alto Maé health center and one unit of Chamanculo Hospital. Activities include voluntary counseling and HIV testing, prevention of mother-to-child transmission of the virus and treatment with antiretroviral (ARV) medicines. As of June 2004, 935 patients were receiving life-extending ARV therapy. MSF hopes to increase the number of patients using ARVs by at least 80 a month.

In the city's Mavalene district, MSF staff work at the Primeiro de Maio health center, providing comprehensive AIDS prevention and treatment services primarily to a destitute urban population. As of May 2004, MSF was providing ARVs to 473 patients in this region. The team conducted 6,942 consultations in the day clinic between January and May 2004. In addition, 975 women had been tested for HIV as part of the mother-to-child prevention program. The MSF staff hope to expand ARV treatment to an additional 700 people in Mavalene district during 2004.

In Lichinga, an isolated city in the north of the country, MSF supports two voluntary counseling and care clinics (one in the provincial hospital and one in the city's health center) and one hospital. Activities include comprehensive HIV/AIDS treatment and education and training of staff members who work in these health structures. As of June 2004, 81 patients were receiving ARVs. MSF recently began a campaign to reduce stigma and dis-

crimination through street theater, radio programs and other activities.

MSF also runs two HIV/AIDS projects in Tete province and another in the northern district of Angonia. Tete has a high concentration of displaced people who arrived during Mozambique's period of civil conflict. The most recent epidemiological surveillance shows an HIV infection rate of 20 percent. As of May 2004, through these projects, MSF had conducted 5,150 medical consultations, had tested 972 women for the virus as part of the mother-to-child prevention program, and was treating 279 people with ARVs.

Combating cholera

To help the government cope with cholera, a recurring health problem, MSF began a vaccination project in December 2003 in the city of Beira, in the province of Sofala. This was the first large-scale field test of a cholera vaccine and was carried out in cooperation with the World Health Organization and others. MSF also responded to a cholera outbreak in Maputo between January and March 2004. In mid-2004, MSF will hand over another cholera prevention program to a local association.

MSF has worked in Mozambique since the late 1980s.

MSF uses street theatre and personal stories to educate the public about AIDS in Mozambique. A man in the crowd embraced one speaker after hearing his story about living with HIV/AIDS.



INTERNATIONAL STAFF 5
NATIONAL STAFF 8

Morocco



Helping immigrants bound for Europe
Morocco is a transit country for thousands of immigrants and asylum seekers on their way to Europe. MSF is focusing attention on sub-Saharan undocumented immigrants based in the city of Tangiers and its surrounding areas.

In Tangiers, MSF runs a clinic in the city center and makes visits to patients in hostels and private houses where undocumented immigrants seek shelter. MSF also uses mobile clinics in the surrounding neighborhood of Massnana to carry out patient consultations and referrals.

MSF works with health authorities to ensure that undocumented sub-Saharan immigrants receive other needed health care services, such as pre- and postnatal care, tuberculosis treatment and HIV/AIDS care. At the same time, the team tries to raise awareness among Moroccan authorities and organizations about these immigrants' vulnerable situation.

Responding to the earthquake emergency

On 24 February 2004 an earthquake hit the northern region of Al Hoceima. An MSF team traveled to the area to assist the affected population. MSF distributed 2,000 blankets and plastic sheeting to families that had lost their homes. These same materials were also distributed in surrounding villages affected by the earthquake.

MSF has worked in Morocco since 1997.

INTERNATIONAL STAFF 9
NATIONAL STAFF 100

Niger



Aiding epidemic victims
In the first quarter of 2004, a measles epidemic occurred in Niger's capital city, Niamey. In March and April 2004, MSF, in cooperation with the ministry of health, carried out a massive measles-vaccination campaign there and in two other districts.

Before the epidemic had ended, more than 30,000 people had contracted the disease, and MSF had vaccinated 100,000 children between the ages of six months and five years. MSF also supplied 500 medical treatments to Niamey's largest hospital to treat children suffering from critical complications related to the disease.

Epidemics have led to an increase in malnutrition in Niger. Currently, MSF runs an emergency nutrition program in the eastern city of Maradi. During 2003, 6,500 children received high-protein treatment in MSF's therapeutic feeding center. The objective of this program is to set up a new approach to treat severe malnutrition, which consists of reducing or even eliminating the hospitalization stage. One-third of the children admitted to the center and all of those who are not severely malnourished are treated as outpatients.

MSF has worked in Niger since 1985.

INTERNATIONAL STAFF 23
NATIONAL STAFF 70

Nigeria

Africa

Alleviating the burden of illness and violence

Malaria is the main cause of death among very young children living in the Niger Delta. The mosquitoes that spread the parasites causing the disease breed in the region's wetlands. In isolated and swampy parts of southern Bayelsa State, MSF teams provide basic health care at three health centers covering a population of more than 50,000 people. The care includes artemisinin-based combination therapy (ACT), the most effective treatment now available for malaria. Team members educate local residents about ways to prevent malaria and to improve basic hygiene. This project is MSF's first using ACT in Nigeria, and the organization believes it will play an important role in promoting the country-wide introduction of this treatment.

An estimated 300,000 of the 12 million people who live in Nigeria's largest city, Lagos, are thought to be living with HIV/AIDS. Most of them have no way of getting treatment for related illnesses. MSF staff are caring for HIV-positive patients at Lagos General Hospital and have improved the hospital's laboratory and pharmacy, rehabilitated a special treatment department, and started a voluntary counseling and testing center. Patients receive care for opportunistic infections that can develop when the HIV virus undermines the immune system and can also receive psychological counseling. The team will start treating patients with life-extending antiretroviral (ARV) drugs during the second half of 2004.

With no fewer than 350 ethnic groups, Nigerian society is extremely complex. Incidents of violence rooted in ethnic, religious or socio-economic differences occur frequently. After clashes and a massacre took place in May between rival groups in Yelwa, Plateau State, MSF assisted thousands of destitute, displaced people who had fled to neighboring Bauchi and Nasawara States. MSF mobile teams began providing basic medical and psychological care to displaced people living in a number of makeshift camps in the area. They also improved water and sanitary conditions to improve the camps' difficult conditions.

MSF has worked in Nigeria since 1996.

Rwanda

Providing psychological and medical care
MSF works with local groups to provide psychological help to survivors of the genocide that occurred in 1994. A team of five psychologists helps women – many of whom were raped during the genocide and have subsequently developed AIDS – to express their anxiety and anger.

Group therapy aims to help them cope with their emotions and rebuild social connections. The team supervises 14 MSF-trained trauma counselors from partner associations who manage 496 psychosocial assistants (local people trained in basic psychosocial care who work in villages around the country).

MSF developed an HIV/AIDS project encompassing both prevention and treatment in 2002. The project first served patients in the zone around the health center in Kigali's Kimironko area, and since June 2003 it has also included patients from a second health center in Kigali's Kinyinya area. MSF staff provide voluntary counseling and testing, home-based care, treat opportunistic infections and give drug therapy to prevent mother-to-child transmission. MSF introduced antiretroviral (ARV) drugs in Kimironko in October 2003 and in Kinyinya in January 2004. MSF plans for at least 500 people to be receiving ARVs by the end of 2004.

In October 2002, MSF opened a reproductive health program in Ruhengeri province, a region where inadequate services raise risks for an already vulnerable population. Working closely with the local community, this program targets obstetrical emergencies, implementation of family planning programs in health centers and maintenance of all general reproductive health services (e.g. staff training, prevention of sexually transmitted infections and improved prenatal care, delivery and postnatal care). Program components related to AIDS and sexual violence are being developed.

MSF operates a cholera-prevention program in Cyangugu province located on Lake Kivu. Activities include educating the population about hygiene and progressively rehabilitating water points (pumps and sources). MSF collaborates with Rwandan health authorities on these activities as well as on constructing wells, providing training and conducting epidemic surveillance.

MSF has worked in Rwanda since 1991.

Sierra Leone

Giving medical care to survivors of war

Much of MSF's work today in this West African country is focused on providing and improving basic health care for both Sierra Leoneans and refugees from other countries. Approximately 60,000 of the refugees are Liberians who continue to reside in Sierra Leone because of continuing insecurity and food scarcity in their homeland.

Poverty and unemployment remain high in Sierra Leone and the introduction of a cost-recovery system involving user fees for medical services has led to a situation where fewer than half of all the people in Sierra Leone can obtain needed care.

In the southern districts of Bo and Pujehun, MSF teams treat patients in public health clinics. Since April 2003, the 50-bed referral hospital in Gondama that was built by MSF has been operating at full capacity. In August 2004, 300 people were admitted to its wards. Its facilities include a pharmacy, isolation ward and therapeutic feeding center. Near the Liberian border, MSF staff assisted people until August 2004 at health clinics in Zimmi, Fairo and Sulimo.

In northern Sierra Leone's Koinadugu district, MSF worked to improve health care among the local population and Sierra Leoneans returning from Guinea now that peace has returned. MSF treated patients at Kabala and Kailahun Hospitals and nine area clinics. Thousands of medical consultations were carried out in 2003, many due to malaria. MSF's work at Kabala Hospital was handed over to local authorities in May 2004. Now that Kailahun Hospital has been rehabilitated, MSF plans to hand over its activities there to the ministry of health by the end of 2004.

In the northern Kambia, Bombali and Tonkolili districts, MSF staff members provide maternal and child health care, emergency obstetrical and general emergency surgery, training and supervision of local medical staff, epidemiological surveillance and health education delivered in 3 district hospitals and 15 clinics. MSF is beginning to integrate HIV/AIDS activities into the current program by supporting voluntary testing and counseling. It is in the process

Every day, thousands of children in Rwanda spend hours collecting water from a river or if they are lucky, a nearby tap. Running tap water in the house remains a luxury enjoyed only by the middle and upper classes.



Somalia



© Doris Burtischer



© Espen Rasmussen

A camel kick broke this little girl's leg. She waits for her crutches to be made at the pediatric ward of the MSF health center in Huddur.

of setting up a program to prevent mother-to-child transmission of HIV and to treat patients with opportunistic infections at Kambia Hospital.

As Liberian refugees begin to return to their own country and the populations in Sierra Leone's refugee camps decline, MSF continues to assist those remaining in camps. MSF works in five refugee camps in the districts of Bo and Pujehun, offering basic health care to camp residents and those in nearby communities. In 2003, MSF began a sexual violence program in Bo. Team members train medical staff to treat victims and provide direct medical and psychological care for survivors of rape or other forms of sexual violence. In the Taiama and Tobanda refugee camps, MSF provides medical care as well as mental health care for refugees who have been traumatized by violence, including former child soldiers.

Malaria is the main cause of death for children under five and the leading cause of illness and death for adults in Sierra Leone. Because traditionally used malaria drugs are often ineffective due to growing parasite resistance, the government of Sierra Leone in March 2004 changed the country's malaria-treatment protocol to artemisinin-based combination therapy (ACT). MSF has advocated strongly for the transition to these more effective drugs and is now working closely with health authorities in all of the medical facilities in which the organization works to implement ACT.

MSF has worked in Sierra Leone since 1986.

Providing care amid prolonged conflict

Despite ongoing conflict, the absence of a formal government and frequent evacuations due to insecurity, MSF teams continue to bring medical aid to thousands of Somalis who would otherwise lack health care. In southern Somalia, where medical infrastructure is completely lacking, MSF is working to reach the 200,000 people who live in the Bakool region. MSF has recently expanded its work to four of the region's five districts, providing treatment for diseases such as tuberculosis and kala azar, and reaching out to nomadic populations.

Since 1997, MSF has worked in Galkayo, in the Mudug region, home to an estimated 350,000 people. MSF supports pediatric and maternity services in two hospitals there, one of each side of the "green line" which divides the town between warring factions. In addition to supplying medicines and materials, training local staff and providing direct patient care, MSF is rehabilitating both hospitals. Between October and December 2003, MSF intervened three times during repeated clan conflicts in Galgudud, 200 kilometers south of Galkayo. MSF teams traveled to both sides of the conflict, treating more than 180 wounded people and replenishing stocks of emergency drugs and supplies.

In Lower Juba Valley, in the Marere region, an area in which most people are members of the marginalized Bantu group, MSF focuses on maternal and child health. While working to improve vaccination coverage and reproductive health, the MSF

team also treats people with communicable diseases. In late December 2003, a Somali MSF staff member was killed in the cross-fire between attackers and guards during a robbery at the compound of a Somali aid organization. The rest of the team was evacuated. By January 2004, the remaining team members had returned and were caring for 48 children in a therapeutic feeding center.

In the southwestern part of the country, MSF runs a 35-bed health center in Dinsor, a town in the western Bay region, near Baidoa. The MSF clinic is the only health facility for the 100,000 people who live in this region. In February 2004, the team responded to tribal clashes near Boale by treating the wounded and referring the most severe cases to the Dinsor health center. MSF staff also have monitored and responded to epidemics, such as a measles outbreak that occurred in January 2004.

MSF is also working in Somalia's capital, Mogadishu, running a primary health care clinic and responding to cholera outbreaks as necessary. At the clinic, MSF provides maternal and child health care, nutritional screening and monitoring of infectious-disease outbreaks. MSF also provides primary health care in 11 clinics in the southern regions of Banaadir and Shabeellaha.

MSF has worked in Somalia since 1991.

South Africa

© Francesco Zizola

An HIV-positive support group gives AIDS education courses in the waiting room of the MSF village clinic in Lusikisiki.

Treating AIDS patients at the heart of the problem

With approximately 5.3 million people infected with HIV, South Africa has the highest number of people living with HIV/AIDS of any country. In November 2003, the South African government approved a new national HIV/AIDS plan that added life-extending antiretroviral (ARV) therapy to the existing protocol and set a goal of treating 600,000 people with ARVs by 2008.

The government's revised HIV policy marked the start of an intensive effort to broaden the use of ARVs in Khayelitsha township, in the Western Cape province. MSF runs three HIV/AIDS clinics within primary health care centers in Khayelitsha. These clinics provide prevention information, HIV testing, counseling and management of opportunistic infections, as well as ARV treatment to people at advanced stages of AIDS. By July 2004, clinic doctors and nurses were conducting 150 to 200 medical consultations per day and providing ARVs to nearly 1,200 people. MSF's aim is for 2,000 people to be receiving ARVs by the end of 2004.

In collaboration with the Nelson Mandela Foundation, MSF operates a second rural HIV/AIDS program in Lusikisiki, in the Eastern Cape province, one of the country's poorest areas. The program has tested more than 600 people for the virus each month and has demonstrated an HIV-positive prevalence of 30 to 40 percent. MSF manages opportunistic infections in 11 rural clinics and in the district hospital and

began offering ARV treatment in the clinics in November 2003.

In October 2003, MSF opened the Simelela Rape Survivors Center in Khayelitsha. The center offers medical and psychosocial care, including post-exposure prophylaxis to prevent HIV transmission, and trauma counseling. The center's staff conducts 25 to 35 consultations per month. More than half of the rape survivors treated are children younger than 14 years of age.

MSF continues to work in partnership with the Treatment Action Campaign to advocate for increased access to treatment. Together, the two groups support patients' adherence to treatment and community education about treatment options, promote the use of fixed-dose combinations of ARVs and monitor the impact on health of southern Africa's free trade negotiations with the United States.

MSF first worked in South Africa in the mid-1980s and returned in 1999 to respond to the needs of people affected by HIV/AIDS.

Sudan

Caring for victims of war

The peace process between northern and southern Sudan that has been underway since 2002 has renewed hopes for an end to Africa's longest-running civil war. The conflict has cost almost two million lives, mostly civilians who have died from hunger and disease. Yet amid talk of peace between the north and the south, the westernmost region of Sudan, Darfur, became the site of a growing catastrophe in the past year (see box on Darfur crisis and photo essay, page 14.)

The ceasefire between the Sudanese government and the southern rebels of the Sudan People's Liberation Army (SPLA) has held – with few exceptions – for two years. The absence of fighting has greatly improved MSF's ability to reach new areas and has reduced the displacement of groups of people fleeing violence.

For years, MSF has assisted people in both northern and southern Sudan, providing basic health care at hospitals or through networks of clinics and health centers. Its work has included treating people with tuberculosis (TB), kala azar (visceral leishmaniasis) and other diseases; providing food; and treating the severely malnourished. MSF also delivers clean drinking water and provides sanitary facilities in areas where displaced people have sought shelter.

In 2003-4 the organization continued these crucial, basic services and also assisted people affected by measles, meningitis, malaria and other infectious diseases. MSF treats people with TB in the towns of Akuem and Mapel in Bahr el Ghazal province, Bentiu in Western Upper Nile province and in Lankien in Eastern Upper Nile province. During the last year, MSF treated approximately 430 TB patients in Sudan.



"I walked through the town asking new arrivals about their villages and what had happened to them. They said that hundreds from each village had been killed. They told stories of children strangled, women burned alive, and men shot to death."

– MSF logistician Jean-Sébastien Matte in Mornay, Sudan



© Marcus Bleasdale/JPG

Because the treatment takes from six to eight months, curing people with TB remains highly challenging. MSF's pioneering experience in this field has paved the way for other organizations to set up similar TB programs elsewhere in the country.

In southern Sudan, sleeping sickness (African trypanosomiasis) is endemic, and unless outbreaks are brought under control, epidemics can emerge rapidly. The disease is fatal if left untreated. MSF is now treating those with sleeping sickness around the towns of Kajo Keji, Ibba and Kotobi in Western Equatoria province. MSF closed a sleeping sickness program in the Western Equatoria town of Kirii after successfully reducing the number of cases to the region's normal level.

MSF also runs a special program to treat people with kala azar, a parasitic disease spread by the tiny sandfly that is fatal in 95 percent of untreated cases. Approximately 3,300 patients received treatment for the disease through MSF projects in the towns of Walgak, Wudier and Lankien in Upper Nile province, in Umm el Kher in the eastern state of Gadaref and in Bentiu in Western Upper Nile province.

In May and June 2004, an outbreak of the hemorrhagic Ebola virus occurred near the town of Yambio, in Eastern Equatoria province. MSF set up an isolation unit and treated 28 patients, of whom 6 died.

MSF has worked in Sudan since 1979.

Darfur: Living in a nightmare

"What you see there is widespread suffering, inadequate relief efforts and continuing violence. Hardly anyone is getting the care civilians should get in a conflict, and there are real pockets of disaster, where people are at grave risk of dying in large numbers."

– Rowan Gillies, M.D., President of MSF's International Council, after returning from Darfur

During the past year, brutal killings, rape and razed villages became all too common occurrences for the people of Sudan's western region of Darfur. Attacks carried out by government-backed militias known as Janjaweed terrorized civilians and forced them to flee to what they hoped would be safer locations. Yet after having survived massacres, raids and looting, the displaced still face continuing violence and a devastating shortage of assistance.

By mid-2004, more than one million people had been driven from their homes. An additional 180,000 people had sought safety in Chad (see page 23). More than 200 international MSF volunteers and 2,000 national staff members are working in an area where approximately 700,000 people have sought refuge, helping those weakened by disease and malnutrition. In July alone, the organization shipped and flew in more than 1,400 tons of supplies, valued at more than three million euros, to Sudan. The supplies included large quantities of medical and logistical material as well as full containers of food.

Across Darfur, MSF is providing medical care in hospitals and clinics for those wounded in the violence, victims of sexual violence and displaced living in camps who suffer from malaria, respiratory infections and diarrhea – the latter the main cause of death, particularly for young children and the elderly. Another important part of the organization's activities centers on feeding malnourished children. MSF has organized "blanket feedings" to distribute survival food rations to children under the age of five. MSF estimates that by the end of 2004 it will have distributed more than 800,000 survival rations. Teams also provide clean water and latrines to reduce the risk of cholera, dysentery and other diseases. In late July, MSF was treating some 10,000 malnourished children in its feeding centers and performing almost 12,000 medical consultations a week.

An MSF assessment carried out in late August found that people living in remote regions of northern Darfur still lacked food and medical aid despite the increased mobilization of international aid agencies in the region. Aside from addressing these needs, MSF will also hold a massive measles vaccination campaign there, targeting 80,000 children between the ages of six months and 15.

In addition to providing immediate relief, MSF has been speaking out on the precarious situation of the displaced and the need for immediate action. Despite the efforts made by MSF and others, many people remain exposed to hunger, disease and violence. The people of Darfur need much more assistance than MSF can provide. The organization continues to call on international aid agencies to increase significantly their delivery of aid, especially in areas that remain cut off from help at present, in order to meet the immense needs and avoid further deaths.

Uganda

Aiding civilians targeted by war

For more than 19 years, civilians living in northern Uganda have faced massive violence inflicted by local insurgents as well as by the national army. Brutal attacks, carried out in countless villages, have led to the displacement of much of the rural population in the districts of Kitgum, Gulu, Lira and Pader, as well as in the many camps set up to shelter them. In 2003, the crisis escalated further, bringing the war to Lira and Teso – regions previously unaffected by the violence. Some 1.6 million people – or 80 percent of the region’s population – has been forced to flee, and the northern Uganda economy is in tatters.

Scattered over more than 150 sites, displaced people try to survive by doing small jobs, cultivating pieces of land around the camp sites, or engaging in small-scale trading in nearby villages. Those without these sources of income are completely dependent on food distributions from relief organizations. In many areas, health staff have fled, leaving the local and displaced population without functioning health facilities. It is no surprise that malnutrition levels are high – above emergency thresholds in some locations – and that people are weakened and vulnerable to disease. Since late 2003, MSF has been providing several of the camps with basic medical care, clean drinking water, latrines, and therapeutic feeding for severely malnourished children.

The government’s response to the violence has been sluggish, with few officials acknowledging the vast scope of the problem, and the ministry of health has been slow to deploy staff to assist overburdened regional hospitals and health centers. An MSF measles-vaccination campaign proposed in October 2003 for the town of Soroti, where 100,000 displaced people have gathered, was delayed by the government’s lack of cooperation. As a result, an epidemic claimed many lives among the displaced population.

The region continues to suffer from food shortages because people are not able to farm, and World Food Program food distributions hover around 50 percent of the daily requirements. The reason: authorities want civilians to return to their own villages and begin farming again as quickly as possible to relieve overburdened public

services. Understandably, civilians have refused to return, knowing that doing so will expose them to more killings, rape and kidnappings.

Moreover, the fighting factions do not wait for people to return. The rebels attack camps and abduct young children to swell their ranks. Once captured, the children are terrorized into cooperating. Thousands of young people have been kidnapped over the years, and tens of thousands more fear staying in their homes at night as a result. Instead, every evening they walk to major towns such as Gulu or Kitgum to spend the night there. The United Nations estimates that approximately 50,000 children make this “commute” each night. In April 2004, MSF opened a reception center in the town of Gulu offering some of them shelter after dark (see page 39).

Treating AIDS, kala azar and malaria

Like most other African countries, Uganda’s population has been hard hit by the AIDS pandemic. In the northwestern town of Arua, MSF provides medical care for nearly 2,500 people living with the virus. MSF was also one of the first organizations to offer free antiretroviral (ARV) treatment in Uganda, and it uses generic drugs in fixed-dose combinations. Today, nearly 800 people are receiving ARVs, and MSF adds 60 to 80 new patients to the program each month. During the second half of 2004, MSF will open an additional HIV/AIDS program in Koboko, north of Arua, near the borders with Sudan and the Democratic Republic of the Congo (DRC). This program will link ARV treatment and prevention of mother-to-child transmission of HIV with

existing voluntary counseling and testing programs.

Along with a number of other African and Caribbean countries, Uganda will be a recipient of funding through PEPFAR, the US government initiative to increase AIDS treatment in countries that are hardest hit by AIDS. PEPFAR requires that the medicines procured be brand-name drugs, a policy that deeply concerns MSF. By using generic drugs, MSF has been able to treat three to four times as many patients for the same cost.

The patient load in Arua is increasing sharply each month and patients have started arriving from neighboring provinces, indicating the lack of access to HIV/AIDS care and treatment in many other parts of Uganda. Despite government openness to treatment and important donor support, expanding access to HIV/AIDS care and treatment is painfully slow throughout the country. MSF also supports Arua Regional Hospital in the implementation of adequate universal precautions and improvement of waste management and nursing care.

In Amudat, a remote town in the eastern district of Moroto near the border with the DRC, MSF teams contribute diagnostics, treatment and care for patients affected by the infectious disease kala azar (visceral leishmaniasis). Some 30 to 35 people are admitted for treatment each month. The MSF team also carries out a number of research projects related to prevention and better diagnosis of this disease. The team also gives support to Amudat Hospital.

Over the years, MSF has made important changes to the treatment of malaria in Uganda, promoting the use of artemisinin-based combination therapy (ACT). Although the government initially resisted changing its national protocol, despite high levels of resistance to current first-line treatments, in June 2004 health officials finally agreed to adopt ACT. However, because of changes in treatment protocols, additional cost and complexities of procurement, teams on the ground fear that the change will not be implemented until well into 2005.

MSF has worked in Uganda since 1982.

"You can see the distress in the kids' eyes. They are really tired but can't sleep."

- Bastien Vigneau, director of operations for MSF's projects in Gulu

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Night commuters: Children in search of shelter

Every night, they arrive in droves in the northern Ugandan town of Gulu. Up to 12,000 children, some as young as two years old, walk several miles from the villages and camps for internally displaced people surrounding Gulu, hoping to find shelter for the night. The next morning, they leave again, to attend school near their home, only to return again that evening.

They are called "night commuters" a euphemism that obscures the cruel reality of thousands of children taking part in such an exodus each night. They seek shelter in town centers out of the sheer terror of being attacked or kidnapped by soldiers to serve as soldiers, porters or sex slaves.

Gulu is home to 30,000 people, and its well-stocked markets bustle with activity during the day. By nightfall, though, the streets are deserted, and the gates of Lacor Hospital on the northwest fringes of town close at 9:00 p.m. on a sea of nearly 5,000 children gathered in the hospital's central square.

Every night in the square, an MSF team treats up to 600 children for scabies, a severe skin disorder caused by burrowing mites, which is exacerbated by crowded living conditions.

In addition to providing needed medical care, the MSF team also offers psychological support to the children through individual and group counseling to help them cope with their experiences during the war.

Below are stories from two children who have received counseling from MSF staff in Gulu:

Justin* is one of the night commuters in Lacor Hospital. Every evening he walks about two kilometers to the shelter in order to sleep.

"I have five sisters and one brother. Three of them come here. My older sister lives with the soldiers, because that is easier. The rebels attack our town very frequently. I come here because of them. I was abducted when I was 13-years-old and I don't want it to happen again. The night I was abducted I couldn't go to a shelter because I was sick. So I stayed home. Then the rebels came and took me. I managed to escape. Because I acted so smart, the rebels trusted me and they gave me a group to lead. They showed us dead bodies, to make us harder. We were forced to attack villages, but I always discouraged my group to kill. And then one night, there was a big attack on a village. I hid in the grass and waited until it all was over and the rebels had left.

I am glad to come here. I like it that there are so many activities. It keeps me from having all those negative thoughts about the things that happened to me and the dead bodies I saw. In the morning I go home to my parents and attend school. I want to be a pilot one day."

Denis* also walks about two kilometers to Lacor Hospital every evening.

"I come on my own every night. The place where I live is more isolated than Lacor Hospital. So I feel more secure here and I like the counseling that I get. It keeps me going and helps me forget what happened to me. I had five brothers and two sisters. One night in 1998, the rebels came and took me and one sister and three brothers. They tied us all to a long rope. We started moving and they would beat us. Then it was my turn and they hit me very hard, and while they did that, the rope got cut. They became very angry with me and blamed me for the cutting of the rope. So they brought my sister and handed her to my brothers and me and told us to kill her. We refused. But they hit us even harder. So we killed her. We walked all the way to Sudan. On the way the rebels killed one of my brothers. I was so afraid, that I was going to die too. I was very scared all the time. But at some point I just did what they told me to do and withdrew in my head to pray, that helped me to go on...."

* Not the boys' real names

MSF and HIV/AIDS: Expanding treatment, facing new challenges

Signs of success, but a long road ahead

Six million people are in urgent need of life-extending antiretroviral (ARV) therapy. Today only 440,000 of them, or a mere seven percent, have access to it in developing countries.

MSF has been caring for people living with HIV/AIDS since the mid-1990s. In 2001, the organization started offering ARV treatment to patients in Cameroon, Thailand and South Africa. A sharp decrease in prices caused by generic competition and the simplification of treatment protocols, including the use of three-in-one "fixed-dose combinations" (FDCs) enabled MSF to rapidly increase the number of patients using ARVs in its programs. In the past two years, MSF's AIDS treatment programs have jumped from 1,500 patients in 10 countries to 13,000 patients in 25 countries. ARVs have transformed the lives of those receiving them, allowing them to work and have normal lives. If these 13,000 patients had not begun ARV treatment,

MSF estimates that at least half of them would have died within one year.

MSF's patients live in capital cities, slums, remote rural areas and regions in the midst of armed conflict. More than half of all of those treated by MSF are women of childbearing age, and there are high numbers of children in need of ARV treatment. Patients tend to be in very advanced stages of HIV/AIDS before they seek treatment and are often affected with one or more complex co-infection such as tuberculosis (TB).

The aim of MSF's ARV programs is to provide comprehensive care for those living with HIV/AIDS. That means projects include prevention efforts (health educa-

tion, prevention of mother-to-child transmission of HIV, condom distribution), voluntary counseling and testing, nutritional and psychological support, care and prevention of opportunistic infections and ARV treatment.

MSF has gained substantial knowledge and learned important lessons from its hands-on experience treating people with HIV/AIDS, but the organization does not pretend to have developed a unique model for implementing large-scale ARV treatment programs. The responsibility for scaling up comprehensive HIV/AIDS treatment programs rests with governments which have a responsibility to provide adequate health care to their people. Of course these governments will continue to need massive sustained technical and financial support from international donors and the World Health Organization if real progress is going to be made.



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The fact that more than 13,000 people are now receiving life-extending antiretroviral (ARV) treatment through MSF is encouraging. However, huge numbers of people still lack treatment – far beyond MSF’s capacity for providing care. Doctors and nurses today face real challenges in giving urgently needed treatment. Limitations on existing care options continue to block treatment for the millions who need it now. MSF is calling for more to be done to dismantle these barriers now.

The need for more treatment options

MSF promotes fixed-dose drug combinations (FDCs) to treat people with severe AIDS. By combining various medicines within a few tablets, FDCs improve treatment compliance, simplify usage guidelines and help prevent dosage errors. Yet there is only one triple FDC now available in our programs and this does not solve all of the related treatment problems. For example, patients co-infected with tuberculosis (TB), the most common opportunistic infection affecting people living with HIV/AIDS, cannot use this simple treatment. This situation has to change as TB is intrinsically linked to AIDS by the growing number of co-infections. Globally an estimated 12 million people are now living with both diseases. In some southern African countries with high HIV prevalence, up to 70 percent of the people who have TB also have HIV/AIDS. Diagnosing TB is difficult in HIV-positive patients. Clinical diagnosis is also more difficult in co-infected patients as weight loss, swelling of the lymph nodes and pulmonary infections can be caused by various AIDS-related infections as well as TB.

Every year an estimated 2.2 million women with HIV/AIDS give birth. Treatment is now available to prevent transmission of the virus from mother to child. But experience has shown that exposure to a single dose of the drug, nevirapine, used at delivery to protect the newborn may induce resistance in the mother and therefore reduce the effectiveness of ARV therapy if the mother needs treatment later.

Koout Chrel (38) is HIV positive and receives antiretroviral treatment from MSF in Cambodia. He lost his leg in a landmine explosion while serving in the army. He did not know his HIV status when he married. Both he and his wife were tested for HIV, found positive and sent to MSF’s chronic diseases unit in Siem Riep. Thanks to his faithful adherence to treatment, he can now work. The couple has three children. Two of them have tested negative for HIV, the youngest has yet to be tested.

“HIV treatment for adults is slowly becoming easier, with increased availability in developing countries of a three-drug cocktail in one tablet. But children who need treatment still have to drink large amounts of foul-tasting syrup or swallow large tablets – that’s if they can actually access treatment at all.”

– David Wilson, M.D., medical coordinator, MSF, Thailand

A glaring lack of medicines for children

The estimated worldwide number of children living with HIV/AIDS was more than 2.5 million in 2003. Around 50 percent of all children with HIV/AIDS die before reaching the age of two. Efforts to prevent transmission of the virus from mother to child have been largely successful in developed countries meaning that relatively few children are born with HIV. Ironically, the low number of pediatric patients in developed countries means there is little profit to be made by developing and manufacturing pediatric treatment formulations there. As a result, these formulations are not available in developing countries despite the growing need for them. This means children with HIV/AIDS do not benefit from active research and have no access to affordable and easy-to-take treatment.

While MSF began treating children with ARVs in early 2002, only five percent of the organization’s patients were children under 13 by March 2004. MSF is now attempting to include more children in its AIDS projects but those efforts are frustrated by the lack of proper tools. Most methods used to diagnose HIV are unreliable in children younger than 18 months old. The lack of pediatric ARV formulations makes determining and administering doses complex and burdensome. Doctors are forced to break tablets in two or crush and dissolve them. Care providers have to give small children foul-tasting syrups and large pills. Syrups and oral solutions are not suitable for older children because of the large amounts needed, but low-dosage tablets and capsules are not produced for most ARVs. What pediatric formulations do exist come at a high price. Both first and second-line ARV treatments for children cost several times more than those for adults.



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During a home visit in Bukavu, Democratic Republic of the Congo, an MSF physician provides new pills to an HIV-positive patient.

"If we have no way of telling when first-line treatment no longer works and no affordable alternative for people to switch to, we will have failed our patients."

– Alexandra Calmy, M.D., MSF

When first-line treatment is not enough

As a medical humanitarian organization, MSF feels a responsibility not only to start people on ARVs but to ensure that their lives are improved and prolonged. This means being able to detect when a first-line treatment no longer works and it is necessary to switch to second-line drugs. From experience in developed countries, MSF knows that the benefit of a first-line combination treatment will not be indefinite for most AIDS patients. People can develop resistance to the medicines they are taking. Patients can also develop side effects that cause them to discontinue treatment. Yet there are few therapeutic choices beyond the first-line and the challenge is to know how long patients can be kept on first-line regimens without threatening their future treatment options and their long-term prognosis. In developing countries, monitoring treatment effectiveness remains very difficult due to the largely unaffordable or impractical equipment that is commonly used.

However, there is no point in diagnosing treatment ineffectiveness if there is no affordable second treatment combination to prescribe instead. Second-line treatments can be more than 20 times more expensive than first-line therapies. Unless things change, the cost of treatment will increase dramatically over the next few years in most countries because of the need to switch patients to expensive second-line treatment. Mortality will also increase if people and

the health systems that serve them cannot afford the treatment they need once first-line treatment no longer works. With treatment costs already a concern, second-line treatments only increase the problem. MSF and others must continue to fight for price cuts on new treatments and in particular, on second-line treatments, as they become an indispensable part of our programs.

In an ideal world, there would be one universal FDC that would be suitable for patients with co-infections (such as TB) and for children and other groups with special needs. It would be non-toxic, lack side effects and be highly effective. However, this perfect tool does not exist. For that reason, health care providers need more options to treat HIV-positive patients who also have TB, who are children, who are pregnant or for whom first-line treatment no longer works.

Protecting access to treatment

After the World Trade Organization's TRIPS Agreement on intellectual property rights is implemented in 2005, access to new drugs will become more difficult. All new drugs will be subjected to 20 years of patent protection in all but the least developed countries. This will affect producers in key manufacturing countries such as India. It will drive up prices and make new medicines more difficult to obtain. Generic producers will be blocked from developing FDCs until patents expire. MSF believes patents should never be a barrier to treatment. This means the public health safeguards in intellectual property law, affirmed in the 2001 Doha Declaration on the TRIPS Agreement and Public Health must be used to protect access to treatment.

Increased attention on the need to expand treatment has not yet been translated into real action in countries hit hard by the epidemic. Governments, international donors and health care providers, including medical NGOs must mobilize the necessary financial and human resources to make ARVs available to those who need them.

The HIV/AIDS pandemic won't be defeated with existing tools. Yet ARVs are the only option we now have to prolong life. Innovative strategies to provide ARVs more efficiently to patients who need them have to be developed. We must be more ambitious and invest resources into vaccine research, immunotherapy and other easy-to-use therapeutic approaches too. At the same time we need to boost efforts to simplify current treatment and monitoring tools. MSF's experience in the field shows that ARV treatment is possible, even in the poorest and most difficult settings, despite the challenges ahead. With more than 13,000 patients on ARVs and about five times as many AIDS patients in our consultation rooms, there is no time to lose in addressing these treatment obstacles.

To read MSF's briefing document "MSF AIDS treatment experience: Rapid expansion, emerging challenges" published for the XV International Conference on HIV/AIDS in Bangkok, visit: www.accessmed-msf.org.

United Republic of Tanzania

Promoting better treatment for those with infectious diseases

The success of local health workers in stopping an outbreak of cholera in the southeastern Mtwara district in September 2003 suggested that MSF's training of staff to respond to epidemics had been fruitful.

The ministry of health's quick reaction to the outbreak stopped it in its early stages. After seven years of operating this cholera-preparedness project, which aimed at improving patient care and government response in Mtwara, MSF handed it over to the ministry in February 2004.

In May 2004, MSF started a project in Zanzibar to improve treatment for malaria patients. The program's key component is to help local health authorities implement a national treatment protocol that includes the most effective first-line treatment, artemisinin-based combination therapy (ACT). In Kigoma, the capital of Western province, MSF closed a malaria project because local health authorities refused to allow the use of ACT, while high parasite resistance to the medicines being used there impeded the organization's ability to treat patients effectively.

An exploratory mission carried out in three sites in the southwestern Makete district to assess the impact of HIV/AIDS on civilians found that many people were in need of care. MSF is now preparing a project that will include activities to prevent the spread of the virus as well as treatment with life-extending antiretroviral (ARV) drugs. MSF will also advocate for free access to ARVs for those who urgently need them.

MSF has worked in the United Republic of Tanzania since 1993.

Zambia

Targeting people living with AIDS

In Zambia, MSF activities are focused on helping people with AIDS. Zambia has one of the worst rates of HIV infection in the world with more than 20 percent of adults estimated to be HIV-positive.

Since 2002, MSF has worked to provide comprehensive care to those living with HIV/AIDS – about one in four people – in the Nchelenge district of Luapula province in northeastern Zambia. Many of these people have little access to medical care, so in addition to education and prevention work, voluntary counseling and testing, care and treatment of opportunistic infections, MSF began to treat people with life-extending antiretroviral (ARV) medications in February 2004. By July 2004, 59 patients were receiving ARVs and MSF aims to treat 400 patients with ARVs by the end of 2005. MSF also carries out operational research in Zambia, documenting the progress and difficulties of providing comprehensive HIV/AIDS care in a poor, rural setting.

Cholera is endemic to Zambia, and outbreaks are common during the rainy season, which lasts from October to April. In January 2004, MSF responded to a cholera outbreak in the capital, Lusaka. In collaboration with others, MSF helped establish seven cholera treatment units and to train local staff. In two cholera-treatment units, located in Matero and Chawama, the MSF team focused on installing latrines and

showers, educating the public about the disease, and providing direct patient care, as well as improving sanitation in nearby neighborhoods. Before the end of the epidemic, nearly 6,500 cases of cholera had been registered and 205 people had died. When the epidemic began to decline in April 2004, MSF handed the project over to local authorities.

The recent peace in Angola has encouraged thousands of displaced Angolans to return home from Zambia and other neighboring countries. MSF began working in Maheba refugee camp in 1999, when an influx of Angolan refugees nearly doubled the size of the camp to more than 50,000. MSF oversaw water distribution and provided support to medical clinics in the camp. The MSF team also assisted the United Nations High Commissioner for Refugees' official return program by providing medical screening of returnees. As the camp has emptied, in October 2003, MSF handed the project over to the Zambian Ministry of Health.

MSF has worked in Zambia since 1999.

During a recent cholera epidemic, patients received treatment at a medical center set up in an old school in Chawama.



© Kemi Soler

Zimbabwe



© Tom Stoddart/IPG

An MSF nurse takes care of an AIDS patient in one of the villages of Mashonaland.

Expanding care for AIDS patients

While the government of Zimbabwe continues to face international criticism for its policies, the country's civilians bear the brunt of the ongoing political crisis. Life expectancy in the country has fallen to 33 years and many Zimbabweans can no longer get basic health care.

HIV/AIDS is the leading cause of death in Zimbabwe, affecting an estimated 25 per cent of the population, or two million people. In March 2004, MSF opened a clinic to treat people with opportunistic infections in Murambinda Hospital. This is the first stage of an HIV/AIDS project in Buhera district of Manicaland province, located 200 kilometers south of the capital city, Harare. In addition to improving treatment for opportunistic infections, MSF teams are providing training for local medical staff to support ongoing HIV/AIDS activities in the hospital, such as voluntary counseling and testing and prevention of mother-to-child transmission. As of June 2004, 900 patients were using the clinic. MSF staff plan to introduce treatment with life-extending antiretroviral (ARV) medicines in the next

few months and hope to have 50 patients using ARV treatment by the end of 2004.

In July 2004, Murambinda Hospital took over the therapeutic feeding activities that MSF had provided in Buhera district when low admissions eliminated the need for a fully operational feeding center. In addition, MSF teams assisted emergency-preparedness planning for the district, having held three cholera workshops in 2004 and planning additional trainings throughout the year.

In April 2004, MSF began treating patients with ARVs in the city of Bulawayo. Currently 150 patients are now taking part in the program, and the MSF team hopes to have 700 patients receiving ARVs by the end of

2004. The team also supports the work of the National Prevention of Mother to Child Transmission program and participates in AIDS research in Zimbabwe as a partner in the Zimbabwe AIDS Prevention Project.

In early 2004, MSF ended a successful nutritional program in Masvingo province. However, in March, initial activities to treat opportunistic infections at a new HIV/AIDS clinic in Masvingo, the capital of the province, were suspended after MSF was asked to leave the province by local health officials. At the time of going to press, MSF had still not received an explanation for this request. MSF is currently identifying other potential locations for HIV/AIDS activities.

In January 2004, a nutrition project that MSF had supported in the Tsholotsho district of Matebeland North province was handed over to the ministry of health. **MSF has worked in Zimbabwe since 2000.**

Asia and the Caucasus



Doung Srei Pich (8) weighs nine kilos and is HIV positive. Both of her parents have already died of AIDS. She lives in Phnom Penh, Cambodia, in an orphanage for HIV-positive children which receives antiretroviral drugs from MSF.

Armenia



© Tim Dirven

Participants in MSF's mental health project attend a day center where they receive care and can do projects that increase their coordination such as sewing.

Improving care for the mentally ill and children

MSF has expanded its activities among people with mental health problems in eastern Armenia's Gegharkunik region. The priority is to improve the way mentally ill outpatients are cared for, reduce their hospitalization rate and minimize their social isolation. The project involves psychologists, nurses, social workers and community educators. In northern Armenia, on the border with Georgia, MSF runs a project which treats patients with sexually transmitted infections (STIs) and HIV, and aims to reduce their prevalence among high-risk groups including commercial sex workers, truck drivers and migrant workers. Each month, approximately 300 people receive services which include treatment of STIs at the MSF clinic, condom distribution and education.

In June 2004, after seven years, MSF's work with the children in a "special education center" in Vardashen ended. The project demonstrated that there was an effective, humane alternative to the violent methods through which such institutions have traditionally controlled their inhabitants. MSF used an educational approach based on respect for the child as an individual. MSF staff also showed that by providing help to the children's families, children could remain at home for longer periods of time and would not have to resort to begging on the streets. MSF has been sharing its

conclusions with Armenian authorities in an ongoing attempt to press the government to reform the ways in which these at-risk young people are treated.

In mid-2004, MSF started providing health care for civilians living in the regions of Vardenis and Tshambarak. Many residents in this area are refugees from neighboring Azerbaijan who fled the country after the 1991-4 war, and unemployment is high. MSF is offering basic medical care as well as treatment for women and children in six health centers, two clinics and two hospitals. The team will also train and supervise local ministry of health staff. In addition, MSF will provide medicines and needed materials and help rehabilitate the facilities. The organization plans to undertake advocacy action to make national authorities and donor agencies more aware of the needs of this regional group.

MSF has worked in Armenia since 1988.

A patient sits in his room during his months-long treatment for tuberculosis in Gulripsh, Abkhazia.



© Simon Lourie

Georgia

Treating tuberculosis patients and the excluded

Prolonged political instability and exhaustion from a variety of violent internal divisions have left Georgia's health care system unable to cope with the demands placed upon it. As a result, thousands of the country's civilians lack the most basic care and medicines. MSF focuses on getting desperately needed help to groups lacking assistance including the disabled and the elderly.

The separatist republic of Abkhazia is the focus for MSF's tuberculosis (TB) work. At Gulripsh Hospital, MSF staff members provide care and medicines for approximately 240 people suffering from TB. They also recently began treating about 20 patients living with multidrug-resistant TB, a type of TB that is more difficult to treat because of its resistant to the first-line drugs usually used to cure the patient. MSF is working to involve the ministry of health in the program's management. A team also screens all prisoners in Dandra prison and separates contagious patients from non-contagious ones in an effort to stem the spread of the disease among this confined group.

In Abkhazia's capital, Sokhumi, and that of Georgia itself, Tbilisi, MSF uses a network of family doctors to provide health care for the most vulnerable and excluded. The priority has been to improve the referral system to hospitals and the overall quality of the free care available to these patients. Some 60 percent of these people are single, isolated individuals above the age of 65, who cannot afford to pay for health care and who have no one to help them get it. In Sokhumi, the program's 13 general practitioners care for approximately 19,000 people, carrying out 2,000 consultations and 30 surgical procedures each month. In Tbilisi, an average of 880 consultations are done every month.

MSF doctors perform surgery, mostly involving emergencies, within Akhmeta's district hospital located in the political and military flashpoint of the Pankisi Valley. The organization created a surgical point in the valley where a local surgeon handles minor operations and emergencies before referral to the district hospital. This first aid point also provides follow-up for patients in the valley after hospitalization.

MSF has worked in Georgia since 1993.

North Caucasus

Helping a displaced, desperate population

The past year has proved particularly difficult for MSF in the North Caucasus. There has been a further deterioration in security in the Chechen and Ingush republics, with violence increasingly spilling over into Ingushetia from Chechnya. At the same time, authorities have conducted a systematic closure of the internally displaced persons camps in Ingushetia in which MSF has been working. The closures have forced thousands of people to return to Chechnya or find private assistance in Ingushetia.

The closing of camps – the last of which occurred in June 2004 – was the result of a so-called “twenty point plan” published by the Russian authorities in March 2002, which scheduled the closures as part of a “normalization” process in Chechnya. This plan has proceeded despite the fact that, during the past year, political uncertainty and violence have, if anything, increased in Chechnya, and despite calls by MSF and other NGOs to give displaced people a real choice between staying and going. While there is little evidence that physical force was used to persuade the displaced people to return home, a campaign of psychological coercion that featured threats and the cutting off of gas and electricity, as well as promises of compensation that have subsequently gone unfulfilled, resulted in many people returning. The same process of squeezing people out was then applied to those living in more dispersed and informal settlements.

Those who returned to Chechnya were placed in what are called Temporary Accommodation Centers. MSF at first hesitated to provide assistance in these new settlements because it did not want to appear to condone the process of “normalization” or run the risk of accelerating the camp closures in Ingushetia. However, as the numbers swelled and the conditions became abysmal, MSF was left with no choice but to provide aid to alleviate the suffering caused by atrocious overcrowding and extremely poor sanitation. MSF now also offers primary health care and counseling services in the settlements. MSF has continued to run mobile clinics, improve hygiene standards, augment

Arjan Erkel freed

One of the year's few positive developments was the release of Arjan Erkel, MSF head of mission in Dagestan, on 11 April 2004. He had been held captive for 20 months. For Arjan, his family and for MSF, his release came as a huge relief after continual lobbying and campaigning. The euphoria surrounding his release was, however, short-lived as MSF and the Dutch government soon became embroiled in a very public argument about a sum of money paid by the Dutch in exchange for his release. As this report goes to press, the dispute remains unresolved and the Dutch government has initiated legal action against MSF.



Beslan and his brother play in front of a window covered only with plastic in a house with no electricity. In 2000, a grenade wounded Beslan in the stomach, he was lucky to survive.

maternity facilities, increase pediatric care, and provide medical supplies and drugs for the displaced people remaining in Ingushetia. In the first four months of 2004, the MSF team working in three maternal and child health care clinics had conducted more than 7,400 medical consultations among a population of whom 95 percent are displaced people and 5 percent are local residents.

The organization also continues the difficult work of supplying hospitals and clinics in Chechnya itself and has started a tuberculosis (TB) treatment project there. In addition to providing medical treatment to those with TB, MSF makes available psychosocial counselors for TB patients, trauma victims and medical personnel caught up in the bloody crises that make up daily life in Chechnya. Since the start of 2004, MSF has conducted more than 10,000 medical consultations in Chechnya including 225 surgical interventions and 960 newborn deliveries.

One small success, though not a lasting one, was that the 140 housing units that MSF had built in Ingushetia for displaced people who wished to stay were finally approved by the Russian authorities. In early 2003, these houses had stood empty while the authorities argued about their legality and at one stage ordered their destruction. However, in February 2004, displaced people received permission to move into them. As this report goes to press, however, the authorities have once

again decided to question the houses' legality and have reversed the decision to let displaced people live in them. In the meantime, MSF has constructed more than 150 new housing units and rehabilitated many more.

The continuing danger in Chechnya and the failure of the “normalization” project were exemplified by the assassination of A. Kadyrov, the Kremlin-backed president of Chechnya, and its aftermath. His death in a bombing in May 2004 was followed by a surge in violence, culminating in an attack by armed groups on the headquarters of the Ingush Interior Ministry, which left more than 90 people dead. MSF provided surgical help and emergency medical kits to nearby health facilities in response to both incidents.

The increase in violence, the level of threat to civilians and aid workers and bureaucratic hurdles have further diminished the space in which independent humanitarian organizations can operate. Because of security concerns, the activities of all of MSF's projects in the region have been carried out mostly by national staff members and managed by international volunteers who are obligated to communicate with the aid team from outside of the area. MSF's core values of providing independent witnessing and solidarity and of working in close proximity with those most in need have become increasingly strained in this region.

MSF has worked in the North Caucasus since 1999.

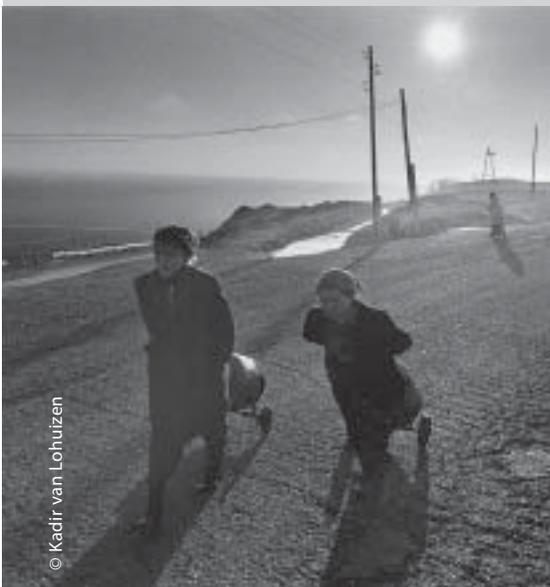
Tajikistan

MSF ends activity

In December 2003, after six years of activity, MSF closed its mission in Tajikistan, a country deeply affected by the breakup of the Soviet Union and a resulting civil war. Tajikistan is one of Central Asia's poorest republics, with little health care for the most vulnerable residents. Among the latter are the mentally ill, who are stigmatized and forgotten. During 2003, MSF continued to help patients in 17 psychiatric clinics in which doctors and other caregivers lack the means to provide proper care, and many patients receive medication only if their families can pay for it. MSF supplied food, clothing, blankets and heaters and drew national and international attention to the predicament of those living in these institutions. In September and October 2003, the organization mounted a photo exhibition in the capital, Dushanbe, to highlight the problems faced by this neglected group. At the end of 2003, MSF transferred responsibility for this project to the World Food Program.

In December, the ministry of health and another aid organization took over a project MSF had established in the Rasht Valley to improve basic health care, particularly for expectant mothers. This was one of MSF's final programs to be transferred once the organization determined that its presence was no longer needed in Tajikistan.

MSF has worked in Tajikistan since 1997.



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Turkmenistan

Uzbekistan



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An elderly couple receive care at a medical facility in Kolkhoz, Sirdariya region, Uzbekistan.

Improving care for children
In December 2003, MSF phased out its involvement in the DOTS (Directly Observed Treatment Short-course) tuberculosis program that it had run in Dashoguz since 1999, handing over all remaining activities to the ministry of health.

MSF then started a new project providing care for children in the economically deprived eastern town of Magdanly. Work started in April 2004 in the local hospital in the pediatrics and children's infectious-disease wards, as well as in the children's intensive care unit. Primary emphasis is placed on implementing more rational drug use and improving diagnostic techniques, with education for health care workers as an additional component. MSF staff members are now refurbishing some of the hospital wards and plan to improve its water supply and waste management system.

MSF was forced to halt abruptly its support to projects in Afghanistan from the Ashgabad Logistical Support Office in Turkmenistan following the brutal murders of five MSF staff members in Afghanistan in June 2004. During the first six months of 2004, that office had handled approximately 120 tons of cargo.

MSF has worked in Turkmenistan since 1999.

Moving forward on TB treatment
MSF is now focusing on the particularly difficult issue of providing care for people with multi-drug-resistant tuberculosis (TB).

A survey found that the Karakalpakstan area has the highest incidence of resistant TB in the Aral Sea region. MSF is now treating 100 patients there in an intensive DOTS-Plus (Directly Observed Treatment, Short-course) treatment program. This program builds on the regimen already in place and adds second-line drugs to overpower the resistant bacilli. Currently, MSF is exploring the potential of expanding the program to treat all patients with resistance in two pilot regions.

MSF has worked in Uzbekistan since 1997.

Afghanistan

MSF leaves country following staff killings and threats

The people of Afghanistan today face a harsh and desperate reality as a result of more than 25 years of war, shifting political leadership and years of drought. To help alleviate their suffering, MSF has been providing Afghans with medical care for almost 24 years.

Tragically, on 2 June 2004, five MSF staff members were shot and killed on the road between Khairkhana and Qala-i-Naw in northwestern Badghis province. After weighing the options, MSF sadly decided to close all of its medical projects in Afghanistan by the end of August 2004. Most activities were handed over to local groups, international NGOs or the ministry of health.

Although Afghan officials presented MSF with credible evidence that local commanders conducted the attack against the three international volunteers and two national staff members, these officials had done little to bring the perpetrators to justice. In addition, after the killings, a Taliban spokesperson claimed responsibility for the murders and later stated that organizations like MSF work for US interests and are therefore targets for future attacks. MSF believes that humanitarian assistance is only possible when armed actors respect the safety of humanitarian workers, more than 30 of whom have been killed in Afghanistan since the beginning of 2003. The targeted killing of MSF staff, the government's failure to arrest the culprits and the false allegations made by the Taliban made it impossible for MSF to continue providing assistance, despite the great needs.

The violence directed at humanitarian aid workers in Afghanistan comes amid consistent efforts by the US-led coalition to use humanitarian aid to build support for its military and political aims. MSF has repeatedly denounced the coalition's attempts to do so. The organization has also spoken out against the military's



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"After having worked nearly without interruption alongside the most vulnerable Afghan people since 1980, it is with outrage and bitterness that we take the decision to abandon them. But we simply cannot sacrifice the security of our volunteers while warring parties seek to rage and kill humanitarian workers. Ultimately, it is the sick and destitute who suffer."

– Marine Buissonnière, Secretary General of MSF, at the Kabul press conference announcing MSF's withdrawal from Afghanistan

attempt to usurp humanitarian aid. In May 2004, MSF publicly condemned the coalition's decision to distribute leaflets in southern Afghanistan that conditioned the continued delivery of aid on local people's willingness to provide information about the Taliban and Al-Qaeda.

MSF's activities in Afghanistan

Before the murders of five of its staff, MSF had been providing health care in 13 provinces of Afghanistan, performing tens of thousands of medical consultations each month. Teams gave basic and hospital-based care, treated people with malaria and tuberculosis and worked to reduce maternal mortality. MSF staff also provided safe drinking water and sanitation facilities. When a malaria epidemic started in October 2003 in Badghis province, MSF teams treated 1,300 patients within the space of a month. In the same year, MSF carried out a study to test the efficacy of chloroquine, the conventional malaria treatment in Afghanistan, because of growing concerns about resistance to the treatment. In its projects, MSF had made a more effective medicine, artemisinin-based combination therapy (ACT), the standard treatment. In addition, staff members vaccinated tens of thousands of children across the southern region between the ages of six months and 12 years old in response to

repeated measles epidemics there. In five districts of Bamiyan province, teams were working to improve access to primary health care and maternal and child care. At the beginning of 2004, a surgical unit was opened in the Panjab district to help pregnant women in need of emergency obstetrical care.

Afghanistan's wars and natural disasters have caused massive population movements in recent years. Before the killings took place in June, MSF was helping displaced people living in various camps inside Afghanistan as well as assisting Afghan refugees living in neighboring Pakistan and Iran. In 2003, under government pressure, many of the displaced returned to their homes or moved to new locations. In response, MSF was gradually reducing its medical activities in the camps. Yet MSF continued to provide basic health care to 40,000 displaced people living in Kandahar province's Zhare Dasht camp and to 22,500 displaced people in the camps near Spin Boldak across the Pakistani border. In the Afghan capital, Kabul, MSF assisted returnees and provided clean water to squatters living in tents in the city's Jangalak and Shahrak-I-Police areas.

MSF worked in Afghanistan from 1980 until August 2004.

Islamic Republic of Iran

Aiding earthquake survivors and refugees

Since the fall of the Taliban regime in November 2001, millions of Afghan refugees in Iran have faced pressure to leave Iran and return home despite the continuing insecurity and difficult living conditions in Afghanistan.



In the city of Kerman, earthquake victims pulled out of the rubble received treatment for "crush syndrome".

MSF assists refugees in the city of Mashhad, in the northeastern border province of Khorasan, and in the city of Zahedan, in the southeastern province of Sistan-va-Baluchestan. The latter is Iran's least-developed region and the main entry point for refugees. MSF provides medical consultations and nursing care at both locations through standing facilities and mobile clinics. At present, there are seven mobile clinic sites in Mashhad and four in Zahedan. In addition, the Mashhad project offers prenatal care and midwifery services, and the project in Zahedan treats malnutrition. Teams in both cities each carry out approximately 4,000 consultations every month. The teams also provide food aid and other basic necessities to the most vulnerable families.

Earthquake relief

In the final days of 2003, MSF sent medical and logistical staff to the southern city of Bam to offer assistance after a devastating earthquake on 26 December 2003. With an official death toll of 40,000 people, the city, along with many of its health facilities, was almost completely destroyed. MSF set up mobile clinics and tent facilities offering medical care, nursing care and midwifery services in several parts of Bam and in the surrounding villages. The medical teams

treated civilians suffering from emergency health problems including trauma wounds, lung infections caused by dust and gastritis. They also cared for people with chronic conditions such as asthma, diabetes, hypertension and epilepsy, who no longer had access to their daily treatment. After

three months of activity, approximately 9,000 consultations had taken place. MSF also sent a team of nephrologists (kidney specialists) and a nurse to help treat victims with "crush syndrome" in two hospitals in the nearby city of Kerman. (Crush syndrome is a condition in which muscle tissue damaged by severe internal injury can release massive quantities of toxins into the bloodstream and lead to kidney failure.) MSF flew in six dialysis machines and medicines needed to treat the syndrome. Teams also built sanitary facilities including 300 latrines and 200 showers.

MSF psychologists treated trauma related to the earthquake and developed a mental health project to support those needing psychosocial care in Bam and in the surrounding area. Approximately 3,000 people met with members of this team in the weeks after the disaster.

In March 2004, MSF ended its program in Bam and transferred oversight of its mental health activities to the ministry of health.

MSF provided aid in Iran following the 1990 earthquake and has worked there continuously since 1995.

Iraq

A spiral of violence

After having been blocked from entering Iraq between 1992 and the very end of 2002, MSF was given permission by the former government to start providing care to civilians in Baghdad shortly before the war began in March 2003.

Weeks later after the most active combat between Iraqi forces and the US-led coalition had ended, MSF visited more than 70 health facilities in 25 cities, assessing the most urgent medical needs and donating medical equipment and drugs as necessary. In some hospitals that were facing staff shortages, MSF also offered the help of its own medical volunteers. While many civilians could not get care amid the chaos that followed the conflict, the country's civilians did not suffer from disease epidemics or huge refugee movements as had been predicted by some.

MSF staff quickly concluded that the most pressing medical problem facing Iraq in the days following the fighting was a lack of leadership within the country's centralized health care system. MSF called on the members of the US-led coalition, as occupying powers, to assume their responsibility as stipulated under the Geneva Conventions and provide basic services, including health care, to the Iraqi people.

Humanitarian aid workers targeted

Although heavy fighting ended in April 2003, the country's security situation deteriorated sharply in mid-2003, and humanitarian aid workers began to be viewed by some as a component of the Western military effort. On 19 August, a bomb attack on the UN compound in Baghdad killed many international and Iraqi humanitarian workers, including UN Special Representative for Iraq Sergio Vieira de Mello. Later, in October, an explosives-packed ambulance slammed into the Baghdad headquarters of the International Committee of the Red Cross, killing 12 Iraqi staff members and injuring 15 others. MSF condemned both of these violent actions as heinous assaults

“While the official war has ended, Iraqi civilians continue to be killed and wounded almost every day. Many people can’t get the medical care they need because of the threat of violence. People here are still living in a war zone.”

– Hans van de Weerd, MSF Head of Mission, Baghdad

INTERNATIONAL STAFF 6
NATIONAL STAFF 400

Central Asia

Pakistan

Assisting Afghan refugees

In 2003-4, MSF teams continued to provide basic health care and vaccinations in the camps along the Afghan border at Chaman and Spin Boldak, where approximately 60,000 Afghans are housed. A measles-vaccination campaign held in Chaman’s Roghani camp during 2004 reached about 6,000 children, and MSF was treating 42 people for tuberculosis (TB) by June 2004. In January 2004, MSF took over the provision of medical care at three health posts in the Mohammed Kheil refugee camp in Balochistan, near Quetta, which has approximately 47,000 residents. On MSF’s first day of operations, hundreds of refugees came to the posts due to the poor level of health care which had been provided previously. The most common health problems seen by the team have been respiratory tract infections, diarrhea, skin diseases and worms.

MSF projects in Pakistan were scaled back in response to the killings of five staff members in neighboring Afghanistan during June 2004 and additional death threats made against MSF volunteers by the Taliban. While many MSF international volunteers were sent home or were reassigned to other MSF projects, members of the national staff, supported by a small team of international MSF volunteers, continue to provide basic services including limited consultations, vaccinations and TB treatment.

From August to October 2003, MSF provided emergency aid following flooding in five districts of Sindh province in southeastern Pakistan. This assistance included basic health care, drinking water and sanitation.

In 2004, the team in Pakistan completed several health assessments of Kashmir, near the Line of Control. MSF is reviewing the feasibility of working in villages bordering the line and cut off from the rest of Pakistan by mountains and weather conditions for a large part of the year. The project would address maternal and infant mortality.

MSF has worked in Pakistan since 2000.



on innocent civilians and on the principle of independent humanitarian aid work. In a statement, MSF emphasized that recent actions and statements made by Western officials attempting to incorporate aid into their political plans were contributing to humanitarian groups’ vulnerability to attacks.

Providing care for those trapped by violence

While MSF had withdrawn many of its international volunteers by September 2003 due to both unacceptable risks and reduced emergency health needs, teams continued to provide assistance in a number of ways. MSF began helping civilians in Sadr City, one of Baghdad’s poorest areas, where the slum’s two million residents had little ability to access clean drinking water, sanitation facilities or basic health care. By mid-2004, MSF teams were providing basic and prenatal care as well as treatment for malnourished children in three of the area’s health clinics, each of which includes a first-aid post. More than 3,000 medical consultations were provided each week in these clinics. MSF staff trained medical and paramedical personnel, supervised nurses and rehabilitated the pediatric unit in the hospital in Sadr City’s Al Thawra district. When Sadr City underwent a siege in mid-2004, the team treated 40 to 50 people wounded during the stand off. In August, MSF began an ambulance service, in cooperation with

other NGOs, to transport the injured to local hospitals.

In August 2004, MSF distributed 1.5 tons of medicine and material to Najaf Hospital and nearby clinics during heavy fighting between US forces and Shia militants around the city’s holy shrine. Although the area had an adequate drug supply, MSF found that civilians had trouble entering local hospitals and clinics that were guarded by military forces.

In September 2003, MSF ended the distribution of medicines to treat people with the deadly disease, kala azar (visceral leishmaniasis) which is endemic in the southern part of the country. The project was started because supply deliveries had been interrupted by the war. The materials were distributed among pediatric hospitals and other facilities in Ramadi, Karbala, Falluja, Hindiyah, Najaf, Diwanayah, Afaq, Samawah, Baghdad (Sheikh-Zaid Hospital) and Nasiriyah. Another organization will now supply the drugs. MSF also donated equipment, reagents and material to help diagnostic-testing facilities resume operations in the public health laboratories of Baghdad and nine other governates in the upper southern region of Iraq.

MSF has worked in Iraq since 2002.

BY SALLY HARGREAVES AND LAURA HAKOKONGAS
FOR THE MSF CAMPAIGN FOR ACCESS TO ESSENTIAL
MEDICINES

Running out of breath? Tuberculosis control in the 21st century



In 2003, MSF's medical staff treated 20,000 TB patients in MSF projects across 21 countries.

© Espen Rasmussen

An MSF physician examines a patient in the TB ward of MSF's health center in Huddur, Somalia.

Treatment of patients with tuberculosis (TB) is at a crossroads. Care providers are forced to use decades-old, difficult-to-use medicines because there are no new, improved drugs and diagnostic tools available. In addition, current treatment strategies focus on reaching those who are easiest to treat while a growing number of people are infected with resistant strains or suffer from another life-threatening illness such as HIV/AIDS. To counter this reality, MSF is calling for a revised global TB treatment strategy and much more effort to expand options for diagnosis and treatment.

Until the 1990s, management of TB was disorganised and ineffective. Treatment regimens varied widely; ambulatory non-observed treatment was common, and reporting mechanisms were largely absent. There was little interest in TB from the international community, including the World Health Organization (WHO), which only allotted US\$10 million for TB in 1992-93.

A variety of factors, including an outbreak of multidrug-resistant TB in New York in 1991-93, and growing evidence of the link between TB and HIV/AIDS, began to change this situation. The WHO and the International Union Against Tuberculosis and Lung Disease started to raise the profile of TB as a global crisis and to develop a new global approach to it. Directly Observed Treatment, Short-course (DOTS), was launched in 1994 as a public health-based management strategy aimed at controlling the disease.

DOTS focuses on identification of the most infectious (smear-positive) patients. This approach was partly based on evidence that detecting 70 percent of smear-positive patients and curing 85 percent of them could reduce TB incidence by 6 percent per year – effectively halving the incidence in 10 years. Yet it is accepted that diagnosis and reporting based on the existing smear-microscopy test, which can only pick up smear-positive patients, represents only 45 to 60 percent of TB patients overall, and therefore reliance on DOTS cannot curb TB globally. DOTS was not only conceived as a medical approach but also as a brand, designed to convince Western donors and developing country policy makers. The message was that DOTS – and only DOTS – could deliver global TB control.

However, WHO's decision to back DOTS as the answer to TB was questioned by the medical, academic and scientific communities. There were widespread objections in industrialized countries to WHO's conservative decision to build its TB strategy around existing TB tools rather than developing more effective diagnostics, vaccines and drugs. WHO and its supporters, on the other hand,



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A TB patient receiving care from MSF in Muynaq, Uzbekistan.

TB kills roughly two million people every year. Around 95 percent of all patients with active TB live in the developing world, where 99 percent of TB deaths occur.

argued for “restraint in the adaptation of new technologies by non-industrialized nations”. They noted that “new technologies are expensive and there is a danger that their introduction would divert attention and money away from the real issues ... the global challenge of TB lies in the implementation of old, tried and tested technologies.” Others were troubled by DOTS’ simplified “one size fits all” strategy, noting that it was based on pilot studies in nine developing countries, and that the results – particularly the failures (Senegal, Mali and Yemen) – had not been properly analyzed.

The debate over DOTS has calmed down during the past five years. Critics have learned to appreciate DOTS’ good points and WHO has toned down what some saw as an inflexible approach to implementation. Multilateral funding has also increased, with new Global Fund and World Bank money becoming available, although WHO still reports serious shortfalls in funds available to DOTS programs.

Although DOTS has many shortcomings, and the normal scientific process of scrutinizing and testing its premises and principles was cut short by its launch as a brand, specialists agree that it can and does work in “normal settings”. That is, in the absence of HIV or multidrug-resistant TB (MDR-TB), where targeting the most infected patients can deliver six to ten percent annual declines in TB incidence.

Room for improvement

TB kills roughly two million people every year. Around 95 percent of all patients with active TB live in the developing world, where 99 percent of TB deaths occur. Improving DOTS is crucial if we are going to try to effectively treat the growing number of patients with the disease.

MSF has had first-hand experience of the current WHO-recommended strategy to control TB. In 2003, MSF’s medical staff treated 20,000 TB patients in MSF projects across 21 countries. While most MSF and other experts agree that DOTS is the best approach we have, DOTS has demonstrated serious limitations in its nearly decade-long existence in the kinds of settings in which MSF works.

The greatest challenge to TB control is HIV/AIDS. An estimated 12 million people are now co-infected with HIV and TB, a rapid increase in recent years. More than two-thirds of them live in sub-Saharan Africa. DOTS was not designed to address the specific context of HIV/AIDS and TB and a major re-think is required here if we are to treat these patients. Even in MSF’s programs, only 4 of the total 25 HIV/AIDS programs directly provide TB treatment in sub-Saharan countries although TB is the most important opportunistic disease affecting HIV/AIDS patients. Most patients are referred to national tuberculosis programs that are often unable to treat co-infected patients.

In addition, far too few patients have access to second-line treatment for MDR-TB. Defined as resistance to at least rifampicin and isoniazid, the two most powerful TB drugs, this strain might be spreading as fast as by 250,000-400,000 new cases each year.

The fate of difficult-to-treat patients?

Elizabeth, a 33-year-old Liberian woman, came to an MSF clinic for care. She was emaciated, short of breath, and had the classic stare of tuberculosis. During examination, an MSF physician discovered a tuberculous abscess had eroded through her chest wall. All the doctor could do was relieve her breathing for a short time by draining two liters of pus from her chest. She died three days later.

Her story is a familiar one. She was a mother of four children, though one was dead and another was missing. She had fled the fighting, moving from one refugee camp to another for more than a year. During that time, she had gone to three temporary camp clinics for care. Her TB sputum test had been negative. She died after being diagnosed too late and never receiving any treatment for TB. This is the reality of many of MSF’s patients.

TB is the most important opportunistic disease affecting HIV/AIDS patients.

Vigorous action for improved, more inclusive DOTS and for resources to develop new tools to fight TB is needed. Improving and expanding DOTS to address “low-priority” patients – those who are not detected as smear-positive with the tests currently available – is crucial if we are going to try to treat effectively the growing number of TB patients. New, shorter treatments need to be developed as the old ones are cumbersome to administer and treatment courses take months to complete. The development of new diagnostic tests and ensuring research and development of new drugs is now urgent. Investment into new tools is critical if we are to have any hope of tackling the global burden of TB. It is critical that the most promising diagnostic tools are prioritized and that their development is properly resourced. Most novel drugs are still on the bench, months if not years away from early trials, and their development should be promoted.

MSF believes that the global TB strategy needs to be revised. WHO should lead the process of adequately addressing the HIV/AIDS pandemic and its consequences for TB care. Access to treatment for smear-negative patients must be ensured. Innovative means of improving treatment adherence must be found, including reduced need for direct observation.

More resources must be brought together to develop new tools to fight TB within resource-poor settings. The development and validation of new diagnostic tools need to become a priority. There is also a need to quicken the pace of developing new, easier-to-use drugs and make them available at affordable prices. WHO and governments must work together to develop and fund an essential TB clinical research agenda, ensuring that needed clinical trials take place. The agenda should consist of developing new tuberculosis treatments among both existing drugs and new compounds. Governments should insist that companies which make compounds that could be used to help treat TB in the future make them available to those willing to develop them into drugs. When commercial interests hamper the development of a potential tuberculosis treatment, governments need to intervene.

To learn more about MSF’s activities on TB, read its report “Running out of breath? TB care in the 21st century” available at www.msf.org.

Bangladesh



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Rose Per brings her six-month-old daughter for malaria treatment at MSF's mobile clinic in Bandarban district.

Improving care for malaria patients

MSF's work in Bangladesh takes place in three districts that make up the Chittagong Hill Tracts region, an isolated area near the country's borders with Myanmar (Burma) and India, in which the need for medical aid is tremendous.

Government policies and insurgent groups have inflicted discrimination, deprivation and marginalization on the region's indigenous people, resulting in decades of conflict and massive displacement. Moreover, public health care services are scarce, and few other NGOs are present.

Since 1999, MSF has a wide network of clinics, malaria-treatment sites and health-education outreach posts in the northern part of Khagrachari district. Recently, the organization extended its activities to the neighboring Rangamati district. The Chittagong Hill Tracts, unlike other parts of Bangladesh, are hard hit by malaria, which produces high rates of illness and death. MSF treats people with malaria using highly effective artemisinin-based combination therapy (ACT). The organization is conducting research on the effectiveness of various treatment regimes, and its studies have shown that resistance to chloroquine, the government's current first-line treatment for *falciparum* malaria, is as high as 40 percent. As a result, MSF is actively advocating for a change in the treatment protocol and the introduction of ACT as the first-line treatment in Bangladesh.

Beside running two standing clinics in Khagrachari, the MSF team uses three mobile clinics to bring health care to remote villages. Many of these areas are so difficult to access that MSF staff must reach them by foot or by boat. Rapid diagnostic tests for malaria and subsequent treatment are also offered in a number of "malaria field sites" and health-education outreach teams visit villages that are near the clinics. The outreach workers promote the clinics and use games and drama to increase awareness of health topics such as malaria prevention, prenatal care and basic hygiene. In December 2003, MSF started a second project in the Bandarban district that also employs a mobile clinic, several malaria field sites and health-education activities in remote villages.

By June 2004, with the malaria season approaching its peak, more than 8,600 medical consultations had been conducted in MSF's health facilities.

MSF has worked in Bangladesh since 1985.

Cambodia

Expanding care for AIDS and malaria patients

Cambodia has the highest prevalence of HIV/AIDS in Southeast Asia, standing at 2.6 percent of the population. In a number of projects around the country, MSF promotes prevention and offers many facets of care, including treatment with life-extending antiretroviral (ARV) medicines. By July 2004, MSF was giving ARVs to 1,428 adults and 56 children at Phnom Penh's Norodom Sihanouk Hospital, and to 303 adults and 19 children at the hospital in Kompong Cham. In the Takeo and Siem Reap provinces as well as Sotnikum district, MSF treats those needing ARVs at Chronic Disease Clinics (CDCs). MSF's CDC in Takeo Provincial Hospital treats some 900 people with chronic diseases, mostly HIV/AIDS, diabetes and hypertension. By June 2004, 276 of these people were receiving ARVs and MSF expects to have enrolled 600 patients in its ARV program there by the end of 2004. At a CDC in Siem Reap Provincial Hospital, where MSF runs an ARV treatment and counseling program, as of June 2004, 384 patients were taking ARVs. MSF plans to increase this number to 700 by the end of 2004. In addition to treating HIV/AIDS, the Siem Reap CDC staff treat other chronic diseases. At the Sotnikum CDC located in a poor, rural area in the northwest of the country, 104 patients were receiving ARVs and counseling by June 2004. This number is expected to increase to almost 200 by the end of the year.

Although malaria prevalence has decreased in the last few years, it remains a serious health concern in Cambodia due to growing resistance to available treatment. In the town of Pailin, located near the Thai border, MSF is providing early diagnosis and treatment of malaria. MSF is seeking to prove that artemisinin-based combination therapy (ACT) can be effective in treating patients in remote areas like this one. The project uses this new combination therapy as first-line treatment and monitors its effectiveness.

MSF has worked in Cambodia since 1989.

India

Improving TB care and treating victims of violence

Each year, nearly two million people develop tuberculosis (TB) in India and more than 450,000 people die from it. In 2003, MSF reoriented its work on TB to better benefit individuals living in Mumbai, where many of those with the disease are excluded from the national TB program. MSF wants to improve the level of TB diagnosis and treatment and to document cases of multi-drug-resistant TB and co-infection with HIV.

Since January 2003, MSF has assisted internally displaced people (IDP) in the Kokrajhar district of Assam state in the wake of violence that displaced more than 300,000 people. MSF provides care to an estimated 45,000 people living in eight camps and to those in surrounding villages. MSF offers primary health care, malaria diagnosis and treatment, prenatal care and water and sanitation services. MSF teams care for patients in existing health centers as well as in the organization's own clinics and they carry out health promotion activities in the region. As malaria is an important concern in India, MSF has conducted drug-efficacy studies as part of its efforts to change India's malaria treatment protocols from recommending chloroquine to artemisinin-based combination therapy (ACT). As of April 2004, MSF has been permitted to use ACT as a first-line treatment.

In the state of Jammu and Kashmir, MSF gives medical and psychosocial care to a population caught in the ongoing violence over Kashmir valley. Both sides of this 14-year conflict have targeted the local civilian population: disappearances, arrests, torture and rape are common. As a result, the people of Kashmir suffer from high levels of trauma and stress-related illnesses. MSF teams work in the districts of Srinagar and Kupwara to raise awareness of psychosocial problems and to improve the level of mental health care available. MSF-trained counselors work with patients in an MSF-supported clinic and directly in communities through mobile "on-the-spot" counseling in Srinagar. MSF counsels about 200 patients daily at the outpatient department of the Srinagar psychiatric hospital. **MSF has worked in India since 1999.**

Indonesia

Helping victims of infectious disease and violence

MSF is assisting patients suffering from infectious diseases, violence and natural disasters in Indonesia. Malaria is a serious illness in various parts of the country, made more serious because there is growing resistance to existing drugs used to treat patients with it. MSF is treating people with artemisinin-based combination therapy (ACT) and promoting its use as first-line treatment for the disease.

From July to October 2003, ACT was used in a malaria-treatment campaign that took place in South Halmahera, North Maluku. Over the course of 10 weeks, the MSF team visited 89 villages and conducted 11,125 medical consultations.

The global HIV/AIDS epidemic has also reached Indonesia, especially the province of Papua. On 15 July 2003, an agreement was signed between MSF and the Merauke district health office to provide care and treatment for HIV/AIDS patients. MSF assists both inpatients and outpatients in the district hospital. By July 2004, through the outpatient clinic, MSF was caring for 70 patients, of whom 26 were receiving antiretroviral (ARV) treatment.

In 2003, MSF started to carry out psychosocial activities in Ambon to help residents cope with violence and subsequent trauma caused by religious conflict in the region. In 2004, the team expanded its activities to include individual counseling sessions, discussion groups and training sessions. In addition, in September 2003, MSF began a short-term, community-based TB project to support and monitor all patients receiving treatment at two health centers.

In April 2004, violent clashes erupted in Ambon between Muslims and Christians, and the MSF office was burned down amid the turmoil. MSF donated medicines and medical material to the city's five main hospitals and began to circulate mobile clinics to assist people unable to reach health services. MSF also undertook water and sanitation activities in the areas of most urgent need. The mental health program was adapted to the conditions,

with psychologists joining the mobile clinic teams and doctors referring patients with psychosomatic symptoms to the psychologist for individual counseling. Two weeks after the clashes had begun, MSF's local TB-project supporters went back to their respective communities and tracked down the 105 patients MSF had been following. They then resumed their home visits and educational work aimed at adherence to treatment.

Assisting earthquake survivors

On 6 February 2004, a powerful earthquake shook the town of Nabire, Papua and its surrounding region. MSF quickly responded by sending a medical and logistical team, along with 600 kilos of supplies. Over five days, the medical team conducted medical consultations in four villages near Nabire.

Responding to disease outbreaks

MSF's emergency-preparedness-system project in Jayawijaya, in the province of Papua, enabled MSF to respond to 28 disease outbreaks in 2003. After evaluating and analyzing alternative ways to carry out the project, MSF decided to end it in December 2003.

In August 2004, after two years of activity, MSF closed its project aimed at improving access to basic health care services for commercial sex workers in Indonesia's capital, Jakarta. The organization will continue to pay for ARV treatment for the 40 patients whom its team had been monitoring, until another organization can be found to assume their care.

MSF has worked in Indonesia since 1997.

China

"When we talk to HIV-positive patients about their experiences, they often cry when they remember how they were treated by hospital staff. HIV-positive patients are frequently unable to get the hospital care they need because nobody wants to touch them. But health staff themselves can also be discriminated against if they work with people who are HIV positive. I was once on a train wearing an MSF t-shirt with a logo about AIDS. People looked at me strangely, kept their distance and even asked me if I was HIV positive. I felt very stigmatized myself." – Yuxin, a member of the MSF health education team in Xiangfan



In Baoji, MSF's program for children helps youngsters rediscover the joy of playing.

© Isabelle Merny/MSF

Providing AIDS care and helping street children

In China, where an estimated 1.5 million people are living with HIV/AIDS, MSF has begun working with local medical staff to provide care and treatment. In May 2003, MSF opened a free clinic in Xiangfan city as part of a project targeting the estimated 45,000 people living with HIV/AIDS in Hubei province. Most of those who are HIV-positive in this part of central China were infected after selling blood to blood banks.

Many are rural subsistence farmers with no access to the local, fee-based health care system. MSF teams are training local staff at various hospitals in safe blood and body-fluid handling and disposal techniques as well as in providing comprehensive care to those living with HIV/AIDS. Other activities include voluntary counseling and testing, treatment for opportunistic infections, home-based and palliative care. At the end of August 2004, 40 people, including 9 children, were receiving full treatment, including antiretrovirals (ARVs), in Xiangfan, and 189 patients overall were receiving care at the clinic.

On 1 December 2003 MSF began a second HIV/AIDS project, in Nanning, Guangxi Autonomous Region. In collaboration with the Guangxi Ministry of Health and the provincial center for disease control, MSF has set up a clinic to provide care and ARV treatment for 10 to 20 new patients a month. As of July 2004, 137 patients were receiving care at the clinic, and of these, 82 were receiving ARV treatment. MSF's goal is for 250 patients to be receiving ARVs before the end of the year. MSF is also creating patient support groups as part of the fledgling network of HIV-positive people in this part of China.

"We are extremely excited about the launch of this project since it marks a breakthrough for HIV/AIDS treatment in a country with an escalating HIV/AIDS problem. Although many Chinese hospitals have the capacity to provide treatment to people living with HIV/AIDS, the huge cost of the drugs means that most sufferers have no hope of ever being able to afford them."

– Luc van Leemput, Head of the MSF project in Xiangfan

Getting children off the street

MSF continues to provide psychosocial support to marginalized children in Baoji city, Shaanxi province where homeless children have become a growing social problem. Many of these youngsters have been exposed to physical and psychological trauma, neglect, abuse, hunger and rejection. In cooperation with authorities in Baoji, MSF has been running the Baoji Children's Center since March 2001. The MSF team and civil-affairs educators work with the children to provide temporary accommodation, medical and psychological care, food, schooling, and access to legal assistance. The full team has also started conducting outreach activities on the streets of Baoji.

Closing a sanitation project

MSF officially closed a water and sanitation project in Kashgar province of Xinjiang Autonomous Region in October 2003. This region of western China is predominantly made up of Muslim minority communities. In the townships of Yarkand and Yengisar, teams worked in cooperation with local authorities to bring clean drinking water to 8,500 people in the area. In addition to installing 58 water points (each providing water for an average 125 people), MSF staff promoted hygiene in the communities. **MSF has worked in China since 1988.**

Myanmar (Burma)

Extending care for malaria and AIDS patients

Malaria is the leading cause of illness and death in the country, and local strains of the disease are highly resistant to common treatments.

For this reason, in 1996, MSF started giving malaria patients highly effective artemisinin-based combination therapy (ACT). This new therapy cures more patients than older treatments and there is no known resistance to it. During the past year, MSF staff members screened more than 300,000 people for the disease and treated more than 160,000 patients.

Providing care for those living with HIV/AIDS is another large part of MSF's medical activities in Myanmar (Burma). MSF started the country's first program using life-extending antiretroviral (ARV) treatment in February 2003 in the capital, Yangon. As of August 2004, 205 people were receiving ARV treatment, including 20 children. The team also treats people with opportunistic infections. An additional 50 patients now obtain ARV treatment from MSF staff in Shan state and 20 more receive this care in Kachin state. A similar ARV treatment program is due to start in September 2004 in Dawei, located in Thanintharyi division. MSF also provides care to pregnant women to prevent mother-to-child transmission of the virus in 14 MSF clinics located around the country. The organization is extending home-based care and adult and pediatric counseling services to support HIV-positive patients and raise awareness about MSF programs.

MSF provides maternal and child health care and treats patients suffering from cholera, sexually transmitted infections and tuberculosis in Yangon. Patients with these health problems or HIV/AIDS can also receive needed assistance from MSF in Rakhine, Kachin and Shan states and in Dawei and Myiek districts.

Assisting isolated civilians

In Rakhine state, the majority of the population is Muslim and they are known as the Rohingyas. This group continues to be persecuted by the authorities and is denied basic civil rights and liberties, most notably the right to move, leaving them essentially trapped within their own villages. MSF aids these civilians by providing primary health care and specifically, treatment for malaria, a common disease in the area. By August 2004, an estimated 35,000 people had received medical assistance.

Near the Thai border, in Mon and Karen state, MSF has started giving medical care to villagers who are isolated by the ongoing conflict between rebel groups and government troops. MSF has also begun providing health care to displaced people living in Kayah state, close to the Thai border.

MSF has worked in Myanmar since 1992.

Lao People's Democratic Republic

Expanding AIDS care



© Ahmed Zouiten

MSF's work in this country focuses on the growing problem of HIV/AIDS. During 2003-4, MSF has been adding care components to its pilot project based in the 170-bed district hospital in Savannakhet.

MSF initially focused its efforts on prevention, home-based care and treatment of opportunistic infections. However, in June 2003, the Laotian government authorized MSF to import antiretroviral (ARV) medicines. In September 2003, the first patient in Laos was treated with ARVs. By the middle of 2004, 110 patients were receiving these medicines. With the goal of adding 12 new patients a month, the MSF team hopes to treat 170 people with ARVs by the end of 2004.

MSF has worked in the Lao People's Democratic Republic since 1997.



© Laurence Hugues

Nepal

© Tomas v Houtryve

Assisting civilians
trapped by conflict

In Nepal, chronic political instability has made it difficult for patients to receive care in a weakened health care system already hindered by poverty and insufficient medical personnel and supplies. For years, government and insurgent groups have vied for control of this mountainous kingdom, creating a bloody civil conflict in which all forces target civilians. In August 2003, the most recent ceasefire in Nepal was broken, further diminishing MSF's ability to bring aid to the Nepalese people.

MSF works in the Rukum district of mid-western Nepal, where living conditions are precarious because the national army occupies the district capital and Maoists hold the surrounding rural areas. Most of the approximately 200,000 people who live in the mountainous region are indigenous farmers. Since February 2003, MSF has run the district hospital in Rukum, carrying out approximately 900 inpatient and out-patient consultations each month. MSF has rehabilitated some hospital wards, the laboratory and the waste area. MSF staff members also treat 70 people with tuberculosis in the hospital. In 2004, MSF conducted mobile clinics in Maoist-controlled territories where access to health care is almost nonexistent.

MSF facilitates airlifts to Nepalganj in southern Nepal for patients needing surgery, in an effort to make urgently needed care more accessible. Although this assistance helps the critically injured, most Nepalese must walk for days to reach the nearest health post.

In March 2004, MSF ended its activities in Jumla, a district in Karnali zone, located in mid-western Nepal. The organization had begun to rehabilitate health posts in Jumla as part of a general health project, but pressure from both sides of the conflict made the work impossible. MSF was forced to withdraw from the district after local authorities asked MSF to suspend its activities in January 2004.

MSF has been working in Nepal since 2002.

Democratic People's
Republic of Korea

© Peter van Quaille

Helping refugees fleeing deprivation and violence

In 2003 and 2004, the food situation remained critical for most people in the Democratic People's Republic of Korea, better known as North Korea, for whom access to international assistance remains impossible.

Economic reforms, introduced in July 2002, officially dismantled the public food distribution system and installed a new price and salary scheme to reflect production costs, but since then, salaries have remained largely unpaid. The reforms have resulted in runaway inflation and have undermined people's ability to find basic food items on the black market, a system increasingly controlled by the North Korean regime.

Amid these stark conditions, North Koreans continue to flee deprivation and violence orchestrated by the country's leaders in Pyongyang. They keep crossing the border into China in search of food for their families or a temporary job that will enable them to buy medicines or other essential goods needed to survive. Considered unwanted economic immigrants by the Chinese authorities, they live in hiding and face the risk of being arrested at any time, forcibly repatriated and subjected to imprisonment and brutal treatment back in North Korea.

For the past year, the systematic hunt for North Korean refugees has continued to intensify on the Chinese side of the border.

Every month, hundreds of North Koreans in search of assistance and asylum have been forcibly repatriated to the North. The humanitarian aid workers who attempt to rescue refugees also face the brutal determination of the Chinese authorities, who deem such assistance a criminal offense. Bounties are commonly given to those who identify humanitarian aid workers or North Koreans. Predictably, in this context, support for refugees in distress is diminishing and assisting them has become a challenge that increasingly few aid organizations, crushed by this sanctions policy, are able to undertake.

The systematic and organized dragnet taking place in China leaves most North Korean refugees no alternative but to undertake a desperate flight to a third country. They cross thousands of kilometers in order to reach more welcoming southeast or northeast Asian countries. Most gain assistance after jumping over embassy walls or dashing through the doors of diplomatic offices. A few hundred North Koreans manage to find their way to South Korea each year, bringing the number of defectors there to more than 5,000 in June 2004.

The Philippines

Sri Lanka

MSF in North Korea and the region

MSF operated inside North Korea from 1995 to 1998. During this time, the organization attempted to supply drugs and medical training for approximately 1,100 health centers and to run 60 therapeutic feeding centers for malnourished children in three provinces. In 1998, convinced that its assistance was not reaching the most vulnerable people, and was, on the contrary, helping to feed the regime oppressing them, MSF withdrew from the country. Certain however that North Koreans were still in dire need of assistance, MSF tried to develop, with local networks, alternative ways of directly assisting North Koreans in the region.

Since 1998, MSF has provided shelter, clothing, food and medical care to hundreds of refugees hiding in China and third countries. In 2003, MSF opened a medical and psychosocial program based in Seoul, South Korea for vulnerable refugees facing immense difficulties resettling in the South. Many are traumatized by years of organized violence in North Korea including man-made famine, a lack of medical care and the resulting deaths of loved ones. Some have faced denunciation, imprisonment and torture. North Koreans may also have experienced brutal situations during their flight such as forced prostitution, arrest, the death or disappearance of friends or relatives and the pain of exile. Plus, once they arrive in South Korea, the refugees encounter stigmatization and rejection. Not surprisingly, North Koreans often find themselves completely unable to restart their lives in South Korea. Of the 60 patients followed by MSF psychologists and medical doctors during the first nine months after their arrival in South Korea, almost 70 percent experienced mild to extremely severe psychological problems.

In addition to providing direct assistance, MSF systematically documents the hardships faced by North Korean refugees by collecting personal testimonies from refugees and speaking out at international forums about their plight.

MSF has been providing support for North Korean refugees since 1995.

Assisting street children

MSF operates a program targeting 200 out of an estimated 200,000 children who live on the streets of the capital, Manila.

The program addresses the medical and psychological problems encountered by these children, their families and their communities. Among its activities, MSF gives medical and psychosocial care to street children who engage in commercial sex work as well as to victims of sexual, physical and psychological abuse. MSF focuses particularly on sexual and reproductive health, because sexually transmitted infections are a key health problem. MSF also helps street children gain access to further health care and to legal support.

Because malnutrition is a recurring phenomenon in the Philippines, MSF continued to operate a supplemental feeding program in Malabon, one of the city's slums, during 2003.

MSF has worked in the Philippines since 1997.



© Roger Job



© Marco Van Ha

MSF hands over activities

The 2002 ceasefire between LTTE rebels (Tamil Tigers) in the north of the country and the government held firm in 2003. As a result of the truce, the humanitarian situation in the north has improved. For the first time in years, hospitals are adequately supplied with medicines, and most people who had fled their villages have been able to return home. As a result of the improved conditions, MSF spent much of 2003 preparing for its departure and ended its work in the country in March 2004.

During 2003, MSF continued to support regional hospitals in the northern Wannu region. In Mallavi, the organization assisted the surgical and maternity departments, completed the training of supplementary staff and constructed a modern system for processing medical waste. A similar system was installed in the hospital in Puthukkudiyiruppu. In December 2003, an MSF doctor worked in the latter hospital to help the nursing department and to prepare the maternity department for the organization's departure. From August until November, MSF supplied a doctor to the outpatient department of the hospital in Mullaitivu. In September and October, the organization provided training courses for laboratory technicians at the hospitals at Mullaitivu and Puthukkudiyiruppu. In the town of Vavuniya, just outside of the Wannu region, MSF continued a project providing psychosocial care and health information for traumatized people who had been displaced from their homes in the north.

In March 2004, MSF handed over its activities to a new Sri Lankan NGO. This organization is comprised of Sri Lankans who had worked for MSF and who will continue the psychosocial program in the town and district of Vavuniya. The activities in Mullaitivu district have been handed over to medical staff working for the national ministry of health.

MSF starting working in Sri Lanka in 1986.

Thailand

Scaling up AIDS treatment

In Thailand, HIV/AIDS affects an estimated 1.5 percent of the population and is the leading cause of death. MSF's work there is increasingly focused on helping those who are HIV positive. MSF works closely with the ministry of public health, which aims to provide life-extending antiretroviral (ARV) medicines to 50,000 people in 800 public hospitals across Thailand by the end of 2004. As part of the "Access Network" supporting the plan, MSF gives training, supervision and technical support to staff at comprehensive care centers in 100 hospitals across Thailand's six regions. Currently, about 1,100 people are receiving ARVs supplied by MSF.



© Stefan Pleger

MSF staff examine an X-ray during a bedside visit to a patient with AIDS in Surin province.

MSF is also providing comprehensive AIDS care in seven district hospitals in four provinces as part of a pilot project to decentralize HIV/AIDS treatment. MSF works in the provinces of Nonthaburi, Petchaburi, Kalasin and Surin as well as in two provincial hospitals in the provinces of Surin and Maharakam.

In Bangkok, MSF runs a home- and community-care project for people living with HIV/AIDS who have limited access to existing health services, such as women prisoners and migrant workers. Activities include palliative care and crisis intervention, as well as follow-up for those

taking ARVs. Community care is offered in partnership with hospices and shelters in the capital city.

Because children living with HIV/AIDS in Thailand have been identified as a population in need of better care, MSF began a pilot project in late 2002 targeting those living in Petchaburi province. Together with local partners, MSF provides training, technical support and medicines to the pediatric department of the provincial hospital. MSF aims to treat 100 children with ARVs through this program by the end of 2004. Elsewhere, in Surin and Maharakam, 79 children have received ARVs through MSF.

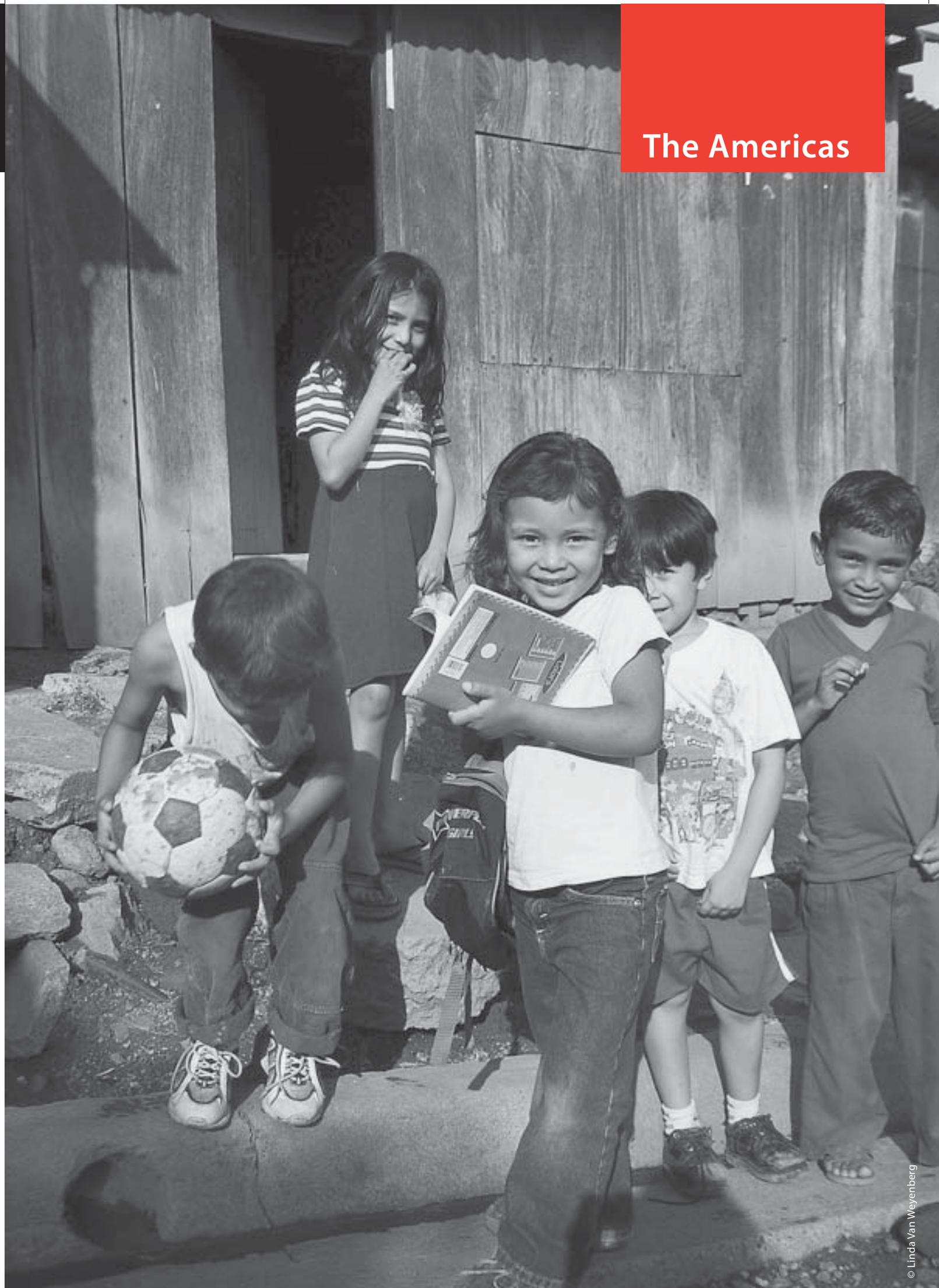
Assisting refugees

MSF's first projects in Thailand targeted refugees living along the border with Laos, Cambodia and Vietnamese "boat" refugees. Work with refugees continues today. In Maela camp in Tak province, MSF provides basic health care to 38,000 refugees, primarily members of the Karen ethnic minority. MSF runs two inpatient and two outpatient health facilities and manages the water supply. MSF also provides food to people who are sick and to pregnant and breastfeeding women, and has set up a therapeutic and supplementary feeding program.

People living with HIV/AIDS in Maela camp have access to ARVs through MSF. Currently 15 people are receiving such treatment. In Tham Hin camp, in Ratchaburi province, MSF provides water and sanitation for the 9,000 Karen refugees and carries out more than 2,000 health consultations per month. In both camps, MSF works to prevent and respond to epidemics that are a constant concern due to overcrowding. Finally, MSF has extended tuberculosis (TB) treatment from Maela camp to the surrounding communities, particularly to the migrant workers who live in this border region and have little access to health care. In 2003, MSF reached 493 TB patients, including some with multidrug-resistant strains. MSF is working closely with the Thai authorities to improve access to the medicines needed to treat this type of TB.

MSF has worked in Thailand since 1983.

The Americas



© Linda Van Weyenberg

INTERNATIONAL STAFF 5
NATIONAL STAFF 5
(until December 2003)

Argentina



© Juan Carlos Tomasi

Providing essential medicines and supplies
Argentina's economic collapse in late 2001 had severe consequences for the country's civilians.

Extreme financial hardship made it difficult for many people to pay for medical care. The public health system went from providing care to 30 percent of the population to assisting up to 70 percent (many of whom previously had been covered by private insurance). While demand at all health structures increased enormously, supplies dwindled and health staff could not meet the ever-growing needs.

MSF started a project in 2002 to provide basic medical supplies and medicines to hospitals in the country's northern region – historically one of its most disadvantaged areas. MSF assisted hospitals in the Salta and Jujuy provinces and in 2003 also aided facilities in the Formosa and Chaco provinces. MSF donated medicines and medical supplies to the hospitals and helped manage pharmacies until December 2003. The project concluded at the end of 2003.

In May 2003, heavy rainfall caused floods affecting more than 110,000 people living in Santa Fe province. For two months after the disaster, an MSF team provided emergency help to improve shelter and increase water and sanitation facilities. The team also monitored the area for disease outbreaks.

MSF worked in Argentina from 2001 until 2003.

INTERNATIONAL STAFF 7
NATIONAL STAFF 22

Bolivia

Chagas disease (American trypanosomiasis) kills more than 50,000 people every year in Latin America. Bolivia is the hardest hit country. The disease affects more than half of the country's inhabitants, mostly those who live in poverty or in rural areas. Approximately 3.5 million people are at risk of contracting it and 300,000 children younger than 12 are infected. Chagas accounts for 13 percent of all deaths in the nation. Yet the problem extends far beyond Bolivia's borders. More than 18 million people have the parasite causing the disease in their blood stream, and 100 million people in 21 Latin American countries are at risk of infection.

A killer that preys on the poor: Chagas disease
MSF has been treating people with Chagas disease in Bolivia's O'Connor province, Tarija department since October 2002. Its teams have found, despite considerable challenges and difficulties that programs to diagnose and treat people with the disease are not only needed, but possible. The Tarija region was chosen because of its particularly high prevalence (28 percent among children under 14), the lack of health care available and the presence of a government program that methodically tracks and kills the insects responsible for the disease's transmission. Controlling the number of insects, and in the long term, their eradication is essential for treatment to be effective as there is no vaccine against Chagas. Even those who are recovering from it can be easily re-infected if no control and surveillance activities are taking place.

MSF's project includes information, education and communication for the general population and for key groups including health personnel and teachers. It also involves active screening of newborns and blood donors in the hospital and for children between 9 months and 14 in the community. Children who test positive for the disease are treated with the drug, benznidazol. The drug, nifurtimox, is used as a second-line treatment for those who cannot tolerate benznidazol. Both drugs were discovered during veterinary research conducted in the 1970s. Because of the possible side effects, children getting treatment are followed weekly at health centers or schools and whenever needed. At the end of 2003, 89 percent of the targeted children had been screened and a prevalence rate of 20 percent was found.

Sixty-one percent of the newborns delivered in the province's hospitals were screened and no positive cases were identified. Prevalence among blood donors was found to be 25 percent. MSF has treated hundreds of people with the disease since the project started.

MSF's experience in Bolivia underlines the relevance of diagnosis and treatment in the framework of a global approach to Chagas disease. Prevention activities, including information and education, need to be included within Chagas programs and all activities should be performed within primary health care systems under the supervision of a hospital physician. Further, congenital protocols need to be adapted to rural contexts where hospital delivery is rare. MSF is now asking the



Bolivian national Chagas program to prepare and implement a protocol for diagnosis and treatment and to create a system for case notification and drug surveillance.

Focusing on a neglected disease

Chagas is a neglected disease – there is virtually no research being done to develop a new and effective drug to treat those infected with it. The reason? There is no profit to be made from drugs that treat the poor. MSF doctors have witnessed the lack of life-saving medicines and diagnostic tools available for Chagas. This “empty pipeline” is a direct consequence of the lack of research aimed at finding less toxic and more effective drugs that would enable Chagas patients of all ages to receive better treatment. Today MSF is doing everything it can to ensure Chagas is recognized

as an international public health risk, but there is a long way to go before new drug treatments become available. MSF is also working with the newly established Drugs for Neglected Diseases Initiative to find potential new drugs to treat this disease and thereby circumvent the lack of interest shown by the pharmaceutical industry.

MSF teams in Bolivia are actively raising concerns related to access to essential medicines and treatments at the national level, particularly those involved in the current negotiation of a free trade agreement between Bolivia and the United States. In May 2004, MSF urged the Bolivian government to exclude intellectual property provisions from the US-Andean free trade negotiations. MSF remains concerned that their inclusion will have a devastating

effect on access to medicines for millions of people living in the country and the Andean region.

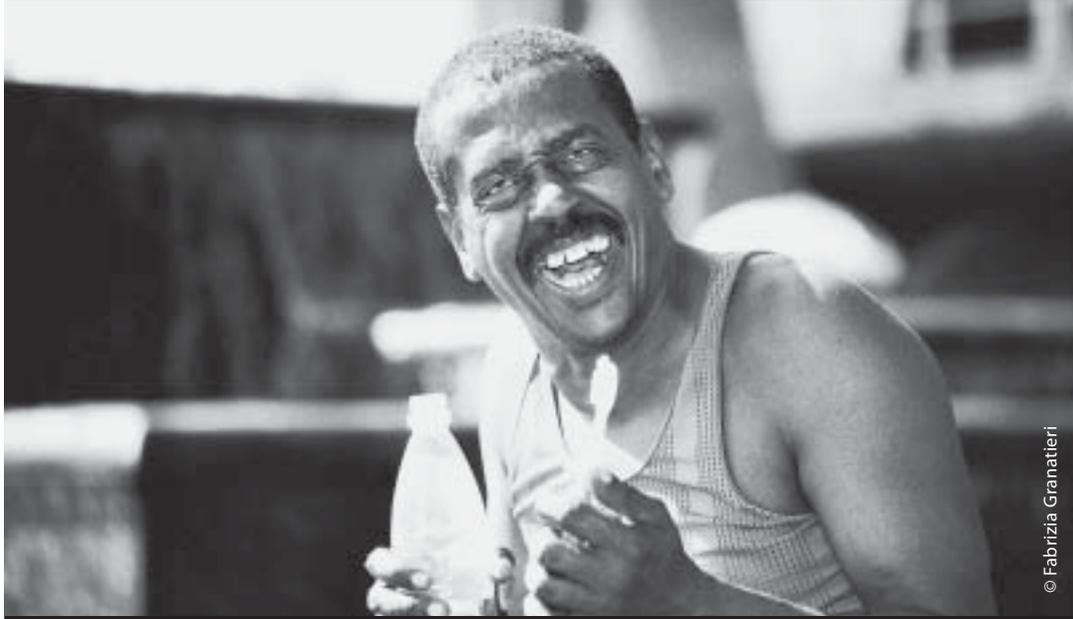
Under current trade conditions, if a new drug for Chagas were developed, the Bolivian government would be able to issue a compulsory license to overcome the patent barrier and produce the drug locally. (A patent allows only the company holding it to produce the medicine and profit from it. A compulsory license enables others to produce the medicine, usually at a much lower cost, while paying a compensatory fee to the patent holder.) This ability would be lost if Bolivia signed the free trade agreement with the US, because the US wants to limit dramatically the circumstances under which compulsory licenses can be issued. It would also affect the availability of generic drugs by reducing competition in the market. This could lead to a monopolistic situation with devastating effects for access to treatment, making the drug unaffordable for the majority of the Bolivian population, the poorest on the continent after Haiti.

Providing emergency assistance

MSF also provides emergency assistance in Bolivia. In January 2004, torrential rains flooded the town of Trinidad, the capital of Beni province. Floods affected nearly 40,000 people – more than half of the town’s population – and approximately 12,000 people had to be evacuated. MSF aided those taken to temporary shelters, donated medicine and organized water and sanitation facilities. The MSF team also worked closely with local health authorities to strengthen the existing epidemiological surveillance network.

MSF has worked in Bolivia since 1987.

Brazil



© Fabrizia Granateri

A homeless man brushes his teeth at the MSF clinic in Rio de Janeiro. MSF has been working with the city's homeless aiming to improve their living conditions and ability to obtain health care and social services.

Aiding women, children and the homeless
Vulnerable groups living in poor sections of Rio de Janeiro, the second-largest city in Brazil, are the focus of MSF's current work in this country. Since July 2003, MSF has been running a primary health center in Marcílio Dias, an impoverished community in the northern part of the city.

The center provides care for the community's 10,000 people, who live in poor conditions with limited access to health care or social services. MSF's project targets women, children and the elderly. The team offers consultations on a daily basis, provides medicines and promotes preventive health. Each month, approximately 1,500 people consult the clinic. A recent vaccination campaign against poliomyelitis undertaken by MSF staff reached all 784 children in the Marcílio Dias community.

MSF has created discussion groups in which residents can talk about their problems, addressing issues such as health, violence and early pregnancy. The team is composed of medical doctors, nurses, a psychologist, a social assistant, an educator, and a group of six local community health agents who visit families on a regular basis to help prevent problems. Another group of women from the community work as volunteers to establish links between the families and the MSF center, mainly through psychosocial activities.

MSF also provides social, medical and psychological assistance to adults living on the streets of the city's downtown and Copacabana neighborhoods. A multidisciplinary team of a doctor, nurse, social worker and psychologist offer help to those who live or depend on the streets to survive. More than 1,000 people have received care from the team since July 2003.

MSF also carries out advocacy efforts with government authorities and within civil society. For example, in an effort to minimize the prejudice and stigma encountered by the homeless, the team has developed a photo exhibition that illustrates their stories, difficulties, needs and expectations. In addition, MSF is doing advocacy work to stop local authorities from carrying out a "clean-up operation" in which the military police, employing a garbage truck, forcibly remove street people's belongings from the places where they are kept.

MSF has worked in Brazil since 1991.

Colombia



© Patricia Rincon Mautner

Caring for those isolated
by war

In Colombia, decades of protracted violence have made conflict a daily reality for civilians. Each day, people are killed, wounded or forced to flee their homes, or they simply "disappear". Trapped amid this unending war, many rural dwellers face restrictions on their movement caused by nearby violence or the fear that they will be seen as sympathetic to one of the armed groups. At the same time, many health professionals are reluctant to provide care in isolated areas for fear that military groups might target them.

MSF attempts to break through this isolation by running mobile clinics that provide medical and mental health care to people who desperately need it. MSF's presence in such harsh locations, rarely visited by authorities or other international organizations, also brings some psychological relief to those forced to live amid chronic violence.

MSF's mobile-clinic teams provide basic medical consultations, deliver essential drugs, treat mothers and children, give individual and group counseling and even perform dentistry. MSF also addresses water and sanitation needs. The mobile-clinic teams are composed of international and local doctors and nurses, a psychologist, a dentist, logisticians and drivers.

Guatemala

They visit sites in the departments of Norte de Santander, Tolima, Sucre, Bolivar, Córdoba, Caquetá and Nariño. Their rounds – made by car, boat, mule or on foot – enable tens of thousands of people to obtain basic health care. For many, MSF is the sole health care provider.

In some areas of the country, where health facilities do exist, the profit-based health system excludes displaced or vulnerable people. In addition, fierce political tensions make it dangerous for some people to register for health care. Because being associated with particular territories imply loyalty to certain armed groups, some people fear that by providing detailed personal data they could be inviting the armed group from which they fled right to their door. Therefore, in a country where no one is outside of the conflict, many displaced civilians remain reluctant to use the health system.

In urban areas such as Quibdó, MSF has persuaded local authorities to stop charging consultation fees for civilians not yet registered with the public health system. The team also helps people navigate the bureaucratic registration process, which must be completed before an individual can obtain medical care. Since 2000, MSF has been working near Bogotá, the capital, in the Soacha district, which is home to one of the country's largest reception centers for displaced people. Each week newly displaced families arrive from all over the country. To assist them, MSF operates a health post that provides medical care, nutrition for malnourished children, and sexual and reproductive health care. The team also refers victims of domestic violence to other care givers.

After six years of activity in Cali, Colombia's third largest city, MSF is handing over its violence-prevention project to local health authorities. The project assists victims of urban violence in the Aguablanca district. Since its creation in 1998, MSF has carried out 34,000 consultations and treated 2,700 victims of urban violence and members of their families.

MSF has worked in Colombia since 1985.

Promoting generics and helping street children

Approximately 67,000 of Guatemala's 14 million people are HIV-positive and 4,800 of them are children. More than 7,500 people have already developed AIDS and are in need of immediate treatment.

Today MSF staff give nearly 1,100 patients life-extending antiretroviral (ARV) medicines in two Guatemala City hospitals, and health centers in Coatepeque and Puerto Barrios.

Getting treatment to those who need it is not easy, though. A number of legal obstacles and heavy US pressure for Guatemala to sign the US-Central American Free Trade Agreement (CAFTA) will limit the availability of medicines to fight AIDS as well as other diseases like Chagas. Since ARV medicines are not under patent in the country, MSF had been able to treat people with generic medicines, which are 75-99 percent cheaper than the brand-name drugs bought by the government. But in July 2003, the government introduced legislation that will limit the use of generics, block the entry of inexpensive treatments and harm local medicine production. The recently signed CAFTA includes excessive levels of intellectual property protections that will restrict access to essential medicines throughout the region. Guatemalan groups and MSF have urged the Guatemalan congress to repeal the July 2003 decree, and insist that intellectual property provisions in CAFTA not go beyond pre-existing World Trade Organization agreements. Removing obstacles to generics and improving access to quality medicines will help save thousands of lives in Guatemala.

Since 1999, MSF has run a project in Guatemala City that provides free health care and psychological counseling to more than 700 street children and young adults, some of whom have been living in the streets for a decade or more. There are high suicide and substance abuse rates among the street kids. MSF psychologists and educators help them on a daily basis, providing basic health care, accompanying them to hospitals and providing counseling to improve their self-esteem. The team works alongside members of the street community to raise awareness of the misery of street life with the aim of relieving the discrimination many street kids face from



©Thierry Buignet

authorities and public services.

The therapeutic day care center in Lomas de Santa Faz, a slum on the outskirts of Guatemala City, provides medical and psychological care for children coping with the consequences of chronic domestic violence and neglect. These children, whose parents were displaced during years of civil war in Guatemala, suffer from malnutrition, physical or sexual abuse and developmental problems. The project, unique in Guatemala, includes a nutrition program, a variety of psychological and social therapies for the children, and offers parents counseling to help them learn to protect and nurture their children. MSF will hand over this program, started in 1996, to a local NGO this year.

MSF has worked in Guatemala since 1988.

Ecuador

Getting care to those who need it

More than half of Ecuador's inhabitants cannot obtain proper medical care – a problem made more dire by the spread of HIV/AIDS. Approximately 40,000 of the country's people now have the virus, and most of them cannot obtain treatment. The combination of insufficient resources, an inadequate number of qualified staff and limited political will impede the development of comprehensive HIV/AIDS programs throughout the country.

In January 2004, MSF launched a project to improve care for people with HIV/AIDS in Guayas province, an area deeply affected by the virus. Each month, the MSF team seeks to treat 10 new adult patients and 6 children with antiretroviral (ARV) medicines, as well as provide treatment to all HIV-positive pregnant women in the area to prevent mother-to-child transmission of the virus. The ministry of health has asked MSF to help develop a system to cope with the treatment needs of people living with HIV in Ecuador.

In addition to providing direct patient care, MSF is working proactively at the national level on policy issues related to access to medicines and treatment. For example, MSF is urging the government to use less expensive generic medicines at a time when Ecuador buys brand-name ARVs at a much higher cost. Another main area of concern involves the negotiations on a regional free trade agreement between Ecuador, Colombia, Bolivia, Peru and the United States. MSF is worried that this agreement will have a devastating effect on access to medicines for millions of patients in the Andean region.

MSF also runs a sexual and reproductive health program in a neighbourhood of Guayaquil, Ecuador's largest city. The program started in the slum of Flor de Bastion in April 2002 with the objective of making quality sexual and reproductive health care services available to this excluded area's inhabitants, especially teenagers. The MSF staff provide counseling and care related to family planning, prevention of sexually transmitted infections and HIV/AIDS, and education on sexual and reproductive health.

MSF has worked in Ecuador since 1996.

Haiti



© Olga Ruiz

Assisting victims of violence and flooding

When civil unrest broke out in Haiti in early 2004, MSF teams who were already working there began providing emergency medical care. In February, MSF started running emergency rooms at the Saint-François de Sales Hospital in the capital, Port-au-Prince, and at Saint Nicolas Hospital in Saint Marc, providing free medical care to those wounded in the fighting or during demonstrations.

Heavy rains in May 2004 resulted in severe flooding in villages located near the border between Haiti and the Dominican Republic. The water devastated an already poor region destroying houses and crops and killing hundreds. MSF organized helicopter emergency evacuations from the region to Port-au-Prince, where victims received medical treatment in Saint François de Sales Hospital. In the flooded region, MSF focused its medical activities on the southern coastal area between the town of Jacmel and the border with the Dominican Republic. MSF treated the most urgent cases at a health center in the village of Ford Verrettes and donated a basic emergency kit for 1,000 people. In the town of Mapou, the team set up a base in a school and conducted more than 100 medical consultations a day in the period immediately after the flooding. For the next two months, the organization operated a dispensary there, providing free medicines. In addition, MSF offered psychological counseling to those traumatized by the disaster and started running mobile clinics in Bodarie, Grand Gosier and Thiotte.

Though these recent crises briefly focused world attention on Haiti, the health situa-

tion in this tiny country might well be considered its own emergency. Women in Haiti have a significant chance of becoming ill or dying while pregnant or when giving birth. Therefore, most of MSF's ongoing activities have focused on ensuring proper care for pregnant women and improving delivery conditions in the district of Artibonite. Since 1994, MSF has provided nurses and doctors as well as supplies to Saint Nicolas Hospital in Saint Marc, part of a Communal Health Unit comprised of an estimated 240,000 people. Because the unit now has qualified medical staff and the necessary equipment, MSF handed over the project's activities to local health authorities in August 2004.

In another part of Artibonite, MSF staff members continue to work in the communes of Petite Rivière, Jean-Denis and Segur, providing care to a population of about 90,000 people. Teams carry out medical consultations at three health facilities and work with local health authorities to improve maternal health. MSF built a maternity care facility in Petite Rivière.

Haiti is a country that experiences frequent natural disasters including hurricanes, tropical storms and floods. MSF has created a special quick-response evaluation team composed of a Haitian doctor and logistician, based in the capital, to assess whether or not MSF can play a role when emergencies or disasters strike the country. This team offers MSF a way to respond extremely quickly to disasters without disrupting the organization's ongoing work in the country.

MSF has worked in Haiti since 1991.

Honduras

Helping those living with HIV/AIDS

Honduras is home to 60 percent of the people living with HIV/AIDS in Central America. For this reason, in August 2001, MSF set up a clinic in the town of Tela, located in northern Honduras, to offer complete treatment for opportunistic infections that often manifest in HIV-positive people. MSF also began prevention efforts, counseling, patient monitoring, prevention of mother-to-child transmission of the virus and community visits. In July 2002, these efforts were supplemented by the use of life-extending antiretroviral (ARV) treatment. By June 2004, 200 people were receiving ARV therapy through MSF's program.

This project was started within the framework of MSF's campaign to increase access to essential medicines for people living in poor countries. MSF's initiative was a first step in demonstrating that it is possible to make progress against AIDS in a country such as Honduras. Other actors, including the Honduran government and the Global Fund on AIDS, Malaria and Tuberculosis, have now promised nearly US\$45 million to provide care and treatment for those with the disease. With funding available and adequate political will and staff present to implement the program, MSF is now handing over its HIV/AIDS activities to local health authorities.

In addition, MSF is exploring the needs of poor, homeless children living in violence-ridden areas of the capital, Tegucigalpa. By conducting qualitative and quantitative research, the organization plans to better define and respond to the needs of these neglected children.

MSF has worked in Honduras since 1998.

Mexico

Changing care to fit current needs

During the past year, MSF reviewed its activities in Mexico due to the improving military and political situation in the country's southern Chiapas state. MSF had been providing basic health care to civilians living in Zapatista-controlled areas for years.

With military fighting ending and the struggle becoming a political one instead, MSF decided to close its programs there as the Zapatista "conflict" no longer resulted in urgent civilian health problems. Before its closure in mid-2004, MSF had been using mobile clinics to give basic health care and hospital referrals at ten sites within Chiapas's Las Cañadas region. In addition, the team had trained a network of health promoters and vaccinated children living in the clinic areas. In the program's last few months, MSF followed up on the remaining medical needs and trained local health promoters who would continue activities after MSF withdrew.

During 2004, MSF gave extra attention to the need to improve treatment for marginalized groups suffering from neglected diseases including Chagas disease (American trypanosomiasis). Chagas is a parasitic disease transmitted by an insect's bite. Once in the blood stream, it attacks the heart and digestive organs, often resulting in early death. In most cases, it is impossible to diagnose the disease clinically and so it is often overlooked. In Mexico, an estimated two million people are infected. However, Mexico stands alone as the only Latin American country lacking a comprehensive national program to fight the disease and help those infected. The problem is bigger than this. Because Chagas disease almost exclusively affects the poor, efforts to develop medicines to treat those with the disease have been minimal. Treatment is only possible for children, otherwise the risk of serious side effects is high and treatment too often ineffective. Even among children, the cure rate is not better than 70 percent.

MSF launched an exploratory mission in Chiapas to look at the prevalence of the disease and transmission rates to determine if there was a need to launch a new program to help those with Chagas. The exploratory mission found that there were

not high rates of infected people in the studied areas. However, the team will provide care for those found to have the disease during the exploratory research phase. MSF will also carry out health promotion activities in the exploratory areas and encourage policy change to get the disease recognized at a national level. Furthermore, MSF's involvement with a network of individuals and groups working on Chagas disease is expected to help advance the momentum to formulate a national or regional strategy to improve care for those with Chagas in Mexico.

In May 2004, MSF staff investigated the health problems facing undocumented immigrants traveling along the Guatemalan border. This activity was triggered by reports of attacks carried out by organized groups against undocumented immigrants trying to enter the country. However, because others are already providing emergency aid to this high-risk group and the government seems to be respecting the rights of immigrants with severe medical needs, MSF did not intervene. MSF also undertook exploratory missions following an earthquake in Colima and severe flooding in Tuxtla. MSF plans to end its work in Mexico at the end of 2004.

MSF has worked in Mexico since 1997.



Nicaragua

Focusing care on women's health and Chagas disease **Poverty and unhealthy living conditions contribute to a vicious cycle of early pregnancy, maternal morbidity, infectious disease and other illnesses and preventable deaths among women and other vulnerable civilians in Nicaragua. To combat these problems, MSF focuses on women's health and neglected diseases.**

During 2003 and until June 2004, MSF continued its sexual and reproductive health project in Ciudad Sandino, a shantytown on the outskirts of the capital, Managua. With high levels of adolescent pregnancy and maternal death following unsafe abortions, MSF's project aimed to improve the level of reproductive health care for this community. Special attention was given to pregnant women, postpartum mothers and their babies, adolescents and commercial sex workers. The staff provided prenatal and postpartum care, offered advice on family planning and treated sexually transmitted diseases. The MSF team also supported three health posts and one health center and worked with a community health worker network in four parts of this shantytown.

In northern Nicaragua, MSF is treating patients with Chagas disease (American trypanosomiasis) around the municipality of Esquipulas in Matagalpa province, where almost 30 percent of the population is estimated to be infected. The project targets 8,000 children under 15 and focuses on prevention and treatment as well as on improving access to good-quality diagnostics and treatment. As part of its international campaign to increase access to essential medicines, MSF is also advocating for national institutions to improve Chagas control and access to diagnosis and treatment.

MSF has worked in Nicaragua since 1983.

Peru



© MSF

An MSF volunteer prepares to give medication to an AIDS patient during a home visit in Peru while the children in the family watch.

Helping those affected by violence

Domestic violence, a hidden but common problem in Peru, is often underestimated among the children and adolescents living in urban slums. Recognizing the enormous human cost of such violence, MSF has developed a program of workshops and trainings in the slum of Villa El Salvador that aims to empower children and adolescents and to improve their potential to succeed despite their violent childhoods. By developing protective mechanisms, learning about healthy relationships and understanding the need for resilience, the program's beneficiaries gain the confidence needed to escape the cycle of violence surrounding them.

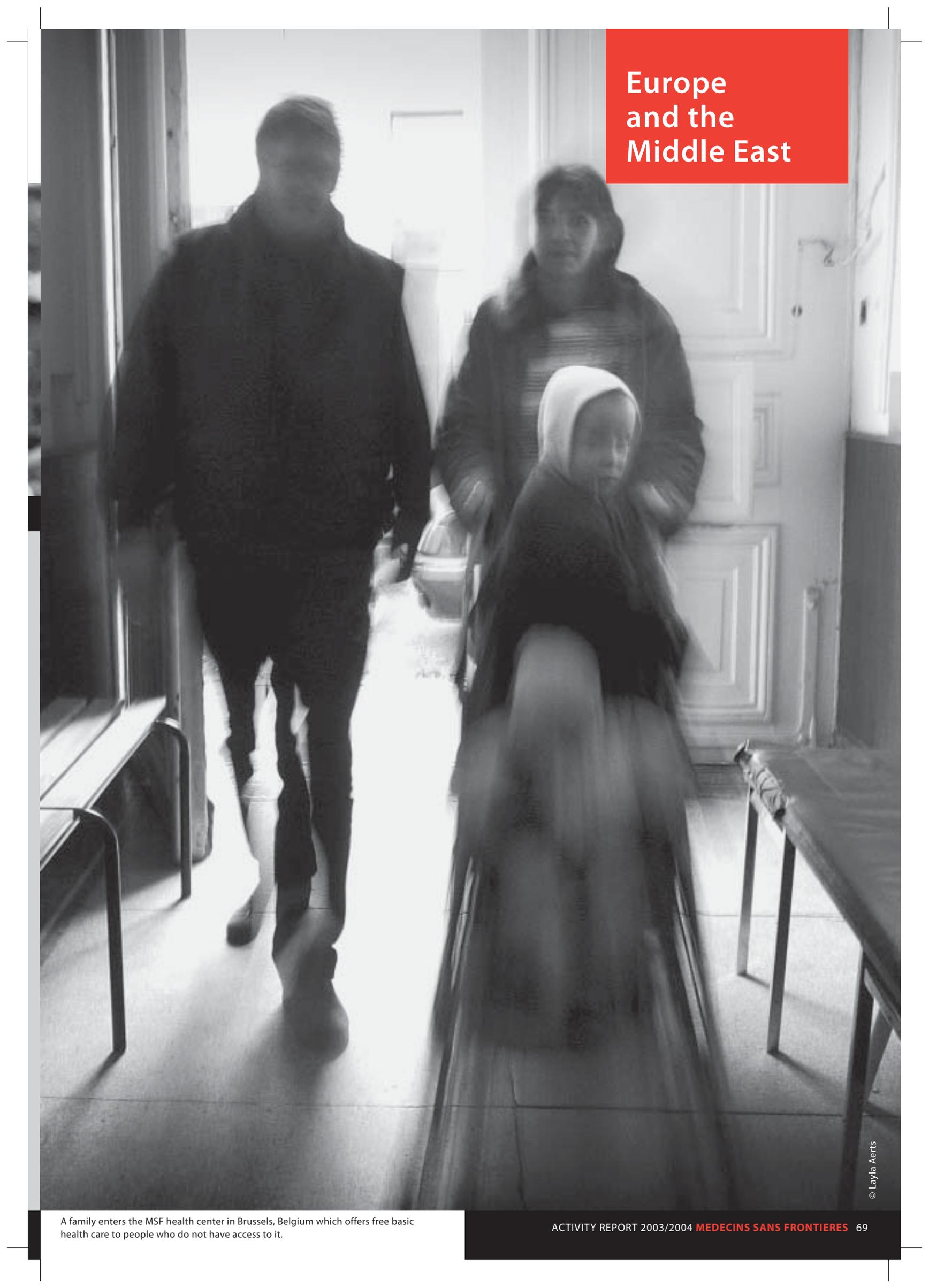
Expanding AIDS-related care

Although health conditions in Peru continue to improve, many of the nation's poorest people still cannot obtain care. An estimated 76,000 people live with HIV/AIDS, and very few of them have access to affordable treatment. In 2003, MSF focused its activities on HIV/AIDS, with programs in Villa El Salvador, a slum on the outskirts of Lima, the capital; and in the Lurigancho prison. In the prison, MSF staff carry out more than 1,600 medical consultations each year, mostly involving care of people with sexually transmitted infections and opportunistic infections related to HIV/AIDS. While awaiting permission from authorities to begin an antiretroviral (ARV) drug treatment program, MSF undertook awareness-raising activities, home-care visits and outpatient consultations to treat

opportunistic infections in HAMA Hospital. Due to bureaucratic delays, the first 20 patients started receiving ARVs in August 2004.

MSF also spoke out on issues related to access to essential medicines – access that is threatened by current free trade negotiations between Peru and the United States. MSF emphasizes that a number of generic medicines, including ARVs, are available today for people living with HIV/AIDS but is concerned that the new trade agreement may undermine this situation for all future treatments and force people to buy more expensive, patented drugs.

MSF has worked in Peru since 1985.



Europe
and the
Middle East

A family enters the MSF health center in Brussels, Belgium which offers free basic health care to people who do not have access to it.

Helping immigrants at Europe's door



Undocumented Algerian immigrants are rescued by the Coast Guard off the coast of Lampedusa, Italy.

© Francesco Cocco

"We were about to go to bed when we heard screaming and shouting.... We thought it must be loads of people drowning at the point! We ran over there and they were clinging onto a large rock. There were about seven or eight of them. In the time it took us to get to our boat and return, several of them had already fallen off.... We managed to save five of those still on the rock. The sea swept the others away. The ones we pulled out were almost dead with exhaustion. The rest we found with the lantern by their shouting. It sounded like a turkey farm, with all the screaming. The howling and wailing was pitiful. Some others came barefoot... their feet shattered and dripping with blood. They were crawling to the huts. We gave them some clothing and hot milk and biscuits and they were so grateful, hugging us, asking us for our address to write to us some day. I gave one of them my shirt, I felt so sorry. And my friend gave his to another. It was a terrible night. A young boy from Kenya told me that there were 29 of them. The next day I passed by there and they were recovering 11 bodies from the bottom of the sea. Only 18 survived."

– Juan Rodríguez, a fisherman from the island of Fuerteventura (Spain) recalling the night a small ship wrecked near Gran Tarajal. Testimony published in *La Vanguardia Magazine* (Spain), 13 June 2004.

This dreadful episode is only one of the many stories that can be heard along the southern coastline of Europe these days. While the setting may change, the human drama is always the same. In 2003, 19,500 north African, sub-Saharan and Asian immigrants arrived in such appalling conditions in Spain alone. Hundreds more died before reaching its shores. Some European governments do not officially recognize the problem and offer little or no assistance to these immigrants. Help only appears in the form of spontaneous aid given by sympathetic local residents like Spanish fisherman Juan Rodríguez.



© Espen Rasmussen

A Sudanese refugee living in the Tiburtina train station in Rome, Italy.

After a grueling 20-hour crossing from Africa, ill immigrants arrive in Fuerteventura, Spain.

"... The next day I passed by there and they were recovering 11 bodies from the bottom of the sea. Only 18 survived."

A lack of political response

In the past few years, MSF teams working on the beaches or in immigrant reception centers have seen more and more undocumented immigrants arrive at the edges of Europe. This desperate group is part of a growing wave of economic and political immigration to Europe which shows no signs of slowing. Countries such as Morocco, are a common transit point for refugees from Africa, while Spain and Italy receive thousands of immigrants along their beaches each year. The path continues into France, Belgium, Switzerland, Holland and the United Kingdom where immigrants ultimately try to settle and work. All of these countries and more play a part in the current immigration drama and each has a large number of undocumented immigrants and asylum seekers trying to survive within its borders. MSF's work with this vulnerable group aims to ensure that immigrants obtain quality medical care and information at a time when they most need it.

MSF assists immigrants and asylum seekers in places where authorities refuse to shoulder their responsibilities for them. Our objective is to alleviate the suffering of populations in vulnerable situations. For this reason, our work is not only limited to giving people the medical attention they need. MSF is also denouncing the inhumane manner in which many undocumented immigrants are treated. By speaking out on the conditions we witness for immigrants arriving in France or in Tarifa, Ceuta and Fuerteventura, Spain, to name but a few, MSF hopes to help provoke needed political action and legislative change to improve the situation for new arrivals.

Aiding a vulnerable group

Immigrants do not only face problems at points of entry into EU territory. If able to slip through this initial net, an immigrant lacking identification papers will join the growing ranks of the illegal immigrant workforce, and may be subjected to exploitation in the underground economy. These individuals are extremely vulnerable, given their lack of recognition as citizens. They are prime targets for economic and physical abuse and have no legal protection. Many of them also lack medical care.

MSF's experience in Belgium demonstrates this troubling trend. After conducting 10,000 medical consultations in MSF clinics based in three Belgian cities during 2003, our teams concluded that the national health care system does little for undocumented immigrants and is hampered by complexity, incoherence and compounded by a lack of will to reform. While the Belgian health care system proports to provide care for everyone in the country, undocumented or otherwise, the reality is that red tape, hidden costs and incoherent policies keep thousands of people outside of it. Many of them are undocumented immigrants and asylum seekers who have few other options for medical care. To help curb these effects, MSF's three Belgian clinics offer free care to those who need it. MSF staff also try to arrange care for people through the official health care system. To date, 70 percent of the Belgian clinics' patients come from outside the European Union.



© Juan Medina

The team in Belgium also assists immigrants whose serious illness would make it dangerous for them to return to their country of origin. With the help of its field missions, staff in the Belgian health centers can provide documentation on the quality of care available in specific home countries. This can help immigrants avoid being repatriated to a country where their illness cannot be treated adequately.

Promoting a humanitarian approach

There have been some humanitarian successes along the way. MSF closed its project in Fuerteventura after the Spanish government finally committed (after an intense denunciation and lobbying campaign) to take responsibility for providing medical attention to the immigrants arriving on its coast. Similar commitments have enabled MSF to end projects in the Spanish port of Tarifa, in Andalusia, and Ceuta, on the coast of northern Africa.

However, these small victories are the exception. Outrageous treatment and rights violations happen every day. For example, in June 2004, a group of people arriving by boat on the Sicilian island of Lampedusa, were detained for three days in a reception center. They were then transferred to another location, where they were forced to sign expulsion orders without understanding what they were signing. Among them was an 18-year-old student, Haysam, who was fleeing the violence of his home region, northern Darfur, Sudan. Haysam told MSF how he had fled to save his life in November after his village was attacked and his father and two brothers were murdered before his eyes. After traveling for six months to get to Europe, he planned to seek asylum and start a new life. However, after being detained for three days in Lampedusa without access to information, translation, legal advice or medical attention, he signed his own expulsion order. Authorities may now decide to return him to the horror he tried to leave behind.

At the gateways to Europe, MSF will continue to provide emergency care to immigrants. From a medical and humanitarian perspective, MSF will keep on fighting so that these immigrants and asylum seekers become informed about their rights and can easily access required medical care. MSF believes all immigrants deserve to be treated in a decent and humane way.

Belgium

Providing care to the disadvantaged

Belgium is one of the most developed countries in the world and has a sophisticated health care system. However, real access to care is often denied to undocumented migrants and asylum seekers.

MSF's work in Belgium focuses on increasing access to health care for the disadvantaged and most vulnerable part of the population. At present, undocumented migrants, asylum seekers and other disadvantaged people may obtain free medical care at MSF clinics in Antwerp, Brussels and Liège. During 2003, clinic staff carried out 10,000 consultations with 4,500 patients. Four percent of the patients were native-born Belgians and 70 percent came from countries outside of the European Union. Since 1998, MSF has also operated the Elisa Center, which provides free, voluntary and anonymous HIV testing. Because the risk of stigmatization remains high, this center also offers confidential counseling.

In recent years, MSF has been asked by several patients with serious illnesses to provide documentation on the quality of care available in their home countries. MSF provides this information to help immigrants avoid being repatriated to a country where their illness cannot be treated adequately. MSF recently coordinated and systematized this information for more general use. Today a patient may fill in a form to request such information, and MSF, with the support of its field missions, can provide clear information about the medical situation in the country in question.

MSF offers assistance to the Rwandan population now living in Belgium – the majority of whom fled Rwanda during the 1994 genocide. Through a project known as "Mpore" (meaning "Get up" in the Kinyarwanda language), MSF provides psychological assistance to Rwandans traumatized by the genocide. Mpore carries out therapy in the form of peer group discussions and individual sessions.

MSF has worked in Belgium since 1987.

Bulgaria



MSF provides training sessions at the sexual health clinic in Sofia.

Helping Romas get care

Increasing access to treatment is the aim of MSF's work within the large Roma community in the capital city of Sofia. In June 2003, MSF began to work in a primary health care center in Sofia's Fakulteta area, which is home to many Romas. Today, six general practitioners oversee health care for a population of about 20,000 people.

In May 2004, more than 7,000 patients (including 1,000 children under the age of five) had registered with these doctors. In order to encourage people to consult health services, MSF employs five community outreach workers. They promote the clinic, help register patients, and refer other social problems to the relevant institutions.

In August 2003, Bulgarian health authorities determined that only 40 to 60 percent of the children in Fakulteta had all of their required vaccinations. MSF started a "catch-up" campaign in collaboration with local authorities to vaccinate vulnerable children against diphtheria, pertussis, and tetanus (DPT), polio and measles between March and June 2004.

Improving sexual health care

MSF also runs the diagnostic, treatment and prevention center known as Maichin Dom (center for sexual health), located in a university hospital in Sofia. The center's staff members provide treatment for sexually transmitted infections (STIs) and work

to help prevent HIV/AIDS. The very poor – a group considered most vulnerable for STIs and HIV – receive medicines free of charge to ensure that they do not go without treatment. The center is also increasing its health education activities in schools. MSF began making rounds with a mobile clinic in September 2003 to reach marginalized residents of Sofia who do not visit the center. Every week the clinic visits four different locations within the metropolitan area. The team offers immediate treatment of acute STIs, information and education on safe-sex practices and STI prevention, and voluntary HIV testing and counseling. Most patients are commercial sex workers and intravenous drug users. The center's STI program has been replicated in the city of Plovdiv. A clinic in Plovdiv University Hospital has been rehabilitated by MSF and Bulgarian medical and paramedical personnel now carry out activities related to treatment and prevention of STIs.

MSF has worked in Bulgaria since 1997.

France

Helping those excluded from care

At the end of December 2003, the French government narrowed the eligibility criteria for its state medical aid program, better known as AME (Aide Médicale d'Etat). AME was created to help the estimated 150,000 economically disadvantaged people residing in France who lack residency permits to obtain needed medical care.

Yet the modifications to AME effectively ended their immediate access to the system and to free medical care. Many medical and social organizations, including MSF, have advocated strongly against these changes in AME and in the related universal sickness coverage system called CMU (Couverture Maladie Universelle). An MSF petition demanding better health coverage for undocumented residents gathered more than 100,000 signatures.

In June 2004, six months after the AME reforms were introduced, teams from MSF and other France-based medical NGOs released testimonies describing the new system's harmful effects on undocumented residents. These accounts included stories of people forced to use already overburdened hospitals for non-emergency treatment. The testimonies also told of people arriving at hospital emergency rooms with serious illnesses because they waited much too long for treatment. Statements by the health minister of France suggesting that access to AME would be re-established for undocumented migrants in need of urgent medical care have not been put into effect.

Before these new restrictions came into effect, the coverage granted by AME and CMU enabled MSF to close a number of the medical/social-service centers it had set up in the city of Marseille in southern France. MSF teams working at these centers had been assisting the most vulnerable people in French society. MSF also ran shelters in the cities of Lille and Colmar (the latter in partnership with another organization) to help young people in extremely precarious situations. A team also started a program to help immigrants in Marseille to demand their legally entitled social benefits.

Today, MSF continues to provide care for drug-addicted individuals living in the capital, Paris. The organization also operates two medical/social-service centers, one in Paris and the other in Marignane (Bouches de Rhône), where local residents can obtain medical consultations and help in securing the care to which they are legally entitled.

MSF has worked in France since 1987.

Sudanese refugees who attempted to escape the violence in their own country found themselves living in Rome's Tiburtina train station for months amid very poor conditions.



© Espen Rasmussen

Italy

Assisting vulnerable refugees

Italy's economic growth and its strategic position on the Mediterranean Sea have made it a prime destination for immigrants from other lands.

Yet the current government's immigration policy severely limits the number of immigrants able to receive legal status and remain in Italy.

In 2003, MSF worked with the national health system in Rome, Sicily and Lombardy to push for implementation of a law that enables immigrants lacking identification documents to receive medical care. Because of its location, Sicily is the point at which boat refugees most frequently land in Italy. Many are fleeing conflict or other dangerous situations in their home countries and risk their lives in crossing the Mediterranean Sea. On Lampedusa, a small island south of Sicily, an MSF nurse provided medical care at the reception center set up to help newly arrived refugees. From September 2002 until December 2003, MSF assisted more than 10,000 people at the center. MSF also offers emergency medical aid to refugees arriving on Sicily's southern coast. An MSF mobile unit remains on standby 24 hours a day so that the team can provide aid and explain Italy's immigration policy to newly arrived immigrants.

In addition, approximately 400 asylum seekers sought shelter in the rundown Tiburtina train station in the center of Rome. They were refugees from Sudan, Ethiopia, Eritrea and other African countries, living in Italy. Facilities at the station were terrible with no running water, electricity or heat. In October 2003, MSF began providing medical care to these asylum seekers. The team also participated in an advocacy action calling for a permanent, humane solution to this dire situation. The action coincided with the reconstruction of the station, whose owners started to evict all of the asylum seekers in August 2004. City authorities have now relocated all of them to other locations in Rome.

MSF has worked in Italy since 1999.

INTERNATIONAL STAFF 0
NATIONAL STAFF 4

Luxembourg

Assisting adolescent drug users

While Luxembourg's inhabitants enjoy a high standard of health, hidden problems remain – particularly the growing use of illegal and psychotropic drugs. Although Luxembourg's conservative culture and strict rules forbidding these drugs keep many from taking them, the number of young people, especially adolescents, using these drugs has rapidly risen in the past few years. Today about 50 percent of minors have used illegal substances at least once. This contradiction between traditional social norms and adolescents' experimentation with drugs can lead to strife within families and between generations as well as severe reactions from school and judicial authorities.

In response to this problem, MSF runs the Solidarité Jeunes project. Through it, MSF works with young people who use drugs, their families and concerned institutions including 40 schools and 10 outreach programs. The program provides medical care, information about drug use and addiction, psychosocial care and individual and family therapy. Between August 2003 and July 2004, more than 230 consultations were carried out.

Exploring the needs of immigrants

MSF started a working group with other NGOs in December 2003 to monitor the health situation of undocumented immigrants and asylum seekers entering Luxembourg. The organization also maintains regular contact with government authorities to assess and develop medical care for asylum seekers.

MSF has worked in Luxembourg since 1996.

INTERNATIONAL STAFF 0
NATIONAL STAFF 19
(until December 2003)

Romania

Caring for Bucharest's homeless

In December 2003, MSF ended a seven-year program in Romania which provided medical and social care to homeless people living in the country's capital, Bucharest.

After 355 homeless adults were reported to have died in Bucharest in 1997, MSF began a project to improve the lives of those living on the streets. Through direct medical and psychosocial care and information activities, the MSF team brought essential services to thousands of homeless people. MSF staff members used mobile teams, night clinics and outreach campaigns to reach the homeless and carried out nearly 500 consultations per month. In addition, a referral network was created with local hospitals. Extensive advocacy work targeted at authorities eventually contributed to important legislative changes including a new social security act which greatly improved the homeless's ability to obtain medical and social services.

In December 2003, a new Romanian association was launched to carry on the work MSF had begun.

MSF worked in Romania from 1997 until the end of 2003.



INTERNATIONAL STAFF 6
NATIONAL STAFF 135

Russian Federation

Helping those living on the streets

The continuing crisis in the Republic of Chechnya and the related kidnapping case of MSF volunteer Arjan Erkel, who was abducted in Dagestan in August 2002 and held for 20 months, have been the dominant issues affecting MSF's work in the Russian Federation during the past year (see page 47 for more information on the situation in the North Caucasus).

MSF's projects in other parts of the country have yielded mixed results. MSF was forced to close its long-term tuberculosis (TB) program in Siberian prisons after Russian authorities prohibited MSF from implementing its treatment regimen for prisoners with drug-resistant TB, which was based on internationally accepted standards. However, MSF refused to agree to the Russian treatment schedule in the prison because of concerns that it would result in a high risk of treatment failure and the emergence of super resistance to the drugs. The project had been running for seven years and had treated more than 1,000 patients.

MSF's project serving the homeless in Moscow, on the other hand, was successfully handed over in November 2003 to city authorities, who are continuing to provide free medical and social assistance to people living on the street. Still, last winter 303 people died from the cold, down from the 437 the year before. MSF is now preparing to publish a book in Russian on its 11 years of experience caring for people living on the street. The aim of the publication will be to promote similar projects for the homeless in other Russian cities. A new program to help street children is now being developed. MSF doctors and psychologists are working with youth living in railway stations and other places where young people are neglected and exploited.

MSF has worked in the Russian Federation since 1988.

INTERNATIONAL STAFF 0
NATIONAL STAFF 13

Spain

© Juan Medina

An MSF staff member helps an exhausted, cold African refugee who has just arrived in Fuerteventura after a harrowing boat trip.

Giving a warmer welcome to immigrants

In the last few years, Spain has become a primary destination for immigrants attempting to enter the European Union. Located at the edge of Europe and close to Africa, the country is now home to 800,000 to one million undocumented immigrants. However, the government's system of receiving immigrants takes little account of their medical and humanitarian needs and focuses instead on expelling those who lack documentation.

In 2003 and 2004, MSF's projects in Spain centered on giving medical and humanitarian assistance to exhausted and sick immigrants arriving in the country's most popular entry areas: the Canary Islands and Ceuta and Melilla, two Spanish enclaves in northern Africa. MSF also collects personal testimony from the immigrants as part of its campaign to raise awareness of their plight among government officials and the public.

On 1 March 2004, MSF started an emergency intervention in Fuerteventura, Canary Islands, to provide humanitarian assistance to immigrants arriving on the island's shores. The 7,858 immigrants who arrived in Fuerteventura in 2003 and the nearly 3,000 who arrived in the first part of 2004 had received no assistance.

The team set up a field hospital and a mobile team who work right on the beaches and in the port where immigrants intercepted by the coast guard are taken. The MSF team provides basic medical care and first aid, identifying those with serious illnesses and referring them to health centers on the island. The team also distributes blankets, water, warm drinks and biscuits.

Fuerteventura has become the main destination for immigrants, especially those coming from Asia and sub-Saharan Africa. Their physical condition, whether on arrival on the beaches or after their interception, is always the same: hypothermia, hypoglycemia, exhaustion, dehydration, hunger and thirst. Many also have cuts, bruises and sprains sustained during their journey.

MSF has denounced the government's current system of reception and is working to build support for an advocacy campaign that calls on the government to take responsibility for these immigrants. MSF is also attempting to improve undocumented immigrants' access to the health care system.

During the first part of 2004, MSF closed a project through which it had provided assistance to undocumented immigrants in Ceuta. The organization's strong advocacy campaign had helped influence the Spanish government to begin to provide the immigrants with appropriate medical and humanitarian assistance.

MSF has worked in Spain since 1994.

INTERNATIONAL STAFF 5
NATIONAL STAFF 35

Ukraine

Europe

Expanding HIV/AIDS care

In the past year, MSF has expanded the scope of its HIV/AIDS project in the southern Ukrainian cities of Odessa, Mikolaev and Simferopol, where the disease is particularly prevalent.



© Philip Wolmuth

MSF's objective is to help improve care for people living with HIV/AIDS and increase access to treatment. The project, which was originally aimed at preventing mother-to-child transmission of HIV, has been broadened to include medical care for opportunistic infections, treatment with life-extending antiretroviral (ARV) treatment, laboratory support and psychological care for both children and adults. In addition, MSF collaborates with the ministry of health to train health care professionals. Currently, some 1,000 mother-and-child pairs participate in the mother-to-child transmission-prevention program and 106 adults and 29 children are now treated with ARVs.

Counseling for infected mothers and their partners, as well as psychosocial training for medical staff, are particularly important elements of the project given the high levels of stigmatization and discrimination suffered by the HIV-positive community in Ukraine. MSF has developed a psychosocial component in which HIV-positive women are trained as peer counselors for newly infected mothers taking part in the program. The peer-counseling program offers psychological support and empowers these women in coping with HIV/AIDS.

MSF has worked in Ukraine since 1999.

INTERNATIONAL STAFF 2
NATIONAL STAFF 22

Serbia and Montenegro



Helping Kosovo's displaced
In the early 1990s, MSF started providing assistance in what was then the Socialist Federal Republic of Yugoslavia. MSF teams worked in five of the six republics of former Yugoslavia to provide basic health care, water and sanitation services to those affected by conflict as the country broke apart. Today MSF staff assist some of the estimated 200,000 Kosovars now living in Serbia.

In July 2003, MSF began making mental health care available to internally displaced people living in camps in the southern Pcinja district's municipalities of Vranje and Bujanovac. In addition to providing direct psychological and social care, MSF staff are lobbying authorities to grant displaced people the same legal status as Serbian citizens. While the government has extended these rights in theory, this is still not the case in practice. Equal status would help the displaced obtain needed medical care and social services.

MSF is monitoring reforms to the health system and their impact on people's lives. The organization is also cooperating with local authorities on emergency preparedness and response to earthquakes and floods which are both common in the region.

MSF started working in parts of former Yugoslavia in 1991.

INTERNATIONAL STAFF 0
NATIONAL STAFF 2.5
(full-time equivalents)

Sweden

Caring for refugees
Sweden is a common destination for refugees and asylum seekers, with more than 10 percent of its population composed of immigrants. The official estimate of undocumented individuals is approximately 10,000 people.

Access to health care is severely restricted for this group. Undocumented migrants can only obtain "immediate" care. This policy is widely misinterpreted to mean that only the most urgent care should be offered, although even for this, payment is required. The Swedish health care system has no budget to cover the cost of care for these people and they are sometimes identified by health care staff to the police. A pregnant undocumented immigrant has no officially sanctioned access to a midwife and cannot receive maternity care from the national health care system unless she has the 18,000 euros needed to cover delivery costs.

MSF began working in Sweden to organize clinicians to provide care for this population. MSF is working with volunteer doctors (many with previous MSF experience) who conduct examinations and treat undocumented immigrants from within the country's health care system. MSF's goal is to raise the quality of services provided to this group and to challenge the inevitability of their receiving second-class care. Because the supply of medicines is controlled by a state monopoly, leaving some people without access to them, MSF also promotes the idea of improving access to essential medicines as part of its work. MSF has worked in Sweden since January 2004.

INTERNATIONAL STAFF 0
NATIONAL STAFF 3

Switzerland

Seeking out the uninsured
An estimated 150,000 to 300,000 people in Switzerland – roughly two percent of the population – lack legal resident status and generally cannot afford to pay for health care. Most of these people are economic migrants, asylum seekers whose applications for asylum have been refused or people who have lost their legal resident status due to divorce or unemployment.

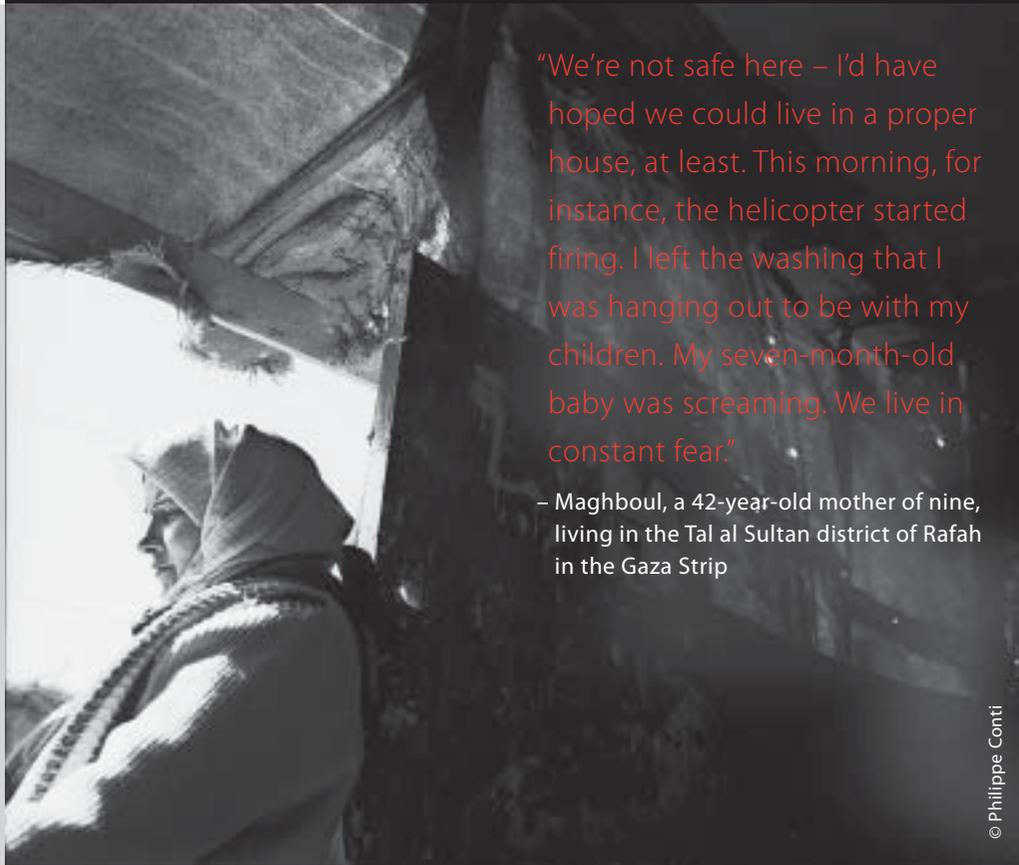
The vast majority of migrants without legal status are uninsured and have very limited access to health care services. According to an MSF evaluation, nearly 50 percent of the people in this group never consult a medical doctor. Of those who do, many wait until they are suffering from an advanced stage of disease.

Since November 2003, MSF has run a pilot medical project in the canton Fribourg. Under the name Fri-Santé, MSF runs a medical facility staffed by one nurse. Consultations at the facility are free of charge. A network of voluntary health professionals (general practitioners and medical specialists, dentists and a psychologist) and pharmacies has been established to treat patients. Depending on their financial capacity and the availability of drugs in the program's reference pharmacies, patients may be asked to contribute toward the cost of their medicines and/or treatment. During the first half of 2004, the MSF team saw 173 patients during 233 consultations. MSF is now exploring the need to replicate the Fri-Santé approach in other parts of the country.

MSF has worked in Switzerland since 2003.



Palestinian Territories



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"We're not safe here – I'd have hoped we could live in a proper house, at least. This morning, for instance, the helicopter started firing. I left the washing that I was hanging out to be with my children. My seven-month-old baby was screaming. We live in constant fear."

– Maghboul, a 42-year-old mother of nine, living in the Tal al Sultan district of Rafah in the Gaza Strip

assesses the situation for Palestinians living in communities near the wall. Using mobile clinics, teams also made regular visits to the Bedouin people living in Hebron's southern Yatta district who lack basic health care.

In the Gaza Strip, a series of Israeli military incursions have left thousands of people homeless, especially in the town and refugee camp of Rafah. Since January 2004, the waves of incursions and demolitions have increased in Rafah and approximately 90 homes have been demolished each month. MSF staff work with local residents who are confined to the area by strict security rules and numerous military checkpoints. An MSF medical doctor, psychologist and social worker also visit families in their homes. The team listens to their stories and provides counseling. They also use drawings and games to help children overcome trauma or the destruction of their home.

In May 2004, more than 200 families – 2,197 people – were made homeless in Rafah after several hundred homes were destroyed by the Israeli army. The incursion left dozens of civilians dead or injured. Many people told MSF that they had been given no time to leave their homes and others who did escape reported being fired upon. On 19 May 2004, more than 60 people were wounded and about 10 killed while taking part in a demonstration in the area. MSF doctors helped triage and treat patients at Najjar Hospital where the injured were brought for treatment. MSF gave the hospital basic medical materials including anesthetics, antibiotics, compresses and bandages. Two MSF psychologists also counseled groups of students from nearby schools and met with local townspeople. MSF teams experienced enormous obstacles in reaching the hospital or parts of Rafah that had been accessible until they came under attack.

Since 2002, MSF teams have also been treating Palestinians needing medical care or psychological counseling in the city of Jenin. MSF staff members visit people in their homes or provide needed care at the organization's office.

MSF has worked in the Palestinian territories since 1988.

Treating trauma

The Palestinian territories of the West Bank and Gaza Strip have witnessed a dramatic deterioration of living conditions since the outbreak of the second Intifada in October 2000. In 2003 and 2004, continuing violence in this area left behind many wounded and dead civilians and destroyed property. MSF teams provide medical and psychological care to those affected by the violence and lacking medical support in the cities of Hebron, Jenin and in the Gaza Strip.

Using outreach consultations, MSF teams comprised of medical and psychiatric experts as well as translators, visit families exposed to violence and daily military activities. Through home visits, the team identifies affected people and proposes appropriate treatment. The main diagnoses are depression, anxiety, post-traumatic stress disorder and psychosomatic disorders. Those suffering from psychological problems are referred to psychologists or psychiatrists. MSF uses brief therapy for individuals, families and groups by giving "on the spot" counseling as soon as possible after a traumatic event has taken place.

In the city of Hebron, MSF psychologists play a key role due to the high number of

patients referred to them by the team's doctors and social workers. MSF's consultation room in the old city enables the team to stay in close contact with the local population. The team is also investigating ways to reach more adolescents and to start psychotherapy groups.

The Israeli authorities' decision to construct a high concrete security wall to separate Israel and the West Bank has made it extremely difficult for civilians in some areas of the southern and eastern part of Hebron district to obtain needed health care. Demolition orders are constantly issued and implemented and the wall already blocks many Palestinians from reaching nearby health facilities. MSF continually

Facts and Figures

Médecins Sans Frontières (MSF) is an international medical humanitarian organization that is also private and non-profit. It is comprised of 18 national branches 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, with an international office in Geneva (which moved from Brussels in 2004).

The figures presented here provide an estimate of MSF's finances on an international level. These combined international figures

have not been audited and are therefore not certified. However, each entity of MSF publishes annual, audited financial statements according to its national accounting policies, legislation and auditing rules. Copies of these reports may be requested from each branch, and the information used for the preparation of the international figures has also been audited.

The figures are for the 2003 calendar year; the Activity Report itself covers the period August 2003 to July 2004. All amounts are in millions of euros.

2003 2002

Income	In M€	In %	In M€	In %
Private Income	296.6	79.3%	295.6	80.8%
Public Institutional ECHO* & EU	30.5	8.2%	24.6	6.7%
Public Institutional Other	46.7	12.5%	45.5	12.5%
Total Income	373.8	100.0%	365.7	100.0%

How was the money spent?	In M€	In %	In M€	In %
Operations	288.4	77.9%	256.1	76.0%
Témoignage	14.2	3.8%	19.2	5.7%
Other humanitarian activities	1.7	0.5%	0.1	0.0%
Total Social Mission	304.3	82.2%	275.4	81.7%
Fundraising	42.8	11.6%	39.7	11.8%
Management, general & administration	23.1	6.2%	21.8	6.5%
Total Expenditure	370.2	100.0%	336.9	100.0%
Net exchange gains & losses (realized and unrealized)	-7.5		-6.8	
Surplus/(deficit)	-3.9		22.0	

* European Community Humanitarian Office

As part of our efforts to guarantee our independence and strengthen our link with society, we have been striving to maintain a high level of private income. In 2003, 79.3% of MSF's income came from private sources. More than 2.6 million individual donors and private funders worldwide made this possible.

Additional public institutional agencies include, among others, the governments of Belgium, Denmark, Luxembourg, Norway, Sweden, Switzerland and the United Kingdom, as well as the United Nations High Commissioner for Refugees (UNHCR).

2003

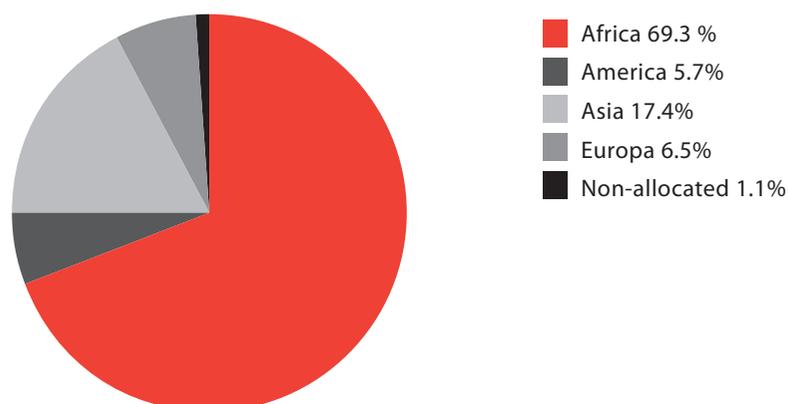
Where was the money spent? (Program expenses above 3 million euros)

Countries/Regions	In M€
Democratic Republic of the Congo	26.4
Sudan	20.1
Angola	19.6
Liberia	14.5
Afghanistan	10.9
Ethiopia	10.3
Burundi	9.5
Ivory Coast	8.4
Sierra Leone	8.2
Chad	7.9
Chechnya / Ingushetia / Dagestan	6.7
Kenya	6.1
Republic of Congo	5.2
Mozambique	5.0
Guinea	4.6
Iraq	4.4
Somalia	3.8
Malawi	3.6
Myanmar (Burma)	3.4
Uganda	3.2
Cambodia	3.2
Russia*	3.0

* Excluding the republics of Chechnya, Dagestan and Ingushetia

2003

Program expenses* per continent



* projects' and coordination teams' expenses in the countries

2003 2002

Balance sheet (year-end financial position):	In M€	In M€
Non-current assets	33.6	32.2
Current assets	47.9	47.8
Cash & equivalents	160.0	173.2
Total assets	241.5	253.2
<i>Permanently restricted funds</i>	4.2	4.3
<i>Unrestricted funds</i>	193.6	199.3
<i>Other retained earnings</i>	-2.8	0.0
Total retained earnings and equities	195.0	203.6
Non-current liabilities	5.2	5.6
Current liabilities	38.4	41.3
Unspent temporarily restricted funds	2.9	2.7
Total liabilities and retained earnings	241.5	253.2

HR Statistics				
International departures (full year):	3,444	100%	2,950	100%
Medical pool	972	28%	837	28%
Nurses & other paramedical pool	1,068	31%	897	31%
Non-medical pool	1,404	41%	1,216	41%
First time departures (full year):	1,092	(*) 32%	915	(*) 31%
(*) in % of the international departures				
Field positions:	17,995	100%	16,623	100%
Expatriate staff	1,896	11%	1,714	10%
National staff	16,099	89%	14,909	90%

Permanently restricted funds may be capital funds, where the assets are required by the donors to be invested, or retained for actual use, rather than expended, or they may be the minimum compulsory level of retained earnings to be maintained by some of the sections.

Unrestricted funds are unspent donor non-designated funds expendable at the discretion of MSF's trustees in furtherance of our social mission.

Other retained earnings represent foundations' capital as well as technical accounts related to the combination process, including the conversion difference.

MSF's retained earnings have been built up over the years by surpluses of income over expenses. As of the end of 2003, their available part (the unrestricted funds decreased by the conversion difference) represents 6.2 months of activity. The purpose of maintaining retained earnings is to meet the following needs: future major emergencies for which sufficient funding cannot be obtained, and/or a sudden drop of private and/or public institutional funding, and the sustainability of long-term programs (e.g. ARV treatment programs), as well as the pre-financing of operations to be funded by upcoming public funding campaigns and/or by public institutional funding.

Unspent temporarily restricted funds are unspent donor-designated funds, which will be strictly spent by MSF in accordance with the donors' desire (e.g. specific countries or types of interventions) as needs arise.

2003

Statement of financial activities	Including satellites in %		Excluding satellites in %	
Private Income	304.2	79.6%	296.6	79.3%
Public Institutional Income	77.7	20.4%	77.2	20.7%
Total Income	381.9	100.0%	373.8	100.0%
Social Mission Expenses	308.3	82.2%	304.3	82.2%
Other Expenses	66.8	17.8%	65.9	17.8%
Total Expenditure	375.1	100.0%	370.2	100.0%
Net exchange gains & losses (realized and unrealized)	-7.2		-7.5	
Surplus/(deficit)	-0.4		-3.9	

Additional disclosures:

The information presented here only pertains to the 18 national branches and the international office. However, the search for efficiency has led MSF to create specialized organizations – called "satellites" – in charge of specific activities such as humanitarian relief supplies, epidemiological and medical research studies and research on humanitarian and social action. They include: Epicentre, Etat d'Urgence Production, Fondation MSF, MSF Assistance, MSF Enterprises Limited, Médecins Sans Frontières - Etablissement d'Utilité Publique, MSF Foundation Kikin, MSF-Logistique, SCI MSF, SCI Sabin, Transfer S.C. and Urgence Développement Alimentaires.

As these organizations are controlled by MSF, the decision was made to include them in the scope of the combined financial statements in 2003 for the first time. However, the 2002 figures have not been restated and consequently they do not include the financial information related to the satellites. In order to allow a proper comparison of the 2002 and 2003 figures, the tables present the impact of including the satellites in the scope of the 2003 combined financial statements.

Balance sheet (year-end financial position)	Including satellites	Excluding satellites
Non-current assets	31.6	33.6
Current assets	56.8	47.9
Cash & equivalents	163.7	160.0
Total assets	252.1	241.5
Total retained earnings and equities	202.9	195.0
Non-current liabilities	7.1	5.2
Current liabilities	39.0	38.4
Unspent temporarily restricted funds	3.1	2.9
Total liabilities and retained earnings	252.1	241.5

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