

Contents

MSF Missions around the World	2
The Year in Review	4
Rowan Gillies, President, MSF International Council Marine Buissonnière, MSF Secretary-General	
MSF's principles and identity	
The challenges ahead	6
By Christian Captier, General Director of MSF in Geneva	
A simple yet crucial demand: Ensuring that crimes against humanitarian workers do not go unpunished	
By Gorik Ooms, General Director of MSF in Brussels	
Seeing through the obstacles to the victims: MSF's medical responsibility to victims of sexual violence	11
By Françoise Duroch, Coordinator, MSF Sexual Violence Programs, Geneva	
Malaria: MSF's constant challenge	14
By Christa Hook, Head of MSF's international working group on malaria and Nathan Ford, Director of MSF's Manson Unit	
The TB/HIV time bomb: A dual epidemic explodes in South Africa	16
MSF Projects around the World	23
Africa	23
Asia and the Caucasus	51
Providing care in the tsunami's wake	52
MSF organizes emergency assistance after disaster strikes South Asia	
The Americas	67
Europe and the Middle East	77
Facts and Figures	86
Contact MSF	88

MSF Missions a



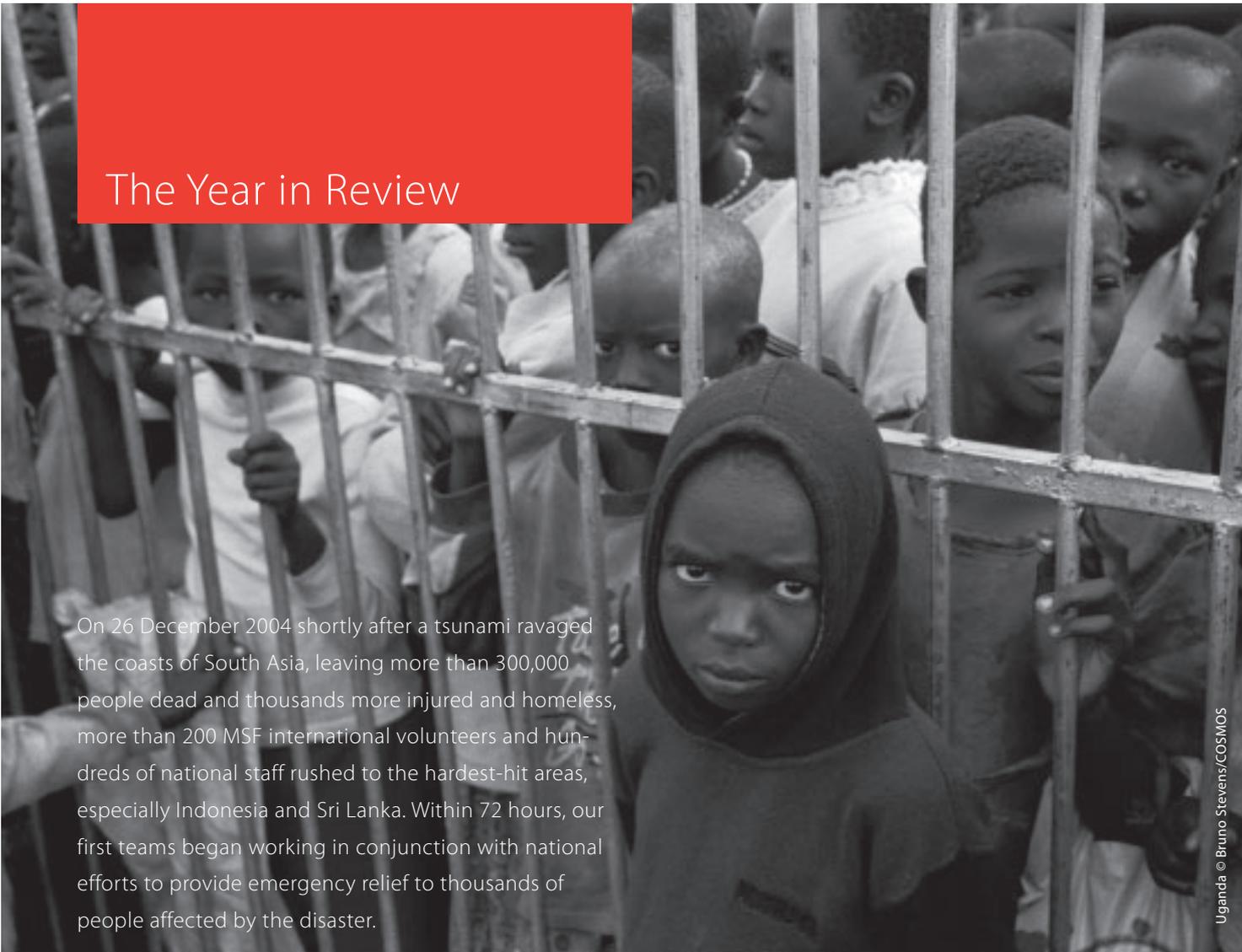
s around the World



- 20 Mozambique, page 38
- 21 Niger, page 37
- 22 Nigeria, page 40
- 23 Rwanda, page 42
- 24 Sierra Leone, page 42
- 25 Somalia, page 44
- 26 South Africa, page 44
- 27 Sudan, page 48
- 28 Uganda, page 32
- 29 United Republic of Tanzania, page 39
- 30 Zambia, page 50
- 31 Zimbabwe, page 50
- Asia/The Caucasus**
- 32 Armenia, page 54
- 33 Georgia, page 54
- 34 Turkmenistan, page 55
- 35 Uzbekistan, page 55
- 36 Islamic Republic of Iran, page 56
- 37 Iraq, page 57
- 38 Pakistan, page 56

- 39 Bangladesh, page 58
- 40 Cambodia, page 58
- 41 China, page 59
- 42 India, page 60
- 43 Indonesia, page 63
- 44 Japan, page 64
- 45 Laos, page 62
- 46 Myanmar, page 61
- 47 Nepal, page 66
- 48 Democratic People's Republic of Korea/South Korea, page 62
- 49 The Philippines, page 60
- 50 Sri Lanka, page 66
- 51 Thailand, page 64
- The Americas**
- 52 Bolivia, page 68
- 53 Brazil, page 68
- 54 Colombia, page 70
- 55 Ecuador, page 69
- 56 Guatemala, page 76

- 57 Haiti, page 72
- 58 Honduras, page 73
- 59 Mexico, page 74
- 60 Nicaragua, page 75
- 61 Peru, page 73
- Europe and the Middle East**
- 62 Belgium, page 78
- 63 Bulgaria, page 82
- 64 France, page 84
- 65 Italy, page 79
- 66 Luxembourg, page 78
- 67 Russian Federation / North Caucasus, page 80
- 68 Spain, page 82
- 69 Ukraine, page 81
- 70 Serbia and Montenegro, page 81
- 71 Sweden, page 83
- 72 Switzerland, page 84
- 73 Palestinian territories, page 84



The Year in Review

On 26 December 2004 shortly after a tsunami ravaged the coasts of South Asia, leaving more than 300,000 people dead and thousands more injured and homeless, more than 200 MSF international volunteers and hundreds of national staff rushed to the hardest-hit areas, especially Indonesia and Sri Lanka. Within 72 hours, our first teams began working in conjunction with national efforts to provide emergency relief to thousands of people affected by the disaster.

MSF's response included providing medical staff and materials to existing health facilities, running mobile clinics where no health care was available, setting up emergency water and sanitation systems where displaced people were gathering, distributing essential relief items, and once initial medical needs had been met, giving psychosocial assistance to those traumatized by the event and its consequences.

In sharp contrast to virtually every other catastrophe that humanitarian organizations addressed in the past year, the tsunami generated an exceptional outpouring of goodwill, solidarity and generosity on an international level. Less than a week after the tsunami, MSF estimated that it had received more than sufficient funds for its foreseen emergency medical activities in the region and asked donors to contribute to our work in other emergencies instead. On page 52 of this report, we explain why MSF took this – at the time – radical stance and how it reinforces our ideas about financial transparency and our own particular role in this type of crisis.

In addition, MSF approached its donors worldwide to request their permission to use their donations in other crisis situations such as Niger, Uganda, Somalia, Colombia or the Democratic Republic of the Congo (DRC), where huge numbers of people continue to suffer year after year in deafening silence. Our supporters were overwhelmingly positive and their donations are now being used in places like southwest Niger, where, by the end of 2005, MSF teams

expect to treat as many as 50,000 severely malnourished children and where an adequate international response to the nutritional and medical crisis has failed to materialize.

It is the ongoing support of thousands of individuals that makes it possible for MSF to assess needs and provide medical relief within hours of a disaster or a crisis. MSF can start working without having to wait for the international community to wake up to the crisis or for institutional donors to release funds. Thanks to its supporters, MSF can retain its independence and intervene when and where our assistance is most needed. This impartiality and independence of analysis and action are crucial elements of MSF's identity that must be upheld despite the changing landscape of humanitarian aid. As described in an essay included in this report, MSF's identity and principles are what enables the organization to work in complicated contexts in which the effects of man-made crises are devastating for individuals.

Working in conflict zones

One conflict in which MSF's neutrality has been crucial is in the DRC, where, for the majority of the people, the so-called transition from war to peace remained little more than a mirage in 2004 and 2005. Thousands continued to die from treatable diseases such as malaria and measles. Violence continued to flare, trapping those living in the provinces of Ituri, North and South Kivu and Katanga. In June 2005, the abduction of two MSF staff members by armed



militiamen forced MSF to withdraw its teams from the outskirts of the town of Bunia, leaving thousands without medical care. Yet MSF continued its work in the city hospital, where surgeons operated on adults and children who had survived gunshot wounds, machete attacks, burning or sexual violence. Elsewhere in the DRC, MSF teams provided hospital and basic care to local populations and people displaced by violence.

In Colombia, people have been forced for decades to live amid violent confrontations among government forces, paramilitary groups and armed guerrillas, which have terrorized and targeted civilians in both rural and urban areas. In its projects around the country, MSF tries to alleviate some of the suffering by bringing medical services, including psychological care, to vulnerable and displaced civilians. Similarly, in the Haitian capital of Port au Prince, civilians have also been caught in the crossfire of political and criminal violence that has wracked their city in waves since September 2004. While living conditions in several of the poorest neighborhoods deteriorate and brutal attacks intensify, the number of people who have been injured by violent acts – and who have received emergency medical and surgical care from MSF – continues to grow. In July 2005, MSF spoke out about the worsening security situation and publicly called on all armed groups to respect the safety of civilians and to allow the wounded to obtain emergency medical care.

Calling attention to Darfur's ongoing violence

Today, approximately two years after violence broke out in Sudan's western region of Darfur, the conflict has faded from the media. But the terror it inflicts on civilians remains ever-present. Many of those gathered in camps within Sudan or just across the border in eastern Chad see no end in sight to their plight, and repeated village burnings, sexual violence and attacks have made returning home an unrealistic option for most. Yet the camps or villages in which they have gathered are far from secure. People living in these areas continue to be subjected to repeated aggression and recurring displacement. During 2005, MSF continued to assist more than one million people forced to flee their homes or otherwise affected by the violence and its consequences.

In addition to the medical care provided, MSF spoke out on a number of occasions, including before the UN Security Council, on what our teams have witnessed in Darfur. After having provided medical care to hundreds of women and girls who had survived rapes or other sexual violence in Darfur, MSF spoke out on violence against women in a March 2005 report. The report's stark findings led the Sudanese government to arrest two MSF international volunteers who directed MSF's work in Darfur. International outcry finally led to the men's eventual release. MSF staff members see it as a responsibility to make people and governments aware of the abuses they witness. To remain silent is impossible. How MSF can best assist victims of sexual violence remains a pressing issue and is highlighted in an essay within these pages.

Meanwhile, the inhabitants of wide areas of southern Sudan have started to suffer from malnutrition due to food scarcity. MSF teams working there are treating a growing number of children suffering from severe malnutrition as the precarious nutritional situation has been aggravated by the return of displaced people and refugees now that the peace agreement is in place.

Improving care for those with neglected diseases

Every day, in countries around the world, MSF confronts another form of violence that touches millions. Patients living with diseases such as malaria, tuberculosis (TB), HIV/AIDS, sleeping sickness and Chagas disease, to name only a few, die simply because the medicines needed to treat them are not available in sufficient quantities, are too expensive or do not even exist. An essay on malaria included here suggests that, because these diseases mainly affect poor people living in developing nations, there is little urgency to increase the supply of crucial medicines, find new treatments or develop better diagnostic tools. In recent years, there has been a timid resurgence of research on these diseases, however, considering the decades of neglect, these improvements are precarious and disproportionately minor for patients awaiting diagnosis and treatment today.

While MSF and many others have shown that it is possible to treat HIV-positive adults – even those living in very resource-poor settings – the same has not been true for the disease's youngest victims. Today our efforts to treat children infected with HIV/AIDS are severely hampered by a lack of appropriate drug formulations and diagnostic tools. Despite the fact that MSF is now successfully treating more than 45,000 patients in 29 countries, our field teams are forced to devise makeshift solutions, such as breaking adult pills in two or struggling to get young children to swallow syrups frequently, to treat them. For HIV/AIDS patients who are also infected with TB (the most common opportunistic infection accompanying HIV/AIDS), the obstacles are just as big. Problems in diagnosing TB, high pill loads, drug interactions, and the lack of coordinated care are some of the difficulties facing our medical teams in various countries, especially in parts of southern Africa, where both diseases kill thousands every year. However, as a feature story in this report shows, it is possible to successfully integrate HIV/AIDS and TB care. In countries such as South Africa, some important headway has enabled extremely ill patients to regain their health and restart their lives.

Fulfilling our commitments

Whether caring for an HIV/AIDS patient co-infected with TB, a gunshot victim in DRC or Haiti, or a malnourished child in Niger, MSF continues to strive to bring medical assistance to those who most need it. Yet our ability to gain access to people in need is challenged by the abuse of humanitarian symbols for political purposes, and the concurrent violence against humanitarian aid workers themselves. The responsibility of states in respecting the role of impartial humanitarian action is something explored in another essay included in this report. This essay discusses the need for action based on principles. MSF has been accused at times of being "old fashioned" and even extremist for reaffirming its basic principles in an evolving world. However, it is the use of these very principles to interpret and respond to a changing environment that allows us to carry out pragmatic actions under such conditions. We hope this report provides insight into the work MSF does, merging principles and pragmatism in many different contexts and different ways. However, we always have one goal in mind: to provide medical assistance to those who need it, whatever the circumstances.

Rowan Gillies, *President, MSF International Council*
Marine Buissonnière, *MSF Secretary-General*

MSF's principles and identity

The challenges ahead



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"Impartiality is vital to continue providing medical assistance to vulnerable populations in need."

An MSF doctor talks about HIV/AIDS with a patient in Zambia.

MSF's identity is intimately tied to its name, Médecins Sans Frontières. That is, doctors (and nurses and other field staff) who are committed to bringing medical assistance to people who are suffering regardless of geographical, political, ethnic, religious or social borders. This action, which aims to be effective and of high quality, is supported and guided by the fundamental humanitarian principles of impartiality, independence and operational neutrality.

MSF has another unique quality that separates it from many other "humanitarian" groups. It is best described by the French word *témoignage*, meaning to speak out and bear witness to the suffering one sees. MSF seeks to bear witness to the fate of populations as precisely as possible, not as defenders of human rights, but simply as direct witnesses to the suffering of the sick and injured and to the stolen dignity of so many men, women and children all over the world. We bear witness because it is part of our understanding of humanitarian responsibility and our desire not to reduce our acts to the merely charitable or logistical. We bear witness because, for many victims, from Chechnya to Somalia to North Korea,

there is nothing worse than neglect or indifference.

This interplay between medical ethics (beneficence, doing no harm, autonomy and justice) and humanitarian principles is the trademark of and the driving force behind MSF's dual identity. And today, both of these forces are being severely challenged because of changes in our environment and MSF's own development. The ethical foundation on which MSF operates dates back more than a decade, to when the movement's leaders created a document to guide MSF's governance. Its key principles were and remain at the heart of a broad international and associative process of

reflection and renewal within MSF. There is no doubt that this process will serve to reaffirm the ethical dimension of our work in this changing environment.

The corruption of humanitarian action

Faced with the almost complete failure of the development-aid system; the transformation of nation states; and the emergence of new international actors of all kinds (NGOs, multinational corporations and private security companies, etc.); and faced with the shocks brought about by globalization and the growing "marketization" of the world, "humanitarian" issues find themselves pushed more and more to the fore-

“Our isolation must not lead to confinement; on the contrary, it must push us to open up toward other actors in order to better understand them, so that we can cooperate more easily where possible or confront them when necessary.”

ground. A victim of its own success, humanitarian action has become a political, economic and social stake in countries in crisis as well as in our own “developed” societies. From its role as a smokescreen to hide political inaction (as in Bosnia-Herzegovina) to its role as a pseudo-catalyst for military intervention (as in Kosovo), the current thinking among many nations, the UN and many non-governmental organizations is that humanitarian action should form an integral part of a “coherent system” – an integrated humanitarian system. But integrated into what? Integrated into policy in the same way as are the use of force, economic development or even justice in a global quest for consistency and effectiveness?

Although this vision has seduced more than one person in humanitarian circles, whether because of conviction, lack of financial or political independence or simple pragmatism, we should be clear that the integration of humanitarian action into a system is tantamount to the disintegration of its very humanitarian values. The trap is set: By integrating humanitarian action, we transform it to the point of removing its substance, even to the point of destroying it. And that would not for one minute trouble those who want to make humanitarian action into a simple tool at the disposal of politics or of military objectives in the war against terrorism or those who see humanitarian action only through the prism of technical standards and cost-benefit ratios.

Isolation as the price of rejection

Faced with this dynamic, MSF’s rejection of this type of cooperation has left it increasingly isolated, both in the plush meeting rooms of the humanitarian jet set – even to the extent that we have been called “humanitarian extremists” at some recent meetings. More tragically, MSF has been isolated in the field, first in Angola, then in Darfur, Sudan, and now dramatically in Niger, where MSF teams have for far too long found themselves alone and largely powerless in the face of a population’s suffering.

Somehow, unlike the International Committee of the Red Cross, whose isolation is largely accepted and recognized

because of its mandate and its function in the international system, MSF is required to explain its position. To some extent, MSF has probably contributed to its own isolation through its own attitude, which has too often been inward-looking. But let us make no mistake: the fundamental cause of this isolation can be found above all in the fact that the humanitarian values of independence and impartiality that we defend are themselves isolated or even undermined. This is done not only by politics, but also by a section of the “humanitarian community.”

It is part of everyone’s responsibility to combat this erosion of respect for human dignity, starting at national level, where there is, at least, a legal commitment to respect and ensure respect for international humanitarian law. On that count, the fact that the government of The Netherlands continues to sue MSF for the repayment of the ransom which the Dutch government negotiated and paid for the liberation of one of our volunteers who was detained for 20 months in the North Caucasus, is more evidence that states, including Western states, prefer to continue to deceive their constituents rather than shoulder their own responsibilities.

Nations’ refusal to act can also be seen in the many months of effort and pressure it took to get the Afghan government to start taking action to find and prosecute the criminals who murdered five of our colleagues on a deserted road in Afghanistan in June 2004. In many countries, at many times, populations have been little more than consumables, to be disposed of at the whim of political and economic interests. Humanitarian action that tries to be close to such populations is not immune to this same risk. The question of how to deal with such violent actors has become a matter of life or death. How can we talk to and convince people who take their own populations hostage that MSF is not just another

“The integration of humanitarian action into a system is tantamount to the disintegration of its very humanitarian values.”

puppet controlled by the military-humanitarian actions deployed by certain states? How can we be convincing enough to be accepted by all actors? In any given situation, how far should we go in this approach, and up to what point should we take the risks inherent in working independently, in physical proximity to the victims of conflicts? Sometimes we cannot. We responded to such a situation in Afghanistan by stopping our activities and withdrawing our teams in July 2004 and again by leaving Iraq in November 2004. Faced with this polarization of extremes, which leaves no room for humanity, we can only respond with increased engagement, tempered with caution, to reaffirm our principles of intervention.

Let us not deny this isolation. On the contrary, let us accept it as part of our right to be different, while providing further explanation to those who support us, including our private donors, or with whom we have contact in the field. With no concessions. Peace, democracy, economic development and justice are the underlying issues in, or the backdrop to, many dramas with humanitarian consequences. But they are not our fights. We must keep our action independent of these processes while still maintaining an awareness of the many interdependencies and frictions that stem from them. This is why we refuse to be involved in the integrated system. We reject the reduction of humanitarian assistance to a role of army after-sales service, whether for the United States government in Iraq or the Russians in the North Caucasus. This is why we are against the UN’s concept of integration, which may ultimately sacrifice part of the population, as happened in Sierra Leone when the choice was made not to intervene in rebel-held areas controlled by the RUF, and in Afghanistan under the Taliban’s rule. Sadly, even the UN’s impartiality is of variable geometry depending on the political interests of the members of the Security Council and cannot be confused with the humanitarian impartiality demanded by MSF.

This impartiality is vital to continue providing medical assistance to vulnerable populations in need. So, if we are forced to choose between operating in an integrated system, choosing who shall be saved as a

"The humanitarian values of independence and impartiality that we defend are themselves isolated or even undermined."

product of the political importance of the population and of working amid "organized chaos," our choice is clear. And the choice is not made to dogmatically defend our independence, but because we are convinced that the co-existence of independent actors is the best option for populations in danger to have a chance to obtain needed care and assistance. Did this famous integrated system respond in Darfur? No. Did it work in a peaceful country like Niger that was edging toward high levels of starvation? Again, no. By contrast, this famous system worked perfectly, even to the point of getting carried away, after the tsunami hit South Asia in December 2004, thanks to the complicity of the media, which converted the disaster into emotional entertainment. If humanitarian action continues to be transformed into a system in which government and humanitarian action is intermingled, MSF will probably have no choice other than to accept even further isolation to maintain a certain tension, at the risk of becoming a kind of stowaway in a system going increasingly around and around in circles.

Using our isolation

In that light, the main issue to be examined by MSF is our capacity to emerge from our humanitarian microcosm in order for populations to better accept our actions. Indeed, above and beyond our certitude in our principles, we must make the effort to understand how we are perceived in the field on account of our attitudes, actions,

views and effectiveness. We must make the effort to change the way we work and think, to adapt to that environment. Our isolation must not lead to confinement; on the contrary, it must push us to open up toward other actors in order to better understand them, so that we can cooperate more easily where possible or confront them when necessary. Accepting this difference implies an ever-growing degree of transparency on the part of MSF and increasingly substantial accountability mechanisms.

This notion of accountability also includes transcending another paradox related to MSF's identity: the fact that, although we are perceived as a global actor, we, in fact, remain a movement comprised of national associations composed of members. It is essential that we succeed in preserving the associative aspect of the movement, which is a genuine anchor in our respective societies and which serves as a real safeguard against the technocratic and bureaucratic shifts facing so many organizations of MSF's size.

A catalyst for progress

Our identity is also linked to the way we seek creative solutions to the medical challenges facing us. I will finish with just one of these, the fight to ensure access to care for those living with HIV/AIDS, because it leads to another situation that is also about to confront MSF. In this area, MSF, in its role of pioneer and thorn-in-the-side of

public institutions and private actors, cannot work alone to achieve its objectives. Our role as a catalyst for change forces us to engage with others, whether in a cooperative way – through partnerships – or in a confrontational way that forces those in power to accept their responsibilities to help millions of people deprived of treatment. To promote access, a few years ago, MSF created its international Campaign for Access to Essential Medicines, which has contributed to a drastic fall in the price of life-extending antiretroviral medicines. Drug prices have plummeted from about US\$ 10,000 per patient per year in 2000 to less than US\$ 300 per patient per year in 2003.

Faced with needs beyond its own scope of work and wanting to safeguard its foundation in the field, MSF later supported the creation of a separate organization, the Drugs for Neglected Diseases initiative (DNDi). DNDi is a logical next step that aims to stimulate the barren field of fundamental medical research for neglected diseases including sleeping sickness, kala azar and Chagas disease. For every step forward, however, new dilemmas arise for us and for our teams in the field, such as financial constraints and the crisis in available human resources that represent the new barriers to access to care in many sub-Saharan countries. These problems go far beyond the "traditional" responsibilities of MSF, and the situation creates another form of pressure on our identity and our principles of action. We continue to ask: How far should we go in our cooperation with others, or with confrontation? How can we set limits for ourselves as a catalyst when there is so much still to be done?

Between the temptation of the alter-globalist illusion and the trap of becoming nothing more than an aspirin to prevent headaches in our own societies, MSF must reaffirm its own medical and humanitarian identity. The current debates within MSF are signs of these tensions and of our will to take on these situations as a movement, in order to preserve the real meaning of our name.



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A simple yet crucial demand:

Ensuring that crimes against humanitarian workers do not go unpunished

BY GORIK OOMS, GENERAL DIRECTOR OF MSF IN BRUSSELS

Government and rebel forces fighting in the Russian republic of Chechnya have terrorized the civilian population and limited the ability of humanitarian organizations like MSF to carry out their work assisting vulnerable civilians due to the risk of abduction and other possible harm.

We know from experience that humanitarian assistance is both most needed and most threatened in areas where people are suffering because of armed conflict – not because of natural disaster or disease. By definition, therefore, part of the territory in which MSF attempts to deliver assistance is outside of any government’s control. This reality makes it somewhat of an empty gesture to call on nations to protect humanitarian aid workers or to urge other governments to pressure those countries in which assaults on aid workers occur.

The Geneva Conventions make clear that states and non-state actors involved in armed conflict have a responsibility to make sure that all “persons taking no active part in the hostilities” (and this includes humanitarian aid workers) are treated humanely¹. The UN Security Council has even passed a resolution urging “...States to ensure that crimes against such personnel [participating in humanitarian operations] do not remain unpunished...”.² With these precedents in mind, should a humanitarian organization like MSF take it upon itself to remind states of their responsibility to protect humanitarian assistance?

We have to consider the argument that calling on governments to protect humanitarian assistance could in fact undermine the impartiality and the independence of

humanitarian organizations that are providing aid.

How far to push?

If we extend too far the argument that nations have a responsibility to protect humanitarian assistance, wherever it is delivered and regardless of whether the government has control over a region, then we risk getting a response that says: “We assume our responsibility, but the only way we can assume it is by prohibiting humanitarian workers from going there.” This type of reply is more or less what MSF heard from the Dutch government when MSF challenged it to act in the case of its kidnapped staff member Arjan Erkel: “The Dutch government bears a general responsibility for the safety of its citizens. The Ministry advises Dutch citizens traveling abroad, and draws their attention to possible dangers. In its advice to travelers to the Russian Federation, it points to the dangers of conflict in the northern Caucasus.”³

Can we blame the Dutch government for this reply? No institution can be obliged to do the impossible. If a government has an obligation to protect its civilians, but knows – or pretends – that it can’t exert any influence on crimes happening in certain areas, then the only protection it can offer is a “no go” order. At the same time, because it has become fashionable in UN and diplomatic

circles to mix humanitarian objectives with political objectives – in other words, to try to turn humanitarian assistance into a convenient tool to build peace or to fight terrorism – some national actors might be very keen to embrace or even highlight their responsibility to protect humanitarian assistance. This assumption of responsibility would give them an alibi to steer humanitarian assistance away from troublesome regions. If we accept that we need some kind of “green light” from governments for our international aid workers to be allowed to work in certain regions, in order for them to enjoy the protection of those governments, then we lose our independence (and in many cases, our neutrality as well, in the event that those governments are not perceived as neutral in the conflict.) We could accept the principle, then argue that the refusal of the green light is wrong, that the alibi is false, that the government refusing the green light does have some influence in the concerned region but refuses to use it for political, diplomatic or economic reasons. But wouldn’t this lead us to discussions in which we don’t want to be involved?

Is governmental protection the only answer?

Some have suggested that states should exercise their responsibility to protect humanitarian-assistance efforts by offering



direct military protection to nongovernmental organizations providing aid. A scholar from a US-based conservative think tank called the Rand Corporation, who also happened to be the wife of the US ambassador to Afghanistan, wrote in *The Wall Street Journal* in August 2004 that 30 aid workers had been killed in Afghanistan in the past two years, all of them unarmed and working in civilian projects. She suggested that their lack of weapons and soldiers-escorts did not protect them but rather only made them easier to kill. She concluded that, in the light of today's reality, security, development and aid were all part of the same whole and that humanitarians would have to operate under the cover of arms – or not at all. But obviously, the armed forces that could offer such protection are seldom neutral in the conflict. Accepting such protection would undermine both our neutrality and our independence.

Behaving like spoiled cats?

In an internal MSF debate, a participant compared MSF's attitude toward protection with the behavior of a spoiled cat, that is, a cat that likes to sit near the feet of the mistress of the house but starts to hiss as soon as she attempts to caress it. In other words, we want protection, but we don't want to be seen as needing or receiving it. This comparison illustrates the confusion that has been created by our repeated calls for nations to assume their responsibilities to protect humanitarian assistance. The confusion lies between the protection of humanitarian assistance and the protection of humanitarian workers. Organizations like MSF don't mind being caressed, but we don't want to be hugged to the point of suffocation. Allowing government actors to decide where humanitarians can or cannot go and allowing governments to impose military escorts as a condition for protection might well protect humanitarian workers, but kills the principles of humanitarian assistance.

What MSF and others are demanding is respect and non-aggression toward humanitarian assistance, not so much in the sense of physical protection for humanitarian workers through international military bodyguards. Obviously, humanitarian aid workers are not volunteering for martyrdom. They cannot give assistance where they are targeted by warring parties or criminals. However, if the price to be paid

for the protection of humanitarian workers is for them to give up their independence or their neutrality, then humanitarian assistance is no longer being protected, it is being destroyed. In such situations, there is not enough water between the Scylla of being embraced and embedded with military powers and the Charybdis of being caught in a general climate of lawlessness. In such situations, the only remaining option could be to withdraw – which MSF was forced to do recently in both Afghanistan and Iraq.

When we demand that states protect our humanitarian assistance, we're merely asking them to attempt to end those Scylla or Charybdis situations. We're asking them to live up to their commitment to create a space in which humanitarian assistance can operate without having to rely on military protection and without offering up its workers as martyrs. Is that such an impossible demand?

The UN Security Council doesn't ask for that much effort on the part of states. What it does urge is that states do not allow crimes against humanitarian workers to go unpunished. One could debate whether this is sufficient. If all states ensured that those committing crimes against humanitarian workers were found and punished, would it be enough to protect humanitarian assistance? Probably not. However, such a commitment would be a solid start, one for which we are still waiting.

Criminals go unpunished

After 20 months of captivity, MSF head of mission Arjan Erkel was released in April 2004 by his kidnappers. Immediately after the release, the media reported that Dutch Foreign Affairs Minister Bernard Bot had said Erkel's release was the result of negotiations and that he knew who was responsible for the kidnapping. He also said that the Dutch government was involved in securing Arjan's release.⁴

The question of to what extent the Dutch Ministry of Foreign Affairs was involved in securing Arjan's release is the subject of a court case, on which we will not comment here. Far more important for this article – and for the future protection of humanitarian assistance – is the foreign affairs minister's admission that he knew who was responsible for the kidnapping.

As explained, MSF doesn't ask much from states when it comes to protecting humanitarian assistance. We don't ask states to tell us where we can or cannot work, we don't ask states to give us military escorts. But we do demand that states do whatever they can to ensure that crimes against humanitarian workers don't remain unpunished.

Of course, this responsibility cannot start once the suspects are known, it must start much earlier. If the suspects are known, it becomes even more unacceptable that the government of a victim of a crime against a humanitarian worker doesn't even try to "ensure that crimes against such personnel do not remain unpunished." What has the Dutch government done to ensure that the crime committed against Arjan Erkel does not remain unpunished?

What about the murderers of MSF staff members Hélène de Beir (Belgian citizen), Willem Kwint (Dutch citizen), Egil Tynaes (Norwegian citizen), Fasil Ahmad and Besmillah (Afghan citizens) in Afghanistan during June 2004? It was the Afghan authorities who indicated that they had identified a suspect. Their prime suspect was a local police commander, who had been fired before the murders and reinstated afterward. It seems that his intention was to demonstrate that he is a key element in the security of the area.⁵ Ironically, the governments of Belgium, Norway and The Netherlands are all donors to the Law and Order Trust Fund for Afghanistan, which has as its first objective to ensure the "nationwide payment of police staff salaries."⁶ For a whole year, rather than ensuring that these murders would not go unpunished, these governments unknowingly contributed to the salary of the prime suspect! It took an intense lobbying campaign on the part of MSF and others before the prime suspect was jailed and a case was brought against him.

Humanitarian aid organizations are not asking for so much. We are not demanding safety guarantees for our workers. We are asking states not to commit crimes against humanitarian workers, and if others do, to do everything in their power to ensure that these crimes don't go unpunished. It's an essential condition to ensuring that the people needing humanitarian assistance receive it.

1. First, second, third and fourth Geneva Conventions, common article 3 (1).

2. UN Security Council resolution 1502 (2003), www.un.org/News/Press/docs/2003/sc7856.doc.htm

3. "Statement issued by the Ministry of Foreign Affairs on the Arjan Erkel case/ ransom money (undated) www.minbuza.nl/default.asp?CMS_ITEM=52D507C03824441A970E3D1A40E5DCE4X1X63760X19

4. Expatica News, "Aid worker surprised by release", 13 April 2004

www.expatica.com/source/site_article.asp?subchannel_id=19&story_id=6541

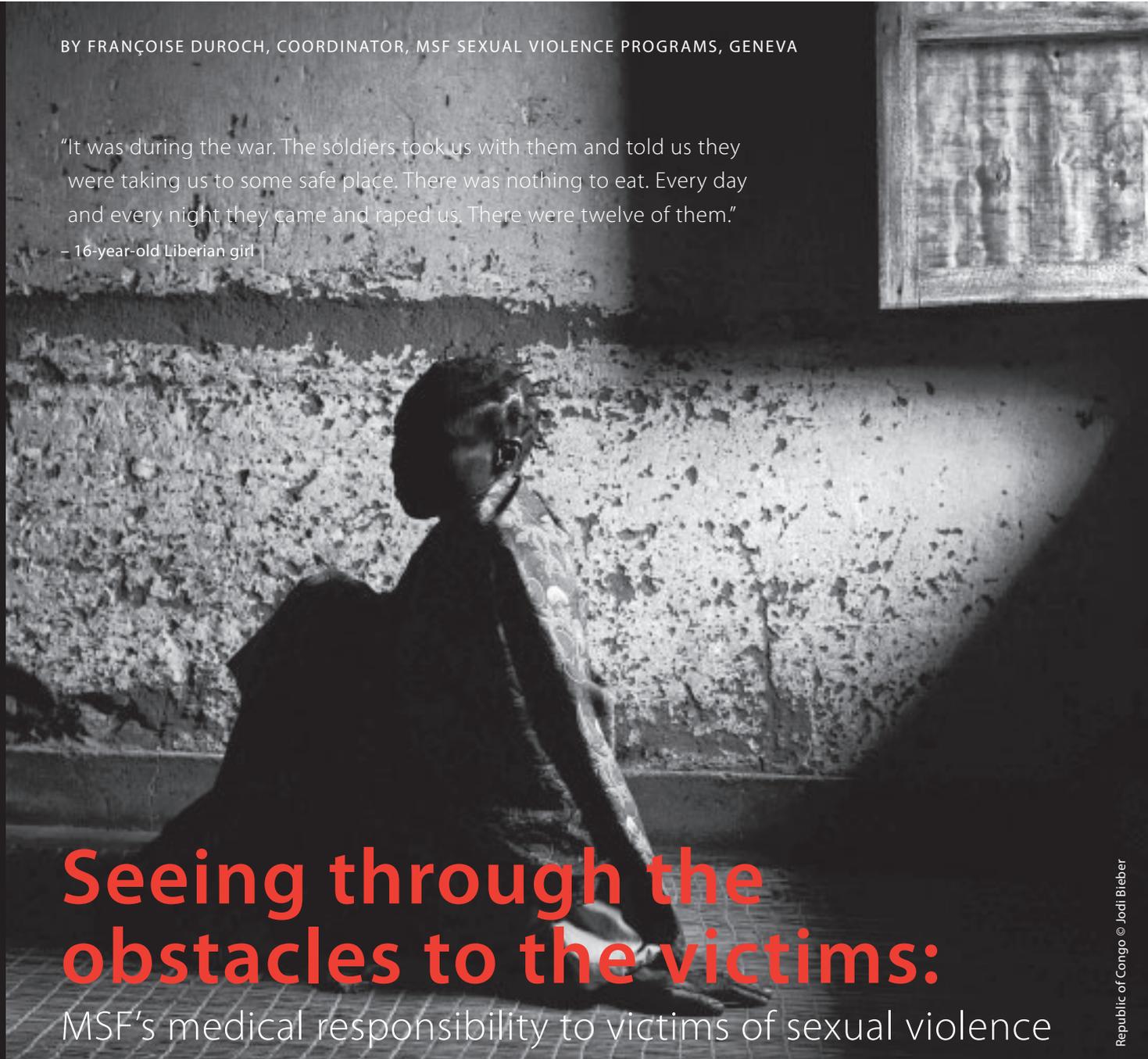
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BY FRANÇOISE DUROCH, COORDINATOR, MSF SEXUAL VIOLENCE PROGRAMS, GENEVA

"It was during the war. The soldiers took us with them and told us they were taking us to some safe place. There was nothing to eat. Every day and every night they came and raped us. There were twelve of them."

– 16-year-old Liberian girl



Seeing through the obstacles to the victims:

MSF's medical responsibility to victims of sexual violence

Republic of Congo © Jodi Bieber

A year ago, all of MSF's offices debated the organization's role in providing specialized health care to women. One particular area of concern that is becoming better recognized as a part of our work is care for victims of rape and other types of sexual violence. It is important to evaluate our success in enabling all of our operational teams to provide suitable care and support to these women and girls and to consider some of the obstacles facing them as they attempt to do so.

MSF teams regularly witness the results of large-scale and diverse types of violence: state-perpetrated violence, massacres, torture, systematic rape, and so on. Despite this, we have had trouble finding suitable responses to these sensitive and complex issues, only fragments of which are even visible to us. These issues are only made more difficult because our response can compromise the safety of our national and international staff.

There are many reasons why it is sometimes difficult for MSF to respond to victims of sexual violence. There are differences of opinion on what constitutes sexual violence, and cultural obstacles linked to the general stigma surrounding rape make the identification of victims difficult. It is hard to provide staff sensitivity training on these issues in an extreme emergency situation where many needs must be met quickly. And victims of sexual violence sometimes refuse to come for help. Those who are strongly influenced by religious ideology or are dependent upon others, may fear ostracism, especially by male partners who could abandon them if it became known that they had been raped.



Burundi © Carl De Keyzer/Magnum Photos

“Beginning antiretroviral (ARV) treatment for a four-month-old baby, repairing the perineum of a five-year-old girl, or relieving the pain a 70-year-old woman feels in her anus is more than a scriptwriter of horror films could imagine...”

– Celia Kohn, MSF gynecologist-obstetrician in Bunia, DRC

Initial data from various contexts in which we work show the huge range and unpredictability of violence in general and of sexual violence in particular. For example, in recent years, MSF teams in the Ituri region of the Democratic Republic of the Congo (DRC) have been told of the kidnappings of young girls which have been linked to acts of extreme cruelty. We have seen how rape and the threat of rape are used to terrorize and control civilians in Darfur’s displacement camps. Teams have seen the consequences of a rise in civilian and domestic violence in Liberia following the waves of armed conflict that have crossed that country.

Medical responsibility is not police work

However, when it comes to responding to the consequences of sexual violence, our medical practices sometimes meet resistance, or we find that our teams are limited by the reality of certain situations. Yet our medical responsibility compels us to avoid making judgments about those who need our help and to overcome any “reflexes” – both conscious or unconscious – that might prevent us from doing as much as we can for victims of sexual violence.

Medical responsibility implies, among other things, an obligation to provide needed resources. That is, a doctor needs to make every possible, up-to-date medical resource available to the patient. Yet putting this imperative into action in the field sometimes can prove to be very complicated. Violence is composed of intent and harm, the aggressor and the aggrieved – and although the notion is often colored by culture and may have political, economic or religious designs, contextualizing our individual and collective responsibility to people and societies beset by this kind of violence makes the exercise of medical responsibility particularly delicate.

MSF workers themselves are not immune from the misconceptions about rape that exist in larger society. Indeed, there may be a temptation to resort to cultural relativism (perhaps making assumptions about the sexual propensities of a beneficiary population) to hide our own distress when faced with phenomena for which our assistance is (and must be) limited. One might even hear a comment such as “Does rape really happen in Africa?” or “You know, some people just have a violent sexuality.” Such comments imply that all values are relative depending on the cultural context in which they are found. Ironically, the only opinions continually missing from the debate are those of the people themselves. In this kind of discussion, we take away their right of self-determination and the values that concern them.

In the field and in the headquarters offices, one can hear snippets of conversations that raise doubts about the victim status of some female patients: Perhaps they want to conceal consensual relations with a partner, or maybe their real motive for seeking treatment after a rape is to get free soap or clothing. Such suspicions also get tangled in a dialogue about whether or not consensual sex between older men and pre-pubescent girls constitutes rape or a form of sexual exploitation.

However, we must remember: medical responsibility is not police work. It is not our job to test the veracity of cases, nor is it our work to explore aspects of anthropology or the social sciences to better understand the context – even though cultural aspects must, of course, be considered. This is true not only in cases of rape, but also in broader terms when dealing with a local population’s concepts of health, body image, violence and sexuality.

“There are many reasons why it is sometimes difficult for MSF to respond to victims of sexual violence.”

Our medical responsibility could therefore begin with easing access to care for these female patients for whom such access is often very limited relative to the general population. This can come down to working with the invisible, leaving the responsibility for establishing these activities entirely up to the will and “militancy” of one or more of our staff members.

In emergency situations, making this kind of care available can sometimes spark competition with other health imperatives that must be addressed. In such cases, we are forced to carry out a kind of triage that threatens to create a form of competition among our patients. Our priorities, often dictated by individual or public health issues (e.g., cholera which can kill within hours), remain solidly anchored in an ideological framework that we sometimes forget to question.

The duty to provide care

While trying to avoid accepting all differences from our norms as “cultural,” we also face the potential for taking on an “imperialist” attitude that consists of dictating the populations’ best interests – particularly when we are denouncing and bearing witness to practices we oppose and when we are establishing medical care where it is limited or completely lacking. Medical responsibility is primarily a matter between patient and practitioner. The obligation to give resources – even when operating in dangerous situations – is above all the obligation to provide care and to ensure its quality. In cases of sexual violence, it could be a matter of giving antibiotic treatment to combat a sexually transmitted infection, giving prophylaxis treatment to prevent HIV infection, providing medicine to avoid pregnancy, performing an abortion or reconstructive surgery, or, of course, addressing psychosocial issues.

Although there is insufficient scientific causal evidence to describe a direct link between sexual violence and HIV transmission, our action in emergency situations must be guided by the time imperative for efficient prophylactic treatment of HIV, despite the fact that these measures sometimes interfere with the management of other public health problems. Apart from pure prophylactic action, post-exposure prophylaxis (PEP) is one of the only tools we have available in the field to hold back HIV transmission in endemic contexts. Looking back, we know that in Rwanda, thousands of women were infected with HIV/AIDS through widespread systematic rape during the genocide of 1994. At the time, MSF was not focusing on victims of sexual violence, while being confronted with so many types of violence and enormous insecurity, including harm to its own teams. However, shouldn’t we let the consequences of that event serve as a guide for our future action on the issue? Shouldn’t care for victims of sexual violence and rape be one of our first priorities in conflict settings, especially knowing the suffering it causes its victims and the long-term health consequences it can have on a whole group?

Is doing something enough?

Experience has shown that it is sometimes difficult for MSF teams to address the consequences of violence without being able to act on the causes. Nonetheless, we should not discount the care that we must and can provide to people, even if it may seem inadequate giv-

“One day I was collecting firewood for my family when three armed men on camels came and surrounded me. They held me down, tied my hands and raped me, one after the other. When I arrived home, I told my family what had happened. They threw me out of the house and I had to build my own hut away from them. I was engaged to a man and I was so much looking forward to getting married. After I was raped, he did not want to marry me and broke off the engagement because he said that I was now disgraced and spoilt... ..When I was eight months pregnant from the rape, the police came to my hut and forced me with their guns to go to the police station. They asked me questions, so I told them that I had been raped. They told me that as I was not married, I would deliver this baby illegally. They beat me with a whip on the chest and back and put me in jail. There were other women in jail, who had the same story... I stayed 10 days in jail and now I still have to pay the fine, 20,000 Sudanese dinars (US\$ 65) they demanded of me.”

– 16-year-old girl, West Darfur, Sudan

en the chronic, structural or political nature of the situation. The responsibility that medical practitioners and organizations carry in these emergency situations goes far beyond a legal concept: It also touches on areas of political, ethical and civil responsibility.

Our ability to provide comprehensive care to victims of sexual violence and rape is limited. Yet when one of our doctors signs a medical certificate and hands it to the patient, this act, to some extent, symbolizes the unique responsibility that the doctor has to provide assistance after an episode of sexual violence. By signing the document, the doctor is committing him or herself personally, and taking part in the practice of individual medicine within group and public health care systems. This can be a healthy exercise for both the doctor and the patient when the suffering of so many victims of sexual violence is often reduced to statistics lacking any names or faces. And it should continue to be the ethical foundation on which our medical practices are based.

“Shouldn’t care for victims of sexual violence and rape be one of our first priorities in conflict settings?”

BY CHRISTA HOOK, HEAD OF MSF'S INTERNATIONAL WORKING GROUP ON MALARIA AND NATHAN FORD, DIRECTOR OF MSF'S MANSON UNIT WHICH PROVIDES SUPPORT TO MALARIA FIELD PROGRAMS

Malaria MSF's constant challenge

"Of the estimated one million people who die from the disease each year, 90 percent are African children under the age of five."

In the past year, a new disease appeared in the media spotlight. The Marburg virus, which killed more than 300 people during an epidemic in Angola (see page 31), had all the drama of a Hollywood film. Yet far from the spotlight, another disease continues, silently, to kill millions each year. Malaria remains the biggest cause of illness confronted by MSF's medical teams, and is one of our most frustrating challenges. The bottom line is this: millions continue to die of a disease that can be cured cheaply and easily. For MSF, this is completely unacceptable.

A twelve-year-old Nuer boy waits to be screened for malaria at a MSF health unit in the Upper Nile region of southern Sudan. Malaria continues to kill thousands of children in the country each year.

Over the last few decades, MSF doctors, along with other health workers in the developing world, have been dismayed to see the struggle with malaria become more and more difficult. Eradication efforts in the United States and Europe wiped out malaria by the 1950s. But in most parts of Asia, Africa and Latin America, the rapid development of parasite resistance to medicines and growing resistance of the mosquito vector to insecticides have combined with waning Western interest in the former colonial world to defeat eradication efforts.

Today, 300-500 million people develop malaria each year – far more than in the 1970s. Of the estimated one million people who die from the disease each year, 90 percent are African children under the age of five. Malaria continues to be the number one cause of illness addressed by our programs. Last year alone, more than a million people were treated by MSF for the deadly form of the disease, falciparum malaria.

Frustrated by the poor availability of effective medicines and diagnostic tools, MSF began three years ago to draw on its field experience to press the international community to take greater responsibility for increasing access to malaria treatment. Because many of the older malaria treatments such as chloroquine and fansidar, have become almost completely ineffective, a new line of medicines, known as artemisinin-based combination therapy (ACT), has been developed recently. Treatment with ACT takes just three days and costs as little as US\$ 0.60 per child and US\$ 2.00 per adult.

MSF has demonstrated the effectiveness of these new treatments: In a high transmission area in Angola, for example, admissions for severe malaria were reduced by 25 percent in the year following the introduction of ACT. Over the same period, mortality was reduced by 75 percent compared to the previous year.



“Millions continue to die of a disease that can be cured cheaply and easily. For MSF, this is completely unacceptable.”

the world – to provide treatment for free. In addition, while demand worldwide for ACT has increased, pharmaceutical companies that had promised to increase production to meet the need have failed to do so.

Second, there is not enough money to allow malaria-burdened countries to provide treatment for free. In Burundi, for example, the main problem with treatment is the cost. In the last few years, the government changed its malaria-treatment policy to ACT, funding was procured, training was implemented, and the old, ineffective drugs were removed from clinics. But like many countries, Burundi has been persuaded by the World Bank that it needs to charge a small fee for a medical consultation. Largely as a consequence of this decision, patients are being denied effective treatment. One MSF survey conducted in the country’s Makamba province found that fewer than 30 percent of patients with malaria were treated with ACT.

This payment policy has been promoted in the hope that “cost-sharing” or “cost-recovery” schemes will make health systems in poor countries more sustainable. This is a false hope in these very poor countries: Rather than adding income to the health system, cost-sharing has proven to be a very effective way of keeping the poorest from receiving treatment.

MSF studies have shown that the death rate from malaria goes up with increasing health-service charges. One study, conducted earlier this year in Chad, found that the cost of ACT was a heavy financial burden for most. For half of the people

surveyed, the price paid at the health center was equivalent to at least 12 days of income; for the poorest 20 percent it exceeded their monthly revenue. Seventy percent of those who sought medical assistance needed to sell goods or borrow money to pay for it.

These policies also have been found to prevent effective diagnosis. Confirmation of clinically suspected malaria by either microscopy or rapid diagnostic test is a crucial part of tackling malaria effectively. These tests are needed for two important reasons: to confirm that a patient has malaria so that ACTs are not misused, and to encourage correct diagnosis so that other causes of fever can be treated (often all fevers are assumed to be malarial). MSF teams have found that the availability of microscopy is limited by lack of sufficient numbers of trained technicians, and the use of rapid diagnostic testing is, like ACT, limited by short-sighted policies that deem them too expensive.

A political, not a medical problem

For MSF, it is clear that the major problems involved in tackling malaria are not technical, medical or scientific. It is entirely feasible to produce enough ACTs and to ensure their distribution so that treatment can reach people in need. But that will only happen if there is urgent and sufficient political action. The responsibility for curing malaria cannot lie with a child’s poverty-stricken family. The responsibility lies with the international community, which can and must provide the funds to treat every child and adult suffering from this entirely curable disease.

In part because of such evidence, there is now widespread recognition by donors, UN agencies and affected countries that ACTs must be made available as soon as possible to halt malaria deaths, mainly of young children who are not treated adequately. Most countries in sub-Saharan Africa have switched their national treatment policies from use of older, inadequate treatments to ACT-based therapy.

Denied effective treatment

However, the problem is far from solved. Even where new policies are in place, MSF has observed that effective diagnosis and treatment remains available to only a tiny proportion of those who need it. Although 33 African countries have agreed to use ACTs, only 11 have begun to do so, and only a handful have done so nationally.

At the international level, two major issues persist: there is a critical shortage of ACTs and not enough money to allow malaria-burdened countries – among the poorest in

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An HIV-positive patient is tested for malaria in the Chisenga Island clinic in Zambia.

© Julie Rémy



The TB/HIV time bomb:

A dual epidemic explodes in South Africa



Twin epidemics, HIV/AIDS and tuberculosis (TB), are spreading illness and death in southern Africa. Today, an estimated 12 million people are now co-infected with these diseases and more than two-thirds of them live in sub-Saharan Africa. With the world's highest rate of HIV/AIDS infection and an ongoing TB epidemic, South Africa's people are at the epicenter of the crisis.

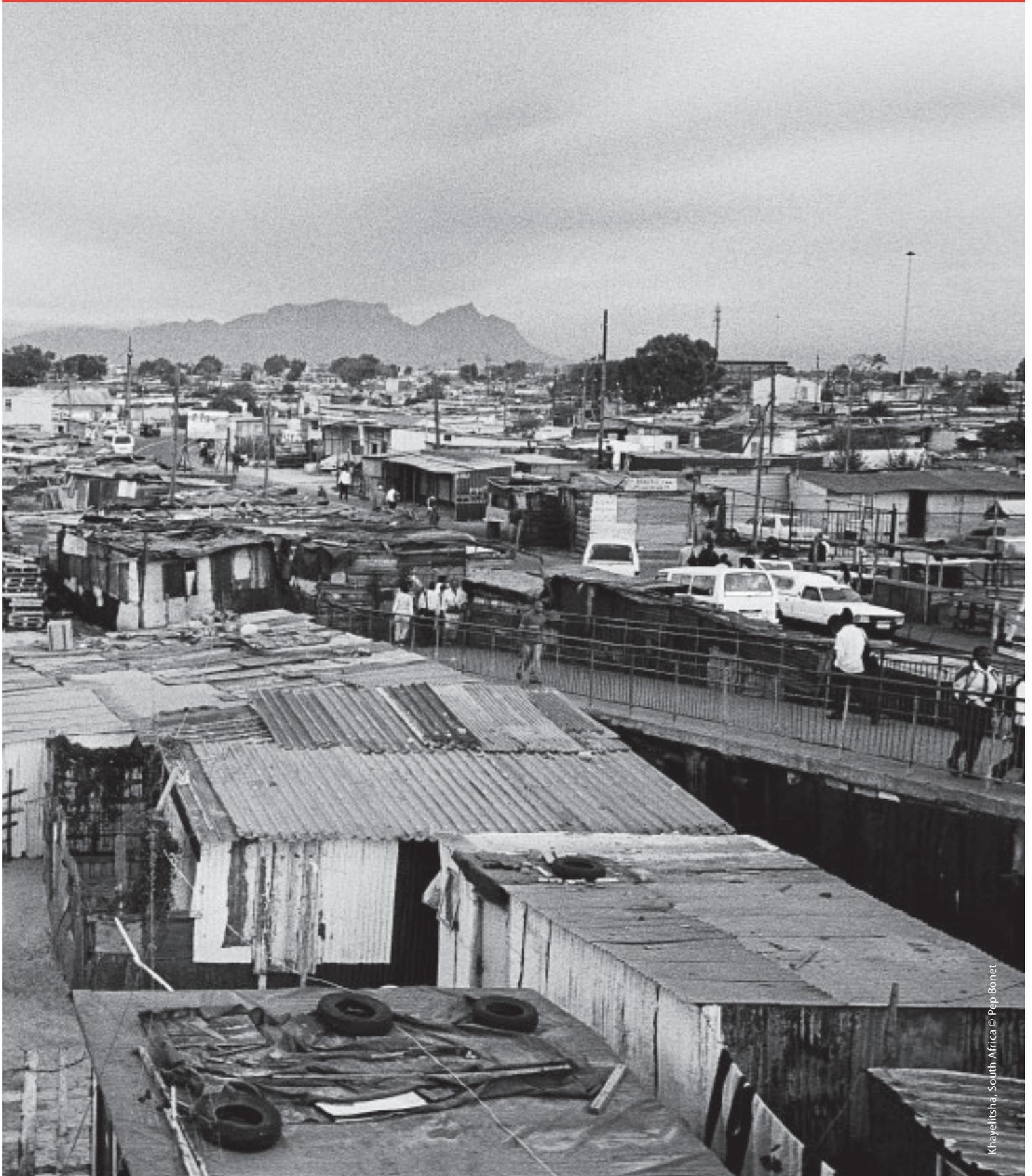
The shape of the TB epidemic has been dramatically affected by HIV. TB is one of the world's leading causes of death, especially in developing countries. The World Health Organization (WHO) estimates it kills two million people each year and another eight million become ill. While one-third of the world's population is infected with the mycobacterium, most people do not become sick unless their immune system is compromised. And that is exactly what the HIV virus does. Today, TB is the leading cause of death among people living with HIV. Despite this fact, few countries have programs that provide TB treatment alongside HIV care.

MSF has been spearheading efforts to integrate care for people living with TB and HIV/AIDS in Khayelitsha, South Africa, a poor urban township near Cape Town. In 2003, in cooperation with the Provincial Administration of the Western Cape and the city of Cape Town, MSF started a pilot project at Khayelitsha's Site B Ubuntu clinic. Khayelitsha has the highest TB incidence (1,655 new cases for every 100,000 people per year) and one of the highest HIV prevalence rates (29 percent) in the metropolitan area. The clinic's "one-stop" services, quick referrals and careful monitoring of both TB and HIV patients have made it the busiest clinic in the Western Cape for both TB and ARV treatment.

Word has traveled quickly that patients can now get care for both illnesses at the same place and the waiting room is full every morning at 8:00. "The patients are coming," says Gilles van Cutsem, an MSF physician working at the Ubuntu clinic. "This clinic is seeing more patients than others. Integration is working for patients. They know it makes it easier to get care."

Integrating TB and HIV/AIDS care has not been easy as treatment for both illnesses have historically been provided through separate programs in the Western Cape region run

High rates of TB infection and a still growing AIDS crisis have made integration of care for patients living with both diseases an urgent necessity.



Khayelitsha, South Africa © Pap Bonnet

Integrating TB and HIV care makes sense medically

by different health authorities. While medical teams on the ground see the obvious need, at a higher level, protecting existing programs and areas of control often seem to have priority over improved, more efficient patient care.

Plus, the WHO's commitment to daily directly observed TB treatment hampers efforts to introduce more flexible and adapted treatments. "MSF is one of the few organizations working to make integration a reality in South Africa," says Marta Darder, coordinator of MSF's Access to Essential Medicines Campaign in South Africa. Places like the Ubuntu clinic show that on a small scale, integration is working, but a lot still needs to happen. Ubuntu is one of only a handful of South African health centers that are offering integrated care for TB and HIV patients and all of these efforts pale in comparison to the immense need for them.

TB is more difficult to detect in HIV-positive patients as they tend to contract less common, more difficult-to-diagnose types of the disease. The fact that in many countries different health staffs and departments handle diagnosis and treatment for these two illnesses means that many patients found to have one disease may not be treated or even tested for the other. Even when they are referred for testing or care, many patients must visit multiple health centers to get the care they need. Health care providers also face frustrating obstacles in getting sick patients tested and started on treatment because of the separate systems.

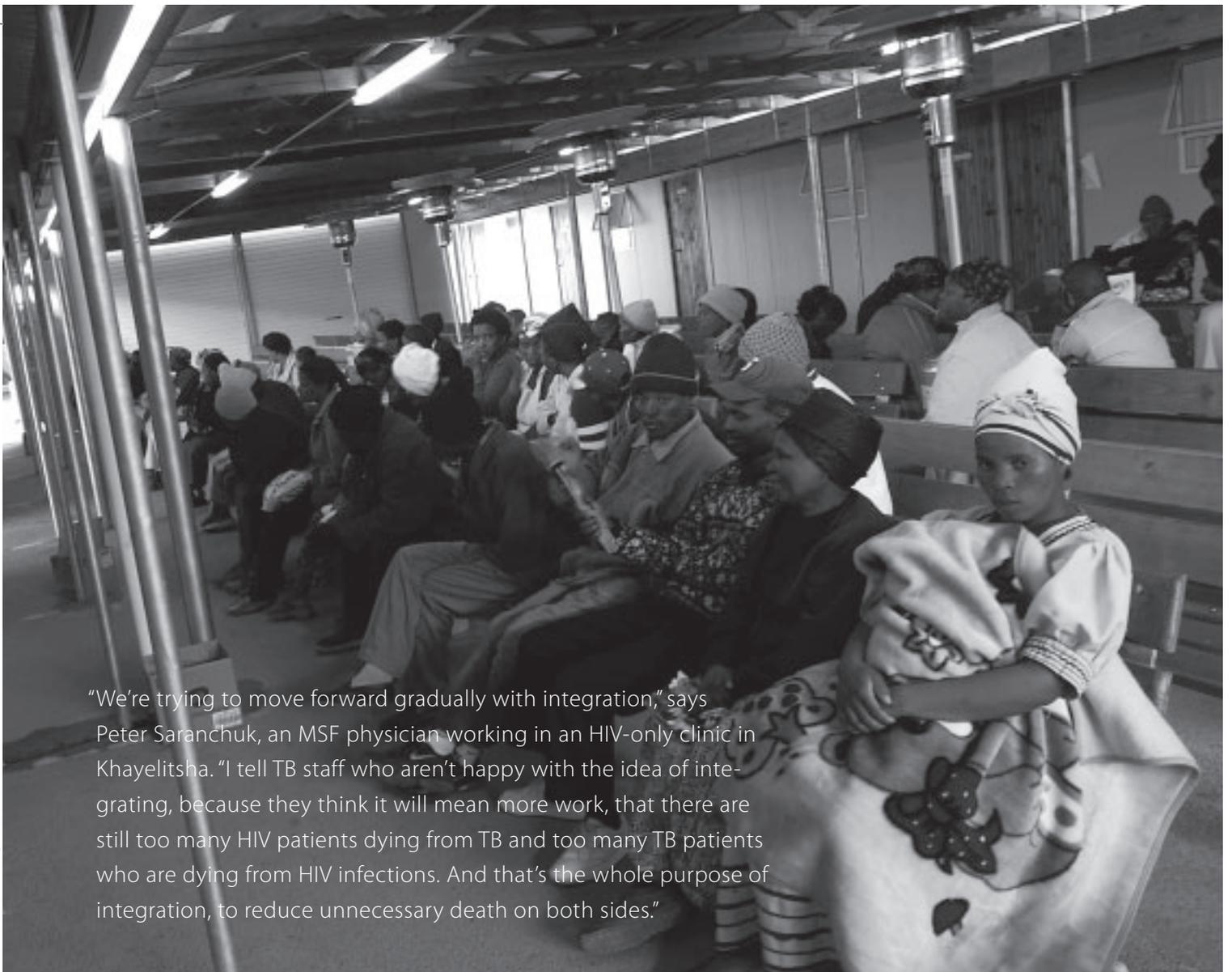


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An MSF doctor studies x-rays looking for signs of TB.



“We’re trying to move forward gradually with integration,” says Peter Saranchuk, an MSF physician working in an HIV-only clinic in Khayelitsha. “I tell TB staff who aren’t happy with the idea of integrating, because they think it will mean more work, that there are still too many HIV patients dying from TB and too many TB patients who are dying from HIV infections. And that’s the whole purpose of integration, to reduce unnecessary death on both sides.”

About 200 people come to the Ubuntu clinic every day for testing, treatment, counseling, blood tests or medical examinations. Health records for TB and HIV patients are filed together for easy cross reference and recall, and all patient information is stored in a central database.

One-stop services

Good ventilation for the new clinic is essential to discourage transmission of TB as more than 200 patients come through the clinic each day. All needed TB and HIV services are available around the perimeter of the new clinic. The close proximity reduces waiting and traveling time for patients and makes referrals much easier.

“Before it was always frustrating when you’d know a patient has TB clinically, but you had to send the patient to another place to be tested,” says Shaheed Matee, the principal medical officer of the Ubuntu clinic working for the Provincial Administration of the Western Cape. “Invariably, patients get lost in the system. So now that we’ve moved over to the HIV site with the TB clinic here, it is much easier for me to say, ‘You’ve got TB. Let’s get you started on TB treatment.’ It makes it easier for the patients. You know your patient doesn’t have to go in your queue and tomorrow stand in another one.”

Because the same patients often face both illnesses, medical staff need to be alert to signs of co-infection and possible drug interac-

tions and side effects. Regular consultations with a doctor or nurse are a crucial part of follow-up care for all HIV-positive patients. They take place every few months – more often if there are complications. The medical staff check the patient’s immune system, weight, adverse reactions and adherence to treatment.

HIV/AIDS patients displaying signs of TB are quickly referred for testing. In the same way, TB patients are encouraged to be tested for HIV once they have been on TB treatment for two months, if they haven’t done so already. Approximately 65 percent of the clinic’s TB patients tested have been found to be co-infected with HIV. If they are found to be positive, they are sent to see one of the HIV nurses. They have blood taken to check their immune system and receive counseling. From then on, their case will be jointly managed. While taking their TB medicine, they will be prepared to start life-extending antiretroviral (ARV) treatment (if needed). They will also be examined by the medical staff for other opportunistic infections. Those who refuse to be tested are regularly encouraged by the staff to change their mind.



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Children are difficult to diagnose for both diseases. They are unable to cough up sputum for the regular TB test. Diagnosis of HIV usually cannot be confirmed solely on clinical symptoms as they may not be present or may mimic other childhood diseases. Tests used in most developed countries to confirm the diagnosis of HIV in very young children are not available in the countries most affected by the AIDS pandemic.

Women and children

The majority of the clinic's patients are women. In South Africa, the clinic's doctors say, the average TB and HIV patient is a woman in her 20s, who often has children, some of whom are also HIV-positive. "It's easier for a woman to become infected with HIV," explains Dr. Saranchuk. "Plus women also tend to come for help early whereas men here wait until they're almost dead before they come in."

Most pregnant women (98 percent) in Khayelitsha agree to be tested for HIV. Those mothers found to be positive are offered treatment to help reduce the risk of transmission of the virus to their newborn. In 2004, MSF saw approximately 150 children in its clinic and about half of them were taking ARVs.

Once a diagnosis of TB and HIV is confirmed, other problems surface in providing treatment to children. Some HIV drugs only exist in tablet form or in foul-tasting syrups requiring refrigeration. Others call for frequent administration, an empty stomach and lots of clean water. Because of drug interactions between some common TB and HIV/AIDS drugs, children may need more expensive drugs or second-line ARV medicines that may not be available. Other drugs have not been studied in children and therefore cannot be used with very young patients. The problem of lack of treatment for co-infected infants and children will be faced more and more often by health care staff trying to treat them.

Educating through counseling

Promoting self-responsibility through counseling has been a key element to treatment compliance for those taking ARVs. Before treatment is started at the Ubuntu clinic, patients are educated about the disease and how ARV treatment works. They must also meet certain conditions before it can begin. These include disclosing their HIV-positive status to at least one person, selecting a "treatment assistant" to help them comply with daily treatment requirements and promising to keep necessary medical and counseling appointments at the clinic. Once patients on ARVs have been on treatment for a few months and show good adherence, they are given monthly or even bimonthly supplies of the medicine to simplify their own lives. New TB patients are also educated about their disease, its treatment and the importance of coming to the clinic for regular monitoring.

The difficulties of diagnosing TB

Patients thought to have TB are given a "sputum test." This test relies on finding signs of TB in the material an infected patient can cough up from their lungs. However, many HIV-positive patients develop types of TB that are difficult to diagnose with this test. Often the bacteria aren't found in the sputum of HIV-positive patients. "The maturation of the HIV epidemic has meant more sputum negative cases," says Dr. Christine Villier, a TB specialist working for the city of Cape Town at the Khayelitsha clinics. "But the message didn't get across that the patient needed further assessment if they were sputum negative. So they would just come back later, sicker."

Approximately 65 percent of the clinic's TB patients tested have been found to be co-infected with HIV.

As a result, many co-infected people remain undiagnosed by national TB programs that focus on "sputum positive" patients as recommended in the pre-HIV era. In the past, the typical patient was consumptive, coughing and losing weight. Although that patient profile is still the most prevalent one, many others have atypical symptoms of TB. The number of people with extrapulmonary TB (TB outside of the lungs) is going up and that is linked to HIV. Patients at the Ubuntu clinic who seem to have signs of TB but have a negative sputum test are given antibiotics and sent for an x-ray or other tests to rule out other infections. In urgent cases, TB treatment may be started the same day before a clear confirmation is made.

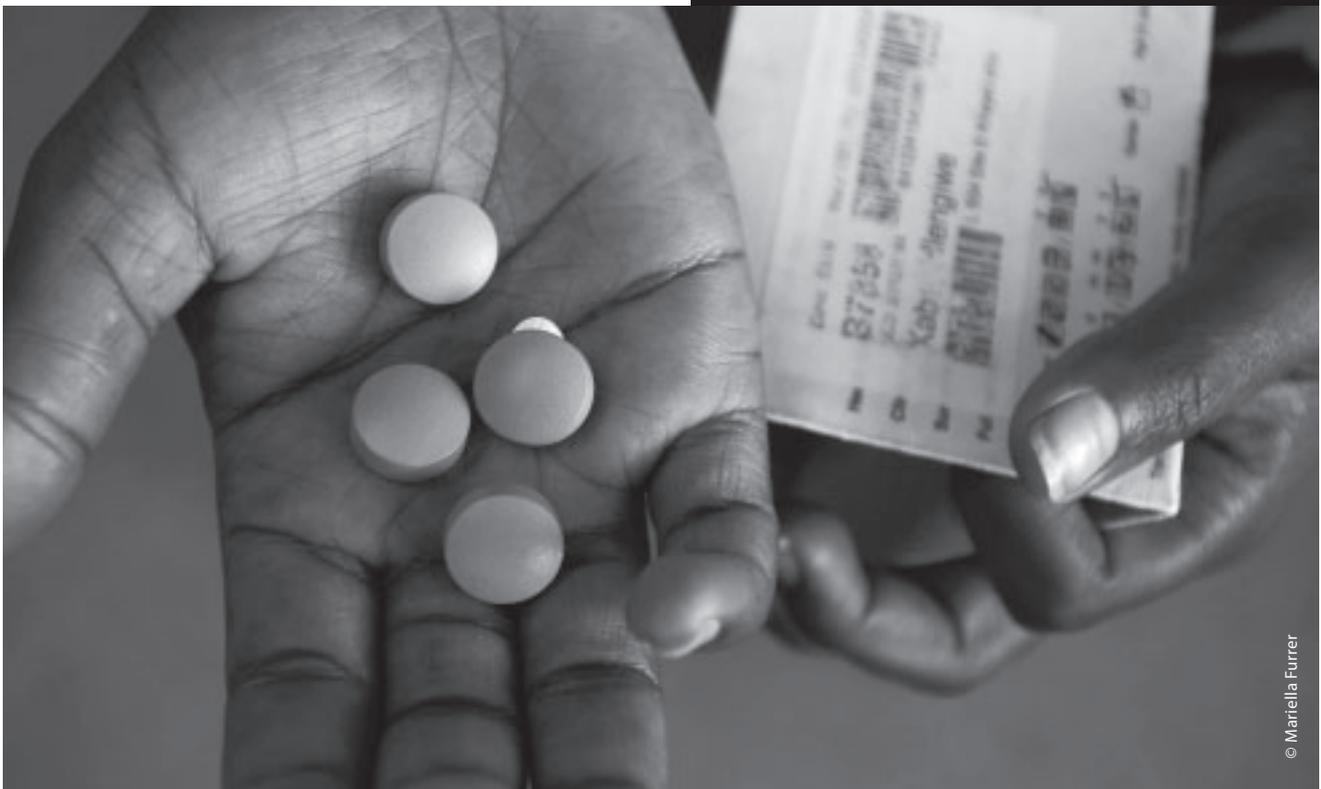
Simplifying treatment

To be cured of TB, a patient must take five or six pills every day for six to eight months. The WHO has adopted a strategy, one part of which calls for patients to take daily medicine in front of a health worker or trained community worker or family member to ensure that they follow the prescribed treatment schedule. When strictly followed, this Directly Observed Treatment, better known as DOT, places a heavy burden on patients who must take the time and money to travel to get their medicine and be watched taking it. It also puts demands on health staff who must observe treatment for many patients each day. WHO recognizes many of these concerns and is now in the process of adapting its global TB policy to address them. MSF and some other organizations advocate a less rigid approach to DOT based on patients' needs and the realities of what care providers are seeing. Based on its experience, MSF promotes modified DOT, a system in which patients take their TB medication

ARVS are my life

Ruben, a 44-year-old HIV and TB patient at the Ubuntu clinic, has been taking ARVs for four years. He was diagnosed with HIV in 1998 after he was admitted to a Cape Town hospital feeling very sick and weak. After a few months of care he began to feel better and transferred to the Khayelitsha clinic which is much closer to his home. There he was diagnosed with TB as well and given treatment. In 2001, he began ARV treatment. Then in December, he fell ill again.

I didn't feel all right. I couldn't walk. I had shortness of breath. I thought, What is wrong now? I went to the HIV nurse, she brought me to the TB doctor who sent me for an x-ray. At the x-ray, the man said, "No, you've got TB." I think: What? Where is the TB coming from now? He told me, "Oh, you are HIV-positive, an infection comes easy to you because your immunity level is low." So in December I started the treatment for TB again. I'm getting the TB treatment here [points to the right side of the clinic] and the HIV treatment there [points to left side of the building.] Now I am feeling very, very well, very powerful. Before I couldn't go from there to the corner. I was just doing that and then I would have to sit down and catch my breath. But now I am all right, I can go! The treatment for TB is working. I feel the drugs are working. Maybe next month I'll finish the TB treatment, and then it will be just HIV. That's my life! I am going for ARVs for my life, I know that.



Treatment adherence is crucial as many TB patients stop taking their pills once they start to feel better which leaves them uncured and possibly still infectious. They also run a greater risk of developing and spreading drug-resistant TB which is much more difficult to treat and expensive to cure and claims many more lives.



The integration efforts at the Ubuntu clinic show that good cooperation between TB and HIV services saves time, effort, and most importantly, lives.

© Mariella Furrer

The clinic's pharmacy assistant dispenses both HIV/AIDS and TB medicines. Both groups of patients can obtain their medication from the dispensary once they have been on treatment for some time, continue to come for regular check-ups and have shown good treatment adherence.

From patient to employee

I was a patient and now I'm working at the clinic. It started long ago in 2000. I was very, very sick. I had headache. I went to the clinic and the doctor tested me for HIV and it was yes. I had to cry and cry. I talked to the counselors and they said, "No, it's no good. Don't cry, you must live!" So they talked to me. They said I must stop with crying. And that I must come to the clinic so they could check me. Then they checked for TB and they found it.

So I had TB and HIV. I had to take tablets for TB and I was very, very weak. And I had to go to the hospital and was not feeling well at home. I thought with this HIV, I must go there to die. I had to take the tablets for eight months for TB. After eight months I was feeling all right, feeling better.

Then I had to come to see the doctor and start taking these ARVs. Then I started to feel better, My CD4 count was 26 when I started, very low. I was feeling very bad. So I've been taken them since 2001. I must still go to the clinic.

I started working for MSF in 2003. Inside I'm feeling so good. The TB is gone. Now while I'm working I see people who are very sick, who have the same problems. I talk to these people. I tell them that I was sick too. And now I'm working every day.
– Nonkululo Kili, a TB/HIV patient in Khayelitsha who now works as a cleaner at the Ubuntu clinic

observed by a DOT provider during the first few weeks of treatment (instead of during the full treatment time) and thereafter be responsible for taking their pills at home. This gives patients much more freedom while enabling health staff to explain treatment and provide support if patients experience side effects in the early phase of treatment. To boost adherence, tools used in AIDS treatment have been duplicated to TB programs, such as adherence counseling and designating a "buddy" for each patient.

The need for new TB treatment

At the same time, the medicines now used to treat TB were discovered more than 50 years ago and virtually no new research was done to develop new treatments and diagnostic tools until recently. Once a patient is cured, there is no guarantee that he or she will not be re-infected, especially those whose immune system is already weakened by HIV/AIDS.

The fact that MSF and its partners can treat people with TB, but cannot address the real causes for the continued high spread of the disease is frustrating. "We treat our patients for six months, and then we have to send them back to the same conditions where they got it the first time," says Dr. Matee. "They go back to the overcrowding, the lack of sanitation, no water, no electricity, that type of thing. So there are social issues that have to be looked at before we can even say we are going to get TB under control."

With both diseases affecting so many people, MSF believes South Africa and other countries hit by the dual epidemic will have to push for integration based on their own national health situation and political climate. "People keep trying to block integration," concludes Darder, "but MSF keeps pushing because medically it makes sense."

TEXT BY LISA HAYES, MSF INTERNATIONAL EDITOR



MSF Projects around the World **Africa**



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In Tine, Chad, a Sudanese refugee surrounded by all of his possessions awaits transport to a new camp set up in Mile, more than 150 kilometers away.

Chad



A young girl is vaccinated in Forchana camp near the Sudanese border.

Benin

Shifting care to
HIV-positive patients

After years of helping patients living with a condition known as Buruli ulcer, MSF is refocusing its activities in Benin to assist the growing number of people affected by HIV/AIDS. A team is providing HIV/AIDS-related care at a health center in the town of Dogbo in the Mono-Couffo department. The project offers voluntary counseling and testing, medical consultations for related infections such as tuberculosis and pneumonia and, since the second half of 2004, treatment with life-extending antiretroviral (ARV) medicines. MSF's program is currently the only one in Benin to offer this comprehensive array of care and treatment components. By the middle of 2005, 200 patients were receiving ARVs, and MSF plans to double this number by the end of the year.

The Buruli ulcer project was handed over to local authorities on the last day of 2004. Since 1997, MSF had focused on assisting people with the debilitating condition. Related to tuberculosis and leprosy, Buruli ulcer destroys skin and bone tissue. To date, there is no medicinal treatment for the disease, and surgery is the only way to relieve its effects. In the town of Lalo in Mono-Couffo department, MSF ran a treatment center that provided surgery and other care for approximately 100 patients each year. To support the transition to local operation of the project, MSF provided financial assistance, medicines and other needed medical materials for the first half of 2005.

MSF has worked in Benin since 1997.

Caring for Darfur refugees and vaccinating thousands

In the last two years, an estimated 200,000 people entered eastern Chad in their effort to flee fighting in the Sudanese region of Darfur. The refugees face harsh living conditions in the numerous camps set up along a 500-kilometer stretch of border between the two countries. The eastern region of Chad is dry and desolate with little potential for farming. Food and drinking water are scarce and temperatures are extreme. Lacking shelter, adequate food and other necessities, many refugees suffer from malnutrition, dehydration, respiratory infections or emotional trauma linked to their experiences in Darfur.

In Adré Hospital, MSF provides medical care, surgery, pediatric and maternal care. And MSF provides food and shelter to many of the 83,000 refugees living in four camps near the Sudanese border.

Immunization: a priority

In January 2005, MSF launched a meningitis-vaccination campaign in eastern Chad following an outbreak among Darfur refugees. Teams vaccinated about 70,000 refugees in the Breidjing and Forchana camps, as well as local residents. MSF continues to improve the surveillance system in the district and treats patients who have contracted the disease. Teams in the displacement camps also provide antenatal care and treatment for malnourished children. MSF built hundreds of latrines, trucked in clean water and opened health posts.

MSF carried out a meningitis vaccination campaign during March 2005 in Chad's southwestern Bongor district, following an outbreak of the disease. The campaign lasted one month and targeted all people between the ages of six months and 30

years, that is, 72 percent of the area's 272,000 people. The campaign was carried out in collaboration with local medical authorities and the ministry of health.

In April 2005, MSF teams determined that more than 6,000 people in Chad were infected with measles, including more than 3,400 in the capital city alone. A first vaccination campaign was launched in Bousso district, some 300 kilometers south of the capital, and targeted 40,000 children under five years of age. MSF provided medical support and drugs for 2,300 patients in Bousso, and supported 17 health centers for less severe cases and 2 hospitals for severely infected patients in N'Djamena. In early May, MSF carried out a massive vaccination campaign in N'Djamena aimed at immunizing an estimated 280,000 children. Working with the ministry of health, MSF opened 29 mobile vaccination sites. Because measles is an aggravating factor for malnutrition, MSF opened two therapeutic feeding centers in N'Djamena and four mobile feeding centers near the city to care for those needing treatment.

In 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 highly effective artemisinin-based combination therapy (ACT). MSF also runs a surgical training program at Bongor Hospital.

MSF has worked in Chad since 1981.

Burkina Faso

Helping street children

Since 1999, MSF has been providing medical care and psychological assistance to street children in the capital, Ouagadougou. MSF is also involved in advocacy efforts toward the public to fight the discrimination they face, and has held informational sessions on their predicament in communities, schools and at the national police academy. Today, this program reaches approximately 900 young children and 140 teenage girls.

A new project launched in 2005 has reached 500 teenage sex workers who operate outside of the city's official prostitution network and lack access to medical care. MSF offers assistance to these girls and treats victims of sexual violence. MSF has also organized meetings to raise awareness about health issues related to prostitution and has trained local health groups to treat girls with sexually transmitted infections.

MSF runs a project to improve the quality and duration of life for some HIV-positive people living in Ouagadougou's Pissy health district. In 2004, MSF tested and counseled almost 6,000 people among whom 20 percent were found to be living with the virus. At the local hospital, MSF provided medical care for more than 14,000 patients with opportunistic infections. In April 2003, MSF started providing life-extending antiretroviral (ARV) treatment as well, and by mid-2005, the organization was providing ARVs to 1,400 patients. MSF plans to be treating 2,000 patients with ARVs by the end of 2005. In Leraba province, MSF continues to provide basic health care, including maternal and child care through a network of seven health centers in the Sindou district.

MSF has worked in Burkina Faso since 1995.

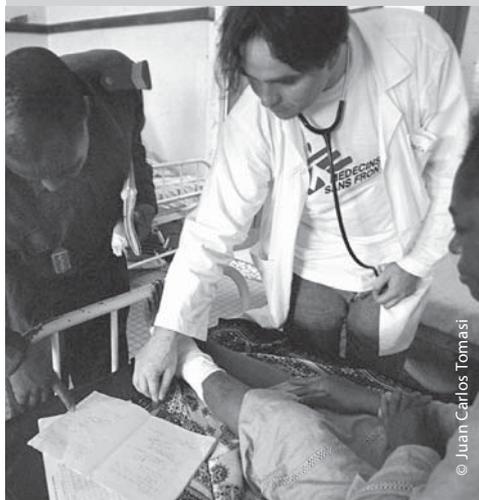
Cameroon

Focusing on people with infectious diseases

In Cameroon, MSF assists some of those living with either HIV/AIDS or Buruli ulcer. The number of people living with HIV/AIDS has increased sharply during the last decade. Today 11 percent of the population is HIV-positive, approximately 937,000 people. In the capital city of Yaoundé, MSF operates an AIDS project that helps more than 1,200 patients. Almost 800 people are now receiving life-extending antiretroviral (ARV) medication. A second prevention and treatment team helps more than 850 patients in the city of Douala. By the middle of 2005, 550 of these patients were using ARVs. In addition to providing treatment, counseling and related medical care, MSF's staff has joined Cameroon's national efforts to find ways to expand access to treatment for people living with HIV/AIDS.

In the district of Akonolinga, MSF helps those living with Buruli ulcer. Related to tuberculosis and leprosy, this illness destroys skin tissue and cause deformities. Although there is no curative treatment yet available for it, the team performs surgery to minimize its effects. More than 300 patients have received this surgery since the program began in 2002.

MSF has worked in Cameroon since 2000.



An MSF doctor conducts daily rounds in Cameroon.

Central African Republic

Treating patients with malaria and sleeping sickness

Malaria causes the highest rates of death and sickness in the country. To help address this problem, in August 2004, MSF and the ministry of health signed an agreement to treat all malaria patients in the eastern prefecture of Haut Mbomou with highly effective artemisinin-based combination therapy (ACT). In addition to offering testing and medical treatment, MSF staff are also training national health staff working in 20 of the area's health structures and rehabilitating hospital wards, sanitation facilities, the laboratory and the waste-disposal center. Pregnant women receive prophylactic treatment to avoid contracting the disease which can cause spontaneous abortion, low birth weight and premature delivery. Free mosquito nets have also been distributed.

MSF continues to help those suffering from sleeping sickness (African trypanosomiasis). MSF staff provide comprehensive care including diagnosis of the illness, treatment, epidemiological surveillance, training of national health staff and support for the national program to control the disease. The teams, working in Haut Mbomou in the eastern region of Mboki, also offer primary health care services.

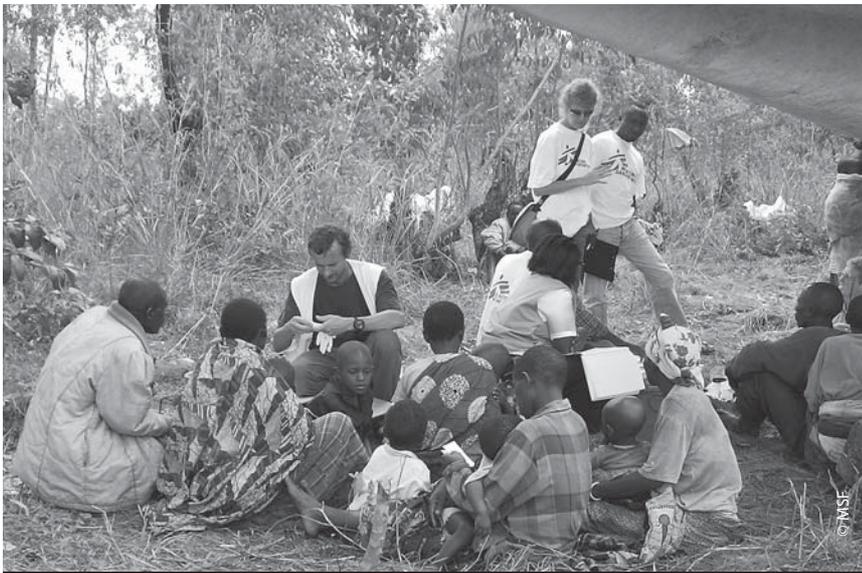
A team located in Bangui offers assistance during emergencies. In March 2004, MSF carried out a meningitis vaccination campaign in Batangafo and Boguila. MSF treated those infected with bloody diarrhea in Kaga Bando from August 2004 until the end of the year. MSF staff also conducted two measles vaccination campaigns in Bangui and Molangué during September 2004.

MSF has worked in the Central African Republic since 1997.

Burundi

Treating civilians affected by war

Many years of war have devastated Burundi's health sector leaving most of the country's more than seven million people without basic care. Life expectancy has fallen to just above 40 years and HIV/AIDS prevalence is increasing. MSF works in many parts of Burundi, treating war wounded, caring for victims of sexual violence, responding to disease outbreaks and providing basic medical care.



MSF staff provide care to desperate Rwandan refugees gathered in the Songore transit camp in Burundi.

In the northern province of Karuzi, MSF staff work to ensure quality primary health care in 10 health centers and secondary health care at Buhiga Hospital. MSF provides medicines, training and supervision of medical activities as well as drug and financial management. The team also implements nutritional activities in the region as needed, providing supplementary feeding to malnourished patients. In the eastern Ruyigi province, MSF offers basic health care. The MSF team supports seven outpatient health centers and two hospitals – the latter located in Ruyigi town and in rural Kinyinya. Activities include direct patient care, waste management, health education and training of local staff. Since 2000, MSF has operated a basic health care program in Ijenda district in the western, rural Bujumbura province. The MSF team supports 10 public health structures in the province, providing training and supplying medicines. In addition, MSF has started supporting a hospital and two

health centers in the Musema region of the northern Kayanza province. Until the end of May 2005, MSF also provided health care services at Makamba Hospital in the southern province of Makamba. The hospital team supported all major services, including surgery, and provided drugs, medical material and technical expertise.

Helping survivors of sexual violence

Since 2003, MSF has assisted victims of sexual violence in a health center located in Bujumbura, the capital. This center serves both the population of Bujumbura and those living in the region's hills. At the facility, a team provides medical and psychological care to women and children. Other services are offered as well, including family planning and care for sexually transmitted infections. The MSF team also focuses on raising awareness about rape in the community and educating residents on sexual violence and its consequences. As of mid-2005, approximately 120 victims were

being cared for each month. MSF teams provide support to survivors of sexual violence in other parts of Burundi as well, including Ruyigi, Kinyinya and Karuzi.

Assisting people with cholera

In January 2005, MSF reopened a cholera-treatment center in the Kamenge neighborhood of Bujumbura. By February 2005, the number of cholera patients had begun to decrease and MSF closed those activities. However, the center is still treating war-wounded civilians from rural Bujumbura, the country's last province still at war. More than one hundred have been hospitalized there and more than 300 people have received outpatient care. MSF also helps Burundians suffering from other diseases and supports the implementation of appropriate treatment protocols, such as the use of artemisinin-based combination therapy (ACT) for malaria patients.

Helping Rwandan refugees

In early June 2005, MSF began offering urgently needed medical assistance to Rwandan refugees living in intolerable conditions in the Songore transit camp in Burundi's northern province of Ngozi, 20 kilometers from the Rwandan border. The camp, which was built for 800 people, soon held more than 7,000 Rwandans, mostly Hutus, who feared possible prosecution by local genocide courts. The refugees had insufficient water, food and shelter. MSF staff quickly began treating people through a mobile clinic and later a health center.

Rwanda and Burundi dismissed the entire group as "illegal immigrants" despite their requests for asylum in Burundi. Later in June, the government of Burundi began to repatriate by force the inhabitants of Songore camp as well as 2,000 people gathered at other camps. This action emptied the camp within a few days. Denied access to the camp at the start of the operation, MSF and other aid organizations protested strongly against the situation and worked to raise awareness about it.

MSF has worked in Burundi since 1992.

Kenya



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An MSF doctor examines a child in the town of Busia where MSF runs an HIV/AIDS program.

A dramatic increase in AIDS care

In the East African nation of Kenya, an estimated 1.24 million of the country's 32 million people are HIV-positive. More than 200,000 people are in urgent need of treatment. Although the average HIV prevalence rate is estimated at 6.7%, in some areas nearly one-third of the people are living with this disease. The health system suffers from chronic neglect and staff and drug shortages are common, especially in rural areas. As a result, many people die due to a lack of care and treatment. MSF's activities in Kenya are an effort to improve the lives of some of those living with HIV/AIDS. Today, MSF is treating more than 5,600 HIV-positive patients and caring for thousands more.

MSF runs HIV/AIDS-prevention and treatment programs in three parts of the country: Western province, Nyanza province and Nairobi, the capital. In Nairobi, MSF cares for people living with HIV/AIDS and tuberculosis (TB) in the sprawling Mathare slum. Activities include medical consultations, voluntary counseling and testing, nutritional support and medical treatment. More than half of the people in the MSF program are co-infected with TB. Pregnant women who are HIV-positive receive care to prevent transmission of the virus to their unborn babies. As of April 2005, 2,012 people were participating in the Mathare program, including 837 who were receiving life-extending antiretroviral (ARV) medicines. Each month, the MSF team carries out about 300 HIV tests and detects approximately 20 new TB cases.

In another part of Nairobi, Dagoretti district, MSF is also providing HIV/AIDS care. In the onsite HIV clinic at Mbagathi District Hospital, MSF staff provide free HIV/AIDS services, including ARV therapy. As of April 2005, 4,000 patients were participating in

the Mbagathi program, including 1,500 who were receiving ARVs. MSF also develops hospital staff trainings in conjunction with the ministry of health, and is working to improve the quality of the laboratory as well as waste- and drug-management services. In the nearby slum of Kibera, MSF works in several clinics. On 28 April 2005, a new comprehensive care center, jointly run by the ministry of health and MSF, was inaugurated in Nairobi.

In Western province's Busia district, near the border with Uganda, the HIV prevalence is estimated at 16 percent but may be as high as 30 percent. MSF has established an HIV comprehensive care center at the Busia district hospital and is caring for approximately 3,500 people there in collaboration with local health staff. Of these patients, more than 1,000 are taking ARVs, including 87 children. MSF has established a laboratory to monitor their progress.

In addition, MSF supports nine health facilities across Busia district, one sub-district hospital, one mission hospital, six health

centers and one dispensary. Activities include voluntary counseling and testing, prevention of mother-to-child transmission and treatment of opportunistic infections such as TB. Two of these health facilities also provide ARVs. To reach patients too weak to come to the health structures, a team of four MSF nurses works closely with more than 140 volunteers to provide home-based care.

MSF staff also run an awareness-raising project with community groups in Busia, actively training people living with AIDS as peer educators and advocates, and carrying out a range of educational activities.

MSF provides HIV/AIDS care in the Homa Bay district of Nyanza province. The organization works in the district hospital as well as in several peripheral health centers, providing voluntary counseling and testing, treatment of opportunistic infections and other services. Follow-up care for stabilized HIV patients is carried out in three health facilities in the district. An average of 100 people have been starting ARV treatment each month, and as of April 2005, 2,330 people were receiving ARVs.

Aid during emergencies

In February 2005, after an estimated 5,000 people were displaced following clashes among ethnic groups in Nairobi, MSF ran mobile health clinics for them and provided blankets and plastic sheeting. MSF also monitors malnutrition and outbreaks of diseases such as cholera.

From September 2004 to March 2005, MSF ran a nutritional project in Marsabit district, Loyangalani province, to combat high rates of malnutrition. MSF closed the project when it was no longer needed. Children in need of further treatment in Marsabit were transferred to other sites.

MSF has worked in Kenya since 1987.

Democratic Republic of the Congo

Another year of misery

The past year has been a so-called transition period in the Democratic Republic of the Congo (DRC); a time when the country was meant to move from war to peace. However, for the majority of the people living in this vast troubled land, the transition is nothing more than a mirage.

Violence continues to flare in parts of Ituri province, in North and South Kivu provinces, and in parts of Katanga province, while the rest of the country languishes in extreme deprivation, lacking food, shelter and the most basic health care. In the capital, Kinshasa, the in-fighting government manages a "virtual" state, if anything exacerbating the wretched situation in which the Congolese find themselves. According to estimates, some four million people have died since the outbreak of the civil war. Some have been swept away by the violence, but the great majority have died of preventable diseases such as malaria and measles, far from the apathetic eyes of the outside world.

Violence engulfs Ituri

During the past year, the northeastern province of Ituri has been the epicenter of violence in the DRC. Despite efforts at disarmament and reintegration, principally by the United Nations, numerous rebel groups continue to wage war, rendering large swathes of the region inaccessible to aid workers and destroying lives with their often indiscriminate terror. Some of the victims are treated by an MSF team working in the Bon Marché Hospital in the provincial capital of Bunia. The hospital offers a full range of medical care including facilities for surgery where MSF regularly treats the war-wounded. Sexual violence is especially prevalent in the region, with more than 2,500 rape survivors treated by MSF's medical teams in the 20-month period between June 2003 and January 2005 (see box).

As tensions have escalated among Ituri faction groups fighting for control of resources, the ensuing attacks, rapes and mass killings have prompted tens of thousands of people to flee to Djugu territory. MSF carried out an emergency intervention in four displacement camps in Tchomia, Kakwa, Tche and Jina, helping more than

70,000 civilians gain access to medical care, water and sanitation. When cholera broke out in the area, MSF was able to recognize and control it quickly, treating more than 1,400 people with the illness.

Two MSF staff abducted

On 2 June 2005, two MSF staff members – a logistician and a driver – were abducted by armed militiamen as they traveled to the Jina displaced persons camp 35 kilometers north of Bunia. The incident forced MSF to suspend its mobile clinics outside of Bunia and to evacuate those teams. However, the Bon Marché Hospital in Bunia continued to provide all of its services. On 11 June, MSF was able to secure the unconditional release of its staff members. Various communities in Bunia and Ituri showed a great deal of support for MSF during the incident and mobilized massive assistance to urge the aid workers' release. However, on 2 August 2005, MSF announced that it had decided to close its projects outside of Bunia as a direct consequence of the abduction and the ongoing insecurity in the area. More than 100,000 people had been benefiting from this assistance.

Insecurity leads to decreased aid

Insecurity is also widespread in the province of North Kivu, in the far eastern part of the country, which borders Rwanda and Uganda. The looting of an MSF base in the village of Kibati on 19 January 2005 by armed and uniformed men left MSF with no choice but to suspend and later close its therapeutic feeding program in the area, where it had treated more than 10,000 children since 2002. The 63 malnourished children who were receiving treatment at the center when it closed on 8 April were transferred to the therapeutic feeding center in Kitchanga for continued care. This suspension came only weeks after another MSF project was suspended in the nearby Masisi and Rutshuru territories due to a similar security incident.

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Around the town of Beni, MSF teams are providing shelter, water, sanitation and health care to displaced people from Ituri. They carried out 98,200 medical consultations and treated 150 victims of sexual violence in this area during 2004. In the towns of Kanya and Kanyabayonga, MSF teams admitted 1,300 severely and 5,000 moderately malnourished children into its programs during 2004. In September 2004, the MSF team started a health program for victims of sexual violence, through which 124 patients have received treatment. Since June 2005, the team has supported Kanya's hospital, including the surgical department. Teams have also organized mobile clinics and responded to health emergencies such as cholera outbreaks that occurred in Virunga Park, Goma and Buhimba.

In South Kivu, which has enjoyed a period of relative calm since the last spate of violence in June 2004, MSF is providing health care in the villages of Shabunda, Baraka and Fizi.

A lack of care in Katanga

MSF focuses its work on health care for displaced people in the southeastern province of Katanga where clashes between militias and the newly unified Congolese army (FARDC) continue to wreak havoc. Working in nearly a dozen towns, MSF is providing a wide range of services including primary and secondary health care, treatment for malnutrition, emergency surgery, mobile health care, long-term tuber-



culosis treatment and care for victims of sexual violence. In August 2005, MSF opened a new program in Mukubu when the resumption of hostilities resulted in the displacement of 15,000 people.

Other emergencies

Nine years ago, MSF created a Congo Emergency Team to provide fast emergency relief to meet sudden needs. Today, such teams are based in Kinshasa, Kisangani, Lubumbashi and Mbandaka. They react to urgent events such as outbreaks of measles, whooping cough, plague or cholera. They also help displaced people and those affected by natural disasters.

Treating those with AIDS

MSF teams have continued to increase access to comprehensive care for those living with HIV/AIDS in the DRC. In the town of Bukavu, South Kivu, MSF was providing 331 patients with antiretroviral (ARV) medicines by April 2005. The team hopes to have 900 patients enrolled in the treatment program by the end of 2005. In a second HIV/AIDS project, in Kinshasa, 870 patients had received ARVs from MSF by the end of April 2005, and the team aims to increase that number to 1,700 by the end of 2005. MSF had also monitored nearly 3,000 patients in less advanced stages of the disease in Kinshasa by spring 2005.

In early 2005, MSF started a new project aimed at treating commercial sex workers who have HIV/AIDS with ARVs. The treatment of sexually transmitted infections is

also a priority for MSF teams and is integrated into basic health care projects across the country and in a targeted center in Kisangani, a city in the Orientale province of the DRC that bore the brunt of fighting during the civil war and retains a large military presence. MSF also runs a specialized clinic to treat people with sexually transmitted infections in Kitchanga in North Kivu, and operates three such clinics in Bukavu, South Kivu.

Care for those who have none

An outbreak of the plague – an apocalyptic but easily treatable disease that last struck Europe more than a century ago – claimed more than 20 victims some 200 kilometers north of Kisangani in January 2005.

Moreover, sleeping sickness (African trypanosomiasis) which was virtually wiped out by missionaries in the 1950s, has returned with a vengeance, because little is being done to control the flies that transmit the disease, and because many displaced people live in the forests where they breed. To help reduce the disease's prevalence, MSF has opened a new testing and treatment project in Isangi, one of the most affected areas.

In Equateur province, MSF supports clinics in nine health zones comprising 800,000 people. In late 2004, a team concluded a measles-vaccination campaign for more than 600,000 children under 15 years of age. The campaign took more than a year to complete because many villages could be reached only by dug-out canoe. Despite successes like this one, thousands of people die due of treatable diseases such as malaria and measles or because of inadequate health care. Avoidable illnesses are regularly lethal when the nearest health center is far away. Like the violence in Ituri, lack of health care is the sad reality of life in the DRC, a land where people continue to die of mass neglect.

MSF has worked in the DRC since 1981.

Shocking levels of sexual violence

MSF's teams in the DRC have witnessed an alarming level of sexual violence in the northeastern province of Ituri. Thousands of women and children, and some men, have been raped as wanton violence escalates. More than 2,500 patients were treated for rape or sexual violence in MSF's hospital in Bunia, the provincial capital, between June 2003 and January 2005. The data show that all ages were affected, from four months to 80 years old.

"What shocks me is that 77 percent of rape victims who presented themselves to MSF

in the last six months were raped by two or more assailants," says Rowan Gillies, M.D., president of MSF's International Council, who worked as a surgeon for MSF in Bunia. "I find these figures horrific and disgraceful. And they are only the tip of the iceberg." He continued, "Rape and gross violations against civilians continue unabated and today we find ourselves unable to reach the victims because of the extreme levels of violence in the area. Each week 40 girls and women who have been raped seek MSF's help in Bunia. Many, many more never reach us."

Angola

Providing care where huge gaps remain

Three years after Angola's civil war ended, its people still face a weakened health system and difficulties in movement due to deteriorated and often heavily mined roads. Angolan authorities, with the support of the international community, have launched a massive effort to reconstruct health and transportation systems. The population's nutritional situation is also improving. Yet despite these developments, 70 percent of the population remains without basic health care. Angola also has one of the world's highest child mortality rates – one in four children dies before turning five.

MSF's work in Angola has changed dramatically as a result of the modest progress that has been made in various areas. While teams continue to support Angolan health authorities' efforts to provide basic health services, more and more responsibility is being transferred back to local authorities. Today MSF is focusing on helping those with malaria, sleeping sickness, tuberculosis (TB) and most recently, HIV/AIDS, all diseases that receive little attention. In 2005 MSF also provided emergency assistance when the country was confronted with an outbreak of the deadly Marburg virus (see box).

Treating those with malaria

As in many sub-Saharan countries, malaria is Angola's number one killer disease, with the heaviest toll among children under five. More than half of all primary health care consultations involve malaria. In Kuito, MSF runs a pediatric malaria-treatment center that admits as many as 750 children a month during the annual six-month malaria peak. In addition, a large number of health posts located in the provinces of Bie, Bengo, Lunda Norte, Malanje, Cuanza Sul, Moxico, Huambo, Cuanda Cubango, Huila and Uige carry out thousands of malaria consultations each month with the support of MSF, which provides drugs, rapid-testing kits and regular supervision and training. In June 2005, in Caala, a city in Huambo province, MSF transferred its support of 13 health posts – along with a six-

month supply of medicines and rapid testing kits – to the ministry of health.

Screening for sleeping sickness

Virtually eliminated in the 1960s, sleeping sickness is making a vengeful comeback in Angola and other parts of Africa. Existing treatments for this fatal, parasitic disease are old, toxic and unsuited for resource-poor settings. MSF operated a sleeping sickness project in Caxito, the capital of Bengo province, and in Camabatela, a municipality in Cuanza Norte province. In addition to admitting patients, MSF conducted active screening campaigns to identify and treat new patients, mostly in remote areas. MSF screened more than 8,000 people and treated a total of 163 patients in 2004. In the first half of 2005, the team screened 3,000 people and treated 23 for the disease. In mid-2005, due to lower-than-expected incidence, MSF handed over activities to the ministry of health and other collaborating partners.

TB and HIV/AIDS increases

TB is a major public health problem in Angola. According to national agencies, the number of reported TB cases increased almost threefold, from approximately 11,500 to more than 31,000, from 1999 to 2002. MSF cares for TB patients in Bie, Lunda Norte, Cuanza Sul, Moxico, Malanje and Huila provinces with more than 1,300 people under treatment.

Angola is at a critical point in its fight against the HIV/AIDS epidemic. While UNAIDS estimated adult prevalence at 3.9 percent at the end of 2003, there is evidence of a growing number of HIV-positive pregnant women and the prevalence could

rapidly increase once transportation routes reopen. MSF is now integrating HIV/AIDS care within its TB projects in Malanje, Bie and Huila provinces because of increasing numbers of patients with both illnesses.

Caring for the most vulnerable

Today MSF conducts a variety of primary health care activities – supporting health facilities and operating mobile clinics – in Malanje, Bie, Moxico, Cuanza Norte, Cuanza Sul, Lunda Norte, Huila and Uige provinces. The main illnesses treated continue to be malaria, respiratory tract infections and diarrhea. In April 2005, MSF's primary health care activities in Cuando Cubango and Zaire provinces were handed over to the ministry of health after 5 and 10 years, respectively.

MSF has supported hospitals in the towns of Mavinga and Menongue, Cuando Cubango province; Camacupa, Bie province; and Luau, Moxico province. During 2005, MSF handed over responsibility for these projects to local authorities.

MSF provides water and sanitation facilities in Moxico, Bie and Cuando Cubango provinces. Teams in Luau, Moxico province provided assistance to refugees from the Democratic Republic of the Congo and Zambia by carrying out screenings and consultations, health education and water and sanitation services until September 2005, when these activities were transferred to government authorities.

MSF has worked in Angola since 1983.



Children pass time at the TB sanatorium in Kuito, Bie province, Angola.



INTERNATIONAL STAFF 25
NATIONAL STAFF 223

The Marburg outbreak

When an epidemic of Marburg hemorrhagic fever was confirmed in March 2005 in Angola's northern province of Uige, MSF quickly mobilized resources, and the first MSF team arrived a few days later to assist local health authorities. Before the outbreak was brought under control in July 2005, more than 300 people had died, sporadic cases were still being found and a dozen patients were recovering from the illness.

Marburg fever is closely related to the better known Ebola virus. Like it, Marburg is almost always fatal and is easily transmitted through body fluids. There is no cure for the illness, and its first symptoms are easily confused with malaria's symptoms.

The MSF intervention included setting up and managing the isolation unit where patients were cared for, maintaining hospital infection control and reinforcing universal precautions. MSF also assisted with case finding and contact tracing, ensuring safe burial practices, and maintaining water and sanitation systems, including disinfection, and conducted needed community education and epidemiological monitoring and analysis. While most cases of Marburg were reported in Uige town, emergency units were also set up in Angola's capital city of Luanda; Songo and Negage in Uige province; and Camabatela, Cuanza Norte province.

Given the infectious nature of the disease, MSF teams had to wear extensive bio-safety gear. This clothing was not only uncomfortable to work in but frightened local community members. While MSF teams initially faced difficulty being accepted locally, and even encountered overt aggression, the organization's efforts to sensitize the community to its work and to understand local beliefs and practices helped ease the situation. MSF took stock of the lessons learned in its attempt to adopt a sensitive, human approach while still battling one of the world's deadliest viruses.

In July 2005, once the Marburg epidemic was controlled and local health staff could manage sporadic cases, MSF ended its involvement in the Marburg emergency operation.

Republic of Congo (Congo Brazzaville)

Aiding victims of war

Having lived through several episodes of war, civilians in the Republic of Congo, also known as Congo Brazzaville, have yet to recover from the devastating effects of the fighting. Despite a ceasefire announced in 2003, there has been little improvement in terms of security, health care or the economy. MSF provides care for many of those displaced by the conflict or suffering from diseases such as sleeping sickness or tuberculosis (TB).

Fighting in the southeastern Pool region has destroyed health structures and forced many health workers and other civilians to flee. MSF helps people living with HIV/AIDS, TB, malaria, war trauma or sexually transmitted infections at hospitals in Kinkala and Kindama. In the Mindouli district, MSF staff give basic health care in the local hospital as well as in five area health centers.

These facilities also offer emergency surgery, maternity care and help for those who have experienced sexual violence. In addition, the teams run mobile clinics. In the first half of 2005, MSF staff conducted a total of 11,000 outpatient medical consultations per month in Kinkala, Kindama and Mindouli.

The health center for the northeastern town of Bétou, in Likouala department, has undergone significant changes since MSF arrived four years ago and expanded the center into a hospital two years later. Originally designed to care for thousands of refugees from the Central African Republic and the Democratic Republic of the Congo (DRC), it now has 40 beds, two operating theatres, and a TB treatment center. More than 2,500 consultations and 280 hospitalizations (including 80 surgical interventions) were conducted during each month of 2004 by MSF staff. A vaccination campaign was also conducted to protect the most vulnerable civilians against polio, measles, yellow fever and other endemic diseases.

Because many of the area's refugees are now returning home, MSF is urging the country's ministry of health to reintegrate the structure into the national health care

system. MSF withdrew from the hospital in April 2005 when the UN High Commissioner for Refugees started repatriating refugees back to the DRC. In the capital, Brazzaville, MSF provided medical and psychosocial care for an estimated 30 survivors of sexual violence each month at Talangaï and Makélékélé Hospitals. MSF gave medical treatment to prevent pregnancy, HIV/AIDS and other sexually transmitted diseases. The team also offered other medical assistance and psychological counseling and follow up. MSF handed over this work to local groups in June 2005.

Success against sleeping sickness

During 2005, MSF continued projects aimed at helping those infected with sleeping sickness (African trypanosomiasis). Caused by a parasite spread by the tsetse fly, the illness is fatal without treatment. Teams run an extensive sleeping sickness program in the areas of Mossaka, in the Cuvette region (on the Congo River) and in Nkayi, in the Bouenza region, in the south of the country. In 2004, MSF mobile teams (including some that traveled by boat) screened 166,941 people for the illness and treated 739 people. MSF ended its sleeping sickness work in these areas at the end of April 2005 because extensive screening and treatment had significantly reduced the disease's prevalence. A mobile MSF team will continue to screen and treat people for the disease in remote or insecure areas until the end of 2005. MSF has developed a new protocol to treat patients with sleeping sickness and is encouraging the country's health authorities to adopt it. In April 2005, MSF conducted an evaluation of its successful project to compile the lessons learned and make recommendations for a national program.

MSF has worked in the Republic of Congo since 1997.



Guinea

Improving malaria and TB care

Current MSF activities in Guinea focus on treating people with malaria, TB and HIV/AIDS, though MSF continues to respond to emergencies as necessary.

As part of its work to prevent and treat malaria, which is endemic in the country, MSF advocates for improved diagnosis and treatment using artemisinin-based combination therapy (ACT). In 2004, MSF staff carried out a malaria study in the prefecture of Dabola, documenting the effectiveness of ACT treatments. MSF uses ACT in all of its projects in Guinea, and advocates for a change in treatment protocols at the national level.

Since 1988, MSF has worked to improve diagnosis and treatment of tuberculosis (TB). In close collaboration with the ministry of health, MSF staff have trained doctors and health workers to manage TB at the district level, have improved case detection and treatment, and have supplied drugs and laboratory equipment. MSF has also carried out activities to raise awareness about TB within communities and has established a database to help health workers track TB cases and provide follow-up care. In April 2005, MSF transferred to local partners the responsibility for its TB activities in Moyenne Guinea, and the organization is planning to hand over its project in Conakry, the capital, at the end of 2005. Patients co-infected with HIV and TB will continue to be supported by MSF through its HIV/AIDS project in Conakry, located on the western Atlantic coast of the country.

The prevalence of HIV/AIDS in Guinea has increased over the past few years, although data are scarce and the true extent of the problem remains unknown. In the Communal Medical Center in Conakry and the prefecture hospital of Guéckedou, on the border with Sierra Leone, MSF is providing comprehensive HIV/AIDS care, including voluntary counseling and testing, and treatment of opportunistic infections (such as TB). The MSF team is helping to build the capacity of local health workers through training and supervision, and provides drugs and medical supplies. In 2004, MSF became the first organization in

the country to offer life-extending antiretroviral (ARV) therapy to people living with AIDS. As of August 2005, approximately 300 patients were receiving ARVs.

MSF provides medical care to refugees living in Lainé and Nonah camps in the southeastern prefecture of N'Zérékoré. Located in heavily forested areas, these camps are home to thousands of refugees from Liberia and Côte d'Ivoire. In June 2005, the MSF team carried out more than 5,000 consultations in Lainé camp and more than 2,000 in Nonah camp. The most common problems were malaria and respiratory infections.

In June 2005, MSF ended activities at Kuankan camp in Macenta prefecture, also in southeastern Guinea, as the population of Liberian refugees living in the camp dwindled. MSF provided basic health services and managed a surgical ward in Macenta Hospital. Nearly 30,000 consultations were carried out in the camp during 2004. Staff also performed 1,000 operations in the hospital in 2004, 40 percent of which were emergency surgeries.

In August 2005, MSF responded to a cholera outbreak in Conakry, providing logistical and medical support to a health care center where almost 700 people were treated.

MSF has worked in Guinea since 1986.

Uganda

A neglected emergency

For the past two decades, war between government forces and rebels has torn apart northern Uganda. The conflict, centered largely in the districts of Gulu, Pader and Kitgum, has already caused more than 1.6 million people to flee from their homes and suffer terrible conditions in makeshift settlements. Those who stay at home risk kidnapping or worse at the hands of brutal members of the Lord's Resistance Army, the rebel force controlling much of this region. Despite the level of suffering facing civilians, assistance to the population remains grossly inadequate.

Hundreds of thousands of people have sought refuge in camps near the town of Lira. Hunger, disease and terror have combined to weaken the area's residents. Surveys conducted by MSF in October 2004 in five of these camps found staggering death rates, mostly caused by malaria and diarrhea. MSF runs a 350-bed therapeutic feeding center that cared for 320 severely malnourished children in August 2005. It also operates clinics and provides water and sanitation facilities in six area camps. Forced displacements mandated by the government have brought almost the entire population of Pader district (290,000 people) into displacement camps. Because the local health center cannot meet the enormous needs, MSF is providing medical care and water-and-sanitation support to those living in the camps around the town of Pader. MSF staff also provide basic health care for young children, mental health counseling and water and sanitation support in the town of Atanga.

Starting in October 2004, in Kitgum district, MSF opened clinics in Orom, Agoro, Lokung, Mucwini and most recently Potika to help those most vulnerable to malaria – mainly children under five and pregnant women. In the district's southern area of Patango, MSF is providing medical assistance and water to 35,000 displaced people. The team is now planning to introduce tuberculosis (TB) care in Lira, Kitgum and Pader camps.

Mental health surveys conducted in the towns of Lira and Pader revealed that many respondents had been exposed to serious



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“Sick one day, and dead the next. It is scary, if this person can die, what about me?”

– Mother of nine, living in Aloi camp

and provided water and sanitation for many months before transferring these activities to local authorities in January 2005.

Facing AIDS, malaria and kala azar
HIV prevalence is growing in Uganda with an estimated seven percent or 800,000 people, living with the virus. In Arua, MSF now provides medical care for nearly 3,000 HIV-positive people. As of July 2005, 1,916 were receiving antiretroviral (ARV) therapy. The program has been extended to reach people living in the city of Koboko, located north of Arua on the border with Sudan and the Democratic Republic of the Congo (DRC). This program supports the local health clinic offering ARV treatment as well as care of opportunistic infections.

In Uganda, kala azar (visceral leishmaniasis) is endemic in parts of the country. In June 2005, MSF was treating 87 patients for this deadly parasitic disease spread by sand flies at Amudat Hospital located in the remote eastern Karamoja region. Approximately 600 patients will receive treatment before the end of 2005. To speed up implementation of highly effective artemisinin-based combination therapy (ACT) for those with malaria, MSF started introducing ACT in a pilot project in the health structures of Pokot subcounty.

Aiding refugees

MSF responded to an influx of refugees from the DRC who fled into Uganda's western districts in January 2005. Teams vaccinated the refugees against measles and polio. In the resettlement area in Kyaka, MSF conducted health screenings for newcomers. An MSF team working at the landing site of Nkondo assisted Congolese refugees crossing Lake Albert. The team vaccinated more than 3,000 people, set up a mobile clinic and provided water and sanitation facilities.

MSF has worked in Uganda since 1980.

traumatic events since 2002 including the abductions of family members, torture and killings. A survey also found that five percent of the respondents had been forced to physically harm someone. In all of its clinics in Lira, Kitgum and Pader, MSF has treated patients for trauma and the consequences of failed suicide attempts. The survey revealed that 63 percent of the women interviewed thought about committing suicide.

In Gulu district, forced displacements have resulted in the creation of about 50 camps holding approximately 90 percent of the population. MSF runs a night shelter on the grounds of Lacor Hospital for up to 4,000 children who seek a safe place to sleep each night. Most are sent by their parents to avoid their children being abducted by rebels and forced into combat or life as a sexual slave. MSF supports a clinic in Pabbo camp, the district's largest, hosting 60,000 people; another clinic in Awere camp (22,000 displaced people); and one in Amuru camp (33,000 displaced people). Overcrowding and a lack of sanitation sparked a cholera epidemic in Pabbo, in October 2004. Medical teams set up cholera treatment centers for patients, caring for hundreds. Since then, MSF has responded to cholera in five different camps where sporadic cases are reported on a weekly

basis. By July 2005, 550 cases had been treated.

In June 2005, MSF opened a new project focusing on maternal and child health in the displacement camps in the Omoro county area of Gulu district providing medical care and setting up a referral system. Activities include specialized treatment for those with malaria or TB, prevention of mother-to-child transmission of HIV/AIDS, and mental health support for victims of sexual violence. MSF is also working to improve the quantity and quality of water and sanitation facilities within the camps.

The more than 100,000 people who sought safety in and around the town of Soroti in Teso region in 2003-4 are now returning home. Today, approximately 17,000 displaced people continue to live in small camps near the town. As a result of improving security, MSF progressively transferred its activities in one of the outpatient departments in Soroti and closed a clinic in Abalang. MSF carried out a measles-vaccination campaign in September 2004 covering 20,000 children under the age of five. The organization transferred responsibility for its feeding center to the ministry of health in late 2004. A team refurbished Amuria's 24-bed health center, supported the inpatient and outpatient departments

Ethiopia

Addressing staggering medical needs

The plight of Ethiopia is well known: Recurrent conflicts, chronic drought, rampant poverty and high illiteracy are the norm. In many areas of the country, health care is nearly non-existent. Government statistics suggest that at least half of all Ethiopians have no access to medical care whatsoever. This East African nation lacks infrastructure, and insecurity plagues parts of the country. Ethiopia's economy relies heavily on agriculture, which is almost entirely dependent on rainfall, and many residents exist on food aid from abroad.

In 2004, the government began a drive to move more than two million people away from the arid eastern highlands. While the program has brought the resettlers to more fertile farmland, many have fallen ill from diseases unknown in the highlands. Across Ethiopia, MSF assists in treating those with diseases that cause devastating effects: malaria, kala azar, tuberculosis (TB) and HIV/AIDS.

Bringing TB treatment to nomads

As in numerous other countries across the region, TB is endemic in certain parts of Ethiopia. Treating the semi-nomadic Afar people in the village of Galaha, in the northeastern desert of Ethiopia poses particular challenges (see box). TB patients are usually required to take their daily medication under supervision and without interruption for several months – a requirement that is highly incompatible with the Afar's nomadic lifestyle. Yet, since January 2001, more than 2,500 Afar patients have been cared for in an MSF rural TB treatment center according to a regimen designed especially for nomadic people living with TB. Approximately 40 new patients are admitted each month.

In May 2005, MSF opened a project in the Gambella region of southeastern Ethiopia, one of the country's most neglected areas where TB and HIV/AIDS are common. Using mobile clinics, MSF brings medical care and food to an estimated 60,000 people who have long resided outside the reach of care due to insecurity and seasonal flooding. A health center in Itang, one of the district's poorest areas, is being rehabilitated by MSF, and the team will respond to other health emergencies as needed.

A long-running TB project in the Ogaden region of southeastern Ethiopia, for which MSF had been providing medicines and laboratory equipment, training staff and monitoring implementation, was handed over to regional authorities in June 2005.

Treating kala azar patients

In northwestern Ethiopia, MSF runs programs to treat people – primarily seasonal workers – who have the deadly disease visceral leishmaniasis. The project is operated in Humera, a town in the Tigray region near the border with both Eritrea and Sudan, and in Abdurafi in the Amhara region. Transmitted by sand fly bites, the disease, better known as kala azar, is a growing plague. Once a person is infected, the disease attacks the immune system, causing fever, wasting, an enlarged spleen and anemia. Without treatment, the disease is almost always fatal.

More than 100,000 workers come to this region each year at the start of the rainy season in search of seasonal farm jobs. Most sleep out in the open, where they are particularly vulnerable to sand fly bites. In 2004, MSF organized an information and awareness campaign in which almost 60,000 people participated. Outreach teams also tested more than 4,000 people for the disease and treated 1,700 patients. On average, one-quarter of kala azar patients are co-infected with HIV/AIDS. MSF is the only organization addressing Ethiopia's kala azar problem and is seeking to raise awareness about the disease, promote increased availability of effective drugs and diagnostics, and encourage other national actors to address this health problem.

Providing needed HIV/AIDS care

Ethiopia is no stranger to the HIV/AIDS epidemic. Experts say at least 1.5 million people already have the disease. With a high number of seasonal workers, soldiers and commercial sex workers, Humera faces a particularly high prevalence. MSF continues to expand the AIDS program that it began there in early 2004 through a network of 20 clinics. Patients receive voluntary counseling and testing, care for opportunistic infections and sexually transmitted infections, treatment with life-extending antiretroviral (ARV) medicines and counseling to encourage treatment adherence. By the end of 2005, MSF plans to be treating at least 500 patients with ARVs. Malnourished patients also receive therapeutic feeding from MSF to boost their response to care.

The threat of malaria

In September 2004, advocacy by MSF and other organizations helped convince the Ethiopian government to change the national malaria policy so that artemisinin-based combination therapy (ACT) could be introduced. The change in protocol meant that older, no-longer-effective treatments could be replaced with the much more effective drug Coartem. The importance of this development cannot be overstated given the fact that approximately five million people contract the disease in Ethiopia each year.

Yet like the protocol change itself, its implementation has been slow. A lack of Coartem production at the international level and a scarcity of Paracheck kits (an inexpensive and reliable rapid test for *P. falciparum* malaria) are the principal problems. Meanwhile, thousands continue to die unnecessarily. To counter these problems, MSF has been advocating for rational use of the existing stock, use of rapid diagnostic tests to prevent overuse of medicines, and ACT treatment to ensure that the older, largely ineffective drugs will not be used.

In the MSF project in the Damot Gale district in the southern part of Ethiopia, almost 5,000 malaria cases were confirmed and treated at 10 government health facilities between November 2004 and March 2005. MSF staff support these facilities, which serve a population of an estimated



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TB patients in Galaha take their daily medicines at the MSF TB clinic.

Treating TB patients in the middle of the desert

MSF is working in Ethiopia's desolate Afar region to treat nomads who are suffering from TB. As herders, the Afars move their animals every three or four months in search of good grazing areas and adequate water. The region's only health facilities are found mostly in towns along the main roads, far from the Afar's pasture land and water sites. The area's remoteness makes it difficult for the Afar to access TB treatment and adhere to the requirements of standard treatment.

Most patients diagnosed with TB must travel daily to a health clinic to receive and be observed taking their medicines. This is part of the WHO strategy to control TB called Directly Observed Treatment Short-course, better known as DOTS. Supervising patients taking their medication is done to avoid having them miss treatments which can lead to treatment failure and to the emergence of resistance to TB drugs.

MSF opened this TB center in 2001 with the aim of providing quality TB treatment adapted to the Afar way of life. Galaha is a cross-roads for nomads bringing their herds to the local river. To maximize the chances that the nomads complete their treatment, MSF adapted a program used successfully in Kenya that was designed specially for nomadic populations. Its central idea is the construction of a "patient village" consisting of houses built in the vicinity

of the health center. MSF has learned that nomads are willing to stay in one place for a length of time if effective treatment is available and food and housing are supplied. MSF also has staff that speak the nomads' native language, something often lacking in other health facilities.

The Galaha TB center has a capacity for 400 huts which are arranged in three sectors, depending on the risk of contagion. Patients visit the nearby health center daily to be directly observed taking their medicines and then are free to carry on their lives in the village. Patients testing positive for pulmonary TB receive treatment under close supervision for the first four months. After that, they are discharged and provided with a three-month supply of medication, which they administer on their own. They are instructed to return to the center after finishing all of the drugs for a final TB sputum test that will show whether they are cured.

"For nomads, this is a good, adapted approach," explains Dr. Ayub, the program's medical coordinator. "They have direct observation for a longer intensive period, but a shorter treatment course. This allows us to guarantee better their recovery before we discharge them to continue treatment on their own. And they can return to their lives to take care of their animals and earn a living sooner."

300,000 people. They also monitor the region for disease outbreaks, distribute mosquito nets and inform the community about health issues. In the Amhara region's Fogera district, MSF offers malaria treatment at one health center and nine government-operated health posts. In the first half of the year, more than 2,200 malaria patients were cared for the MSF teams.

MSF also battles malaria through its primary care programs in Galaha. MSF staff diagnose and treat those with the disease while

working on efforts to control its spread. Teams in various parts of the country have established emergency-response networks in case of epidemic outbreaks. MSF runs a primary health care program in the Cherrati district of the Somali region – home to approximately 75,000 people. The team has also worked to improve hygiene conditions through a water-and-sanitation project. This work will be completed at the end of 2005.

After November 2004, some 2,000 families moved from the Oromiya region to the Guradamole district of the Somalia region. MSF started an emergency intervention to assist both the local and displaced populations (about 60,000 people in total) who required primary care and adequate food. MSF supports the health center in Haro Dibe and runs a therapeutic feeding program.

MSF has worked in Ethiopia since 1984.

Liberia

Responding to many needs

Although Liberia's bloody civil conflict has ended and a transitional government was created in 2003, most Liberians continue to struggle for their very survival. A shortage of health personnel, particularly in rural areas, leaves many people without basic health care. As a result, Liberians suffer from high rates of preventable diseases and poor maternal and child health.

Improving access to primary and secondary health care services is at the heart of MSF's work in Liberia. In November 2003, MSF opened Mamba Point Hospital in Monrovia, Liberia's capital, which is located in Montserrado county. During 2004, the MSF team carried out more than 1,650 operations there. Respiratory infections and malaria were the main causes of hospitalization, and nearly half of all operations were related to childbirth. MSF staff assisted 150-200 births per month in 2004. MSF is fully supporting Redemption Hospital and its annex, Island Hospital which admit more than 1,200 patients monthly. MSF is renovating Redemption Hospital and increasing its bed capacity.

An MSF team is also working at the city's Benson Hospital, a women's and children's facility. Patients receive outpatient medical consultations (including gynecological and obstetrical care), reproductive health care including treatment of sexually transmitted infections, nutritional screenings and immunizations for children. The Benson Hospital inpatient facility provides emergency care; gynecological, obstetric and pediatric care; and an operating theatre. The organization also fully supports five clinics in Monrovia. In addition to providing direct health care, MSF supplies drugs and medical materials, gives administrative and logistical support, trains local health personnel and maintains water and sanitation facilities at the clinics.

In the northern part of the country, MSF offers basic health care in western Lofa county. Through its two hospitals in Foya and Kolahun, the MSF team provides primary and secondary health care services, including treatment for malaria and tuberculosis. Security conditions have improved in 2005 and many residents have already

returned or are currently returning to the area, increasing demand for MSF services.

MSF supports several health structures in Grand Bassa county, in west-central Liberia, carrying out an average of 800 consultations per month at each of three clinics. A fourth clinic opened in July 2005. In addition, the MSF team treats malnourished children at its therapeutic feeding center in Buchanan. The center provides daytime nutritional support to an estimated 40 children per month, while an additional 250 moderately malnourished children are fed each week through a broader supplementary feeding program.

MSF is active in Nimba county in northeastern Liberia, supporting the GW Harley Hospital in Sanniquellie and clinics in four towns. Health posts are staffed by MSF in an additional two towns. In River Cess county in western Liberia, MSF supports the St. Francis Health Center and the Sayah town clinic, where an average of 1,000 patients are seen each month. In Grand Gedeh county, in the southeast, MSF works in a 50-bed hospital.

In May 2005, MSF closed a therapeutic feeding center and weekly supplementary feeding program in Bushrod Island, Montserrado county. During 2004, when the need was acute, MSF treated more than 4,500 children there.

Helping the displaced

During the recent years of armed conflict in Liberia, MSF has responded to health needs in displaced-persons camps. In Montserrado county, MSF runs clinics in three camps, Seigbeh, Ricks and Plumcor, where an estimated 30,000 people are living. MSF carries out approximately 7,500 consultations per month.

MSF is also working in a camp in Saclepea in Nimba county, where both internally displaced Liberians and refugees (mostly from Côte d'Ivoire) live. In addition to running a field clinic that carries out about 3,500 consultations a month, MSF is supporting two health posts. Mobile health teams travel to surrounding locations.

Until the summer of 2005, when many displaced people returned home, MSF provided clean water and medical services in two camps in Bong county: Maimu and Totota. The organization will continue to work in a third, Salala, where approximately 15,000 displaced people live, until its closure, possibly at the end of 2005. The MSF team set up outpatient clinics in each camp as well as a central hospital, and until November 2004 ran a therapeutic feeding center to help malnourished children. For both camp residents and people from surrounding communities, MSF performed more than 100,000 consultations at the clinics and referred most of the surgical cases to its hospitals in Monrovia.

Sexual violence

In Liberia, sexual violence is a serious problem. MSF integrates care for those who have suffered abuse in most of its projects there. MSF cares for those who were victimized during the protracted conflict as well as for people – mostly women and children – who continue to face sexual assault. MSF also raises awareness among national health staff and is working to build a network to give continued support to victims of sexual violence.

Responding to emergencies

MSF responds throughout Liberia to outbreaks of disease, such as cholera, which is endemic. In one week alone, in June 2005, more than 100 cases were identified in Monrovia. MSF responded by assisting at the cholera-treatment unit of the John F. Kennedy Hospital.

MSF has worked in Liberia since 1990.

Niger

Battling malnutrition

High food prices, financial barriers to health care and failed harvests have worsened malnutrition among young children in Niger. From January to June 2005, MSF treated more than 10,000 severely malnourished children – more than the total number treated during all of 2004.

A study conducted by Epicentre, MSF's epidemiological research partner, in late April 2005 (well before the "hunger gap" that runs from July until the October harvest) found that one in five children under age five and almost one in three children under 20 months of age were suffering from acute malnutrition in the provinces of Maradi and Tahoua. A second Epicentre study carried out in the region of Zinder in August 2005 confirmed these alarming findings.

Tens of thousands of children affected by acute malnutrition remained without access to treatment at the end of September 2005. As the hunger gap emerged, coinciding with seasonal peaks of malaria and diarrheal diseases, MSF staff expressed concern that many of these already weakened children would die. Despite the growing crisis, the population still must assume the full costs of medical care, which the most vulnerable simply cannot afford. Similarly, what little food aid has been distributed has come with a cost to avoid endangering market dynamics, making it too expensive for the most affected.

MSF teams are treating children with severe malnutrition through a network of ambulatory feeding centers located in the Maradi, Tahoua and Zinder regions. Each week, children at these centers receive medical care and a therapeutic food supplement. Because the most vulnerable families have exhausted their food reserves, MSF since May has provided each child's family with a weekly food ration composed of five kilograms of enriched

MSF medical teams will treat as many as 50,000 severely malnourished children in Niger during 2005 – the overwhelming majority on an outpatient basis. This new approach to treatment has greatly expanded MSF's capacity to respond to a large nutritional crisis and is helping to save many lives in southwestern Niger.



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Previously all severely malnourished children were hospitalized for periods up to one month so that they could receive medical care and gradually increasing quantities of therapeutic milk. With the 2001 introduction of new products which are essentially the solid equivalent of therapeutic milk, MSF has largely switched to the ambulatory management of all children not requiring intensive medical care. This new solid food is a ready-to-use, fortified peanut butter paste that requires no preparation, water or cooking. Because it comes in individual packets that are resistant to microbacterial contamination, it can be stored for months. Unlike therapeutic milk powders, these qualities make the product ideal for treating a severely malnourished child at home, thus sparing the

mother the need to leave the rest of her family for an extended period. Instead, the mother brings the sick child once a week to one of MSF's ambulatory centers where the child is examined and given medical treatment, if necessary, along with a week's supply of the solid therapeutic food. Only those who develop complications or severe illnesses are referred to one of MSF's inpatient units.

Visible results

The introduction of outpatient care has had a huge impact on treatment during the crisis in Niger. Without it, says Dr. Milton Tectonidis, a nutritional specialist for MSF who has worked in Maradi, Tahoua and Aguié, Niger, "we wouldn't have been able to treat nearly as many children. Before, we probably would have limited ourselves to Maradi, with maybe three or four fixed therapeutic feeding centers. Caala, Angola, in 2002, was MSF's last big nutritional response that did not include outpatient care. Through three nutritional centers, we treated 8,600 children, whereas we are heading towards 30,000 in Maradi and the neighboring areas. So it's a huge difference. The experience in Niger may make the combination of outpatient and inpatient care the definitive strategy for MSF. I don't think we can go back again."

flour and one liter of oil. When the child is cured and leaves the program, the family is given enough staple foods – cereal, beans and oil – to last another month.

The most severe and complicated cases among the severely malnourished are referred to one of MSF's ten inpatient feeding centers. Each center has sufficient capacity for 150 to 200 patients. They are fed and given intensive medical care until their conditions stabilize and they are able to return to one of the ambulatory centers.

To meet the challenges of the most difficult months of the hunger gap, MSF boosted the program's capacity and had already treated 35,000 children by September 2005. MSF medical teams estimate that

they will treat more than 50,000 children for severe malnutrition by the end of 2005.

Despite emergency appeals launched by MSF in April and again in June, the response to the nutritional crisis in Niger has been woefully inadequate. In its June appeal, MSF called on international organizations such as Unicef and the World Food Program to assist the government in providing free medical care to all young children and sufficient, free food distributions – based on need – to the villages most affected by malnutrition.

MSF has worked in Niger at various times since 1985.

Morocco

Helping immigrants

Every year thousands of undocumented immigrants and asylum seekers, mostly from Africa, enter Morocco. They stop there before attempting to cross into the European Union. European nations, especially Spain, have pushed the Moroccan government to tighten its border-control efforts in a desperate attempt to stem the growing tide of poor immigrants passing into Europe. The result of these measures has been that many undocumented immigrants must wait in Morocco's border areas, under inhumane conditions, for a chance to enter Europe.

Undocumented immigrants in Morocco are extremely vulnerable. Many suffer from poor health due to pandemic illnesses, such as AIDS or tuberculosis and have little access to treatment. Once in Morocco, they may be easily exploited or forced to make money through prostitution. Injuries caused by violence, inflicted at the hands of the police, other authorities and smugglers, is the most common reason for immigrants to be treated by MSF.

In the northwestern city of Tangier and the surrounding areas, including Bel Younech forest, MSF works to improve the health and living conditions of this extremely disadvantaged group. An MSF team conducts mobile medical clinics and monitors the immigrant community for epidemiological outbreaks. Medical staff provide preventive care (vaccinations, antenatal care, family planning), HIV/AIDS care (including prevention of mother-to-child transmission) and logistical supplies. In addition, the team works to sensitize Moroccan authorities about the vulnerability of these migrants.

MSF works in the region of Nador and Oujda on the Mediterranean Sea, providing medical care to undocumented immigrants, especially those living in the Gourougu Mountains near the Spanish enclave of Melilla, where hundreds of would-be immigrants live in appalling conditions while they wait to cross into Spain.

MSF has worked in Morocco since 1997.

Mozambique

Providing HIV/AIDS care and building local capacity

An estimated 1.4 million people are living with HIV/AIDS in Mozambique, a country with minimal resources to respond to the crisis. As 500 people become infected each day, AIDS has begun to eclipse other medical concerns in the country. MSF is working to build the capacity of local health workers to provide comprehensive, quality care for the growing numbers of people living with this disease.

In the capital city, Maputo, MSF works in the Alto Maé health center, where the organization conducts more than 3,000 consultations per month, and in Chamanculo Hospital, where more than 650 patient visits are held each month as part of a project to prevent mother-to-child transmission of the virus. By mid-2005, MSF was providing 2,733 patients with life-extending antiretroviral (ARV) medicines in the Chamanculo district. MSF continues to provide medical consultations and ARV treatment for HIV-positive patients in Maputo's Mavalane health district, addressing opportunistic infections and supporting the laboratory in the Primeiro de Maio health center. By the middle of 2005, 1,600 patients were receiving ARV therapy in the health center. Programs aimed at preventing maternal-to-child transmission of the virus and home-based medical and social support are also provided at the health center.

Because of Maputo's high HIV prevalence rate (nearly 20 percent) and the enormous need for treatment, MSF is seeking to transfer its voluntary counseling and testing activities to local health authorities. The change should enable MSF to turn its attention to HIV-positive patients who are currently on a waiting list for treatment, including ARVs. MSF staff are also providing treatment for opportunistic infections and prevention of mother-to-child transmission of the virus.

In western Tete province, situated between Zambia and Zimbabwe, the MSF team works with the ministry of health and other local partners in Tete town and in the districts of Moatize and Angonia to provide a comprehensive program of HIV/AIDS prevention, treatment and care. Activities in

Tete are based in the provincial hospital but are also decentralized to peripheral health structures to enable more people to access care. By mid-2005, MSF staff were carrying out a total of more than 3,000 HIV/AIDS consultations per month in Tete, Moatize, and Angonia. Every month more than 100 women were being enrolled in a program to prevent transmission of the virus during pregnancy. Over 1,000 patients are currently receiving ARVs from MSF in Tete town and Moatize district, and MSF began treating patients in Angonia district with ARVs in April 2005. MSF staff are also bringing HIV/AIDS care to the people of Lichinga town and district in Mozambique's northern Niassa province. In this rural setting, MSF carries out approximately 550 consultations per month at the provincial hospital. As of June 2005, 200 patients were receiving ARV treatment from MSF in Lichinga and 100 pregnant women were receiving care to prevent transmission of the virus.

Another essential component of MSF's work in Mozambique is fighting the stigma and discrimination that isolate HIV-positive people. This work is done through information, education and awareness-raising activities. Since October 2003, in Maputo and Linchinga, MSF has trained medical students and doctors, as well as those who operate AIDS telephone hotlines. Other activities to fight discrimination include radio campaigns, the use of peer AIDS ambassadors working in hospital waiting rooms and street theater in areas where MSF is conducting home-based care.

MSF also works closely with various groups including associations of people living with HIV/AIDS in Tete Lichinga and Maputo, providing information, training and institutional support.

MSF has worked in Mozambique since 1984.

United Republic of Tanzania

Introducing ACT

Malaria is the principal health problem facing the people of the United Republic of Tanzania. An estimated 100,000 people, 70,000 of whom are children, die from the disease each year. The MSF project on the Zanzibar Archipelago treated 65,000 people in 2004. Focusing on three districts on the islands of Unguja (known as Zanzibar) and Pemba, MSF works with the Zanzibar Malaria Control program to introduce highly effective artemisinin-based combination therapy (ACT) and rapid diagnostic testing. MSF also helps staff at local facilities treat children with childhood illnesses, including respiratory infections, anemia and diarrhea. The team has also created infrastructure for waste disposal and elimination and constructed latrines. Local health authorities are expected to assume responsibility for this project at the end of 2005.

In February 2005, MSF responded to high malaria rates in the Muleba district of the Kagera region, in the northwestern part of the country, with a six-month emergency intervention. MSF introduced ACT and rapid diagnostic testing in this area.

The number of Tanzanians living with HIV/AIDS has rapidly increased in recent years. Estimates suggest that as many as two million of the country's 36 million people have already contracted the virus, yet merely 8,000 have access to life-extending antiretroviral (ARV) medicines.

In October 2004, MSF opened a project to treat HIV-positive patients in the Makete district, a remote rural area in the Iringa region of southern Tanzania near Lake Malawi. The team provides comprehensive care for patients and introduced ARVs in January 2005. By the end of April 2005, 705 patients had been registered in the program, and 250 had started treatment.

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

Mauritania



Treating and preventing cholera

Concerned about a major cholera outbreak in the capital city of Nouakchott, MSF has opened a new emergency project in Mauritania after years of providing basic health care and treatment for malnourished children.

While carrying out a nutritional assessment in late July 2005, MSF medical staff came upon a growing cholera epidemic just south of the capital. The team immediately began to treat patients and constructed shelters, hygienic barriers, taps and a drainage system. By the end of August, MSF had received more than 1,000 patients. Though not all were suffering from the disease, the vast majority were and needed immediate care. The outbreak of the highly contagious disease centered on the capital's El Mina slum. MSF worked with other organizations to bring the epidemic under control and raise awareness about the disease among the local population.

MSF has ended or turned over to local organizations several other projects it had conducted in the country. In 1999, MSF opened a primary health clinic in Bouhdida, a slum area of Nouakchott, to enable residents to have access to quality health care. In the last year, approximately 4,500 consultations were carried out, many for patients with diarrhea or respiratory infections. More than 1,800 antenatal consultations were conducted with 226 deliveries performed in 2004. In 2002, MSF transferred all of the program's medical responsibilities to the national staff while continuing to provide technical support and supervision. In July 2004, a national

organization assumed responsibility for the project's remaining components.

In June 2004, MSF closed its supplementary feeding center that helped malnourished children in Nouakchott's poverty-stricken neighborhood of Saada, as fewer children required care.

In September 2004, MSF ended its project to improve pregnant women's access to reproductive and prenatal care in Sélibaby, the chief city of the southern Guidimakha region. The program was able to successfully reduce maternal morbidity and mortality rates. However, plans to introduce a second phase of the project were stopped due to a lack of commitment on the part of local and national health officials and a lack of available staff. A nutritional project located in the same region was also handed over to the ministry of health in 2004 after meeting its objectives.

MSF has worked in Mauritania since 1994.

Madagascar

MSF closes project for street children

After 12 years of working with children in severe need in the capital city Antananarivo, MSF closed this project in March 2005.

Over the years, MSF's work has helped raise the profile of this population both in the political sphere and in public opinion, leading to concrete changes in the way these children are viewed and treated. MSF has also shown that it is possible to reach these desperately stigmatized youngsters with high-quality health care. In addition to its medical activities, MSF supplied social and legal support to minors participating in its program in cases of mistreatment, conflict with the law or wrongful detention.

Despite these small victories for children in need, MSF ended this program because it was no longer reaching this specific population, but instead, attracting a pauperized population too large and beyond the scope of MSF's actions. Indeed, the increasing level of poverty – an estimated 70 percent of Antananarivo's inhabitants live below the poverty line – has made it impossible for the majority of the city's inhabitants to afford health care, and it is impossible for MSF alone to assist all of those in need because it does not have the capacity and does not see its role as replacing the public health care system. MSF believes the principal responsibility to address the large-scale crisis now lies with the Malagasy state.

MSF will continue to work elsewhere in Madagascar. Teams that conducted an exploratory mission in the southeastern region found worrying malnutrition rates, and consequently, MSF plans to open a new project in the area in the second part of 2005.

MSF has worked in Madagascar since 1987.

Nigeria



An MSF psychologist talks to children about their drawings as part of the mental health outreach program done through schools in Yelwa, Plateau State, Nigeria.

Reducing the burden caused by disease and violence
In Nigeria, MSF is treating people with malaria and AIDS, providing therapeutic feeding to malnourished children and offering mental health care to those exposed to violence.

HIV/AIDS is a growing problem in Nigeria. Most of those in urgent need of treatment for AIDS or related illnesses have no way of getting it, because treatment is too expensive or otherwise unavailable. MSF is now treating more than 500 patients with life-extending antiretroviral (ARV) medicines at General Hospital Lagos Island. The program also offers voluntary counseling and testing, support programs to encourage adherence to treatment, care for opportunistic infections, and social and psychological support. In total, more than 1,000 people are receiving HIV/AIDS care from MSF.

In the oil-rich Niger Delta region, the majority of the population has little access to basic health care because facilities are few and far between and because medi-

cines and medical staff are in short supply. Malaria is the main cause of death for children under five living in the region's wetlands where mosquitoes thrive. In isolated and swampy parts of southern Bayelsa state, MSF teams provide basic health care and train local staff at several health centers. The team uses artemisinin-based combination therapy (ACT), the most effective treatment available for malaria.

Following a measles outbreak in Borno state in the north of the country, and in Adamawa state in the east, in March 2005, MSF conducted an emergency intervention, providing treatment to those (mainly children) who had developed complications from the disease, such as pneumonia, corneal ulcerations and diarrhea and sub-

Healing invisible wounds

MSF uses art and counseling to treat children's trauma

For two days in May 2004, fear ruled the central Nigerian town of Yelwa. Homes were destroyed and people were killed, raped and abducted as inter-communal violence flared. Before the military brought the massacre to an end, around 700 people had been killed. MSF started to provide emergency medical aid to those who had fled. While treating many physically injured and sick adults and children in displaced persons camps, members of the MSF team began hearing horrific stories about what people had experienced. The team realized that many survivors, including a large number of children, were living with severe psychological trauma. In response, MSF started a psychosocial program to help adults and children as they returned home and tried to rebuild their shattered lives. The program for traumatized children used creative techniques and community support to achieve its success.

Getting started

The MSF team visited schools and community leaders in Yelwa to explain how children might manifest their trauma. Difficulty concentrating, crying jags, becoming easily upset in the classroom, missing school or abusing substances – any of these behaviors might be seen after such an event. “Making the teachers and schools aware of the symptoms was a way to offer them support so the teachers weren't so overwhelmed with containing the emotion,” explains Gwen Vogel, the MSF psychologist who directed the MSF project. “It's all a byproduct of the trauma.”

In group or individual sessions, the youngsters learned how their feelings and behaviors were linked to their personal experiences. MSF counselors used drama, drawing, breathing techniques, and most of all mutual listening to help reduce the psychological pressure. MSF provided art therapy and counseling to approximately 2,500 children enrolled in schools in Yelwa and the surrounding area.

During their initial visits to schools, the MSF team distributed paper and pens and asked the children to draw what they had experienced in May. The youngsters leaned over their pieces of paper, concentrating intensely as horrific scenes took shape: men with oversized weapons, people riddled with bullets, burning houses and people with severed limbs.

“Some children find it hard to express their emotions and traumatic memories verbally,” explains Vogel. “These children can often present their emotions better by drawing, and the pictures they draw show what worries, scares and moves them.”

During the sessions, Vogel and other members of the team asked the children to explain their drawings and listened to the descriptions: a father being shot, uncle decapitated, sister abducted, house ransacked and burned down. This sort of scene cropped up hundreds of times, recounted by the children in strangely absent, calm voices.

Helping the children move on

Once the program had been under way for several months, Vogel and other staff members began talking to the children about their changing feelings. Most were feeling better and more secure, and their pictures started to reflect it. The MSF staff encouraged them to draw bridges to illustrate how they were moving away from the dark days of May toward a brighter and safer time. In the final months of the project, the team helped the children start creating pictures that reflected their hopes and dreams for the future.

MSF's project appears to have been successful in helping these children break free of their traumatic experiences. Gwen and her team gave them a safe place to tell their stories and taught them how to integrate these horrific experiences into their lives, allowing most of them to move on. “It's not as if all of the problems are healed,” concludes Vogel, “but I think they have returned to the way things were before the crisis. In some ways, everyone who participated became a mini-therapist themselves. They said it felt so nice just to have someone listen – not to judge them or tell them what to do. That means a lot.”

sequent malnutrition. Despite its strong efforts to receive authorization from federal authorities, MSF was not permitted to undertake a wide-scale vaccination program. Although the number of measles cases decreased, the poor nutritional status of children remained a great concern, and both measles projects were reoriented to treat those with malnutrition. In Borno, MSF opened a therapeutic feeding center in Biu Hospital, treating about 260 children by the end of July 2005. Mobile teams also traveled to remote communities in four parts of the region to let people know about the program and provide food and care to children who could not get to the therapeutic feeding center. In Adamawa state, MSF treated more than 2,000 children in outpatient clinics and cared for

others in intensive care units in two hospitals. MSF also provided therapeutic feeding and epidemiological surveillance in the towns of Numan and Mubi until August 2005. In May 2005, MSF responded to a nutritional crisis in Katsina state, near the border with Niger, where high rates of severe malnutrition were linked to a measles outbreak and an inadequate diet. More than 2,100 children were admitted to MSF's feeding center there in six weeks.

After hundreds of people were killed during violent clashes in the town of Yelwa in Plateau state, in May 2004, MSF assisted thousands of destitute, displaced people who had fled to neighboring states during the violence. When the population started to return, MSF offered basic medical care to

those living in and around Yelwa. As tremendous mental health needs were found among those who either had witnessed or were subjected to extreme violence, MSF provided mental health care services for returning civilians until May 2005. The team also developed a special school outreach program (see box) to help traumatized children.

MSF has worked in Nigeria since 1996.

Rwanda

Helping those affected by HIV/AIDS

In addition to addressing substantial health problems in Rwanda, MSF is assisting survivors of the country's 1994 genocide in which an estimated 800,000 people were killed.

In Kigali, the capital, MSF cares for HIV-positive people at the Kimironko and Kinyinya health centers. These projects offer comprehensive AIDS care including voluntary counseling and testing, treatment of opportunistic infections and medication to help prevent mother-to-child transmission of the virus. Patients in both locations can obtain life-extending antiretroviral (ARV) medicines, supplied in part by MSF, if needed. By mid-2005, 1,340 patients in the Kigali area were using ARVs. To help prevent further spread of the disease, MSF provides public education, particularly to those with high-risk behavior, about prevention methods, available treatments and the services it offers through two health centers. MSF is also helping health authorities implement the national AIDS policies and is encouraging them to use generic ARVs as less-expensive alternatives to patented brands.

MSF has been working with three local associations since August 2000 to provide psychological help to survivors of the 1994 genocide. A team of five psychologists supervises 12 MSF-trained trauma counselors from partner associations and assists them in supporting women, many of whom were raped during the genocide and contracted AIDS. Individual support and group therapy sessions are held to help women cope with their emotions and develop stronger social connections. MSF has helped the local group of counselors to train and monitor 45 psychosocial community workers who now run therapeutic discussion groups in villages.

Another team offers reproductive health services to women living in Ruhengeri province, which borders Uganda. This work is based in the maternity ward of the provincial hospital and in six health centers in the Gitare health district. Working closely with the community, MSF assists with obstetrical emergencies, medical and psychological care for survivors of sexual violence, implementation of family planning

in the health centers, ensuring access to basic health care and maintenance of general reproductive health services (staff training, sexually transmitted infection prevention, delivery and post-natal care and improving health during pregnancy). In early 2005, the program began providing ARV treatment in three health centers. In mid-2004, MSF launched new cholera-prevention activities on the Gafunzo peninsula of southwestern Cyangugu province. MSF provides public education about hygiene and works with government ministries and individual communities to rehabilitate pumps and other water sources, construct wells, provide training and conduct epidemic surveillance. MSF continues to cooperate with the Rwandan ministry of health to improve epidemiological surveillance.

In May 2004, MSF intervened on a small scale to aid displaced Congolese civilians in Cyangugu province and provided care during a typhoid fever outbreak in Ruhengeri province during July and August 2004.

MSF has worked in Rwanda since 1991.



Sierra Leone

Aiding survivors of war

Eleven years of armed conflict destroyed much of Sierra Leone's existing infrastructure, and though the country is now stable, most of its people have minimal or no access to basic health services. Women and children are especially vulnerable. In a country where most people survive as farmers and large families are believed to be essential, women are expected to have as many children as possible. Many die in childbirth or on their way to get help, or suffer serious complications; and many babies do not survive infancy.

MSF works in the pediatric and maternity wards of the district hospital in Kambia, in northwest Sierra Leone. MSF provides staff for emergency and obstetric surgery and all needed material for the laboratory. In addition, the MSF team works with six peripheral health units in Kambia district, providing supervision, training local health workers, and supplying medical materials and drugs. Outreach workers go into the nearby communities to provide health education.

MSF runs a similar program in Tonkolili district, working at the district hospital in the town of Magburaka, supporting six peripheral health units and conducting outreach and education. In both districts, the MSF team gives life-extending antiretroviral (ARV) treatment to HIV-positive, pregnant women. MSF staff also educate mothers about how to care for their babies without exposing them to the virus. This work is done in collaboration with the national AIDS secretariat. MSF has established "maternity houses" in Kambia and Tonkolili, where women in the final weeks of pregnancy can stay near the hospital in case of complications. MSF staff carry out around 3,600 consultations per month in Kambia, and 4,200 per month in Tonkolili.

In Southern province, MSF provides basic health services at the Gondama Medical Center located near Sierra Leone's second largest city, Bo. Though the facility initially served mainly refugees, it now primarily helps Sierra Leoneans who live in the district. The facility includes a pediatric ward, an adult ward, an intensive care unit and a therapeutic feeding center for malnour-



INTERNATIONAL STAFF 27
NATIONAL STAFF 254

Africa

Malawi

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In Thyolo province, an HIV-positive woman must spend a lot of time under a mosquito net donated by MSF due to her frequent bouts of malaria.

ished children. The MSF team admits more than 400 people each month. Most patients suffer from diseases such as malaria and respiratory infections.

In 2000, MSF set up a consultation area in Taiama camp, in the country's western Myamaba district, which was home to internally displaced Sierra Leoneans. By 2002, the population of the camp had risen to 6,000 – and shifted to housing mostly Liberian refugees. During 2004, many Liberian refugees returned home, and the camp's population decreased. MSF continues to provide basic health care, vaccinations, pre-natal and postpartum services and maternity care for the camp's remaining residents. Teams provide similar care in the Kenema district's Tobanda and Largo camps.

MSF supports eight health clinics located near refugee camps in Southern province. Though more than 20,000 Liberian refugees continue to live in the camps, most of the clinic's patients come from nearby communities. In addition to basic health services, these clinics give nutritional treatment for mothers and their children, mental health support and a program for victims of sexual violence. MSF staff conduct more than 20,000 consultations in these clinics each month.

MSF also responds to medical emergencies in the country. In August and September 2004, MSF responded to a cholera outbreak in Freetown, treating more than 1,800 patients.

In November 2004, MSF closed a clinic in Kailahun district, following the reopening of the public hospital. More than 1,200 consultations had been carried out at the clinic each month since it opened in 2001.

MSF has worked in Sierra Leone since 1986.

Improving AIDS care

In Malawi, most MSF activities are focused on improving care and services for those living with HIV/AIDS – a population numbering more than one million adults and children. Although the government has plans to scale up HIV/AIDS services, in reality, 90 percent of public health facilities lack the capacity to offer even the most basic health care. MSF cares for people living with HIV/AIDS, and provides treatment with life-extending antiretroviral (ARV) medicines to 6,900 patients.

In the southern district of Chiradzulu, MSF is working with local and national partners to provide comprehensive HIV/AIDS care through the district hospital and 10 community health centers. Activities include voluntary HIV testing and counseling, education and awareness-raising and treatment for opportunistic infections. Since 2001, MSF has provided patients with free ARV medications.

For the past two years, an average of 200 new patients have been added to the ARV program each month. (MSF has temporarily halted new admissions to the program while it develops new criteria to ensure that the quality of care remains high amid spiralling enrolment.) Currently 4,000 patients are receiving ARV treatment through the Chiradzulu program.

The MSF team visits each health center in Chiradzulu twice a month and runs training sessions for local nurses to enable them eventually to run these centers autonomously. Tasks normally performed by doctors, who are in short supply in Malawi, as

in the rest of sub-Saharan Africa, will be delegated to nurses and health workers.

MSF launched its first HIV/AIDS program in Malawi in 1996, in the southern district of Thyolo, a mainly rural area where an estimated 500,000 people live. Today, that program is implemented largely through cooperation with local partners, ranging from the district hospital to small community groups. More than 2,250 people are now receiving ARV treatment there. MSF teams try to involve traditional medical practitioners in AIDS-prevention and ARV-therapy programs as well. In addition to HIV/AIDS care, the MSF team in Thyolo works to prevent and respond to other health needs, including malnutrition, cholera and malaria.

In July 2004, MSF began a new HIV/AIDS project in the eastern part of the Dowa district in central Malawi. The team provides diagnosis and treatment to HIV-positive residents of the area, including those living in the Dzaleka refugee camp in the south-eastern part of the district. Estimates suggest that approximately 8,500 people there are living with HIV/AIDS, and 1,500 are in immediate need of ARV treatment. Operating out of one hospital and nine health centers, the team gives medical care to HIV-positive patients and works to increase access to treatment. MSF plans to enroll 60 new patients each month so that approximately 800 people will be receiving needed care, including ARVs, by the end of 2005. MSF is also carrying out prevention activities throughout eastern Dowa district.

MSF has worked in Malawi since 1986.



South Africa

Treating AIDS patients and rape survivors

With more than 6.5 million people living with HIV, South Africa has the largest number of HIV-positive people in the world. MSF is working in low-income areas of the Western Cape and Eastern Cape, providing life-extending antiretroviral (ARV) medicines and related care for HIV-positive patients.

In cooperation with the Western Cape Department of Health, MSF has been working since 1999 at three HIV clinics within primary health care centers in the impoverished township of Khayelitsha, located on the outskirts of Cape Town. The township, home to almost 500,000 people, was created during the late years of apartheid. Its inhabitants suffer from high unemployment, poor living conditions and a staggering HIV infection rate of 29 percent. The clinics' staff members provide HIV care including ARV treatment for those with advanced AIDS and care for opportunistic infections. A pilot project to integrate TB and HIV care is being conducted at the Ubuntu clinic, (see page 16). By August 2005, the Khayelitsha HIV/AIDS clinics were providing ARVs to 2,600 people and conducting more than 8,000 medical consultations per month.

A partnership between MSF and Cape Town health authorities led to the opening of a youth center in mid-2004. The center aims at providing medical care, psychosocial support and life skills to youngsters living in the township. Its services include family planning and care for sexually transmitted infections and HIV including voluntary HIV counseling, testing and education. It also hosts activities such as debates, dances and planning meetings.

Sexual abuse is one of the major problems facing poor South African communities. Nevertheless, its magnitude is hard to estimate since it remains largely unreported. Since 2003, MSF has supported the Simelela Rape Survivors Center in Khayelitsha, which is run in partnership with provincial health and social services authorities, the police and a local organization specializing in rape crisis work. Simelela offers medical, psychological and social care – including post-exposure

prophylaxis for HIV – a police service and ongoing monitoring of patients. The center's scope of activity expanded in August 2005 to include forensic examinations, and its hours have increased to 24 hours a day, seven days a week. In the month of August alone, Simelela's staff provided assistance to more than 130 rape victims – about half of them children under the age of 14.

Since early 2003, MSF has run another HIV project in Lusikisiki, in partnership with provincial health authorities of the Eastern Cape province. Lusikisiki, one of the province's poorest regions and a former homeland, has an HIV prevalence rate of 30 to 40 percent. Since MSF established its program in the central hospital and 12 clinics, more than 600 people have been tested for the virus each month. Three MSF mobile teams provide medical care to those with HIV-related infections. MSF began offering ARV treatment in November 2003, and by August 2005, 1,000 people were receiving these medicines through the program.

Central to all of MSF's activities in South Africa is a strong, fruitful partnership with the Treatment Action Campaign, a grassroots movement, to advocate for better access to HIV care and treatment. At community level, both groups support patients' adherence to treatment, fight stigma and discrimination against people with HIV and promote prevention of new infections. Joint campaigns are also developed at the national and international levels.

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.

Somalia

Providing care amid chaos

Since 1991, Somalia has been a state without a government on its own soil. Fourteen years of lawlessness has left the country with enormous unmet medical needs and a high level of daily violence. The ongoing civil war has brought about a virtual collapse of public-health structures and services. In most parts of the country, clinics and hospitals have been looted or seriously damaged. There are estimated to be only four doctors and 28 nurses and midwives for every 100,000 people in Somalia.

Unsurprisingly, Somalia has some of the worst health indicators in the world. More than one in ten children dies at birth and of those who survive, a quarter will perish before their fifth birthdays. Malnutrition is one of the many scourges of Somalia. Mass poverty and dry rainy seasons also contribute to the problems. On a national level, there is no authority to take up the challenge of feeding Somalia's people, nor of providing them with health care. The effects are obvious: the average life expectancy for a Somali is only 47 years.

Violence is so widespread and the country's clan structure is so complex that few aid agencies choose to work there. But with no state and thus no state medical services, Somalia is a country in desperate need of this type of assistance. With significant numbers of international and national staff on the ground, MSF tries to fill some of the huge gaps. Its projects involve primary health care across the worst affected areas in south and central Somalia, and include treatment for those with tuberculosis (TB) or kala azar, therapeutic feeding of malnourished children, pediatric care and even surgery.

In the Bakool region, which borders Ethiopia, MSF operates a health center in the regional capital of Xuddur and three health posts in surrounding villages. Through inpatient and outpatient facilities, MSF offers vital services that would otherwise be out of reach for the 200,000 impoverished inhabitants of the region. The team gives primary health care, and treats people with TB and kala azar. Severely malnourished children are also treated in the health center.

The city of Galkayo in the northwestern Mudug region is divided between two warring factions (see box). MSF supports two hospitals in the city, in each of the areas controlled by the two factions. The organization provides inpatient and outpatient care, therapeutic feeding, surgery, TB treatment, maternal health care, and pediatric and emergency services.

In Mogadishu, MSF runs a primary health care clinic, providing outpatient services and maternal and child health care. The organization also does epidemiological surveillance and intervenes when needed.

In the Middle Shabelle region in the west of the country, MSF provides basic health care and epidemiological surveillance in the districts of Jowhar, Mahaday and Aden Yabal. MSF's activities include running 10 outpatient dispensaries, 6 maternal and child care health dispensaries, 1 emergency room and 5 mobile immunization teams. In the Lower Juba Valley in the Marere region in northeastern Somalia, MSF provides inpatient care for pediatric, medical and maternity cases; therapeutic and supplementary feeding; and outpatient services for the rural population, including the marginalized Bantu ethnic group.

MSF also runs a health center in Dinsor in the Bay region in central Somalia. In addition to providing outpatient health care and immunizations, it runs an inpatient department with 40 beds, provides emergency surgery, gives antenatal health care, and has opened a laboratory to support its TB work. The staff also treats malnourished children and patients with TB and kala azar. In addition, MSF maintains an emergency-response system in cases of epidemics or clashes.

MSF has worked in Somalia since 1991.



Where mercy is in short supply

Roda Musa lies on a bed, cradling her arm. Her flowing, colorful clothes are a stark contrast to the white plaster that covers her from hand to shoulder. She appears to be in her early 20s, but her face is lined with anger when she explains why she has found herself in the trauma ward of the MSF-run hospital in the town of Galkayo.

"A Somali man shot me in the arm," she says. "I have no idea why." She is not alone. The same hospital has treated more than 300 patients for trauma injuries related to violence in the first six months of 2005. Around 80 percent of these are bullet wounds.

Galkayo, situated in central Somalia, is an important trading town with a population of 80,000. It has all but literally been torn in two. Viewed from the air, Galkayo is a small area of identical metal roofs in the midst of an unforgiving desert. But with no authority other than warlords and no law other than the gun, a dispute between two clans has escalated to the point where people from the southern part of Galkayo cannot venture north and vice versa. A "green line" – which is more like a no man's land – is guarded by opposing militia and splits the town into two halves. When MSF reopened the North Galkayo Hospital in collaboration with local doctors in 1997, restarting a service that had collapsed at the start of civil war in 1991, it became the first hospital accessible to all for hundreds of kilometers in every direction. Except for those directly to the south, of course.

"We quickly realized that the green line prevented those in the south of Galkayo from traveling the four or five kilometers north to get treatment," explains MSF head of mission Colin McIlreavy. It would be six more years before MSF would finally deem it safe to begin the process of opening a similar hospital on the southern side of the line.

For the majority of the people in Galkayo, to venture across the "green line" – even to come near it – is to risk death at the hands of one militia or another. The latest flare-up of violence took place in April 2005 when a price dispute in the market that straddles the green line escalated into a full-scale battle that left at least 18 dead and 37 wounded, many of the victims caught in the crossfire. The MSF staff cared for the battle's victims.

The division between Galkayo's two factions may seem impassable, but in the hospitals, the suffering is identical. "The needs are huge," explains McIlreavy. "We do over 40,000 consultations per year in the two hospitals but this barely scratches the surface. It is not just for residents of Galkayo. People come from up to 700 kilometers away to get medical care, because there is nothing else available to them. Across great swathes of the country there is literally no possibility of access to medical treatment. This is why people come for hundreds of kilometers to reach us in Galkayo. Worst of all, we know that for every person we reach, there are many more who die for the want of sometimes basic care."

Côte d'Ivoire

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Renewed violence deepens crisis

The conflict that started in 2002 has resulted in thousands of civilian deaths and has forced hundreds of thousands of desperate residents to flee their homes. Renewed violence broke out in November 2004, causing more casualties and forcing civilians to flee again. The ongoing violence has left many without basic health care or sufficient food. MSF is the only provider of basic primary and secondary health care in many of the areas where its teams work.

MSF works on both side of the conflict's frontlines, providing medical personnel for health facilities and urgently needed care. At hospitals in Bouaké, Man and Danané, MSF staff provide essential medical care including pediatric consultations, emergency medicine, obstetric and gynecological care and surgery. Mobile clinics are also used in the west to bring care to those living in more isolated areas. A team in the town of Guiglo provides more than 2,500 medical consultations each month (many of them for children with malaria), assists malnourished children and gives aid to those displaced by violence.

Because malaria is the largest threat to children's health in Côte d'Ivoire, MSF treated more than 70,000 malaria patients in the last year, using artemisinin-based combination therapy (ACT), the most effective treatment available. MSF also carried out a mass measles-vaccination campaign for almost 10,000 children in the Bangolo area south of Man, in 2004.

More violence rocks the country

The eruption of violence in November 2004 posed a challenge to MSF's work in the country. Government and rebel forces clashed, resulting in the intervention of

French troops who, together with UN troops, guarded the demilitarized zone in the center of the country. The unrest caused such strong anti-French sentiment that more than 8,000 foreigners were evacuated from the country. Despite the tense situation, MSF managed to keep its projects running with skeleton teams of international and national staff.

In the western town of Danané, hospital services continued throughout the crisis, providing up to 70 consultations a day. Airstrikes on a military base in Bouaké injured many civilians, and on 4 November, 39 people were urgently referred to the town's public hospital where an MSF medical and surgical team were prepared to treat them. MSF also responded to the needs of those who had been displaced by the fighting. In other parts of the country, basic medical assistance was given to wounded civilians caught in the crossfire. Tons of medical and surgical material including medicines, dressings, bandages, compresses and gloves were distributed to several hospitals throughout the country.

At the end of February 2005, an attack on the rebel-controlled village of Logoualé, south of Man, created new tensions in the

"demilitarized zone". Since that incident, MSF teams have witnessed a pattern of attacks on villages followed by population movements that raise concerns that a form of ethnic cleansing could be under way.

Prison riot

MSF teams also provided assistance during a week-long riot that began on 2 November in the MACA prison, formally known as the Maison d'Arrêt et de Correction d'Abidjan. MACA prison holds about 5,000 inmates, although it was built to house only 1,500. The growing political tension in November permeated the prison, and inmates began a mutiny to demand better living conditions. These conditions – overcrowding, poor hygiene and insufficient food – give rise to frequent cholera epidemics, high levels of tuberculosis (TB) and malnutrition. The riot injured 75 people and resulted in 24 deaths. The MSF team transferred 12 seriously wounded patients to the university hospital in Yopougon.

MSF conducts more than 1,200 medical consultations with prisoners each month. In 2004, the organization extended its activities in the prison's TB ward in collaboration with the country's national TB program and began treating six people who had multidrug-resistant strains of the disease. An estimated 150 detainees benefit from a supplemental nutrition program established by MSF.

Since its teams began working in the prison, MSF has been able to improve health care and increase the number of medical staff on duty. In addition, the prison's budget has been increased. Because of these positive developments, MSF is now decreasing its support in the prison and plans to close most of its projects there, except for the multidrug-resistant TB program, by the end of 2005.

MSF has worked in Côte d'Ivoire since 1990.



A silent crisis

A patient arrives semiconscious at the Danané Hospital in northwestern Côte d'Ivoire. She has abdominal pain and no blood pressure can be detected. The concerned midwife finds that the patient's vaginal walls are encrusted with a thick, solid discharge. This is one of the worst cases of sexually transmitted infection (STI) that the midwife has seen in her 20 years of experience. Despite immediate treatment by the hospital staff, the patient goes into cardiac arrest and dies of septic shock. She is 13 years old.

A 14-year-old girl comes to a mobile clinic complaining of general pain in her head and stomach. She does not know whether she is pregnant, but the nurse examining her discovers that she is carrying both a baby and an STI. The young girl tells MSF that she is unmarried but often has sex with a boy in the military. She explains that, in exchange for sex, she receives money, clothes and protection for herself, her brothers and sister.

The civil war and subsequent collapse of the country's health care system have provoked a medical crisis in parts of Côte d'Ivoire. MSF teams in the western part of the country have encountered alarmingly high rates of STIs. These infections can lead to horrible complications in reproductive health. While drastic in its own right, the high level of STIs is also a clear indicator that HIV/AIDS is spreading in the region, making prevention and treatment efforts all the more urgent. Family separations and the influx of soldiers have left many women and young girls vulnerable to sexual violence, prostitution, unwanted pregnancy and STIs.

MSF teams diagnose STIs in about 20 percent of the adults visiting their clinics in some towns. The teams are convinced that the actual prevalence is higher, and that many STIs, including HIV/AIDS, often go undiagnosed and untreated.

The teams are frustrated by these alarmingly high numbers of STIs and the lack of effort to prevent the spread of these diseases, including HIV/AIDS. Despite an estimated 10 percent prevalence rate for HIV in Côte d'Ivoire, little is being done to combat it outside of the major city centers. In addition to boosting education, prevention and treatment of STIs, MSF is advocating for increased prevention of mother-to-child transmission of HIV, treatment of opportunistic infections and treatment of AIDS with effective medication.

INTERNATIONAL STAFF 8
NATIONAL STAFF 80

Mali

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Africa

Improving malaria and cholera care

While civilians in Mali face recurring epidemics of cholera, measles and meningitis, the basic medical needs of the country's 12 million inhabitants remain largely unmet. MSF makes a priority of improving people's access to care and the quality of treatment.

Partially in response to malaria research carried out by MSF, Mali adopted in 2005 a new treatment protocol that calls for highly effective artemisinin-based combination therapy (ACT). In the rural commune of Koumantou, in the Sikasso region, MSF had found high levels of resistance (90.5%) to the drug chloroquine, which was being used to treat those with malaria. The MSF team discussed its results with government officials and strongly recommended the switch to the more effective treatment.

Between August 2003 and October 2004, a cholera epidemic spread along hundreds of kilometers near the river Niger. More than 4,200 cases were reported, and 324 people died. By sending mobile teams to treat victims and pre-positioning equipment and medicines in at-risk zones, MSF helped to curb the epidemic.

In the northern town of Gao, MSF helps to manage the Sahel Formation nursing school and provides technical support to its teachers. The school prepares health staff including nurses and midwives for Mali's three northern regions.

In 2004, in the district of Sélingué in the Sikasso region, MSF continued to work in four health areas that serve some 70,000 people. The organization assisted in the

management of health structures and helped to upgrade the quality of care. The success of this project led MSF to start a new project in the Bougouni district of the same region in May 2005.

From 1996 to 2004, MSF supported the management of health structures in the Gao region's desert district of Ansongo. At the end of 2004, MSF transferred these activities to a Malian association to promote local leadership in monitoring the delivery, quality and accessibility of health services in the region.

Since 2000, MSF has been conducting mobile surgery in central Mali's Mopti region to combat its high prevalence of eye illnesses. The team removes cataracts, corrects trichiasis (a condition in which the eyelashes grow inwards) and treats those with trachoma (a viral disease that can cause blindness). Having supported efforts to extend the cataract program to the Ségou region MSF handed these activities to local authorities at the end of July 2005.

MSF has worked in Mali since 1992.



Sudan

"Their lives are dangling by a thin thread
that is humanitarian aid."

– Dr. Nathalie Civet, MSF Head of Mission in Sudan,
addressing the UN Security Council "Arria Formula"
meeting on 27 July 2005

Bringing assistance to desperate civilians

After more than 20 years of civil war between the government of Sudan and southern rebels, a peace deal signed in January 2005 seemed to open the possibility of a brighter future for the Sudanese. Yet as government forces and rebels agreed to lay down their arms, fighting continued in the country's western region of Darfur.

Since early 2003, the Darfur conflict has cost thousands of lives and forced millions to flee while government-backed militias have carried out a campaign of terror against civilians (see opposite page). While the peace agreement has brought hope to the country's devastated south, a better future is far from guaranteed for most of the region's inhabitants. Chronic underdevelopment combined with continuing violence in Upper Nile state indicate that even if the new peace does hold, any real improvement in living conditions remains a distant hope.

In southern Sudan, an estimated six million people rely on food assistance, and illness is rampant. The main causes of disease and death are treatable endemic illnesses including malaria, tuberculosis (TB), kala azar and sleeping sickness. Despite the peace initiative, it is likely that humanitarian aid will continue to be needed in Sudan for some time due to recurrent medical emergencies (caused by both disease and malnutrition), sporadic fighting and a massive return of refugees to areas with little or no access to care. MSF works in hospitals, health centers and mobile clinics in both northern and southern Sudan to bring basic health care to those who most need it. MSF provides TB care in towns located in the provinces of Equatoria and Upper Nile.

MSF also cares for those who have kala azar (visceral leishmaniasis), a disease that is almost always lethal if untreated, and is spread by sand flies that live in the country's dense forest. Thousands of patients receive medical treatment for kala azar in Upper Nile province. A diagnostic lab in the town of Lokichokio, Kenya, allows MSF to monitor regional outbreaks of the disease, and staff members provide training, medicines and support to other groups treating kala azar patients. In June 2005, MSF's kala

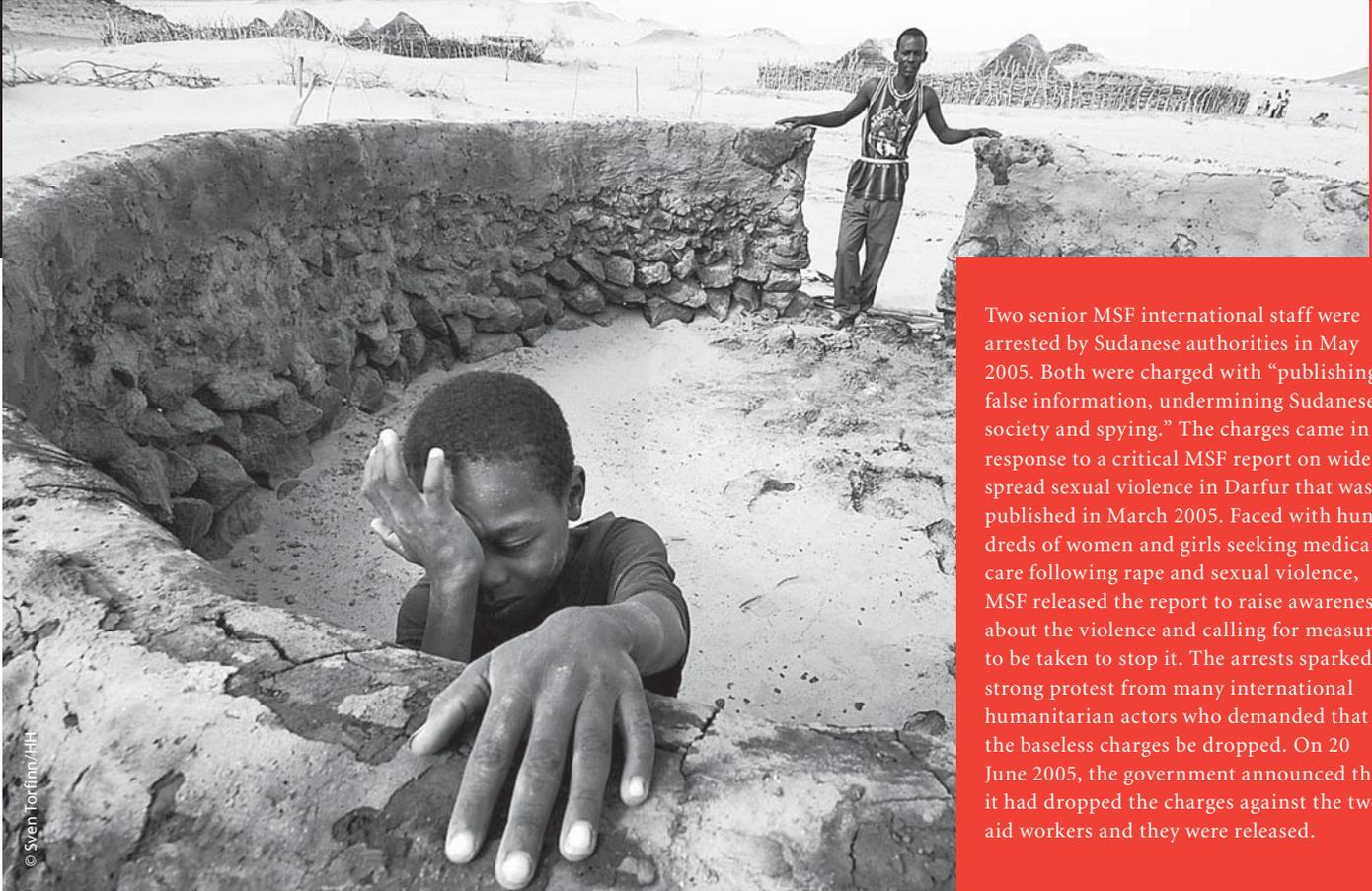
azar project in Um el Kher in the northern state of Gedaref closed after nine years. MSF had treated more than 29,000 patients and supported treatment in seven government-run clinics in the region that cared for several thousand additional patients. Sleeping sickness, a parasitic disease carried by tsetse flies, is another common cause of death in Sudan. MSF teams carry out community screenings and treat those with the disease in numerous towns in West Equatoria state. Staff screened more than 37,600 people in 2004, treating 757 in the same period. During the first half of 2005, more than 10,000 people were screened.

Teams also provide food and medical care in areas where malnutrition is rife. Currently, MSF runs a hospital and five feeding centers in the town of Marial Lou to treat people affected by malnutrition. In Upper Nile state, during the first half of 2005, more than 1,000 malnourished children – nearly three times the number for the corresponding periods in 2004 and 2003 – were admitted to 11 clinics in which MSF operates feeding programs. MSF responded in September 2005 to acute nutritional needs in South Bor county, located in Jonglei state, by providing support to local health centers and ambulatory care programs. In Aweil East county, located in northern Bahr el Ghazal state, in July 2005, MSF teams observed a significant increase in admissions to their nutritional centers in the town of Akuem. A nutritional survey conducted in late June 2005 showed that four percent of children were suffering from severe malnutrition and 26 percent from less severe malnutrition. MSF re-opened a therapeutic feeding center there and opened three additional mobile feeding centers. In addition, a team carried out two food distributions, each for 16,000 children under the age of five. A similar situation unfolded in July in Bahr

el Ghazal's Tonj district. At mid-year, more than 6,000 were estimated to be suffering from malnutrition and in need of emergency help. MSF distributed supplementary food rations to more than 5,000 children under five and their families in August 2005.

During 2005, MSF expanded its operations in some parts of Sudan. In March, a new project was opened in the Red Sea coastal city of Port Sudan, providing primary and secondary health care at the local hospital to people living in one of the city's shantytowns. In Kajo Keji, in the south, MSF began offering care to HIV-positive patients in January 2005. Treatment with life-extending antiretrovirals (ARVs) began in April, and soon 12 patients were receiving them. In Malakal, Upper Nile state, and in Um el Kher, Gedaref state, MSF provided voluntary counseling and testing as well as care for opportunistic infections for HIV patients co-infected with TB or kala azar. In addition, a new primary health care project began in April in the former garrison town of Pibor, Jonglei state. In early 2005, MSF was able to establish a permanent presence in the Upper Nile town of Nasir, which was previously cut off from all outside assistance.

In Wau county, Bahr el Ghazal state, MSF's primary health care center and four outpatient centers were handed over to health authorities and another nongovernmental organization in June 2005. Similarly, in the Walgak area of Jonglei state in Upper Nile province, MSF handed over five health care units and a kala azar clinic to another medical relief organization. And, after 10 years, MSF ended its project in the Nuba Mountains. Over the years, teams had provided basic health care, carried out measles-vaccination campaigns, responded to two outbreaks of West Nile virus, provided TB treatment, and distributed drugs. The organization also had undertaken considerable work to combat malaria, conducting a study on parasite resistance to malaria medications, introducing artemisinin-based combination therapy and distributing 25,000 bed nets. Because the impact of the disease was reduced and regional stability improved, the project was handed over to an indigenous nongovernmental organization.



© Sven Torfinn/HH

In northwest Darfur, a young boy cries within the burned remains of his house destroyed by Janjaweed fighters who attacked his village.

Two senior MSF international staff were arrested by Sudanese authorities in May 2005. Both were charged with “publishing false information, undermining Sudanese society and spying.” The charges came in response to a critical MSF report on widespread sexual violence in Darfur that was published in March 2005. Faced with hundreds of women and girls seeking medical care following rape and sexual violence, MSF released the report to raise awareness about the violence and calling for measures to be taken to stop it. The arrests sparked strong protest from many international humanitarian actors who demanded that the baseless charges be dropped. On 20 June 2005, the government announced that it had dropped the charges against the two aid workers and they were released.

Darfur: The crisis continues

Close to two years after the world began to notice the emergency unfolding in Sudan’s western region of Darfur, little has changed to improve the lives of the people there. Despite reassuring statements to the contrary, the situation is not stabilizing, and the need for humanitarian assistance continues to grow as the conflict goes on. Hundreds of thousands of people are still living in displacement camps, receiving just enough assistance to keep them alive. Not only do they struggle with physical ailments but many suffer from mental trauma related to both the violence that drove them to these camps and the uncertainty that keeps them there.

By mid-2005 more than two million people had been displaced by the ongoing violence plaguing the region. This number includes more than 200,000 people who have fled to neighboring Chad. However, last year’s scorched-earth campaign has been replaced by less overt, but equally devastating, forms of violence and intimidation against civilians, which still include sporadic fighting, beatings and sexual violence. In all locations where MSF provides medical care, teams continue to see a significant number of victims of direct violence. From January to May 2005, MSF staff treated more than

500 people for violence-related injuries and 278 women for rape. Rape and sexual violence remain pervasive, inflicted on women and girls who must venture beyond the borders of camps to find firewood, water and food for their families.

Although late to arrive, humanitarian assistance has increased significantly during the past year. Faced with high rates of diarrhea, respiratory infections, and malaria; appalling water and sanitation conditions in many areas; and outbreaks of meningitis and hepatitis, MSF has worked to provide medical care, nutritional help and safe water. Despite these improvements, the living conditions of the people in Darfur remain precarious. And while health indicators in some of the biggest camps and settlements have improved, aid has not reached some remote areas or parts of rebel-held territory.

Obstacles to giving aid

Security remains a limiting factor for the adequate provision of medical assistance in Darfur. Given the size of the region and the dispersed population, access is highly dependent on road transportation, which is sometimes interrupted by logistical problems and weather, but mostly by insecurity.

With hundreds of international staff and more than 4,000 national staff operating in 32 locations across the region in July 2005, MSF continues to make a priority of providing aid in Darfur. In the past year, teams throughout the region conducted more than a million medical consultations and treated more than 50,000 children suffering from malnutrition. MSF has also spoken out on a number of occasions, including before the UN Security Council, on what its teams have witnessed and called on other actors to provide more help to the region’s civilians.

For the majority of the displaced people with whom MSF teams have spoken, returning home now is not an option. Some have started to buy land or construct homes with more permanent materials. Many have found ways to earn money, and others, who have become accustomed to living near medical services and schools, now prefer to stay in a more urban environment. Some of those who do attempt to leave the camps face continued intimidation and direct violence, and many end up returning to refuges that pose similar dangers but offer security in numbers and the limited, daytime presence of humanitarian aid organizations.

Zambia

Providing AIDS care

An estimated 89,000 adults and children now die from AIDS each year in Zambia, a country of nine million people. More than sixteen percent of adults are estimated to be HIV-positive, with much higher prevalence rates in some areas.

MSF is working in Kapiri, a town in Central province, approximately 200 kilometers north of the capital, Lusaka, where the rate of HIV among people aged 15 to 49 is estimated to be 37 percent. From a rehabilitated clinic near the rural hospital of Kapiri town, MSF cares for more than 1,250 patients living with HIV/AIDS. In collaboration with the Zambian Red Cross, MSF also offers high-energy food to those patients who need it. As of March 2005, approximately 50 new patients each month have started life-extending antiretroviral (ARV) treatment, for a total of 354 people currently receiving ARVs through MSF. In June 2005, MSF also began to provide voluntary counseling and HIV testing, treatment of opportunistic infections and laboratory services.

Since 2002, MSF has run an integrated HIV/AIDS care project in the Nchelenge district of Luapula province in northeastern Zambia. This program includes voluntary counseling and testing, follow-up counseling, care and treatment of opportunistic infections, nutritional support, home-based care and treatment with ARVs. By the end of July 2005, 330 patients were receiving ARVs, with approximately 40 new patients entering the program each month. MSF aims to treat 500 to 600 people with ARVs in Nchelenge by the end of 2005. MSF staff also run a program to prevent mother-to-child transmission of HIV in Nchelenge, in which 45 women are participating. The MSF team also facilitates support groups for patients and their loved ones, and carries out awareness-raising activities in communities using local counselors and educators.

MSF has worked in Zambia since 1999.

Zimbabwe

Helping those evicted from their homes

During the last few years, Zimbabwe has been the scene of ongoing crises. The country's health care system is now on the verge of total collapse. Many civilians have no way to get needed health care, and the system is unable to respond to emergency situations such as growing malnutrition and epidemics. HIV/AIDS continues to be a huge health disaster in the country, with about a quarter of the population (two million people) already living with the virus.

From May to July 2005, the Zimbabwean government's campaign Operation Restore Order demolished illegal settlements and marketplaces in major urban areas, leaving approximately 700,000 people homeless, according to UN estimates. After their houses were destroyed, civilians had no choice but to move in with family and friends, relocate to rural areas or sleep in crude shelters. Others moved to government-run transit camps for the displaced, which offered little or no support or amenities. In July 2005, the government began closing down these camps in an effort to force the inhabitants to rural areas.

Prior to the camps' closure, poor living conditions within the camps had led MSF, already active in the country, to begin operations in the camps and destroyed neighborhoods. In June 2005, in the capital, Harare, MSF cooperated with Unicef to improve the water supply in Caledonia Farms, a displaced-persons camp housing approximately 5,000 people. MSF also worked in parts of Harare that were severely affected by the demolitions as well as in

the nearby town of Chitungweza, providing medical care and relief items, such as blankets and shelter material. MSF also used mobile clinics to bring medical care to this population. In the southern city of Bulawayo, MSF ran mobile clinics inside a number of churches where the city's displaced had gathered, offering health care as well as water and sanitation.

In eastern Manicaland province, in Mutare's Sakubva suburb, located 250 kilometers southeast of Harare, where MSF runs an HIV/AIDS project, the organization is incorporating some of the affected evicted people into its support groups for those living with the virus and is also donating medicines to the local clinic. MSF is also working in hospitals in Murambinda and Buhera, and staff in these areas have traced HIV-positive patients who disrupted their antiretroviral (ARV) treatment when they were evicted in order to get them started again. A team has also carried out an assessment of the medical and nutritional needs of people living in the province and has visited the Tongogara camp to analyze needs in order to provide future assistance.

In the western province of Matabeleland North, MSF provides HIV/AIDS care to patients in Mpilo and UBH Hospitals and in the Tsholotsho district. By August 2005, 1,000 adults and 250 children were being treated with ARVs. The team plans to start providing care in decentralized clinics in Bulawayo to prevent mother-to-child transmission of the virus, treat people with HIV/AIDS and care for victims of sexual violence. In the first half of 2005, MSF received permission to start treating people with HIV/AIDS in collaboration with the ministry of health in the central Midlands province. Preparations are now underway to begin this program.

MSF has worked in Zimbabwe since 2000.



© Miguel Cuenca

Asia and the Caucasus



After the December 2004 tsunami, MSF staff brought urgently needed supplies to people living in remote villages along the coastline of Aceh in northern Sumatra province, Indonesia. On the return trip, injured and sick patients were transported to Banda Aceh for treatment.

© Francesco Zizola

Providing care in the tsunami's wake

MSF organizes emergency assistance after disaster strikes South Asia

On 26 December 2004, a powerful earthquake off the coast of Sumatra created an enormous tsunami that swept over parts of South Asia, killing more than 300,000 people and leaving behind unimaginable destruction and suffering. Hundreds of kilometers of coastline were destroyed. Houses, boats and infrastructure were washed away.

Two days later, MSF started, in conjunction with national efforts, to provide emergency assistance to individuals in need of medical care, food, clean water, shelter and other basic necessities. The majority of MSF's work was carried out in devastated communities in Indonesia and Sri Lanka, although staff also provided help to people in Thailand and India. Initial exploratory teams assessed the need for aid in Malaysia, Myanmar, Bangladesh and Somalia, but did not find any serious unmet medical needs.

"At nine in the morning I received a message from a former colleague in Bireuen on Aceh's east coast. Flooding everywhere, it said. Then I saw the first reports from other countries hit by the disaster and realized this was something very big. We put a team on standby, looked at emergency stock in our warehouse, started negotiating clearance with the authorities, and of course, had regular contact with the emergency desk in Brussels."

– Ibrahim Younis, member of MSF's emergency pool, who led the first team arriving in Aceh, Indonesia

Responding to a disaster

The first MSF team of eight people, including two doctors and three nurses, arrived in the hard-hit Indonesian regional capital of Banda Aceh on 28 December. They brought with them 3.5 metric tons of medical and relief materials. The team immediately set up a clinic and began assessments and relief operations in the city. Shortly thereafter, members of the team took to the air, renting helicopters to bypass washed-out roads to conduct assessments and deliver aid to isolated communities along the country's western and northeastern coasts.

"In my 12 years with MSF, I've never seen so much get done in so little time."

– Rémi Carrier, MSF logistical director

In the week following the tsunami, MSF staff brought in nearly 200 metric tons of additional medical, water/sanitation and relief materials. Cargo shipments continued to arrive. Soon more than 200 international volunteers and over 600 national staff including doctors, nurses, psychologists, logisticians, and water and sanitation experts were working in the area. Teams found many survivors suffering from injuries and wounds (many of them infected), respiratory tract infections, skin diseases and mental trauma. In various locations, MSF ran mobile clinics, performed surgery, conducted vaccination campaigns against measles and tetanus, distributed supplies, evacuated patients by helicopter, organized aid deliveries by boat and carried out counseling sessions. The organization also donated food, shelter and medical equipment. In a few weeks, MSF was supporting hospitals and distributing more household items including tents, kitchen kits and tools.

The exceptional nature of the situation required an exceptional response. As needed, teams organized small-scale boat-building, land clearing and house construction projects. By mid-2005, teams had conducted approximately 28,000 medical consultations.

The tsunami had washed away whole villages and towns. Thousands who were left homeless were encouraged to move to displacement camps. Maintaining water and sanitation facilities in these camps was crucial in the first few months after the tragedy, particularly during heavy rains. MSF staff trucked in clean water, built latrines and cleaned and disinfected wells. As people began to return to their villages in the months after the disaster, MSF slowly handed over the majority of its water and sanitation projects to other groups but continued to monitor the camps for disease outbreaks.

Focusing on trauma

Once emergency needs had been met, MSF closed many of its tsunami-related projects in the belief that it was not the organization's role to conduct the long-term development work and reconstruction work that would be required in many places. MSF has now reoriented most of its work to provide mental health care to those still haunted by the tsunami and its tragic consequences. In July 2005, 93 international staff and more than 650 national staff continued to work in affected areas of Indonesia and India. In some areas, MSF has been able to organize networks of local doctors to provide psychosocial support or has transferred responsibility for mental health activities to local organizations.

In addition to doing psychosocial work with tsunami survivors, MSF started providing basic health care to some isolated communities in Aceh that have little or no access to quality medical care because of the region's long-standing conflict between government and opposition forces.

Overwhelming public support

"The solidarity has been exceptional and has allowed MSF to deploy teams in the worst-hit areas and provide care to survivors and displaced populations in Sri Lanka and Indonesia. At this point, however, we feel the need to be open and transparent with our donors and let them know that we have received sufficient support for our foreseen operations in Southeast Asia. Donors have given us money to be spent on the tsunami and we consider it an ethical responsibility from our side to tell them where and how we spend it. Now that we have received sufficient support for our foreseen operations, we have asked them if they would agree to continue to help us in other crises."

– Marine Buissonnière, MSF Secretary-General explaining MSF's decision to stop accepting funds for tsunami-related activities

In an extraordinary show of support, the public contributed 109 million euros in donations to MSF to provide emergency relief to people affected by the tsunami. By the end of August 2005 MSF had spent 20.9 million euros on tsunami-related operations. The organization expects that, by the end of 2005, it will have spent a total of 24.6 million euros for activities in the region affected by the tsunami. (For more financial details, see page 86-87.)

Within a week of the tsunami, MSF had deployed many teams on the ground and estimated that more than sufficient funds had been received to support its wide range of foreseen emergency activities. MSF decided that, in the interest of public transparency and honesty toward its donors, it would halt its call for donations for this particular crisis. MSF offices around the world began contacting individual donors requesting their permission to use their funds to support MSF's work in other emergencies and "forgotten" conflict areas such as the Democratic Republic of the Congo, Niger, Somalia and the Darfur region of Sudan. An overwhelming majority of donors have agreed to have their donation used elsewhere. This generosity has enabled MSF to support activities in forgotten areas that receive far less public and media attention but where humanitarian needs are staggering.

Helping to heal invisible wounds

"She was so tired of crying she just didn't know what to do," says MSF Indonesian psychologist Ferdy Fabian as she remembers Nur, a 52-year-old mother of 11 who came to see her at one of MSF's drop-in counseling centers in Aceh. "She had lost one of her daughters in the tsunami and simply wasn't able to get over it. In that first session with me, she just cried and cried."

"Nur came back saying she had stopped crying, and had finally accepted her daughter's death. She felt she was now ready to move on and was already feeling much better," says Ferdy. "I think simply coming here was the first step. She'd made up her mind she wanted to get over this. She just needed some help getting there."

Armenia

Treating mental illness and HIV/AIDS

In Armenia, MSF is treating people with sexually transmitted infections, including HIV/AIDS – all growing problems. Medical teams are also working to increase access to care for refugees now in the country and improve the quality of mental health care.

In the Shirak region of northwestern Armenia, an MSF team is working to reduce the spread of HIV/AIDS and other sexually transmitted infections. Since the beginning of the project in March 2005, more than 300 patients have been treated by MSF staff in a clinic in the town of Giumri. MSF has also provided the town's blood transfusion center with diagnostic and laboratory material. The team also offers counseling, a confidential telephone line and individual and group education sessions. MSF trains local health staff on topics related to the clinic's work and provides monthly deliveries of drugs and laboratory and medical equipment. MSF has also opened primary health centers in poor, rural areas which offer free care.

In northeastern Armenia's Vanadzor city and its surroundings, MSF runs another HIV-prevention project. Safe sex practices are promoted among the general population and among at-risk groups such as commercial sex workers, truck drivers and adolescents. MSF is implementing the project with a national partner.

MSF provides outpatient psychiatric, psychological and social support to people with mental illness in eastern Armenia's Gegharkunik province. The priority is to improve the way mentally ill outpatients are cared for, reduce their hospitalization rate and minimize their social isolation. In 2004 MSF began working in the regions of Vardenis and Tshambarak, home to many Azerbaijani refugees who fled their country after the 1991-1994 war. MSF helps this population, which has little or no access to health care, by renovating existing health structures and providing equipment, material and medicines.

In the second half of 2005, MSF plans to open a project in the Malatia-Sebastia and Shengavit districts of Yerevan, the capital, to better detect, diagnose and treat people living with both non-resistant TB and harder-to-treat, drug-resistant strains of the disease.

MSF has worked in Armenia since 1988.

Georgia

© Maria Steen/MOMENT

A 14-year-old refugee from Abkhazia, now living in Georgia, da

Caring for TB patients and the vulnerable

Wars with the secessionist republics of South Ossetia and Abkhazia and the dismantling of the Soviet Union have left Georgia close to economic and social collapse. Its public health system is in shambles, and the basic health needs of thousands of vulnerable, disabled and elderly people remain uncovered.

Tuberculosis (TB) is one of the area's leading causes of illness and death. MSF suspects that many people with TB in this area suffer from harder-to-treat multidrug-resistant (MDR) strains of the disease.

MSF runs both TB and MDR-TB programs in the separatist republic of Abkhazia. During 2004, the team increased its admissions to an average of 19 patients a month in the regular TB program and three patients a month in the MDR-TB program. In 2004, MSF changed its TB treatment so that patients could leave the hospital earlier and finish their drug treatment as outpatients at various clinics throughout Abkhazia. At Abkhazia's Dandra prison, MSF is also treating prisoners with TB and by mid-2005, 10 patients were receiving care.

The team supports 11 dispensaries as well as the surgery and cardiology departments in the city hospital in Sukhumi, while an MSF mobile clinic helps reach bed-ridden patients. In 2004, an average of 2,700 med-



© Tim Dirven

Children at MSF's psychiatric day center in Gavar.



INTERNATIONAL STAFF 6
NATIONAL STAFF 41

Turkmenistan

Improving the quality of children's health care

Since gaining independence in 1991, Turkmenistan's people have grown increasingly poor. In April 2004, MSF began providing health care for children in the municipal hospital of the eastern city of Magdanly after an assessment showed unacceptably high rates of illness and death among children. By January 2005, MSF was working in the hospital's three pediatric wards (general, infectious disease and intensive care) and caring for neonates in the maternity ward. The predominant conditions for which MSF treats children are diarrhea and respiratory infections. MSF provides these wards with medical staffing support, medicines, medical tools and equipment. Since early 2005, the central laboratory has received intensive MSF technical support and training which has resulted in significantly improved diagnostic services.

To improve and maintain hygienic conditions, MSF has made clean water and sanitation facilities available in three of the four supported wards, and plans to do the same for the remaining MSF-supported facilities shortly. MSF has also supported significant improvements to the management of medical waste, for which a waste compound was constructed at the hospital in May 2005.

MSF recently expanded its primary care work by joining family doctors and nurses in their work at the Magdanly city polyclinic. Since July 2005, in cooperation with the poly-clinic team, MSF runs a child screening room where MSF staff perform triage with children before giving possible treatment. MSF also started supporting three "health houses," which operate like outpatient clinics. In addition, MSF volunteers train local health professionals, including general practitioners, to help them make better diagnoses and improve their treatment of children. The training program hopes to set an example of appropriate and high-quality care for children throughout the country.

MSF has worked in Turkmenistan since 1999.

INTERNATIONAL STAFF 13
NATIONAL STAFF 130

Uzbekistan

Helping patients with resistant TB

In Uzbekistan's Karakalpakstan region, near the shrunken Aral Sea, the harsh environment and lack of health care services have caused severe health problems. While tuberculosis (TB) has long been a scourge, irrational medicine use and long treatment regimes have increased the number of people now resistant to the drugs used for first-line treatment. Today, Karakalpakstan's 1.5 million residents have one of the highest incidences of multidrug-resistant TB (MDR-TB) in the world. Currently, 13 percent of all new TB patients and 40 percent of those needing treatment again suffer from multidrug-resistant TB strains.

MSF works in the city of Nukus to treat people living with MDR-TB. The treatment is demanding. To kill the bacilli that cause the disease, patients must take medicines that can have serious side effects, for 18 to 24 months. The long regimen is difficult to follow fully for many patients, especially those who move often, are homeless or are the main providers for their families.

Through this project, MSF is seeking to demonstrate that non-wealthy countries such as Uzbekistan can conduct complex treatment programs. In cooperation with the ministry of health, MSF runs the 60-bed TB Hospital #2, which was established to treat patients in the first phase of MDR-TB. During the early phase, patients are at their most infectious and require intensive inpatient treatment. MSF and the ministry also work together in a number of specialized medical clinics that treat patients in the second treatment phase. In this later phase, patients can be treated on an outpatient basis, with careful monitoring. To prepare the hospital to facilitate their care, MSF rebuilt its outpatient polyclinics and a specialized laboratory. The team has also trained hospital personnel. In 2004, approximately 100 patients were under treatment through this program. In May 2005, after 18 months of treatment, the first two patients were declared cured.

MSF has worked in Uzbekistan since 1997.



...gia, dances for family and friends in Tbilisi.

ical consultations were conducted and 40 surgeries carried out each month at the hospital. This is a 35 percent increase from 2003.

In the Georgian capital, Tbilisi, MSF operates a medical clinic, dispensary and a mobile team. Together, they carry out an average of 790 consultations per month for people living in the district of Varketeli-Tazisubani. More than half of those identified as medically vulnerable are being cared for through this program, among them elderly people, orphans, pregnant women and isolated mothers without income. MSF is now advocating for local authorities to assume responsibility for this vulnerable population and hopes to hand over the program to the government by the end of 2005.

In addition, MSF supports the surgical department of the district hospital in Akhmeta. The number of operations performed there doubled in 2004, reaching almost 30 a month. The program helps some of the 2,000 Chechen refugees living in Georgia's Pankisi Valley as well as the local population of approximately 40,000 people. At the hospital, MSF is working to improve medical practices, waste-disposal systems and hygiene. In early 2005, the team also began working in the hospital's gynecology and obstetrics department.

MSF continues to support the Douisi surgical post in the Pankisi Valley where a local surgeon handles minor surgeries and medical emergencies. An average of 100 consultations and 40 minor surgeries are performed each month.

MSF has worked in Georgia since 1993.



Pakistan

Providing medical aid during tense times

The recent war and continued fighting in Afghanistan have had large consequences for neighboring Pakistan and for MSF's work there. The murder of five MSF staff in Afghanistan in June 2004 forced the Pakistan-based team to decrease its activities due to security concerns. This reduction of aid comes at a time when many Pakistanis lack health care and many Afghan refugees are trying to survive in border camps.

MSF works in the Mohammad Kheil refugee camp, home to approximately 16,500 Afghans, located in the tribal areas of Balochistan near Afghanistan. Thousands of refugees reluctantly left the camp in September 2004 when the UN ended its assistance in an effort to force the refugees to repatriate. To ensure that those refugees who have not returned to Afghanistan out of fear for their safety will continue to receive needed health care, MSF transformed its basic health unit in the camp into a centralized clinic that provides health care services 24-hours-a-day to camp inhabitants as well as local residents. MSF also opened a laboratory to support its medical work in March 2005.

In Kurram Agency, a remote region in the northwestern part of the country, MSF staff work in the pediatric ward of Shasho Hospital. Both inpatient and outpatient consultations are conducted for the local and Afghan refugee populations. MSF is assessing ways to address the health needs of women in the area.

After three years of providing humanitarian assistance in a refugee camp in the Pakistan-Afghanistan border town of Chaman, MSF ended its work there in October 2004. The camp's population had decreased rapidly since the Pakistani government and the UN ended their support of the camp in an attempt to encourage residents to repatriate or move to other locations in Pakistan. MSF had worked in the camp since 2001, providing medical care, supplying clean drinking water, and building sanitary facilities for those who had fled war or drought in Afghanistan.

In the contested Kashmir region, fighting between Indian and Pakistani forces has destroyed the area's health care system. Basic health care is provided by the military hospital in Leepa Valley, but women there suffer from a lack of maternal care, predominantly due to the lack of female hospital staff. MSF plans to start a maternal health project in the Leepa Valley during the second part of 2005.

MSF has worked in Pakistan since 2000.

Islamic Republic of Iran

Helping earthquake survivors and refugees

In February 2005, a powerful earthquake centered in south-eastern Iran killed more than 500 people and injured 900 others. The snowy, cold weather of the mountainous Zarand region exacerbated the difficult conditions that faced survivors. MSF sent medical support and material to those hardest hit by the disaster, which ultimately affected more than 30,000 people.

In collaboration with Iranian authorities, an MSF team worked in the health center in the mountain village of Hotkan, home to more than 100 families. Located near the epicenter, Hotkan was almost completely destroyed by the quake. MSF carried out medical consultations and distributed needed supplies including blankets and hygiene kits. The team aided approximately 3,000 people living in this and other villages.

In the month following the quake, MSF set up mobile clinics to carry out medical consultations in the most affected villages. The organization brought in two tons of medicines, and medical and logistical supplies from Tehran, Mashad and Zahedan, where MSF runs medical programs for Afghan refugees. Following the Bam, Iran earthquake of December 2003, MSF had stocked these materials at these sites for quick access in response to future emergencies.

Iran has for decades received large numbers of Kurdish, Iraqi and Afghan refugees. Since the war in Afghanistan ended and a provisional government, with access to international aid, was established, Iran is now pressuring Afghan refugees to return home.

Many Afghans in Iran today, who fled from wars over the last 20 years, do not want to be repatriated immediately. A lack of ade-



INTERNATIONAL STAFF 5
 NATIONAL STAFF 94
 (until November 2004)

of Iran

Iraq

quate security, economic opportunities, health care, education and equal repatriation of aid are all reasons not to return. Although the refugees suffer increasing exclusion and impoverishment in the host country, many prefer to stay.

This resistance to leave has been met with increasingly strong repatriation efforts since 2002. Since then, more than one million Afghans officially have returned to Afghanistan, according to UN estimates. Almost one million more remain registered in Iran, and approximately 300,000 more live there without legal status. Facilitating access to care for Afghans remaining in Iraq is MSF's main activity in the country.

In Mashad, a city near the Afghan border in Khorasan province, a team provides free medical consultations to the most vulnerable Afghans, including pregnant women, and facilitates referrals to high-level care. More than 28,000 consultations were conducted by MSF staff in the first half of 2005. Mobile-clinic teams conduct approximately 1,200 additional consultations per month. MSF also provides food and other aid to more than 150 destitute families in the area. Through MSF's home-visit network, trained volunteers visit approximately 800 families each month to provide needed assistance or direct them to other care.

In the economically deprived city of Zahedan in Sistan-va-Baluchestan province near the borders with Afghanistan and Pakistan, MSF carries out medical and nursing consultations and mobile clinics. Mobile teams conduct approximately 400 consultations a month, and staff provide more than 500 consultations each week at the Niatak refugee camp.

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



MSF leaves Iraq

"It has become shockingly clear that the work of humanitarian organizations is not being respected by certain insurgent groups, and that humanitarian agency staff are by no means immune to kidnappings and brutality.... The level of risk for humanitarian aid workers is now simply unacceptable. It would be irresponsible for us to ask any of our staff to continue working in these conditions."

– MSF statement on leaving Iraq, 4 November 2004

The continuing violence rocking Iraq – sometimes directly targeted at humanitarian aid workers – forced MSF to close its projects there in early November 2004. Given the considerable needs of the Iraqi people, this decision was made with a great deal of regret. However, MSF considers it irresponsible to expose its staff to serious risks that now come with being associated with an international humanitarian organization working in Iraq.

During the project's nearly two years of activity, MSF teams worked in various parts of the country. MSF supported Baghdad's Al Thawra Hospital as well as three health clinics located in the Sadr City slum, in which it provided approximately 100,000 medical consultations. When fighting broke out in early August 2004 in Sadr City, MSF assisted dozens of wounded civilians.

MSF staff at the three clinics provided emergency care while two ambulances transported severely injured people to hospitals in Baghdad. Meanwhile teams assessed medical needs in the cities of Fallujah, Najaf and Kerbala, which endured heavy fighting, and supplied needed materials to health workers there. Shelter material was also distributed to some 15,000 displaced people who had fled fighting in Fallujah and settled in the town of Al Habanniyah.

MSF worked in Iraq from December 2002 until November 2004.



Bangladesh

Assisting people in neglected areas

MSF offers medical care in three parts of the southern Chittagong Hill Tracts region of Bangladesh where health care is almost nonexistent. The region's indigenous inhabitants have faced discrimination and marginalization for years due to conflict and forced displacement. Today MSF is one of the few nongovernmental organizations offering help in this part of the country near the border with Myanmar and India.

People living in the region face high rates of illness and death caused by malaria. MSF's research on malaria-treatment regimes – which demonstrated parasite resistance to the traditional chloroquine-based therapy – has led to changes in the national treatment protocol. Efforts by MSF and others to introduce highly effective artemisinin-based combination therapy (ACT) as the first-line treatment for *P. falciparum* malaria in Bangladesh were successful, and the Bangladeshi government agreed to the change in November 2004. Malaria treatment is given through a wide network of clinics and malaria-treatment sites located in the northern part of Khagrachari district, nearby Rangamati district and the southern Bandarban district.

MSF also brings mobile clinics to remote villages to provide urgently needed basic health care. Often teams must enter areas on foot or by boat because roads are inadequate or nonexistent. Using games and drama, MSF's outreach workers also raise awareness about the care available at the clinics and teach villagers about malaria prevention, prenatal care and basic hygiene.

Flood relief

MSF supported mobile clinics in the districts of Sirajganj and Tangail and in the capital, Dhaka, when floods hit the region during July and August 2004. More than 30 million people were affected by the floods.

MSF has worked in Bangladesh since 1985.

Cambodia

Focusing on HIV/AIDS care

MSF's activities in Cambodia focus on treating people with HIV/AIDS, tuberculosis (TB) and malaria. An estimated 130,000 people are living with HIV/AIDS in Cambodia. MSF is providing life-extending antiretroviral (ARV) treatment to some 5,400 of the 25,000 people who need it. That is more than half of all the people in Cambodia now receiving ARV treatment.

MSF is active in the infectious disease ward of Preah Bat Norodom Sihanouk Hospital in the capital city, Phnom Penh. MSF staff treat patients with ARVs; diagnose and care for opportunistic infections; and train social workers and family caregivers to reduce their risk of HIV exposure, improve the quality of care provided and increase treatment compliance. By mid-2005, 2,064 adults and 110 children were receiving ARVs at this hospital, and MSF staff were conducting an average of 2,170 HIV consultations each month. Even more commonly, MSF treats patients with TB in the hospital's infectious disease ward. Many of the organization's patients are infected with both HIV and TB.

A similar project is operated by an MSF team in Kampong Cham province at the provincial hospital and through home-based care. MSF staff members in this province conduct an average of 1,370 consultations per month, and by the second half of 2005, 920 adults and 100 children had started ARV treatment. Throughout 2005, MSF's goal has been to add 65 patients per month to its ARV-treatment program.

In the past, MSF cooperated with other organizations in Sotnikum operational district, located in Siem Reap province, a poor rural area in the northwest of Cambodia, to implement a program to improve the quality of health services. MSF transferred this project to partners in October 2004 so that it could focus exclusively on improving the quality of medical care in Sotnikum. MSF has run a chronic diseases clinic there since September 2003 and started a community TB-care project in October 2004. As of mid-2005, MSF was caring for 321 people with HIV/AIDS in Sotnikum, of whom 210 were receiving ARVs.

MSF also runs a chronic diseases clinic in Siem Reap Provincial Hospital. As of mid-2005, 881 adults and 180 children were receiving ARVs through the MSF clinic in Siem Reap and more than 2,500 people with HIV/AIDS were under the care of MSF. In March 2003, MSF opened another chronic disease clinic in Takeo province. By June 2005, more than 1,500 adults and 192 children were getting comprehensive care in Takao, including 923 adults and 86 children receiving ARV treatment.

MSF is also caring for those with malaria in Cambodia. In the western municipality of Pailin, close to the Thai border, several village malaria volunteers and mobile teams travel among 60 villages, reference hospitals and health centers. Malaria is the main health problem in this isolated area, where resistance to the drugs traditionally used to treat the illness have rendered it even more deadly. The MSF team is working to bring early malaria diagnosis techniques and essential new medicines to Cambodia.

MSF supports school hostages

Masked gunmen stormed into a school in the town of Siem Reap in June 2005, taking hostage 29 kindergarten pupils, many of them the children of foreign workers. A few hours later, Cambodian police freed the hostages by force, killing one child and two of the kidnapers in the process. MSF supported the local hospital by providing blood to the blood bank and identifying psychologists in Phnom Penh who could give trauma counseling to the affected families and school staff.

MSF has worked in Cambodia since 1989.

China

Expanding AIDS care
and helping flood victims

In China, an estimated 840,000 people are living with HIV/AIDS, although the actual number could be higher because only a small percentage of them have actually been tested and diagnosed as HIV-positive. Access to HIV/AIDS care is difficult for many due to China's market-oriented, fee-for-service approach to health care as well as ignorance, stigma and political sensitivity related to the disease. MSF provides care to HIV-positive individuals as well as emergency medical services for other vulnerable populations in China, including street children and flood survivors.

In early 2003, MSF began a comprehensive HIV/AIDS-treatment project in the city of Xiangfan in Hubei province. An estimated 45,000 people in this part of central China were infected with HIV through selling blood to illegal blood banks in the 1990s. At Xiangfan clinic MSF provides HIV-positive people with voluntary counseling and testing, care for opportunistic infections such as tuberculosis (TB), and treatment with life-extending antiretroviral (ARV) medicines. MSF is working closely with the Xiangfan Center for Disease Control to establish a model of care that can be replicated in other parts of China. As of July 2005, more than 300 patients were receiving care through the MSF clinic, and more than 90 of them were getting ARVs.

MSF is working to reduce stigma in the community and to improve support for HIV-positive people through the use of peer educators, support groups and community meetings. MSF staff are also helping to improve care for HIV/AIDS patients at area hospitals.

MSF also runs an HIV/AIDS project in the southern city of Nanning in Guangxi province. In operation since December 2003, the project had enrolled more than 400 patients, including 210 receiving ARVs, by August 2005. MSF offers comprehensive care including counseling, ARV treatment, care for opportunistic infections and specialized care for HIV-positive pregnant

women and children. The MSF team is working actively with city and provincial health authorities to improve methods of diagnosis, treatment and management of HIV and related opportunistic infections. In conjunction with its HIV/AIDS projects in China, MSF is trying to remove barriers and improve access to essential medicines through advocacy and analysis. Despite China's policy of providing free ARVs to rural and poor urban populations, access to certain drugs remains problematic. One impediment is that intellectual property laws block the use of three-in-one ARV fixed-dose combinations (FDCs) which MSF uses widely in other countries. These combination pills are among the main tools used in AIDS programs to simplify treatment, improve adherence and reduce the risk of resistance. Access to FDCs for treatment of TB is also difficult, so patients co-infected with TB and HIV can be faced with a large number of pills that must be taken at specific times every day. Moreover, most pediatric formulations of ARVs are not yet available. Difficulty in obtaining the right tools for treatment makes it harder to provide patients with an acceptable quality of care. An MSF team consisting of a pharmacist, government-relations liaison and a Chinese staff member works full-time to document and conduct advocacy about these issues.

Since March 2001, MSF has run a crisis center and shelter for children in Baoji,

Shaanxi province, in collaboration with Chinese authorities. Some 20-30 children stay in the center at a time. Most of the youngsters have come to the center off the streets, where they collected plastic bottles for money and begged to survive. Abandoned by their families, sold into forced labor or left at a busy railway station, these children have been physically and psychologically abused or neglected. They arrive in need of psychological care and support, as well as food, shelter and medical care. After four years of operating the project, MSF has reached its program objectives. For example, authorities have altered laws that persecuted street children and are more aware of their problems. MSF will transfer responsibility for the project to another nongovernmental organization in January 2006.

In July 2005, MSF responded to flooding in the southern provinces of Guangxi and Guangdong, along the South China Sea. After a quick evaluation, the team found that most medical needs had been covered but that the local population desperately needed housing and emergency supplies. MSF staff distributed hygiene kits, cooking utensils, building supplies, plastic sheeting, clothing and blankets to more than 1,240 families.

MSF has worked in China since 1988.



An MSF doctor examines a child living with HIV/AIDS.

Asia

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India

Bringing medical care

In India, MSF is providing medical assistance to people who have limited access to health services due to conflict, displacement or natural disaster.

Providing care in conflict areas

In the state of Jammu and Kashmir, on the border with Pakistan, the ongoing conflict between India and Pakistan has left many civilians suffering from mental health conditions related to their experiences with insecurity and violence. In addition, many people living in remote areas lack access to any medical care. MSF offers psychosocial support and counseling to individuals and families suffering from the conflict. Teams are also rehabilitating the infrastructure of hospitals and primary health care centers in some of the area's more remote villages.

Conflict also affects those living in the northeastern state of Manipur, bordering Myanmar. A combination of lawlessness, conflict and poverty has meant that most of the state's residents have minimal access to basic health services. Drug abuse is widespread and Manipur state has one of the country's highest HIV-prevalence rates. Although the Indian government limits access to Manipur for foreign citizens, MSF obtained permission in 2004 to work in the hilly Churachandpur district in the southwest corner of Manipur. The organization began with a project that treats people with malaria. In 2005, the team expanded its work to treat those with sexually transmitted and other infectious diseases, such as HIV/AIDS and tuberculosis (TB).

In neighboring Assam state, conflict between indigenous groups and minority, immigrant populations has resulted in the displacement of thousands. Lack of access to health care and ineffective malaria treatment have led to high death rates in the state. MSF provides basic health care to populations displaced by conflict and living in makeshift camps, as well as residents in remote communities.

For the past six years, MSF has supported India's TB program in the city of Bombay, in Maharashtra state. In addition to building laboratory capacity and developing a reference network among health partners, MSF

has conducted outreach and education on TB to vulnerable urban populations. Currently, MSF is working closely with local authorities and an association of HIV-positive people to begin an HIV/AIDS treatment project.

Responding to natural disasters

When a devastating tsunami hit South Asia on 26 December 2004, MSF responded immediately, mobilizing staff already on the ground. While emergency medical needs in India were adequately met by the government and local communities, the disaster resulted in widespread psychological trauma that called for additional resources. MSF offered psychological support in the southern coastal districts of Cuddalore and Nagappattinam, training community volunteers to be counselors and psychosocial assistants. In southern India's Tamil Nadu, across the strait from Sri Lanka, MSF trained medical students to identify and refer those tsunami survivors in need of medical or psychological assistance. In July 2005, MSF handed over its training work to a local group but will continue to monitor and support the project in Tamil Nadu until the end of 2005.

In July 2005, flooding in Bombay killed an estimated 1,000 people, destroying 10,000 homes and displacing more than 200,000 people. In the city's Kurla slum, MSF provided emergency medical care and tested water to make sure that it was safe to drink. MSF staff saw more than 300 patients on the first day of consultations.

MSF has worked in India since 1999.

The Philippines

MSF ends work with street children

MSF started working in The Philippines following a typhoon in 1984 and continued to provide assistance to people affected by natural disasters during the mid-1980s and '90s. From 1987 to January 2005, the organization worked there steadily, developing programs to assist the most vulnerable particularly children and adolescents living on the streets of the capital, Manila.

The program for street children in Manila operated in the city's District 5 and targeted 200 of the district's estimated 2,200 street children. MSF provided medical and psychological care, particularly to young people who worked in the country's large commercial sex industry, and helped children suffering from sexual, physical or psychological abuse. In addition, the team helped street children gain access to health care and legal aid. In January 2005, MSF handed over the project to other organizations working specifically with the country's street children.

MSF worked in The Philippines in August 1984 and from 1987 to January 2005.

Myanmar



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A young boy is tested for malaria. During 2004, MSF screened more than 350,000 people in Myanmar for the disease and treated more than 175,000 suffering from it.

Helping the most vulnerable

MSF's activities in Myanmar target the most vulnerable groups in the country including those living with malaria, tuberculosis and sexually transmitted infections including HIV/AIDS.

Malaria is a concern throughout the country, and MSF has been involved with malaria-treatment programs in Myanmar for nearly a decade. MSF's studies on parasite resistance to malaria medications in this country contributed to the government's decision to change the national malaria-treatment protocol to artemisinin-based combination therapy (ACT).

MSF teams run malaria projects in Mon state, Kayin state, Rakhine state and Thanintharyi division, operating village malaria clinics that provide a variety of basic health care services and conducting mobile clinics in more difficult-to-reach areas. In some cases, the mobile clinics are run exclusively by national staff due to restrictions on travel by foreigners.

In Rakhine state in the western part of Myanmar, MSF provides basic health services to Rakhine Muslims (or Rohingya), a

vulnerable and poor group whose citizenship is disputed and whose movement is restricted. In this region, which has scarce health care services, MSF teams support a network of simple malaria diagnosis-and-treatment sites – many of them based within state health structures – and hold "mobile malaria days" to improve access to treatment. In 2004, MSF tested more than 350,000 people and treated more than 175,000 for malaria in Rakhine state.

MSF provides HIV/AIDS services in the country's capital, Yangon, and in Thanintharyi division, Kachin state, Shan state and Rakhine state. Activities include health education, condom promotion, outreach to high-risk and vulnerable populations, treatment for sexually transmitted infections and general health services, including antiretroviral (ARV) treatment and home-based clinical and palliative care. HIV-prevention efforts target groups engaging in

high-risk behavior, such as commercial sex workers and intravenous drug users. MSF began providing ARVs to its patients in 2003, and the next year, approximately 541 patients received this treatment.

MSF recently began a project in Kayah state on the Thai border. In this area, the local population suffers from the consequences of intermingled clashes between the army and its opponents. MSF teams aim to provide basic health care through two fixed clinics and two mobile clinics.

As part of its response to the tsunami of December 2004, MSF carried out needs assessments along the southern coast of Myanmar and found no urgent medical needs. MSF teams also traveled to the west coast of Thailand, where Burmese migrants work in six Thai provinces. In response to the poor health conditions facing this group, MSF plans to open a project to improve their access to health care.

MSF has worked in Myanmar since 1992.

Lao People's Democratic Republic

Advancing AIDS treatment
HIV/AIDS has been spreading slowly across the Lao People's Democratic Republic – better known as Laos – and proper care for those living with the disease has been just as slow to get underway. MSF's work in Laos targets HIV-positive people living in the province of Savannakhet, the country's most populous area.

Officially, the country has 1,400 people now living with the virus, but experts believe that the number could actually be twice as high. MSF's team works in the 170-bed district hospital, where, since June 2003, it has provided patients with life-extending antiretroviral (ARV) medicines and cared for those with opportunistic infections. The team also provides home-based care and conducts HIV-prevention efforts. By mid-2005, MSF had registered 353 patients into the program, and 223 of them were receiving ARVs. Approximately 20 new patients join the project each month. MSF's HIV project in Savannakhet Hospital is still the only place in the country where HIV/AIDS patients can receive free ARV treatment.

In addition to treating patients directly, MSF is hoping to demonstrate to its national partners both the potential for, and effectiveness of, using ARV treatment in cases of advanced AIDS. The team is now working to attract financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria in order to secure more sustainable access to ARVs through the national health system

MSF has worked in Laos since 1989.

Democratic People's Republic of Korea / South Korea

Aiding traumatized refugees

For years, hunger, persecution and abuse at the hands of the regime leading the Democratic People's Republic of Korea, better known as North Korea, have forced thousands of the country's citizens to flee and settle in other countries. In recent years, governments have attempted to close escape routes through Myanmar, Thailand, Laos, Mongolia and Russia and have dismantled many of the clandestine networks that had helped those fleeing North Korea.

Since 2003, when a crackdown made it almost impossible to cross China to reach a third country, some North Koreans have tried to enter foreign embassies and international schools to obtain asylum. However, reinforced security around these international institutions has made them more difficult to enter. As a result, fewer and fewer refugees manage to reach a country other than China, where they are considered illegal and hunted like criminals.

After years of assisting North Korean refugees in China and other countries, by providing shelter, clothes, food and medical assistance, MSF is now focusing its activities on providing psychological support to refugees who have reached South Korea, where some 6,500 North Korean refugees live, primarily in Seoul, the capital city.

An estimated 100,000 to 300,000 North Koreans are hiding in China. Some are waiting to find a way to escape to another country, but the majority are working to make enough money to survive at home. If they are discovered, they are arrested and imprisoned in North Korea, considered traitors to the country. MSF is now indirectly providing medical support to some of these refugees in China too.

Since 2003, MSF has assisted North Korean refugees upon their arrival in South Korea, helping them to overcome the recurrent trauma they faced under the violent regime and during their escape from it. In December 2004, an MSF team first gained access to the state-run transition center of Hanawon, where refugees are placed for three months after their arrival in South Korea. From January to August 2005, MSF

psychologists began therapy with 90 new patients. The stories the patients have told MSF staff reveal unimaginable suffering, the loss of loved ones, violence and fears of an unknown future. The team also intervenes in welfare centers in the capital and in a suburban town that is home to a community of North Koreans.

MSF worked in North Korea from 1995 to 1998 and has worked with North Korean refugees since 1998.

Indonesia

In the aftermath of disaster and conflict

Days after an enormous tsunami battered parts of Indonesia's coast, MSF teams began working in cooperation with national efforts to provide assistance to people in need of medical care, food, clean water, shelter and other basic necessities.

The extent of death and destruction in Indonesia was severe – more than 100,000 dead, 120,000 missing and several thousand injured. MSF teams quickly assessed emergency needs, provided medical care and responded to outbreaks of diseases such as tetanus, which was caused by wounds sustained when survivors waded through sharp debris.

MSF has a history of emergency work throughout the archipelago in conflicts, epidemics and natural disasters, and in a variety of provinces including Maluku, West Papua, West Timor and Sunda. This proximity enabled MSF to dispatch emergency teams to areas destroyed by the tsunami soon after the catastrophe. On 28 December, the first team arrived with 3.5 metric tons of relief supplies in Banda Aceh, the regional capital of Aceh province on Sumatra's northwest coast. The team immediately set up a medical clinic and began assessments and relief operations. Soon more MSF staff and materials poured into Indonesia, bolstered by unprecedented support from international donors. While the roads were still impassable, MSF teams traveled by helicopter to areas along the west and northeastern coasts, rapidly assessing needs, dropping emergency materials and mobile teams, and transporting the most seriously injured to hospitals.

Additional logistical support was provided by Greenpeace's flagship, the Rainbow Warrior, allowing MSF to reach isolated areas quickly. Nearly 200 metric tons of medical, water-and-sanitation and relief materials, as well as dozens of MSF doctors, nurses, psychologists, logisticians, and

water-and-sanitation experts arrived in Aceh the week following the tsunami. By the second week, MSF was also supporting two district hospitals in Aceh's devastated towns of Meulaboh and Sigli, and teams carried out assessments on Simeulue island and in the Banyak Archipelago, south of Aceh. When another undersea earthquake hit the island of Nias, located near Simeulue, on 28 March 2005, MSF teams distributed tents and relief items to the island's Tuhenberua district.

By March, the acute emergency phase had ended. Teams began focusing on rehabilitating health structures and addressing the basic health needs of affected communities. From the beginning of the disaster response, MSF psychologists had joined the emergency teams, counseling hundreds of patients, and now particular attention was given to communities' mental health needs. Educational sessions were also organized to help people understand the tsunami itself and the many possible physical and emotional reactions to it. Between February and April, MSF also distributed approximately 80 boats to fishermen in Sigli after the community requested assistance in obtaining boats to regain their livelihoods.

Current activities

In the second half of 2005, medical care has become more easily available in parts of Indonesia hit by the tsunami. MSF's effort to distribute emergency aid and to provide water and sanitation largely have been completed or handed over to partners. However, MSF continues to run mobile clinics in remote areas of Aceh, where access to medical care is severely limited due in part to the protracted con-

flict between rebels and the government, including inland areas in the Aceh Barat district, in the town of Takengon in Aceh Tengah district, and in nearby Bener Meriah district in the central mountains. Teams also provide care in the Mane and Tangse areas of Pidie district. MSF is treating people in villages and camps for displaced people in areas affected by the disaster including Lamno and around Sigli.

Mental health care is one of the greatest ongoing needs in Aceh. A team of psychologists travels to camps, relocation centers, villages and schools, offering a combination of psychosocial education, group discussions and individual counseling. Teachers and health staff receive ongoing training to recognize common symptoms of trauma. And MSF has set up mental health clinics in Banda Aceh and Sigli. In Aceh, more than 10,000 people affected by the tsunami have attended psychosocial and psycho-educational group sessions in Meulaboh and Lamno on the west coast, in Sigli and Lhokseumawe on the north coast and in Banda Aceh. MSF and local psychologists continue to offer treatment to hundreds of patients each month.

MSF also continues to monitor disease outbreaks and other emergencies in Indonesia. In May 2005, MSF responded to an outbreak of malaria in the Gorong Archipelago in the eastern part of Maluku province. MSF is also carrying out a malaria study in Indonesia to document the successful use of artemisinin-based combination therapy (ACT) in an effort to change national malaria treatment protocols.

MSF has worked in Indonesia since 1995.



An Indonesian psychologist leads a discussion group of tsunami survivors near the town of Meulaboh.

Japan

Caring for the homeless

As a result of the economic slump that followed Japan's economic growth in the 1990s, the number of Japanese homeless has increased dramatically in large cities. The city of Osaka has the largest homeless community in the country, officially estimated at 8,000. There is only one hospital that responds to the medical needs of this group, and the problem has grown beyond its capacity.

In August 2004, MSF attempted to open an outpatient dispensary in the Miyakojima ward of the city. This location was easily accessible to the homeless population living in Osaka's northern parks, riversides and transportation terminals. However, strong opposition from a part of the local community forced MSF to halt plans for the clinic. Instead, the team decided to start the project using mobile clinics that regularly visit various parts of the city.

A mobile-clinic team composed of a medical doctor, nurse, social worker and logistician-administrator, now visits four city parks, providing care to the approximately 1,000 homeless people who live nearby. The MSF team monitors some 130 regular visitors a month, providing basic medical consultations, prescribing medicines and referring those who need more help to other medical facilities or social agencies.

The majority of MSF's patients have chronic diseases such as hypertension, asthma, chronic back pain or gastritis, due to their older age, their limited diet or their harsh living environment. Only 20 to 30 percent of the patients have acute health problems related to exposure to the cold, wounds or severe pain.

While MSF waits to establish a fixed dispensary, consultations are carried out in a large van. The team also refers patients needing more sophisticated tests or longer-term care.

MSF has worked in Japan since October 2004.

Thailand

Assisting marginalized groups

Comprehensive care and treatment for people with HIV/AIDS has become a principal activity for MSF in Thailand, where more than one million people are estimated to be HIV-positive. MSF also assists marginalized groups such as refugees, migrant workers, and women and children who struggle with health problems and inadequate access to basic care in parts of the country.



This young HIV-positive boy must learn how to take his daily medicines--12 pills as well as drugs in powder form that must be mixed with water every morning.

In 2001, the Thai Ministry of Public Health committed itself to providing life-extending antiretroviral (ARV) medicines to 50,000 people living with HIV/AIDS by 2005. Treatment is being provided through more than 800 hospitals across the country. Working in tandem with government efforts to expand treatment, MSF is collaborating with patient groups and other non-governmental organizations to provide people with adequate knowledge to make informed decisions regarding treatment, to become partners in their own care and to help their peers adhere to treatment. MSF treats patients directly with ARVs in the capital, Bangkok, and in the provinces of Surin, Rayong, Nonthaburi, Petchburi and Kalacin. Depending on the location of the project, MSF offers home- and clinic-based care, treatment of opportunistic infections and technical support to district and provincial hospitals.

In June 2005, MSF was able to turn over to the national AIDS program a project that, by the end of 2004, was providing ARV treatment to 965 people, of whom 10 percent were children. Operating from two provincial hospitals and four district hospitals in the provinces of Surin and Mahasarakham, the project gradually turned its attention to training Thai health care providers to offer their HIV/AIDS patients high-quality care, including adherence counseling and tracing of those who discontinue treatment. Although MSF has successfully transferred all of its patients to the new national program, the organization will continue to provide drugs to the program in Surin until December 2006 if needed, as part of the handover.

Unmet needs

Thailand's HIV-prevention campaign is regarded by some members of the coun-

try's large Islamic community as insensitive to its religious and cultural beliefs. Therefore MSF is working with Islamic representatives to develop a culturally appropriate training curriculum on HIV/AIDS. Together with another organization, MSF has opened an office in Hat Yai, in southern Thailand, to look at the particular issues facing Muslim women with HIV/AIDS.

In spite of the government's commitment many groups such as HIV-positive prisoners continue to have limited access to treatment and care. During 2004, MSF started to provide ARVs in one small prison in Bangkok. A team now also visits Thailand's largest prison to give technical support for both HIV prevention and ARV treatment, with medicines provided by the government. The prison programs are carried out in partnership with two community-based organizations.

HIV-positive undocumented migrants and unregistered ethnic minority groups cannot obtain comprehensive care in Thailand. In Chiang Rai province, MSF gives technical support to two district hospitals, one of which treats 30 patients actually living in Myanmar who cross the border to receive treatment. MSF has begun to develop a support group for people living with HIV/AIDS in the town on the Myanmar side of the border.

Twenty years into the HIV/AIDS epidemic, HIV-prevalence rates among men who have sex with men in Thailand are now approximately 17 percent, and few prevention interventions that are effective for this population have emerged. MSF is working with others near Bangkok to develop a model combining HIV prevention and care for this population.

Helping refugees and migrants

Every year, thousands of migrant workers enter the country illegally to work in the agricultural, fishery or textile industries. They usually work for low wages, live in dire conditions and are excluded from social-welfare or health programs.

In Maesod, a town in Tak province near the border with Myanmar, MSF has expanded its tuberculosis (TB) program for undocumented migrants. Patients needing to be

hospitalized are brought to a "TB village," but most continue to work in agriculture or factories, and some cross the border daily from Myanmar. They are seen daily by MSF's TB treatment supervisors. By October 2004, more than 500 patients were taking part in the program. Seventy-five percent of the 500 patients admitted to the program in 2004 successfully completed their treatment. To help patients adhere to treatment, the team has boosted its counseling and patient-education program.

Until June 2005, MSF teams in Mae La refugee camp, near Maesod, provided basic health care for almost 40,000 refugees, mostly members of the Karen ethnic minority. Of the 300 people admitted to MSF's inpatient department each month, some 15 to 20 percent came from outside the camp. MSF also operated two outpatient health facilities in which staff conducted about 12,000 medical consultations a month, of which 10 percent came from outside the camp. The team also managed the camp's water supply.

MSF also handed its activities in Tham Hin camp in Ratchaburi province to another group in June 2005. MSF had provided health care, water and sanitation for 9,000 Karen refugees from Myanmar. The team conducted more than 2,000 health consultations per month at the outpatient clinic and admitted some 130 people to its inpatient ward each month. MSF also treated those with chronic diseases including TB, obstetrical problems and HIV/AIDS.

MSF is currently giving medical aid to 7,000 people of the Mon minority group who live near Sangklaburi on the Thailand-Myanmar border. MSF supports health structures in Myanmar's New Mon state by providing medical care and supplies. During 2004, the team supported activities in 10 clinics in Myanmar's districts of Halochanee, Beeree and Tavoy. However, MSF has had to withdraw the international staff who supervised these activities, due to increasing insecurity and communication problems. Malaria is the most common disease in all of these projects, although acute respiratory infections and diarrhea are significant threats.

Assistance to migrant workers

The labor provided by migrant workers, especially those from Myanmar, has been essential for redevelopment of the tourist and fishing industries in coastal provinces affected by the 2004 tsunami. MSF has established a project in Phang Nga province to help migrant workers receive health care and other needed services.

The tourist resort of Khao Lak, in Phang Nga province, was severely damaged by the tsunami, and tens of thousands of migrant workers are expected to help reconstruct it. MSF plans to assist the public health system in providing health care to migrant workers, to provide health education to migrant-worker communities, to set up a community-based system of mental and psychological support and to advocate for equitable access to health care for all migrant workers. Partners in this project include government district health departments and local nongovernmental organizations.

Maternal health in Yala province

Maternal mortality and the death rate of children under five in the three southern provinces of Yala, Pattani and Narathiwat are reported to be significantly higher than in other comparably poor provinces elsewhere in Thailand. This is a longstanding problem, but the situation is becoming more critical with growing civil unrest in the area.

People face increasing difficulty accessing services, particularly at the primary health care level, because both patients and staff fear the insecurity. There has been a reduction in the availability and quality of services, and many health center staff now work only during daylight hours and implement fewer community-outreach activities. In response, MSF recently established an office in Yala province to manage a project alongside local partners to increase women's and children's access to health care.

MSF has worked in Thailand since 1983.

Nepal

Civilians caught in conflict
Since 1996, Nepal has been embroiled in a conflict between the monarch-led government and Maoist guerrilla forces. More than 100,000 people have been displaced by the violence. Nepal is among the world's poorest countries, and as a result, health services are nonexistent in many places, leaving most people without basic health care.

In the mountainous western area of Rukum, MSF runs the district hospital, treating patients, supplying medicines and clean water and managing waste disposal and hygiene. Most of the 190,000 people populating this region live amid widespread poverty, illiteracy and the threat of violence. The small hospital is located in an enclave under government control, near areas controlled by Maoist forces. In 2004, the MSF team in Rukum carried out an average of 64 hospitalizations and 830 consultations per month.

MSF plans to expand its work outside of Rukum village later in 2005 in order to help those living in the surrounding area. Plans are also underway to send an MSF team into the region's mountains for three months to treat ill civilians while also assessing general needs. Many areas remain accessible only by foot. In addition, MSF has conducted an exploratory mission in the Terai Valley along the Indian border, an area inhabited by displaced people who have fled the conflict's violence.

In July 2005, MSF opened a primary health care project in the western region of Kalikot. This project, carried out in collaboration with the ministry of health, provides outpatient and inpatient treatment and emergency care.

MSF has worked in Nepal since 2002.

Sri Lanka

Helping rebuild lives after the tsunami

In late December 2004, MSF returned to Sri Lanka to provide emergency assistance to survivors of the tsunami that hit the coast, killing more than 30,000 people and displacing 500,000 more. After many years in the country, MSF had closed its last projects there less than a year earlier.

MSF teams arrived in the capital, Colombo, and found a fast international response already coordinating clean up and rebuilding efforts. Initial assessments revealed no large-scale medical emergency so MSF staff began to provide help to support local efforts and fill gaps in available medical care, with respiratory tract infections and diarrhea the most common problems. Within days, MSF had flown in more than 200 metric tons of supplies and dozens of international volunteers, including doctors, surgeons, nurses and logisticians. Assistance was mainly directed toward the most affected areas – Trincomalee, Batticaloa and Ampara – on the east coast.

In the first weeks after the disaster, MSF supported eight mobile clinics on the east coast, each one providing approximately 150 medical consultations a day. In the Ampara district, where the government estimated that more than 180,000 people had become homeless and where less assistance was arriving, MSF teams set up three temporary hospitals in Karaitivu, Nintavur and Marathamunai. The teams also supplied other health structures with needed medicines and medical equipment. In addition, MSF established an epidemiological surveillance system to watch for disease outbreaks.

MSF staff distributed mats, jerry cans, buckets, blankets and soap to 6,000 families living in camps or with relatives in 18 villages of the Ampara district. MSF also built 1,100 temporary shelters with water and sanitation facilities in the towns of Kalmunai, Pottuvil and Tirukkivil. MSF brought the Spanish organization Payasos Sin Fronteras (Clowns Without Borders) to perform for children affected by trauma in the displacement camps in which the organization was working. Performers put on 23 shows, attended by more than 7,500 people in camps and schools.

In the district of Batticaloa, MSF provided medical consultations and water and sanitation assistance. In the Trincomalee and Kuchchaveli region, MSF staff cleaned a new hospital that had been damaged by the tsunami and distributed hundreds of tents and non-food items to more than 3,000 displaced families. Farther north in Tiriya, MSF started a mobile clinic, provided tents and organized clean water and sanitation facilities. In several areas, water distribution had been severely damaged by the tsunami and wells were contaminated with salty water. For five months, MSF provided drinking water to an average of 20,000 people and organized water trucking and the cleaning and chlorinating of wells. In the far northeastern areas of Mullaitivu and Killinochi, MSF supported an area hospital and a clinic and brought in tons of relief goods.

Once urgent health needs were met, MSF reoriented its activities to support the most vulnerable people as they worked to rebuild their lives. In the northeast, MSF staff distributed fishing nets and tool kits and created furniture workshops and small brick factories. MSF rented machinery to clear land so that people could resettle. Near the southern tip of the country, in the Tangalla region, MSF began building semi-permanent houses at relocation sites for 180 families. MSF also started an outpatient clinic and set up shelters for local homeless families. In the southern town of Matara, an MSF team assisted more than 3,000 displaced people and started mobile medical clinics. An outpatient clinic was also opened in the nearby town of Hambantota.

In some areas, MSF worked with local medical staff to create a network of doctors to provide psychosocial support to those traumatized by the disaster and its aftermath. Similarly in Ampara and Killinochi, MSF provided psychosocial support in collaboration with a local nongovernmental organization that had been established by MSF national staff when MSF closed its projects in 2004.

In May 2005, MSF ended its activities in Sri Lanka.



The Americas

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A young girl gets a medical examination at MSF's health clinic in the Altos de Cazuc shantytown, near Colombia's capital, Bogotá. Internally displaced families arrive here every day in search of a better future. The clinic also has a dentist and psychologist to help new arrivals in need of other kinds of care.

Brazil



© Fabrizia Granatieri

MSF has worked with Rio's street population in an effort to improve their living conditions, increase their access to health care and social services and promote their inclusion in society.

Helping slum dwellers

Today one-third of Rio de Janeiro's inhabitants live in extreme poverty within slums, where there are few or no health care services available. To help remedy this problem, MSF runs a basic health center in Marcílio Dias, a slum area located in the northern part of the metropolis.

Marcílio Dias is generally regarded as one of the slums with the highest levels of social exclusion and violence. Many residents come into daily contact with violence whether between police and drug traffickers or within families, and women and children are particularly vulnerable. Residents also face high rates of drug and alcohol use and teenage pregnancy.

The MSF team provides medical and psychosocial consultations and medicines, and carries out educational activities to help prevent health problems. Each month, approximately 1,500 people consult the clinic's staff.

The team is composed of medical doctors, nurses, a psychologist, a social assistant, and an educator, as well as community health workers who live in the neighborhood and regularly visit families to spot problems and perform health-prevention and promotion activities. A women's community group provides psychosocial activities including group discussions with local women and youth that address such topics as domestic violence, teenage pregnancy and drug abuse. Dance, sports and handicraft activities led by community volunteers in the health unit have mobilized people to join discussion groups. MSF also supports the realization of citizenship and civil-rights workshops, community social

events and the growth of a local newspaper by area youth.

MSF will continue its work at the health center until the end of 2005. Afterward, the municipal health secretary will include Marcílio Dias in the city's family health program expansion plan. At that point, it will be handed over to local authorities and community organizations.

MSF's project that provided social, medical and psychological assistance to homeless people in the city's downtown district was closed in December 2004. Although exclusion remains, and the street population has not diminished, MSF has observed an increase in public services for street people. A permanent monitoring commission, co-founded by MSF and composed of local organizations, street people's delegates and public institutions linked with this population, now acts as a consultant for municipal and state authorities in designing special policies toward the street population.

MSF has worked in Brazil since 1991.

Bolivia

Treating Chagas patients and more

Since October 2004, MSF has been working in the northern Pando department, along the border with Brazil, in a project to improve diagnosis and treatment of those with malaria, tuberculosis (TB), leprosy and leishmaniasis.

Historically, this region has been underserved by the government and its health system, and the main objective of MSF's project is to reduce the prevalence of these four diseases in the area. In addition, MSF is seeking to implement a new treatment protocol including artemisinin-based combination therapy (ACT), a more effective treatment for people with malaria.

Elsewhere in Bolivia, MSF is working to help those with Chagas disease, a parasitic and ultimately lethal illness (see page 75). Bolivia is home to the world's largest number of people suffering from Chagas, with 1.8 million already infected and 3.7 million at risk. MSF treated more than 750 children with the disease between April 2003 and December 2004, and another 199 children in the first half of 2005. Chagas mainly affects those living in poverty or in rural areas. MSF is treating people with Chagas disease in the town of Entre Rios in O'Connor province and in the slums of the city of Sucre. In Entre Rios, the team screens newborns and children between



© MSF

In southern Bolivia's O'Connor department, a home is insect that spreads Chagas disease.



INTERNATIONAL STAFF 13
NATIONAL STAFF 21

Ecuador

9 months and 15 years of age, and in Sucre, it treats children up to 18 years old, as well as hospital blood donors and pregnant women. Children who test positive for the disease are treated with the available medicines and monitored closely for side effects.

In March 2005, MSF presented a new book of photography on Chagas disease at a meeting in Santa Cruz of INCOSUR, an organization of South American countries working to eliminate many of the diseases affecting the region. The book highlights the consequences and contexts of the disease, and most of the photos were taken at MSF's project in Entre Rios. The photos were also displayed as part of an exposition shown at the meeting to help raise awareness about this health problem.

At the national level, MSF teams in Bolivia have raised concerns about access to essential medicines and treatments, particularly those that could be affected by negotiations over a free trade agreement between Bolivia and the United States. During negotiation rounds held in 2004 and 2005, MSF urged the Bolivian government to exclude intellectual property provisions from the US-Andean free trade negotiations. MSF is concerned that such provisions would have a devastating effect on access to medicines for millions of people living in Bolivia and across the Andean region because they would dramatically limit the availability of generic drugs on the market.

MSF has worked in Bolivia since 1986.



sprayed to protect its inhabitants against the



© Juan Carlos Tomasi

MSF is working to make HIV/AIDS care more accessible to people living in western Guayas province, a part of the country where many people cannot obtain the medical care they need.

Pushing for more access to AIDS medicines

More than half of Ecuador's inhabitants cannot obtain proper medical care – a problem that has intensified with the spread of HIV/AIDS.

In January 2004, MSF launched a project to improve care for people with HIV/AIDS in western Guayas province. Each month, the MSF team seeks to treat 10 new adult patients with life-extending antiretroviral (ARV) medicines, as well as to provide treatment to all HIV-positive pregnant women in the area to prevent mother-to-child transmission of the virus. At present, MSF staff care for approximately 330 patients, of whom more than 90 are receiving ARVs.

From April 2002 to June 2005, MSF ran a sexual and reproductive health program in the Flor de Bastion slum of Guayaquil, Ecuador's largest city. The goal of the program was to make quality sexual and reproductive health care services available to this excluded area's inhabitants, especially teenagers. The MSF staff provided counseling and care to help with family planning, prevention of sexually transmitted infections and HIV/AIDS, and offered reproductive health information.

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 begin using and facilitating the registration and marketing of less expensive generic medicines instead of costly brand-name ARVs.

Due to enormous pressure at different levels, the national protocol does not include "fixed-dose combinations." These combinations reduce the number of pills to be taken and in that way help improve adherence to treatment and access to it. MSF has been working with other groups in the country to raise concerns about the potential effects of negotiations toward a regional free trade agreement among Ecuador, Colombia, Bolivia, Peru and the United States. The agreement's chapter on intellectual property rights threatens access to medicines, and MSF believes that US negotiators will push to reduce the possibility of providing generic medicines to patients in these developing countries through reduced registrations of generic versions of new medicines (produced in the country or imported) for certain periods of time. As a result, the pharmaceutical market will be monopolized during that time by brand-name products available only at higher prices. MSF is thus worried that this agreement will have a devastating effect on access to medicines for millions of patients in the Andean region.

MSF has worked in Ecuador since 1996.



Colombia

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Eleven-year-old Lydia lives with her mother and three sisters and brothers in the shantytown Obrero located on the outskirts of Quibdo. The father has left them. Their home is a shed. Lydia cares for the other children while her mother works as a maid. None of the children has an identity card that entitles them to health care.

Inescapable violence

In Colombia, violence is the major public health hazard and the leading cause of death. For decades, government military forces, paramilitary groups and armed guerrillas have fought one another against the backdrop of an illicit narcotics trade and conflict over natural resources, terrorizing and targeting civilians in both rural and urban areas.

It is no wonder that three million people have fled their homes, many gathering in shantytowns outside major cities, where they seek safety and anonymity among the masses. Estimates suggest Colombia now has the third highest number of internally displaced people in the world, after Sudan and the Democratic Republic of the Congo. In an effort to alleviate some of the suffering, MSF brings essential medical services to vulnerable and displaced civilians in Colombia, while advocating for improved services and medical care for those who have been displaced. MSF teams are currently at work in the departments of Cauqueta, Chocó, Córdoba, Sucre, Bolívar, Nariño, Norte de Santander, Tolima, Cundinamarca and in the Bogotá capital district.

Millions outside the system

Since 1999, MSF has been working in Altos de Cazucá-Soacha, in the Cundinamarca department, aiding the displaced popula-

"We are here without work. We don't know what we are going to do when we are told to leave. Our children don't go to school. But how can I even think of going back? It would be like a death sentence."

– A displaced man living in Soacha with his family

tion. Soacha is a one-hour drive southeast of Bogotá. Each day, the MSF team brings medical equipment and supplies to this shantytown where they operate a clinic. Though Colombian law provides for health benefits for the displaced, in reality a lack of information is one of the leading causes for people to remain outside of the health

care system. Others are worried that entering the system could make them vulnerable. Participation in government programs requires registration and detailed personal information that could be misused. As a result of these factors, MSF estimates that about two-thirds of the displaced population remain unregistered and therefore without access to medical help from the government.

In Soacha, as in many shantytowns, the most common health problems are respiratory complaints and diarrheal diseases caused by crowded living conditions, poor sanitation and a lack of clean water. In addition to offering medical care, MSF staff inform internally displaced people about their rights and provide mental health support. Home visits play an important role. While visiting families, the team often detects medical or family problems that need to be addressed.

“One day some men arrived. They accused us of supporting the guerrillas. They threatened my husband with a weapon in front of the children, and told us to leave by dawn. My children cried a lot. We were all very scared and so we did not take anything with us, concentrating only on leaving as fast as we could. That is why we are here.”

– An internally displaced woman living in Soacha, Colombia

More than 100,000 people live in the western city of Quibdó, in Chocó department, Colombia's poorest region. The city is surrounded by tropical jungle, and half of its inhabitants fall outside of the health care system. MSF teams support two health centers in the shantytowns of Porvenir and Reposo as well as large hospital center, Ismael Roldan. In November 2004, an MSF team expanded the program by beginning to offer assistance in the maternity ward of San Francisco Regional Hospital in the city center. For those who live in the jungle, medical care can be days away, and health conditions can worsen or become fatal, before people ever reach a health facility. In 2004, MSF staff treated more than 16,000 people through six health posts in Quibdó.

Reaching isolated populations

In many parts of Colombia, MSF staff use mobile clinics to reach isolated populations that have almost no other way to obtain health services. To limit risk and help ensure the safety of the team and patients, MSF is always completely transparent about the mobile clinics' travel plans. Mobile-clinic teams mostly treat respiratory, skin and parasitic infections and provide vaccinations, psychosocial care for victims of trauma and some dental care. The mobile-team doctors are sometimes the first caregivers communities have seen in more than a year.

In the department of Tolima, home to more than a million people, MSF mobile teams bring medical and psychological assistance to those living in conflict zones. This department and the western part of Cundinamarca department comprise a strategically important area because the main roads leading from Cali and Medellín to Bogotá pass through them, and all armed groups are active in the region. In 2004, MSF carried out an average of 2,000

consultations, including more than 100 mental health visits, each month in Tolima.

MSF is also working to bring health care to people in the Norte de Santander and Córdoba departments in northern Colombia. Communities are visited by mobile teams every six to eight weeks, depending on both needs and accessibility of the area. To reach these isolated communities, MSF teams travel by four-wheel drive vehicle, on foot, on mules or by canoe. Spending two to three days in each site, MSF staff see an average of 90 patients a day. MSF has also established a fixed health clinic in Saiza within the conflict zone to provide more consistent quality care than is possible through mobile clinics. MSF has also started working in the town of Sincelejo in Sucre department, opening a primary care clinic within the vast urban slums of this town.

Mental and reproductive health

MSF teams counsel patients about stress, trauma, insomnia, fear and grief as part of their work in Colombia. According to MSF mental health experts, many patients who seek care from the mobile clinics report generalized body pain or headaches. Some have also travelled long distances to request common medicines that could be obtained elsewhere. These are indications that people are suffering from fear of the continuous violence. Moreover, domestic violence, sexual assault and child abuse are so common that many people have come to accept them as inevitable. Although mental health services are included in all of MSF's work in Colombia, in some places, such as the south-central city of Florencia in Caqueta department, they are the primary focus.

Sexual and reproductive health care are also important parts of the work being

done in Colombia. For adolescent girls, sexual and reproductive health problems are the primary medical issues for which they seek care. Most of MSF's patients are single mothers with numerous children. Maternal and child mortality remain huge problems, exacerbated by domestic violence.

Emergencies

MSF also responds to emergencies in Colombia. In October 2004, after floods enveloped the west coast city of Montería, displacing more than 20,000 people, MSF teams assisted with basic health care, water and water-container distribution, provision of hygienic supplies and referral services. Most of the displaced had been living in shantytowns at the time of the floods, which occurred during the peak of the rainy season. MSF also provides emergency assistance in the wake of war-related displacement. This year MSF staff in Córdoba and Norte de Santander offered emergency health and psychosocial care as well as water and sanitation services following two massacres and subsequent population displacements.

MSF advocates for better living conditions for vulnerable and displaced people in Colombia. In February 2005, MSF submitted an open letter to the governments and organizations participating in a donor's table for Colombia. MSF called for an end to the practice of displacement of civilians as a war strategy and sought aid and care for the millions of displaced people who require and are entitled to it.

MSF has worked in Colombia since 1985.

Haiti

Working amid intensifying violence

Many people in Haiti's capital city, Port au Prince, live in constant fear. They have been trapped by widespread politically motivated and criminal violence since President Jean-Bertrand Aristide was pressured into exile in 2004. More than one-third of the city is considered extremely dangerous and at the mercy of armed groups. Violence against civilians in Port au Prince is a daily occurrence, and the number of wounded treated by MSF continues to grow.



© Gaël Turine

In response to the growing needs, in late December 2004 MSF opened a 56-bed trauma center at St. Joseph's Hospital, providing free, high-quality emergency medical and surgical care. By late August 2005, MSF had treated more than 3,500 patients including 1,550 people with violence-related injuries, of whom 1,132 were gunshot victims. Half of those treated for injuries related to the violence were women, children or the elderly. Since March 2005, MSF has provided post-surgical physiotherapy at a 27-bed physical rehabilitation center in Port au Prince.

The deteriorating security situation in Port au Prince led MSF on 5 July 2005 to call publicly on all armed groups to respect the safety of civilians and to allow the wounded to obtain emergency medical care. Ironically, the following day, the UN Stabilization Mission in Haiti launched a day-long military operation in the Cité Soleil slum, and the trauma center received 27 gunshot victims – three-quarters of whom were women and children.

In April 2005, MSF opened a basic health care project in the city's Decayette area. The MSF team provides primary health care at no charge to city residents, especially women and children in an effort to promote and improve access to high-quality health care for this population. By mid-2005, the team was carrying out 120 consultations a day. In August 2005, MSF also started operations in Cité Soleil, where it carries out more than 150 consultations each day in the primary health care center of Chapi Hospital and St. Catherine Laboure Hospital.

MSF is also treating victims of sexual violence in the capital, through its existing programs for victims of violence. The program offers outreach, treatment and referral to further psychological care, protection and legal assistance. Despite the availability of these services, it remains difficult for victims to gain access to them, because of the severe social stigma surrounding rape and because of victims' fear of retaliation. In the country's central Artibonite department, south of the coastal city of Gonaïves, MSF works in the commune of Petite Rivière within health structures in Jean-Denis, Segur and Charles Colimon, providing basic health care, with a special focus on women of reproductive age and chil-

dren. In the Charles Colimon health center, MSF has integrated voluntary HIV counseling and testing to help prevent mother-to-child transmission of the virus.

Renewed flooding

In September 2004, tropical storm Jeanne hit northwestern Haiti, causing severe flooding in Gonaïves. With more than 2,000 people dead, 3,000 injured and tens of thousands left homeless, MSF mobilized an emergency team and began offering care in a health center in Robateau, in the western part of the city. Medical equipment and supplies, including emergency kits sufficient to treat 10,000 people, were transported from Port au Prince. MSF conducted more than 500 consultations a day, many involving minor surgery, during the initial period. Mental health care, malaria treatment and water and sanitation support were also provided.

From mid-October 2004 until the end of the year, MSF worked in other areas affected by the storm, carrying out more than 2,000 consultations in the health center of the town of Chansolme, near the city of Port au Paix, and an additional 500 consultations in the villages of Paulin and Aubert. MSF supported the public hospital in Port de Paix, reorganized the emergency room enabling it to receive up to 80 patients a day and provided staff to reinforce the pediatric and maternity wards. The team also helped rehabilitate the hospital's pediatric ward, water system and waste management area. Toward the end of 2004, MSF started working in a second health center, named K-Soleil, in Gonaïves, providing emergency medical care and maternity care and treating children at the town's public hospital. This emergency intervention ended in February 2005.

MSF has worked in Haiti since 1991.

INTERNATIONAL STAFF 4
NATIONAL STAFF 41

Peru



Giving HIV/AIDS care to slum residents

An estimated 90,000 of Peru's 27 million inhabitants are now living with HIV/AIDS. MSF runs projects in poor areas of the capital, Lima, to provide comprehensive care for some of those affected by the virus.

In the Lima slum of Villa El Salvador, MSF has begun a pilot community-based AIDS-treatment project. The project, started in August 2004, treats slum residents with AIDS, using life-extending antiretroviral (ARV) medicines at the Centro Materno Infantil San Jose health center. By mid-2005, 91 patients were receiving this treatment. Providing medical care in the community was a breakthrough, because HIV/AIDS care in Peru had been restricted entirely to large hospitals. Poor people were obligated to travel long distances to receive care, and to pay high prices that effectively excluded many.

MSF continues to speak out on issues related to access to essential medicines – access that is threatened by current free trade negotiations that would force people to buy more expensive, patented drugs. In collaboration with a local nongovernmental organization, MSF has been advocating for the government to increase free access to HIV/AIDS medicines. Partly as a result of this action, the cost of ARV therapy has started to decline, and less-expensive, non-patented, generic drugs are now available in Peru.

MSF is working in the Lurigancho prison in northeastern Lima – home to 9,000 prisoners. MSF carries out prevention and treatment activities in cooperation with the national penitentiary institute, targeting

prisoners living with sexually transmitted infections (STIs) including HIV/AIDS. The work includes comprehensive care for HIV-positive prisoners as well as awareness-raising efforts aimed at reducing transmission of infections. MSF has held workshops for prison staff on voluntary testing and counseling and has trained medical staff to manage symptoms. In 2004, more than 3,700 prisoners entering Lurigancho benefited from briefings on HIV, STIs and tuberculosis. An estimated 1,600 prisoners received HIV counseling, and more than 1,440 volunteered to be tested for the virus, of whom 50 were found to be positive. MSF plans to hand over the project to local health authorities at the end of 2005.

In December 2004, MSF transferred its project aimed at helping youngsters improve their own lives despite violent experiences in the past to local community groups. The program taught the children how to develop protective mechanisms, healthy relationships and greater resilience.

MSF has worked in Peru since 1985.

INTERNATIONAL STAFF 5
NATIONAL STAFF 31

Honduras

**Caring for street children
Children and young people constitute a particularly vulnerable group within the Honduran population. Those who are poor, homeless and living in an urban area are often victims of violence.**

In April 2005, MSF, in cooperation with local organizations, started a program to assist street children and youth in the capital city, Tegucigalpa. Currently, about 30 street children visit the center each day, with approximately 400 extremely poor children between the ages of a few months to 24 years, registered in the program. MSF's medical assistance includes psychological care as well as a program of recreational and socio-education activities. Special emphasis is placed on addressing girls' and adolescents' sexual and reproductive health needs due to their risk of pregnancy, commercial sex exploitation, violence and sexually transmitted infections. MSF conducts approximately 15 medical consultations each day.

In 2001, MSF began offering care to people living with HIV/AIDS in the town of Tela on the northern coast of Honduras. The project aimed to support the community's response to the country's HIV/AIDS crisis and to broaden the range of available services by including key public and community service providers in the provision of HIV care and prevention efforts. Today the Honduran ministry of health has 20 HIV/AIDS treatment centers in the country offering comprehensive care including ARV treatment. In June 2005, MSF transferred responsibility for this project to three clinics in the area. MSF will monitor the program until mid-2006 to ensure that patients receive treatment.

MSF has worked in Honduras since 1998.

Mexico

Chagas project closes

Until MSF ended its activities in Mexico in 2004, the organization had been active in Chiapas state, one of the country's poorest, most unstable areas. The work included completing longer-term projects providing basic health care through mobile clinics and carrying out studies on health issues related to people suffering from Chagas disease.

Chagas is one of the world's most neglected diseases (see box). According to Mexico's National Institute of Cardiology and Institute of Public Health, an estimated 1.8 million Mexicans are infected with this little-recognized disease. Mexico is the only country in Latin America where Chagas is present that has no national program to address it. Only 50 cases are identified each year by the ministry of health – despite some studies findings that as many as 30 percent of the people in some isolated communities are living with the disease.

In 2004, an MSF study of the disease in selected high-risk zones of Chiapas found a Chagas prevalence rate of 2.3 percent among children under the age of 14 – the age up to which successful treatment is still possible. All of the children who tested positive were older than eight, confirming the likelihood that they had not been recently infected. The 2.3 percent prevalence of Chagas in those under 14 did not justify an MSF intervention. Nevertheless, it was enough to justify a public health response. MSF lobbied the Chiapas government and Mexican Ministry of Health to recognize Chagas as a problem deserving

attention. The Chiapas Ministry of Health has committed itself to work on Chagas in 2005.

Still, much more needs to be done on the national level to prevent the disease, particularly as people continue to become infected by the vector in high-transmission areas and through blood transfusions. While the Drugs For Neglected Diseases initiative (DNDi) of which MSF is a founding partner, has put the development of new Chagas medicines high on its agenda, progress will take time.

MSF ended its activities in Mexico at the end of 2004. MSF worked in Mexico from 1998 through 2004.



A young girl gets a blood test for Chagas disease in Olopa, Guatemala.

© Juan Carlos Tomasi

Nicaragua

MSF ends work with Chagas patients
MSF's project to fight Chagas disease and treat its victims in Nicaragua has closed, bringing an end to 22 years of work in the country. Now that the national health ministry has included Chagas disease in a new 10-year plan, and the rate of infections has dropped in one of the two municipalities in which MSF was active, it is no longer necessary for the organization to provide support to the Nicaraguan health authorities.

In the municipalities of Esquipulas and Totogalpa in Matagalpa province, MSF had assisted health authorities in prevention, identification and treatment of the disease, which is transmitted by a blood-sucking insect. MSF held a symposium in May 2005 and published a booklet describing its work and recommendations, thereby transferring its knowledge and experience to local health authorities, nongovernmental organizations and other parties involved in helping those with Chagas.

The insects that spread Chagas disease live in the walls and roofs of huts made from

hay and mud in rural areas across Latin America. Because the victims are almost all poor, Chagas does not attract significant investments from the pharmaceutical industry. As a result, health workers generally have to treat patients with old and often-ineffective drugs. These medications are unable to kill the parasite in the chronic, lethal phase; are powerless against certain varieties of the parasite; and often cause serious side effects.

MSF operated its project in Esquipulas for two years and in Totogalpa for seven months. Its teams of experts have conduct-

ed groundbreaking work in screening and treatment as well as in killing the bugs. In addition, the projects in Nicaragua have contributed to the organization's global campaign aimed at putting neglected diseases on the agendas of governments and pharmaceutical companies.

The MSF intervention leaves an important legacy. Its role in promoting Chagas as part of the government's 10-year health plan has been an important step toward curbing the disease. The May symposium inspired a local organization to improve 500 houses in an area heavily affected by Chagas, to minimize the risk that children receiving treatment for the disease could become re-infected by the insects. In addition, the MSF team introduced a new method for rapidly screening large numbers of people for the infection.

MSF worked in Nicaragua from 1983 until May 2005.

What is Chagas disease?

First identified in 1909, Chagas disease is a mostly asymptomatic, parasitic disease that attacks the heart and the nervous and digestive systems. A very small percentage of those who are infected by the insect that carries the parasite develop an immediate and potentially lethal reaction. Most carry the parasite for years without knowing it. Approximately 30 percent of those infected develop chronic symptoms over a period of 5 to 20 years. As symptoms progress, one's quality of life is deeply impacted and ultimately those with the disease die prematurely of related problems. Even when common symptoms such as fatigue and stomach pain are identified, many people are misdiagnosed because of ignorance of the disease. Only a blood test can accurately diagnose Chagas and, in the absence of conclusive research, there is disagreement about the most appropriate test to conduct.

Approximately 50,000 people die from Chagas disease each year in Latin America,

and 100 million are at risk of contracting it. Combating the disease is not easy: diagnosing it in the acute (first) phase is very difficult and treating it is extremely hard once it has reached the chronic phase.

Today there are only two medicines available to treat Chagas, nifurtimox and benznidazol, which are highly aggressive drugs with cure rates of 60 to 70 percent, at best. For chronic patients (those who have been infected more than 10 years) the cure rate drops below 50 percent, and the side effects are so severe that health professionals consider it unethical to treat them with these medicines.

The situation begs the question: Why, with so many individuals infected, are the diagnostic and treatment tools so poor? The answer is linked to the fact that the disease mainly affects the poorest, most marginalized people of Latin America. Although Chagas is now starting to affect a broad

range of people through unscreened blood transfusions and population migration, it mostly harms those living in rural areas where the vector, a common beetle, thrives. Because the pharmaceutical industry sees little profit to be gained, there has been no development of Chagas medicines for decades.

"Chagas patients are of no interest to pharmaceutical companies; many people die without ever being diagnosed. We desperately need new drugs to treat people with Chagas."

– Silvia Moriana, coordinator of MSF's mission in Bolivia

Guatemala



© Juan Carlos Tomasi

A mother sits with her children during a medical consultation in Olopa, Chiquimula where MSF provides basic health care.

Confronting a growing AIDS crisis

HIV is a growing crisis in Guatemala, where approximately 78,000 of the country's 14 million people are living with the virus. While an estimated 13,500 people are in urgent need of treatment for AIDS, merely 3,900 Guatemalans receive it – almost half of them (1,900) treated by MSF in hospitals and clinics.

Gaining access to HIV/AIDS medicines was a crucial issue in Guatemala during 2004 and 2005. Following the 9 March 2005 national passage of Decree 31-88 and the July 2004 signing of the US-Dominican Republic-Central American Free Trade Agreement (CAFTA), the region now grants excessive levels of intellectual property protection that can restrict access to essential medicines and make drug prices unaffordable for the vast majority of Guatemalans. In addition to its direct work with patients, MSF is urging national officials to find ways to ensure greater access to needed treatment and care.

For those who live outside of Guatemala City, HIV/AIDS care is difficult to obtain due to the centralization of care in the capital. To counter this, MSF runs projects in Puerto Barrios and Coatepeque. These are the only two locations outside of Guatemala City where HIV-positive people can receive needed care and treatment. MSF is pushing the government to extend the country's HIV/AIDS program to reach people living in more remote areas of the country.

Today, MSF staff provide HIV/AIDS care at the Yaloc clinic in Guatemala City for

approximately 1,800 patients, of whom 740 people were receiving antiretroviral (ARV) medications by August 2005. In Puerto Barrios, a town in the Izabal department, MSF was providing care to 519 patients as of August 2005, with 219 receiving ARVs. At MSF's HIV project in the town of Coatepeque, near the border with Mexico, MSF staff provide comprehensive care to more than 1,500 people, including 371 who were using ARVs by the end of July 2005. Prevention efforts are another priority. MSF has trained teachers and has developed sexual-education materials, including information on preventing HIV transmission, which are now being used with more than 3,500 students at 14 schools in Coatepeque. The ministry of education plans to incorporate the teaching material into its regular curriculum at the end of 2005.

An MSF doctor, nurse and health educator travel to various departments near the Mexican border to teach and offer informational sessions on HIV/AIDS to health staff working in public health facilities. The area has a high prevalence of HIV (65 cases per 100,000 people) because a Pan-American

transportation route passes through it. MSF is informing communities about the disease to help avoid discrimination against people living with it and to help those in need of care to obtain it.

In June 2005, MSF transferred responsibility for its HIV/AIDS project in Guatemala City's Roosevelt Hospital to the ministry of health. In 2001, the project was the first in the capital to provide comprehensive care for HIV-positive patients. At the time of the handover, 625 patients were receiving ARVs and more than 2,000 were being followed by the medical staff. MSF will follow the transfer process closely to ensure high-quality treatment and the continuous flow of ARV stocks.

Helping those with Chagas disease and street children

MSF is providing primary health care to people living in Chiquimula department. To ease access to care, the team has rebuilt three area clinics, supports an existing health center and has trained staff members who now work for the ministry of health. Because Chagas disease is endemic in the area, the team is screening children who may have been infected with the parasitic disease to locate those who are within the early phase of the illness, which is still treatable (see page 75). By August 2005, almost 9,000 children in the Olopa municipality – approximately 46 percent of the target population – had been screened.

For most of 2004, MSF also provided medical and psychological care for children affected by domestic violence or neglect at a therapeutic day care center in Lomas de Santa Faz, a slum on the outskirts of Guatemala City. The project's activities were handed over to a local organization in September 2004. During 2004, MSF hosted 82 children at the day center, performed 729 psychological consultations for 399 children, and conducted 1,053 medical consultations. In addition, MSF runs a project in Guatemala City that provides free health care and psychological counseling to more than 700 street children and young adults.

MSF has worked in Guatemala since 1988.

Europe and the Middle East



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Since arriving in Sweden as an asylum seeker, this woman has had to move nine times and even tried to commit suicide. Now she is moving again. Many of those who come to MSF in Sweden suffer psychologically from the stress and insecurity involved in hiding from authorities.

Belgium



© Layla Aerts

Helping those outside of the system

Belgium's sophisticated health system includes provisions for providing care to all, yet vulnerable groups within the country often face obstacles to obtaining needed medical care. A complex bureaucracy, long and difficult administrative procedures, fee-based services and misinformation about current laws all contribute to keeping some groups out of the system.

MSF is focusing on ways to improve access to health care for the most disadvantaged groups in Belgium including asylum seekers, undocumented migrants and the very poor. While undocumented migrants and asylum seekers have the right to receive health care services, in practice, access is very complicated. In response, MSF staff run three clinics in Brussels, the capital, and in Liège and Antwerp, that provide free care to disadvantaged people. During 2004, MSF's medical team carried out 10,000 consultations for approximately 4,500 patients. Based on its experience, MSF and other organizations are lobbying government officials to develop a structural solution to health care gaps within the current system.

In response to requests from seriously ill refugees who receive care in Belgium, the organization provides information about the availability of quality health care in various countries of origin. This type of information can be crucial to refugees seeking to avoid repatriation to countries where their health needs will not be met. In the first half of 2005, MSF staff received and fulfilled approximately 80 requests for information each month.

In Brussels, MSF operates the Elisa center, which provides free, anonymous HIV testing. Voluntary counseling is also provided to anyone who requests the test, and more extensive psychological support is available to those who want it. For the past 15 years, MSF has been advocating for free, anonymous testing to be integrated into the country's health system. The organization hopes that this goal will be achieved by the end of 2005 and plans to close the center at that time.

In 2004-5, MSF staff also continued to provide psychological support to Belgium's Rwandan refugees, who fled the 1994 genocide in which an estimated 800,000 people were massacred. Management of the program – which offers group and individual therapy – is gradually being turned over to the Rwandan community involved in the work. The project will become completely independent and supported by an external donor by the end of 2005.

MSF has worked in Belgium since 1987.

Luxembourg

Reaching drug users

A growing number of Luxembourg's adolescents use recreational drugs. Because the health risks associated with the use of illegal and psychotropic drugs by youth are significant, MSF is working with adolescent drug users, their families and concerned institutions.

MSF staff provide psychological and social care, information about drug use and addiction, and individual and family therapy. During 2004, MSF held more than 1,220 consultations, assisting 267 adolescents. The project network now includes 40 schools as well as several educational centers and outreach programs. MSF emphasizes collaboration with the juvenile justice system, offering an alternative to more traditional responses.

Immigrants' health needs

MSF participates in a working group of nongovernmental organizations and government authorities that aim to monitor closely the medical and psychological situation of immigrants and asylum seekers entering the country. MSF has called attention to the difficulties these vulnerable individuals face when attempting to use the country's health care system. MSF developed guidelines describing the needs of this group with regard to access to the health system. The guidelines have been incorporated in a statement on their rights distributed to newly arrived migrants. The working group is also investigating questions such as the procedures and practices surrounding the expulsion of sick migrants.

MSF has worked in Luxembourg since 1996.

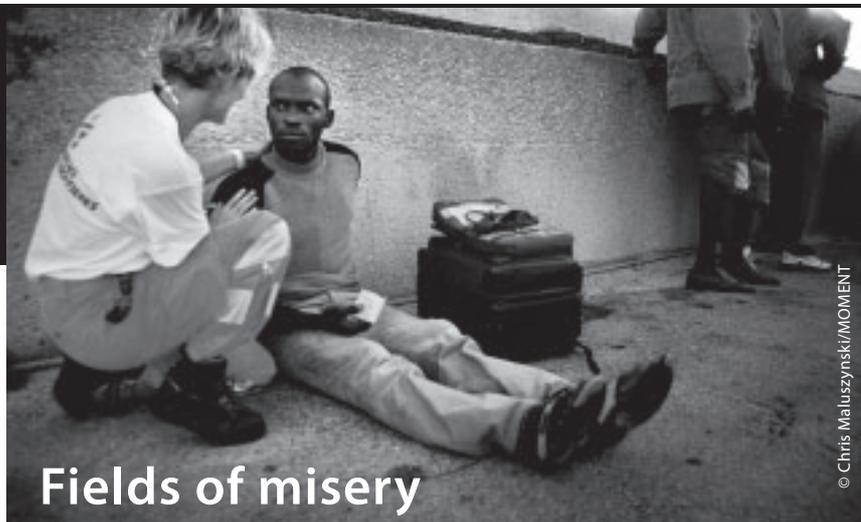
Italy

Aiding boat refugees and farm workers

Italy's strategic position on the Mediterranean Sea makes it an attractive destination for immigrants attempting to enter Europe. Because many immigrants arrive in need of care or become sick once they settle in the country, MSF helps provide health care and legal information to desperate boat refugees and undocumented immigrants working in the countryside. In October 2004, MSF and other non-governmental organizations condemned the Italian government's forced removal of 300 people who had recently arrived on the island of Lampedusa, south of Sicily. MSF protested this action, calling it a violation of Italian law and international asylum conventions.

At the end of 2004, MSF signed an agreement with civilian authorities to continue its work on Lampedusa, no longer within temporary detention centers but directly in the harbor areas where refugees arrive. (The Italian government barred MSF from working in the centers after MSF published a report in 2004 that was critical of the conditions facing these refugees.) MSF staff provide initial medical screenings and follow-up for patients who are referred for urgent treatment. Teams also provide this kind of assistance in Sicily.

In southern Italy, thousands of undocumented immigrants and asylum seekers work as day laborers on Italian farms. Their living and working conditions are often dismal, and they have limited access to health care. During 2004, MSF staff, traveling in a mobile clinic provided 770 medical consultations and interviewed more than 700 people in the regions of Campania, Puglia, Basilicata, Sicily and Calabria. While caring for people, the MSF team collected information about their working and living conditions in areas where large numbers of foreigners gather to seek work during the growing season. They turned their findings into a scathing report on the conditions facing these desperate immigrants in an effort to raise awareness about their predicament and to advocate for a change in government policy toward this vulnerable group (see box).



Fields of misery

The findings of MSF's March 2005 survey on the conditions facing seasonal farm workers in southern Italy are alarming. Among the approximately 700 seasonal workers interviewed for the survey, most were men between the ages of 20 and 45. Although they should have been a healthy population, 30 percent of the workers had become ill during their first six months in Italy. After 19 months in the country, 93 percent of the people surveyed needed to see a doctor. Almost all of the immigrants who sought a medical check-up by MSF were suffering from one or more health problems. The most common were infectious diseases, skin problems, intestinal parasites, mouth or throat infections and respiratory infections (including tuberculosis). The most severe illnesses were found among those immigrants who had lived in Italy the longest – 18 to 24 months.

Far from finding the easy life

In March 2002, I left my house and saw my family in Sierra Leone for the last time. I started a long trip to reach North Africa and from there embarked for Europe. Once I found a boat, we navigated for at least six days. The crossing wasn't easy. We got lost and were running out of water and food. Finally, we arrived in Italy. I have no idea where I was. I just know that after 48 hours in a first-aid post they took us to a reception center in Croton. I stayed there many weeks. When they let me go, I took a train and arrived here where I found a place to sleep together with other Africans. This house is not very big and there are 102 of us sleeping here.

Here life is hard: I get up at 4:00 every morning and I go to the crossroads waiting for someone to offer me a job for the day. Unfortunately, my situation at the moment is as precarious as it was in Africa. The environment around us is very poor and needy, the government does nothing to help us. I asked for asylum from the Italian government. I have a residency permit but I can't work according to the law.

In Africa, people think that in Europe everything is easier. Unfortunately here in Italy, I haven't found the protection I was hoping for as a refugee. The only thing I can do to survive is work as a fruit picker. It's hard work and badly paid and precarious: today you work, tomorrow you don't know. Besides I have to live in that house and pay rent. In my room, there are 10 of us. Three of us share a mattress and the last person to arrive sleeps on the ground. What am I expecting from the future? At this moment everything depends on my asylum-seeker status, but I would like to go to school to learn Italian, maybe find a job, change house, make friends. I would just like some normality."

– Story of A, an asylum seeker from Sierra Leone, whose story is included in the MSF report "The Fruits of Hypocrisy"

In the first half of 2005, MSF opened a project in the southern city of Naples that aims to improve access to health care for undocumented migrants.

During 2004 and early 2005, MSF transferred to local authorities a project through which it had cared for undocumented

immigrants at clinics in Sicily and in Brescia, Lombardy. MSF continues to work in health clinics aiding immigrants in Rome, providing medical care and information about legal rights.

MSF has worked in Italy since 1999.

Russian Federation/ North Caucasus

Aiding civilians bearing the brunt of low-level conflict
The conflict in the republic of Chechnya, between Russian Federation forces and Chechen rebels, is characterized by low-level, attritional warfare, with civilians all too often caught in the cross fire. While fighting continues to destabilize neighboring Ingushetia and the nearby republic of Dagestan, authorities are pushing for Chechen refugees to return home. At the same time, the Chechen conflict has all but disappeared from the international political agenda.

Despite the region's insidious, ongoing conflict, MSF has been organizing ways to meet a small part of the population's needs in this changing environment. Teams continue to address some of the medical needs of the region's people, and in 2004, international staff were again able to visit Grozny, Chechnya's capital – where they had the vital opportunity to observe and discuss the MSF programs that have been managed for some time by national staff.

The last of the tented camps that since 1999 had provided refuge to Chechens who had fled to the Ingush republic was closed in June 2004. Faced with the prospect of homelessness, the majority of the internally displaced people (IDPs) chose reluctantly to return to Chechnya, leaving about 32,000 of the displaced people in Ingushetia. They live mostly in derelict buildings roughly equipped for human habitation. Their living conditions vary from difficult to unbearable, in overcrowded, dank, dilapidated buildings that enable diseases such as tuberculosis (TB) and pneumonia to flourish. MSF continues to support these IDPs by providing drugs and equipment to local health structures, and by providing shelter, logistical support and psychosocial counseling. In Malgobeck, MSF uses mobile clinics to help some of the area's 5,000 displaced people. The team provides approximately 200 medical consultations, 250 gynecological consultations and more than 130 pediatric examinations each month. MSF staff works in the Ingushetian town of Sleptsovskaya and the city of Nazran, providing maternal and pediatric care, giving about 700 gynecological/obstetric clinic consultations and 750 pediatric consultations per month. In July 2005, MSF stopped similar work in the town of Karabulak.

Despite official claims that the situation in Chechnya has "normalized", so-called sweep operations to round up suspected rebels, landmine accidents, disappearances and violent trauma are common. Among the Chechens who have returned, many remain internally displaced, because their homes have been destroyed or their towns remain insecure. An August 2004 MSF survey conducted among displaced people in Chechnya showed that 92.2 percent had been displaced for at least five years. The most destitute are housed in temporary accommodation centers (TACs) run by local authorities. There are 32 TACS across the republic, the majority in or near Grozny. The TAC population (which local authorities estimate at about 37,500) lives under grim, unhealthy conditions. MSF has provided a range of services to TAC dwellers through mobile clinics that care for some 1,000 patients each month. The clinics focus on mental health services, in response to evidence that many among the population suffer under severe strain and that much of their psychological illness is directly related to the pervasive climate of violence and fear.

MSF also continues to provide the central maternity facility in Grozny with drugs and medical materials and runs pediatric and gynecological/obstetric services in two of the city's polyclinics (for a combined 1,900 consultations per month). In July 2005, MSF started to support two more polyclinics, providing general consultations, pediatric and maternal care.

Treating TB patients and survivors of Beslan

MSF continues to respond to one of the most significant health crises in the North Caucasus: TB. Many of the republic's TB



An MSF psychologist plays a game with a street child that is hol abuse are common among these homeless children.

"Recently, it is the absolute sense of despair and hopelessness which is proving hardest to treat."

– MSF nurse from Chechnya who is herself displaced and now working with MSF in Ingushetia

hospitals and sanatoriums are in poor condition after 10 years of war and neglect.

MSF focuses its work on three TB hospitals in the towns of Nadterechnye, Gudermes and Shali. It recently completed the rehabilitation of the hospital in Shali in January 2005, and has treated a total of 249 patients since June 2004. MSF has established a directly observed treatment system to help discharged patients adhere to their treatment.

In the republic of North Ossetia, the tragic death of more than 300 children and members of their families during a siege on a school in the city of Beslan, in September 2004, shook the region. MSF provided emergency medical kits to help treat some of the injured.

Helping Moscow's street children

In 2003, MSF opened a program that catered to the health and psychosocial needs of more than 15,000 homeless children and adolescents living on Moscow's streets. Like many capital cities, Moscow is a magnet for runaways, orphans and neglected children, many of whom have physical or mental health problems. Many of the youths with whom MSF works have acknowledged using injectable drugs. Glue inhalation is very common and is often combined with tobacco and alcohol use. Unhealthy living conditions, including



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INTERNATIONAL STAFF 7
NATIONAL STAFF 34

Ukraine

Preparing to hand over HIV/AIDS work

An estimated 360,000 people between ages 15-49 are living with HIV/AIDS in Ukraine – about 1.4 percent of the population. However, only about 76,000 of them have been diagnosed with HIV or are aware of their status. Ukraine continues to have one of the fastest growing rates of HIV/AIDS in Europe. In response, during 2004 and the first half of 2005, MSF has been caring for people living with the virus in the southern part of the country.

In the cities of Odessa and Mikolaev, during 2004, MSF provided medicine to 341 HIV-positive pregnant women to help prevent transmission of the virus during pregnancy or delivery. MSF also gave life-extending antiretroviral (ARV) treatment to 120 adults and 30 children and provided laboratory diagnostic support. MSF staff cared for more than 300 patients in the hospital, and more than 1,000 patients who needed outpatient treatment for HIV-related infections.

The team also conducted treatment-adherence and psychosocial-support sessions for all of the project's patients and many others living with HIV in the area. In addition, MSF collaborated with the country's health ministry to train almost 1,500 health care staff on topics related to HIV.

MSF supports the use of ARV treatment in Ukraine and advocated for the government to accelerate access to it. The team participated in a national campaign aimed at raising awareness about the disease, empowering those who live with it and reducing the stigma surrounding it.

In late 2004, MSF began preparations to transfer its projects to the ministry of health and other nongovernmental organizations after achieving the program's objectives – demonstrating a model of care for HIV-positive people in Ukraine – and seeing evidence of increased national capacity, funding support and political commitment. MSF plans to withdraw from Ukraine by the end of 2005.

MSF has worked in Ukraine since 1999.

INTERNATIONAL STAFF 2
NATIONAL STAFF 22

Serbia and Montenegro

Europe

Ending mental health care for the displaced

Serbia and Montenegro are still recovering from years of war. Area conflicts have caused high numbers of displaced people – more than 220,000 internally displaced people and 140,000 refugees – to gather there where they live under difficult conditions.

MSF provides mental health care for displaced people living in "collective centers" located in the towns of Vranje and Bujanovac in the southern Pcinja district of Serbia along the border with Kosovo. The staff is also advocating for changes in the republic's administrative, medical and social infrastructures that should enable the country's displaced people to enjoy equal status with other citizens. As more sustainable solutions start to be implemented for these groups, MSF is planning to hand over its remaining activities in the region by the end of 2005.

MSF has worked in parts of former Yugoslavia since 1991.

is designed to help him give up smoking. Tobacco and alco-

cramped quarters, early unprotected sexual activity and needle-sharing have enhanced the emergence of TB, sexually transmitted infections and HIV/AIDS among this group. MSF's mobile outreach team composed of doctors, psychologists, social workers and teachers work daily with the most vulnerable street children who gather in the vicinity of railway stations, public squares and markets. The outreach team gives medical, psychological and social support to more than 650 children and adolescents each year and tries to create awareness of alternatives to living on the street.

In March 2005, MSF opened a day center as a complement to its outreach activities. The center sees as many as 20 children each day, providing them with a temporary refuge from the harsh realities of the street. More importantly, it offers various types of training and therapy, such as job-searching skills, health education and resilience-oriented therapy. Basic medical care is also provided, as are laundry and bathing facilities.

The street children project builds on MSF's 11 years of experience with the adult homeless population in Moscow, but is adapted to the hardships specific to the young. Among them are coercive national policies that empower police to arrest young street children and force them to enter hospitals and public shelters. Those who are not from Moscow can also be faced with removal to their place of origin.

MSF has worked in the Russian Federation since 1988 and in the North Caucasus since 1999.



Bulgaria

© Sylvia Hirschi



An MSF doctor carries out a medical consultation with a child before giving a vaccination at the MSF health center in Fakulteta, Sofia.

MSF ends work to support the excluded

In Bulgaria, MSF has worked for a number of years to help vulnerable civilians, especially members of the large Roma community in the capital Sofia, to gain access to health care services.

In 2004, the national health insurance organization started enforcing payment into a new insurance system, requesting that all of those who had not paid their monthly contributions since the start of the new system be excluded. Many of the country's poorest people owed money for months or even years of unpaid monthly contributions.

In response to this dire situation, MSF organized a media campaign in September 2004, demanding amnesty for back payments. MSF's message was that the amount of money owed was an insurmountable obstacle for many of the country's poorest people. MSF also called on authorities to better inform the public about the system and to let people know quickly if they fall behind in payments.

At the end of 2004, the Bulgarian government amended the health insurance law. The law now calls on those in arrears for 15 months to pay a small fee that will place them back on the insurance rolls. Once that is done, the person must continue to pay his or her monthly contribution. Failure to do so will result in removal from the list again. MSF's view is that the amendments are merely a cosmetic solution to the ongoing payment dilemma, and that the real social problem, poverty, needs to be addressed.

In 2004, MSF ended its work in the primary health care center in Fakulteta, the capital's

largest Roma community. Six local general practitioners plan to continue the project, caring for some 20,000 people living in the area. However, the doctors' work in Fakulteta is also threatened by the changes in the health care system. Today, 7,776 patients are registered with the six general practitioners. Of that group, 2,664 (34 percent) are on the list of those to be excluded from the insurance system if they do not pay their back contributions by the end of 2005. An MSF survey conducted in Fakulteta, found that 95 percent of those interviewed did not plan to pay, simply because they could not afford to do so.

Hand over of medical activities

From January 2000 until March 2005, MSF ran the diagnostic, treatment and prevention center Maïchin dom (center for sexual health) in Sofia. MSF provided patients with free treatment for sexually transmitted infections and care to help prevent HIV/AIDS. The team's nurses also provided health education in schools within Sofia and in the countryside. In March 2005, MSF handed over the center's work to national staff who plan to continue the activities. MSF will help finance the project for at least one year and continue to provide some operational support.

MSF worked in Bulgaria from 1997 until March 2005.

Spain

Assisting migrants

There are more than one million undocumented migrants in Spain, and thousands continue to enter the country each year. The government announced measures in October 2004 to legalize hundreds of thousands of undocumented immigrants already in the country in an effort to boost the failing economy and incorporate these people into the tax-paying labor market.

Many undocumented immigrants enter Spain through the Canary Islands, or the Spanish enclaves of Ceuta and Melilla in North Africa. The immigrants arriving here are often exhausted, sick and in desperate need of medical care, shelter, food and water. They may also be traumatized by what they have experienced in their hours or days at sea. However, the country's reception areas are overloaded by the sheer numbers and do not respond to the needs of these desperate new arrivals.

MSF's projects in Spain provide medical care to these shaken and often ill immigrants. The team also collects testimonies from individuals about their experiences and plight in an effort to press the government to accept responsibility for them and improve their situation.

On the island of Fuerteventura, and in Ceuta, MSF has been giving medical assistance. At present, teams continue to monitor the situation, ready to take part, when it is needed. At the end of 2004, the organization began a project to promote access to health services for undocumented immigrants in Madrid's Carabanchel and Villaverde health districts. The team used the personal testimonies it had collected to demonstrate the dire situation facing many immigrants and their need for appropriate medical care.

MSF has worked in Spain since 1994.

INTERNATIONAL STAFF 0
NATIONAL STAFF 3
(full-time equivalents)

Sweden

Caring for undocumented immigrants

Access to the public health care system is severely restricted for undocumented migrants living in Sweden today. This small immigrant group – mainly comprised of rejected asylum seekers – is estimated to be 10,000-15,000 people.

MSF has organized a network of volunteer health care providers to care for this population. These doctors and midwives provide examinations and treatment from within the country's health care system and refer patients for further care when necessary.

Women constitute the largest patient group seen by this network and many are seeking care for pregnancy and other gynecological concerns. Many of the people treated suffer from serious mental trauma as well. The trauma is linked to deeply troubling experiences in their home countries, hopes and disappointments involved in the asylum process and the extremely stressful situation of hiding from authorities in Sweden.

The project aims to improve access to quality health care. MSF plans to continue its work in Sweden by seeking solutions for individual patients and alerting decision makers to the structural obstacles facing undocumented migrants seeking health care.

MSF has worked in Sweden since 2004.

"We cannot close our eyes to a population that lives among us who are among the most vulnerable in Western Europe."

– Mattias Ohlson, director of MSF's program in Sweden



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Europe

Filling the gap – until others step in

MSF made the decision to organize medical care for undocumented immigrants in Sweden after finding in 2003 that many of these people sought medical care only at a very late stage of illness – or not at all. MSF built a network of doctors who were willing to see and treat people at no charge outside of their normal practice hours. At the same time, the organization established a phone number for immigrants to call if they needed care but felt unable to approach regular health services. Two full-time nurses employed by MSF answer the phone and mediate among the undocumented immigrants, the MSF network and hospitals.

Doctors and nurses taking part in MSF's project for undocumented immigrants in Sweden conducted more than 500 consultations in 2004. The vast majority (87%) of the 168 patients involved say they turned to MSF because they were afraid of going directly to a hospital. Administrative procedures in hospitals are regulated to such a degree that getting past the reception point is a major obstacle for undocumented people. Their legal rights are poorly defined, which creates confusion and negative attitudes towards this group among administrative health care staff.

In comparison with other Western European countries such as Italy, Spain, Belgium and France, in which similar MSF projects seek to facilitate access to health services for undocumented immigrants, Sweden has far worse legislation. Its legislation on health care for undocumented migrants is among the most restrictive, and Sweden is one of the few countries that actually charge these people for emergency care. A newborn delivery costs, for example, about 3,000 euro – if there are no complications. This makes undocumented immigrants extremely vulnerable.

"Access to health care for rejected asylum seekers and other undocumented people is, first of all, a problem on the political level," says Mattias Ohlson, the director of the program. "If decision makers made a commitment to provide health care to this small group, a large part of the problem would be solved. The visceral fear among many of our patients for any public institution, including hospitals, is much harder to come to terms with," says Ohlson.

The children of undocumented immigrants have suffered from the country's policies as well, although their legal right to health care was recently improved. "Some of the children we meet have been refused care previously at a hospital due to their status, while others have had to pay 250 euros to see a doctor or up to 1,100 euros for surgery," adds Ohlson. "In addition, many parents have been too afraid to take their child to the hospital. They feared that someone would turn them into the immigration authorities or the police – something that is rare but unfortunately has happened."

Ohlson concludes: "Sweden is a country where an organization like MSF should not be needed for providing health care. The main difficulties facing undocumented migrants accessing health care in Sweden are clearly part of a structural problem. I'm hopeful that we will soon not be needed here anymore."

France

Helping undocumented residents

In January 2004, 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 ensure the availability of health care for economically disadvantaged people in France, who lacked residency permits and health insurance or other social assistance. The modifications to AME, such as the new requirement of at least three months' residency on French soil, abruptly ended access to the system and to free medical care for many. Today, an estimated 200,000 people without residency permits have no access to free medical care, unless it is an emergency.

During 2004, MSF reorganized its projects in France to help those most in need of medical and social assistance as a result of the changed system. MSF teams now run free medical clinics in Paris and in the southern city of Marseille. People can visit the clinics for medical consultations and referrals to other organizations offering additional medical care, food, clothing or accommodations. The clinics operate with extended hours to enable as many people as possible to use them.

MSF's decision to focus on activities in these locations resulted in the closure or transfer of other projects. The project providing sterile needles to intravenous drug users in Paris was handed over to a local organization in January 2005. The medical and social-service center in the southern city of Marignane, Bouches de Rhone, and the temporary accommodations that it offered to youngsters in difficult situations in the northern city of Lille and the Alsace region's city of Colmar have been closed. However, MSF's involvement with the association Espoir, which provides temporary accommodations in Colmar, will continue until the end of 2005.

MSF has worked in France since 1987.

Switzerland

Aiding the hidden uninsured

In Switzerland, MSF provides hard-to-find health care to marginalized civilians without health insurance, many of them asylum seekers. These residents, who number in the hundreds of thousands, often lack legal status and/or resources, which complicates their ability to attain needed health care. Switzerland's health care system requires almost all legal residents to purchase health insurance from one of the country's many private health insurers. Although migrants who are in the country illegally technically have the right to purchase insurance, they face many obstacles in doing so. Varying laws, differences among insurers in accepting migrants and expensive policies combine to keep them out of the system. Many migrants are unaware that they can buy this insurance, and others hesitate to do so for fear that health authorities could alert the police – although this practice is illegal.

Between November 2003 and October 2004, MSF ran a project in the Fribourg canton, providing care and organizing a network of groups to address the medical and social needs of excluded people. During this period, MSF staff itself conducted 392 consultations for 180 patients and referred 56 percent of them to other health care facilities for further care. In November 2004, a new local association assumed responsibility for the project. The project will continue to receive support from local health authorities.

With the successful launch and hand over of the Fribourg project, MSF has now turned its attention to Zurich. MSF believes that its exploratory work will reveal many people living in difficult conditions in this large city. A team plans to assess their needs, determine how much medical care is already available to them, and look at where local groups may already be providing services to them. MSF is also considering carrying out additional evaluations in other parts of the country.

MSF has worked in Switzerland since 2003.

Palestinian Territories

Providing crucial mental health and medical care

Since the beginning of 2004, the humanitarian situation in the Palestinian territories has continued to deteriorate. A continuing cycle of attacks and retaliation between Israelis and Palestinians killed 931 people in 2004. This figure includes 816 Palestinians, the overwhelming majority of them minors, and 115 Israelis, including eight children. Army incursions, arrests, demolition of property, sieges, rocket attacks, targeted killings and suicide bombings have become a horrifyingly normal part of daily life for most people.

The region's political atmosphere was strongly affected by the announcement of unilateral disengagement from Gaza by Israeli Prime Minister Sharon in August 2004 and the illness and death of Palestinian leader Yasser Arafat a few months later. Both the direct violence (incursions, shootings, bombings) and indirect violence (occupation, closure, control) have affected the mental health status of the Palestinian population. MSF provides medical and psychological care to those who have been injured or mentally traumatized by the conflict as well as to those who lack access to medical care in the cities of Hebron and Nablus in the West Bank, and in the Gaza Strip.

MSF has expressed growing concerns about the long-term psychological impact that high levels of concentrated violence can have on communities. MSF psychologists conducted more than 4,000 consultations during 2004 with patients in the Gaza Strip, Hebron, the town of Jenin and later Nablus.

"This year, it was not uncommon in Gaza to find, within one single family, violent experiences ranging from a death, to the destruction of the house, to the arrest of some members and a wide incursion into the area where they live."

- Sue Mitchell, MSF psychologist in the Palestinian territories

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After her son was killed and their house was destroyed by bombs, this mother moved with her other eight children to a garage on the other side of the street. The family depends entirely on support from others and participates in MSF's trauma treatment program.

After a traumatic event takes place, the MSF team attempts to conduct assessments of victims to identify their most urgent needs. MSF provides medical and psychological care or social support at the request of families. Those who need long-term care receive home visits from the team. While most of the psychosocial therapy sessions are held with individuals, MSF also provides a great deal of family therapy and some group therapy with children and teenagers. Whenever possible, MSF tries to use the existing Palestinian network to deliver medical and social care and urges families to use this network.

The population of the West Bank lives amid more than 700 roadblocks and permanent checkpoints, which severely hamper their movement within the territory. A significant consequence of the closure policy has been the collapse of the economy and the impoverishment of the population. The World Bank estimates that 47 percent of the territories' population lives in poverty.

In the southern West Bank city of Hebron, MSF's team of physicians and social workers refers numerous patients to MSF psychologists. The main health problems encountered include gastrointestinal diseases, skin infections (often caused by poor hygiene) and respiratory illnesses (often linked to harsh living conditions). Many civilians complaining of body pain are actually experiencing some sort of mental distress.

The Israeli authorities' decision to construct a high concrete security wall to separate Israel from the West Bank has made it extremely difficult for civilians in the southern Hebron district to obtain needed health care. Immunization rates for children have also declined. MSF continually assesses whether Palestinians living in communities near the wall need medical or psychological help. Teenagers and children who have witnessed violence during the arrest of family members are among MSF's target populations in this area, and the organization has created a new therapy group focused on women.

In the Gaza strip, a series of Israeli military incursions has 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, and approximately 90 homes have been demolished each month.

Since September 2004, and the onset of Israeli military action, MSF medical teams have not received authorization from Israeli authorities to visit the vast majority of their patients in the southern and central areas of Gaza. Even before this development, MSF faced challenges gaining access to patients among Gaza's three distinct segments. Until September 2004, MSF staff had been working with residents who were confined to the area by strict security rules and numerous military checkpoints. When possible, an MSF doctor, three psy-

chologists and a social worker had visited families in their homes to listen to their stories and provide psychotherapy, medical care or social support. The team had also used drawings and games to help children overcome traumatic experiences such as the destruction of their homes.

Leaving Jenin, opening in Nablus

In October 2004, MSF ended its activities in the northern West Bank city of Jenin due to a severe drop in symptoms and a large decrease in patients. These improvements seemed due in part to fewer destructive incursions and a less volatile security situation. However, in mid-2004, an assessment conducted in Nablus in the northern part of the West Bank found a population under constant pressure, with Israeli army incursions taking place nearly every day. In November 2004, MSF began giving medical care and psychological counseling to civilians living in the area, which has been cut off from the outside world by checkpoints, security fences and other measures. The teams report that the daily experience of violence has had social, cultural and economical impacts and has led to anxiety, stress, depression and the weakening or even destruction of some families.

MSF has worked in the Palestinian territories since 1988.

Facts and Figures

Médecins Sans Frontières (MSF) is an international, medical humanitarian organization that is also private and not-for-profit. It is comprised of 19 national branches in Australia, Austria, Belgium, Canada, Denmark, France, Germany, Greece, Holland, Hong Kong, Italy, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland, the United Kingdom, the United States, and with an international office in Geneva.

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, they are included in the scope of the financial statements presented here. The figures presented here describe MSF's finances on a combined international level. These 2004 combined international figures have been set up in accordance with MSF international accounting standards

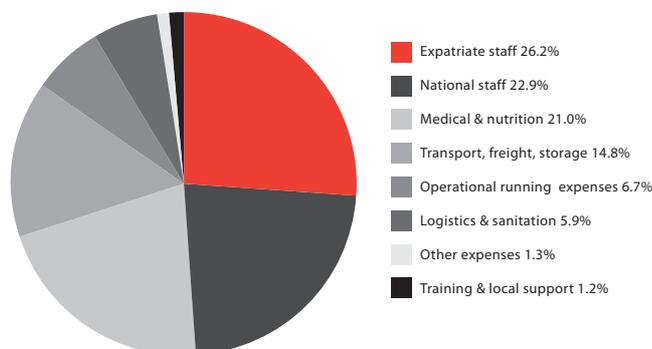
which comply with most International Financial Reporting Standards (IFRS). The figures have been audited by the accounting firm KPMG according to international auditing standards. Because of these new procedures, the figures for 2003 are presented in a slightly different format than in previous years. A copy of the full 2004 financial report may be obtained from the International Office upon request. In addition, each branch office 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 the national offices.

Due to the fact that the Greek office rejoined the international movement in 2005, it is not included in the scope of the 2004 combined financial statements presented here. However, for information purposes, its total expenditures in 2004 were 5.3 million euros. Its total income was 4.5 million euros and its total balance sheet amounted to 5.3 million euros.

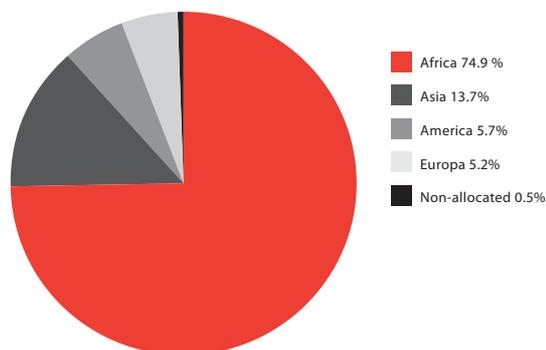
The figures presented here are for the 2004 calendar year. The Activity Report itself covers the period mid-2004 to mid-2005. All amounts are in millions of euros. *NB: Figures in these tables are rounded off and this may result in slight addition differences.*

Where did the money go?

Program expenses* by nature



Program expenses* by continent



Program expenses by country/region

Countries/Regions	In M€	Countries/Regions	In M€
Africa		Asia/Middle East	
Sudan	50.4	Afghanistan	5.4
Democratic Republic of the Congo	27.6	Myanmar	4.6
Angola	16.0	Cambodia	3.7
Liberia	13.5	Thailand	3.2
Cote d'Ivoire	9.2	Indonesia	2.6
Chad	9.0	Pakistan	2.0
Burundi	8.9	India	2.0
Ethiopia	7.9	China	1.8
Kenya	7.3	Armenia	1.7
Uganda	6.5	Georgia	1.6
Mozambique	5.8	Uzbekistan	1.5
Sierra Leone	5.6	Bangladesh	1.3
Republic of the Congo	5.0	Palestinian territories	1.2
Somalia	4.9	Iran	1.1
Malawi	4.1	Other countries*	4.3
Guinea	3.5	Total	38.0
South Africa	2.9	Americas	
Nigeria	2.2	Guatemala	3.9
Burkina Faso	2.0	Colombia	3.7
Rwanda	1.9	Haiti	2.5
Zimbabwe	1.9	Ecuador	1.0
Cameroon	1.9	Honduras	1.0
Mali	1.8	Other countries*	3.7
Zambia	1.6	Total	15.8
Niger	1.2	Europe	
Central African Republic	1.1	Chechnya / Ingushetia / Dagestan	6.3
Tanzania	1.1	France	2.3
Other countries*	2.8	Belgium	1.1
Total	207.6	Ukraine	1.1
		Other countries*	3.5
		Total	14.3

* project and coordination team expenses in the countries

* "Other countries" combines all of the countries for which program expenses were below 1 million euros.



Income	2004		2003	
	In M€	In %	In M€	In %
Private Income	342.8	74.8%	288.3	75.5%
Public Institutional ECHO*, EU & DFID**	55.9	12.2%	40.8	10.7%
Public Institutional Other	47.0	10.3%	36.8	9.6%
Other Income	12.4	2.7%	15.9	4.2%
Total Income	458.1	100.0%	381.9	100.0%

* unaudited figures

How was the money spent?

Operations	321.5	76.3%	285.9	76.2%
Témoignage	14.5	3.4%	14.3	3.8%
Other humanitarian activities	7.9	1.9%	8.0	2.1%
Total Social Mission	343.9	81.7%	308.3	82.2%
Fundraising	49.2	11.7%	43.0	11.5%
Management, general & administration	28.0	6.6%	23.8	6.4%
Total Expenditure	421.1	100.0%	375.1	100.0%
Net exchange gains & losses (realized and unrealized)	-2.8		-7.2	
Surplus/(deficit)	34.2		-0.4	

* European Community Humanitarian Office ** UK Department for International Development

Sources of Income

As part of MSF's effort to guarantee its independence and strengthen the organization's link with society, we strive to maintain a high level of private income. In 2004, 77.5% of MSF's income came from private sources. More than 3.1 million individual donors and private funders worldwide made this possible. Additional public institutional agencies providing funding to MSF include among others, the governments of Belgium, Canada, Ireland, Luxembourg, The Netherlands, Norway, Spain, Sweden and Switzerland.

Expenditure

Expenditures are allocated according to the main activities performed by MSF. Operations gather program-related expenses as well as the headquarters' support costs devoted to operations. All expenditure categories include salaries, direct costs and allocated overheads.

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 non-designated donor 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 2004, their available part (the unrestricted funds decreased by the conversion difference) represents 6.6 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.

Additional closures: Tsunami disaster

Public donations received in response to the December 2004 tsunami disaster resulted in contributions totalling an estimated 109 million euros, of which 36.4 million euros were received in 2004, and the balance in 2005. The funds received will be used for tsunami-relief operations or "derestricted" with the consent of donors and spent where they are most needed within MSF's ongoing work. MSF expects to spend 24.6 million euros in 2004 and 2005 on operations in the regions affected by the tsunami, with 19.5 million euros in Indonesia, 4.1 in Sri Lanka and 1.0 in India, Malaysia and Thailand. Expenditures stood at 20.9 million euros at the end of August 2005. In 2004, 2.1 million euros were used and recognized as resources. The remaining donations received in the year are carried in the balance sheet (totalling the amount of 34.3 million euros) and are presented within the liabilities as "unspent temporarily restricted funds".

Balance sheet (year-end financial position):	2004	2003
	In M€	In M€
Non-current assets	31.7	31.6
Current assets	91.2	56.8
Cash & equivalents	201.8	163.7
Total assets	324.7	252.1
Permanently restricted funds	2.8	5.7
Unrestricted funds	236.6	199.6
Other retained earnings	-3.7	-2.4
Total retained earnings and equities	235.8	202.9
Non-current liabilities	7.6	7.1
Current liabilities	43.3	39.0
Unspent temporarily restricted funds	38.0	3.1
Total liabilities and retained earnings	324.7	252.1

HR Statistics

International departures (full year):	3,803	100%	3,444	100%
Medical pool	1,034	27%	972	28%
Nurses & other paramedical pool	1,257	33%	1,068	31%
Non-medical pool	1,512	40%	1,404	41%
First time departures (full year):	1,340	(*) 35%	1,092	(*) 32%
(*) in % of the international departures				
Field positions:	24,666	100%	17,995	100%
Expatriate staff	2,026	8%	1,896	11%
National staff	22,640	92%	16,099	89%



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