Médecins Sans Frontières experience in the provision of health care in complex settings

Since 1970, *Médecins Sans Frontières* (MSF) has been providing medical care to vulnerable populations. This article aims to show the role of MSF as a medical non-governmental organisation and its impact on the health of populations. *Médecins Sans Frontières* is best known for its emergency interventions, providing assistance to victims of natural disasters, epidemics, and armed conflicts. The expertise of this group includes setting up medical and health services that range from surgical and nutritional to psychosocial care in difficult settings. The determination of medical and non-medical volunteers has brought them to work in war-torn countries such as Rwanda, Congo, Sierra Leone, Sri Lanka, and Afghanistan, as well as in less well-known areas of conflict such as Mindanao in the southern Philippines, Moluccas in Indonesia, and Colombia. At the moment, MSF is working on approximately 400 projects in 80 countries. Apart from emergency settings, MSF has also developed protocols for complex diseases such as HIV/AIDS for populations that have neither the means nor the technical knowledge to deal with these health calamities. *Médecins Sans Frontières* is the first medical organisation to apply simplified antiretroviral treatment protocols to treat AIDS in resource-poor areas in South Africa. Currently, MSF has experienced medical teams in nine developing countries using the simplified treatment models for AIDS patients.

Médecins Sans Frontières also carries out epidemiological programmes for rare diseases such as Ebola. In 1995, there was a major outbreak of haemorrhagic fever in the town of Kikwit in the south-west of Zaire, now called the Democratic Republic of Congo. A team of MSF medical volunteers went to investigate and help the local authorities set up control measures. It was an elaborate operation as the team had to address several issues at once—strengthening treatment facilities at the local hospitals and dispensaries, confirming the nature of the epidemic, and instituting control measures. In principle, the clinical features of the Kikwit disease could have been caused either by yellow fever or Ebola. The severity and high case fatality rate seemed to point to Ebola, however, as did the pattern of transmission—initial epidemiological surveillance of cases appeared to implicate person-to-person transmission, rather than transmission by a mosquito vector. Indeed, the groups most affected were pregnant women and young children. A particular risk factor was living within close proximity of a health centre or hospital. Closer questioning of the people affected revealed that many of the patients had received an injection during the previous days or weeks—the women against tetanus in the context of their antenatal care, and the children as part of their regular immunisations. This information led to urgent investigation of sterilisation techniques by local medical staff and it was found that needles and syringes were being reused without proper sterilisation. The first intervention, therefore, and the most effective step in bringing an end to the outbreak, was to provide adequate supplies of sterile equipment and to provide training for the staff on how to prevent contagion. Another task in which MSF has gained tremendous expertise in the past decade is the response to massive epidemic outbreaks in countries that have little or no capacity to manage them. In January 2001, MSF had to handle a major yellow fever outbreak in Guinea. During that time approximately 100 000 refugees from Sierra Leone and Liberia trapped in a war zone had no possibility of fleeing and no access to health care. Together with the local population, a total of one million people needed to be vaccinated. The Guinean government simply did not have the resources to deal with such a health disaster and, as a result, MSF successfully intervened with a large-scale vaccination campaign.

The above examples serve to illustrate how MSF attempts to complement formal health sectors. But there are also moral dilemmas involved in providing health care to vulnerable populations. Dependence on external assistance can have detrimental effects since it can hamper and minimise governments' responsibilities to improving the well-being of their populations. External assistance can even be manipulated to support systems that might have caused the failure in the first place. For example, MSF was the first independent humanitarian organisation to enter the Democratic People's Republic of Korea in 1995, yet teams were often unable to have full and unfettered access to the population and to independently monitor the nutritional and medical status of vulnerable groups. Despite individual reports of major famine in some areas, MSF feeding centres had low numbers of malnourished children, who could not be assessed without the presence of authorities. For these reasons, MSF left in the fall of 1998 to avoid its medical and food assistance being manipulated.

At the heart of its humanitarian principles, MSF does not wish to substitute formal health structures in countries where it works. *Médecins Sans Frontières* believes that it is the governments' responsibilities to provide health care to their people, which is why MSF so often speaks out and seeks to provoke change and catalyse initiatives. Wherever possible, MSF will pass on its knowledge to populations and institutions that may benefit from the group's years of experience in patient care and treatment.

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