

A Case Study of Medecins Sans Frontiers and International Humanitarian NGO Effectiveness

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Undergraduate Honors Program

International Studies

**A Case Study of Medecins Sans Frontiers and
International Humanitarian NGO Effectiveness**

by

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submitted in partial fulfillment of the requirements
the degree of

B.A.

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Abstract

This essay examines the effectiveness of international humanitarian aid. It focuses on the case study of Medecins Sans Frontiers (MSF), analyzing how its organizational structure and principles can act as a measure for the effectiveness of its field operations. MSF's HIV/AIDS clinics throughout Kenya as well as their international campaigning efforts are presented as an effective way to provide access, care, and treatment for HIV/AIDS. The overall conclusions of the essay draw specifically from MSF, suggesting that their long-term aid commitments should expand in both breathe and depth and that the organization is a model of effectiveness for other large international humanitarian aid organizations to follow.

Table of Contents

Index of Abbreviations.....	page 1
Chapter 1: Introduction.....	page 2
Chapter 2: Case Study and Organizational Theory.....	page 12
Chapter 3: History and Organizational Structure.....	page 25
Chapter 4: Humanitarianism in Principle and in Practice.....	page 41
Chapter 5: HIV/AIDS Prevention and Treatment in Kenya.....	page 60
Chapter 6: Concluding Remarks and Recommendations.....	page 90
Appendix 1: James Orbinski Nobel Prize Acceptance Speech 1999.....	page 103
Works Cited.....	page 109

Index of Abbreviations

ART	Anti-Retroviral Therapy
ARV	Antiretroviral
EU	European Union
FTAA	Free Trade Area of the Americas
GATT	General Agreement on Tariffs and Trade
HAPAC	HIV/AIDS Prevention and Care
HBC	Home-Based Care
ICRC	International Committee of the Red Cross
MDM	Medecins du Monde
MOH	Ministry of Health
MSF	Medecins Sans Frontiers
PCC	Prevention and Care Clinics (card)
PLWHAs	People Living With AIDS
POS	Political Opportunity Structures
R&D	Research and Development
TB	Tuberculosis
TRIPS	Trade Related Aspects of Intellectual Property
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WTO	World Trade Organization

Chapter 1: Introduction

“Our action is to help people in situation of crisis. And ours is not a contented action.”

-James Orbinski, 1999 Noble Prize Acceptance Speech

Chapter 1: Introduction

Some wonder why the medical relief organization Medecins Sans Frontiers (MSF), also known as Doctors Without Borders, is often referred to as the “cowboys” of humanitarian aid. This rough and tough group of doctors and their medical teams that “go where no one else will go” have quite the reputation for affecting change in some of the dire situations that the world has ever seen. What makes this group so special? What drives their successes? As medical non-governmental organizations (NGOs) around the world wonder about and debate where their place is within the international community, MSF seems to act independently, essentially paying no heed to any expressed limitations. Their recent expansion into “long-term” medical aid is a perfect example. They are supposed to be a medical relief organization, yet since the mid 1990s they have been setting up shop in numerous countries, starting clinics and working with the countries’ governments to get those in need access to treatment. The HIV/AIDS crisis in Kenya and MSF’s actions through its Access to Essential Medicines Campaign and treatment clinics provides a detailed case study for the reader or researcher interested in understanding the complex puzzle of MSF and its unique and effective work in humanitarian aid.

Presently, more than 28 million people on the African continent are infected with HIV.¹ With the current fragmented and selective response of the international community, UNAIDS proposes that Africa will remain within a whirlpool of “traps and legacies” and 80 million people globally will have died from AIDS by 2025.² Global AIDS conferences,

states, international and national organizations have promised “Access for all” in regards to treatment. But with the amount of time, money and other resources pledged, this is a blatant impossibility. What is clear, however, is that without treatment, most of these people will die over the next decade and the number of people infected will most likely double. “AIDS is not only a deadly disease; it is the greatest scientific, political, and moral challenge of our era.”³ If organizations, such as MSF, wish to attempt to stop the tide of this epidemic, they must combat the crisis of HIV/AIDS as a long-term medical emergency.

There are indeed thousands of NGOs working hard at improving the plight of those affected by HIV/AIDS, but most fail to raise awareness for this medical emergency. In contrast, not only does MSF recognize the scientific and moral need but it is one of the few that speaks out about the political side of the crisis and advocates for change. It was the first non-governmental organization to provide emergency medical assistance and publicly bear witness to the plight of the populations they served. Its commitment to “temoignage” or bearing witness to the underlying causes of suffering makes it unique among NGOs that focus on emergency healthcare aid. The former President of MSF France, Rony Brauman, stated, “We are by nature an organization that is unable to tolerate indifference. We hope that by arousing awareness and a desire to understand, we will also stir up indignation and stimulate action.”⁴

Though the organization discourages the use of the playful nickname, the cowboys are indeed crossing into a new frontier and are doing quite well. In essence, this essay will discuss MSF’s efforts to extend into long-term medical emergency relief for HIV/AIDS and seek to illustrate that they are the most effective in providing care and treatment to those in need. This effectiveness is due to the influence of MSF’s unique history, principles,

organizational structure, and the implementation of its values.

Methods

There are two types of inquiry that will be performed - one is practical the other is organizational. The former is in large part a consequence of the latter. Organizational theory will be discussed briefly as will an in depth analysis of the structure and organization of MSF. The practical inquiry will examine MSF's long-term medical field efforts in Kenya to provide HIV/AIDS care and treatment. Its aim is to illustrate how one organization has brought theory and concept into reality to make an effective organization. The overall goal is to start out with a broad scope of the theoretical analysis and gradually narrow it as the MSF comes into focus as a progressive international NGO within the sector of long-term humanitarian aid. The thorough analysis of Medecins San Frontiers (MSF) as an international NGO dedicated to the crisis of HIV/AIDS in Africa, most specifically Kenya, will be based on a single case study, and at times use the comparative method with other NGOs in the same field, analyzing and explaining how and why they are effective in their mission towards treating those in need with high quality health care. That which seems to cause this effectiveness will be closely and thoroughly analyzed to illustrate the hypothesis that MSF is the most effective international non-governmental organization providing long-term medical relief, including prevention, care, and treatment, in the medical emergency of HIV/AIDS.

There are certain causal claims that will be made in order to support the hypothesis for the effectiveness of MSF. These claims will be an answer to the question: what is it about MSF that makes it appear to be the most effective as a large international organization

in treating HIV/AIDS in crisis ridden areas? A thorough analysis of this single case study will be performed to reveal the important aspects of MSF's mission and charter, their method of operations, their funding, their political stance, particularly dealing with neutrality, which lead to their effectiveness.

In order to illuminate these key features of the causal narrative, a system of measurement for the effectiveness of NGOs, such as MSF, in their efforts towards treating and preventing HIV/AIDS must be developed. This system will weigh certain variables more than others as well as take into consideration any antecedent conditions that may be present. These conditions could include that of a direct conflict, the national government, culture and society, the particular group that is in the most need, and anything else that makes a particular case truly unique. My measurement for effectiveness will be comprised of qualitative evaluations of MSF's impact on the Kenyan HIV/AIDS epidemic, its political and social contexts, and the international impact MSF has had as a result of temoignage. The impact of MSF's political presence will focus on greater access to affordable medicines, in particular anti-retroviral drugs (ARV's), official or unofficial changes in policy or legislation, and their political activism to combat the epidemic. The impact of MSF's social presence will focus on the quality of care given to the patients, MSF's ability to reach those in most need, and any change in the social stigma that the disease carries. A summary of these efforts and their effectiveness based on these qualitative evaluations and recommendations for change will be made.

The goal of the in-depth process-traced case study of MSF and the use of the comparative method to include other international NGOs is to show the importance of key variables, such as MSF's sources for its funding. I am basing the use of this method off of

Evera's comment that, "hence a thorough process-trace of a single case can provide a strong test of theory" (Evera, 65). The comparisons will allow MSF to be evaluated against their own peers, yielding fruitful recommendations for both sides. The same goes for presenting the different MSF programs. This analytical inductive approach to theory development that will analyze how the approach that MSF takes in its stated mission and adherence to its principles through operations is better than other NGOs.

Finally, the study will be carried out in three phases. The first phase will explain organizational theory and develop a working knowledge of MSF, investigating their history, organizational structure and principles. The second phase will carry out the case study of MSF in Kenya, its clinics and its efforts of temoinage. The third phase will look at the results of the case study to assess MSF's effectiveness and make both theoretical and operational suggestions.

Sources

The research for this project has been concentrated within four categories: organizational theory, humanitarian aid, the organization of MSF, and MSF in Kenya.. The research also followed a progression that began in general terms and moved towards the more particular. It started with NGOs within the international community have been combating HIV/AIDS and gradually moved to how emergency medical relief NGOs within the arena of humanitarian aid have become involved. The research then began to specifically focus on MSF and its medical efforts, most specifically in Kenya. The organizational structure, its relationships, and the principles that the organization lives by were considered crucially important aspects to the research findings. In particular, MSF's Access to Essential

Medicines Campaign was carefully analyzed and researched in order to assess its impact on the Kenyan society. Thus, the case study of MSF in Kenya and its efforts towards HIV/AIDS prevention and treatment was born. In addition, research on other large international organizations with a medical component was performed for the sake of comparison, making the case study of MSF in Kenya more applicable.

In general, the resources necessary for this project include: books, journals, book reviews, Kenyan newspapers, and internet websites. An informal interview was conducted from a fellow colleague who had volunteered under MSF France in Homa Bay for a period of a few weeks in spring 2004. The resources needed for such a project have been found at the libraries of Boston College, online, through phone conversations or interlibrary loan. Two websites in particular, www.doctorswithoutborders.org and www.msf.org, have been fully utilized. They have been particularly useful in obtaining detailed information about the HIV/AIDS clinics and programs in Kenya which MSF runs. The particular journal, *Journal of the American Medical Association*, which MSF uses to publish many of its findings has been used. Online access to *The East African* and *the Daily Nation*, two Kenyan newspapers, has been the main source of information directly from Kenya. The book, *Hope in Hell: Inside the World of Doctors Without Borders*, by Dan Bortolotti has been used extensively for information regarding the structure, organization, and history of MSF. David Rieff's book, *A Bed for the Night: Humanitarianism in Crisis*, has been particularly useful as a source for the comparison of MSF to other medical humanitarian organizations, most specifically International Committee of the Red Cross (ICRC), as well as information on the international debates taking place over the definitions of neutrality, impartiality, and independence. Fiona Terry's book, *Condemned to Repeat? The Paradox of Humanitarian*

Action, was influential for the overall conclusions of the case study.

External Validity

The validity of this project will be four-fold. First, it will provide MSF with new resources to evaluate their programs throughout Kenya, enabling them to make judgments on the current status of projects and perhaps offer suggestions aimed towards change and improvement towards greater effectiveness. Secondly, it will give other international humanitarian NGOs a single case study to compare and contrast themselves, possibly leading towards institutional or organizational change. Thirdly, it will inform the general reader about the organization of MSF and how such an activist organization is fighting the overwhelming crisis of HIV/AIDS in a particular context of a developing African country. Finally, it will help illustrate to the reader how they as individuals may actively participate on a small scale in order to help alleviate the suffering of so many in combating an overwhelming worldwide crisis.

The principles and organizational structure of MSF, and consequently its operations, are the most effective approaches for reaching those in greatest need. This conclusion will be of importance for the practical and effective implementation of theory and moral obligation. HIV/AIDS is an archetypal case that the international community, specifically international humanitarian NGOs, should utilize as a great opportunity to implement their professed priorities and values. What role these organizations claim within the international community, will be determined by how they react to the AIDS crisis. The purpose of the MSF case study is for the organization to serve as a progressive role model that takes

advantage of their unique role within the international community, advocating for institutional changes and implementing their own practical goals worldwide.

Secondly, there is a general claim that HIV/AIDS has become an economic and social security issue. Where the disease is rampant, it affects that society to the core. The working class in those societies is the first to die off, leaving the young and the elderly no one to help them meet their needs. With the majority of a population left unable to support themselves, a society is vulnerable to collapse which greatly destabilizes the state and increases the possibility for conflict. The economy is also negatively affected as fewer workers, especially less skilled workers, equal less production and therefore less income. The decrease in a developing country's economy translates into a decrease in economic potential for the affluent nations in this interconnected world. How MSF has gone about its medical relief will shed light on how to deal with the security issues that arise from the pervasive character of the virus.

The dedication of MSF to helping those in need works towards putting into practice the moral imperative that natural law suggests. Considering the effects that MSF has on the moral framework of humanitarian action is important because its principle of bearing witness gives it influence over other similar organizations and the general public. General Romeo Dallaire, head of the United Nation's peacekeeping efforts in Rwanda during the genocide in the 1990's, said in a television interview regarding the genocide, "Are we all human? Or are some more human than others?" A hope for this project is to build up and maintain within these concerned humanitarian organizations and individuals awareness and support of what has been coined the "humanitarian imperative."

Why We Should Care

“The global common good, including participation in the good of health care, is an indispensable moral criterion for evaluating policies and politics, as well as for our personal investments of votes, dollars and time.”

-Lisa Sowle Cahill, “Realigning Catholic Priorities”

Lieutenant General Romeo Dallaire often asks questions, “Are all humans human? Or are some less human than others?” When one considers that there are currently 40 million people living with the virus around the world, almost 30 million of those in Africa alone, and with grossly insufficient action being taken by world governments to combat the crisis, it is hard to say that those infected with HIV/AIDS are allowed to maintain the same human dignity as others. The sick are merely a statistic and in fact, are less than human. Unfortunately, many people do not even realize that their answer to Dallaire’s question is “yes.” MSF, on the other hand, has been committed to answering “no.” MSF’s principle of helping those in greatest need has led them to care for those infected with HIV/AIDS in Kenya as well as other places. They are there to heal and bear witness to the sick and their plight; to reach out to those in a poor resource setting in need of healing.

For those who are passionate about people, any kind of people, just because they are people, this analysis is extremely important. Social justice demands that the individual give all s/he can for the common good in his attempt to help restore human dignity to all. The global common good should be thought of as a link among local and global realities where certain goods are shared and beneficial for all members of the global community. In July 2001, the recently deceased Pope John Paul II spoke of the consequences that the global common good should have on nation states to President George W. Bush. “Respect for

human dignity and belief in the equal dignity of all the members of the human family demand policies aimed at enabling all peoples to have access to the means required to improve their lives...."⁵

MSF contributes to the common good by helping to restore human dignity in supplying medical care to the poor and bearing witness, stressing the importance of a more just distribution of healthcare. For other organizations or individuals, their contribution to social justice and the common good may mean something else. MSF has merely set a precedent for encouraging those who wish to uphold the humanitarian imperative by contributing to the common good in order to respect the human dignity and equality of all, so that all humans are human. Even though the ordinary United State's citizen may feel too distant from those dieing of HIV/AIDS to help, "the humanity of such persons calls us to recognize their dignity" and therefore, we must act to restore it.⁶

Chapter 2: Case Study and Organizational Theory

Case Study

My central concern about international NGO effectiveness in long-term medical relief in HIV/AIDS will gradually narrow its scope from the more theoretical to the single case study of MSF. The examination of MSF and its efforts towards HIV/AIDS care and treatment in the East African country of Kenya, what it does, why it does it, and how it does it, combines the practical with the theoretical. The reader will begin to see the relevance of theory as well as its importance as she examines the way it is implemented in MSF, an effective organization at combating the HIV/AIDS crisis for those most in need. The narrative of MSF will seek to identify certain aspects or principles of the organization that set the NGO apart from others, proposing it is because of these aspects that MSF is more effective. The case study of MSF will begin with a background of the organization's history and organizational structure and then will be Kenya specific, focusing on the areas of Homa Bay, Busia and Nairobi. The history and present day efforts of MSF in HIV/AIDS prevention and treatment in each of these areas, how these efforts reflect the organization's principles, priorities, and stated goals, and finally how effective MSF seems in each region will be examined. Within the analysis, different programs and organizations will be compared and contrasted with each other illustrating the different options and choices there are for international NGOs to organize and implement their goals.

The strength to a case study approach is the ability to test how the independent causes the dependent variable, illustrating how a theory or hypothesis actually works (Evera, 55). In this case it is to analyze how numerous independent variables cause the dependent variable, namely effectiveness. Its use as an analytical tool of actual reality, however, will ultimately

be limited to what Njolstad calls the “indeterminacy of historical interpretation” (Njolstad, 223). There are plenty of social scientists who consider the methods of case study and comparison to be strong methods of analysis. However, some such as Njolstad, do point out limitations and weaknesses, but none regard case studies as pointless or useless. It is precisely because of their strengths of in depth analysis and ability to explain *how* that I desire to use the case study in my thesis. Thus, I will attempt to adhere closely to a standardized method of analysis in order to produce a structured and focused comparison.

Validity

In terms of King, Keohane, and Verba, “validity refers to measuring what we think we are measuring” (p.25). My in-depth analysis of MSF as an organization as well as a relatively narrow component of MSF - its long-term medical HIV/AIDS programs in Kenya - will provide the reader with a rich array of data and evidence with which to measure the key concepts that are presented within this single case study. Any statistical analyses that were to be made about the impact of MSF in Kenya would be virtually impossible. There would be no isolated data that just included MSF as an organization. All the numbers would also include the impact of the Kenyan government and other NGOs that are present, such as International Committee of the Red Cross (ICRC) and Catholic Relief Services (CRS). Therefore, qualitative analysis of a case study is the most fruitful method of study in which to realize the extensive impact that MSF has had.

Limitations

Limitations in validity will occur in the motivations behind the interview that I conducted, my own bias in approaching the analysis of MSF, and my choice of it as a case study in the first place. Lack of extensive personal experience with either the organization itself or the specific Kenyan programs will also put limits on the depth of analysis possible, however, at the same time decreasing some of the possibility for biases. Also, the exact replication of programs or institutional organizations is not recommended as conditions always vary between organizations and countries. Implementation into other organizations must be tailored to best fit that particular organization's needs within the context in which they are working. However, organizational values, such as the humanitarian imperative, temoinage, and sources of funding can be more generally applied.

By using a simple research design of a single case study, my research and its conclusions will be easily repeatable by any interested parties. The in-depth analysis will also make it easy for readers to continue in any comparison study that they wish to develop between MSF and other like NGOs.

Organizational Theory – Restructuring World Politics

The past 25 years have seen a wave of increase in the number of non-governmental organizations and transnational advocacy groups. Not only are the groups growing in number, but also in breadth, depth, and impact. In fact, they are a part of a larger movement of transnational advocacy groups working together to establish new, as well as strengthen old, international norms to restructure world politics.⁷ The goal of these groups is to “create, strengthen, implement, and monitor” international norms.⁸ Creation of these new norms helps to support and continues to create an “international community” in which state and

non-state actors see themselves bound by a set of common rules and norms. How these groups go about accomplishing these goals, when they are successful, and the complications and challenges they run into on the way will be alluded to through this study, specifically their desire to establish international norms of justice in healthcare and treatment.

For the purpose of this paper, nongovernmental organizations are defined as private, voluntary, nonprofit groups whose primary aim is to publicly influence some form of social change.⁹ This third sector within the international community, with the first two sectors being comprised of states and business, is unique. While states always search for authority and businesses search for profit, transnational advocacy groups such as MSF, search for meaning. Their motivation for action derives from the principles and beliefs that are thought to uphold this meaning. They could be considered “moral entrepreneurs.” Most NGO’s and other transnational actors, such as transnational advocacy networks, coalitions, and movements, when considered on an individual basis among states, are relatively weak. Their power within international politics comes with their ability to persuade and apply pressure based on the dissemination of information, images, and moral arguments.

These groups wield this power in order to help create and institutionalize new international norms. A norm within international relations literature is defined as a “shared expectation held by a community of actors about appropriate behavior for actors with a given identity.”¹⁰ It is through pursuing this goal that this third sector of the international community has become a significant and important actor. For instance, there is a subset of international norms that both states and businesses are bound to and claim to uphold which are not necessarily in line with their own self-interest. These norms do not directly promote stability between states through economic or political collaboration nor do they promote the

bottom line of profit making. States and businesses have, therefore, adopted a set of norms that limit their authority and ability to maximize profit in all circumstances, in large part because of the influence of the third sector.

Success in establishing these norms lies partially in the availability of what is often known as “political space,” similar to what Khagram, Riker, and Sikkink call “political opportunity structures (POS).”¹¹ A “closed” POS is generally an authoritarian or semi-authoritarian regime which is compared to an “open” POS consisting of most democratic regimes. Although Khagram’s article speaks first on the importance of governmental POS’s, for the sake of this paper and the third sector, it is more important to concentrate on the POS’s that international institutions, such as MSF, also create for transnational advocacy. Relatively closed to relatively open political structures can have an important impact on the types of issues taken up by transnational advocacy groups and the priority by which they pursue them.

The increased stature of international norms is important for helping to create international political space for humanitarian issues such as international public health or human rights. Key initiators of new norms are international organizations and transnational nongovernmental actors, who are not only creating temporary political space for their issues but are also establishing themselves as a permanent political feature within the international community.

The ability that these groups have to establish a permanent power and presence within the international community stems from their possession of what Keohane and Nye have called “soft” or informal power.¹² This type of power stems from the ability to communicate and persuade with the dissemination of information. Through information and discussion, groups

can question, criticize, publicize, and propose ideas or norms. In doing so, they present new voices and ideas, enhance deliberation and representation within international institutions, and promote accountability and transparency. It is through these actions that the third sector gains moral authority, the power to influence the international agenda, and shape the way in which issues are perceived and understood. Although the power of the NGO is more “hidden,” many NGOs are successfully attempting to incorporate their power more formally into international debates. For example, there are many NGO’s that are now welcome to attend UN global conferences, giving them unprecedented opportunities for organizing, media attention, and lobbying.¹³ The soft and informal power of NGO’s makes them an unquestionably important and contributing actor to the international community.

It is because these non-state actors are crucial to the dialogue about and decision for the creation of new norms through their exercise of soft power that Sikkink, Riker, and Khagram speak of them as “restructuring world politics.” Within the international community, the absence of a world government is “attenuated by a parallel structure of common rules and norms.”¹⁴ This divided power structure between states and norms creates two potential sources for regime change: power shifts (such as the decline of a hegemon) or norm change. For NGO’s, access to the second power structure based on international norms allows them to “mobilize and achieve influence beyond their command of traditional power resources because world power is as much about authority and legitimacy as it is about material resources.”¹⁵ Thus, the extent to which transnational advocacy groups alter the norm structure of the international community is the extent to which they restructure world politics.

Organization of NGO’s and Its Challenges

If NGO's are restructuring world politics, it is both useful and important to examine the way in which they choose to organize themselves so that one can understand why and how they accomplish their goals and thus, the potential effects their actions have on the international community on both a universal and a particular level. In general, NGO's have four significant internal organizational features that fundamentally shape and affect what the organization is and what it does. The four organizational features are: origination, internal distribution of power and influence, sources of funding, and willingness for collaboration. Each of these organizational features is basic to the priorities and activities of an NGO and its effectiveness.

First, where an NGO originated is important to examine because there is often uneven influence and representation driven by the political or structural logic of North-South differences. Although the geographic variety has increased, the vast majority of NGOs originates and remains based in the developed world, with Europe and North America being the top two locations. This pattern can have a number of detrimental effects. The most powerful and influential NGOs that possess the most extensive networks and resources are most likely located in the North because they are more likely to be connected to rich and powerful developed states that have strong influences in international organizations. This uneven distribution of influence also causes uneven representation. For instance, Northern NGO's are more likely to promote what is typically known as "liberty rights" or individual political and civil rights, whereas Southern-based NGO's focus more on "bread rights" or communal social, economic, and cultural rights.¹⁶ Although many NGOs proclaim to advocate for both sets of rights, many do not realize their commonalities between each other because of their different focuses and consequently sacrifice potential collaboration. The

origination of NGOs therefore affects their networks, resources, representation, and collaboration.

The second important organizational feature, the internal distribution of power and influence, represents the NGO's commitment to being democratic within its own structure. The internal hierarchy of the institution, such as who participates in decision making about leadership and policies (staff, boards, volunteers, members, donors, those on whose behalf they organize) helps to show who is represented, to whom and if they are held accountable, and the degree of transparency. Sometimes, even while institutions promote democracy, they are not themselves internally democratic.¹⁷ Is it better, for instance, for the field staff or the management to decide on operational policies? To whom will they hold themselves most accountable – donors? Staff? Those to whom they organize? Who will they tell of their activities? Will decision-making be concentrated or decentralized? Will their staff be primarily local or mostly made up of ex-patriots? An NGO's internal democratic system of organization is daunting yet fundamental to its task.

The source of funding for an NGO is the third organizational feature. Many NGO's are not membership based and therefore cannot rely on membership dues and donations for sustenance. Instead, many rely on grants from foundations or governments and donations from other private organizations. For example, almost half of all international human rights funding provided by United States foundations between 1973-1993 was provided by only one foundation – the Ford foundation. Governments are also extremely important sources of funding for NGOs and have a way of influencing the NGO towards its own agenda. Issues that often arise because of the source of funding or the competition for funding and are as such: that a few key individuals or governments can greatly affect NGO priorities; funding

for an NGO may come from the very government or organization that they monitor, influencing their independence; and useful collaboration and innovative new programs may be sidelined or even blocked.¹⁸ Also, foundations and governments tend to be biased toward larger and more established NGOs, effectively marginalizing the smaller ones and creating a false hierarchy of importance. The problem has begun to be wrestled with, however, with the establishment of institutions such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria where money is first collected from multiple governments and then distributed based on need.

Finally, an NGO must decide on the extent to which it is willing to cooperate with other NGOs, governments, or institutions that are doing similar or complementary work. For instance, while an NGO's standards and protocol for field operation may be regulated and set in order to ensure the best care of its patients, the management may be committed to being flexible and talking with other organizations in the area to brainstorm ideas for collaboration. Another factor that influences collaboration is competition for limited resources. Funding, educated staff, and information are precious commodities and competition for them tends to diminish cooperation.

It is through these three primary organizational features that an NGO takes shape. However, it must also acquire legitimacy in world politics. An important aspect of this legitimacy is the attainment of "moral authority" to use as a power resource, thus giving the organization influence beyond its material capacity.¹⁹ This type of authority is crucial to effectiveness, particularly in relation to humanitarian crises. In order to obtain legitimacy and make this claim on authority so that they may raise questions about the morality and legitimacy of states, institutions or international norms, NGOs must be perceived as having

some of the following attributes: impartiality and independence, veracity and reliability, representation, accountability and transparency. A heated international debate is currently taking place about the definition and practical implementation of some of these attributes, particularly independence and impartiality and will be expanded on later with direct relation to MSF. For now, the discussion will focus on why these attributes are essential for an effective NGO. As already stated, the perception that others have towards an organization is extremely important. It is through being perceived, both in theory and practice, as having these attributes that organizations receive their legitimacy.

The first two attributes, impartiality and independence, have one goal in mind – an organization that possesses them can be perceived as not being self-interested. The NGO's legitimacy and moral authority stems from the perception that it is disinterested in acquiring economic or political power. In essence, the organization exists to help others in need, not themselves. Yet, there is a difficult balance to maintain because in order to continue its work, the NGO must obtain significant amounts of funding from different wealthy and powerful groups or persons or governments whose own priorities may influence those of the NGO. However, as globalization continues and the world grows more interconnected, maintaining independence, particularly in funding, is fundamental for the humanitarian organization. Amnesty International set an example once by self-limiting its resources by refusing to accept any money from governments or corporations. In contrast, Helsinki Watch, the main United States NGO formed to monitor the Helsinki agreements, was created by a senior United States diplomat who was simultaneously the head of the Ford Foundation, the largest donor to Helsinki agreements.²⁰ Thus, although access to public funding is

essential for many NGOs, it is a difficult balance to keep without it serving to undermine both the actual and perceived independence and impartiality of the organization.

Veracity and reliability of information provided by the NGOs are the second important attributes in developing and maintaining legitimacy and moral authority. An NGO's power to persuade and spur into action relies heavily on the power of information and images. For example, the Save the Children advertisements on television that promote sponsoring a child are full of pictures and stories of children. Without the power of information to support their claims, an NGO's authority is unsupported. Also, any suggestion that an NGO's information is inaccurate suggests that the legitimacy and moral authority of that organization is minimal at best.

The next attribute, representation, relates back to the internal democracy of an organization. Part of an NGO's authority comes from its ability to claim to represent those who lack representation: the sick, the poor, the repressed, the weak. Human rights organizations, for example, claim to represent the voices of individuals and groups in other countries that cannot speak for themselves.²¹ The characteristic of internal democracy is therefore necessary in order to ensure that this representation remains accurate and valid, especially when the headquarters of an NGO are located outside the culture or far away from the group of people the organization claims to represent.

The last two attributes, accountability and transparency, are also closely related to an organization's internal democracy. In a sense, the extent of an NGO's internal democracy as well as its moral authority reaches only as far as they are perceived as being accountable. Transparency, of information sources, activities, funding, and composition, is a prerequisite for accountability. Unfortunately, many NGOs do not have effective mechanisms in place

for either attribute, thus significantly reducing their moral influence and power. Even more regrettable, some are hesitant to establish any mechanism for measuring transparency or accountability, mistaking what would help to increase their moral authority and legitimacy for a limitation on their ability to act. If NGOs wish to be seen as social change instigators, they must begin to take a more proactive role in solving the lack of actual and perceived accountability.²² A possible mechanism to develop could be modeled after the existing mechanisms of accountability for an interest group model or a professional model. With the interest group model, representation of members, dues, and voting procedures for leadership, would be the main source of accountability. The decision-making process would become transparent and the representation more democratic. In the professional model, accountability would result from a greater amount of bureaucracy. An organization could set up mechanisms to set standards of credentialing, and monitoring of standards and staff to ensure accountability.²³ Other models or combinations of models can and should be developed in order that each organization is able to create and implement a mechanism of accountability to help ensure its internal democracy as well as its legitimacy and moral authority.

NGOs and their networks are antidotes to domestic and intergovernmental networks. They are the third sector of the international community and occupy an important and formative role in world politics. In order to be effective, there are crucial organizational features and attributes that must be developed and maintained. As NGOs occupy a unique place in the international community, so also must their features and attributes be distinctive. There are many ways in which NGOs choose to ascribe to each of these characteristics. But when measured against the ideal standard of democracy, representation, and accountability,

most of these organizations fall short. However, their capability and capacity to pursue morally significant issues through the assertion of soft power is restructuring world politics by affecting the structure of norms under which the international community operates. Improving upon their organizational short-comings is therefore in their own self-interest as well as the interest of the international community.

As a practical application of organizational theory, the history, development, and principles that MSF holds to will be discussed in detail so that the reader may understand their importance in the daily activities of MSF and their influence on the effectiveness of these activities.

Chapter 3: History and Organizational Structure

“(MSF is) the most important humanitarian NGO in the world. Its medical protocols have become the model for other relief organizations, and it is both envied and resented by other groups. It is, in an important sense, the conscience of the humanitarian world.”

- David Reiff, *A Bed for the Night: Humanitarianism in Crisis*

And it all started with a couple of young dissatisfied French doctors.

Formation

In 1967, Biafra declared itself independent and seceded from Nigeria which caused a break out of civil war. At the time, the International Committee of the Red Cross (ICRC) was largely in control of the humanitarian aid within the country and was able to deploy the most resources to the victims of the crisis. They were, however, obliged to recruit doctors, many of them French and just out of medical school, to help with their projects. One of these doctors was Bernard Kouchner, who would later be described in *The Economist* as, “Impulsive, provocative, frenetically energetic, teeming with ideas, articulate, generous, and courageous, Dr. Kouchner is also blunt, abrasive, impatient, disorganized, opinionated, and quick-tempered.” - and would later co-found MSF.²⁴ Even though he was not officially part of the ICRC, Kouchner was expected to adhere to the principles of the organization. As part of his employment, Kouchner had to sign a statement in which he promised that he would not speak of or communicate about his mission in Nigeria, even after its termination, without prior authorization from the ICRC. Little more than twenty years after Auschwitz, where this self-censorship had formed the basis of the silent approach ICRC had taken towards the concentration camps, Kouchner, as a Jewish doctor, felt that history was repeating itself. He

believed that the Nigerian government was systematically killing the Ibo people while the ICRC stood silent.²⁵

At some point, Kouchner decided to break publicly with the organization, later stating that, “By keeping silent, we doctors were accomplices in the systematic massacre of a population.”²⁶ When Kouchner returned to France, he organized marches and media events in Paris to raise awareness about the events in Biafra. He and his colleagues also began to envision the formation of a humanitarian organization that would combine medical aid with a willingness to speak out about injustices experienced or seen by the volunteers in the field. At the same time, a group of medical journalists published a call for volunteer doctors to help the victims of earthquakes and floods. The culture of Paris was active and assertive as France’s colonies claimed independence. Posters were hung on the streets that featured a figure in riot gear with the words *Frontiers* (borders) = *Repression* below it.²⁷ Thus, on December 20th, 1971, Kouchner and his colleagues and the group of medical journalists came together to make Kouchner’s vision a reality. The independent relief organization, *Medecins Sans Frontiers*, was destined to refuse to conform and be an obedient member of the “humanitarian community,” and would instead learn to chart its own course of action. Although some jokingly MSF “the bastard child of a doctor and a journalist,” it was this bastard child that became the largest medical humanitarian organization in the world, sending more than 3,000 volunteers to over 80 countries every year to projects in conflict zones, refugee camps, and rural health clinics.²⁸

MSF’s first name was “Group d’Intervention Medico-Chirurgical d’Urgence, The name was meant to prioritize the rights of victims, thus opposing the type of silent relief that the ICRC had offered in Biafra.²⁹ Although MSF was formed as a relief agency and remains

one to this day, it continues to take on more long-term care, such as providing anti-retroviral treatment for people with AIDS or treating tuberculosis and malaria. While it is dedicated to alleviating the burden that HIV/AIDS brings to so many societies, MSF is clear on the limitations of its aid. The project sites do not attempt to eradicate the root causes of poverty even though MSF knows that the lack of resources is a root cause of the spread of AIDS. Although MSF's desire to remain in relief agency status limits its field activities from those of development agencies, it continues to advocate for those activities that will help complement their efforts.

Where there is a distinct difference between development and relief agencies, there is also one between humanitarian organizations and human rights organizations. MSF is of the former group. While human rights organizations' primary goal is to lobby for the protection of international humanitarian law, humanitarian organizations will remain neutral in order to gain access to victims. From the beginning, MSF has struggled with its neutrality, valuing the principle of "temoinage" or bearing witness and not wanting to be an agent of complicity within a regime of oppression and torture.³⁰ On the other hand, neutrality is the fundamental principle that aid organizations must hold to in order to prove that they have no political agenda and to gain access to victims. MSF recognized this limiting factor at its inception, and although there was considerable division, placed the principle of neutrality in the fourth article of their charter.³¹ Kouchner, the leading opponent of the neutrality article, signed the charter as a compromise, knowing that the dispute would not end there. In 1974, when a Kurdish envoy asked Kouchner if MSF would help support their rebellion in northern Iraq, he accepted. Raymond Borel, co-founder of MSF with Kouchner and leader of the medical journalists, seethed at Kouchner's decision. Borel had led the fight to uphold the neutrality

principle in the charter, and Kouchner's decision to help the Kurds was blatantly taking sides in a political dispute. The disagreement grew more intense as Kouchner acted on his decision to help by sending a team to Iraq. The following year, 1975, at MSF's annual assembly meeting, Kouchner and a colleague were elected into the top two positions within the organization. The debate over which principles MSF should adhere to continued to simmer as Kouchner led MSF through its first successes in the following three years.

First of all, in the mid 1970s, the amount of refugees in the world doubled, measuring up to 6 million people.³² The exploding refugee situation caused Claude Malhuret, a prominent doctor in MSF who worked with Cambodians fleeing the Khmer Rouge regime, to develop a new vision for MSF that included longer-term missions, better organization in logistics and administration, and more funds. The young Malhuret quickly gained internal support, and Kouchner's leadership became less popular. In 1979, just eight years after their formation, MSF's leadership was divided over its plan of action concerning the Vietnamese boat people crisis. Kouchner wanted to send a "sea-borne ambulance" to save the stranded boat people and in the process attract media attention which would help to stimulate action from Western states. However, Claude Malhuret and Rony Brauman, another young doctor, disagreed. For them, the boat people were "symbolic" of the greater crisis occurring in Cambodia and not something to be used as a media stunt. They should concentrate their resources on the mainland instead of using the majority of them to save a few.³³ In the end, it came to a vote and 90 out of 120 were in favor of Malhuret and Brauman. The outcome had enough serious implications for the NGO that Kouchner abandoned ship to start his own NGO called Medecins du Monde (MDM, doctors of the world). With its new leadership, MSF would become more professional; their budget would triple its size in a year; and

ironically, it would once again push the limits of neutrality.³⁴ As with the leadership of MSF, its principles remain fluid, evolving through internal debate, according to what is happening around them.

As it grew, MSF developed country focused offices. Each country – France, Belgium, Holland, Switzerland – ran their own offices, had considerable autonomy, and consequently, acquired different ways of doing things. The country-based offices were efficient at logistics and admired for their frugal use of resources. MSF developed the ability to have people anywhere in the world quicker than anyone else by plane, Land Cruiser, or foot. As its offices grew, so did its voice. While MSF Belgium stayed quiet, MSF France was not afraid to criticize Pol Pot’s regime in 1980, or Colonel Mengistu’s in Ethiopia (for which it was expelled from the country). It is through these decisive actions and an internal culture of debate that these “medical mavericks” acquired a paradoxical image. On one hand, their movement was very informal, decentralized, and full of young opinionated doctors. On the other, their technical expertise was sophisticated and efficient, and their actions were decisive.³⁵

This new image helped to increase the popularity of MSF in the 1980’s, with 32 percent of the French public that was polled naming MSF as their dream job.³⁶ The 1990’s saw the globalization of MSF, with offices spreading beyond Europe to the United States, Canada, Japan, Hong Kong, and Australia. However, the innocence and simplicity that many associated with humanitarian aid was subverted during the crises of Rwanda, Somalia, Bosnia, and Kosovo, causing disenchantment with those that supplied aid. MSF was forced to face the complex reality of each crisis and the limitations it placed on their ability to help.

Fortunately, the disdain experienced by so many aid organizations during the 90s motivated some to work harder in order to fix what was broken. James Orbinski was a hard-working graduate from medical school in 1990 with a specialty in pediatric HIV and a previously earned international relations master's degree. Three years after he graduated, he was in Somalia with MSF and later volunteered in Rwanda during the genocide. Also a philosopher, Orbinski was a perfect fit to be the new international president, helping to inspire new images in humanitarian aid, which, as it turned out, helped the organization win its first Nobel Peace Prize in 1999. Orbinski used his presidency as an opportunity to present to the public a different type of humanitarian crisis, "More than ninety percent of all death and suffering from infectious diseases occurs in the developing world," and tropical illnesses are killing people because, "life-saving essential medicines are either too expensive, or not available because they are not seen as financially viable, or because there is virtually no new research and development," into new treatments. "This market failure," Orbinski stated, "is our next challenge."³⁷ With this speech, Orbinski advocated for the creation of a new humanitarian space for infectious diseases and HIV/AIDS. MSF now had a new avenue in which to channel their relief efforts and embarked on their campaign of "change, not charity."³⁸

Today, less than ten years after the beginning of Orbinski's campaign, about half of all the relief agency's projects are focused towards long-term medical assistance that seeks to collaborate with the Ministers of Health in the national government, rehabilitate the hospitals, and organize vaccination programs.³⁹ Programs and clinics are located in countries with collapsed or insufficient health care systems, with the aim of establishing a stable and self-

sufficient healthcare structure. In addition to field work, MSF also puts enormous time and energy into its worldwide Access to Essential Medicines Campaign.

The origin and development of MSF has been fueled by controversy. From its beginnings in Paris, through its multiple changes in leadership, and finally to its commitment to long-term medical care in the face of enduring humanitarian health crises, it has proven itself flexible, changeable, intelligent, and successful in the face of adversity and crisis.

Structural Organization

The history of MSF has heavily influenced the current structure of the organization. For instance, constant disagreements and diverse opinions have allowed for the autonomous development of each country's own office, giving an overall decentralized atmosphere. The institution, funding, program and staff policies, and priority of individual care are no accident. Each has been carefully crafted by the organization in order to increase effectiveness.

Institution

Although MSF started in France, its world headquarters is in Geneva, Switzerland. Its coordinating body is located there and is named the International Council which includes the heads of each section or office, and an international president. The Council serves as an overarching authority, but its power is limited and it does not decree to each operational section any orders. MSF as a whole is a relatively nonhierarchical organization, purposefully providing to everyone a sense of ownership and commitment. The decentralized structure creates for MSFers a “movement of like-minded members.” Instead of a formal, top-down organization.⁴⁰ Each country office, such as MSF France or MSF Holland, has quite a bit of

autonomy, giving it a unique style and personality which helps to add to MSF's unique the culture of debate. For instance, the French are passionate, arrogant, and disorganized while the Dutch are technical and organizational geniuses, and the Belgians have the most experience with HIV/AIDS work.⁴¹ With offices as different as these, opportunities for disagreement as well as great visions abound.

As an institution, MSF's operational offices in the field must be administered by the original five – France, Belgium, Holland, Switzerland, and Spain. The newer offices or the “partner” offices, the United States, Canada, Japan, Hong Kong, and Australia, are responsible for fundraising, recruiting volunteers, and raising public awareness and must always work in conjunction with an operational office.⁴² This structure can often appear to be quite inefficient. For instance, it is possible to have multiple operational sections in one crisis area, each with its different heads of mission and supplies and each with its own focus and responsibilities. Executive director of MSF Holland, Austen Davis helped shed light on the reasons for the operational structure when he said:

One of the chief challenges to humanitarian aid is getting access to victims. It's a very entrepreneurial business, and putting all your eggs in one basket and having a monolithic structure isn't as conducive as floating around a crisis with lots of little groups, lots of little teams, lots of contacts, trying different things.⁴³

For many, MSF is a model of something that shouldn't work, but does. Even though it has no clear central authority, it is renowned for its ability to act quickly. In fact, MSF's capacity to succeed seems to resemble an urban legend that says that aerodynamically, the bumble bee shouldn't be able to fly, but it doesn't know it, so it goes on flying anyway.

Another important aspect of MSF's structural organization is its private and voluntary nature. One of the reasons that Kouchner lost the internal power struggle in the 70s was because he insisted that humanitarianism should be in the service of states and at the heart of

state policy.⁴⁴ For Kouchner, states needed to learn to be humanitarian. They needed to be willing to fight for justice if a revolution of moral concern over human rights was to affect the international community. His main opposition on this point was found in the other co-founder of MSF, Raymond Borrel who saw relinquishing independence as the end of the humanitarian movement.⁴⁵ Kouchner quit and MSF remained both private and voluntary, an organization that represents civil society. This civil society organizational status has allowed MSF to capitalize on the new ‘global role’ of civil society by creating informal legitimacy for action and support through public opinion.⁴⁶ It is also a great base from which to draw support.

Funding

Compared to the significant impact that MSF has had around the world, both in the number of lives saved as well as publicity about crises, their budget is not huge. It’s about \$400 million and over 80 percent of it comes from private donations. Other agencies often spend more, such as the \$1 billion that World Vision’s US branch spent in 2002. Some humanitarian aid NGOs, give the impression that they rely much more on donations from the public than they really do. It is often the case that these NGOs are heavily dependent on funding from government agencies. In contrast, only about 20 percent of MSF’s total budget comes from international agencies, such as the United Nations High Commissioner for Refugees (UNHCR) and the European Commission’s Humanitarian Aid Office (ECHO) and other governments. These are the agencies that often become the “pork barrel” of other aid organizations, sometimes donating a large majority of their aid.⁴⁷ Dependence on governments and the UN donors usually leads to increased institutionalism, bureaucracy, and unwillingness to speak up against those who provide the money.⁴⁸ In support of its

independence from any outside influence, MSF relies on shrewd fundraising, frugality, low-paid staff and unpaid volunteers, and monthly checks from private citizens.⁴⁹ Often, MSF's policy of "go first, worry about money later," incites frustration and jealousy in the organizations that lack a public base and have to wait for government funding. MSF has also made a strategic choice to stay small and independent, whereas others, such as CARE International that also possesses a private base, have used government funding to grow larger.⁵⁰ MSF's financial independence is MSF's "trump card." Since they can literally be seen as advocating for the people through their financial donations, they have no need to support needless or even harmful strategies that other governments or UN programs have developed in order to maintain financial stability.⁵¹

A recent article by the President of Catholic Relief Services (CRS) discusses the way in which CRS faces its funding challenges. The president is responding from a Catholic point of view to the argument that an agency is only as independent as its major public donors allow it to be.⁵² The president's first assertion is that it is the organization's responsibility to preserve their identity based on Catholic social teaching and defend their faith. Next, he says they must look at the positive side of accepting public funding - a chance to make the government aware of their stance on important issues. Although their roots and values lie in their Catholic origins, but they are not ignorant about the important role the US government could play in helping the poorest of the poor. He acknowledges that any major donor will always exert influence, but it is still up to the agency to respond. Third, CRS is not obliged to take the money, and does not take money for something they disagree with, for example the second Iraq War. The Pope did not acknowledge it as a just war and so neither did CRS. CRS showed their allegiance to the Pope by refusing to participate in any relief

“pre-planning.”⁵³ After defending CRS against the government influence, the article also points to the fact that many corporations are getting intricately involved in development and that they may give more money than any bilateral or multilateral aid.⁵⁴ In the end, the article speaks to the maintenance of a balance. “Just as there is no contradiction in being both actively American and actively Catholic, there is no contradiction for us, as an American, Catholic agency to work within our civic system.”⁵⁵ Therefore, they:

stand forth as unapologetically Catholic and American. Our commitment to our faith tells us that what we are doing is right; our commitment to our country affords us the opportunity to act according to these beliefs and to effect change from within where change is needed.⁵⁶

Although MSF would appreciate the words of the CRS president, it would state some precautionary measures and perhaps some disagreements. First, even though there may be no literal contradiction between being Catholic and American, there are times in which tension is created by the dual identity does and a person is forced to choose between one over the other. Also, MSF would disagree with the priority allegiance that CRS gives to America as a state. Instead, MSF finds its allegiance in the people that make up the country they are in as well as the victims of a particular crisis. Overall, the CRS article presents a respectable defense for accepting significant amounts of United State’s government money but it is far from the perceived and actual independence that MSF has gained as a result of its private donors.

Staff

Along with money, the quality and type of people that work for an organization are also crucial to its success. And once again, MSF is surprising in their policies for their employees and volunteers. Even though their name “Doctors Without Borders” may suggest an image of a team of doctors running around the world trying to save people, about three-quarters of its staff and volunteers are not even doctors.⁵⁷ Other unexpected aspects of the

MSF staff life are: that most are not even staff at all, but volunteers who are crucial in maintaining the dynamic culture of MSF; and the majority of the staff in field projects are national or local staff.

Volunteerism is one of MSF's core values and the mainstay of the organization. Without it, the organization could not operate. MSF deliberately chooses inexperienced volunteers to be its main actors. Although the policy seems somewhat backward, placing an inexperienced and low/unpaid volunteer in a leadership position, it actually works quite well in protecting MSF's first priority of helping those in the most need. Aid workers often get used to working in high stress and horrible conditions, which many times immunize them to doing anything radical about it. With new, fresh and ambitious volunteers, MSF keeps ideas flowing in with vigorous energy and keeps a close emotional connection to those who are suffering. In a sense, MSF is trying to institutionalize the initial reaction against suffering and injustice and the desire and drive to change it as well as developing a check against experiential cynicism. In essence, they are looking for this reaction: "I don't give a damn that you have seen twenty places that are worse than this. This offends me, and I want to do something about it."⁵⁸

Having a majority of their staff being national is also a priority for MSF. Not only does this provide community involvement and education, but the expatriate operational staffs learn from the national staff how to treat the patients that they are trying to help because they know the diseases and parasites, etc.⁵⁹ MSF is also deliberate in mixing both expatriates and national staff to promote relationship between societies, seeking solidarity. Other NGOs, in comparison, often only hire expatriates for managers, leaving the field work to the local staff.⁶⁰

Both the expatriate staff and the local staff are low paid and the volunteers are unpaid. Local staff, however, is paid slightly more than the going rate of other NGO's in the area. While all travel and health insurance is paid for, a first-time field volunteer may receive a stipend of less than \$1,000 a month, and an eight-year veteran manager, only three times the amount. Even the executive director's salary in the New York office has a ratio of three to one to the lowest paid employee.⁶¹ Although there is little pay involved in working with MSF, the organization will make sure that while an employee or volunteer is away from his home, he is not accruing any debt. Even though there is no extravagant life to be lived off of MSF salaries, the low pay attracts unique people, especially those uncomfortable with the wealth of the West, just the type it is looking for.

In the field, most expatriates are neither doctors nor nurses (non-medical staff is about 40 percent), but serve rather in supportive roles so that the doctors and nurses can treat as many patients as possible.⁶² Each section has a head of mission who oversees all the projects within a particular country. There are project coordinators that organize a specific team's daily activities, financial coordinators, water and sanitation engineers, and logisticians (PCs, fincos, watsans, and logs respectively). There are also humanitarian affairs officers and human rights lawyers who are there to help advise the field staff through their expertise.⁶³

Altogether, the policies that MSF has put into place for its staff and volunteers help to keep the organization vigilant to the problems at hand, pure in their motivation for working, and focused on the needs of the individual people they are there to heal.

Individual Care

It is the individual, one who is sick and in need, that is MSF's first priority. Each of the doctors and each of the volunteers that work for the organization are charged to assist those who need medical help now. Every individual deserves care, and there is a responsibility placed on those who can provide that care to someone who cannot access it in order to restore that individual's personal dignity. There is urgency in this care because if a mass deprivation of healthcare is allowed to continue, human rights are systematically denied and the situation threatens to become "normal" to those not involved and the sense of responsibility diminishes. It is the conviction of duty that MSF has to care for those in need that drives it to uphold the responsibility to human rights. It is this priority of individual care that all of MSF's principles are meant to uphold. For instance, one must have neutrality, independence, and impartiality in order to gain maximum access to the patient that needs care in crisis ridden areas.

MSF's loyalties lie most strongly with the sick. Distance must therefore be maintained from political and military actors so that the line between state action and humanitarian action is not blurred, says Nicolas Torrente, executive director of MSF USA, when speaking of impartiality and humanitarian aid in the Iraq war.⁶⁴ Making peace is not in the business of MSF, nor is deciding who is right in the war. MSF's business is helping people in need which is only part of a jigsaw puzzle to peace. In James Orbinski's Nobel Prize speech, he said this: "Humanitarianism is not a tool to end war or to create peace. It is a citizens' response to political failure...and cannot erase the long-term necessity of political responsibility."⁶⁵ Though the limitations may be frustrating, this realistic view is a great strength. MSF refuses to be idealistic to the dangers of giving aid and is, instead, realistic about the limiting factors and influence of its own aid and the responsibility of other groups.

MSF's priority for individual care to those in greatest need is essentially defined in negative terms: its mission is to stop the harm that is already being done to an individual. All of MSF's efforts are therefore meant to answer the question: what is a human being? as "one who is not made to suffer."⁶⁶ By structuring and organizing this hope into its organization, MSF has been effective in alleviating suffering.

Although MSF has strong organizational strengths, it is far from perfect. One of the largest complaints and criticisms heard about the NGO is its general reluctance to collaborate in its field work projects. It is slow to coordinate and they are unwilling to work under another's project. They want to "be in the loop, but not in the noose."⁶⁷ There is value in MSF's ability to criticize and evaluate "but they should do more to coordinate with partners."⁶⁸ For example, although MSF is providing the best AIDS care and treatment in Busia, Kenya it is in the process of building an entire hospital literally next door to the community hospital. The MSF team there claims that they are not a development organization and that the effort they would have to put forth to cooperate with the existing hospital would hinder their provision of HIV/AIDS care. Although MSF's collaboration with the community hospital would probably affect the number of patients treated, it would have the positive attribute of working closely with the community and developing its healthcare skills.

Even though its actions can and should be questioned, MSF's ability to adapt and to lead by example stems from its deliberate structural organization, giving the organization remarkable leadership in humanitarianism. No structure or policy is put into place by accident or without plenty of debate involved. It is constantly looking for new and better ways to reach more people in need. In fact, David Reiff writes in his book, A Bed for the

Night, “the group’s next great accomplishment may be to rescue and redefine the ideal of humanitarianism itself.”

Chapter 4: Humanitarianism in Principle and in Practice

“We must make up our minds. Neutrality favors the oppressor, never the victim. Silence encourages the persecutor, never the persecuted.”

- Eli Wiesel

In the quote above, Eli Wiesel, a Jew and an echoing voice of the Holocaust, states his opinion about the neutrality and silence of supposed aid organizations in times of crisis. Although there has been a recognized need for humanitarian aid organizations to purport and practice the fundamental principles of neutrality, impartiality, and independence, Wiesel points to the damage that can occur if an organization is blinded by strict adherence to principles without recourse to the reality of a crisis situation. To avoid this misuse, these three principles should be utilized as ‘operational tools,’ helping to obtain consent of belligerents and the trust of communities, and not as tools for conflict resolution. They are not in themselves virtuous, but are a means to an end – and that end is to save the lives of people in urgent need. Unlike charity, humanitarianism does not exist in a vacuum and the principles are a needed asset in order to maintain the *Sans Frontiers* (without borders) mentality that operates in a dirty reality, struggling to place humanitarian principles into practice.

As a progressive humanitarian organization, MSF has been witness to the complex and energy-ridden international debates on neutrality, impartiality, and independence. The affability and effectiveness of each are being questioned, particularly in regards to “politicized humanitarianism,” yet for MSF, these principles, their interpretation, and their usage are critical to the NGO’s survival as a humanitarian organization. Though their

practical implementation must be carefully constructed, these principles are essential to maintain the humanitarian organization's "single-minded purpose of alleviating suffering, unconditionally and without any ulterior motive."⁶⁹

It is critical that MSF maintains its first focus on their responsibility to provide direct assistance to people in immediate need. It is the humanitarian imperative that implies this need for universal and 'borderless' humanitarian responsibility and action. If there is someone, anyone, in need anywhere in the world, the humanitarian is obligated to respond. He must be ready to challenge governments and the international community, since it is mainly the inaction of both that allows crises to persist. For MSF the humanitarian act is: "to seek to relieve suffering, to seek to restore autonomy, to witness to the truth of injustice, and to insist on political responsibility."⁷⁰ It is an apolitical and civilian based act – the act of one human responding the need of another.⁷¹ It is concern for the humanitarian imperative as well as guaranteeing equal access to its humanitarian assistance that motivates MSF to maintain the principles of neutrality, impartiality, and independence.

Misconceptions

Unfortunately, these principles and their usage are often misconceived, which can lead to unintentional yet horrifying results. Case in point is the experience of Eli Wiesel in the Holocaust. Humanitarian aid organizations, such as the ICRC, remained silent in the face of mass murder and human rights violations, in the name of neutrality and impartiality, so that they could maintain access to victims of concentration camps. While desiring to help, their silence over the presence of the camps was in fact harmful to the situation. "Silence has long been confused with neutrality, and has been presented as a necessary condition for

humanitarian action.”⁷² It is the misinterpretation of the use of neutrality that was the cause of Wiesel’s disgust of the principle. Yet such terrible instances cause many to question: Does neutrality mean an organization has no backbone? That they take no moral stance? Is it even possible to remain neutral in a world dominated by power struggles? What makes the debates on these questions complex and difficult is that while every humanitarian organization purports to be neutral, each has a slightly different way of implementing the principle the consequence of which has led to many harmful results. In reaction, large groups within the international community have come to see the defense of neutrality as: naïve, meaning when an organization do not say anything, the absence of their opinion still has a political impact; a smokescreen, meaning its presence is for the protection against something else, such as deterrence; passivity, meaning they do not care to take a stance, such as whether or not a war is just; and guilt, meaning they are reluctant to distinguish themselves between the “guilty” and the “innocent.” The pervasiveness of these misconceptions, spoken here specifically of neutrality, is threatening to the humanitarian act which is motivated by the humanitarian imperative.

Neutrality

The word “neutrality” comes from the Latin *ne-uter*, meaning “neither one thing nor the other.” As is evident from the above misconceptions, neutrality is not in it of itself a virtue.⁷³ In fact, neutrality is probably the most debated of the three principles within the humanitarian aid circles today. Most organizations see its assertion as absolutely essential in obtaining access to those in need. MSF is more careful in its adoption of the principle, however, by further clarifying what it means to them: “The principle of neutrality is not a

synonym to silence.”⁷⁴ MSF will not support either side of a conflict, asserting its own political stance and evaluations of the conflict, but will speak out against atrocities that are occurring, regardless of which side the actions originate from. It will not stand by as the vulnerable suffer without a voice. This policy concerning neutrality did not, however, develop overnight.

As recounted in the historical chapter, it was during MSF’s formation that the co-founder Bernard Kouchner was adamant the new organization have the right to speak out against injustice when they saw fit and possessed substantiated evidence. If it were not, he feared that MSF would end up like the ICRC and its incident in the Holocaust. For Kouchner, this meant doing away with the principle of neutrality since it had been misused to the extent that he believed there was no way to rescue it. Raymond Borel, one of the other key players, was a strong supporter for neutrality and believed that it could coexist with advocacy. In the end, MSF’s charter was clear and concise about its principle of neutrality.⁷⁵

1974 saw the organization’s first real test on the implementation of its proclaimed neutrality. The Kurdish envoy that was leading a rebellion in Iraq asked for and received support from a Kouchner led MSF. The action had blatantly taken a side and could not be considered neutral. For the next twenty years, MSF would struggle with the seeming paradox of protecting the crucial humanitarian principle of neutrality yet also maintaining its priority of aiding those in urgent need. It was in 2001 that this debate came to a climax for MSF as an organization. It had become so intense that the organization was deciding whether or not to completely remove its commitment to neutrality from its charter. One side argued that aid had always been political and could not be kept from that fate and finally admitting this fact would better serve the organization and the people it desired to serve.

Others argued that without neutrality MSF's humanitarian aid was necessarily politicized and assessments on which people to help could no longer be based on need alone. In the end, the article remained in the charter with the understanding that neutrality is only a means to the end of helping those in need, and if that end cannot be accomplished, something else must be done.

The Position of ICRC

Since, in MSF's opinion, the origin of its organization is directly related to the ICRC's failure to utilize its neutrality to the greatest good in Biafra, it is helpful to compare and contrast the definition as well as the practical implementation of neutrality between the two organizations.

The International Committee of the Red Cross is also an impartial, neutral, and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of war and internal violence and to provide them with assistance. It is the oldest of the humanitarian organizations as well as the richest and most organized.⁷⁶ The ICRC is in a unique position to deal with the international debates on principles because it is hybrid in nature; it is both a non-governmental organization as well as an intergovernmental organization (IGO). While NGO's are always private organizations, intergovernmental organizations are established by governments through a treaty and have their own special organs to fulfill particular functions.⁷⁷ Thus, IGOs have a mandate from governments for their existence and activities and enjoy certain working facilities known as privileges and immunities. ICRC is not a full-fledged IGO because its organization as a whole is not

mandated by governments; rather it is its functions and activities that are through international humanitarian law, specifically the Geneva Conventions.

The organization works within its international mandate to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles. The three principles of neutrality, impartiality, and independence are, for the ICRC, necessities in order to work for protection, assistance, preventive action, and cooperation with national societies. For example, in order to help civilians and detainees, restore families, and find missing persons, the ICRC must be free to move about, to talk to many people on any side and search through the country.

One way the ICRC utilizes their neutrality is by making no distinction between good wars and bad wars; between just and unjust causes; or even between aggressors and innocents.⁷⁸ For the ICRC, neutrality means dealing with authorities on any side of a conflict that so that they can help the vulnerable. In order to continue to enjoy the confidence of all, the ICRC believes that the movement may not take sides in hostilities or engage at any time in controversies of political, racial, religious or ideological nature. It also states that:

Neutrality is not an end in itself, but rather a means towards an end, which is to be able to act on behalf of people protected by humanitarian law and to make a positive difference to those who are affected by armed violence. Neutrality means making no judgment about the merits of one person's needs as against another's; it does not mean condoning violations of International Humanitarian Law.⁷⁹

At first glance, this definition of neutrality may seem identical to that which MSF acts upon. However there are two crucial differences. First, when dealing with victims of a humanitarian crisis, MSF does measure one person's needs against another's. Their stated purpose is to help those in *greatest* need. The practical differences that this implies between the two organizations are evident in a case study of the Rwandan refugee camps in the mid 90s after the genocide had occurred. The refugees in the camps were being provided their

basic food and health needs, but not their acute need for protection. Both organizations, ICRC and MSF, had been present before, during, and immediately after the genocide working in the refugee camps. However, by the end of 1994, MSF had decided to completely withdraw from providing any humanitarian assistance due to their desire to protect those in greatest need. The refugee camps consisted of two types of people: those that had been victims of the genocide and its perpetrators. After the genocide had ended, militia members and former members of the Rwandan army had re-armed themselves from within the camps, causing the refugees to become hostages and relief workers found themselves aiding and abetting the *genocidaires*.⁸⁰ By the presence of the refugee camps and through the provision of international humanitarian aid, the killers were granted impunity, given access to healthcare, and fed. The camps were undeniably a breeding ground for violence and MSF decided to withdraw its aid completely, the consequences of which stimulated other organizations to follow suite and the United States to revise its policy with regard to its support for the camps.⁸¹ This decisive and influential act of speaking out was not done by the ICRC because they do not distinguish between aggressors and innocents and it would have meant that they could not longer help anyone in need. For MSF, it is exactly this type of situation that led to the ICRC knowing about the concentration camps before World War II and yet remained silent.

This leads to the other crucial difference between the two organizations' practical interpretations of neutrality. For MSF, the negotiation with leaders of a conflict is limited to getting by roadblocks and other avenues of access. MSF is only concerned with helping those in need. The ICRC, on the other hand, is also dedicated to being a neutral intermediary

between opposing sides in a conflict.⁸² Therefore, for them, engaging in conversation between both sides remains a priority.

Today, there appears to be many different “levels” of intensity to neutrality and which level a humanitarian organization decides to sign on to is up to its discretion. Some organizations, such as the ICRC, are strictly neutral; some promote neutrality but in fact in many instances act against their claims; and some are by nature politicized, such as many arms of the United Nations. Up to this point, however, all of them agree that there is to be no aid workers whom carry weapons. MSF even discourages former military personnel to volunteer in their organization. Even in the most war torn areas, there are to be no weapons in compounds, vehicles, or anywhere else that aid workers may be.⁸³ On the other hand, some agencies have allowed guards to stand outside of compounds in certain extreme circumstances. The ICRC, for instance, has begun to post armed guards outside the homes of its delegates, its medical depots, and food warehouses. Interior armed security, however, is still banned.⁸⁴ Without weapons, a humanitarian aid organization’s security depends on the understanding or symbol of what their organization represents so that anyone they come across will not feel threatened and in turn threaten the security of the aid workers. Therefore, both actual and perceived neutrality must be maintained.

Impartiality

The second principle, Impartiality, can be defined as, “the allocation of assistance based on immediate need alone.”⁸⁵ Therefore, in the provision of humanitarian assistance, race, ethnicity, religion, political or social affiliation, gender or age is not taken into

consideration. Since MSF is also a medical relief organization, it will not provide assistance unless it determines that there is a desperate need for medical care.⁸⁶

The ICRC also adheres to impartiality. MSF's disagrees with ICRC's impartiality when it comes to remaining impartial between the "Serb militiaman and the Muslim civilian or the machete-wielding Hutu and the Tutsi victim."⁸⁷ The ICRC is more tolerant in adhering to their principles during a crisis because their mission and mandate are more complicated. Along with caring for those who are sick, the ICRC also serves as an intermediary and reunites families with loved ones who were missing. While they are taking into account how their actions might affect the number of sick they are treating, they are also forced to take into account these other factors. MSF has greater liberty to make decisions on how to implement its principles purely based on those in the greatest need because of their single-minded mission. It is, therefore, in a better position to speak out and advocate for those in need than ICRC is, in particular when it concerns the militarization or politization of humanitarian aid.

In his 1999 speech, James Orbinski stated that "humanitarianism is not a tool to end war or to create peace. It is a citizen response to political failure." What is implied in this statement is that humanitarianism is *not* a tool of conflict resolution that should be wielded by governments or the international community. There are limitations that both humanitarians themselves and governments should recognize to the humanitarian act. They are not helping to create peace, even though their aid may help to set the concerned parties on a right (or wrong) course, but are there to simply save lives. The language of humanitarianism should reflect these limitations and distinguish it from any 'relief' aid given by governments or government sponsored agencies.

Jean-Michel Piedagnel, director of MSF, told the British Medical Journal why the concept of a “humanitarian war” is wrong. The problem starts with language – that the word “humanitarian” has become synonymous with charity or assistance. It has lost its original meaning, which is of neutral, impartial, and independent assistance, with no political or religious aim.”⁸⁸ In the past 10-20 years, the use of the word “humanitarian” for political concerns has increased. After the end of the Cold War and the beginning of a multi-polar world in which the West has been focused on the spread of democracy, the developed nations have often chosen to use ethical language to justify armed intervention. Promoting the concept of a “humanitarian war” is nonsense because soldiers are not sent out for humanitarian reasons, but for war. In fact, government sponsored aid would be better described as ‘relief.’

It is easy to confuse relief aid with humanitarian aid. Relief aid can be very valuable assistance, given to people in different contexts. However, when it is NOT given SOLELY on the basis of needs and the principles of independence, neutrality, and impartiality, it is not humanitarian aid.⁸⁹

Another problem with the coexistence of armies and humanitarian organizations in the same area is when the aid begins to come into a country at the same time that government forces do. The citizens there will associate the two together, as has happened with the United State’s “humanitarian war” in Afghanistan. MSF has had a presence there for the past 24 years and was forced to leave recently after the murder of five staff workers due to their perceived association with the United States military presence.⁹⁰ Piedagnel sees peace-keeping as a political process as well, something that humanitarian organizations should not be involved in. Their goal is to help the people, not to create peace. Piedagnel made this perfectly clear when asked about long-term reconstruction. “you have enough politicians,

enough diplomats, and enough military people to plan that, without asking a humanitarian worker... We will not participate in the political settlement in Afghanistan.”⁹¹

In November of 2004, Dr. Rowan Gillies, President of the MSF International Council, spoke on the organization’s concern over the militarization of humanitarian aid in his acceptance speech of the King Hussein Humanitarian Leadership Prize. In response to his opinion that Western governments are increasingly using humanitarianism in combination with combat attempts, he reminded his audience of what being a humanitarian is NOT and what it IS. It is not about:

winning the hearts and minds of the people. It is not about imposing a political or cultural system, good or bad and it is not about winning wars or, even, building peace. It is a visceral and practical response of one human being to the suffering of another. It is an apolitical act and by definition a civilian act.⁹²

In southern Afghanistan, however, this is what aid was portrayed to be. It was made to be conditional on the population’s collaboration with US military forces through the distribution of leaflets.⁹³ As a result, MSF became closely associated with the United State’s military aid and has had to pull out of both Afghanistan and Iraq to due the threat to their staff. Overall, since early 2003, more than thirty international and national aid workers have been killed in Afghanistan, the Taliban claiming responsibility for some of the deaths, illustrating the dangers of association with political and military agendas and the severely limiting factors it creates for providing aid to populations in need.

Independence

Independence is the third and final principle and the one that is a necessary condition for the previous two principles. If an organization desires to be neutral and impartial, they must first have the ability to decide their own priorities. Independence is essential for

humanitarian organizations, in order to ensure that they act exclusively out of concern for those in need, free from political, religious, or other influences. A liberty that results from this independence, both political and financial for MSF, is MSF's ability to go to what they call the "10 Most Forgotten Humanitarian Crises of the World" and help those who are forgotten. This past year, the crises such as those in Sudan, Democratic Republic of the Congo, and Uganda made the list. In the past ten years, over 3 million people have been killed in the Congo because of the civil war conflict.

MSF's first aspect of independence is one vis a vis states, international organizations, political parties, churches, economic powers, etc. When working in hostile environments, it is an organization's independence that is most crucial for the warring parties to recognize. In Afghanistan, this independence was clearly compromised. A Taliban spokesperson once offered the following comment, "Organizations like Medecins Sans Frontiers work for American interests and are therefore targets for us."⁹⁴ A second example is MSF's work in North Korea in the 90s. MSF was the first independent humanitarian organization to gain access in the country in 1995, but ended up leaving only three years later in 1998. During its work, MSF was unable to provide assistance that was free of the North Korean's government influence.⁹⁵

The second aspect of MSF's independence is its financial independence from any major donors, such as rich western governments, looking to influence the policies of humanitarian organizations for their own interests. 88 percent of MSF's funding is from private sources, leaving less than 15 percent to be donated by large influential organizations such as the European Union, United Nations High Commissioner for Refugees, and the United States government.⁹⁶ In comparison, many other large international NGOs receive

their funding in exactly the opposite manner; up to 80 percent of their funding can come from public sources. This financial independence allows MSF to set its own objectives and to better understand and react to the needs of those objectives. MSF is well-known to be the first medical relief organization to arrive at any international crisis they have deemed a medical emergency. This ability is a result of MSF's unique capability to go first, get the money later. Others must first wait for financial backing that often comes from governments with strong political agendas before it can intervene. For MSF, being financially independent is a necessary reality if they are to be both perceived as and act as an independent humanitarian agency.⁹⁷

Out of the three principles, independence is the most enabling. It is MSF's independence that allows them to spend money in order to do impartial assessments and to assist the most vulnerable in places such as the Democratic Republic of the Congo, Northern Uganda, the Ivory Coast, and all many other places that do not make it to the news headlines. Independence allows for them to provide aid based solely on a needs analysis as well as speak out about the lack of response to civilian suffering because of war and disease.

Maintenance of Principles

In order to remain effective, however, independence, impartiality, and neutrality, must be safeguarded through MSF remaining distinct from other mere 'relief' and not 'humanitarian' agencies and other service providers. This task, as is evident in recent political conflicts and debates, remains extremely difficult. Many believe, such as Lt. General Romeo Delleire, that it may even be impossible. Delleire, who is the general that led the peacekeeping mission (UNAMIR) in Rwanda during the genocide, along with others

purports an integration of humanitarianism into the political arena. Nicolas de Torrente, President of MSF USA, wholeheartedly disagrees in his article, “Humanitarianism sacrificed: Integration’s False Promise,” stating that “merely saving lives” would be sacrificed for “higher” yet untenable goals.

Torrente recognizes the international trend to integrate humanitarianism into the political arena, “in the pursuit of a stated goal of comprehensive, durable, and just resolution of conflict.”⁹⁸ Humanitarian aid, in this proposal, would support the “international community’s” political objectives. An implication of this “coherence agenda” is that the principles that have long characterized humanitarian aid “should be set aside in order to harness aid to the ‘higher’ goals of peace, security, and development.”⁹⁹

This is a dangerous trend because it misplaces the use of humanitarian aid. Humanitarian organizations must necessarily have different priorities than politically motivated governments or groups. For politicians, an end goal of peace, stability, or democracy may be the top priority. For humanitarians, it is always the immediate relief of suffering for those in need. The vulnerable are always the top priority. This is not to say that humanitarian organizations are, of course, against these end goals of peace, but simply that their mission would be jeopardized and miscalculated were they to consider these as well. As states common knowledge, it is impossible to do everything at once, most particularly if one wishes to be successful. For this reason, Torrente says that “transforming humanitarian action into a presumptive tool of conflict resolution is unjustifiably and unnecessarily detrimental to people who suffer the ravages of war.”¹⁰⁰ As long as a crisis creates victims, humanitarian action carried out independently and impartially to meet their urgent needs remains extremely relevant.

If the trend to place humanitarianism within the coherence agendas of the international community were to be executed, the mission of helping the vulnerable first and foremost would be severely hindered in three different ways. First of all, if aid is used as an element to conflict resolution, it is often only given as a reward or denied as a sanction according to political principles, thus resulting in avoidable deaths. Secondly, the priority of humanitarians to help those in need is often made to take a back seat to possible unproven future benefits that other organizations or governments desire to obtain. This situation is ethically indefensible with the mission statement of a humanitarian. Thirdly, linking aid with the response of the international community to a crisis situation often communicates a false reality that the international response is actually serving the best interest of those in need, when in actuality, it is their interests they are serving.¹⁰¹

Due to these dangerous associations, it is up to the humanitarian organizations to continue to implement the three principles and provide immediate relief to those in need, whenever, wherever, and whoever they are. Instead of undermining humanitarian action by untenable and idealist ideas such as peace and justice, the international community should rather focus on promoting international humanitarian law and mobilizing resources for meaningful assistance, consistently and proportional.¹⁰² Finally, it is more crucial now than ever before that humanitarian organizations do not ignore their responsibility to publicly challenge and hold governments, businesses, and the international community accountable, especially if these groups are making it impossible for the humanitarian to meet fulfill his responsibilities to the needy. And that is what MSF is so good at.

Temoignage – “Bearing Witness”

It is MSF's unique principle of "temoignage" or "bearing witness" that makes it so good at intelligently speaking out about injustices they have experienced first hand. Whenever possible, MSF volunteers give interviews and make presentations. MSF's worldwide offices facilitate gatherings of various organizations, individuals, and communities for the collaboration of information. The organization as a whole releases publications and gives exhibitions on issues it has deemed important to speak out on, such as violations of human rights.¹⁰³ It not only confronts those in violation of the law, but draws the international community into the confrontation by issuing public information to create pressure. For MSF "there isn't such a distinction between speaking and acting. I think we permanently speak out, in a way."¹⁰⁴

Temoignage is an integral part of MSF's mission and its medical action. It illustrates that the primary responsibility of the organization is to put the population of people in distress as its priority. This active participation is an act of resistance to violence, discrimination, exclusion, etc....for the people. Temoignage demands that the sole interest for the populations in danger is the amelioration of the situation, through medical care and bearing witness. For Kouchner, the Biafra crisis was severely devoid of temoignage, and for MSF, the organization's pull-out from the refugee camps in and around Rwanda after the genocide was the boldest move of temoignage yet. During the Rwandan genocide, MSF France published a letter to Mitterand, the French president at the time and an ally of the Hutu regime, in *Le Monde*, the nation's largest newspaper, attempting to persuade Mitterand to accept political responsibility and stop the genocide. Mitterand did not appreciate the letter.¹⁰⁵ However, with the pull-out from Rwanda, MSF managed to not only attract

international media attention, but a collaborative change of the distribution of aid for the remaining NGO's, hoping to improve the situation.

Temoignage is not a conservative principle. Where it has publicly denounced a regime, such as Ethiopia or North Korea, MSF has been forced to leave. Risks of retaliation as well as the risk of compromising its neutrality are possible consequences of its actions that MSF must take into account if, when, and how it decides to speak out. Though MSF recognizes that publicly denouncing human rights violations should be left up to organizations such as Amnesty International and Human Rights Watch, it will use its principle of temoignage when medical aid is being abused or not even being distributed at all in a crisis or when they are the only witnesses to massive crimes against civilians.¹⁰⁶ Its advocacy is based on first-hand observation, not reports from other groups, and supported by evidence, such as: tracking of disease outbreaks, nutritional surveys, epidemiological data, etc... There is even an organization in Paris called Epicentre that MSF created in 1987 to do just these tasks for them as well as other organizations.¹⁰⁷ For MSF, much of its vitality and rebellious nature stems from bearing witness. Their constant critical analyses of the crisis in which they are involved make it a step ahead of most. Instead of reacting, MSF desires to act, and to act loudly.

Realistic view

Despite their drive for change, James Orbinski, former President of MSF, stated that MSF has a realistic viewpoint about the atmosphere that they operate in.

Humanitarian action is more than simple generosity, simple charity. It aims to build spaces of normalcy in the midst of what is abnormal. More than offering material assistance, we aim to enable individuals to regain their rights and dignity as human beings. As an independent volunteer association, we are committed to bringing direct medical aid to people in need. But we act not in a vacuum, and we speak not into the wind, but with a clear intent to assist, to provoke change, or to

reveal injustice. Our action and our voice is an act of indignation, a refusal to accept an active or passive assault on the other.¹⁰⁸

Orbinski realizes that after all of these grand political and academic debates that humanitarianism has a single-minded mission in reaction to the humanitarian imperative: helping those that are in greatest need. And MSF adds its own twist to this act by telling the world what they have seen. MSF realizes, however, that humanitarianism by itself is not enough to solve the problems that create the crises they find their selves in. Aid agencies are no substitute to the action of the international community and agencies, such as the multilateral institution of the United Nations, that act for the sake of creating peace, finding and rooting out the sources of conflict, protecting human rights, and promoting safe access for aid. As is evident in the term, “international community,” it is a conglomeration, most notably of states but also of non-state, actors that are required to fulfill their respective duties and responsibilities to the community as a whole and work together in order to promote peace and justice.

Conclusion

The principles of neutrality, impartiality, independence, and temoignage form MSF’s core identity. During MSF’s direct work with patients, within its bureaucracy, and within its advocacy for policy change these principles are absolutely essential. The practical implementation of the principles within each area of MSF’s work dictates its actions in both the field and the advocacy arena. Impartiality allows MSF to asses who those in greatest need are so that they can make ethically based decisions on their action in the field. Independence and neutrality enable access to those in the most need as well as creating the trust that is essential to help those who have been betrayed, attacked, or neglected. The two

principles also allow for *temoignage*, giving MSF the ability to speak out freely about the unjust conditions in the field or in the policy arena, helping to change the status quo. In the end, each of the foundational principles allows MSF to carry out its ultimate objective: to help those most in need of medical assistance, now.

Finally, MSF is not naïve about the frailty of the humanitarian position within the international community. They fully recognize that “the humanitarian aid worker is not a powerful negotiating partner. We come to the table with no force of arms. We offer practical assistance to those in need.”¹⁰⁹ However, they are aware that it is only through the maintenance of these principles both in the field as well as within the perception of the international community that will allow humanitarianism to continue. There will always be a need for humanitarians, but their ability to exist is ultimately dependent on each and every other actor in a crisis respecting the boundaries and principles that have been established. Maintenance of these three principles requires that there is increased respect for international humanitarian law, and that states refrain from labeling activities of their military as humanitarian. “Pretending that humanitarian action is a way to meet political goals is as erroneous as pretending that humanitarian actors can provide political solutions.”¹¹⁰ For MSF, this is precisely why they confront power and make it clear that there is no desire to ever be a part of it through their policy of *temoignage*. Their goal is to “merely” save lives.

Chapter 5: HIV/AIDS Prevention and Treatment in Kenya

*“They are not Gods though they would like to be;
they are only human trying to fix up a human.”*

- Anne Sexton, “Doctors”

MSF became involved in the fight against HIV/AIDS in Africa in the early 1990s and has been in Kenya since 1997. The medical relief organization has been focusing its long-term solution to alleviating the medical crisis of HIV/AIDS in two areas: first, by campaigning to tear down obstacles hindering access to antiretroviral treatment that were previously thought to be insurmountable and second, by providing effective quality medical treatment to patients with HIV/AIDS in resource poor settings. These two goals are rooted in MSF’s long-standing commitment to bearing witness and providing medical treatment. In this case, MSF’s campaign to essential medicines was deemed necessary for the accomplishment of the second goal, providing effective medical care to those in need. With successful project sites in Nairobi, Busia and Homa Bay, MSF continues to expand. It is determined to have the ability to treat more and therefore has embarked on an enormous “Access to Essential Medicines” campaign that works to reduce the price of drugs and increase access for those in the most need in developing countries.

It is clear that the epidemic of HIV/AIDS is not a medical emergency in the sense that it has not been caused by any outright conflict or direct violence yet the epidemic, along with pervasive infectious diseases, such as malaria, tuberculosis, and sleeping sickness, causes millions of violent deaths every year. The international community has failed to respond adequately to the health crisis, and because of its inaction has caused a “war of silence” to erupt which has in turn created an emergency medical crisis. Unfortunately, this emergency

and lack of commitment to help has persisted for so long at this point that millions dying every year from lack of access to healthcare has become “normal.” How this urgent situation become so unmanageable to the point of a long-term medical emergency and yet remained so blind to the eye of the developed world? Thankfully, MSF is an organization that is dedicated to combating the crisis of HIV/AIDS, and their response has been two-fold: bearing witness to the political vacuum and providing clinical care and treatment.

Kenya and AIDS

Often considered East Africa’s powerhouse and most stable country, Kenya is not without its ominous threats to stability. Although it has crucial needs for constitutional reform, debt relief, and economic development, what happens in Kenya concerning its battle with HIV/AIDS will be foundational in determining the country’s long-term stability. It was in the mid 90s that MSF decided to set up shop when it recognized the plight of the Kenyans and their need for a long-term solution that was based around the prevention, care and treatment of the disease. As the Kenyan society suffers because of the far-reaching effects of AIDS, the dedicated work of the MSF volunteers has fought for radical change that would impact the life of every individual living with the virus. MSF’s efforts have been concentrated within Kenyan politics and its three different clinical sites and therapy programs. For the organization as a whole, the principles that it is based on take an extremely important role in determining what it gets involved in as well as how it gets involved. Kenya, in particular, has been a great example of the MSF’s activist and creative bent towards solving a problem that much of the world sees as insurmountable.

It is estimated that approximately 2.2 million people in Kenya are living with HIV/AIDS, with about 13 percent of the adult population testing positive. While Europe and

America have experienced an 80 percent decrease in the mortality rate of AIDS because of access to life-prolonging antiretroviral (ARV) drugs, around 700 Kenyans continue to die every day from the disease.¹¹¹ In Kenya, HIV/AIDS remains a death sentence – and not only to its victims. Since there is such a significant number infected from the adult population - seven out of ten HIV-positive Kenyans are 18-25 years old - there are also far-reaching socioeconomic effects which hinder the growth and development of upcoming generations as well as the care for the elderly. As the working age generation becomes sicker and sicker, production decreases, profits erode, and GDP will decrease by 14percent in 2005.¹¹²

MSF has been providing HIV/AIDS treatment in Africa since the mid-1990s with its first program in South Africa. Its programs and clinics are run in city slums as well as remote rural areas, offering a comprehensive care package to its patients. More than half of the HIV/AIDS patients are women of child-bearing age or children. Currently, MSF provides ARV treatment to more than 23,000 patients in 27 countries, which is a 150 percent increase compared to December of last year when MSF was treating 9,000 patients in 22 countries.¹¹³ MSF chose Kenya as a pilot program to demonstrate the efficacy of anti-retroviral (ARV) treatment because of the country's significant level of HIV prevalence, high rates of infection, and resource poor setting.¹¹⁴ Better known in Swahili as “Madaktari wasio na Mipaka,” MSF's presence has had a significant impact on the care and treatment of HIV/AIDS patients largely because of its decisive activist stand which stems from its foundational principles as well as its organization wide “Access to Essential Medicines Campaign.” Advocacy within the MSF “temoinage” movement has been a part of its long-standing principle but in recent years, these advocacy campaigns have focused on individual issues with universal themes, the most prominent of which is MSF's access campaign.

Access to Essential Medicines Campaign

Out of six million people that immediately need antiretroviral (ARV) treatment in developing countries, only 440,000 currently have access to it.¹¹⁵ The campaign has existed since 1999 because one-third of the world's population today (rising to one-half in the poorest parts of the world) lack access to essential medicines, either because they are too expensive or they are no longer produced. As a humanitarian organization, it is fundamentally unacceptable to MSF and its organizational principles and values that this access is increasingly impossible, most particularly for the most common global infectious diseases, such as malaria and tuberculosis (TB), or HIV/AIDS.¹¹⁶ MSF is committed to raising awareness or bearing witness in crisis situations; being the voice of the vulnerable when no one else is speaking for them. Therefore, the aim of MSF's Access to Essential Medicines Campaign is simply to increase the number of people that have access to treatment. Some examples of MSF's policy and advocacy work can be found in its articles on its website specifically made for the campaign. Titles include: "Access to AIDS Care Increasing at Snail's Pace," "MSF Challenges Ministerial Summit on Health Research to Ensure Development of New Medicines," and "Access to Medicines at Risk Across the Globe: What to Watch out for in the Free Trade Agreements with the United States."¹¹⁷ Because of the needs of the developing world for access to healthcare, MSF has expanded upon its foundation of emergency medical relief by developing long-term solutions to this crisis. The campaign is based on three pillars which reflect the overall goals of MSF: overcoming access barriers, such as lowering the prices of medicines and bringing abandoned drugs back into the market, globalization, and stimulating research and

development. In general, MSF supports solutions to these problems that include encouraging generic competition, voluntary discounts on branded drugs, global procurement, and local production.¹¹⁸

The first pillar of the campaign is “overcoming access barriers.” The barriers are created for one of two reasons: either the drugs were not profitable enough so manufacturers ceased to produce or improve them, or they are too expensive for developing countries to afford. By overcoming these barriers, those in the developing world that are in need of life-saving medicines will have increased access to them. MSF has four different strategies to attain this goal. The first is to conduct global price analyses of selected essential drugs that are too expensive, such as fluconazole and ciprofloxacin, which will enable better negotiation for price changes. Second, MSF studies the quality of all sources of select expensive drugs in order to identify high-quality low-cost producers. Third, reflecting its willingness to help those who want to help themselves, MSF works to support health ministries that are fighting to increase their own country’s access to essential drugs. Finally, in regards to abandoned drugs, MSF works with the World Health Organization (WHO) and drug industry, advocating for the restart of manufacturing of those drugs.¹¹⁹

The second pillar to MSF’s access campaign is “globalization.” With this pillar, MSF aims to influence the direction in which globalization happens, specifically concerning medicines. Its goal is to improve developing countries’ access to medicine by supporting good-quality local production of medicines or the importation of those less expensive. Secondly, MSF advocates for existing international trade rules, such as the TRIPS agreement, to be implemented as they were designed – to protect people’s access to essential goods such as life-saving medicines. To do this, countries need to have appropriate laws,

which is why MSF is also dedicated to working with willing governments towards improving their public health.¹²⁰ The global trade system, with the WTO at its center, has set the rules for the buying and selling of products, including medicines. MSF sees medicines being treated in the same light as a product such as steel as unacceptable because the result is market monopolies for large pharmaceutical companies which result in high pricing of the drugs and consequently, the inability of those in the developing world to extend, improve, or save their lives. In order to be successful, MSF has developed three strategies. First, it provides evidence about the harmful effects that strong patent protection has on poor countries. For example, some patented drugs are more expensive in poor countries than in Europe and America.¹²¹ Second, MSF organizes events in order to mobilize advocacy groups, drug industry, international organizations, and governments to use legal measures, such as compulsory licensing and parallel imports, to help poor countries. Third, through providing information, MSF seeks to specifically influence European Union (EU) and United States policy concerning trade agreements and their impact on access to essential medicines.

Not only are new drugs too expensive, but the health needs of the poor are being ignored. That is why MSF's third pillar for the campaign is to "stimulate research and development (R&D) for neglected diseases," such as tuberculosis, malaria, and sleeping sickness. MSF is demanding from governments, drug industry, international organizations, and nongovernmental organizations that each one separately, as well as all together, invests in the development of effective, affordable, and easy-to-use medicines for these diseases. Between 1975 and 1999 only 13 out of 1,393 new drugs developed (1 percent) were to treat tropical diseases, which account for over 9 percent of the worldwide disease burden.¹²² 90 percent of the money spent on health research is spent on the health problems of less than 10

percent of the world's population.¹²³ Those diseases which have experienced investment are known as “lifestyle” diseases in rich western countries.

We research on drugs to grow hair, relieve impotence and fight cholesterol, ulcers, depression, anxiety and high blood pressure when cholera is wiping out people in western Kenya. We spend billions to market a new obesity drug rather than pioneer a new malaria treatment.¹²⁴ Since R&D is almost entirely within the private sector, it is driven by the prospect for profit instead of public health concerns. In fact, some of the pills for infectious diseases are so old that an MSF nurse working in Angola said that, “some of our patients are more afraid of dying from the treatment than of dying from the disease.”¹²⁵ The nurse was speaking of a 55 year-old pill for sleeping sickness that burns the veins and kills one in 20 patients. MSF aims to accomplish its third pillar with increased funding, investing in the R&D capabilities of developing countries, and supporting alternative models for R&D. For example, with “abandoned drugs” or those that have not had any new research for quite some time, MSF lobbies governments and companies to renew production of the unprofitable drugs that are sorely needed in resource poor settings.¹²⁶ The organization now tells governments that they have a duty to force the pharmaceutical multinationals to turn their attention to abandoned diseases such as malaria, tuberculosis, and sleeping sickness.¹²⁷ MSF's advocacy also includes: revealing its own experience of ineffective old drugs; raising awareness about the lack of R&D being allocated to abandoned drugs; and convincing policy-makers in large, powerful western countries, international organizations, and researchers of the need for a shift in the paradigm to a need-driven global R&D agenda, which would include creating new mechanisms for funding such endeavors.¹²⁸

Although these next two priorities are not considered by MSF to be “pillars” of the campaign, they are most certainly the goals that the pillars aim to accomplish. The first is developing a long-term and substantial solution towards AIDS. At its foundation, MSF

recognizes the ethical imperative to help those being deprived of dignity. MSF's detailed, long-term, and political access campaign was developed for the same reason that it embarks on each medical relief emergency -they are there to help those who are sick and without the means to be healed. In regards to HIV/AIDS, this long-term solution must include the combination of prevention and treatment. These priorities and goals are way too large for MSF to accomplish by itself. Thus, it has invited many actors from all levels of communities to come out and take up their responsibility. From the field, the healthcare providers have an immediate responsibility to demand the best possible quality of care for their patients. Local and national governments are responsible for promoting and passing public health legislation to increase the value and reach of available healthcare for their citizens. International organizations, such as the Global Fund, the World Bank, and UNAIDS should focus on protecting and aiding public health by adopting and advocating for new policies. Large pharmaceutical companies must cut prices for developing countries in a transparent and predictable way as well as support further R&D for neglected diseases. Funding should be provided by international donors for drug purchasing and treatment programs in addition to prevention. Finally, and possibly the most important stimulus, civil society must monitor, expose, demand from, and hold accountable each of these actors.¹²⁹ For MSF, the Global Fund should play an intricate part in helping to promote these priorities.

TRIPS

As the discussion on patent rights rages within the international community, the chairman of CIPLA, an Indian pharmaceutical company that produces cheap generic drugs, has interesting insights. Yusuf Hamied has offered free drugs to MSF, which it gladly took,

but his offer to Third World governments for free technology to produce their own anti-AIDS drugs has been left standing. So has his offer to his own government to provide free drugs to prevent mother-to-child transmission.¹³⁰ When asked about what the Indian government should do to prepare for 2005, Mr. Hamied said that unless the patent rules of the WTO are changed, India should get out. “If somebody wants something I’ve got, they can have it regardless of GATT or the WTO,” he said.¹³¹

As we begin the WTO’s new implementations of the TRIPS agreement, which started in January 2005, MSF is anxious that a lot of the work that has been done for cheap affordable access to essential medicines will in essence be undone. For example, the generic production of ARVs from CIPLA will likely be undermined with the new implementation rules, as after 2005 CIPLA will no longer be able to copy any drugs it does not have a process patent on.¹³² This concern is not without merit. Take the possible Free Trade Area of the Americas (FTAA) agreement, for example. If agreed upon, the FTAA will increase the restrictions on intellectual property rights which will decrease the competition that large pharmaceutical companies have to face, increasing their monopoly rights. Generic competition will essentially be blocked, giving little hope to further the lowering of prices and the provision for greater access to them for those in need, therefore hurting the health of the people in developing countries significantly.¹³³ The bi-lateral agreement could set a precedence of undermining the possibilities of protection currently in place within the TRIPS agreement, having negative effects on developing countries around the world.

Access Campaign in Kenya

In Kenya, MSF's Campaign for Access to Essential Medicines has had a multi-sectoral approach that has resulted in significant influence and change within the government and MSF's own clinics in the country. During its campaign, MSF has been dedicated to lobbying pharmaceutical manufacturers, distributors and the Kenyan government for more affordable AIDS medicines and increased access to them.

In June of 2001, at a MSF-sponsored discussion called "Dying from Lack of Treatment: The International AIDS Crisis," Dr. Chris Ouma, a former MSF director of the Nairobi clinics and a Kenyan himself, spoke out about the five biggest problems in Kenya that continued to drive the AIDS epidemic. The biggest problem, Ouma said, continues to be the unwillingness that people have to even talk about HIV/AIDS. The second is poverty and ignorance; people cannot afford the medical treatment nor do they even know what they may need because they are too poor to afford education. These first two problems seem even by themselves to be insurmountable. Yet Ouma goes on to talk about mother-to-child transmission, the serious lack of leadership, especially political, and finally cultural beliefs and practices, all of which significantly contribute to the spread of HIV/AIDS in Kenya.¹³⁴ MSF has not become overwhelmed, however, and has instead continued to push for reform, maintaining its value of "bearing witness." For instance, one of the fundamental principles that MSF Kenya has had first on its agenda to be widely accepted as fact is the mutual dependence and synergy between prevention and treatment.

Kenyan Government influence

MSF is working in Kenya because the government has expressed interest in restructuring its public health system to make it stable and self-sufficient. For example, based on national

AIDS policy, the government plans to implement interventions such as: strengthen the infrastructure for the management of sexually transmitted infections (STIs) and opportunistic infections; strengthen community-based health care through the involvement of individuals, families, and communities; and manage and coordinate HIV/AIDS programs using a multi-sectoral approach.¹³⁵

With these stated initiatives, the government overturned its previous policy which did not even recognize the presence of HIV/AIDS in Kenya until 1987 when a National AIDS Control Program (NACP) was established. However, not until 1997 did the government truly increase its commitment to alleviating the effects of the disease by passing a multi-sectoral national AIDS policy (Sessional Paper No. 4 on HIV/AIDS) that would last 15 years (its initiatives are stated above). Only last year, did the Kenyan government pass a National Development Plan for 2003-2007. In 2001, the government held a week-long workshop with 16 heads of units from various ministries aimed at developing an HIV/AIDS curriculum to be incorporated into the activities of the ministers.¹³⁶ It was the first step towards a capacity building program that would empower all sectors of the government to play an active role in the AIDS crisis.

Skepticism on how much effort and dedication the government is really willing to put forth lingers as it remains inactive on many critical legal, ethical, and cultural issues concerning the virus and supplies insufficient means and funds. For example, the Kenyan government spends more on its national debt than it does education and health combined. This lack of active political will and, consequently, lack of dedicated resources is one of the greatest barriers that MSF is fighting to overturn. Changing this attitude of the government is

crucial if MSF is to achieve its goal of a stable and self-sufficient public health system in Kenya.

TRIPS in Kenya

As previously discussed, in 2005 the promised stricter implementations of the TRIPS agreement in the WTO has the potential to further limit access to medicines for developing countries. MSF has been aware of this possibility and was the main stimulus and determining advocate in the past five years towards passing a patent law that would help to benefit and protect the Kenyan people from these new implementations. Actually the national Industrial Property Bill, initiated by the Kenyan government, began asking for more restrictions than TRIPS required on patent laws since Kenya originally obtained its advice from the WTO. Fortunately, MSF was successful in completely changing its direction. In August of 2002, MSF's lobbying, advocacy, organizing, mobilizing, media briefs, and petitioning with the Kenyan Coalition for Access to Essential Medicines paid off when the government signed into law the Industrial Property Act Bill of 2001, a progressive patent law permitting compulsory licensing and parallel importation.¹³⁷ Compulsory licensing is a provision that allows for public authorities to grant licenses to a third party without the consent of the patent holder but the patent holders still receive compensation. The licenses may be issued in the interest of public health and are a common feature to patent law. It is neither a legal loophole nor a form of pirating, but rather a power granted to the government so that it may counter the negative effects that patents may have on public interests.¹³⁸ Parallel importation is the importation of patented products without the approval of the patent holder. It allows a country the opportunity to find the best price of a branded drug on the

market, but does not involve the purchase of generics. For example, Kenya would have an interest in parallel importation from India of ciprofloxacin if the drug from Bayer were sold in country for more than it was sold in India. The lower price in India would be due to generic competition there.¹³⁹ Both of these provisions are allowed by the TRIPS agreement and help to protect Kenya from any further tightening of restrictions that may hinder its access to medicines. This new bill is often seen by Kenyans as the “Patient Rights over Patent Rights” bill because the civil society of Kenya, represented through the Kenyan Coalition for Access to Essential Medicines, started by and maintained by MSF, was able to place enough pressure on the government to affect change. In the end, the passage of this bill is hopefully the means to the basic right to health, allowing cheap, quality treatment, tipping the balance back from favoring corporate protection of patents and profit margins.

Kenyan Access to Essential Medicine Coalition influence

Since MSF has been in Kenya, one of the most important achievements it has accomplished is the extensive collaboration between all different types of NGOs and community organizations through similar interests and concrete goals. The main goals of the coalition have been to encourage and pressure the national treatment policy for HIV/AIDS towards actual implementation, advocacy for generic production of drugs within Kenya, the reduction of stigma that is still related towards AIDS, and education about HIV/AIDS to children and the general public. The Kenyan Coalition for Access to Essential Medicines members include, but are not limited to: Action Aid, The Association of People Living with AIDS, Women Fighting AIDS in Kenya, Nyumbani, International Federation of Women Lawyers, Kenyan Medical Association, and MSF themselves.

An example in which MSF provided an arena as well as a lot of political pressure for the Kenyan government to take a stand on its AIDS policy was in April of 2003 when it organized a symposium on ARV treatment. Everyone was represented: researchers, doctors, OMS (organization mondiale de la sante), various medical NGOs, private sector actors, and patients living with the disease. It was an opportunity for all the actors concerned with the HIV/AIDS epidemic in Kenya to discuss and develop concrete action plans for their responses to the crisis.¹⁴⁰ It was at that time, the government of Kenya announced target figures for ARV treatment to reach 20 percent of AIDS patients in need of ARVs by 2005 and 50-60 percent by 2008.¹⁴¹ In order to accomplish this goal, the government proposed opening 15 establishments around the country, but no further information on how it was to accomplish any of this was given.¹⁴² In reaction, MSF is advocating for the government to hold to its promises, demanding action from any concerned actors.

Drug Prices

As is widely known, in part because of MSF's access campaign worldwide, in order to significantly increase access to medicines for developing countries worldwide, the prices of the drugs need to be lowered. Kenya's patent bill will help the country to protect itself from any further restrictions the WTO may place on the TRIPS agreement in 2005, but this does not take away the necessity of advocating for permanently lower drug prices. And once again, MSF has taken up the challenge. There have been lots of tests in the fight so far, including false promises for price deductions and a lack of transparency within the negotiations over price changes.

In late 2000 and early 2001, the Kenyan government, UNAIDS, and five multinational pharmaceutical companies took up negotiations to lower the price of ARVs in Kenya. Ms. Indra Van Ginsbergen, MSF's drug campaigner for Kenya, said about the negotiations to lower prices in 2000 that, "drug companies and health ministries have so far been characterized by a lack of transparency, lots of puff PR from these companies, and very little real action."¹⁴³ The negotiations were carried out behind closed doors, with no reports on what was being done. Doctors, for instance, were receiving faxes of price reduction in ARV treatment, direct from companies, with no other information being offered.¹⁴⁴ Given the fact that AIDS drugs must be taken for a lifetime and the negotiations were likely to have a lasting impact on the price of those drugs, the coalition, representing AIDS patients, civil society, and medical associations, demanded more transparency.

During this time, Ms. Van Ginsbergen, MSF, and the coalition were lobbying for the companies to grant voluntary licensing, which would grant Kenyan manufacturers the ability to produce generic medicines in country. MSF began to advocate this position after their research had shown that other countries that had not waited for pharmaceutical companies to lower prices but had voluntary licensing had been able to significantly reduce the cost of AIDS medicines.¹⁴⁵ For instance, Brazil has over 90,000 people on free dual and triple drug combination treatment programs, possible only because of government dedication and nationally produced generic drugs, while Kenya has only about 1,000 people on such treatment largely because of the high costs of drugs.¹⁴⁶

In terms of permanent price deduction, the coalition pressured the government to not trade long-term rights for access in order to obtain short-term deductions. While looking to reduce the price of ARVs by 85 percent in a deal with five pharmaceutical multinationals, the

coalition encouraged the government to not forget about CIPLA's offer to provide US quality approved ARVs at an even lower cost than the one the companies were proposing.¹⁴⁷ The CIPLA drugs could be legally imported under the Kenyan Industrial Property Act of 1989 since it was considered to be a vital public interest. Therefore, any short-term price cuts being negotiated that would take away this right of generic importation in the long-term were not worth it. Duly noted by the coalition, the negotiations on price with the companies had coincided with the Kenyan government's decisions to discuss a new Industrial Property Bill, in 2000.¹⁴⁸ Even with a significant drop, however, the proposed cost per year per patient was completely out of reach for the average Kenyan. In reaction to these debates, MSF stated that price cuts were not the answer and were, "just a tool of multi-nationals to try and stop Africa producing its own drugs."¹⁴⁹

Certain organizations that are members of the coalition along with MSF, or even individual activists, have also taken a stand towards lowering the price of ARVs. Father D'Agostino of Nyumbani Wa Toto Wa Mungu Orphanage, a member of the coalition, stated during the negotiations that it would not wait any longer for multinational price reductions and was importing a donation of AZT given by the Brazilian government which would benefit 76 orphans.¹⁵⁰ MSF expressed its support for the initiative taken by Father D'Agostino in importing the generic drugs.¹⁵¹ In May of 2001, AIDS activists targeted Members of Parliament (MP) in their criticisms, holding a two day vigil outside parliament to monitor the MP's activities.¹⁵² Dr. Chris Ouma, who is now the ActionAIDS's national coordinator, pressured the MPs to "think about the plight of their people" as they were being handed the power to alleviate their suffering.¹⁵³

While MSF has helped to organize and provide the arenas for these particular activists, some of its most important work is done in the field, with its patients. The ground zero and crucial foundation for MSF's activism and value of bearing witness is the information and experiences that it gathers through its doctors, logisticians, and administrators in the field. Without this vital element, MSF would not be the civil society based grassroots organization with a global impact that it is today. Its field operations for HIV/AIDS are run through its clinics and local community based organizations.

MSF Clinics in Kenya

In general, when MSF decides to enter into a field site, its operations include: an exploratory evaluation of the site and its needs, training and supervision of medical personnel, water and sanitation improvement, data collection, feeding, patient care (especially maternal and pediatric), distribution of drugs and medical supplies, and rehabilitation of hospitals and clinics. Depending on the specific needs of the site, a field operation may also include massive vaccination campaigns, mental health care, and HIV/AIDS care and prevention.¹⁵⁴ Currently, MSF has three main field sites in Kenya running HIV/AIDS care and prevention programs. These sites are Homa Bay, Busia, and Nairobi.

Homa Bay

A town off the shore of Lake Victoria and on the northwest Border of Kenya, Homa Bay has one of the highest prevalence rates of HIV in Africa – around 35 percent of the adult population.¹⁵⁵ The high infection rate is due especially to the fact that it is a high-traffic area,

with a significant amount of the infections having an origin in the fishing and transport industries.¹⁵⁶ The clinic in Homa Bay has several main offerings, with the aim of increasing the quality of care for those who are infected and to lower the risk of contracting opportunistic infections.¹⁵⁷ The focus for the program is a free AIDS & TB treatment program. The ARV therapy for Homa Bay was secured in collaboration with the Ministry of Health in February 2001 and treatment began that November. Currently, the clinic serves about 400 patients, which is double the amount from 2002, and has proven successful in slowing down the effects of AIDS and sometimes even taking away the effects altogether.¹⁵⁸ The patients are residents of Homa Bay and are selected by medical and social criteria, usually focusing on those who are the closest to death. Within its 2003-2004 Activity Report, MSF France stated that the program is characterized by reorganization since it is capable of integrating about 100 more patients per month into its multi-therapy ARV program.¹⁵⁹ With this significantly increased capability, the objective of the ARV-treatment program is to put all those in need of the therapy on ARVs. Other principle objectives include, but are not limited to: increasing the number of children on ARV treatment, guaranteeing safe blood transfusions, and evaluating the activities of the mother-to-child transmission prevention program.¹⁶⁰ The program is run in collaboration with the Ministry of Health and other community organizations.

Prior to the ARV-treatment program, activities for the clinic already included: a voluntary counseling and testing (VCT) center, treatment of opportunistic diseases, home-based care for AIDS patients, prevention of mother-to-child transmission, and education in schools for prevention. Other offerings of the program in Homa Bay that are not immediately associated with MSF's HIV/AIDS campaign include: TB prevention,

professional training for nurses, pharmaceutical dispensary development, and the rehabilitation of the District Hospital with clean water supplies for improving hygienic conditions.

Busia

MSF has also run a clinic in Busia, a town further north than Homa Bay and on the Ugandan border, since 2000. Busia's HIV prevalence rate increased from 17.1 percent in 1990 to official figures varying between 34 percent in 1999 and 22 percent in 2000.¹⁶¹ Thus, the goal of the MSF program there is for HIV/AIDS prevention education through school programs, such as anti-AIDS clubs, which attempt to break the stigma surrounding the disease and dispel myths about its transmission.¹⁶² Many teachers have been trained on the national HIV/AIDS curriculum for primary schools, helping to reinforce the message of MSF's anti-AIDS clubs of prevention. Activities for these clubs might include, for example, a drama piece performed by the students aimed at sensitizing them about the treatment for AIDS.¹⁶³ Other members of the community, such as religious leaders, parents, and village elders have also been a significant part of the effort. This grassroots campaign has been unique to the Busia clinic whereas the HIV/AIDS care and treatment is seen at each site in slightly different forms and operations.

For those already affected by HIV/AIDS, MSF has a Preventative Care Clinic at the Busia District Hospital. The clinic is there to give services that include medicine to reduce the incidence of opportunistic diseases, patient screening, and counseling services. In 2003, MSF's commitment to AIDS treatment in Busia was significantly augmented with the addition of an AIDS & TB treatment clinic, similar to the one in Homa Bay, which carries

out free testing, treatment and home-based care. At the opening of the clinic, MSF illustrated its dedication to working with local and national leaders as the District Commissioner of Busia, the Mayor of Busia, and the Head of Mission for MSF all spoke.

Nairobi

MSF has multiple clinics throughout the capital city of Nairobi which are entirely concentrated within the cities numerous slum areas. There are programs in the slums of Mathare, Dandora, and Kibera that have been initiated in collaboration with other local organizations in order to reduce the transmission rates within the densest parts of the country. In addition, MSF also runs prevention, care, and testing programs in Mbagathi hospital at the edge of the Kibera slum. The focus for all the sites up until recently had been on primary health care and HIV-transmission prevention education. Two examples of this care are in-residence care of patients and prevention from mother-to-child transmission (now the leading cause of death for children under 5 across Africa).

Nairobi's ARV-treatment program began in the Blue House in the slums of Mathare in April of 2003. It currently serves over 700 patients, has about 150 of them on ARV-treatment, and provides counseling for over 80 patients per day. Its goals in expanding the program include increasing the number of patients on ARV-treatment and evaluating the possibility of starting a mother-to-child transmission prevention program.¹⁶⁴

While each clinic has its own focus, MSF Kenya in general has learned several important lessons in expanding AIDS treatment in the past few years that has led to a sharp increase of the amount of patients treated. The uses of simplified treatment regimens that are adapted to the needs of the poor, such as one-a-day pill programs, have been successful. For

example, adherence rates, critical for slowing any development in drug resistance, have risen close to the level of western countries with new simple program designs in which MSF offers free treatment, support, and education.¹⁶⁵ MSF Dr. Morten Rostrup, President of MSF's International Council, told reporters in Nairobi that, "to scale up treatment on a large scale, we have to adapt treatment models to real life. Adaptation means fewer pills per day, fewer lab tests, and free treatment, dispensed in the communities where people live, that is at district facilities and at community health posts."¹⁶⁶ For example, treatment programs are now based on clinical diagnosis and not lab tests.¹⁶⁷ For a long time, people had thought, and still do think, that ARV treatment was too "complex, sophisticated, and technical" for poor and rural communities, but MSF has shown otherwise with its patients in the slums of Kenya. MSF stresses, however, that the success of the ARV-treatment programs is dependent upon the treatment being free for those it treats. If it were not free, those who need it would not be able to afford it on a consistent basis or even at all, as an average cost for therapy for one year is \$270 US.¹⁶⁸

Home-Based Care Model

While the clinics that MSF runs in Homa Bay, Busia, and Nairobi help to provide part of the much needed infrastructure that is absolutely vital in combating HIV/AIDS and their advocacy campaign helps to raise awareness and disseminate information in order to persuade people into action, it is the home-based care (HBC) model that most actively combats the crisis of access to medical care on a day to day basis with the victims of HIV/AIDS. The majority of families do not have immediate access to healthcare facilities and the spread of the disease has only compounded this problem. With the HBC model,

MSF has sought to attend to the area most lacking in the HIV/AIDS campaign in Kenya - provision of proper medical care in resource poor settings. In fact, up to one third to one half of all health and education services are provided by the NGO community in Kenya.¹⁶⁹ MSF, for example, is the only medical organization offering Anti-retroviral Therapy (ART) in both Homa Bay and Busia.¹⁷⁰ Providing HBC allows the sick to obtain quality treatment on a regular basis without having to travel back and forth from a medical facility, thus helping to relieve some of the pressure on over-crowded hospitals as well as providing medical access to those that lack the infrastructure needed.

MSF's clinics and home-based care help to provide much needed treatment to those who are already sick as they continue to fight and advocate for prevention in the global debate through increased education, infrastructure, and funds. For MSF, treatment and prevention are mutually reinforcing tactics that should be implemented simultaneously. Employing a "treatment/prevention synergy," such as the combination of the Access Campaign and HBC, is the most effective strategy in combating the humanitarian crises that arise from AIDS and the disease itself.¹⁷¹

HIV prevention and treatment for people with HIV and AIDS are not mutually exclusive options. On the contrary, a growing body of evidence suggests that the availability of treatment actually advances prevention goals. Prevention and treatment support each other.¹⁷²

Each of the ART programs in Homa Bay, Busia, and Nairobi have shown a marked increase in health, very low default rates, and decreased stigma. Also, the maintenance of this program seems both plausible and sustainable in low-income areas of the world.¹⁷³

The model of home-based care is specialized to be a bottom-up community-based capacity building program, particularly for low-income settings. It is a grassroots foundation that is meant to connect the community to the greater network of formal health sector infrastructure while also shifting the provision of service away from the government to create

more efficient and cheaper results. The HBC model also focuses on improving the quality of life for people living with AIDS (PeopleLivingWithAids) on both a physical and social level.¹⁷⁴ In Kenya, the national HBC model has four main components: clinical care, nursing care, counseling and psycho-spiritual care, and social support. The clinical care includes diagnosis, treatment, and planning for regular follow-up care. The nursing care encourages good health, nutrition, and hygiene. The counseling support helps the patient make informed decisions, is used as a mechanism for creating behavior change, and helps to reduce stress, anxiety, or depression that is correlated with the disease. The social care is for welfare support for both the infected and the affected members of the family or the greater community. The model also outlines the caregiver as part of a team that works with patient, the family members, and the health worker on many levels in the home, in the clinic, and in the hospital.¹⁷⁵ This model gives a theoretical advantage towards a long-term disease, such as HIV/AIDS, because it provides lasting access to treatment in areas of high poverty and lack of transportation. Also, due to the individual care that each patient is given, diets, family dynamics, and the condition of the home are all factors to the disease that can be observed and taken into consideration by the community health worker or volunteer.¹⁷⁶ As hospital wards continue to overflow, with multiple people sharing beds, with people staying for up to three months because of long-term diseases, and with AIDS patients occupying about 80 percent of the medical wards in certain areas, the success of the HBC model in Kenya is necessary in order to provide medical access to the majority who need it.¹⁷⁷

The model of HBC that MSF employs is not the only model that is used in Kenya. In fact, in order to examine how and why it is both useful and effective, it is important to compare and contrast it to another model that Mild May International created to work in

collaboration with the Ministry of Health (MOH) in Kenya and the National AIDS and STD Committee Program. The program is called HAPAC (HIV/AIDS Prevention and Care). This initiative emphasizes the follow-up of a discharged patient with a HBC Coordinator in each district. These individuals are selected and trained and then in turn are in charge of training the community health workers and caregivers. In each community, everyone involved (community leader, a spiritual leader, a trained caregiver, PLWHAs, health workers, youth leaders, women's group leaders, and the Coordinator) will hypothetically form the Constituency AIDS Control Committee (CACC). The Committee will hold regular meetings on current issues, problems, or accomplishments. In this model, the overall emphasis is on the autonomy of the community but the relationship between it and a government health facility is stressed. The main objective is to attain the maximum training and education with the minimum cost in order to help strengthen the health infrastructure in communities.¹⁷⁸

In contrast, MSF's HBC project is less organized, more autonomous, and more focused on biomedical care. First of all, instead of relying on coordinators to train caregivers and health workers, MSF itself has a direct relationship with each volunteer and its workers are personally responsible for the volunteers' training and support. The volunteers are selected on the basis of advice taken from the sub-chief of the community. There are often many community based organizations (CBOs) that will offer volunteers, but MSF chooses to work directly with the volunteer instead of through the CBO that recommended her, avoiding potential grassroots corruption and allowing more direct communication.¹⁷⁹ Secondly, although MSF has a strong relationship with the MOH, it works independently from the government most of the time. Rather than train volunteers and then send them out to jobs,

using precious money and time, the MSF coordinator does ‘on the job training’ with each HBC volunteers while visiting patients and giving medical assessments. In this way, the patient is cared for and educated at the same time that the volunteer is being trained. The ‘on the job training’ of volunteers is one example of how MSF employs their resources in order to achieve a much more simple program that does not require a lot of funds nor bureaucracy.¹⁸⁰

After understanding how the management of the HBC is handled, it is important to understand the process that each patient must go through in order to obtain treatment. First, a patient must come in for Voluntary Counseling and Testing services (VCT) provided by MSF, as well as most other health related NGOs, either on her own initiative or from the recommendation of a HBC volunteer. In contrast to most of these NGOs, however, MSF offers VCT in conjunction with ART, greatly increasing the number of individuals that utilize VCT since the ART offers them treatment if they are indeed infected with the virus. In South Africa, for example, MSF’s VCT program saw a 1100 percent rise in the number of VCT patients when ART was introduced.¹⁸¹ Once an individual has gone through her first session of VCT, she receives a Prevention and Care Clinics card (PCC card) that will be checked by the HBC volunteer in her community as well as by the nurse at the clinic on each visit to ensure past attendance to counseling sessions and drug adherence.¹⁸² The card also acts as a check to the history of the patient on file as well as allowing the patient to go to different clinics for appointments. The patient is also given a “client exercise book” which she keeps at home and the HBC volunteer records symptoms, social issues, and the record of visits. The client is encouraged to bring the book to appointments so the nurse can reference

it to better understand the history of the client and the progression of the disease – two important pieces of information for deciding treatment.

Once a patient has attended her first VCT and has received her PCC card and exercise book, she must make an appointment in two weeks to receive antibiotics and palliative care.¹⁸³ After this appointment, another is made two weeks later and provides counseling on drug adherence and what anti-retrovirals are and how they work. The nurse may then give one weeks worth of medicine to the client who will then come back the next week to obtain more. This routine of checking in helps to establish a relationship with the client as well as provide assurance of commitment to drug adherence. After the third appointment, the trips to the clinic become less regular, once every six weeks and then once ever three to six months, unless unexpected sickness occurs. At each appointment, the client shows more commitment to treatment and she is reminded that it is a life-long regime that must be maintained.¹⁸⁴

The HBC project also depends on a referral system mechanism so that the patient can receive proper medical care when necessary. The HBC volunteers are given referral forms with demarcated sections for name, date, location, symptoms, comments, etc. This increases the continuum of care since symptoms or side affects pertinent to clinical diagnostics may be present at home, but absent at the clinic. Even though the medical diagnosis of the HBC volunteer is given little weight, her observations and advice often prove helpful to the nurse at the clinic. Furthermore, every PCC has a list of the HBC volunteers that have been trained by MSF. If a patient comes for VCT or treatment independently, he or she is given the name of the HBC volunteer in their community. This removes some of the burden from the HBC volunteer in seeking out the sick and grants greater autonomy to the patient. Also, it should be noted that there are other regular open channels of communication between a coordinator

and volunteers for a specific area. It would be impossible for the HBC coordinator to spend time with each volunteer on a regular basis, learning about the patients. Instead, the coordinator stops by previously specified checkpoints around town everyday where the volunteers can come and meet him with questions or concerns, such as a patient needing immediate care. These open lines of communication are extremely important for everyone; the patient, volunteer, nurses; so that the patient can receive the best care possible.

In addition to HBC projects, MSF also provides a complementary program called CAN – communication, advocacy, and networking. With this program, the local MSF team organizes planned events focused on community outreach that are meant to educate specific target groups. At least once a week, the MSF team supplies tea, lunch, pens and paper, in order to facilitate discussions, answer questions, and identify specific needs within the target group. There is also support sessions available for clients to share stories and develop community, encouraging each other and sharing their experiences.¹⁸⁵ The existence and operations of the CAN program illustrate MSF's attempt to provide simultaneous prevention and treatment efforts. Engaging the community, containing both sick and healthy individuals, in discussion and support sessions provides social treatment for the sick and prevention education for the healthy. MSF's HBC program in Busia, for example, coupled with CAN has increased awareness, reduced stigma, and offered life-sustaining treatment to hundreds of individuals.¹⁸⁶

Although the two HBC programs are striving to achieve many of the same goals, they are very distinct in their approaches. While MSF has the comparative advantage of being an older program, the MOH/MMI incorporates all actors, increasing collaboration and human resources. However, it does not seem that there is sufficient manpower or resource to

continue the high level of collaboration necessary to carry out the MOH/MMI program.¹⁸⁷ MSF's program is also more vertical in nature and has a more direct relationship with the community. The vertical strategy does not initially appear as sustainable as the MOH/MMI program, and sustainability is not something that MSF emphasizes. The MSF project manager in Busia, Maria Vallés, stated, "MSF is a humanitarian relief organization. Sustainability is not in our vocabulary."¹⁸⁸ However, the "decentralized, minimal energy strategy" of MSF is more sustainable in the short run and may prove true in the long run as well.¹⁸⁹ The major drawback of the MSF program is its limited capacity; they do not have the resources to reach all communities. However, they are laying the foundation within the community and within the rural health facilities that will prove instrumental in the years to come because they are building the competence and the capacity of both the community and government systems. Thus, identifying the gaps in both systems and working to resolve issues within the formal health sector and on the grassroots level appears to be a successful strategy. Not only do the MSF programs directly affect all stakeholders, but also the stigma, the poor moral, and the plethora of demotivated individuals are being combated on all levels. On the other hand, the MOH/MMI program, in response to an over-burdened health sector, appears to be shifting the responsibility too far on the continuum of care. The program appears to be placing the burden of care on the community with no concrete plans to intensify the development of the rural health facilities. There is a plan for "capacity building" of the rural infrastructure; however, without increased human resources, this will not become a reality.¹⁹⁰

The organizational methods and mechanisms that MSF has put into place have helped the program to be a success. In each project area, MSF is able to provide life-sustaining

treatment to hundreds of individuals. While the MOH/MMI program has placed the responsibility of accessing adequate medical care on the community, MSF has managed to bring it to the communities in need. MSF Busia is simultaneously scaling up the rural health facilities, increasing the capacity of the referral system, thus decreasing the burden on the patient in her attempt to access care.¹⁹¹ The program also has a system of accountability built into it for drug supply, patient attendance, education and counseling. The records kept on file at the clinic, the PCC card, and the communication between the HBC coordinator and volunteers are all mechanisms to ensure this accountability. Accountability, along with giving legitimacy to the program, also helps with the success of drug adherence as well as MSF's efforts to increase awareness and reduce stigma.

Along with the successes of MSF's HBC model, there are also challenges that threaten the long-term sustainability of the program. First of all, the program is limited in capacity. It is successfully treating a couple hundred people in each area, but if it were to expand beyond that the communication would decrease, more resources – drugs, personnel, vehicles – would be necessary, and the HBC volunteers would feel more dislocated from MSF itself. The program, therefore, can only continue to be successful on a larger scale if parallel improvement of infrastructure occurred. The sustainability of volunteerism is a concern as well. The care of a patient is long-term and volunteers, who may even be sick themselves, sometimes stop their work or visit their patient less and less due to financial or time constraints, the project manager for Homa Bay, Saleban, stated.¹⁹² Finally, the referral system, which the patient depends on to receive proper medical care when in need, contains dangerous weaknesses. Many HBC volunteers, in attempting to help their patients, will make the mistake of diagnosing and treating illnesses that necessitate a health facility and

properly trained nurses. This creates two problems: first, that the patient is not receiving the proper care, and second, she is given the misconception that the health facility is unimportant and inaccessible. If a failed referral system is combined with the inadequate health facilities, patients delay their visit to the clinic and eventually arrive with diseases that have progressed beyond the scope of the facility, which results either in permanent disability or death.¹⁹³

Conclusion

As the world and its inhabitants continue to ask the question of what should be done about the raging HIV/AIDS epidemic, especially within developing countries, MSF is providing an answer in Kenya in both word and deed. MSF's constant activism through its Access to Essential Medicines Campaign has provided crucial and much needed political and social leadership, helping to pressure the Kenyan government into much needed reforms. MSF's strong and much heeded words are such because of their efforts in the field, at their clinical sites. Working everyday with dying patients, trying to increase both the number of patients they can care for and the quality of care, MSF workers seem tirelessly dedicated to each individual Kenyan suffering from the deadly disease of HIV/AIDS. Its efforts in the field are not only to be commended, but are highly respected for the unique insight it provides towards bearing witness. This duality of activism, on a local and individual level as well as a large-scale national and international level, has led to the success and expansion of MSF's Access Campaign and its clinical sites.

Chapter 6: Concluding Remarks and Recommendations

Concluding Remarks

MSF is the best international humanitarian medical organization. In immediate, short-term humanitarian crises, it is always the first organization there offering primary care with pre-packaged medical kits.¹⁹⁴ In long-term medical crises, such as the HIV/AIDS pandemic, its clinics are widely available and predominately utilized by those who are sick. Its worldwide access campaign, the first of its kind within the organization, brings awareness, advocacy, action, and change. Both areas illustrate MSF's single-minded commitment to the individual in need through both medical care and bearing witness. Throughout this essay, it has been demonstrated that the principles which embody humanitarianism are found within the structure and practices of MSF.

The analysis of MSF has been a qualitative case study. The documented voices have been those of the organization itself, former and current employees of MSF, journalists, and other institutions – all of which have dealt directly with those in need. Although further quantitative data would have served to support the conclusions made, it is ultimately the opinions of those being cared for and the leaders of international institutions that matter, both of whom have expressed MSF's pragmatic ability to reach those in greatest need in short-term crisis and long-term epidemics. Therefore, the conclusions have bearing on MSF as an organization, on various other organizations that are similar to or work closely with MSF, and on the non-governmental community around the world. Even though it has been a qualitative study, it is telling that MSF has the highest number of programs and is treating the greatest number of people with proper medical care within the HIV/AIDS pandemic of any

other organization around the world (providing ARV's for over 25,000 patients in 27 countries).¹⁹⁵

Chapter three discussed the history and organizational structure of MSF, after having presented a general organizational theory in chapter two. Through the documentation of MSF's institutional structure, financial policy, volunteerism, and focus on individual care MSF embodied the four principles put forth through organizational theory successfully. Through their non-hierarchical and decentralized structure, they have successfully empowered the grass roots sections of their institution to make change and serve those in need effectively. They also have the ability to act quickly and correctly in times of crises. Their financial independence allows them great freedom in their budget, in their choice of projects, and in their desire to bear witness to injustice. Volunteerism helps to maintain the vitality, flexibility, and eagerness that drive the determination, willpower, and creativity of the organization. Without its first volunteer, Bernard Kouchner and the organizational structure that he helped to develop, MSF would not even exist.

Chapter four discussed the principles of neutrality, impartiality, independence, and temoignage. While each is complicated by politics, economics, ideology, and perception, MSF has demonstrated insight in their implementation from principle to practice in both short-term and long-term humanitarian crisis. In extreme cases, such as the Rwandan genocide, MSF has shown its ability to discern how best to implement, if at all, its aid by utilizing these principles. Its own leaders, such as Nicolas Torrente, have been highly influential in the international debates concerning the interpretation and implementation of these principles, specifically concerning the militarization and politicization of humanitarian

aid. Over and over again, these leaders and the organization itself have stressed the necessity to use these principles as merely a means to the end of caring for those in greatest need.

Chapter five discussed the practical implementation of MSF's principles, most specifically bearing witness and proper individual medical care and treatment, in its long-term HIV/AIDS programs throughout Kenya. In terms of the access campaign, MSF has had measurable national and international influence. The campaign was instrumental in the international initiative to significantly reduce the price of ARVs. MSF works closely with the Ministry of Health in Kenya and consequently, has helped to pass legislation and start coalitions all aimed towards the end of helping Kenya's AIDS population. On a more grassroots level, MSF works within communities and home-based care models to help increase awareness, decrease stigma, and provide proper care and treatment. This extensive knowledge of MSF is enough to critically analyze humanitarianism as it relates to the works of MSF and the organization: where it has been, where it is now, and where it is going.

Recommendations

Humanitarianism in general has faults that are of concern, both for the humanitarian and those individuals, agencies, or governments that work with them. First of all, humanitarianism is more than simply executing a plan to heal a so-called "population in need." "It is a moral endeavor based on solidarity with other members of humanity."¹⁹⁶ Therefore, the militarization or politicization of aid is of utmost concern. Integration of humanitarian aid into the international community's "coherent agenda" for solving an urgent humanitarian crisis allows it to become subservient to organizations that have only their own interests in mind. And the "my way or the highway" attitude is nothing close to solidarity.

Secondly, the existence of humanitarianism does not absolve governments and international institutions from the responsibilities of peace and justice. It also does not allow for humanitarian assistance to become the “paradigm for North-South relations in the post-Cold War period,” especially when Western governments are promoting the idea of a new humanitarian order yet decreasing their budget for aid to the poor.¹⁹⁷ Also, it is not humanitarians that pull the triggers and drop the bombs that most often are a major source of crisis in the first place.¹⁹⁸ Thirdly, it is crucial that humanitarianism only be considered a piece of the jigsaw puzzle for solving urgent humanitarian crises. It could be considered the most critical piece because it represents civil society, i.e. those in need during a crisis. In recognizing that they are only a piece of the puzzle, it is important for humanitarians to continue to promote the fundamental principles for they serve as a guideline for consistent humanitarian action. As Neil MacCormack argues:

Whatever be the variations in possible moral positions which people may have, there are criteria of coherence and consistency of judgments and principles which can be and ought to be applied to anything which claims to be a ‘moral position,’ as distinct from mere gut reaction or knee-jerk prejudice.¹⁹⁹

Finally, Humanitarian organizations must adopt MSF’s single-minded focus on caring for those in greatest need and encourage others to do their part.

Concerning MSF, there are two separate sections in which to make recommendations, short-term aid and long-term aid. In general, MSF has been remarkably effective in providing medical care for those in greatest need in the humanitarian crises around the world. However, with the spread of the HIV/AIDS and its co-infections, MSF has shifted its focus from crises situations to long-term primary care. Unfortunately, it has failed to shift its principles and practices accordingly, creating a new gap between the needs of a community and the provision of care.

In regards to short-term aid, MSF is the best. In fact, it was created to do just this – to be the most effective emergency medical relief agency. Based off of its organization, its structure provides MSF with immense flexibility. There is always an arena in which to debate among country offices concerning the best actions to take and there is also the freedom to try multiple options at the same time within different operational offices. MSF's financial freedom gives it the ability to go anywhere they want, whenever they want. Their private donor base is so strong that they never find themselves in the situation where they must wait for donor money to come in before they can provide care in a time of crisis. Quick and correct thinking, coupled with freedom of action are the most critical components for short-term medical aid, and MSF has mastered them.

These two qualities can also be very useful within a long-term medical crisis, but they are not enough. Where MSF commits themselves long-term, they also commit more time, energy, and resources. Since it was created as a short-term aid agency, the principles that are important in that situation are also important in long-term crisis, but they are inadequate. In order to be more effective in their long-term medical care, specifically considering HIV/AIDS, MSF must learn to root themselves in the community they are working in, developing a wider and deeper impact. In this way, long-term aid is very different than short-term. For short-term, an organization is there simply for emergency care only. It is not for them to get further involved in any of the other aspects of the crisis. In this scenario, it is vital that the principles of neutrality, impartiality, and independence are adhered by and used simply as a means to helping those in greatest need. In doing so, MSF does not, and should not, become deeply invested in the political, economic, and social activities within that

community. In contrast, long-term medical care requires the addition of different components and mindsets that do not need to be considered in short-term medical care.

In MSF's long-term aid programs, they need to become inextricably connected to the community in which they work. Their adherence to their fundamental principles, in long-term aid, will become more indefinite as a means to the end of caring for those in greatest need. Social justice oriented practices, such as beginning to combat the problems of poverty and lack of education which help to perpetuate the disease, will become more applicable. If MSF indeed desires to provide proper long-term medical care and treatment to those suffering of HIV/AIDS, they must learn to combat some of the root causes of the disease. This is not to say that their long-term care should become a development organization. MSF's mission in long-term care remains the same as in short-term – provide proper medical treatment to those in greatest needs. Their primary aim is not to promote development. It is not the end that is different, but the means.

There are two steps that are recommended here which MSF could take in its programs in Kenya in order to become inextricably linked to the community. First of all, MSF needs to develop a community-based care model. In the home-based care model, the programs are not run by nationals. This promotes the undesired perception of the North treating the South because they are sick; a perception of charity instead of solidarity. A community-based model, on the other hand, is specifically oriented to go to the people of the community and be run by them. MSF currently has a policy which does not allow national staff to be directors of its programs. The policy was put into place hoping to foster inter-cultural relationships and information sharing. However, this is not how it works in reality. In Busia, almost all of the international staff is Spanish, and they are all managers of the national staff. The

Spaniards spend time with each other and the national staff talks about the international staff. An unhealthy domineering relationship is the result. This policy must be the first to change if MSF is to become more effective in its long-term medical care through the integration of practices that promote social justice. If national staff were allowed to become directors of programs, MSF would develop a more direct, involved, and equitable relationship with the members of a community in crisis. For Homa Bay, this would most likely translate into MSF training nurses and doctors in the teaching hospital that already exists there. For Kenya as a whole, MSF would integrate more services with the public sector that were more closely focused on grass roots development while continuing to work with the Ministry of Health. Ideally, the community would gradually come to see MSF's presence in that community, not primarily as international, but national.

The second step that is recommended for MSF to take in Kenya is for it to “psychologically” recognize that they are there for the long-term and it will subsequently have a profound effect on what type of organization they run. Their flexible and autonomous nature will become more useful once their mindset changes from emergency relief to long-term care and treatment. Their principles will be used in different way as a means to its end of caring for those in need. For instance, even though those in need should not be sacrificed in order to attain peace, if a peace process has a direct positive effect for those in need in the long-term, MSF should get involved. A parallel structure that is in need of a similar mindset change is the United Nations Security Council. The Council was originally meant to operate under a Cold War mindset. Its structure and actions therefore reflected this; however, the situation has changed. The Cold War has ended and thus, both the mindset and the structure of the Security Council should reflect that change. For MSF, it must recognize that it started

out as a short-term medical emergency relief organization, but has ended up as something else. This realization will be reflected in changes to their philosophy concerning long-term care, changes to their structure, and consequently, changes to their practices.

Finally, understanding the lived experience of those whom MSF is committed to treating is just as an important means as understanding the epidemiological impact of prevention and care treatment projects. Establishing long-term relationships with the people in the community will allow MSF to draw on the world's wealthiest countries' resources and on the lived experience of the world's poorest communities. The community based model, for instance, allows MSF to weigh the resources of wealthy nations and the lived experiences of the poor and sick on an even scale. They are on the right path, but they need to go wider and deeper in their commitment to long-term medical care projects.

From the outset, MSF was both a moral and a medical organization. They provide effective assistance to those who are in greatest need. Their commitment to the world's sick and suffering reflects the commitment we have to our families, friends, and even ourselves, offering a lesson to all of those who consider themselves a member of the global community.

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Appendix 1

Médecins Sans Frontières – Nobel Lecture

Nobel Lecture by James Orbinski, Médecins Sans Frontières, Oslo, December 10, 1999

Your Majesties, Your Royal Highness, Members of the Norwegian Nobel Committee, Excellencies, Ladies and Gentlemen:

The people of Chechnya – and the people of Grozny – today and for more than three months, are enduring indiscriminate bombing by the Russian army. For them humanitarian assistance is virtually unknown. It is the sick, the old and the infirm who cannot escape Grozny. While the dignity of people in crisis is so central to the honor you give today, what you acknowledge in us is our particular response to it. I appeal here today to his excellency the Ambassador of Russia and through him, to President Yeltsin, to stop the bombing of defenseless civilians in Chechnya. If conflicts and wars are an affair of the state, violations of humanitarian law, war crimes and crimes against humanity apply to all of us.

Let me say immediately that the extraordinary distinction that the Nobel Committee has given Médecins Sans Frontières is one that we accept with sincere gratitude. But also a profound discomfort in knowing that the dignity of the excluded is assaulted daily. These are the forgotten populations in danger, like the street children who struggle each grinding hour to live off the waste of those who are «included» in the social and economic order. These too are the illegal refugees that we work with in Europe, denied political status, and afraid to seek health care, lest this contact leads to their expulsion.

Our action is to help people in situations of crisis. And ours is not a contented action. Bringing medical aid to people in distress is an attempt to defend them against what is aggressive to them as human beings. Humanitarian action is more than simple generosity, simple charity. It aims to build spaces of normalcy in the midst of what is abnormal. More than offering material assistance, we aim to enable individuals to regain their rights and dignity as human beings. As an independent volunteer association, we are committed to bringing direct medical aid to people in need. But we act not in a vacuum, and we speak not into the wind, but with a clear intent to assist, to provoke change, or to reveal injustice. Our action and our voice is an act of indignation, a refusal to accept an active or passive assault on the other.

The honor you give us today could so easily go to so many organizations, or worthy individuals, who struggle in their own society. But clearly, you have made a choice to recognize MSF. We began formally in 1971 as a group of French doctors and journalists who decided to make themselves available to assist. This meant sometimes a rejection of the practices of states that directly assault the dignity of people. Silence has long been confused with neutrality, and has been presented as a necessary condition for humanitarian action. From its beginning, MSF was created in opposition to this assumption. We are not sure that words can always save lives, but we know that silence can certainly kill. Over our 28 years we have been – and are today – firmly and irrevocably committed to this ethic of refusal.

This is the proud genesis of our identity, and today we struggle as an imperfect movement, but strong in thousands of volunteers and national staff, and with millions of donors who support both financially and morally, the project that is MSF. This honor is shared with all who in one way or another, have struggled and do struggle every day to make live the fragile reality that is MSF.

Humanitarianism occurs where the political has failed or is in crisis. We act not to assume political responsibility, but firstly to relieve the inhuman suffering of failure. The act must be free of political influence, and the political must recognize its responsibility to ensure that the humanitarian can exist. Humanitarian action requires a framework in which to act.

In conflict, this framework is international humanitarian law. It establishes rights for victims and humanitarian organisations and fixes the responsibility of states to ensure respect of these rights and to sanction their violation as war crimes. Today this framework is clearly dysfunctional. Access to victims of conflict is often refused. Humanitarian assistance is even used as a tool of war by belligerents. And more seriously, we are seeing the militarisation of humanitarian action by the international community.

In this dysfunction, we will speak-out to push the political to assume its inescapable responsibility. Humanitarianism is not a tool to end war or to create peace. It is a citizen's response to political failure. It is an immediate, short term act that cannot erase the long term necessity of political responsibility.

And ours is an ethic of refusal. It will not allow any moral political failure or injustice to be sanitized or cleansed of its meaning. The 1992 crimes against humanity in Bosnia-Herzegovina. The 1994 genocide in Rwanda. The 1997 massacres in Zaire. The 1999 actual attacks on civilians in Chechnya. These cannot be masked by terms like «Complex Humanitarian Emergency», or «Internal Security Crisis». Or by any other such euphemism – as though they are some random, politically undetermined event. Language is determinant. It frames the problem and defines response, rights and therefore responsibilities. It defines whether a medical or humanitarian response is adequate. And it defines whether a political response is inadequate. No one calls a rape a complex gynecologic emergency. A rape is a rape, just as a genocide is a genocide. And both are a crime. For MSF, this is the humanitarian act: to seek to relieve suffering, to seek to restore autonomy, to witness to the truth of injustice, and to insist on political responsibility.

The work that MSF chooses does not occur in a vacuum, but in a social order that both includes and excludes, that both affirms and denies, and that both protects and attacks. Our daily work is a struggle, and it is intensely medical, and it is intensely personal. MSF is not a formal institution, and with any luck at all, it never will be. It is a civil society organization, and today civil society has a new global role, a new informal legitimacy that is rooted in its action and in its support from public opinion. It is also rooted in the maturity of its intent, in for example the human rights, the environmental and the humanitarian movements, and of course, the movement for equitable trade. Conflict and violence are not the only subjects of concern. We, as members of civil society, will maintain our role and our power if we remain lucid in our intent and independence.

As civil society we exist relative to the state, to its institutions and its power. We also exist relative to other non-state actors such as the private sector. Ours is not to displace the responsibility of the state. Ours is not to allow a humanitarian alibi to mask the state responsibility to ensure justice and security. And ours is not to be co-managers of misery with the state. If civil society identifies a problem, it is not theirs to provide a solution, but it is theirs to expect that states will translate this into concrete and just solutions. Only the state has the legitimacy and power to do this. Today, a growing injustice confronts us. More than 90% of all death and suffering from infectious diseases occurs in the developing world. Some of the reasons that people die from diseases like AIDS, TB, Sleeping Sickness and other tropical diseases is that life saving essential medicines are either too expensive, are not available because they are not seen as financially viable, or because there is virtually no new research and development for priority tropical diseases. This market failure is our next challenge. The challenge however, is not ours alone. It is also for governments, International Government Institutions, the Pharmaceutical Industry and other NGOs to confront this injustice. What we as a civil society movement demand is change, not charity.

We affirm the independence of the humanitarian from the political, but this is not to polarize the «good» NGO against «bad» governments, or the «virtue» of civil society against the «vice» of political power. Such a polemic is false and dangerous. As with slavery and welfare rights, history has shown that humanitarian preoccupations born in civil society have gained influence until they reach the political agenda. But these convergences should not mask the distinctions that exist between the political and the humanitarian. Humanitarian action takes place in the short term, for limited groups and for limited objectives. This is at the same time both its strength and its limitation. The political can only be conceived in the long term, which itself is the movement of societies. Humanitarian action is by definition universal, or it is not. Humanitarian responsibility has no frontiers. Wherever in the world there is manifest distress, the humanitarian by vocation must respond. By contrast, the political knows borders, and where crisis occurs, political response will vary because historical relations, balance of power, and the interests of one or the other must be considered. The time and space of the humanitarian are not those of the political. These vary in opposing ways, and this is another way to locate the founding principles of humanitarian action: the refusal of all forms of problem solving through sacrifice of the weak and vulnerable. No victim can be intentionally discriminated against, OR neglected to the advantage of another. One life today cannot be measured by its value tomorrow: and the relief of suffering «here», cannot legitimize the abandoning of relief «over there». The limitation of means naturally must mean the making of choice, but the context and the constraints of action do not alter the fundamentals of this humanitarian vision. It is a vision that by definition must ignore political choices.

Today there is a confusion and inherent ambiguity in the development of so-called 'military humanitarian operations'. We must reaffirm with vigor and clarity the principle of an independent civilian humanitarianism. And we must criticize those interventions called «military-humanitarian». Humanitarian action exists only to preserve life, not to eliminate it. Our weapons are our transparency, the clarity of our intentions, as much as our medicines and our surgical instruments. Our weapons cannot be fighter jets and tanks, even if sometimes we think their use may respond to a necessity. We are not the same, we cannot be

seen to be the same, and we cannot be made to be the same. Concretely, this is why we refused any funding from NATO member states for our work in Kosovo. And this is why we were critical then and are critical now of the humanitarian discourse of NATO. It is also why on the ground, we can work side by side with the presence of armed forces, but certainly not under their authority.

The debate on the «Droit d'Ingerence» – the right of state intervention for so called humanitarian purposes – is further evidence of this ambiguity. It seeks to put at the level of the humanitarian, the political question of the abuse of power, and to seek a humanitarian legitimacy for a security action through military means. When one mixes the humanitarian with the need for public security, then one inevitably tars the humanitarian with the security brush. It must be recalled that the UN Charter obliges states to intervene sometimes by force to stop threats to international peace and security. There is no need, and indeed a danger, in using a humanitarian justification for this. In Helsinki this weekend governments will sit down to establish the makings of a European army, but to be available for humanitarian purposes. We appeal to governments to go no further down this path of dangerous ambiguity. But we also encourage states to seek ways to enforce public security so that international humanitarian and human rights law can be respected.

Humanitarian action comes with limitations. It cannot be a substitute for political action. In Rwanda, early in the genocide, MSF spoke out to the world to demand that genocide be stopped by the use of force. And, so did the Red Cross. It was however, a cry that met with institutional paralysis; with acquiescence to self-interest, and with a denial of political responsibility to stop a crime that was «never again» to go unchallenged. The genocide was over before the UN Operation Turquoise was launched.

I would like for a moment to acknowledge among our invited guests Chantal Ndagijimana. She lost 40 members of her family in Rwanda's genocide in 1994. Today she is a part of our team in Brussels. She survived the genocide, but like a million others, her mother and father, brothers and sisters did not. And nor did many hundreds of our national staff. I was Head of Mission in Kigali during that time. No words can describe the sheer courage with which they worked. No words can describe the horror that they died in. And no words can describe the deepest sorrow that I and all in MSF will carry always.

I remember what one of my patients said to me in Kigali: «Ummerra, Ummerra-sha». It is a Rwandan saying that loosely translated, means «courage, courage, my friend – find and let live your courage». It was said to me in Kigali at our hospital, by a woman who was not just attacked with a machete, but her entire body rationally and systematically mutilated. Her ears had been cut off. And her face had been so carefully disfigured, that a pattern was obvious in the slashes. There were hundreds of women, children and men brought to the hospital that day, so many that we had to lay them out on the street. And in many cases, we operated on them then and there, as the gutters around the hospital literally ran red with blood. She was one among many – living an inhuman and simply indescribable suffering. We could do little more for her at that moment than stop the bleeding with a few necessary sutures. We were completely overwhelmed, and she knew that there were so many others. She knew and I knew. She released me from my own inescapable hell. She said to me in the clearest voice I

have ever heard «allez, allez ... ummera, ummera-sha» – «go, go... my friend; find and let live your courage».

There are limits to humanitarianism. No doctor can stop a genocide. No humanitarian can stop ethnic cleansing, just as no humanitarian can make war. And no humanitarian can make peace. These are political responsibilities, not humanitarian imperatives. Let me say this very clearly: the humanitarian act is the most apolitical of all acts, but if its actions and its morality are taken seriously, it has the most profound of political implications. And the fight against impunity is one of these implications.

This is exactly what has been affirmed with the creation of the international criminal courts for both the Former Yugoslavia and Rwanda. It is also what has been affirmed with the adoption of statutes for an International Criminal Court. These are significant steps. But today on the 51th anniversary of the Universal Declaration of Human Rights, the court does not yet exist, and the principles have only been ratified by three states in the last year. At this rate it will take 20 years before the court comes into being. Must we wait this long? Whatever the political costs of creating justice for states, MSF can and will testify that the human costs of impunity are impossible to bear.

Only states can impose respect for humanitarian law and that effort cannot be purely symbolic. Srebrenica was apparently a safe haven in which we were present. The UN was also present. It said it would protect. It had Blue Helmets on the ground. And the UN stood silent and present – as the people of Srebrenica were massacred.

After the deadly attempts of UN intervention in Former Yugoslavia and Rwanda, which led to the death of thousands. MSF objects to the principle of military intervention which do not stipulate clear frameworks of responsibility and transparency. MSF does not want military forces to show that they can put up refugee tents faster than NGOs. Armies should be at the service of governments and policies which seek to protect the rights of victims.

If UN military operations are to protect civilian populations in the future, going beyond the «mea culpa» excuses of the Secretary General over Srebrenica and Rwanda, there must be a reform of peacekeeping operations in the UN. Member States of the Security Council must be held publicly accountable for the decisions that they do or do not vote for. Their right to veto should be regulated. Member States should be bound to ensure that adequate means are made available to implement the decisions they take.

Yes, humanitarian action has limits. It also has responsibility. It is not only about rules of right conduct and technical performance. It is at first an ethic framed in a morality. The moral intention of the humanitarian act must be confronted with its actual result. And it is here where any form of moral neutrality about what is good must be rejected. The result can be the use of the humanitarian in 1985 to support forced migration in Ethiopia, or the use in 1996 of the humanitarian to support a genocidal regime in the refugee camps of Goma. Abstention is sometimes necessary so that the humanitarian is not used against a population in crisis. More recently, in North Korea, we were the first independent humanitarian organization to gain access in 1995. However, we chose to leave in the fall of 1998. Why? Because we came to the conclusion that our assistance could NOT be given freely and independent of political influence from the state authorities. We found that the most

vulnerable were likely to remain so, as food aid is used to support a system that in the first instance creates vulnerability and starvation among millions. Our humanitarian action must be given independently, with a freedom to assess, to deliver and to monitor assistance so that the most vulnerable are assisted first. Aid must not mask the causes of suffering, and it cannot be simply an internal or foreign policy tool that creates rather than counters human suffering. If this is the case, we must confront the dilemma and consider abstention as the least of bad options. As MSF, we constantly call into question the limits and ambiguities of humanitarian action – particularly when it submits in silence to the interests of states and armed forces.

Last week, the United States Congress passed a bill authorizing direct food transfers to the Rebels in South Sudan. This is a misappropriation of the meaning and intent of humanitarian assistance. It makes food a fuel of war. And it is a dereliction of a state's duty to use any and all political means to address a 17 year-long civil war that has left millions dead. Sudan's civil war today is a human misery where millions are displaced and at risk of starvation and disease; where people are bombed, robbed, looted constantly, and even enslaved, while corporate oil interests are protected, where humanitarian space is so severely restricted that it exists only in pockets; and where we and other NGOs and UN Agencies struggle to bring humanitarian assistance and protection. Is food the only political option to curb war? Food aid or humanitarian assistance, if it is to be «humanitarian assistance» – cannot be a tool in state-craft. In this case we must denounce the perfidious use of food that confuses the meaning of humanitarian assistance. If the political masks itself in an ambulance, then it is certain that the ambulance will be fired on. As well, if food is allowed to be used as a weapon of war, then it also legitimates that populations can be starved as a weapon of war.

Independent humanitarianism is a daily struggle to assist and protect. In the vast majority of our projects it is played out away from the media spotlight, and away from the attention of the politically powerful. It is lived most deeply, most intimately in the daily grind of forgotten war and forgotten crisis. Numerous peoples of Africa literally agonise in a continent rich in natural resources and culture. Hundreds of thousands of our contemporaries are forced to leave their lands and their family to search for work, food, to educate their children and to stay alive. Men and women risk their lives to embark on clandestine journeys only to end up in a hellish immigration detention centre, or barely surviving on the periphery of our so called civilised world.

Our volunteers and staff live and work among people whose dignity is violated every day. These volunteers choose freely to use their liberty to make the world a more bearable place. Despite grand debates on world order, the act of humanitarianism comes down to one thing: individual human beings reaching out to their counterparts who find themselves in the most difficult circumstances. One bandage at a time, one suture at a time, one vaccination at a time. And, uniquely for Médecins Sans Frontières, working in around 80 countries, over 20 of which are in conflict, telling the world what they have seen. All this in the hope that the cycles of violence and destruction will not continue endlessly.

As we accept this extraordinary honor, we want again to thank the Nobel Committee for its affirmation of the right to humanitarian assistance around the globe. For its affirmation of the road MSF has chosen to take: to remain outspoken, passionate and deeply committed to its

core principles of volunteerism, impartiality, and its belief that every person deserves both medical assistance and the recognition of his or her humanity. We would like to take this opportunity to state our deepest appreciation to the volunteers and national staff who have made these ambitious ideals a concrete reality, and who have, we believe, brought some peace to the world that has experienced such immense suffering and who are the living reality of MSF.

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