
ACTIVITY REPORT ⁹⁴₉₅



**MEDECINS
SANS FRONTIERES**



ACTIVITY REPORT

1994 - 1995

Published by :

MÉDECINS SANS FRONTIÈRES

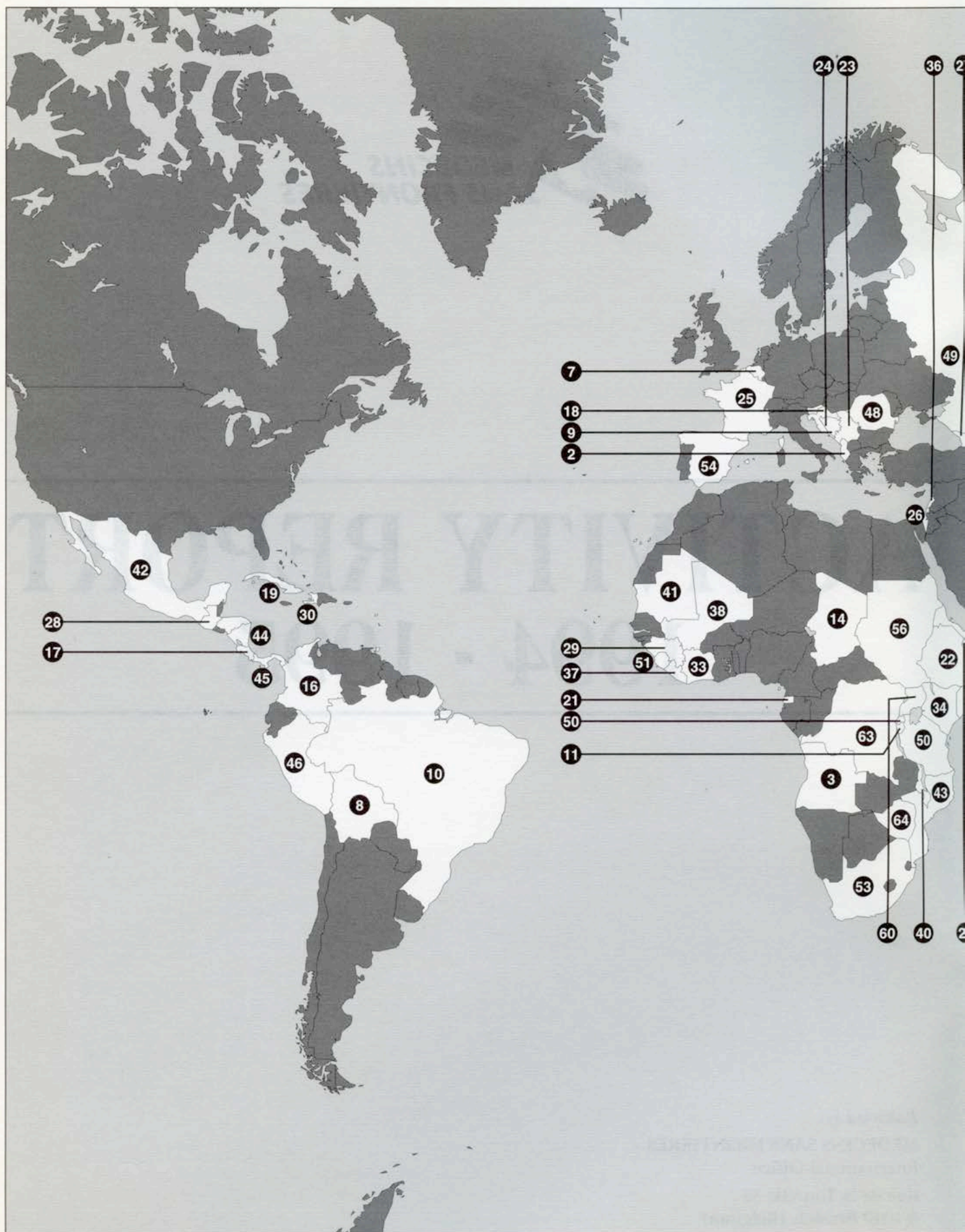
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INTRODUCTION

In 1994, Médecins Sans Frontières (MSF) had 2,950 volunteers working in 64 countries throughout the world. Every year, much of our energy is channelled into the humanitarian emergencies of the moment. In 1994, the biggest assistance programme ever was launched during the Rwandan crisis.

Between April and June 1994, MSF spoke out strongly against the genocide perpetrated against the Rwandan Tutsis and the political opposition, calling on the international community to take appropriate action in the face of the killings. When the United Nations pulled out all but 270 of their Blue Helmets, we called for their return with a mandate that truly allowed them to protect civilians.

Up to a million Rwandans were slaughtered during the genocide, while live pictures were relayed throughout the world. An MSF team remained inside the country during the killings. This was one of the most distressing moments in MSF's history, not least because hundreds of our local staff disappeared without trace.

When the Rwandan Patriotic Front (RPF) took Kigali in July 1994, one of the biggest refugee influxes ever recorded took place on the borders of Burundi, Tanzania and Zaire. In Goma, Zaire, one million people arrived in a matter of days. Within nine days a cholera epidemic had broken out and MSF focused all its energy on reducing the death toll.

Once the cholera, dysentery and other illnesses were brought under control and mortality rates had dropped, we became increasingly concerned by the violence in the camps. It had become clear that the instigators of the genocide were setting up a government in exile and exerting complete control over the refugees. Refugees wishing to return to Rwanda were being threatened, the distribution of aid disrupted and violence incited in the camps. In October 1994, MSF made it clear that it would be unable to continue its assistance programmes in the camps if the leaders were not separated from the main body of refugees, all weapons removed from the camps, the registration of refugees carried out and an international police force installed. Consequently, registration took place but none of the other measures were implemented. Confronted with continued abuses of the refugee population by those responsible for the genocide, MSF decided to pull out of several camps.

Today, MSF runs an extensive assistance programme throughout Rwanda, where tensions continue to simmer. Refugees often return to their villages of origin to find their property confiscated. Others languish untried in overcrowded gaols. In May 1995, MSF was present in Kibeho when in an effort to disband the last of the big camps for the internally displaced, the Rwandan Patriotic Army (RPA) launched a bloody clampdown which resulted in the deaths of thousands. There are still an estimated two million Rwandan refugees. Therefore, lobbying and witnessing on the situation both inside the country and in the refugee camps remains a priority. We will continue to support the work of the international war crimes tribunal and, most importantly, to advocate the rebuilding of Rwanda's national legal system. The future stability of the region largely depends on the establishment of an efficient and fair jurisdiction.

MSF teams have continued to provide assistance throughout Bosnia. During the siege of Gorazde in April 1994, MSF's expatriates pursued

their work in the hospital. In July 1995, our team in Srebrenica was once again working inside the hospital when the enclave was taken and remained with the wounded and other refugees at the UN base in Potocari until the evacuations had taken place. In Tuzla, the MSF team was strengthened in order for an emergency programme to be launched for the 25,000 new arrivals from Srebrenica.

MSF was already in Chechnya at the end of 1994. During the two preceding years it had been running a medical distribution programme. However, the clampdown on the rebellion in Chechnya by the Russian army was unprecedented in its violence. MSF first relaunched health care services in the south of the country and eventually in Grozny. MSF was the only aid agency working in the south when it was finally expelled before a major offensive by the Russian forces.

MSF also remained active in chronic emergencies such as Sudan, Somalia and Afghanistan, where seemingly eternal conflicts continue to result in massive population movements, famine and epidemics. 1994 was by far the worst year of fighting in Afghanistan since the Russians left.

MSF also worked in many areas where major emergencies have effectively come to an end, but where rehabilitation and restructuring needs are massive. Long-term assistance programmes in countries such as Mozambique, Ethiopia and Cambodia focus on the training of local staff and the rehabilitation of health structures.

In Central and South America MSF's programmes are longer term in perspective. Teams mainly work in isolated regions, with indigenous populations who are denied access to basic health care. In addition, local health care structures benefit from management support and training.

There has been an increased focus on projects in the urban centres of the Far East and South America, where people have little access to health care and children are among the most deprived members of the population. AIDS programmes are now becoming an integral part of MSF's assistance in several countries, most notably Uganda, Guatemala, Thailand and Vietnam.

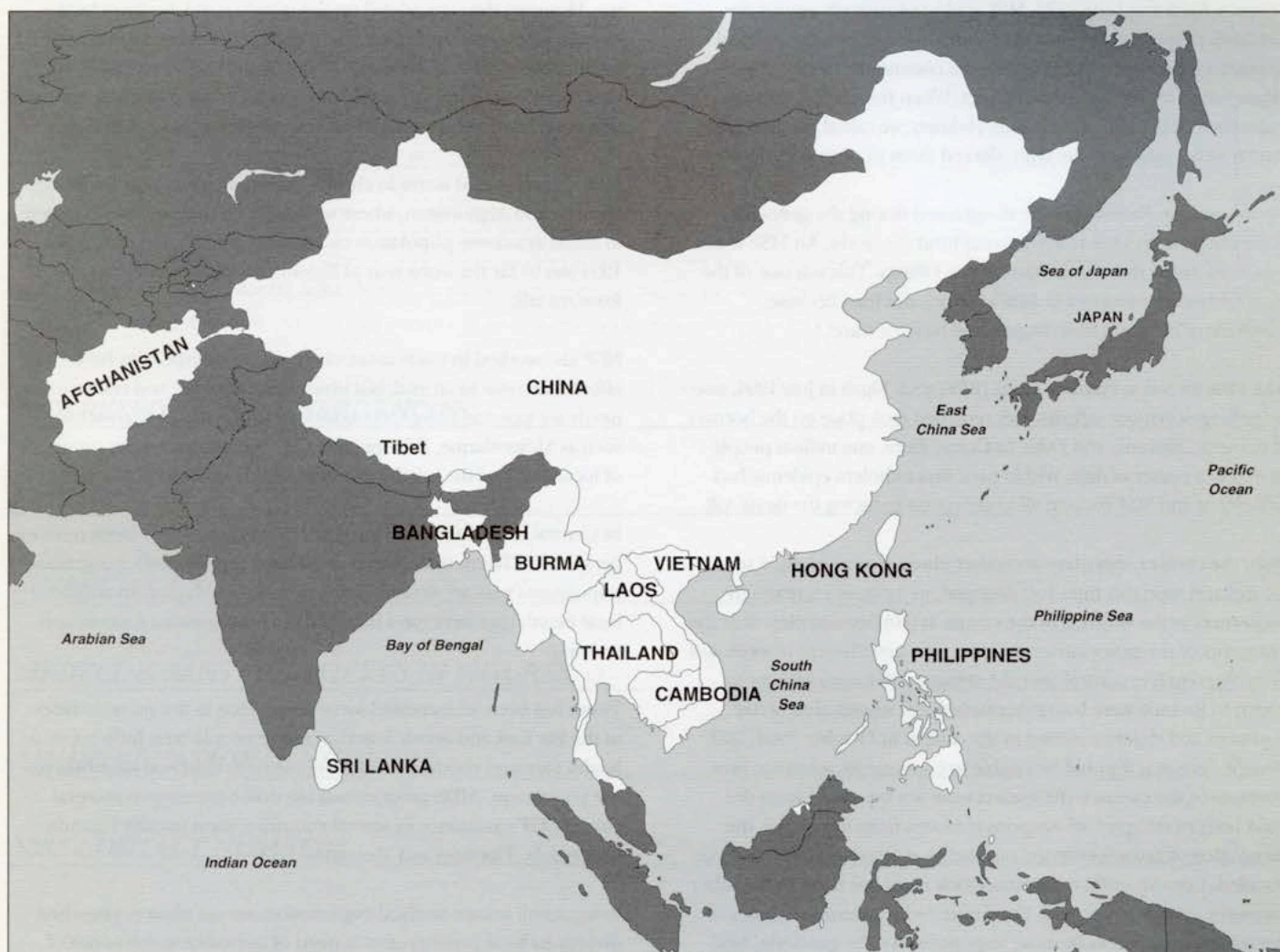
Being a well known medical organisation, we are often approached directly by local communities in need of assistance at the outset of epidemics. For example, MSF was the first international aid agency to be contacted by the local committees in Kikwit, Zaire, when the Ebola epidemic broke out. While the Institute for Tropical Medicine of Antwerp and the Centres for Disease Control of Atlanta were carrying out epidemiological studies, MSF sent in a team to boost local efforts to curb the epidemic. Activities centred around prevention, training, hygiene, quarantine and tracing reported outbreaks.

We would like to thank all those who have supported our work. We are particularly grateful to the 2.4 million individual donors around the world. We are also indebted to the continued support of the European Community, the United Nations High Commissioner for Refugees and the governments of Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Holland, Hong-Kong, Italy, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland, the United Kingdom and the United States.

■ Doris Schopper
International President

MISSIONS - PART I

ASIA



*Afghanistan, China/ Tibet, Sri Lanka,
Bangladesh, Burma, Cambodia, Thailand,
Vietnam, Hong Kong, Laos, Philippines*

AFGHANISTAN : THE FORGOTTEN WAR



allow it to function adequately in wartime. MSF supervises the work of the local team, tops up local salaries, distributes food to patients and supplies medicine and medical material. MSF also supports six other clinics in and around the capital. Until spring 1995, there were tens of thousands of displaced people living in public buildings, entirely dependent on the services of the clinics and health posts. Most have since resettled into their districts of origin. MSF still supports the clinics. MSF also provides logistical and medical support to the Metarlam hospital in Laghman province.

ASSISTANCE TO THE DISPLACED

1994 was the worst year of fighting in Afghanistan since the Russians left the country, with more casualties than ever. The situation is comparable to that of Somalia, in that the war is characterised by factional fighting, and yet, there are whole areas untouched by violence, areas such as Herat. They are also alike in the fact that the international community remains oblivious to what is actually going on in Afghanistan.

On New Year's Day 1994, heavy fighting broke out in Kabul between the government forces loyal to Professor Burhanuddin Rabbani (*Jamiat-e Islami*) controlling the northern part of the city and forces loyal to Gulbudin Hekmatyar (*Hezbe Islami*) allied with those of General Rashid Dostom based in the city's southern quarters. Although the war spread throughout the north of the country, there was a brief lull in the fighting between April and August.

In early November 1994, a new political force appeared in the southern part of the country: the Talebans. These fundamentalists style themselves as "students of religion" fighting for peace and disarmament. They are thought to have Pakistani support. In February 1995, the Hezbe Islami was driven out of Kabul. By April 1995, tension had broken out between the Talebans and the government in Maydan Sharr and Shindand.

There have been major population movements owing to the shelling of Kabul, both within the capital itself, and to the southern town of Jalalabad and to areas north of the capital, such as Mazar-i-Sharif, Kunduz, and Pul El Khumri. MSF provides assistance to the displaced both north and south of Kabul, with the mission in Peshawar, Pakistan, providing logistical backing to the teams.

KABUL UNDER FIRE

Since August 1992, MSF has run the Jamuriat Hospital, the operational capacity of which has been reinforced in order to

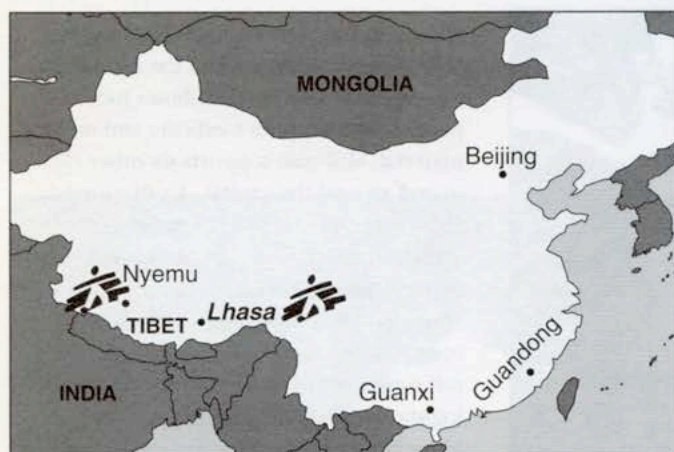
The Jalalabad project started in 1994, when many of those fleeing the fighting in the capital stopped here en route to Pakistan. The Sharshahid camp is located on a stretch of wasteland. The climate is one of extremes and the ground too hard to dig wells. MSF immediately started a relief programme for the 80,000 settlers. The team set up health care facilities and a food distribution programme as well as a system for clean drinking water. MSF also set up five health posts. Diseases treated most frequently include diarrhoea, malaria and measles against which children are inoculated. Seriously ill patients are transported to one of the two hospitals in Jalalabad. MSF helps with the distribution of food and initially operated four feeding centres, later only one. Malnourished children and pregnant women receive supplementary food rations. Numbers of displaced increased in 1994. To accommodate these new arrivals, a second camp, Hadda, was set up in October. MSF took charge of medical care here as well. In December 1994, the population of both camps combined was 200,000. The camps are under the strict supervision of the *shura*, a sort of executive council which embodies various fundamentalist movements.

MSF works in two camps for the displaced in and around Mazar-i-Sharif, Kamaz and Ghor. In each MSF runs dispensaries. The organisation also runs a mobile clinic for the displaced of Mazar city. At the Shamarq camp in Pul El Khumri, MSF also runs a dispensary. Aid is also provided for local populations at Baghlan and the displaced at Kunduz. Given that this area is unstable and often host to mass influxes of people, MSF runs an emergency preparedness programme.

At the Tajik refugee camp at Sakhi near Mazar where there are presently 7,000 people, MSF manages health activities. MSF provides support for two dispensaries for 3,000 refugees at Taloqan.

Funding: MSF, EC, Canadian, Dutch and Belgian governments
Expatriates: 26

CHINA/TIBET



CONTEXT

In 1994, MSF was active in the autonomous region of Tibet. Here far-reaching changes occurred, more particularly as relates to the strengthening of the Beijing Government's economic openness policy. As one of the very few foreign organisations working in Tibet, MSF continued to provide support and assistance to the Tibetan population.

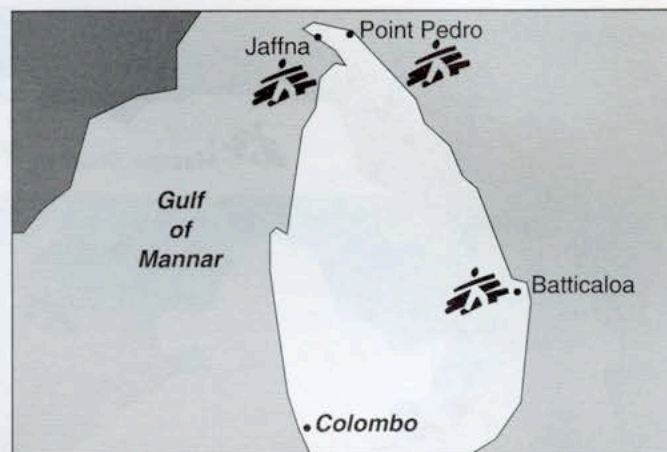
ACTIVITIES

In 1994, MSF introduced a list of essential drugs for the various health-care units in Nyemo and Lhundrup counties in the Lhasa prefecture. MSF provided training for staff in the use of these drugs. Supervision activities and in-service training for "village doctors" were also begun. MSF's team of physiotherapists continues to treat patients suffering from what is known as big-bone disease, a crippling illness of unknown origin. In 1994, the number of health-care units was increased to twenty-three. The water and drainage programme was extended to two more districts. Ten thousand people living in 34 villages now benefit from functional water-supply systems. The special protection measures against the severe cold of the Tibetan winter made it possible to re-use the conduits and watering points installed the previous year.

In July 1994, major floods affected the Guandong and Guanxi provinces in the south of China. An emergency programme made it possible to contribute to the re-supply and re-equipping of the damaged health-care units and to the implementation of a sanitation programme.

Funding: MSF, EC, French, Canadian and Hong Kong governments
Expatriates: 9

SRI LANKA



CONTEXT

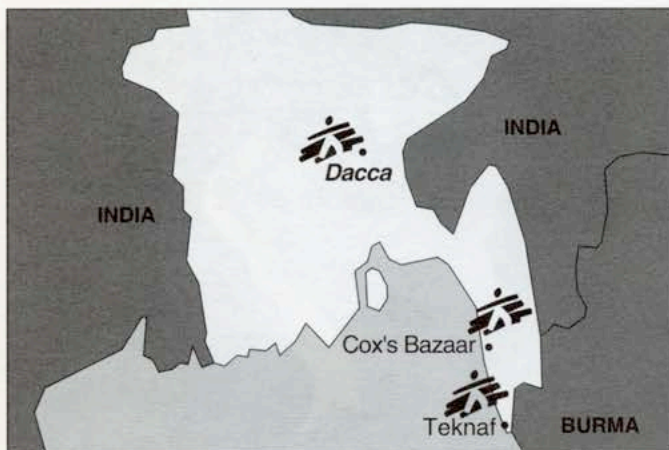
Tensions between Sri Lanka's Tamil minority (20% of the population) and the Sinhalese majority (70% of the population) continue. The LTTE (*Liberation Tigers of Tamil Eelam*) want an independent Tamil state in the east and the north of the country. Following India's military intervention between 1987 and 1990 and a short period of calm, war resumed between the Sri Lankan government and the Tigers still in control of the north of the island. 1994 was marked by a period of relative peace during which the government and the LTTE negotiated. However, tensions broke out again in April 1995 and more fiercely than ever.

ACTIVITIES

MSF's main objective has been the substitution of absent Sri Lankan health workers (surgeons, anaesthetists, pediatricians) and witnessing in the case of human rights violations. In Point Pedro, MSF carries out surgical operations in the hospital on the Jaffna peninsula, an LTTE stronghold. The presence of the team ensures a neutralisation of the hospital. In Madhu Church, MSF provides medical assistance to the displaced camps at Madhu and Pallappiddi where at the beginning of 1995 there were 7,000 people. MSF also works in Batticaloa, where activities involve pediatrics and surgery. Mobile clinics cover isolated areas. In Mannar, the surgical assistance programme was relaunched at the beginning of 1994. In Kilinochi the obstetrics programme started in October 1994 in the town to the north in the LTTE zone.

Funding: MSF, UNHCR, WHO, IRC, OXFAM, UK, Swiss, Dutch, Canadian and US governments
Expatriates: 21

BANGLADESH



CONTEXT

Since 1992, hundreds of thousands of Rohingyas, a Moslem ethnic minority, have sought refuge in South Bangladesh in the districts of Teknaf and Cox's Bazaar where they have settled in 19 different refugee camps. From the outset, it was clear that the Bangladeshi government was in favour of speedy repatriation. In 1993, an agreement was signed between the Burmese and Bangladeshi governments for their repatriation. By April 1995, there were only 60,000 Rohingyas left in the camps.

MAIN ACTIVITIES

In April 1994, there were still 190,000 Rohingyas left in the camps as a cyclone had devastated the camps, slowing down the repatriations. Within a month, MSF had rebuilt all the damaged facilities in the camps. In July, August and September 1994, the UNHCR carried out the mass registration of refugees, declaring that the vast majority were willing returnees. This caused a major disagreement between the UNHCR and the humanitarian agencies. By December 1994, the refugee population in Cox's Bazaar was almost halved to 23,000. MSF provides medical aid and runs feeding centres and a sanitation programme. Training courses are provided for traditional midwives and other medical personnel. MSF also took on the medical responsibility of the Nayapara II camp in November 1994. Following the decision to close Gundhum camp in mid-1995, MSF prepares to scale down medical activities while continuing the lobbying effort.

Funding: MSF, EC, UNHCR and Dutch government

Expatriates: 10

BURMA (The Union of Myanmar)



CONTEXT

The Burmese people continue to be victims of political repression and international isolation. Although, in 1992 the country opened its borders, change has been very slow in coming and the international perception of Burma is that of a military regime which flouts universal conventions on human rights and systematically represses its people. The many reported cases of forced labour and child labour worry human rights organisations. Forty percent of the population belong to one of the seven ethnic groups in the country and, thus, have no right to full citizenship, income or health care. Persecution and fighting have caused hundreds and thousands of Burmese to flee to the neighbouring countries of Bangladesh and Thailand.

ACTIVITIES

MSF's Rangoon project was launched in February 1993. The emphasis was on making medical care accessible to the shanty town dwellers. In the past few years, 250,000 people have been forced by the Burmese government to move to Hlaingthayar and Shwepyithar, two townships near the capital. Living conditions are abominable. Health structures are lacking in medicine and medical material and have little or no equipment. MSF supports hospitals, outpatient clinics and health centres in the two townships. An important part of the project is the registration of illness and mortality rates. MSF supplies the necessary medicine and medical supplies and sometimes surgical materials. Malnutrition is rife. Two feeding centers were set up by MSF in Hlaingthayar and staff training provided. In May 1994, MSF ran an anti-cholera campaign when the epidemic broke out in two districts.

The Arakan project was launched in January 1994. Malaria, the country's worst health problem, is endemic in this region which is near the border with Bangladesh. MSF has provided existing medical structures with necessary laboratory equipment and provided staff training.

Funding: MSF, WHO, UK, Australian and Japanese governments

Expatriates: 14

CAMBODIA



CONTEXT

In early 1994 the Cambodian army was humiliated by the Khmer Rouge which took back some important bases: Pailin and Anlong Veng. However, its power base is clearly diminishing. A deadline for amnesty was set for 7 January 1995, and many rebels have defected to the government side. The main rebel base remains Kampot province, and Phnom Kulen in Siem Reap. Although the newly-elected government had a difficult year, a harmonious and consistent new Cambodian health system has begun to emerge.

ACTIVITIES

MSF worked in Kampot until December 1994, when it became too dangerous to continue. Medical assistance is provided in Banteay Meanchey. This includes the rehabilitation of medical structures, the upgrading of the water supply and the digging of latrines. Despite insecurity in the province in 1994, a project was launched in Kratie city and the Sambo district. The programmes include the supply of medicines and medical material to the hospital, training and support of its management and the rehabilitation of health structures. Security problems have taken their toll in Siem Reap. In 1994, the Samrong district hospital was finally opened and the provincial hospital rehabilitated by MSF. MSF has also provided assistance at the Pursat provincial hospital. In Bakan district, there are now two new health centres. The training of laboratory trainees also continues. MSF launched a local NGO that will operate a private outpatients clinic in a suburb of Phnom Penh, with an outreach post in a red light district. Medical assistance is provided and surgery carried out at the hospitals of Battambang, Kompong Cham and Kompong Thom. This includes rehabilitation, medical supply and training. Activities in the Krau Chmar district hospital centre around rehabilitation, sanitation and national health programmes. MSF is also involved in training anaesthetics nurses.

Funding: MSF, EC, UNDP, UNCDF, Belgian, Swiss and Dutch governments

Expatriates: 58

THAILAND



CONTEXT

Since 1992, Thailand has a democratically elected government and the general evolution of the political scene is positive. 1994 was marked by frequent security incidents along the Burmese and Cambodian borders, and the periodic arrival of refugees. HIV has spread throughout Thai society. By the end of 1994 the government had estimated that 600,000 people (1% of the general population) were infected with HIV. Tuberculosis is also on the rise.

ACTIVITIES

MSF runs a mother and child health care programme in the Bangkok slums. MSF is also responsible for a youth programme and is in charge of a day-care centre and a mobile clinic. A second day-care centre is to be opened in 1995. A programme providing support to families of babies born from HIV+ mothers runs in collaboration with the department of paediatrics of the Chulalongkorn University Hospital. MSF also provides medical support to local agencies caring for HIV+ people and AIDS patients. Psychological and medical support is also provided to AIDS sufferers in Chiang Mai.

In 1995, refugees in the Vietnamese refugee camp in Sikhiu will be returning to Vietnam when the UNHCR's voluntary repatriation programme enters into force. MSF teams run an extensive assistance programme for the Karen people both in the displaced camps and across the border in Burma. MSF does the same for the Mons people both inside and outside the country. Teams focus on upgrading the health structures, mother and child health care and sanitation in the displaced camps. On the other side of the border, MSF takes care of medical supervision, supply and carries out sanitation programmes. Support is also given to the Karenni populations in the Tavoy Mergui district.

Funding: MSF, EC, UNHCR, NCA, IRC, US and Australian governments

Expatriates: 21

VIETNAM



CONTEXT

Vietnam is undergoing increasingly rapid socio-economic change. However, political and bureaucratic change is slow in coming. There is a high level of provincial autonomy, which can mean that national laws and initiatives are difficult to implement. The state health service has virtually collapsed, leaving citizens dependent on a poorly-regulated private sector.

ACTIVITIES

MSF has been providing assistance for people with AIDS and STDs (*sexually transmitted diseases*) in Nha Trang since September 1994. The central feature of the project is a "semi-private" clinic providing reproductive health care to women. MSF also works in Da Bac where it provides health care assistance. MSF has already reorganised the hospital. Since September 1994 two hydraulic centres were built in Hat and Ke polyclinics which have also been rehabilitated. The rehabilitation, training and sanitation programme in Quang Tri province which was launched in December 1993, has been completed successfully. The project in Hung Nguyen was also closed in December 1993.

Funding: MSF, EC, Luxembourg, Canadian and Belgian governments and French local authorities

Expatriates: 6

HONG KONG



CONTEXT

In April 1994, 1,200 Government forces were deployed to move 1,500 Vietnamese refugees from the Whitehead Detention Centre. 557 rounds of tear gas were fired into that section, burning many. A Government enquiry was called for and a report produced. The number of forced repatriations increased in 1994 and the Hong-Kong Government made the announcement that these kind of operations would take place every five to six weeks in 1995.

ACTIVITIES

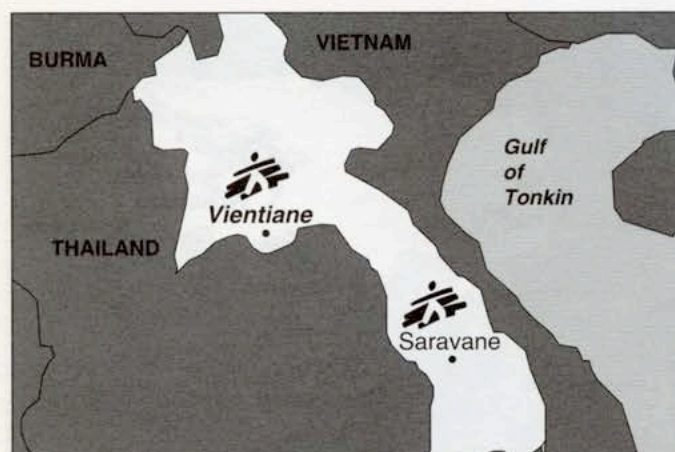
In September forced repatriations were carried out in High Island Detention Center. The same month, a "project committee" reconfirmed the commitment of MSF to provide medical care and assistance to the Vietnamese Boat People present in the detention centres and in Pillar Point. In October 1994, forced repatriations were carried out in High Island camp. MSF is opposed to the repatriation programme favouring voluntary repatriation and has made a request to the authorities to be present during such operations as an independent monitor to report any abuse on human rights.

MSF is currently providing outpatient services and ante-natal care in the Whitehead Detention Center and carried out a study on post-traumatic stress syndrome in the child population. MSF has taken back responsibility for the Well Baby Service activities of Whitehead. MSF carries out consultations in the refugee camp at Pillar Point, where drug abuse remains a problem.

Funding: EC, UNHCR

Expatriates: 3

LAOS



CONTEXT

Despite economic development, Laos has still several problems to confront. The State is investing less in the public-health sector. The basic problems that still require solving are under-equipped, poorly supplied health structures and over-staffing with under-qualified and under-paid personnel.

ACTIVITIES

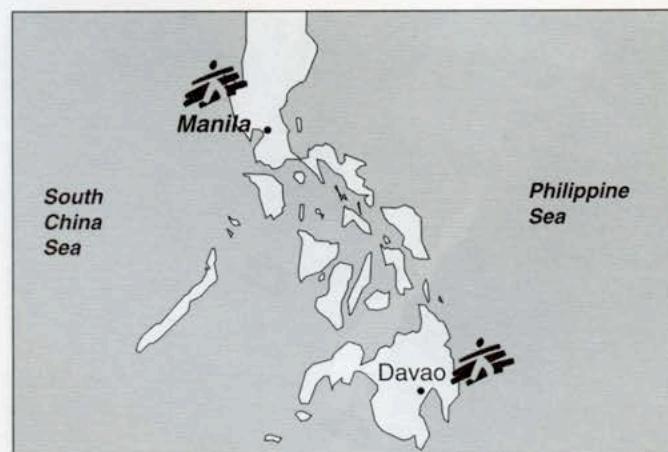
MSF has taken part in the development of three districts in the southern province of Champassak and in the province of Saravane. In the district of Bachiang and Sanasoumboune, the supervision of activities is mainly carried out by local staff. In the pilot district of Champassak, the hospital has been rehabilitated. The MSF Essential Drugs Guidelines has been recognised by the Ministry of Health as a reference tool for the whole country.

In Bokeo province, MSF continued to assist the Laotian returnees from Thailand. MSF activities include rehabilitation, medical supply and pharmacy management in the provincial hospital, the district hospital and health centres as well as training. In June 1994, MSF also intervened in the wake of a cholera epidemic.

Funding: MSF, EC, UNHCR, Australian, US and German governments and Belgian local authorities

Expatriates: 13

PHILIPPINES



CONTEXT

Like many developing countries, the Philippines is a society with a marked gap between the rich and the poor. The inhabitants of the cities and towns are now facing many of the problems incurred by rapid urbanisation and industrialisation. The country is also particularly prone to natural disasters.

ACTIVITIES

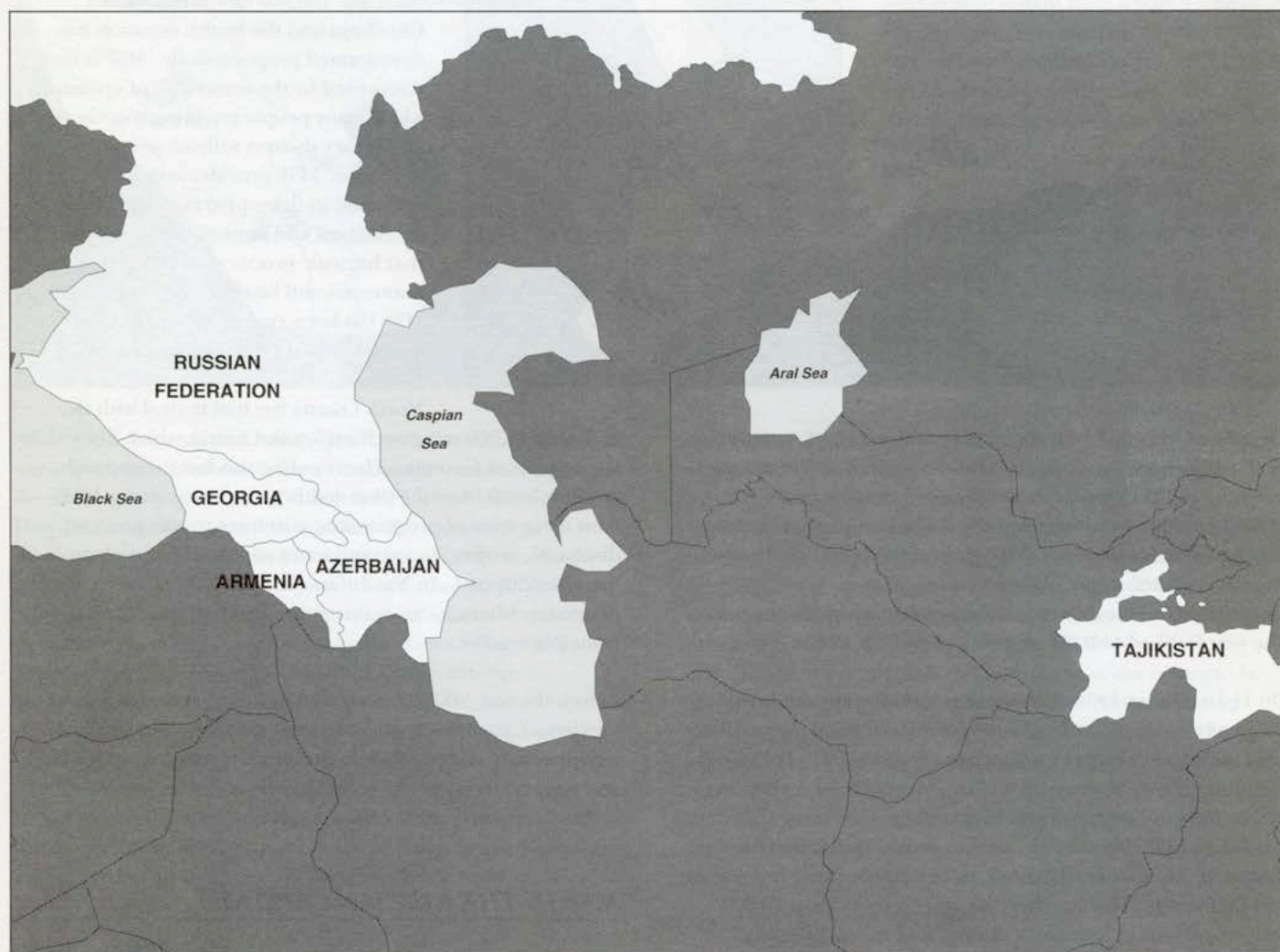
In 1994 MSF consolidated its different projects in the Philippines. The tuberculosis programme has actually been re-integrated into the Department of Health, and a new programme has been launched combating sexually transmitted diseases (STDs) and providing information on HIV prevention. MSF started an emergency preparedness programme in Pampanga province after the mud flow originating from Mount Pinatubo forced 30,000 to evacuate during the rainy season. In the capital, Manila, MSF runs a project for street children.

Funding: MSF, EC

Expatriates: 1

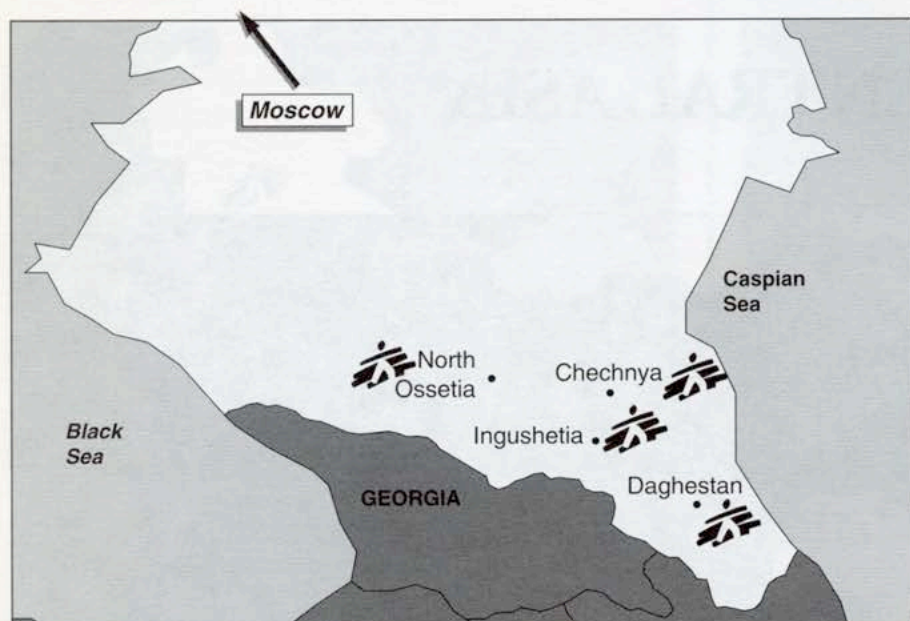
MISSIONS - PART II

CENTRAL ASIA



*The Russian Federation,
Armenia and Azerbaijan,
Tajikistan, Georgia*

THE RUSSIAN FEDERATION : INTERNAL CONFLICT



Before the Chechen conflict, Ingushetia had already seen the arrival of more than 67,000 displaced following its own war against North Ossetia for the sovereignty of the Prigorodny region. However, now there are 130,000 new arrivals from Chechnya and the health situation has deteriorated proportionally. MSF is most concerned by the severe risk of epidemics when many people are living together in temporary shelters without proper sanitation. MSF provides assistance to the displaced in three pharmacies, carries out vaccination and sanitation and sees to it that hygienic products, disinfectants, mattresses and blankets are distributed. MSF has been running a distribution programme in the area for two years.

The salient features of day-to-day post-communist life appear to be the disintegration of the social and economic fabric and the widening gap between new capitalists and the new poor. The disorganisation of the State and the collapse of payment systems has created new categories of beggars on the streets of Moscow: pensioners, intellectuals, skilled workers. Moscow is still struggling to keep all the different Russian republics within the fold. The year finished with the outbreak of civil war in Chechnya.

On 11 December 1994, Moscow sent 10,000 men with heavy weapons into the tiny Chechen republic to subdue the rebels. Chechnya had declared itself independent in 1991. Following the onslaught on the capital, Grozny, most of the inhabitants fled to the south of the republic or into neighbouring republics. MSF immediately tried to provide assistance for the displaced, whether in Chechnya, or in neighbouring Ingushetia and Daghestan. To date, there have been more than 20,000 deaths and tens of thousands of displaced inside Chechnya itself or in neighbouring Ingushetia and Daghestan.

MSF ACTIVITIES IN CHECHNYA

Until 15 December, MSF was supplying the Grozny health centres with medicine and medical material. From its bases in Daghestan and Ingushetia, teams continued to monitor the health situation and send supplies to between five and six hospitals. At the beginning of March, two surgical teams were finally able to enter the capital where they set to work in two of the city's hospitals. Other teams worked in two other hospitals in the south, in Vidino where MSF set up a makeshift surgical ward, Kurchaloy and Chatoy. Dispensaries and polyclinics in the capital and the south of the country were re-launched with the help of MSF. A medical distribution programme to health structures in the south of Grozny, as well as a similar programme for Daghestan and Ingushetia continue.

North Ossetia has had to deal with the arrival of 45,000 refugees from South Ossetia, which lies within the borders of Georgia. The republic also has to cope with another 5,000 from the disputed Prigorodny territory. MSF runs three sorts of programmes: assistance to refugees and displaced, medical supply and water supply to hospitals and aid for waste disposal. In North Ossetia, MSF has opened a refugee pharmacy, where it can evaluate the health of the returnees from Prigorodny.

Before the war, MSF concentrated its activities in this part of the northern Caucasus on the supply of medicine and medical material, vaccination, cholera prevention, refugee assistance and support to hospitals, including the construction of incinerators and reservoirs for surgical wards.

MSF IN THE RUSSIAN CAPITAL

In Moscow, MSF runs a programme for the homeless which includes immunisations against diphtheria around the Paveletski and Kourski train stations. This programme is to be enlarged to cover more of the city's stations in 1995. MSF has also opened a dispensary cum outpatients clinic in a centre for the homeless. MSF is also involved in emergency hospitalisations organised in accordance with the Ministry of Health. Psychological consultations are also offered to this target group.

MSF is also planning to set up an anti-tuberculosis programme in a prison in Siberia.

Funding: MSF, EC, UNHCR

Expatriates: 36

ARMENIA and AZERBAIJAN



Since 1988 Armenia and Azerbaijan have been undergoing the consequences of the war Armenia initiated to annex Nagorno-Karabakh, the population of which is 90% ethnic Armenian. Despite a cease-fire signed in mid-May 1994, the energy blockade applied by Azerbaijan on Armenia has given rise to grave economic difficulties. Since 1 December 1994, Yerevan has been attempting to start up a market economy. Prices have been liberalised and there are many shortages. The Armenian people are going through a period of great hardship.

Peace negotiations were organised by the Russians in order to create an intervention force between the parties. However, to date there has been no agreement. Armenians continue to refuse to surrender any newly-gained territory. They still call for the recognition of Nagorno-Karabakh as separate from Baku and are adamant that they will retain what is known as the Lachin Corridor.

Fighting in the enclave has already cost 15,000 lives and resulted in an estimated 700,000 displaced persons inside Azerbaijan. 1994 saw the Armenians make further incursions into Azerbaijan. Health care facilities have been badly damaged by war.

ASSISTANCE IN ARMENIA

In December 1994, MSF ended the assistance programme for mentally handicapped children in Kharberd and started a similar programme in an institution for adults at Vardenis. Here, medical staff is trained, buildings refurbished MSF has even set up occupational therapy wards. On 1 April 1995, a medical aid programme was launched in the northern region of Noyemberian. The focus of the project is medical management and training. MSF continues to monitor the rehabilitation of a home for mentally handicapped children at Gumri where training is also provided. A new programme

should be launched soon in Yerevan, whereby syphilis treatment will be provided and other sexually transmitted diseases (STD's) diagnosed effectively. MSF is in the throes of reorganising the medical distribution system from a warehouse in Stepanakert, from where it supplies medicine and medical supplies to all the health structures in the Martuni region in Armenia (28 dispensaries and one regional hospital).

ASSISTANCE IN AZERBAIJAN

In late 1993, an MSF aid programme began in a number of areas along the front line. The first mission was launched in the Barda region, but in the first half of 1994, MSF missions opened in Yevlah, Agdam

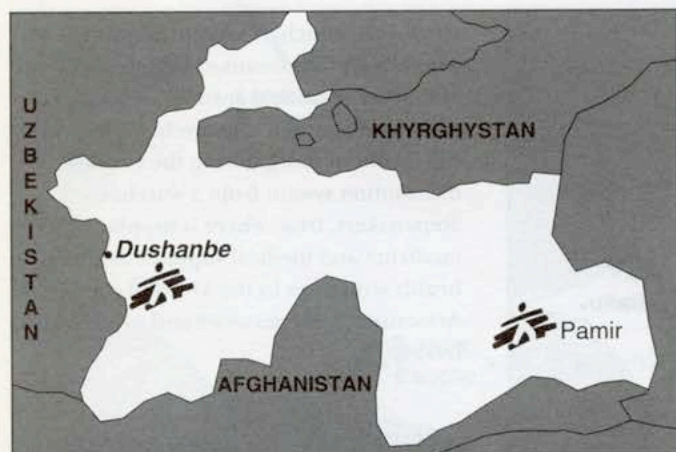
and Terter. MSF supports local medical facilities on which some 450,000 people depend. Support in the form of medicine and medical material was also provided to two regional hospitals, each with about 75 beds. In addition, MSF monitors and trains medical staff. In the second half of 1994, MSF began to concentrate on the larger regional hospitals and children's hospitals, from where medicine and medical material are distributed. In December 1994, MSF also began a distribution programme in the north-west of the country. In 1995, it will support the hospitals in Baku. Alongside drug distribution, MSF runs a medical programme in eight displaced camps in the Imlishi/Bilasuvay region. Medical training is included as is rehabilitation of certain medical structures and sanitation and water supply. MSF also runs an emergency preparedness programme.

ASSISTANCE IN THE NAGORNO-KARABAKH ENCLAVE

MSF supplies drugs to the enclave's health structures, and plans to open a psychological centre at Stepanakert where it will start training staff. This centre looks after traumatised children. MSF supplies HIV tests for use before blood transfusions to the health structures in the area.

*Funding: MSF, EC, UNHCR, Dutch and Greek governments
Expatriates: 28*

TAJIKISTAN



CONTEXT

1994 marked the return to normality, although guerrilla attacks from the north of Afghanistan are frequent. In September 1994, elections were delayed as there were no concrete signs of democratisation. When elections finally took place in December, although they were not recognised by the opposition party or by the international community, they did manage to reinforce the status quo. Russia not only controls the border with Afghanistan, but also the Tajik economy. The country survives thanks to massive food aid from the European Union. Some 20,000 Tajik refugees remain in exile in Afghanistan and, with the help of Arab and Iranian organisations, continue to prepare their Jihad.

ACTIVITIES

MSF's emergency medical programme ran until September 1994 when the emergency was deemed over. However, teams remain present in the Pamir region. MSF supplies medicine and medical material to 196 structures in the Gorno Badakhshan region and also brings assistance to civilians affected by the war in this isolated region. The provision of aid is difficult. At the moment assistance has to be transported through Kyrgyzstan. MSF has had to travel in convoys on mountain roads before joining the MSF base at Kholog. Last year, the MSF team distributed millions of tonnes of medicine and medical material despite difficult climatic conditions and security problems. MSF was also active in the surveillance of infectious diseases and vaccination (diphtheria and typhus) and the training of health care personnel.

Funding: EC, Canadian, US, Finnish and Dutch governments
Expatriates: 7

GEORGIA



CONTEXT

In 1994, Georgia concluded a ceasefire agreement with its north-western region of Abkhazia. In 1993, the civil war had claimed thousands of lives. More than 200,000 ethnic Georgians had fled the region. The return of the displaced has been delayed while peace negotiations continue. Georgia is presently suffering runaway inflation, poverty is widespread and there is a nationwide dependence on humanitarian aid. Following the Chechen rebellion, the Russian Federation imposed a severe embargo in order to dissuade the Abkhazian rebels from coming to the rescue of their Chechen neighbours.

ACTIVITIES

Following the Abkhazian war, there were 15,000 new arrivals on top of the permanent 385,000 in Adjara. Many are forced to live in public buildings. From Batumi, MSF supplies health facilities and provides training and medical aid to the displaced in relief centres. In 1994, distribution was extended to include Guria and Poti. A total of 39 hospitals and outpatient clinics are supplied with vital stocks of medicine and medical material. At the end of 1994, MSF began to give its support for the regular vaccination programme and rehabilitation of the cold chain. MSF is also active in Abkhazia, where it continues its two major medical programmes which include the supply of medicine and medical material and vaccines. Treatment for mine victims is provided and backed up by a prevention programme. Epidemiological surveillance is also carried out. MSF distributes drugs for about 564,000 displaced and war-wounded in Megrelia, Zugdidi and Tbilisi. MSF also trains health workers in their use. Since October 1994, the team has also been carrying out the rehabilitation of health structures. There are 7,000 refugees in South Ossetia, receiving MSF assistance. The agency has also rehabilitated the water system in Tskhinvali hospital.

Funding: MSF, EC, UNHCR
Expatriates: 33

MISSIONS - PART III

EASTERN EUROPE



*Former Yugoslavia (Croatia-Bosnia-F.Y.R.),
Albania, Romania*

FORMER YUGOSLAVIA : A DETERIORATING SITUATION



MSF continues to carry out activities in Bosnia-Herzegovina, Croatia and the Federal Yugoslav Republic. The support programme for refugees in the Former Yugoslav Republic of Macedonia was closed, as foreseen, at the end of July 1994. In Bosnia-Herzegovina, MSF is the leading medical agency. Teams have been working here since the end of 1991, when MSF opened a medical-logistical base in Sarajevo.

THE WAR INTENSIFIES IN BOSNIA-HERZEGOVINA

Over a period of three years, the war in Bosnia-Herzegovina has caused 300,000 deaths and seriously wounded 200,000. Most of the victims were civilians. Four million people have been displaced or have fled. The Serb offensive on what is left of Bosnia continued throughout 1994, which meant that cities such as Bihac, Tuzla, Srebrenica, Sarajevo, Maglaj, Mostar and Gorazde were continually under fire, and the international community was either unwilling or powerless to do anything about it. Although, in February 1994, a NATO ultimatum brought about a halt in the bombardment of Sarajevo, it would have been overly optimistic to believe that the Bosnian Serbs were willing to agree to the terms of western powers.

The peace plan of the international Contact Group for Bosnia was continually opposed by the Bosnian Serbs. One positive note, was the signing of an agreement in March, between Croats and Muslims to put an end to fighting in central Bosnia, which opened up Mostar and Maglaj. However, on a more negative note, by the end of July 1995, both Srebrenica and Zepa had been taken by the Bosnian Serbs, and Bihac, Gorazde and Sarajevo were undergoing daily attacks.

Enclaves come under increasing shell-fire in 1994 and 1995

On 29 March 1994, the month-long Serb offensive against Gorazde began. It lasted four weeks, during which shelling killed 750 people and wounded over 2,000. During this time, the MSF team worked continually with the wounded. The

international community, powerless, allowed the offensive go ahead despite the fact that the UN Security Council's Resolution 836 had decreed this to be a "safe zone". A few months later, a further offensive was launched against Bihac, further highlighting the powerlessness of the UN and the inability of NATO to move. However, in 1994 none of the "safe zones" fell, thereby contributing to the impression that they were indeed safe. In Gorazde, MSF's medical programmes include training, medical care and the supply of medicine. MSF also provides sanitation and water assistance in the enclave.

Access to the Bosnian enclaves for the relief convoys gradually became impossible. It took six months to get a truck load of drugs to Gorazde and sometimes six weeks to change the MSF team. During this time, the Bosnian Serbs pursued a policy of "ethnic cleansing". Amid widespread indifference, some 10,000 Bosnians were driven out of their towns and villages and deported from Bjelina to Tuzla, from Banja Luka to Central Bosnia. In the space of three years, over 750,000 non-Serbs have been expelled from the zones in Bosnia which were under Serb control. However, in July 1995, the most dramatic population movement of all took place when 25,000 people from Srebrenica were moved to Tuzla over a period of days.

The so-called safe-zones are constantly under attack and access to victims is more difficult than ever. The arms embargo continues to be ignored and the war drags on.

MSF's distribution project for Bosnia

MSF's distribution and monitoring project was set up for the whole of Bosnia. The target group is two and a half million people. MSF supplies 280 medical facilities with medicine and medical material. In 1994, MSF supplied medical facilities in Sarajevo, Krajina, Bihac, Split, Kiseljak, Tuzla and Banja Luka.

In 1994, four mental hospitals and several other medical facilities in the Banja Luka region were supplied with fuel for the winter. MSF encouraged the local production of a number of important medicines, including drip fluids. MSF carried out

BOSNIA - HERZEGOVINA



a winter programme in Sarajevo, involving the distribution of hepatitis-B vaccines, chlorine tablets and emergency supplies of medicine. In Mostar, MSF provided assistance in the evacuation of mental patients to Ancona (Italy) and Zagreb and also supplied equipment for testing the quality of drinking water.

The development of the surgical programme

On 31 December 1994, MSF finally succeeded in reaching Bihac, where it launched a programme of surgical support and where it started to restore the water supply. Surgery is no new departure for MSF in Bosnia. Since 1993, five MSF teams have worked in the hospital in Tuzla, where MSF has also provided support in the area of orthopaedic surgery. Teams have also been sent into besieged Bosnian towns on short term missions. Since October 1993, MSF provided support for the plastic surgery programme in the Kosevo Hospital of Sarajevo. In 1994, physiotherapy was also introduced as part of the programmes in Tuzla and Sarajevo.

MSF evaluates mental health care in Banja Luka and Sarajevo and has set up a project to train local counsellors who are then able to treat people with post-traumatic stress symptoms. Three mental health care centres opened in 1994 and another two in 1995.

In the enclaves of Gorazde and Srebrenica, MSF has supported and taken part in health-care activities: surgery and anaesthesia, gynaecological and obstetric assistance, primary health care and the supply of drugs and surgical equipment. Logistic activities have focused on the rehabilitation of health structures and housing as well as water. In the smaller enclave of Zepa, MSF has been attempting to provide the dispensary with regular drug supplies. Between October 1994 and March 1995, access to these enclaves became nearly impossible. In July 1995, Srebrenica fell to the Bosnian Serbs.

In Central Bosnia, the main activities have been food distribution programmes targeting the most destitute (around 30,000 people), programmes to supply water to health-care structures, primary health programmes (Maglaj) or specialist programmes (anaesthesia at Mostar) in conjunction with drug supplies. An extensive rehabilitation programme for health care centres and community centres has actually improved the quality of health care and shelter.

CROATIA



Some 30 health units in eastern Serb-occupied Bosnia have been provided with supplies of drugs and medical equipment by an MSF team based in Pale.

CROATIA

Along the Dalmatian coast, to the south of Zadar, MSF has been developing a psycho-social programme directed towards the families of displaced persons or refugees who suffered psychological trauma during the Bosnian war. At the present time, over 250 families are being monitored by a local team.

In 1994, MSF continued to provide aid in the Gasinci camp in Slavonia where former Bosnian prisoners and civilians expelled from Banja Luka and Prijedor have settled. At present, there are 3,500 refugees. This project focuses on primary health care, work in the dispensary as well as geriatric and gynaecological care. As there is always a risk of tensions resuming in Croatia, MSF is evaluating health structures near the front line.

FEDERAL YUGOSLAV REPUBLIC

MSF also works in Serbia and Montenegro. Other than sending supplies to Serb hospitals on a regular basis, evaluations have been carried out in order to assess the real needs of the Gypsy minority and to look into the possibility of giving them assistance. Other evaluations are to be carried out in the Sanjak and Voïvodine areas. In Pristina, in the Kosovo region, where a majority of the inhabitants are ethnic Albanians, MSF has developed a major drug supply and medical equipment distribution programme through a local association. MSF has also participated in the rehabilitation of maternity wards and health centres. Given the poor sanitary conditions, water supply and hygiene are priorities.

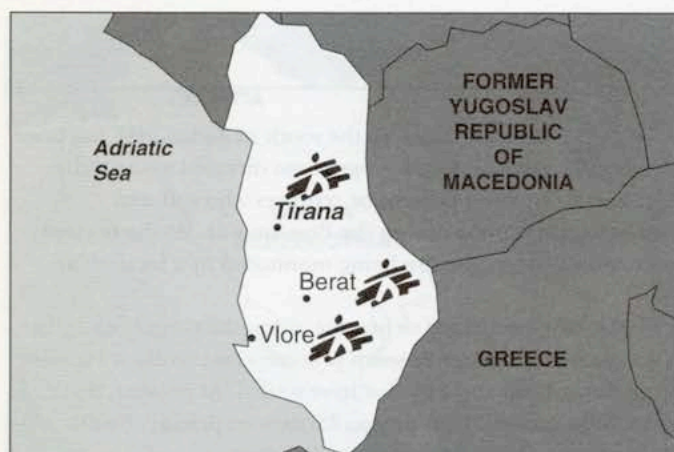
Funding: MSF, EC, UNHCR, Canadian, Dutch, Swedish and US governments, French local authorities, Mercy International, Nationwide Campaign Bosnia.

Expatriates: 49

F. Y. R.



ALBANIA



CONTEXT

Albania is Europe's poorest country. Adequate housing, food and clothing are scarce. Health care functions poorly. There is a grave shortage of basic materials and equipment and medical structures are run-down. Infant mortality is three or four times higher than the average rate in western Europe.

ACTIVITIES

MSF's main programme in Albania in 1994 was the distribution of medicine and medical material to health structures nationwide. MSF managed to supply and re-establish 2,279 ambulances, 500 health-care centres, 40 out-patient clinics and the country's eight hospitals. A priority has also been the rehabilitation of the cold chain, the system of refrigerated storage and transport of vaccines. In 1994, a total of 2,400 people were trained as part of this programme. MSF also runs a training programme for obstetricians in the districts of Berat and Skrapar. In 1994, this benefited 240 obstetricians. MSF is also rehabilitating and evaluating the care provided at the Ali Mahali mental hospital in Vlora. MSF also provides care to tuberculosis patients from all mental clinics in Albania. Following a cholera outbreak in September 1994, MSF intervened.

Funding: MSF, EC

Expatriates: 14

ROMANIA



CONTEXT

Romania now wishes to become a fully-fledged member of the international community and is applying for membership of the EC, NATO etc. The political landscape has evolved significantly over a five-year period. Several new political groups have emerged, many of whom are strongly nationalist in tendency. The transition to the market economy has been difficult for all Romanians, but particularly the weakest groups of society including orphans, handicapped children and the important Gypsy minority. State social policy is almost non-existent.

ACTIVITIES

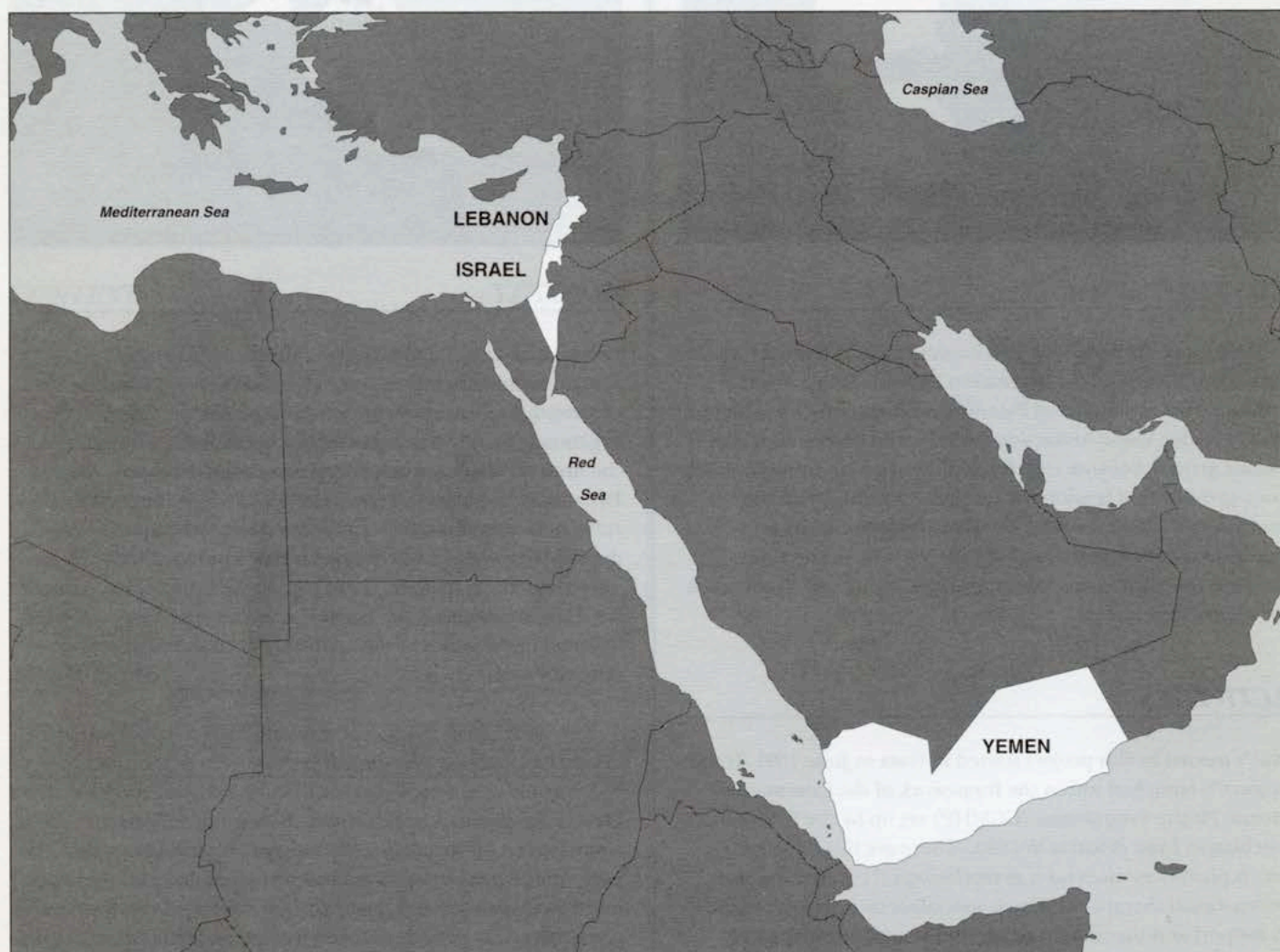
MSF has been carrying out a medical and social project in favour of the Gypsy community in three districts of Transylvania for some years now, where it has also run a family planning programme and provided assistance eight orphanages. Since May 1994, MSF has been providing assistance to institutionalised children in the department of Constanza. Other than the psychological, social and medical assistance being provided in orphanages, MSF trains Romanian staff and works in some of the areas' maternity wards, where the importance of the mother/child bond is stressed. MSF also runs a family planning programme in Constanza and Prahova, where the emphasis is on training, presentations and finding ways for local bodies to recoup costs. MSF also supports the organisation Noi de Asemenea in the Neamt department.

Funding: MSF, EC

Expatriates: 8

MISSIONS - PART IV

MIDDLE EAST



*Israel/ The Palestinian Authority, Lebanon,
Yemen*

PALESTINIAN AUTHORITY



CONTEXT

In 1994, the Gaza Strip and Jericho were given a limited form of autonomy. However, the agreement between Israeli prime minister Yitzhak Rabin and Palestinian Liberation Organisation (PLO) leader Yassar Arafat was severely criticised by extremist Islamic groups, because they felt it did not go far enough. 1994 saw a great deal of tension following the accord. With the exception of East-Jerusalem, the Palestinian authority is in charge of health care throughout the West Bank and Gaza. Unemployment remains extremely high, giving rise to countless social problems.

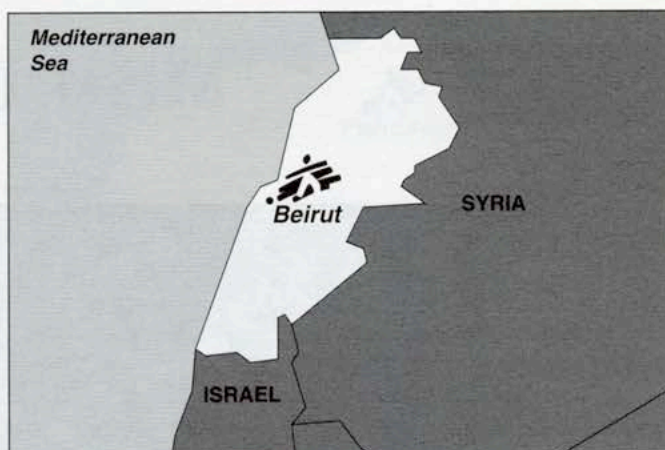
ACTIVITIES

MSF's mental health project started in Gaza in June 1991. It was originally launched within the framework of the Community Mental Health Programme (GCMHP) set up by the Palestinian psychiatrist Eyad el-Sarraj in 1990. There are three clinics which provide services such as psychological counselling and occupational therapy. MSF sent specialists on a mission to Gaza to support and supervise training and occupational therapy until the end of 1994. MSF also supplied relevant literature and documentation. From 1995 onwards, MSF will provide no more staff for this programme. However, the occupational therapy will be financed until April 1996 at which time MSF will provide assistance on a consultancy basis. MSF also provides counselling in North Jenin in the West Bank. In partnership with the Palestinian Counselling Centre (PCC). The team has a twofold objective: to provide training for Palestinian counsellors and to ensure that the centre functions adequately. This centre will be the example of a multi-disciplinary centre.

Funding: MSF, Dutch government

Expatriates: 7

LEBANON



CONTEXT

Lebanon must now face the task of reconstruction and reorganisation after 20 years of war. From an economic point of view, there is an enormous division of wealth. Local organisations, often as not religious, try to bring some aid to the impoverished, but not always in a rational fashion. The Palestinian population is the worst off. Packed into makeshift refugee camps, the aid they were used to receiving is diminishing as there is a deliberate attempt being made to encourage them to leave. 1994 was the first year when, except for a few incidents on the border of the security zone instituted by Israel in the south of the country, the country has remained relatively calm.

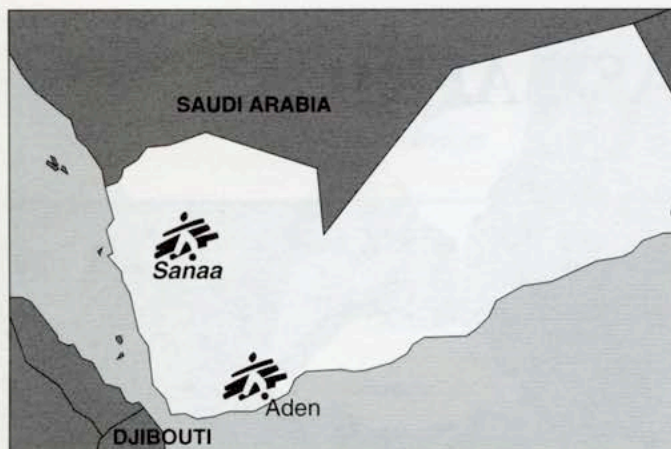
ACTIVITIES

Having supported a health centre at Biakout, MSF has committed itself to a project to support rural dispensaries. The programme is made up of 3 elements: rehabilitation, the supply of medical material and medicine and training. The Bir Hassan dispensary does provide medical treatment, but its main activity is preventive care (pre-natal consultations for the people in Beirut's southern suburb. The dispensary staff is attempting to set itself up as a non-governmental organisation under Lebanese law.

Funding: MSF, Luxembourg government

Expatriates: 2

YEMEN



CONTEXT

Although North and South Yemen were officially reunited in 1990, in May 1994, civil war broke out once again and continued until the end of July. The southern socialist party declared independence in June, fearing the Islamicisation of the state. However, in the end the Al Islah party of the north won the day and retains the presidency. Islamic law is now being introduced into all sectors of society. An opposition movement led by former southern socialists has been formed in London.

ACTIVITIES

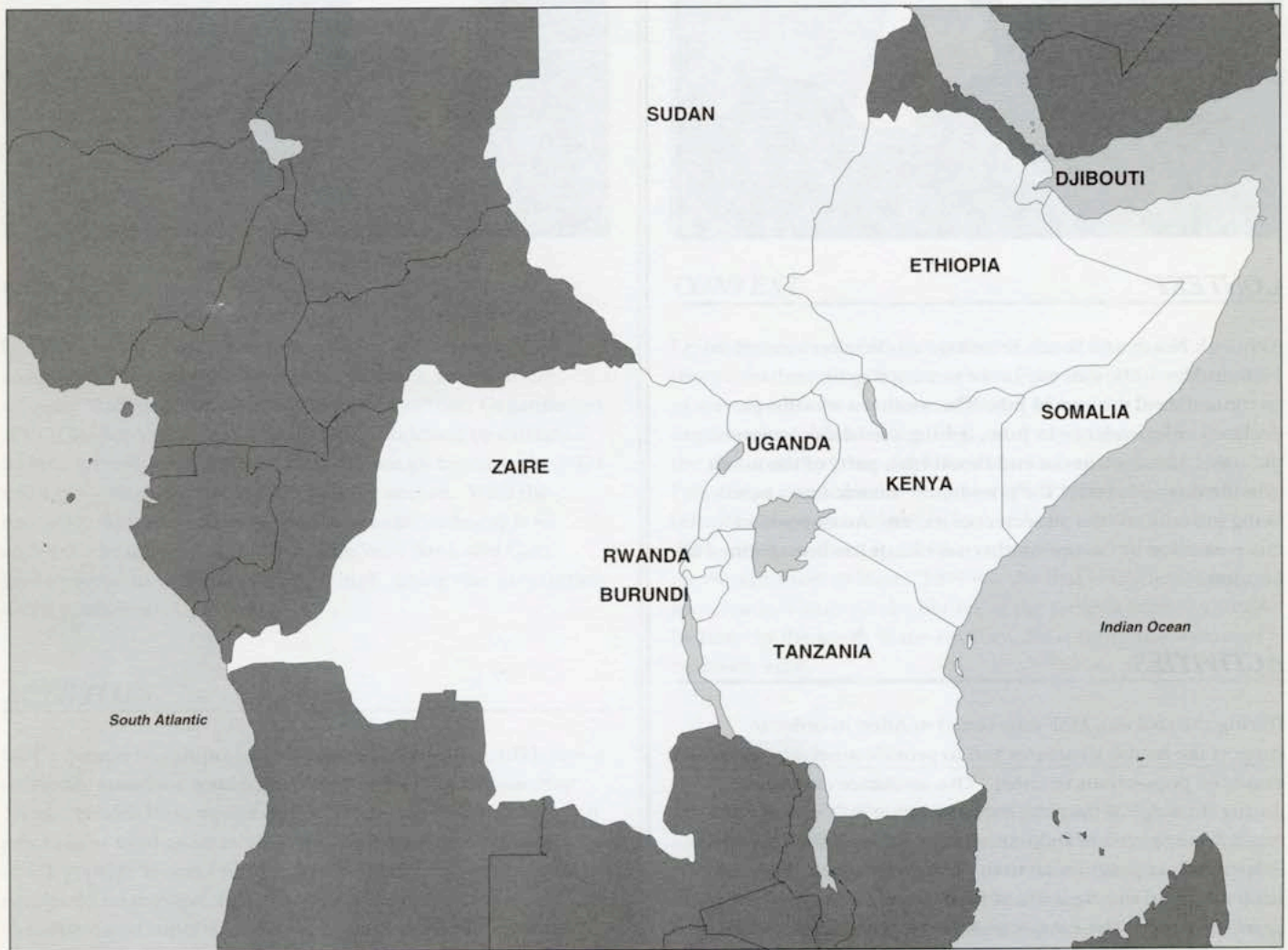
During the civil war, MSF intervened in Aden in order to support the health structures and to provide assistance to the displaced populations in Lahej. This assistance continued during the siege of the city, but at this time the city was only reachable by sea from Djibouti. In December 1994, MSF finished its aid programme to the Somali refugees. They had been caught in the cross-fire of the war and were out of the aid agencies' reach. The camp was shifted to Lazdar where MSF resumed its activities once access to these people became possible once again by way of Sana'a. In Dhi Soufal, MSF tries to upgrade health care on a district basis. Activities include rehabilitation, the supply of medicine and medical material, the dissemination of information and the training of health care workers. The project had to be suspended during the civil war and the goals will be redefined in 1995.

Funding: EC, UNHCR and Dutch governments

Expatriates: 3

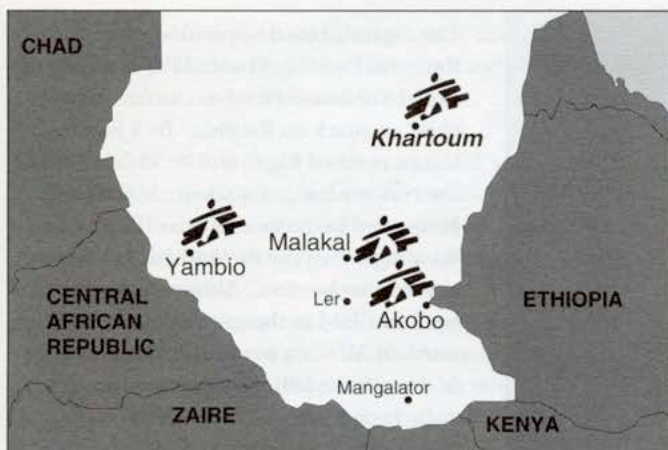
MISSIONS - PART V

CENTRAL & EAST AFRICA



*Zaire, Rwanda, Burundi, Tanzania,
Djibouti, Ethiopia, Somalia, Kenya,
Uganda, Sudan*

SUDAN



CONTEXT

The 12-year civil war in Sudan has claimed one million lives. 80% of the people from South Sudan are displaced or have become refugees in neighbouring countries. Prolonged civil war has eroded the social and economic infrastructures resulting in cyclical hunger and chronic ill health which has taken its toll on the inhabitants of South Sudan, only a quarter of whom have access to health care. In March 1995, a cease-fire was agreed upon by the government and the Sudan Peoples' Liberation Army (SPLA).

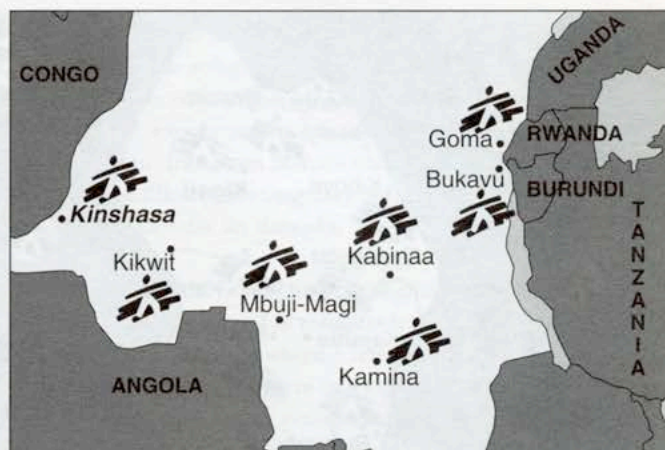
ACTIVITIES

In Khartoum MSF provides medical and sanitation assistance to the displaced and supports the Kala Azar ward in the Soba Hospital. Some 2,500 patients with this disease were treated in Western Upper Nile in 1994 alone. In Ler and Duar, treatment was also provided for tuberculosis. In Akobo, the rural hospital is being upgraded and immunisation carried out. A Kala Azar project began recently in Chotbura, Eastern Upper Nile. The health care project for the displaced continues in Mangalore. MSF provided mother-child health care and training in Waat until September 1994. Health care structures are being supported in Malakal, where MSF also supplies medicine and medical material and trains local staff. In Maridi, essential medical services are provided for the displaced. Emergency medical and nutritional assistance is also provided to the displaced in Mundri. In Lietnham, a nutritional programme is being carried out.

Funding: MSF, EC, UNICEF, WHO, IRC, Oxfam, UK, Swiss, Dutch, Canadian and US governments.

Expatriates: 44

ZAIRE



CONTEXT

Two parallel governments, a shambles of an administration, wide scale corruption, a plummeting economy and extreme social tension characterise today's Zaire. Ironically, President Sese Seko Mobutu, until recently reviled as a ruthless and corrupt dictator presiding over a potentially-rich country falling apart at the seams, managed to use the Rwandan crisis to his advantage, and is now seen by some as a strong leader capable of maintaining his grip on the country. Some Western powers are now renewing their diplomatic and economic links with his regime.

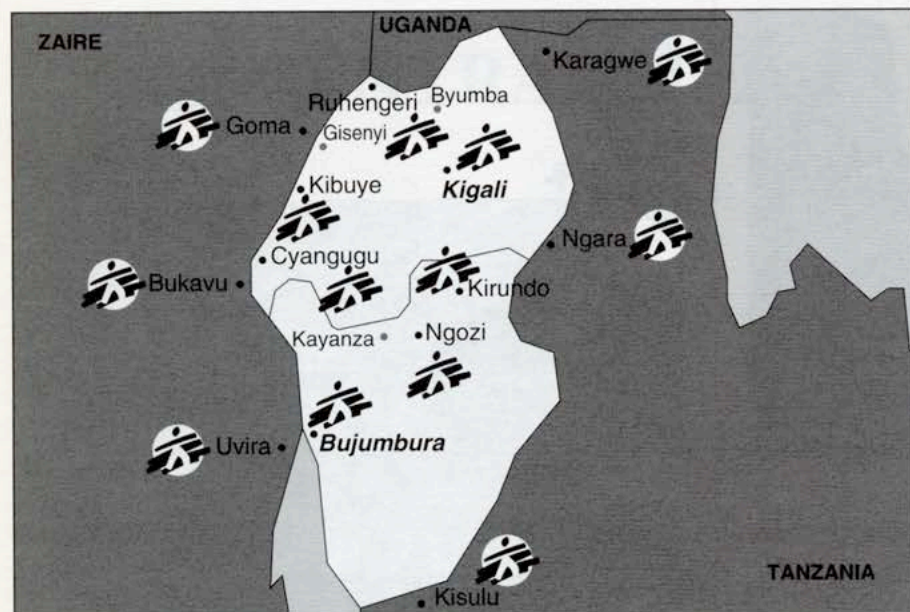
ACTIVITIES

The emergency aid programme to the displaced persons from Shaba continued in 1994 and 1995. 65,000 people in Likasi, 17,000 in Kolwezi and 2,000 in Kamina all benefited from MSF assistance. In Kabinda, MSF provides badly needed assistance to people of Kasai origin as it did in Mbuji-Mayi until April 1995. In Kasai itself, at Mwene Ditu, the "returnees" receive medical and other assistance. In Bolomba-Basankusu, in Equateur province, MSF continued its health-care programme. In Kasenga, the training of local personnel went ahead and preventive activities were relaunched. MSF continued to assist the Angolan refugees in Dilolo until the end of 1994. In Kinshasa, nutritional assistance continues to be provided for children through 30 centres. MSF also distributes medical kits in six Zairian regions. The clinic for prostitutes at Matongué continued its activities by providing prostitutes with medical care for AIDS and informing them on ways of avoiding infection. Support for the blood-transfusion centre in Lubumbashi is also set to begin. MSF also launched a massive assistance programme for the Rwandan refugees in the middle of 1994 - see following article.

Funding: EC, German, Dutch, Belgian and US governments

Expatriates: 45

RWANDA - BURUNDI - TANZANIA - ZAIRE :



In 1994 a genocide took place in the tiny central African country of Rwanda which was watched on television in the outside world. As in neighbouring Burundi, the majority of the population is Hutu and the minority Tutsi. In early April 1994, on the eve of the killings, political power was in the hands of a Hutu government, extremist in tendency, while many Tutsi leaders were in exile.

But of course, this was not the first time, that massacres had been carried out between populations in this region. In the months prior to the Rwandan genocide, the region was recovering from the massacres which had taken place in Burundi at the end of October 1993 provoking the flight of 700,000 across the Rwandan, Burundian and Tanzanian borders. Here the death toll had been heavy and the bloodshed intense, but nothing could have prepared outside observers for what was to happen in Rwanda.

Suddenly, on 6 April 1994, an aeroplane carrying the Rwandan and the Burundian Presidents (*Juvénal Habyarimana and Cyprien Ntaryamira*) was shot down killing them both. It is not known who took this initiative. However, within hours, road blocks went up and all those suspected of being of Tutsi origin (as well as all Hutu members of the political opposition) were singled out to be killed. The exterminations had begun in earnest.

THREE MONTHS OF HELL

The genocide against the Tutsis in Rwanda was to result in between 500,000 and one million deaths between April and June 1994. Most killings were carried out by militia groups acting on behalf of the government. The Rwandan Armed Forces, the Presidential Guard and the self-proclaimed transitional government launched appeals to eradicate the Tutsis, using the propaganda-driven Radio des Mille Collines which incited listeners "to kill or be killed".

The Uganda-based opposition, the Rwandan Patriotic Front (RPF) made up of exiled Tutsis and Hutu moderates, launched an attack on Rwanda. By 4 July, their troops reached Kigali and by 13 July 1994, the country had been taken. Millions of Hutus fled in the face of this offensive flooding across the Burundian, Tanzanian and Zairian borders. Although, many had been involved in the genocide and feared retribution, often people who had nothing to do with the killings were persuaded by radio broadcasts and militia leaders that they had no choice but to flee or face certain death. At this time, 600,000 Rwandan Tutsis returned to the country they were driven out of in 1959.

Operation Turquoise was launched by the French Armed Forces between June and

August 1994, in an attempt to stabilise the south-west of the country. Following the withdrawal, 400,000 displaced persons were to remain in the camps in the prefectures of Kibuye, Gikongoro and Cyangugu.

MSF ACTIVITIES DURING THE EMERGENCY

When the crisis began in April 1994, MSF had been present throughout Rwanda for many years. To the horror of the teams, many members of the local staff were targeted by the militia groups resulting in a death toll unprecedented in the history of this organisation. This fact, combined with the staggering news that the UN was pulling out most of its Blue Helmets, made it too dangerous for MSF to continue its extensive aid programme throughout the country. Instead, MSF restructured its teams, evacuating all but the most experienced volunteers. An MSF team immediately went to work with the International Committee of the Red Cross (ICRC) near Kigali, where it remained for several months.

The refugee programme in the south was disbanded as remaining Burundians headed home having heard of the tensions in Kigali. MSF sent in a new team to Butare to work in the University Hospital. On 23 April 1994, a militia group stormed the wards, killing 170 patients and local staff. It was clear that it was too dangerous to work in militia-controlled zones.

Activities were, thus, oriented towards surgical care for the wounded and assistance for the displaced in RPF-held territory which was expanding daily. MSF started to work with the wounded in Byumba and Nyamata. In early June, activities were extended to the Ruhango region. However, when the RPF decided to evacuate the Ruhango-Nyanza population to Bugesera, 100,000 displaced persons, many in poor health, were thrown out onto the Bugesera roads finally winding up in Rilima where MSF set up an emergency 1,000-bed hospital. Many

CRISIS IN THE REGION OF THE GREAT LAKES

collapsed on the roadside. At this time, MSF launched a surgical programme in Kigali's King Faycel hospital, and started assisting the displaced in the Amahoro stadium.

On 13 July, the RPF took the country and MSF's aid operation in Rwanda was stepped up in preparation for the expected return of refugees. In Ruhengeri and Gisenyi, transit centres for returnees were set up and six health-care centres rehabilitated. A centre for unaccompanied children was opened beside the Rubavu health centre. In Gikongoro, MSF continued to provide assistance in the displaced camps. MSF also launched programmes in Cyangugu and Nyagatare, supporting health structures and providing health care. The Kabutare hospital in Butare was reopened. In Gitarama, MSF took charge of Kabgayi hospital.

THE REFUGEE EMERGENCY

When the killings began, all Tutsis who had not yet been rounded up by the militia groups fled the country. 27,000 arrived in Burundi where assistance was provided to them by MSF. The agency was already in the area assisting Burundian returnees. These refugees headed home in July. However, this coincided with the arrival of 200,000 Rwandan Hutus, once again in the Ngozi and Muyinga provinces of Burundi. MSF relaunched the medical programme.

On 14 July 1994, within a day of the RPF victory, up to a million refugees arrived in the small town of Goma, Zaire. Never in recorded history, have so many refugees arrived at one time over the same border. Although, MSF was already working in the area, no aid agency had foreseen an influx of this dimension. Water was to be a problem from the outset because of the unprecedented numbers as was the need to purify, transport and distribute it. This was MSF's first priority, particularly given the high risks of epidemics. Within nine days, the MSF team was increased from 50 to 630 local and international staff.

As early as 19 July, the first cases of cholera duly broke out, a fatal illness cured by rehydration. Despite its every effort, the aid community could not get an effective water system going in time to prevent thousands of deaths. MSF opened cholera camps in Katale, Kibumba, Munigi and Goma. At the height of the epidemic, MSF was flying several full charters into Goma each week. Within a month an estimated 60,000 refugees had died. By the end of August, refugees were receiving adequate supplies of clean drinking water and the death rate had dropped. However, as cholera cases were diminishing, the dysentery epidemic took off. The fact that the infected patients were resistant to most antibiotics, complicated treatment for the epidemic which raged until November. An anti-meningitis programme was launched before the epidemic had time to spread throughout the region.

During the last five months of 1994, camp life was organised in Goma. Feeding centres and hospitals were set up, orphans taken care of and sanitation work undertaken. By December, the emergency phase was over. The assistance programme for the

80,000 refugees in Bukavu, Zaire, ran until November 1994. Given that these refugees were fewer in number, their medical care was easier to manage. MSF also provided assistance in the town centre, supporting health structures. However, MSF felt forced to withdraw from Bukavu when it became clear that the camps were filled with instigators of the genocide planning to launch an offensive on Rwanda.

Already in May 1994, MSF had taken charge of medical aid and sanitation for the Rwandan refugees in the Benako camp in the N'gara area of Tanzania where a refugee population of 489,000 settled. The biggest problem was supplying drinking water for so many people. MSF began pumping and distributing two and a half million litres of water a day from a nearby lake. Three months later another aid agency took over this task. By this time feeding centres, cholera camps and health centres had sprung up in the camps. In June 1994, a mental health project was started for the refugees. MSF also continued to run a medical and sanitation programme for the refugees in Karagwe district and the Burundian refugees in the Kasulu district.

A MORAL DILEMMA

Following an assessment of the humanitarian situation in the Region of the Great Lakes in October 1994 by representatives of MSF's International Council, the organisation concluded that many of the camps in Zaire and Tanzania were being run by the exiled political and military forces, many of whom were directly implicated in the Rwandan genocide. The result of the camp structure was that there was a continuing security threat and ongoing misappropriation of aid.

MSF presented its concerns to the international community in a document entitled *Breaking the Cycle*, which illustrated the problems and made recommendations that would provide Rwandan refugees with a minimum of security and dignity, enabling MSF and other agencies to operate under more acceptable circumstances.

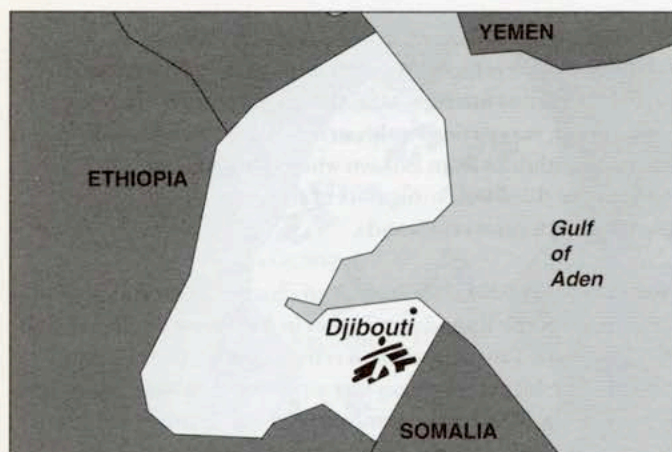
The recommendations would have ensured that:

- *those individuals inciting violence against refugees and disrupting delivery of humanitarian aid be separated from the main body of refugees;*
- *all weapons be removed from the camps;*
- *the registration of refugees take place immediately in order to facilitate the distribution of food and assistance;*
- *an international police force be deployed in the camps to ensure the above.*

MSF considered it unacceptable not only to ignore the reality existing in the camps, but to contribute to the coercion and manipulation of a population indirectly by bolstering the power base of the camp leaders.

Continued on page 32

DJIBOUTI



CONTEXT

MSF started working in Djibouti in July 1993 following an outbreak of cholera. Several cholera treatment centres were opened in Djibouti town and in the different refugee camps where Somali and Ethiopian refugees were infected. Teams started upgrading water supply and sanitation. Local health workers received training in treatment and prevention. In March 1994, the last remaining cholera treatment centre, next to the general hospital, was handed over to the Ministry of Health.

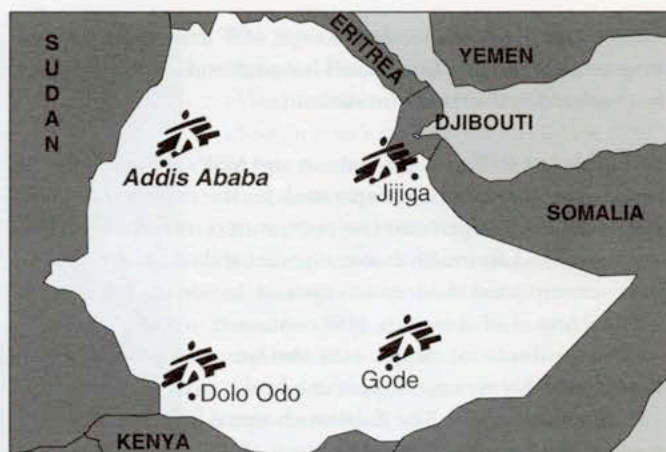
ACTIVITIES

In November 1994, there was a new outbreak of cholera following floods. A treatment centre with a capacity of 40-60 beds was built in the Balbala shanty town. When this centre was closed in February 1995, MSF handed over a cholera preparedness plan, including medical and non-medical supplies, to the ministry of health. The Djibouti office will be kept operational until the end of 1995 for the Somaliland project and to monitor the situation in Djibouti/Somaliland.

Funding: MSF, EC, UK government

Expatriates: 2

ETHIOPIA



CONTEXT

The recent elections in Ethiopia have brought victory to the EPRDF (*Ethiopian Peoples' Revolutionary Democratic Front*). Along with their allies, they will occupy 90% of the seats both in the regional and national assemblies. It is to be seen whether the Oromos, a powerful ethnic group, will accept these results. Insecurity is mounting in the Ogaden region as a result of conflicts in Somalia and major ethnic tension in the south-east of the country.

ACTIVITIES

Throughout 1994, MSF continued to supply medicines, vaccines and medical material in Borena where it rehabilitated nearby clinics and health posts. Feeding programmes had been successful in the camps for Somalis, Ethiopian returnees and displaced in Dolo Odo, Suftu and Bare. In Afder, a new programme was launched for the rehabilitation of health-care system where 200,000 nomads live. MSF is now in charge of health-clinics in the Jijiga area where it runs a rehabilitation programme. MSF continued its work in Gode until the end of 1994. In Woldya, MSF launched a rehabilitation and surgical training programme in August 1994 in order to improve standards in the reference hospital. Medical and sanitary assistance is provided to the displaced in Addis Ababa, including the 30,000 Ethiopians who were expelled from Eritrea.

Funding: MSF, EC, UNHCR, UNICEF, German, Luxembourg, Dutch, Swedish, UK, Norwegian and Cambodian governments

Expatriates: 26

SOMALIA



CONTEXT

Calm has not been restored in Somalia. General Mohamed Farah Aideed, who controls Mogadishu South, declared himself president and formed a new government, but is still vying against Ali Mahdi for control of Mogadishu North. General Mohamed Siad Hersi "Morgan" controls Kismayo and the area to the south, whereas Omar Jess and the Ogadenis have their power base north of Kismayo. The UN troops left in December 1994.

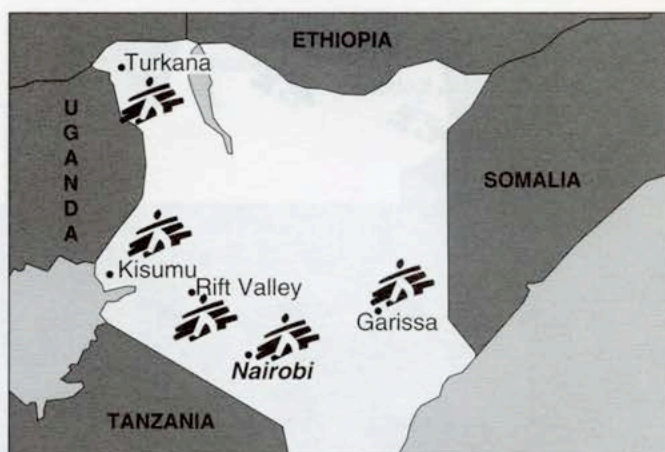
ACTIVITIES

In Kismayo, MSF's main activity is running the hospital. In 1994, a cholera epidemic broke out in the capital and MSF treated more than 2,500 patients. MSF also worked in the Yaqshid district of Mogadishu North where the 102,000 inhabitants and 5,000 displaced have little access to medical care. MSF carries out vaccinations and pre-natal consultations and runs mobile medical services. Drugs are distributed and local staff trained in their use. MSF also provides primary health care in Giohar and Aden Yabal. In Somaliland, MSF supported the general hospital in Burao and nine health centres around Burao and Hargeisa. Since tensions began at the end of March 1995, MSF set up temporary clinics for the displaced and provided additional medical supplies for the war wounded.

Funding: MSF, EC, UNDP, US, UK and Dutch governments

Expatriates: 31

KENYA



CONTEXT

After the civil war in Somalia, a massive influx of refugees arrived in Kenya's Northeastern Province. To date, there are 200,000 Somalis still living in the country. MSF's work with the Somali refugees is now being scaled down following repatriations. However, the very pessimistic outlook of Somali politics in the aftermath of the UN's departure from Mogadishu, means that many refugees will remain in Kenya.

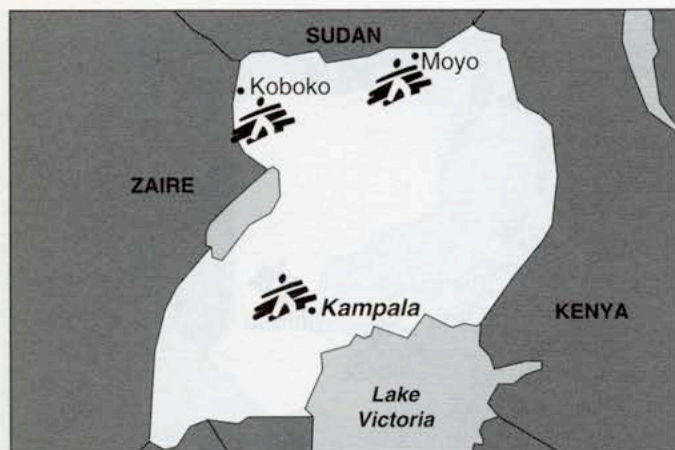
ACTIVITIES

For several years, MSF has provided medical and nutritional assistance to Somali refugees in the Hagadera Camp and at Ifo and Dagahaley. In 1994, a programme was started for the drought affected nomads of Turkana. A dispensary was opened for a target group of 12,000 settled nomads in Makutano. In Garissa, medical and nutritional assistance is provided to 20,000 Kenyan-Somali nomads severely afflicted by drought. This project is now closing as many have returned to the bush. In February 1994, MSF launched the Kenya Emergency Programme to improve the health conditions of displaced persons living in camps and trading centres in and around the Rift Valley. About 85,000 people have benefited from activities involving the provision of medical services and improvement of shelter, water, and sanitation facilities.

Funding: MSF, EC, UNHCR, UNICEF, Japanese, US, UK and Dutch governments

Expatriates: 43

UGANDA



CONTEXT

Despite occasional incursions by rebels, the political situation is stable in Uganda. Reconstruction is now in full swing throughout the country. However, AIDS remains a major problem. It is thought that more than one million people are now infected. The country has also been a haven for refugees particularly from South Sudan. A new influx of refugees from South Sudan arrived in August 1994 to add to the numbers already present in the northern refugee camps.

ACTIVITIES

In August 1993, Sudanese refugees began arriving in Koboko where they settled in seven camps. In 1994, their numbers had increased to 100,000. MSF provides medical assistance and monitors nutrition. In Kyaka II, the Zairian refugee camp, MSF ran a medical programme until September 1994. In Moyo, the sleeping sickness programme continues. The dispensaries in West Moyo have all been rehabilitated. In Adjumani, the MSF team seeks out those suffering from sleeping sickness, many of whom are Sudanese refugees. A meningitis epidemic broke out in the north in February 1995 and MSF supported the hospital and the dispensaries during the ensuing vaccination campaign. A programme to prevent the spread of AIDS in Moyo district is also being carried out as is an AIDS programme in Kampala.

Funding: MSF, EC, UNHCR, WHO, Dutch, Japanese and Canadian governments
Expatriates: 31

RWANDA - BURUNDI - TANZANIA - ZAIRE CRISIS IN THE REGION OF THE GREAT LAKES

Continuation of page 29

The lack of any improvement in the protection of refugees in the camps led some sections of MSF to withdraw from four camps in Zaire and Tanzania at the end of 1994 and the beginning of 1995. MSF continues to monitor the situation and though strongly committed to assisting the most vulnerable populations among the refugees, will continue to close camps if conditions remain unacceptable.

SITUATION TO DATE

The emergency phase is over in Rwanda and the refugee camps, but many problems remain. Returning refugees often find their property confiscated. Prisons are overcrowded and inmates often languish without fair trial. Refugees do not always have an incentive to return. MSF remains present throughout Rwanda, providing medical assistance and supporting six hospitals and 60 clinics and health posts. MSF also supports the provision of medical aid to prisoners and provides direct medical assistance to orphans. An estimated 100,000 consultations are carried out by our teams each month. In May 1995, MSF vaccinated 10,000 children against measles.

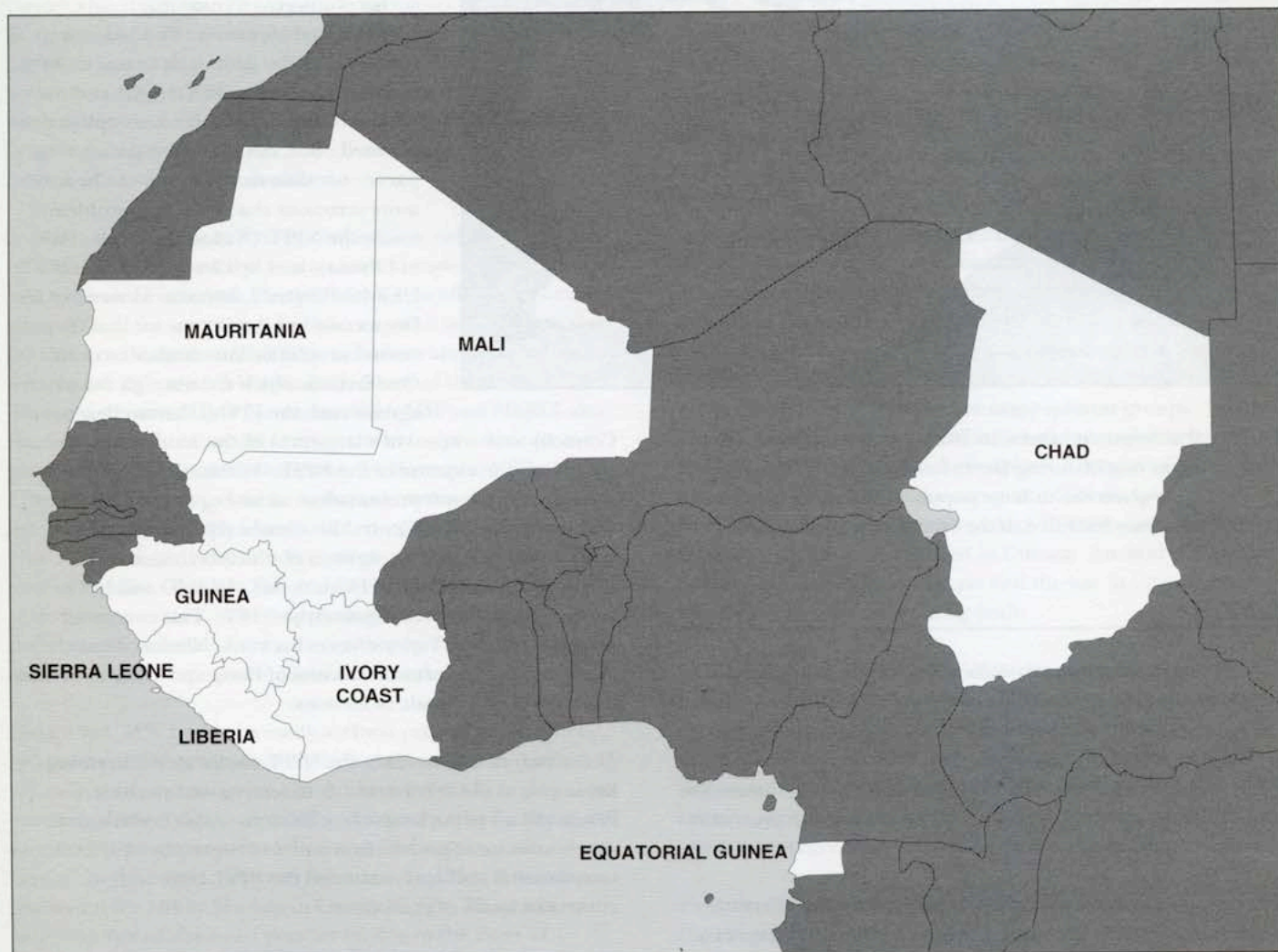
In Burundi, a policy of ethnic cleansing against the Hutu population is being pursued by the army. Extremists on both sides of the ethnic divide contribute to a spiral of violence. Whole districts of Bujumbura are becoming inhabited exclusively by one population group or another. MSF provides medical and sanitary assistance to the Burundian population, especially the displaced and the dispersed, but also to local inhabitants. MSF is working in Ngozi, Karuwi, Ruyigi, Kirundo, Bujumbura and the project in Cibitoke is on standby. MSF provides its assistance through hospitals and health centres.

There are an estimated one million Rwandan and Burundian refugees in Zaire, 200,000 in Burundi and 800,000 in Tanzania. The trials of the perpetrators of the genocide in Rwanda have not got underway. Nor has there been any attempt to bring the perpetrators of the massacres in Burundi to trial. Unfortunately, for Rwandans and Burundians alike, impunity reigns in the Region of the Great Lakes.

Funding: MSF, EC, UNHCR, Canadian, Japanese, Swedish, UK, US, French and Australian governments. French and Belgian local authorities, La Chaîne de Bonheur, HelpAge International, Nationwide Campaign Rwanda, Europe Tiers Monde, Mercy International
Expatriates: 360

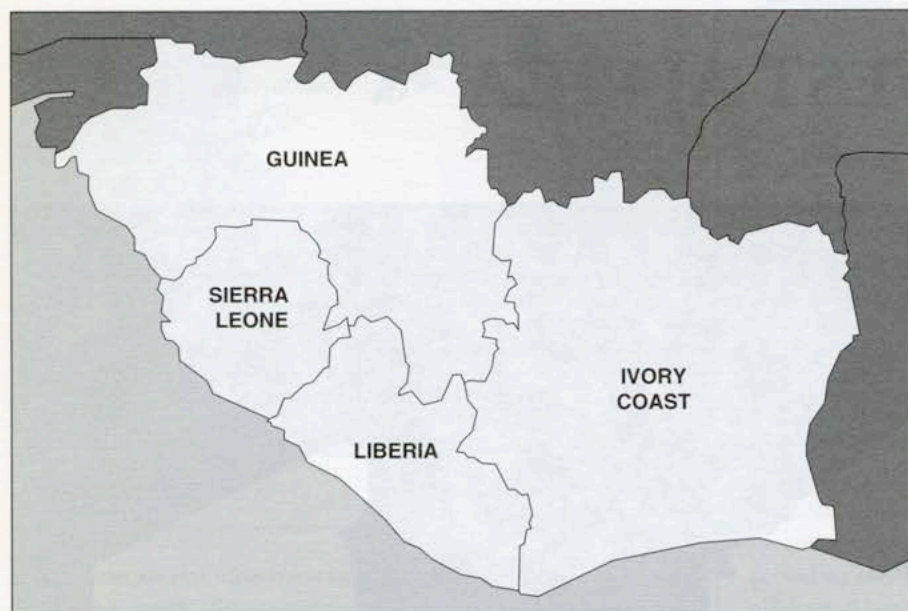
MISSIONS - PART VI

WEST AFRICA



*Liberia, Sierra Leone, Guinea, Ivory Coast,
Equatorial Guinea, Mali, Mauritania, Chad*

LIBERIA, SIERRA LEONE, IVORY COAST, GU



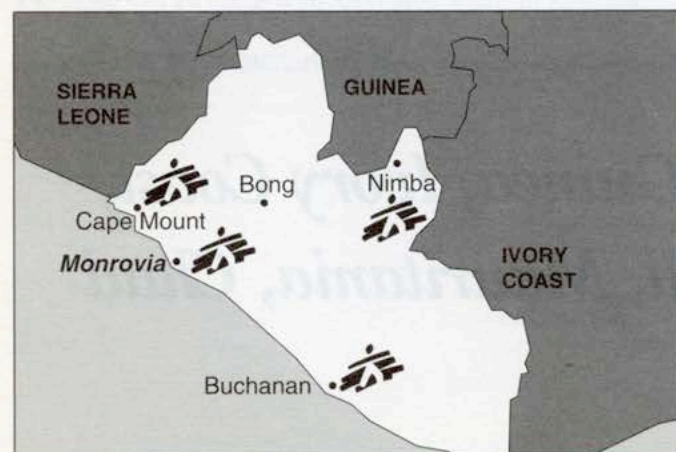
The war that began in Liberia in 1989 continues as does war that started in neighbouring Sierra Leone in 1991. These conflicts have given rise to huge population movements. About 800,000 Liberians have fled to the Ivory Coast and Guinea.

LIBERIA

Inside Liberia, the Monrovia-Kakata-Buchanan triangle is the only accessible zone. Since one of the warring factions looted aid agencies facilities in September 1994, aid agencies have been more limited in their access than ever. Access is so difficult in Liberia that 1.5 million Liberians content themselves with 5% of the territory. 300-400,000 people are still present in territories under siege.

The Cotonou agreements signed in July 1993 by the three major warring parties, made a provision for the setting up of a

LIBERIA



new transitional government on 7 March 1994. At the time, elections had been planned for September of the same year. Doctor Amos Sawyer and the Interim Government of National Unity duly took up his position as transitional head of state in the capital Monrovia. The peacekeeping forces of the Economic Community of West African States (ECOMOG) and the United Nation observers were deployed as planned. But, not only were the warring parties not disarmed, but the war became more ferocious than ever, and problems inside the NPFL (National Patriotic Front of Liberia), lead by Charles Taylor and ULIMO (United Liberation Movement for Democracy in Liberia) meant that they too started to splinter into smaller factions. One faction, which did not sign the peace

agreements, the LPC (Liberian Peace Council) took control of a large area of the south-east of the country at the expense of the NPFL. Within the NPFL itself, some government representatives turned against their leader and set up the CRC (Central Revolutionary Council). A coalition of factions, the fighters of which belonged to the Khran group, attacked NPFL positions. ULIMO and LPC stepped up their attacks against the NPFL. This concerted offensive repelled Taylor's forces back into Nimba County alone, leaving the central counties of Bong and Marghibi under the control of a mosaic of factions.

At the start of these events, the NPFL confiscated everything belonging to the relief agencies to feed its war machine. Practically all of the hospitals, clinics, re-supply centres, and warehouses were looted. By the end of September 1994, all international staff had evacuated the NPFL zone with enormous losses of equipment.

While the fighting continued to rage, the three signatories of the Cotonou agreements signed a further agreement in Akasombo which met with violent opposition within political circles and from the population at large. This led to further tensions, chiefly owing to the fact that some factions had not been included in the discussions. In November, all of the parties involved in the civil war conducted further negotiations in Accra and signed a new agreement. The new agreement provided for a cease-fire to come into force on 28 December. The cease-fire has not held.

MSF activities in Liberia

Of the 300,000 inhabitants of Cape Mount and Bomi, 60,000 are displaced and there are 100,000 refugees from Sierra Leone. In March 1994, MSF started a distribution programme for the clinics in the area and Guthry Hospital in Bomi. However, the security situation deteriorated and the MSF team

NEA : THE WEST AFRICAN CONFLICT

had to be evacuated. Distribution continues to the six clinics which are still accessible.

MSF has never stopped working in and around the capital. In March 1994, 15,000 people arrived in Brewerville, on the outskirts of Monrovia. These people were from Cape Mount, Bomi and Lofa, all regions under ULIMO control. There were 85,000 new arrivals during the year. Among these, 22% of the under-fives were malnourished. MSF launched feeding programmes in August and September 1994. MSF sought to improve sanitary conditions. Wells were drilled and latrines built in 11 camps for the displaced.

In Montserrado County, MSF in conjunction with the Liberian NGO MERCI, continued to run a network made up of 12 clinics and a reference hospital. This private, non-profit network covers some 40% of the population in the area, estimated at 800,000 inhabitants. More than 22,000 consultations are provided each month and 800 patients hospitalised. Many of them are displaced persons. Until November 1994, MSF and MERCI also ran four clinics in Margibi County, mainly to provide care for people fleeing the nearby war zones. In Monrovia, MSF and the Liberian Red Cross operate an ambulance system which allowed aid workers to act swiftly when a cholera epidemic broke out in May 1994, and oral rehydration centres were organised in all of the city's clinics. Between July and December 1994, 7,000 patients were treated. Water-supply conditions, in a city whose population has doubled since the war began, create the right environment for repeated epidemic outbreaks.

Since 1993, MSF has run a medical/food project in the NPFL-held areas of Bong, Upper Margibi and Grand Bassa. Unfortunately, it was too dangerous to do the same for Lofa. 15 clinics were refurbished, water supplied and sanitary systems installed, vaccination programme launched and feeding programmes begun. In June 1994, MSF was forced to evacuate. Assistance was begun for Lower Margibi in October 1994. There were a large number of displaced persons staying in the cities of Harbel and Unification Town, with new arrivals daily. MSF supports four clinics and a health centre with medical care, distribution of medicine and medical material and a supplementary feeding programme.

The lootings in September meant that the medical and food programme for over 300,000 people in Nimba county had to end: two referral hospitals, 25 clinics, ten food rehabilitation centres and two intensive food centres depended on the programme for their medical and food supplies. Also an additional programme had just been started in the south of Nimba to provide assistance for the newly-displaced in counties under LPC control.

Of the 100,000 people in Buchanan, more than half are new arrivals. MSF launched two clinics and started to work in the hospital, where screening activities take place. A vaccination campaign launched with UNICEF has been carried out. MSF follows up on the health of the displaced. In June 1994, MSF

started activities in the town Bong Mines and its surrounding territories. The programme had to be ended in November because of tensions and proliferation of land mines. The programme started off with an anti-measles vaccination campaign and focused on work in the health centre including both external consultations and hospitalisation. MSF also provided assistance during the cholera epidemic during the summer of 1994 in Buchanan.

Funding: MSF, EC, Canadian, Dutch, US, Luxembourg, Danish, Swedish and French governments

Expatriates: 37

SIERRA LEONE

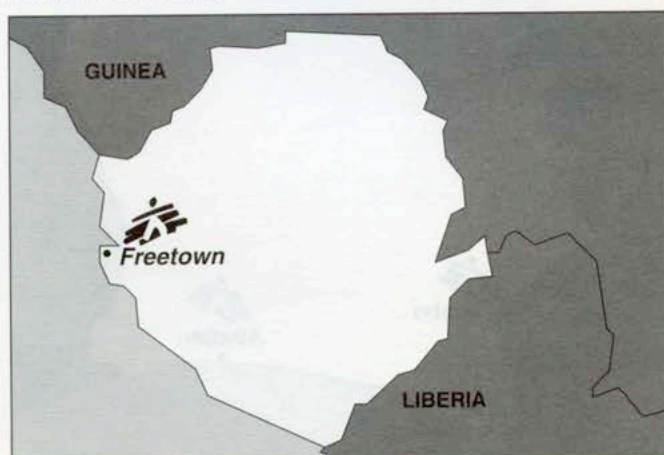
The war in Sierra Leone began in 1991. Most of the country is inaccessible to aid agencies other than by helicopter and security conditions are not favourable to humanitarian intervention. The situation is even more chaotic than in Liberia, in that there are no clear-cut frontlines and it is never clear which factions are fighting at a given time. The main division is between the government forces and the Rebel Unit Front (RUF). However, there are many splinter groups. Like in Liberia, young gangs and local militia groups hold the power. Human rights abuses are commonplace. The war has given rise to a massive population movement into Liberia, Guinea and Ivory Coast. Between March and May 1995, an estimated 20,000 Sierra Leoneans arrived in Guinea. Another similarity between the war in Sierra Leone and the war in Liberia, is that interests in Guinea are fuelling both.

In February and March 1995, MSF sent an exploratory mission into Sierra Leone. In April 1995, MSF set up a programme in Freetown to provide aid to the displaced. Following the outbreak of cholera, MSF set up a camp. The team also supervises in the Good Shepherd Hospital. Evaluations in the interior are carried out by MSF regularly and it is hoped that an assistance programme can be launched in Bo soon.

Funding: MSF, EC, Dutch and Swedish governments

Expatriates: 5

SIERRA LEONE



IVORY COAST

Following intense fighting in September 1994 in Liberia, about 150,000 people sought refuge in neighbouring countries. Ivory Coast received about 130,000, 110,000 of whom arrived in the Tabou and Grabo region. There were already refugees in the area who had arrived in 1991/1992. The total number of refugees in Ivory Coast stands at 330,000. The Liberian refugees do not have refugee status and are not properly registered. There are no traditional refugee camps. The new arrivals have settled in villages inside the border. This poses a great strain on the national health system which is already overburdened.

An exploratory mission was launched in Tabou-Grabo in November 1994, which resulted in the launch of a programme. MSF's first step was the initiation of a mass anti-measles vaccination programme. A joint MSF/Epicentre survey carried out in January 1995 showed that among the refugees there was 12.2% acute global malnutrition and 3.3% severe malnutrition. The mortality rate among the Liberian population was shown to stand at 2/10,000/day. Mortality rates revealed to be higher among the Liberian under-fives than the local population. A medical and nutritional programme was put in place. This included feeding programmes in Tabou, Goson and Grabo. MSF also worked in a dispensary with in-patient facilities in Goson and several other health posts in the region.

Funding: MSF

Expatriates: 14

GUINEA

Context

Guinea is also host to 400,000 Liberians and 100,000 Sierra Leoneans. 1994 brought with it an influx of 100,000 new refugees. In Guéckédou the situation became precarious with a malnutrition rate of 20%. Integration on the periphery of the prefecture has been difficult. The refugees have tended to flee towards the city thus aggravating the population pressures

there. The arrival of 15,000 Sierra Leonean refugees on the Guinean border justified the opening of the new mission in Forecariah. The anti-measles vaccination is now over. MSF was involved in the setting up of the camp (shelters, water, latrines) with other agencies. MSF is in charge of medical follow up and epidemiological surveillance. Further influxes are a real possibility. MSF takes part in PARLS (Programme d'Appui aux réfugiés Libériens et Serra Léonais) with a programme in the west in Guechedou and in the east in N'Zerekore. The MSF programme is progressively integrated in the national health system. A cholera programme was also carried out in Guechedou and Macenta.

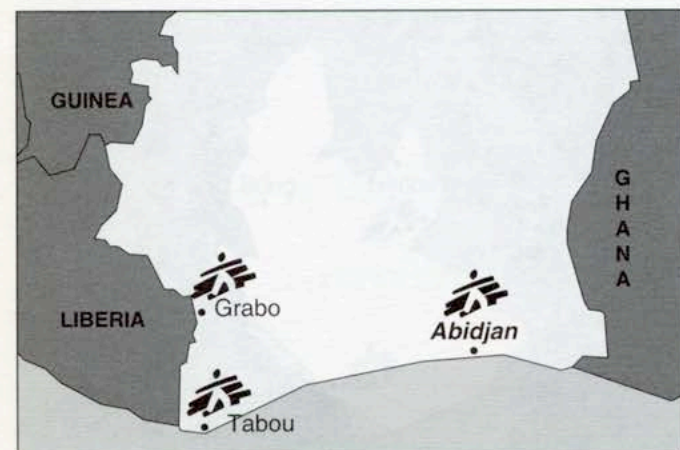
Programmes in the rest of Guinea

MSF's anti-tuberculosis programme continues in three specialist centres at Conakry, Mamou and Labé. Each is the focal point for several satellite centres throughout the country. MSF continues the integration process with national structures. It supports decentralisation of the health logistics of the national programme. MSF is still involved in providing surgery, anaesthetics, public health, health economics. Training courses are provided for Guinean medical staff. MSF has relaunched three hospitals and thirty health posts in four prefectures of Upper Guinea (Kouroussa, Dabola, Mandiana and Kankan) within the Bamako initiative which involves the recovery of costs, and management support. These projects will all come to an end during the course of 1995. MSF continues to supply medicine and medical material to health centres, through the warehouse in Kankan and the national programme of UNICEF. Since January 1995, a cholera epidemic has mobilised the team in different parts of Upper Guinea. MSF is carrying out a structural programme in Guinée Forestière, which involves technical assistance, training, construction and rehabilitation.

Funding: MSF, EC, UNHCR, UNICEF, Canadian, French, German, Japanese, Luxembourg and Norwegian governments

Expatriates: 40

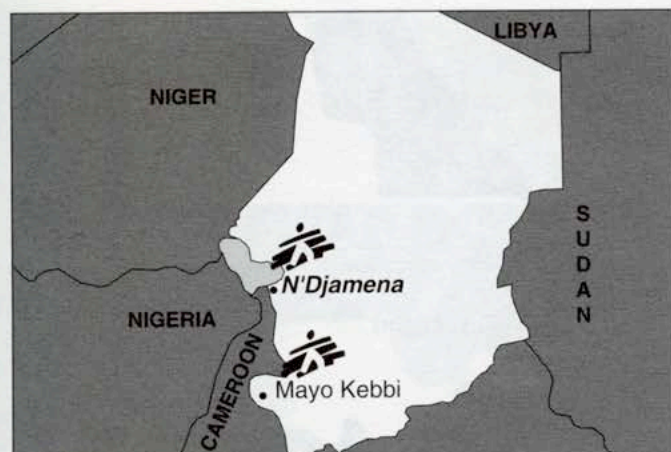
IVORY COAST



GUINEA



CHAD



CONTEXT

Although, Chad is in the middle of the democratisation process, human rights violations continue to be commonplace. There has been little improvement in the social climate. Despite foreign aid, late payments of wages are normal and strikes take place regularly. Chad is the typical Sahel country with limited resources.

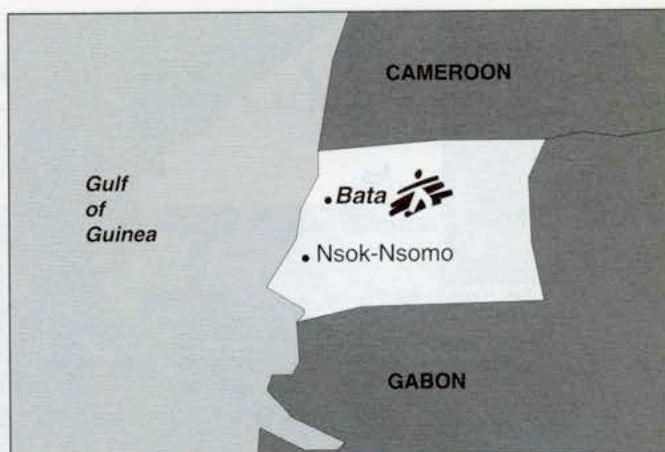
ACTIVITIES

The Mayo-Kebbi health-care structure support programme has reached maturity. The pre-financing of salaries, a system first implemented in 1993, made it possible to obtain a degree of "labour peace" in at least three districts. With only a few exceptions, there were no work stoppages anywhere in the prefecture. Mayo-Kebbi now has the highest hospitalisation rate in Chad and the best vaccination coverage. Traineeships for young Chadian doctors were organised by MSF in several Chadian hospitals. In the capital, Ndjamen, the co-operative which produces vitamin-enriched flour "Vitafort" stepped up its activity (45 tonnes of Vitafort products over the year). It was only at the end of the year that certain difficulties related to staff management and recognition of the co-operative society's status were clearly perceived. In 1995, two private dispensaries will be opened. In August 1994, a cholera epidemic hit Ndjamen and MSF introduced an emergency-aid programme.

Funding: EC, Canadian, French and Belgian governments and Belgian local authorities.

Expatriates: 15

EQUAT. GUINEA



CONTEXT

This small country has a population of 400,000. Despite the elections which took place at the end of 1993, the dictatorship of Teodoro Obiang Nguema and the Mongomo clan continues. Diplomatic relations between this former Spanish colony and Madrid have deteriorated substantially, which has meant a reduction in cooperation.

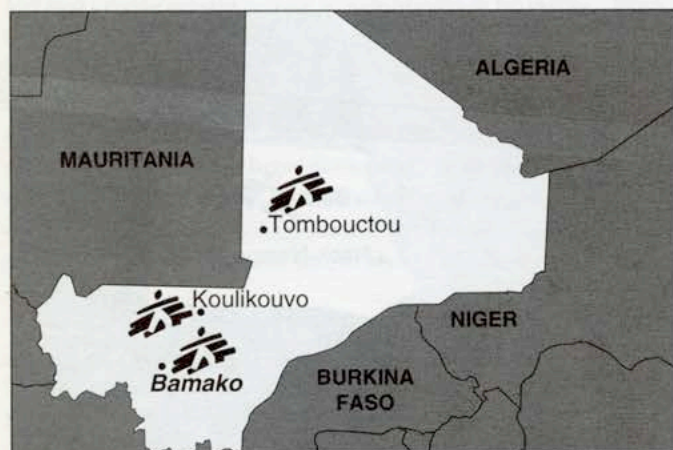
ACTIVITIES

MSF has been in Equatorial Guinea since 1989. In July 1994, MSF started a new project in Bata. The project is planned for four and a half years. The general objective is to lower the mortality rates and develop health services, by focusing on management and intensifying mother/child health care. Activities include, the construction of a health centre, training, the medical supply system and management of medical referrals.

Funding: MSF, Spanish government and Spanish local authorities, Farmacéuticos Mundi

Expatriates: 3

MALI



CONTEXT

In 1994, the Malian army launched a far-reaching purge of the Touaregs which heightened insecurity in the region. It became virtually impossible to provide humanitarian assistance in many rural areas.

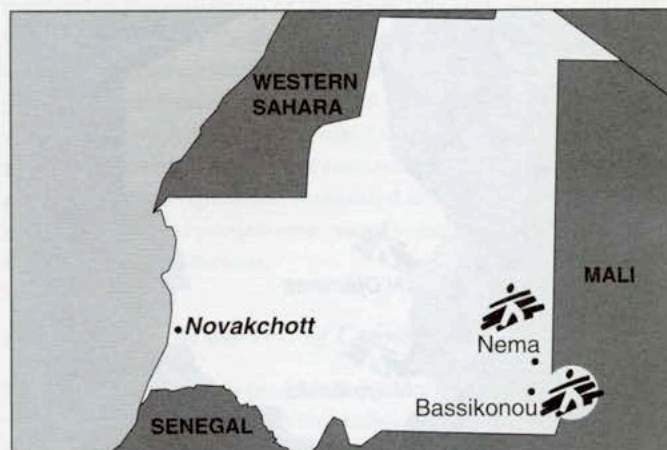
ACTIVITIES

The ophthalmological project was launched in collaboration with the Malian Union of the Blind responsible for the nation-wide Yeleen project in the Tombouctou Hospital. The project includes the relaunch of the Yeleen centre (diagnosis, health care, etc...) depending on the fluctuations of foreign financing, the training of an ophthalmological nurse for cataract operations and the relaunch of mobile teams to carry out diagnosis and treatment in the bush. Another project of the same type is being looked into for the region of Koulikouvo to the south.

Funding: MSF, Luxembourg government

Expatriates: 5

MAURITANIA



CONTEXT

The Malian army's clampdown on Touaregs and Moors has given rise to a population influx into Algeria, Niger and Mauritania. During 1994, refugees arrived continually but by January 1995, the influx had stabilised. Some refugees are now returning. In Mali, the national peace agreement concluded in April 1992 is still not being applied.

ACTIVITIES

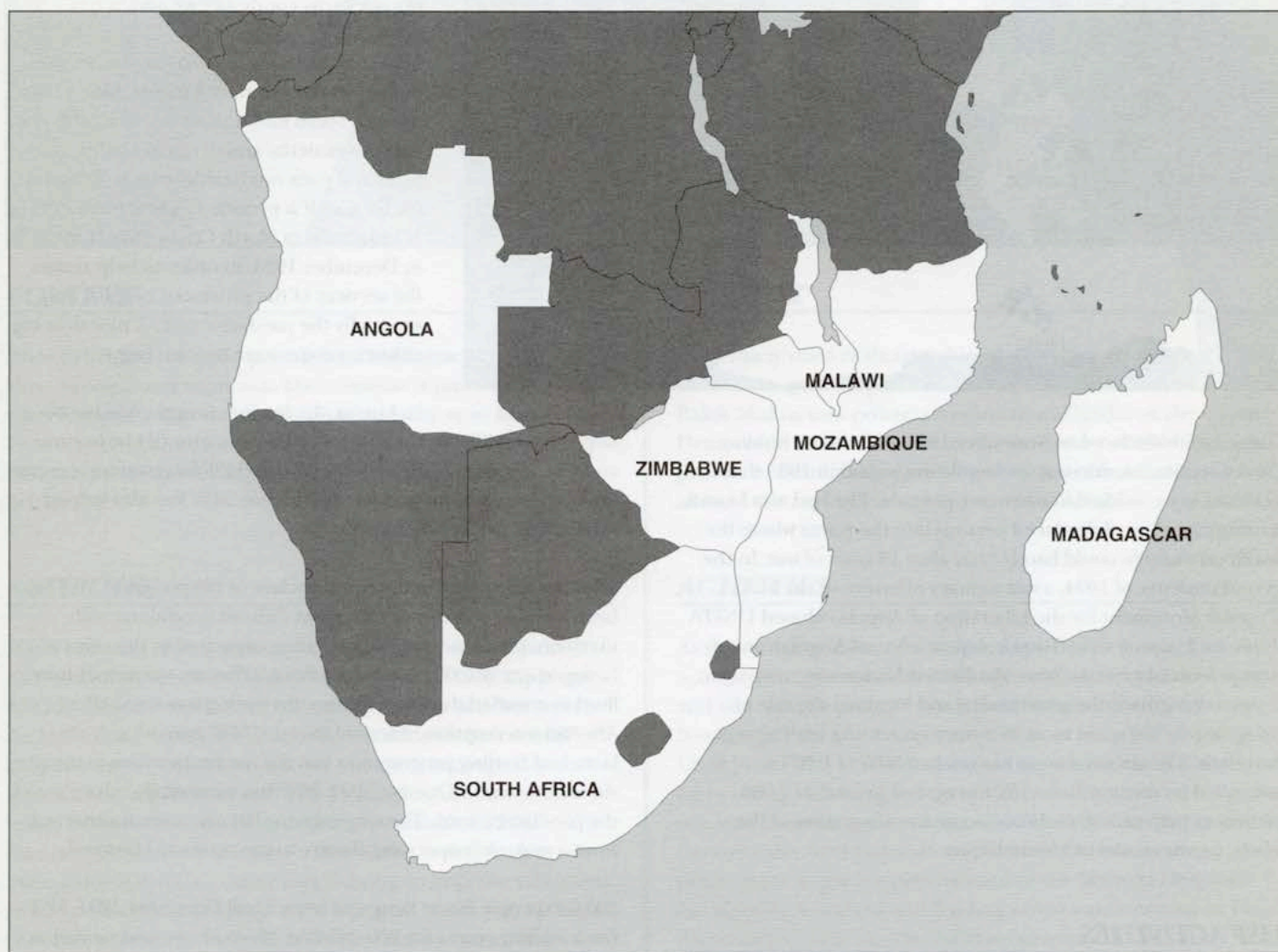
MSF works in two camps for returnees in Bassikounou and Aghor in the extreme south-east of the country where the team provides health care assistance to a target group of 25,000 people. MSF continues to evaluate nutrition although malnutrition is rare. An exploratory mission in Mali is foreseen for the second semester of 1995 in order to evaluate the health structures in the refugees' regions of origin.

Funding: MSF, UNHCR

Expatriates: 4

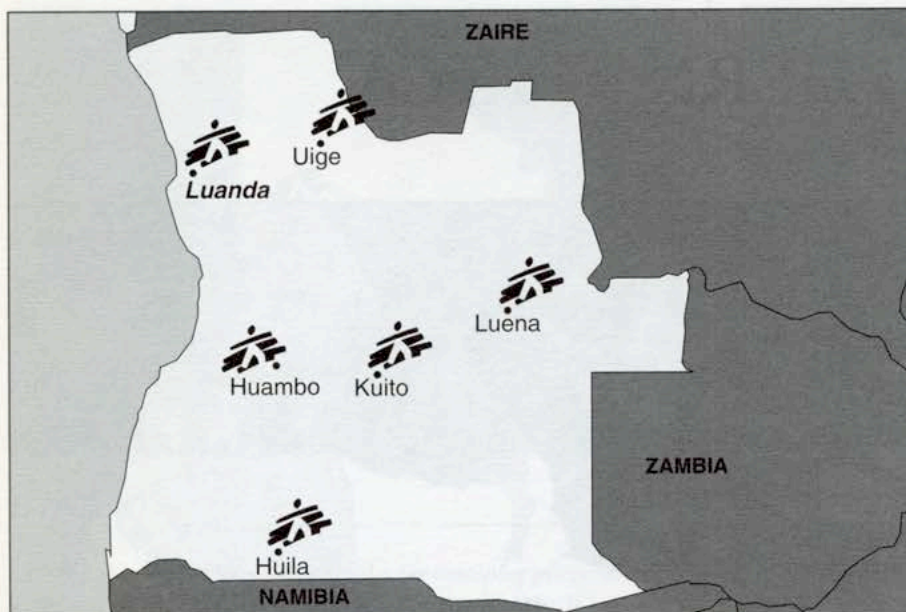
MISSIONS - PART VII

SOUTHERN AFRICA



*Angola, Madagascar, Malawi, Mozambique,
South Africa, Zimbabwe*

ANGOLA : A PERIOD OF RENEWED HOPE



The ceasefire declared in November 1994 seems to be holding. The humanitarian situation in Angola was so bad in 1994 that food had to be airlifted in whenever possible. There had also been a continuing influx of displaced persons into the towns where the health care system could barely cope after 16 years of war. In the second semester of 1994, a vast military offensive of the MPLA (Popular Movement for the Liberation of Angola) chased UNITA (National Union for the Total Independence of Angola) out of most provincial capitals. Since the United Nations Security Council recognised the government and legalised the sale of arms, Angola has spent most of its money on arming itself against the rebels. The national army has retaken 80% of UNITA-controlled territory and the UN has agreed to send in 7,000 soldiers to help with demobilisation and reintegration of the rebels, on the model of Mozambique.

MSF ACTIVITIES

In Uige, MSF provides nutritional assistance, supplies essential medicine and carries out vaccination. The team recently launched a new programme in Songo. The first stage of the project will include supervision and technical assistance, the supply of medicine, and medical material and training.

MSF continued to work in Malange in 1994. From May to August, however, air lifts were interrupted during the government troops' offensive on the enclave. The MSF expatriates were also forced to evacuate. Fortunately, 300 local health workers were able to carry on the project as the team had built up some food stocks. In May 1994, 6% of children were malnourished. However, this percentage shot up to 15% during the food shortages, but by December had come down to 2.8%. Despite the presence of thousands of displaced people, only five of the city's 14 outpatient clinics were functioning. The city hospital was functioning at only half capacity and medicine and medical material were in short supply.

In August 1994, MSF launched a project to improve basic health care in and around M'banza Congo, in Zaire province. Security was so poor that on 28 October the team was forced to evacuate with a view to returning once security conditions permit.

Maternal mortality rates in Angola are the highest in the world. In Luanda, MSF runs a delivery room and trains midwives. MSF also supplies material and drugs to health structures and runs two health centres. Training for local staff is provided. A new mission in N'Dalatando in North Cuanza was launched in December 1994, in order to help restart the services of the provincial hospital and especially the paediatric unit. A new sleeping sickness programme has also begun.

In Luena, the feeding programme has been stepped up. MSF has opened an intensive centre (24 hour care) and two supplementary feeding centres. MSF intervention centres around consultations and paediatric care. MSF has also helped rehabilitate five health centres.

1994 was a dire year in the Kuito enclave of Bié province. MSF has been working there under the most difficult conditions, with nutrition, medicine and surgery being organised in the ruins of a besieged city. 30,000 people (of whom 50% were wounded) have lived in crowded dwellings for months during intense shelling. After an interruption of several months, MSF immediately re-launched feeding programmes and the medical services in the provincial hospital in October 1994. MSF has successfully rehabilitated the paediatrics ward. The surgical wing has also been transferred from a makeshift operating theatre to the provincial hospital.

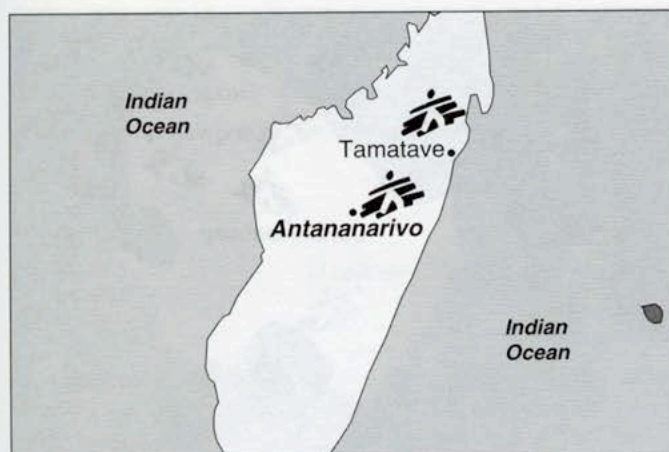
200,000 people live in Benguela town. Until December 1994, MSF ran a feeding centre for 200 children. Medical care and sanitation assistance is provided for 10,000 displaced in three camps. Epidemiological surveillance is also provided. MSF runs three programmes in Cubal including nutrition, consultations and sanitation.

In Huambo, MSF runs huge feeding centres and provides medical assistance for the 350,000 inhabitants. In Kaala it runs another for 20,000 and in Balombo for 30,000.

In Matala, Huila province, MSF's objective is to upgrade health services and intervene in emergencies. This includes vaccination, the improvement of health care, nutrition, and encouragement to local health structures. In Caconda, MSF has been in place since April 1995, where it supervises and trains health care workers, supplies medicine and medical material, provides technical assistance, carries out reference consultations and rehabilitates health structures.

Funding: MSF, EC, UNHCR, Dutch, Swiss, French, US, German, Swedish and Canadian governments, Spanish local authorities
Expatriates: 68

MADAGASCAR



CONTEXT

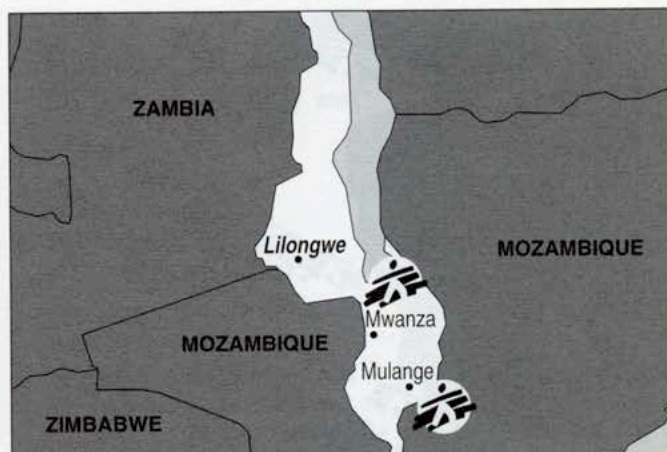
Since February 1993, the president of Madagascar is Albert Zafy. Political and economic liberalisation is yet to come as 15 years of dictatorship had brought the country to its knees. In February 1994, the Hurricane GERALDA caused large-scale destruction on the coast, particularly in Tamatave and Brickaville.

ACTIVITIES

MSF's activities centre around poor districts of the capital, Antananarivo, where 36,000 people are targeted. MSF supports ASERN (Association for Nutritional Education and Recovery). An MSF nurse supervises 21 mobile nutritional clinics. MSF supports the health centre, carries out epidemiological surveillance, trains local staff and provides information on infant malnutrition, diarrhoea, and prevention of STDs (sexually transmitted diseases). MSF is also trying to improve the quality of drinking water and is trying to improve sanitation and hygiene. Since October 1994, a project is also run for street children, providing them with free medical consultations, treatment and information. The team also visits minors held in penal institutions and follows up on their nutrition. In Madagascar "preventive detention" is not uncommon. In May, 1995, MSF denounced this practice to the authorities. When the cyclone hit, MSF ran an emergency programme for six weeks. This involved sanitation, support to health structures and the distribution of plastic sheeting for the victims of this natural disaster.

Funding: MSF, EC, UNICEF, French local authorities
Expatriates: 4

MALAWI



CONTEXT

After thirty years of dictatorship, the struggle for democracy has born fruit. general elections in May 1994 have put President Bakili Muluzi into power, a moderate and leader of the United Democratic Front (UDF). During the course of 1994, the peace process in Mozambique and the elections of last October have allowed the repatriation of thousands of refugees to go ahead.

ACTIVITIES

As the refugees leave, MSF is able to phase out many of its activities: the Mwanza and Mulanje refugee camps are closing and our refugee programme is concentrated rated on the Nsange district, where there are still more than 50,000 refugees. Until June 1995, MSF will continue to provide medical care and carry out epidemiological surveillance and sanitation. However, two new programmes have started in the Mwanza district in favour of the local population. The team runs a feeding programme in the paediatrics ward of the Mwanza Hospital. Local staff are trained and feeding centres are opening in 14 dispensaries. MSF runs an AIDS programme in the same hospital and several dispensaries where consultations are provided for those suffering from STDs as well as information given on how to prevent infection.

Funding: EC, UNHCR, US government
Expatriates: 6

MOZAMBIQUE



CONTEXT

With a peace agreement signed and demobilisation taking place, elections were able to take place in October 1994. Although Renamo (National Mozambican Resistance Movement) did extremely well in the elections, President Joaquim Chissano opted for a purely Frelimo (Liberation Front of Mozambique) government. Needs in the Renamo areas are still considerable, however, the emergency phase is over. MSF is gradually handing over many programmes to local authorities. Much of the emphasis is on training and technical assistance. However, as refugees return in large numbers, MSF is involved in preparing sites. Land mines remain a problem.

ACTIVITIES

In José Macamo, MSF provides support to the health structures, notably in the area of paediatrics, gynaecology and nutritional assistance. In Matutuine, MSF rehabilitates health structures and provides technical assistance in preparation for returnees. In Moamba, MSF runs a health and rehabilitation programme, while upgrading the water supply. In Gaza, a health care project for returnees started in June 1995. A similar programme runs in Maputo where MSF provides mine-awareness information throughout the province. In Tete, MSF provides health assistance. MSF continues to support the establishment of blood banks in Nampula province and refurbishment of the laboratory in the Nipepe district. Until early 1995, MSF was supporting health care in Cuamba and Angoche and assisting returnees. MSF also provided health care to demobilised Renamo soldiers. The project in Manica aimed to relaunch five health structures in those areas to which refugees return, train all their salaried staff, and carry out medical supply. In Zambezia, MSF also relaunched five health structures which the agency still supports partially.

Funding: MSF, EC, UNHCR, UNOHAC, WHO, UNDP, Spanish, Norwegian, Swiss, Danish, US, and Dutch governments.
Expatriates: 85

SOUTH AFRICA



CONTEXT

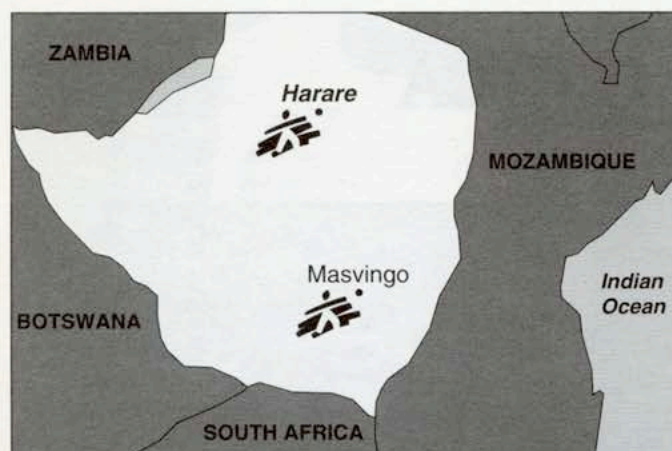
On 10 May 1994, Nelson Mandela was elected president of South Africa, in the first democratic elections. The ANC (African National Congress) leads the Government of National Unity which is about to undertake important reforms. A new and just society needs to be forged. The priorities are education, health, employment, lodging and access to water. Amnesty still needs to be granted to many prisoners languishing in jail for involvement in the struggle against apartheid. The Zulu crisis between the Zulu monarch Zwelithini and the leader of the Inkatha Freedom Party, Dr. Mangosuthu Buthelezi, must also be resolved, as open conflict between the two sides could plunge the Natal province into a blood bath. Repatriation was foreseen by the UNHCR for 200,000 Mozambicans, however, only 30,000 chose to return.

ACTIVITIES

MSF ensures the smooth functioning of the transit camps, provides medical examinations for refugees before their departure and leads an awareness campaign on land mines. MSF also takes care of the water supply to ex-Homeland areas. In Kangwane, MSF is involved in well rehabilitation, the protection of water sources as well as the construction of reservoirs and latrines. However, this project came to an end in 1994. In the Wellers Farm Squatters Camp, MSF set up a nursery which takes in 40 children under six. The project includes the rehabilitation and construction of water systems, hygiene and sanitation. MSF plans to leave South Africa in 1995.

Funding: MSF, EC, UNHCR, UK, Canadian and Japanese governments
Expatriates: 2

ZIMBABWE



CONTEXT

The first Mozambican refugees arrived in Zimbabwe in 1983 as a result of the civil war. The Zimbabwean State is finding it increasingly difficult to continue providing adequate health care, especially in peripheral areas. The structures dating back to the colonial era are proving inadequate to present-day needs, while the economic and political situation has led to a tidal exodus of young doctors seeking better fortune in South Africa. This has resulted in a gradual breaking down of the health-service system.

ACTIVITIES

Over a period of time MSF developed a programme to reinforce the health-care system in the five refugee camps still open in 1994: Tongogara, Nyangombe, Chambuta, Mazowe River Bridge and Nyamatikiti. By the end of the year they had all closed following the swift voluntary repatriation of the Mozambicans. MSF has also been supporting two health districts (Shamva and Nkayi) in partnership with the Ministry of Health. At the same time, MSF started to prepare health programmes in two districts (Shamva and Nkayi) in partnership with the ministry of health. The aim was a medium term high level programme in the areas of medical care provision health co-management and sanitation. The rather abrupt halt in the refugee project (and the consequent pressures to accelerate the new programme), a basic misconception as to what MSF's plans were about and the pre-electoral climate (which was characterised by a reaction against "foreign interference") made the launch of the new programme impossible in the given time frame. Consequently, MSF presence is discontinued for the time being. MSF may re-examine the needs in the future.

Funding: MSF, EC

Expatriates: 9

MISSIONS - PART VIII

SOUTH AMERICA



Bolivia, Brazil, Colombia, Peru

BOLIVIA



CONTEXT

At the present time, Bolivia is politically stable, which has facilitated MSF's assistance programme. However, drug trafficking has meant that some areas are extremely insecure, notably Chapare. Bolivia is also one of the poorest countries on the American continent. Unemployment is high and there is too little investment in education and health.

ACTIVITIES

MSF has been here since 1987 and is carrying out programmes in Illampu, and Mizque (TinTin). One very important aspect of MSF's work is the setting up of a central pharmacy for the supply of medicine and medical material. In Illampu, MSF provides medical assistance with a special emphasis on mother/child health care. MSF is also involved in the rehabilitation of health posts and provides logistical backup. In TinTin (Mizque) MSF also runs a health care development programme which has integrated the community in the project. Already, the project is being run by local staff. It has been successfully particularly in the realm of preventive medicine. Mizque has been turned into a health district by the central government and MSF is trying to help the local staff who have no experience in cost recovery to manage the budget.

Funding: MSF, EC, Spanish government, Spanish local authorities.

Expatriates: 6

BRAZIL



CONTEXT

The most extreme social divide continues to exist in Brazil, giving rise to a range of basic political, social and economic problems. Elementary education for the majority is disastrous and the public health-assistance and welfare structures bankrupt. The dozens of favelas around Rio de Janeiro are mostly controlled by drug-traffickers and it is they rather than the public authorities who keep order. The new federal government supports the Rio State Government in its attempt to regain control over the favelas, but no relevant structural changes have been put forward.

ACTIVITIES

MSF gives support to institutions working with street children in the capital. The team provides consultations in the favelas, and also provides home visits, carries out group work with adolescents and runs psychiatric assessments. In the country's interior, the indigenous population, notably the Yanomani Indians, are threatened. The arrival of gold miners has almost devastated their communities. In some areas, almost half the Yanomani population has been wiped out by influenza, tuberculosis and malaria. In Roraima, MSF runs an aid programme in favour of the Yanomani and the Macuxi. Local health workers receive training from MSF. Medicine and medical materials are supplied to health structures and epidemiological research carried out. In 1995, a new project starts in the valley of the Javai river, west of Manaus. The reservations at Xavante, Bororo de Parabubure, Areols, Pimental, Barbosa and Marechal Ronchon are totally without health and sanitation assistance. The infant mortality rate wavers between 30 and 140 on every thousand children. MSF supports the primary health structures, with vaccination, training and rehabilitation of sanitary structures.

Funding: MSF, EC, Swiss and Luxembourg governments

Expatriates: 12

COLOMBIA



CONTEXT

MSF has been present in Colombia since 1987. Colombia is regularly affected by natural disasters such as earthquakes and floods as well as cholera epidemics. Medical needs are mostly covered. MSF focuses on providing logistical back up for earthquakes. Emergency stocks are kept in Bogotá.

ACTIVITIES

MSF has projects in Buenaventura, on the Pacific Coast, and runs two health posts at Cristobal Colon and Playita. MSF also works in the rural area at Bajo Calima. In June 1994, the town of Inza in the Cauca region, was shaken by an earthquake. MSF intervened on behalf of the local population. Activities centered around the construction of an aqueduct, latrines and logistical support to medical activities. When the next earthquake took place on 19 January 1995, MSF brought aid to the Casanare region by providing water tanks and sanitation assistance. Following a landslide in the slum-dwellings at Bogotá, MSF teams organised emergency shelters. Orthodontistry and surgery have been introduced in the hospital at Puerto Merizalde. Buenaventura Hospital functions as a reference centre for the whole Pacific Coast and department of Valle. The aim of the MSF project here is to upgrade the paediatrics and emergency services. MSF provides training and supplies medicine and medical material. In Silvia/Piendamó, MSF is supervising the work of local health care workers and rehabilitating health structures.

Funding: MSF, EC, Luxembourg and Spanish governments and Spanish local authorities.

Expatriates: 12

PERU



CONTEXT

The activity of the terrorist group El Sendero Luminoso (*The Shining Path*), the government army and the rebel group MRTA (*Tupac Amaru Revolutionary Movement*) have claimed the lives of 25,000 people. The Shining Path lost a lot of its power after the head of the organisation was captured. However, several regions remain highly insecure. More than half of all Peruvians live below the poverty line.

ACTIVITIES

MSF provides assistance to the many displaced in Huamanga, Ayacucho province, where local teams support the health care system. In 1994, MSF provided support for the six remaining health centres. MSF works in the Huanta district, as well as Cangallao and Tambo. Assistance is also provided to the 25,000 people living alongside the Apurimac River, which until 1991, was controlled by the Shining Path. The Ashaninka Indians have suffered greatly from epidemics and infant mortality high. MSF provides health care assistance, training and the supply of essential medicines and material. In June 1994, MSF carried out a vaccination programme in San Martín de Pangoa, Mazamari and Perene. MSF and another local charity run a school health programme in two shanty towns near Lima. In April 1995, MSF opened a mission on the banks of the Ucayali river which has as its objective the relaunch of the health care system and the protection of human rights. Earlier in the year, a project had been launched in Contamara targeting the 40,000 inhabitants of the area. All of the projects in Loreto are carried out by boat. In June 1994, an emergency project was launched in the area following the flooding in the region. In Requena, MSF supplies the health structures with medicine and medical material, and focuses on training, logistical support, rehabilitation and epidemiological surveillance.

Funding: MSF, EC, Dutch and Spanish governments, Spanish local authorities

Expatriates: 17

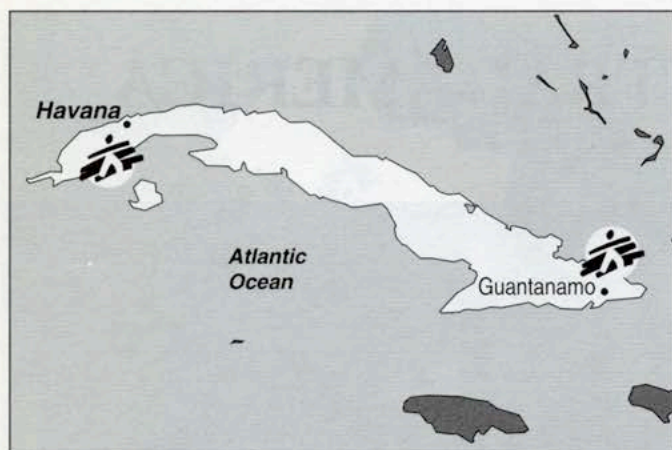
MISSIONS - PART IX

NORTH AND CENTRAL AMERICA



*Cuba, Haiti, Panama, Nicaragua, Guatemala,
Mexico*

CUBA



CONTEXT

Since the disintegration of the communist eastern bloc, Cuba has been more isolated than ever. The health care system is well organised and medical staff well trained. However, owing to the economic problems besetting the country, drugs are in short supply. The US embargo against Cuba remains in force.

ACTIVITIES

MSF launched its project in Cuba in 1993. The project mainly consists of distribution and the supply of medicine and medical equipment to Cuban health structures. It is estimated that about one million people benefit from MSF's assistance. The project came to an end in March 1995, having achieved what it set out to do. In 1995, MSF hopes to continue working on two projects to purify water, one on a national level and the other on a provincial level in the Guantanamo region, one of the most economically depressed.

Funding: EC, Spanish local authorities

Expatriates: 4

HAITI



CONTEXT

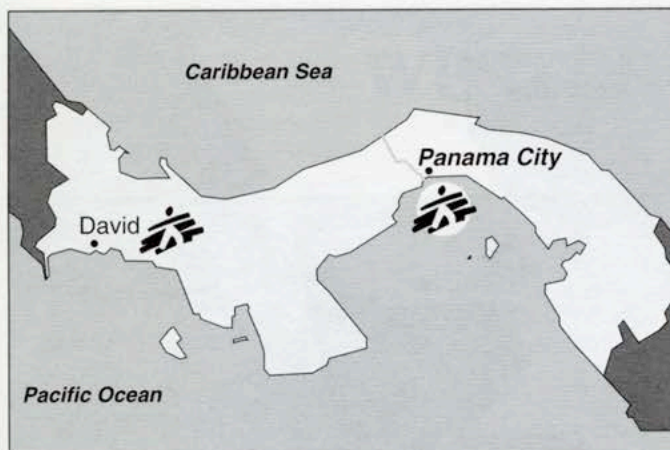
Following the coup d'état in 1991, a reign of terror followed during which at least 1,500 supporters of the deposed president, Jean-Bertrand Aristide, were murdered. On 19 September 1994, US troops went in to Haiti with UN backing, clearing the way for the President's return. A constitutional government was installed and the international embargo lifted. On 15 October 1994, the president finally returned. In November, Hurricane Gordon killed 500 Haitians and destroyed 45,000 homes. Some 50% of the population receives less than 75% of their basic food requirements. AIDS has affected nearly 10% of the urban population.

ACTIVITIES

MSF runs a community health care programme in Grande Anse, which includes mother-child health care, family planning and supplementary feeding. The teams have also been supporting the relaunch of Jérémie Hospital. When the hurricane devastated the region, an emergency aid programme was launched. Supplementary feeding was introduced as was sanitation and the rehabilitation of wells and other water systems. MSF continues its project in Ile de la Gonave. This island is two hours by boat from Port-au-Prince and has a population of 80,000. It is very poor with an acute scarcity of clean drinking water. MSF supports medical care and is responsible for distribution of essential medicines and medical material. MSF is trying to improve the quality of diagnosis, prevention and treatment of diseases. In 1995, MSF aims to rehabilitate Haiti's central pharmacy in order to improve medical distribution. MSF has launched a surgical programme and provides emergency care in the Saint Marc district hospital, sixty miles north-west of Port Au Prince. MSF is working in Haiti's second biggest hospital in Cap Haïtien. Activities involve a feeding programme inside and outside the hospital and training for staff, support for the management of the central pharmacy of the hospital and improvement of hospital hygiene.

Funding: MSF, EC, Luxembourg government and French local authorities
Expatriates: 20

PANAMA



CONTEXT

Panama is enjoying relative political stability at the moment and the global health situation compares favourably to neighbouring countries. However, the indigenous populations have less access to health care than the rest of the Panamanian population.

ACTIVITIES

MSF works in Soloy, a district of San Lorenzo, with a target group of 15,000. MSF is trying to improve the health coverage of the population. The team works in the Health Centre/Soloy hospital as well as local health posts to which it supplies medicine and medical material. The programme carried out in Soloy Hospital includes, an anti-tuberculosis programme, mother/child health care, training and supervision of the pharmacy and its staff and epidemiological surveillance. In 1995 it is hoped that all the health posts will be rehabilitated and built and that MSF will continue the project.

Funding: Spanish government and local authorities, Bicis por la Paz.
Expatriates: 7

NICARAGUA



CONTEXT

There has been a split in the Sandinista party, nearly destroying all their remaining chances of victory in the 1996 elections. Conflicts over the ownership of goods and property confiscated under the former government remain unresolved, a situation that does not inspire confidence in potential investors. The chief of the armed forces was replaced, as demanded by the US government. Armed groups continue to be present in the north of the country, where we run most of our projects.

ACTIVITIES

In 1994, MSF completed its work in a shanty town of Managua where volunteers were involved in the rehabilitation and construction of two health posts as well as their supply of drugs and medical equipment. A community pharmacy has been created for each post. In Wiwili, support is given to a health district, with one rural reference hospital and seven health posts covering 56,000 inhabitants. The project came to an end in November 1994. By this stage, the hospital had already been partially rehabilitated, a tuberculosis ward opened and emergency surgery relaunched. In Cua-Bocay, MSF provides support to a health district, with two health centres and six health posts benefiting 45,000 inhabitants.

Funding: MSF, EC
Expatriates: 4

GUATEMALA



CONTEXT

Human rights violations continue to be a problem in Guatemala. There is a kind of Apartheid between ladinos and native American Indians. The indigenous peoples who are in a majority continue to be treated like second class citizens. The government, although elected democratically, is under the control of the army and big landowners. There is an absence of social policy, and the citizens are victims to growing violence and poverty. During the last big wave of repression 10-20,000 Indians hid in the mountains, where they organised themselves in the underground group the CPR (*Community of Populations in the Resistance*).

ACTIVITIES

In 1993, MSF started to provide health care to a target group of 15,000 in the Quiche region, a functional enclave. Witnessing is as much a part of the project as the assistance programme which involves preventive and curative medical care, rehabilitation of health care structures, and water and sanitation assistance. The Guatemalan refugees began to return in 1993. MSF re-opened its mission in Nentón in January 1994. MSF also works in the slums of Guatemala City, where the health programme is based on management training. The water project is also important. Technical and financial assistance is provided to a local charity Nina Madre working with single mothers on the streets. In Izabal, MSF works in the municipalities of Livingston and San Luis, focusing on upgrading health care and training local personnel. MSF supervises work in the health posts. MSF also works in the Peten area near the Mexican border where it provides medical assistance and sanitation for the returning refugees. The rural health care programme in Todos Santos involves training and support for health association and sanitation. Health care assistance is provided for returnees in Barillas.

Funding: MSF, EC, UNHCR, Dutch, Swiss, Canadian, Swedish and Spanish governments, French local authorities, Bicus por la Paz
Expatriates: 30

MEXICO



CONTEXT

On 1 January 1994 the Chiapas-based rebel group, Ejército Zapatista de la Libertad Nacional (EZLN), came out of hiding and took over several villages. Their slogan *Tierra y Libertad* (*Land and Liberty*) brought hope to tens of thousands of rural people, who claim that for generations they have suffered exploitation by landowners and their militia groups. In January 1995 a national military offensive pushed back the rebels into the neighbouring mountains. Following the offensive, 50,000 fled into the forests and 20,000 into government-held territory. Half would return within a short delay despite the military presence to find their houses looted and their crops destroyed.

ACTIVITIES

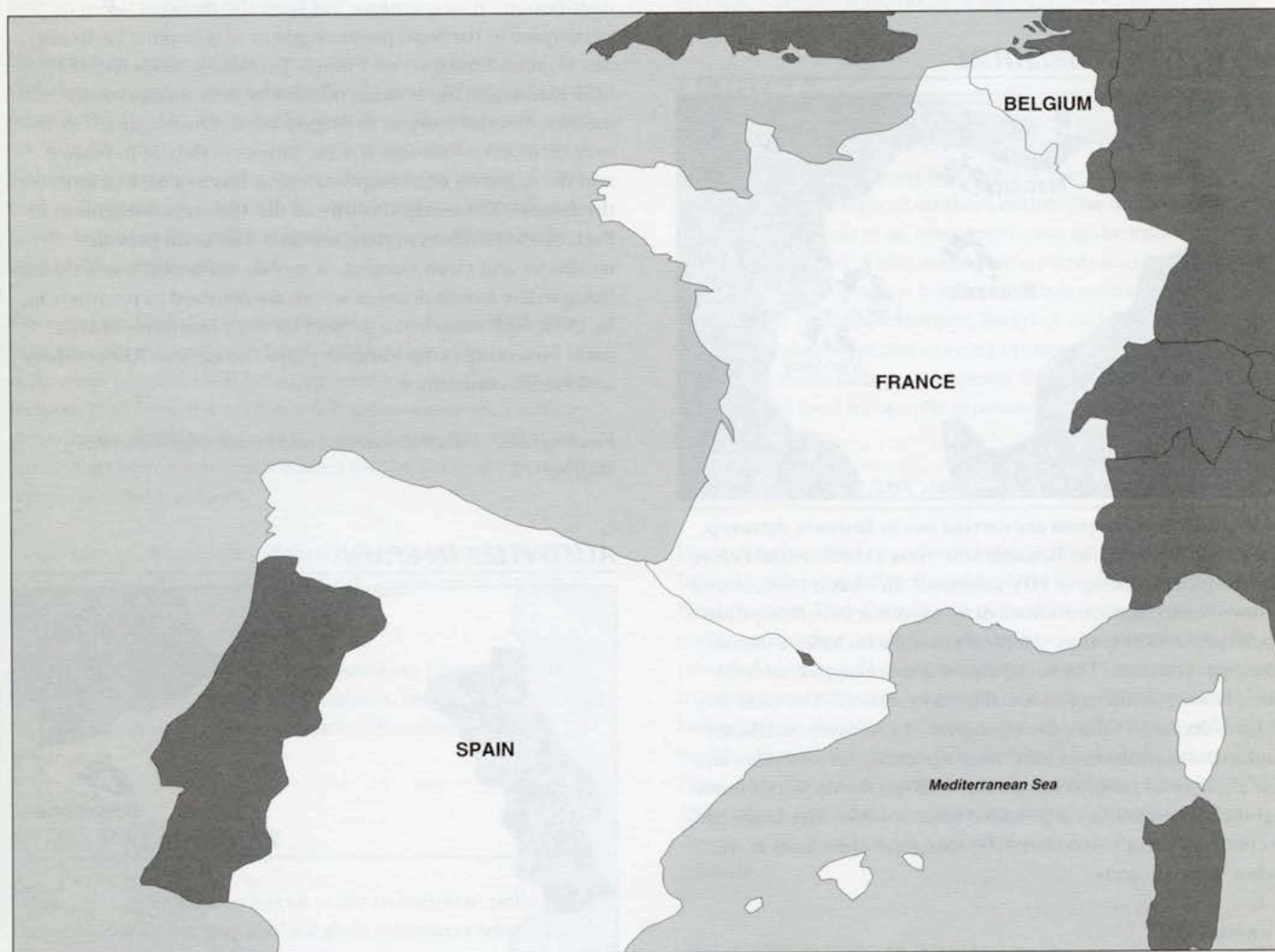
Already in November 1994, an exploratory mission identified 30,000 civilians in the zone under EZLN control, without access to health care. MSF received authorisation to start a project in March 1995. Activities included the distribution of blankets for thousands of returnees. MSF ran three mobile medical teams, and had staff at three health posts. MSF intends to remain in the area in order to witness the situation as well as to provide health care. Health care is good in the major cities such as Ocosingo and Comitán, but the rural population refuse to go there for political reasons. In the countryside, there are few operational health-care posts, and all of them ill-supplied.

Several exploratory missions were carried out from the MSF regional base in Costa Rica where MSF has two volunteers. This office also evaluated the situation in Colombia after the earthquake, the droughts in Honduras and Nicaragua as well as various other natural disasters in the region.

Funding: MSF
Expatriates: 6

MISSIONS - PART X

WESTERN EUROPE

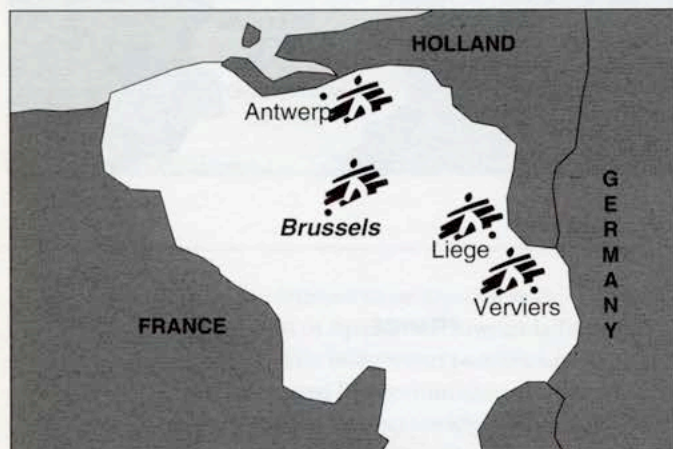


Belgium, France, Spain

BELGIUM - FRANCE - SPAIN

In many European countries, social marginalisation is on the rise. An increasing number of people are at present excluded from any social protection system and, consequently, unable to gain access to health-care. The vulnerable group includes drug addicts, prostitutes, illegal immigrants.

ACTIVITIES IN BELGIUM

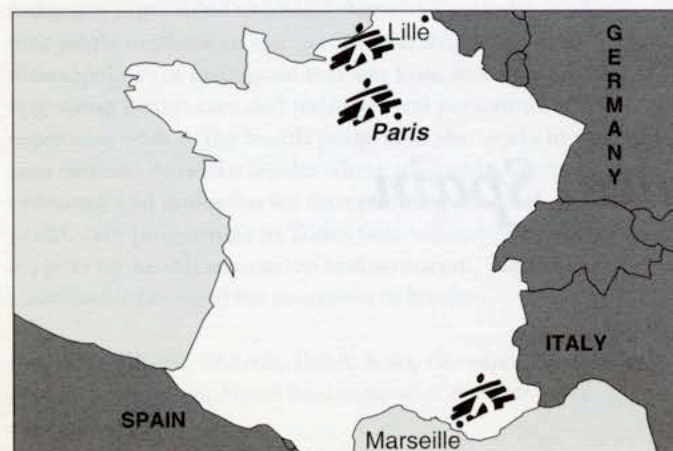


MSF projects in Belgium are carried out in Brussels, Antwerp, Liege and Verviers. In Brussels MSF runs a confidential centre for the free screening of HIV infection. In March 1995, consultations started for intravenous drug users not benefiting from a social protection system. Medical coverage includes a methadone programme. The social aspect is more angled towards their reintegration in the Social security system. The next step is for a doctor to follow their progress. In Antwerp, medical and social consultations have been operating for two years and the number of patients has doubled (200). In Verviers a medical-social consultation is provided twice a week. The Liège project started up in November 1994 along the same lines as the other three projects.

Funding: MSF

Staffing: 6

ACTIVITIES IN FRANCE

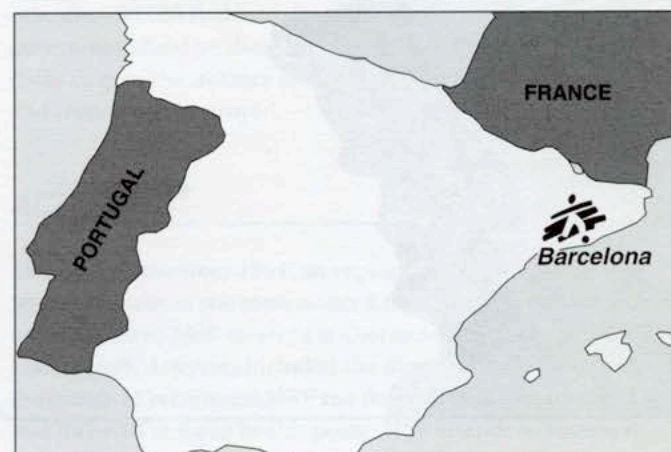


The programmes for those excluded from health care in Lyons has been closed, because of the new possibilities in hospitals and improvements in legislation. In 1994, MSF focused more intently on social work such as the projects in Lille and Marseille. MSF continues to focus on information, training and distribution. A new venture has been the decision taken to participate in the legal pressure group Action pour les Droits des Malades Etrangers en France (ADMEF). With ADMEF, MSF challenges the laws introduced by the minister of the interior, Charles Pasqua, in August 1993. Once again, immigration has become a main subject of debate in France and the question of immigrants' rights has to a MSF priority for the future. The medical centre of the 18th arrondissement in Paris opens its doors to drug addicts. The team provides treatment and clean needles. A mobile team works with addicts living in the streets many of whom are involved in prostitution. In 1994, MSF launched a project for the prevention of lead paint poisoning (saturnism) in public housing in Aubervilliers and Pantin communes.

Funding: MSF, French government and French local authorities

Staffing: 17

ACTIVITIES IN SPAIN



In Barcelona, MSF runs what is known as the Cuarto Mundo or Fourth World project. This project began in earnest in July 1994. The main objective is to improve health care among the marginalised people of this urban centre, including the many illegal immigrants. MSF hopes that a health care project of this kind will allow these people better health coverage and may serve to integrate them into the formal health care system and community life. A mobile clinic stops in known areas of the city, where the team provides medical assistance to the many homeless people and those who spend long hours on the streets of the city. Condoms are distributed and a needle exchange is run for intravenous drug users.

Funding: MSF

Staffing: Spain

THE RESPONSE TO EMERGENCIES

WHEN AND HOW MISSIONS ARE LAUNCHED

Médecins Sans Frontières' field missions are launched in areas where either war, massive population movements, famine or natural disasters have led to a situation where outside assistance is considered necessary.

When Médecins Sans Frontières is alerted to a new crisis situation in a given area, it immediately sends a fact-finding team to the field to evaluate the situation. The team will assess the humanitarian needs and the practicalities of intervention. Either on its return or directly by satellite from the field, the team will report on the medical, nutritional and sanitation needs, as well as the political and logistical constraints to be taken into consideration.

Once it is decided that the conditions are such that Médecins Sans Frontières should go ahead and launch a mission, a co-ordination task force will be set up within hours. This task force includes staff from the operations, human resources, logistics and communications departments, who define the project's initial objectives and set up a budget for the necessary personnel, equipment and transport.

Médecins Sans Frontières will then immediately begin sending volunteers and equipment to the field. Teams are backed up by large numbers of local staff.

Médecins Sans Frontières' four key assets are provided by its department of human resources, logistics, medicine and finance, all of which serve to ensure the smooth functioning of MSF missions.

HUMAN RESOURCES

Médecins Sans Frontières has an active recruitment policy. Training courses are provided for most volunteers selected. Volunteers are briefed before leaving on mission and debriefed on their return.

For emergencies, the organisation relies on a stand-by staff of experienced professionals, all of whom are ready to leave on short notice. Recruitment focuses on members of the medical

profession, but a variety of support staff is also required for any mission to function adequately.

Médecins Sans Frontières, therefore, sends out numerous logistical and administrative personnel, financial managers, sanitary engineers and mechanics, who work alongside the doctors and nurses.

LOGISTICS

In the absence of efficient logistics, emergency intervention is impossible, Médecins Sans Frontières is able to depend on reliable logistical support on short notice. The organisation can decide to intervene in an emergency zone in the knowledge that planes will be loaded with cargo over a twenty-four hour period. Médecins Sans Frontières has five logistical centres based in Amsterdam, Bordeaux, Brussels, Bangkok and Nairobi. These centres purchase, test and store equipment such as vehicles, communications facilities and power supplies to water processing facilities and food for specific numbers of people.

TECHNICAL SUPPORT

Humanitarian relief requires a certain amount of technical know-how which is provided to the missions by specialist teams based at headquarters. They foresee and make allowance for nutritional needs, vaccination, sanitation and hygiene. handbooks are also provided to teams. These cover several areas of expertise and are translated into different languages. Médecins Sans Frontières has helped create three consultancy and training bodies in public health which also carry out field surveys. They are Epicentre in Paris, Aedes in Brussels and the Amsterdam-based HealthNet. These three specialist centres now operate independently but remain of invaluable support to Médecins Sans Frontières field missions.

INDEPENDENT FUNDING

Financial independence allows the organisation flexibility when deciding when and how to intervene and guarantees the rapid response to emergency which Médecins Sans Frontières is always able to provide.

SPEAKING OUT

Médecins Sans Frontières considers that speaking out on wide scale or systematic human rights abuses to which it is a witness is as important a part of its mission as its work in the field. There are two principal purposes to such speaking out.

INFORMATION

In general, Médecins Sans Frontières promotes the defence of humanitarian principles and the right to humanitarian aid (free access to victims and the right to control the distribution of aid). But MSF also attempts to draw the attention of the international community to the plight of populations in danger, particularly when they are given little media coverage. In certain cases, MSF will encourage an international humanitarian response.

DENUNCIATION

Denunciation is not a tool used by MSF as a matter of course. It is its rarity value which contributes to its effectiveness. When

MSF considers it to be in the interest of the victims, it will denounce massive and repeated violations of human rights and/or of humanitarian law, such as the crime of genocide, forced movements of population, genocide, crimes against humanity and war crimes, etc.

Médecins Sans Frontières is very aware of the ever present conflict between giving assistance and acting as a witness in such situations. Each case is treated individually as MSF weighs up the impact of witnessing against the effects it might have in the field.

When acting as a witness in this way, all evidence and public statements must be in agreement with the events and situations which are being denounced, either because they have been experienced at first hand by Médecins Sans Frontières, or because they involve massive violations of which MSF has knowledge.

FINANCIAL ETHICS

Médecins Sans Frontières is a private independent, non-profit organisation, without political, economic or religious affiliations.

Médecins Sans Frontières requires funding in order to carry out its operations. Apart from donations by private individuals, the organisation also accepts contributions from governments, international organisations, businesses, churches and foundations.

However, Médecins Sans Frontières will only accept these contributions under the following conditions:

- It must be clearly understood that all projects have a strictly humanitarian objective;
- Each project must be proposed and carried out in conformity with the Charter of Médecins Sans Frontières;

- The donor receives no direct benefit, whether political, financial, economic or otherwise, from any project.

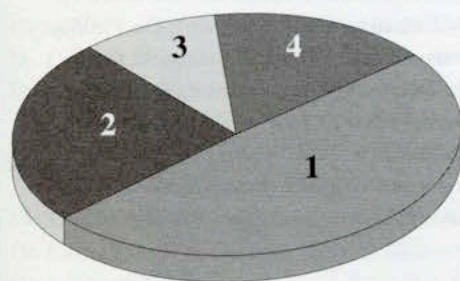
The organisation's independence, particularly its financial independence, is guaranteed by the following:

- Médecins Sans Frontières always retains its freedom to select projects;
- The high percentage of private funding, which comes from donations made by private individuals;
- Diversity in institutional funding.

MSF IN FIGURES

	1994	1993
Permanent expatriate posts	1239	972
Volunteers sent to the field	2950	1957
Total income	\$306 m	\$205 m
Private donors	2.4 m	2.1 m

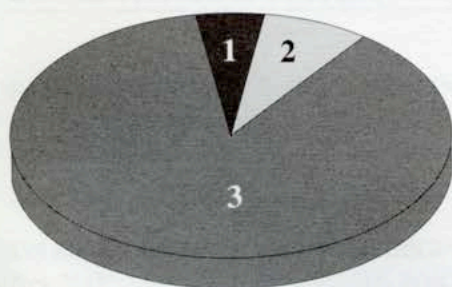
MSF'S INCOME IN 1994



1	Private income :	49.4 %	 (\$151m)
2	European Community :	24.9 %	 (\$76m)
3	UNHCR* :	9.6 %	 (\$30m)
4	Other Funders :	16.1 %	 (\$49m)

*UNHCR : United Nations High Commissioner for Refugees.

MSF 'S SPENDING IN 1994



1	Administration :	5 %
2	Communications and Fundraising	8 %
3	Operations	87 %

AN INTERNATIONAL NETWORK

HOW MEDECINS SANS FRONTIERES IS ORGANISED

Médecins Sans Frontières is a network made up of six operational centres, thirteen delegate offices in Europe, North America and Asia and the Brussels-based International Office.

OPERATIONAL CENTRES

Six operational centres (sections) based in Amsterdam, Barcelona, Brussels, Geneva, Luxembourg and Paris are responsible for carrying out the operations of Médecins Sans Frontières in the field. The operations department, which is the centre of each section, is supported by several other departments: logistics, medical, human resources, financial, communications, and fund-raising. During emergencies or major crises, the operational centres combine forces, recruiting and dispatching volunteers as well as co-ordinating logistical support and finances.

Each section is run by a President and a General Director. The Board of Directors of each section is composed of volunteers. It outlines the section's strategy. The Board, as well as its President, are elected by the annual General Assembly.

DELEGATE OFFICES

Delegate offices, a major development in the MSF structure in recent years are responsible for recruitment, public awareness, and fund-raising. They are providing an increasing number of health professionals for field missions and back-up for the

operational centres. Based in Australia, Austria, Canada, Denmark, Germany, Greece, Hong Kong, Italy, Japan, Norway, Sweden, the UK and the USA, they represent a true internationalisation of the MSF movement.

INTERNATIONAL COUNCIL

The International Council is a quarterly meeting of the Presidents and General Directors of the six operational centres and the Director of the International Office. It outlines the main strategic orientations of the MSF movement. It has a rotating presidency (one country succeeding another). The International Council meetings are organised by the international president with the assistance of the International Office.

The members of the International Council are: Dr. Marleen Boelaert and Dr. Eric Goemaere (MSF Belgium), Dr. Philippe Biberson and Dr. Bernard Pécoul (MSF France), Dr. Carlo Faber and Dr. Béchara Ziadé (MSF Luxembourg), Dr. Hans Emans and Dr. Jaques de Milliano (MSF Holland), Dr. Pilar Carrasco and Dr. Paco Sanchez (MSF Spain), Dr. Doris Schopper and Dr. Benoît Tullen (MSF Switzerland) and Dr. Jean-Marie Kindermans (MSF-International Office)

INTERNATIONAL OFFICE

The International Office represents the MSF network to international institutions and organisations. It also facilitates the co-ordination of the network. Based in Brussels, it has two antennae to the international organisations in Geneva and in New York.

MSF CONTACT NUMBERS

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THE CHARTER OF MEDECINS SANS FRONTIERES

Médecins Sans Frontières is a private international organization. Most of its members are doctors and health workers, but many other support professions contribute to MSF's smooth functioning. All of them agree to honour the following principles:

- ▲ Médecins Sans Frontières offers assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict, without discrimination and irrespective of race, religion, creed or political affiliation.
- ▲ Médecins Sans Frontières observes strict neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance and demands full and unhindered freedom in the exercise of its functions.
- ▲ Médecins Sans Frontières' volunteers undertake to respect their professional code of ethics and to maintain complete independence from all political, economic and religious powers.
- ▲ As volunteers, members are aware of the risks and dangers of the missions they undertake, and have no right to compensation for themselves or their beneficiaries other than that which Médecins Sans Frontières is able to afford them.

