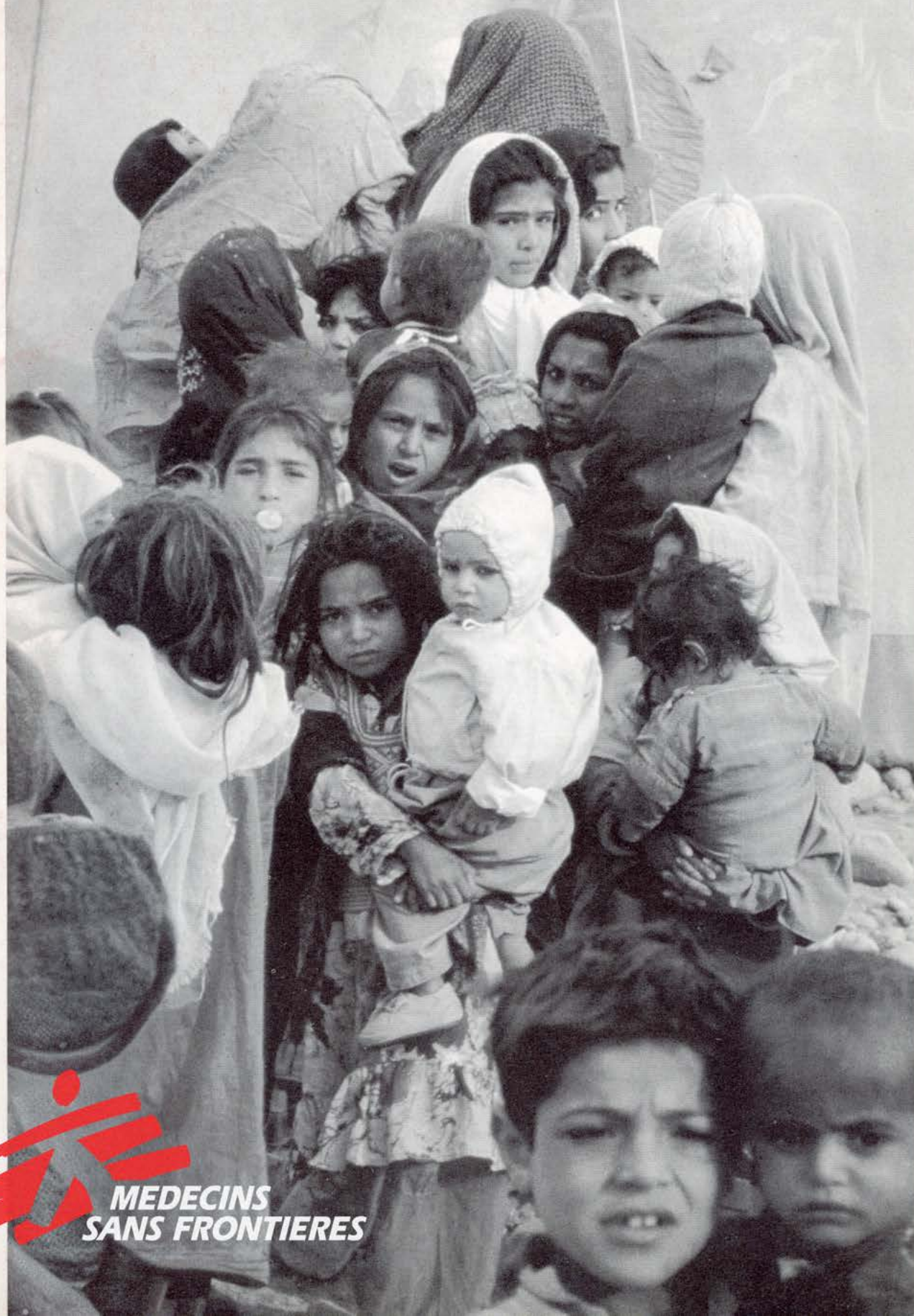


ACTIVITY REPORT

JULY 1995 - JULY 1996



**MEDECINS
SANS FRONTIERES**

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When more than one of the above mentioned sources have documented the same indicator, the most recent figure has been used.

Some of the indicators on Belgium, France and Spain come from Médecins Sans Frontières.

Abbreviations

n.a. = No information available

Refugees

= The statistics on refugees do not include asylum-seekers. The figures cover persons recognised as refugees by governments which have signed the 1951 United Nations Convention Relating to the Status of Refugees or

its 1967 Protocol, persons recognised as refugees under the 1969 Organisation of African Unity (OAU) convention, and persons recognised by the UNHCR as so called "mandate" refugees.

IDPs = (Internally Displaced Persons). According to the United Nations High Commissioner for Refugees (UNHCR), IDPs are people who are displaced within their own country for reasons that would make them of concern to the UNHCR.

x = Measurement that does not cover either the entire country or the whole calendar year.

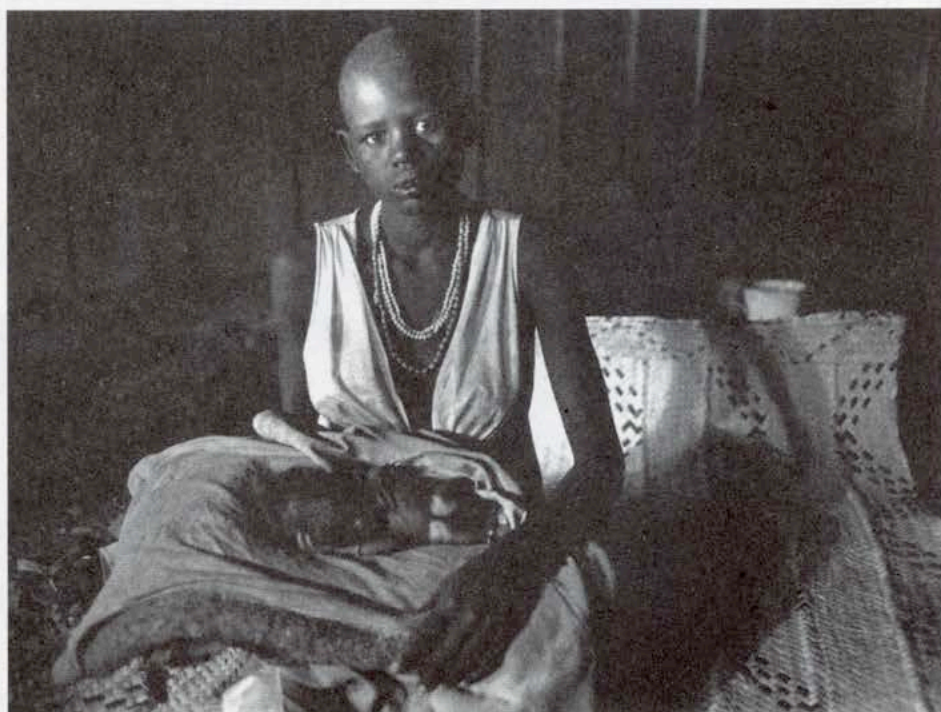
Note on introduction to country entries

The information contained in the introductory paragraphs to each country entry in this report comes partly from Médecins Sans Frontières own internal information and partly from external sources. The main external sources were The Economist Intelligence Reports and various issues of The Latin American Weekly Report.

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S Salgado, Sudan, 1995

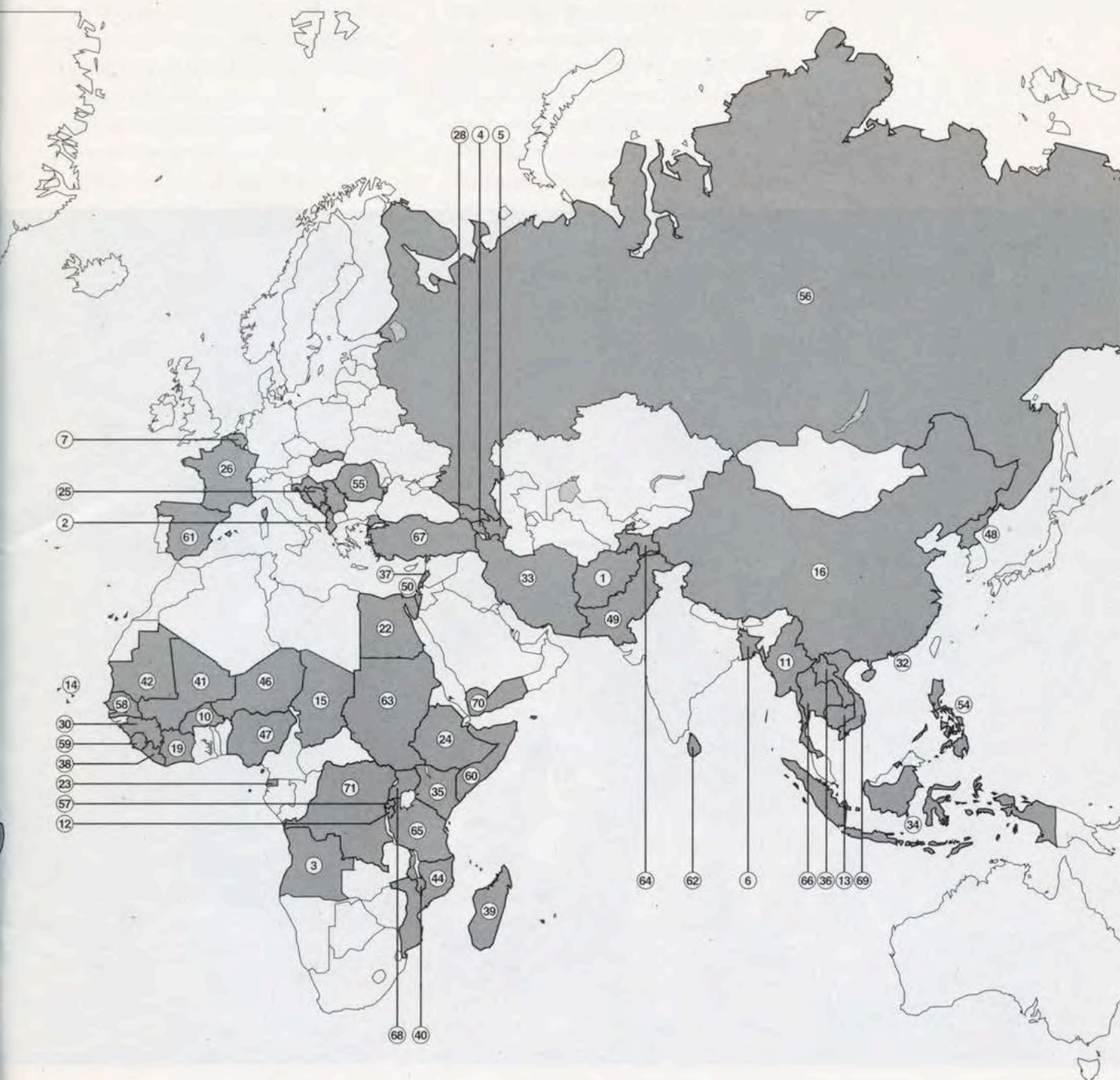
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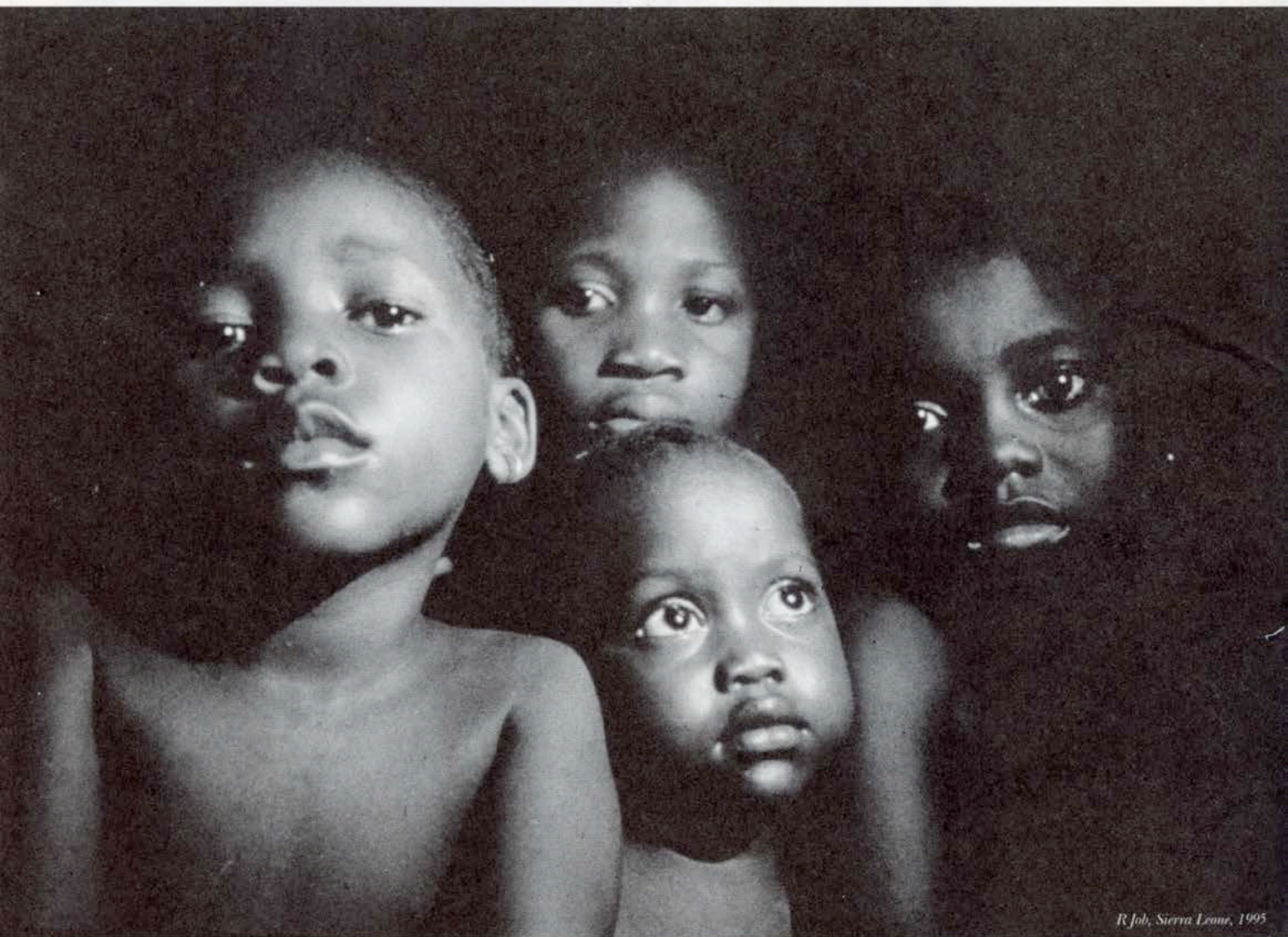
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R. Job, Sierra Leone, 1995

as Médecins Sans Frontières (MSF) goes into its 25th year of operations, the nature of war and humanitarian action has changed dramatically. Frontlines have all but disappeared, warring factions have multiplied, civilians are indiscriminately targeted, and the respect for humanitarian activities can no longer be simply assumed. Millions of people are in need of assistance.

Over the past year, one of the most difficult situations still being dealt with by MSF is the fall of the Bosnian enclave of Srebrenica. After months of treating the local population and despite repeated calls on the international community for protection, MSF volunteers had to watch as the enclave was taken and thousands of people went "missing". MSF spoke out on the mass violations of human rights throughout Bosnia, and while our medical programmes continue, we remain committed to seeing that justice is done and support is given to the International War Crimes Tribunal.

Work continues in emergency zones, and while no single crisis has dominated our activities this past year, a series of lesser-known conflicts have demanded regular medical interventions. In Chechnya, MSF was one of the only independent aid agencies to remain on site throughout the conflict. In Liberia, teams worked in the hospitals and health centres up until May 1996, when fighting forced them to suspend operations for one week. In Burundi, insecurity is a factor of daily life, but our presence and assistance has provided essential health care for more than two million people.

Although MSF is known for its expertise in emergency medical relief, it is important that the care continues long after the crisis peaks. Two years after the genocide in Rwanda, and despite the unclear expulsion of an MSF team, from Rwanda, MSF continues to work rebuilding the health system and working with the displaced Rwandans. In September 1995, MSF did take the difficult decision to pull out from the Rwandan refugee camps in Tanzania and Zaire, as manipulation of humanitarian relief and the ongoing domination of the refugees by former organisers of the Rwandan genocide had become insurmountable. Still, work continues in the Great Lakes Region where our assistance ensures basic medical care and a degree of stability for the populations.

A significant initiative taken by MSF over the last year has been the creation of a specialised Emergency Team (ET), made up of the most skilled and experienced staff members from all our operational centres. Members of the ET are on constant standby for rapid deployment. The speed and effectiveness for the ET was proven at the beginning of 1996, when Nigeria was hit with an unprecedented meningitis epidemic. Four million people were vaccinated in just three months.

Over the past year, more than 14,000 national and international staff worked together in 70 countries. This Activity Report attempts to provide you with an overview of our interventions around the globe. Motivation is high, proving that the concept of "Sans Frontières" is alive. We thank both our private and institutional donors for the support which allows us to continue this work.



G Turine, Angola, 1996

J. Kindermans

*Dr. Jean-Marie Kindermans ■
Director of the International Office*

1971

In the wake of the Biafran war, a group of disillusioned French doctors and journalists return to Paris from a Red Cross mission, and create Médecins Sans Frontières, which as the name implies will be an organisation which resolves to provide assistance where needed, even if it means crossing borders or using media pressure to do so.

1972

Nicaragua - intervention following earthquake.

1974

Honduras - Long-term mission following Hurricane Fifi.

1975

Vietnam - first mission in a war zone.

1976

Lebanon: Team of 56 work in Beirut hospital during the siege. Thailand - First big refugee programme for Indochinese.

1978

Africa - MSF works in refugee camps in the Western Sahara, Djibouti, Sudan, and Zaire.

1979

Thailand - MSF sends 100 volunteers to Cambodian refugee camps.

1980

Afghanistan - MSF launches first mission. Uganda -feeding programme for victims of the civil war and drought MSF becomes an international organisation.

1984

Ethiopia - extensive feeding programme launched for famine victims.

1985

Ethiopia - MSF denounces diversion of humanitarian aid and forced migration and is expelled by the Mengistu regime.

1987

MSF starts to develop socio-medical programmes in western Europe, beginning with France.

1988

Sudan: MSF raises the alarm to save the Dinka people from famine.

1989

Health programmes in Eastern Europe following collapse of Communist bloc. Armenia: earthquake relief.

1990

Liberia - MSF brings assistance to inaccessible areas.

1991

The flight of the Kurds - MSF launches biggest refugee programme following Gulf War. Somalia - MSF sends emergency aid to the victims of the civil war. Former Yugoslavia - MSF launches mission in the war zone. MSF awarded European Human Rights Award and Philadelphia Liberty Medal.

1992

Somalia: Civil war and famine decimate the population. MSF increases its activity in the field and alerts international opinion. MSF launches first International Day for Populations in Danger, in November, publishing accompanying report Bosnia-Herzegovina - MSF denounces ethnic cleansing and crimes against humanity.

1993

Somalia: MSF denounces the methods of the United Nations troops in Somalia which violate the very humanitarian principles by which they are supposed to operate. Burundi: Following attempted coup d'état, vicious round of killings begin which triggers refugee emergency. Within a few weeks, 180 MSF volunteers are providing emergency aid to 600,000 refugees in Rwanda, Tanzania and in Burundi itself. MSF receives Nansen medal for its work amongst the world's refugees.

1994

Bosnia: work continues during the siege of Gorazde. MSF and the International Committee of the Red Cross are the only humanitarian presence in the enclave.

Rwanda: Genocide begins. MSF takes out all but its most experienced staff and works with the wounded in extremely difficult circumstances. MSF calls on the International community to intervene in the genocide.

One million Rwandan refugees fleeing the Rwandese Patriotic Army (RPA)'s advance, arrive in the small town of Goma, Zaire.

Within days, thousands are dying of cholera. MSF collaborates on water distribution system, launching biggest cholera programme to date.

1995

Bosnia: MSF is the only international presence during fall of Srebrenica enclave.

North Korea: MSF intervenes following floods.

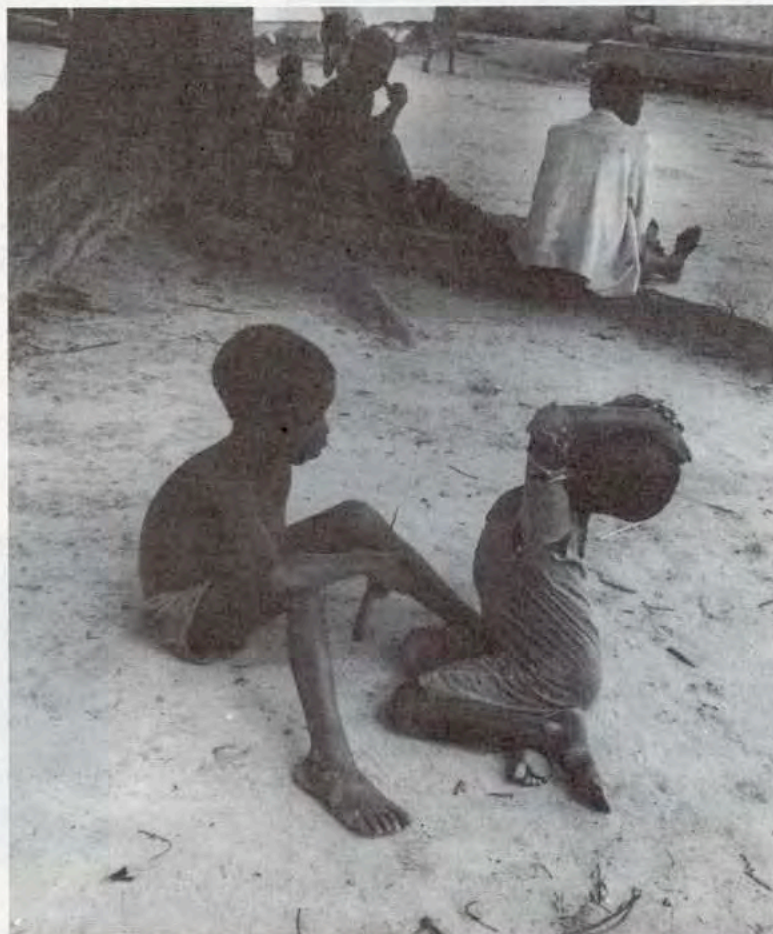
Chechnya: MSF brings aid inside the republic and to the refugee camps of neighbouring countries.

1996

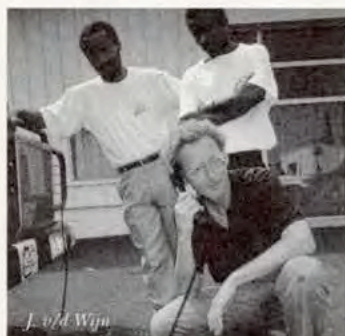
Nigeria: MSF vaccinates 4.5 million people against meningitis.

Chechnya: MSF calls on G-7 members attending Moscow summit to put pressure on Russian government to stop gross and systematic targeting of civilians and violations of humanitarian law.

Sierra Leone, Burundi: MSF brings aid to the victims of war.



G Turine, Angola, 1996



EXPLORATORY MISSION TO CRISIS AREA

2-3 PEOPLE, 2-10 DAYS,

SUPPLIES:

- Satellite phones, radio-telexes
- Emergency Kits and Guidelines
- Supply and Order Lists
- Personal Survival Kits: including food, blankets, compass, backpack

**CRISIS INFORMATION
TWENTY-FOUR HOUR**

Sources : Médecins Sans Frontières
the field, international
medical professionals
news reports



COMMUNITY



LOGISTIC EXPERTS

- Carry out population surveys and site planning
- Assess available water supply
- Evaluate sanitation needs
- Negotiate entry requirements with governments and local leaders
- Coordinate transportation systems



MEDICAL PERSONNEL AND EPIDEMIOLOGISTS

- Assess public health and existing health structures
- Investigate epidemics via environmental assessment and case control studies
- Develop project approach, objectives and strategies

EVALUATION: SHOULD MÉDECINS SANS FRONTIÈRES



PROJECT COORDINATION

The project head coordinates all activity, determines organisational and personnel needs, assesses security situation, negotiates with local authorities

YES

In as short a time as 24 hours
teams are prepared and sent



MEDICAL RELIEF

New hospitals, clinics, feeding centres and mother & child health programmes are set up. Existing health structures are bolstered and local medical staff is trained.

ION REACHES
ERGENCY WATCH TEAM

s Frontières teams in
organisations, local
ministries of health,
arts, etc.

ICATION ➤

EMERGENCY DESK
COORDINATES ALL ACTIVITIES



Remy Bohle

LOGISTICS CENTRE

- Plans shipment and transportation
- Identifies landing strips for cargo planes
- Fills Exploratory Team's supply orders



Roger Job

HUMAN RESOURCES

Assembles standby team from pool of volunteers recruited by 19 Médecins Sans Frontières offices worldwide



John Vink

MEDICAL DESK

- Analyses data gathered by Exploratory Team
- Develops situation-specific strategy for medical intervention
- Laboratories analyse specimens

DO WE START AN EMERGENCY RELIEF MISSION ?

Materials and
to the field

NO

- The population does not require emergency medical intervention.
- The population's needs are being fulfilled. Médecins Sans Frontières avoids duplicating efforts of local or international groups.



Roger Job

LOGISTICS

- Coordinate purchase and transport of supplies
- Set up latrines and sanitation system. If necessary, water supply is treated or water is trucked in.
- Set up local and international communications system
- Secure local transportation



M. Wittenberg

LOCAL STAFF

Profiles:

- Medical personnel
- Outreach workers to serve as liaisons with community
- Drivers, logisticians and technical assistants

THE MEDICAL EMERGENCY OF THE YEAR

Twenty-five years after we sent our first doctors and nurses to the field, millions of people throughout the world continue to die of preventable diseases every year. It is even more alarming that they are continuing to do so at an increasing rate. Meningitis, polio, measles, yellow fever and diphtheria, diseases which can easily be prevented by early immunization, have come back with a vengeance in countries where their incidence had dropped in the late 1970s. Cholera, tuberculosis, malaria and sleeping sickness are on the increase, even though there are effective methods of treating them. Since the early 1980s we have also had to deal with a sharp increase in AIDS cases. Even previously rare diseases, such as Ebola, which was first identified in 1976, are beginning to pose a threat. Last summer in Zaire alone, MSF teams intervened in four simultaneous epidemics. The diseases in question were polio, measles, cholera and meningitis. This is unprecedented. There can be no doubt about it, the emergency of the year has been the high incidence of epidemics.

There is no one reason why we are faced with this alarming situation. There are, however, several contributing factors to the massive decrease in investment in the health care sector in many countries. War is the number one cause of the disintegration of a functional health care service. The poor allocation of resources comes a close second. There is also a lack of sustained commitment from donors. On our own, we cannot solve the problem, but we can save lives.

Since 1971, MSF teams have become more competent than ever in dealing with these issues. This past year alone we have carried out more mass vaccination campaigns than ever before - most notably vaccinating 4 million Nigerians against meningitis, 1.5 million Liberians against yellow fever and thousands of children against measles. In an effort to strengthen our impact, we

have created a specialised pool of health care professionals who are permanently on standby. More often than not, it is the Emergency Team which will carry out the initial exploratory mission. We only intervene in epidemics if the national authorities need our help and our presence will make a difference.

We are also concerned by those diseases, which may rarely meet epidemic proportions but where numbers of cases are increasing at an alarming rate. When there is no vaccine available, we focus on traditional preventive methods and treatment. In the case of a contagious disease, we try to find ways to guarantee a successful cure for patients. In the case of those diseases which are spread by a non-human vector, such as malaria and sleeping sickness, we have a two-fold approach. Firstly, we treat the patients quickly so as to decrease the chances of infection of the vector (with malaria and sleeping sickness, the vectors are the mosquito and the tsetse fly). Secondly we try to exterminate the vector. Thirdly, we introduced preventive techniques, which in the absence of vaccines consists of a range of methods from upgrading sanitation to distributing mosquito nets.

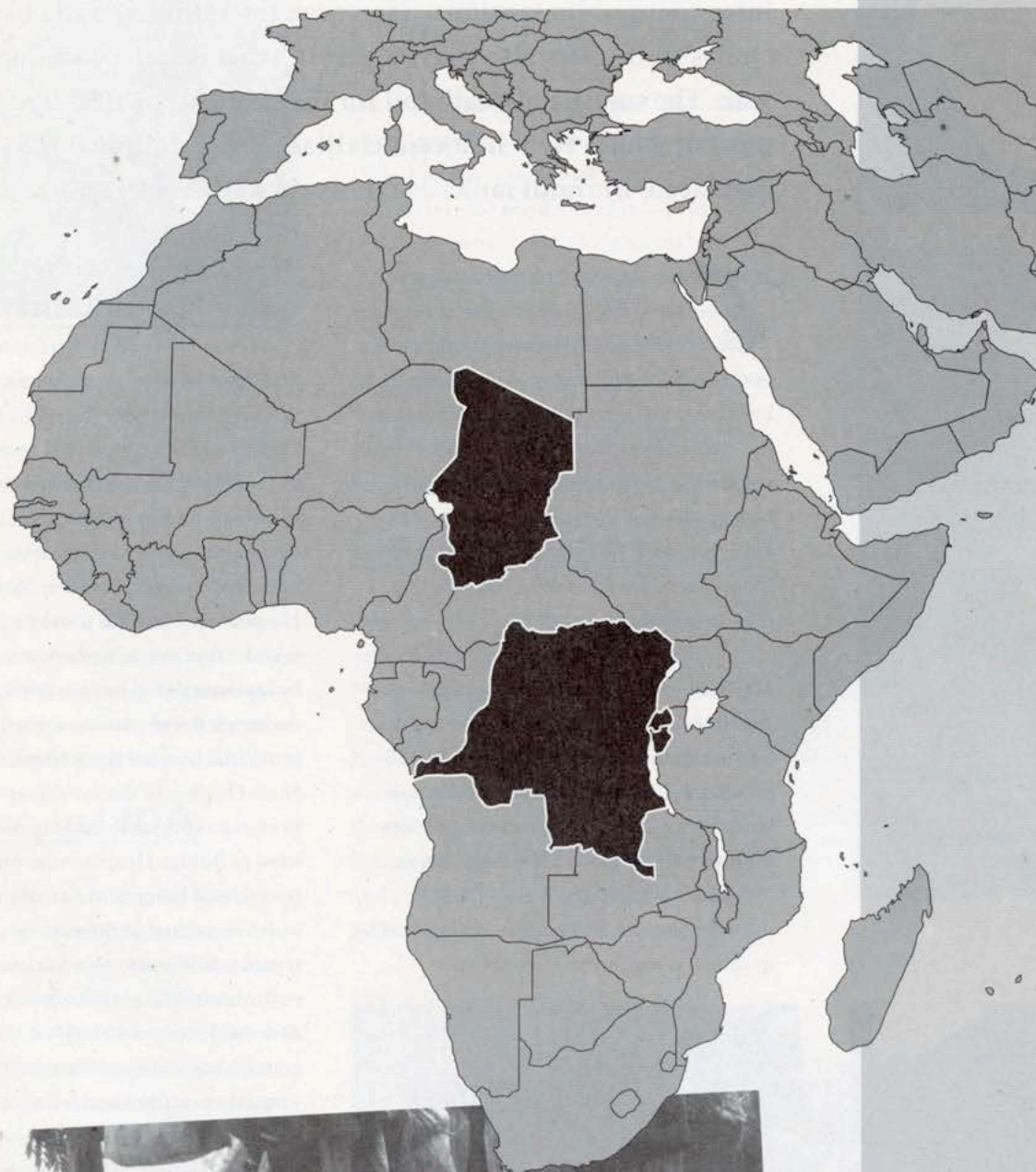
The task we have given ourselves is not easy. We are often faced with strains of illnesses that do not respond to anything but the most costly and sophisticated anti-biotics, which can be often hard to come by. We are often powerless in the face of little understood diseases such as Ebola. Although, we hope that answers will be found in the future, in the meantime, MSF medical teams bring tried and trusted techniques while in the medical departments we try to deepen our knowledge of the diseases themselves.



Dr. Myriam Henskens ■
International Medical Coordinator

CENTRAL AFRICA

AFRICA



P Dral, Zaïre, 1995



POLARIZATION OF TWO COMMUNITIES



POP. IN YEAR 1994
6.2 m

POP. IN YEAR 2000
7.3 m

GNP PER CAPITA
180 USD

ADULT LITERACY RATE,
MALE/FEMALE
45%/19%

LIFE EXPECTANCY
50 yrs

0-5 MORTALITY RATE
176 per 1,000

POP. PER DOCTOR/NURSE
16,667/n.a.

MEASLES VACC. COVERAGE
43%

NO. OF REFUGEES/IDPs
300,300/300,000

Burundi continues to be riven by an extreme violence. As in Rwanda, Burundian politicians play the ethnic card exacerbating inter-community tensions. However, the informal trade in precious stones from Zaire also plays a part in what is fast becoming an open war. The unofficial death toll for the first half of 1996 was 8,500, most of whom were innocent civilians. An additional 500,000 were displaced. Burundi ranks as the world's sixth poorest nation.

The ongoing violence has aggravated the humanitarian situation in Burundi. In many areas, such as Cibitoke, the lack of access to basic health care services is a major problem for the civilian population. There has been no respite for the Burundian people, who having survived the massacres of October 1993, have had little chance to return to their normal lives in the knowledge that they are safe from attack.

MSF is more committed than ever to its projects in Burundi. In fact, activities have now been extended to cover 7 of Burundi's 16 provinces. The organisation provide assistance in hospitals, health centres and sites for internally displaced/dispersed persons. MSF also works alongside the UNHCR providing assistance Rwandan refugees living in camps along the northern border.

Hospitals and Health Centres

MSF has extensive programmes in seven hospitals throughout Burundi. In August 1995, it was brought to MSF's attention that the numbers of wounded had risen alarmingly in Kayanza province, in the north of the country. A medical team was immediately sent to work in Musema Hospital. In Kirundo province, which is even further north, and an area also plagued by insecurity, MSF has provided assistance in the surgical and paediatric wards of the provincial hospital since November 1993. Since October of the same year, teams have been managing and running the surgery ward of Buhiga Hospital - the only operational hospital in Karuzi province which is situated in the eastern part of the country. MSF teams also work further south in Ruyigi and Kinyinya Hospitals with the national Ministry of Health. Other than general hospital care, the teams carry out surgical operations and train staff. Rehabilitation work has also been carried out on the hospital buildings. Activities in Ngozi province were extended from local health centres to include the hospital in January 1995. In March 1996, MSF sent a surgical team to Makamba hospital - this is the only permanent surgical team in southern Burundi. However, within two weeks security conditions were such that the team was forced to evacuate, although it was able to return shortly afterwards.

In the absence of any medical authorities in Karuzi province, MSF supervises health care and the distribution of medicine and medical materials to 11 health centres, and



W Van Cappellen, Burundi, 1994



provides technical assistance. MSF works in 19 health centres in Ruyigi province. A mobile clinic does rounds in 15 provincial health centres in Kirundo province. Teams carry out consultations in the orphanage and prison where rehabilitation work has also been carried out. MSF teams are supporting 20 health centres in Ngozi province. At the beginning of 1996, MSF activities were extended to provide health care in the seven health centres in the southern Kayanza province, where the team works out of the rehabilitated Musema hospital.

Refugees and IDPs

Regular assistance, including the distribution of medicines, blankets and plastic sheeting and installation of latrines, is provided for the 45,000 internally displaced persons (IDPs) and the dispersed who have gathered in sites in and around Karuzi province. In Ruyigi, sanitation assistance is also provided in 10 sites for the internally displaced. In Ngozi, water and sanitation facilities have been installed in nine camps for the displaced and medical consultations are provided in three of them. Since the beginning of 1996, MSF has also been working in four camps for the displaced in Kayanza province and in camps in Kirundo province.

MSF has been active in Ngozi for several years. Teams first ran a programme following the 1993 massacres and they were reinforced following the influx of refugees from Rwanda in April 1994. Medical and nutritional care was provided to 76,000 Rwandan refugees in three camps. The

team is still responsible for therapeutic feeding programmes and medical screening for repatriating refugees. The remaining refugees are expected to be repatriated to Rwanda before the end of 1996.

Cholera in the capital

In certain quarters of the capital, Bujumbura, access to medical facilities was difficult in 1995. For this reason, MSF set up a mobile team to provide regular medical consultations for people in the least accessible communes. At the end of 1995, a cholera epidemic broke out during severe water shortages. MSF provided emergency relief alongside other agencies. Currently the team works in 15 sites providing medical consultations, distributing medicines and installing latrines and water drainage systems.

Emergency surgery

Over the past year, MSF teams have tried to assist Burundians wounded in attacks. However, as is often the case, access can be limited in the insecure areas. MSF teams have carried out surgical operations for the war-wounded the Johnson health centre in the outskirts of the capital's notoriously tense Kamengue quarter. Many people with bullet and machete wounds have also been treated in the Ngozi, Karuzi and Musema hospitals.

MSF is deeply concerned by the present humanitarian situation in Burundi and is worried by the international community's apparent lack of awareness for what is a potentially explosive situation. In an effort to draw media attention towards the situation in Burundi, MSF published a report in November 1995, detailing attacks on the civilian population.

Following the murder of the health care workers from the International Committee of the Red Cross (ICRC) at the beginning of July 1996 and further attacks on other organisations, humanitarian assistance is becoming increasingly difficult to deliver in Burundi.

International staff: 71

National staff: 1738



POP. IN YEAR 1994
7.8 m

POP. IN YEAR 2000
9.0 m

GNP PER CAPITA
210 USD

ADULT LITERACY RATE,
MALE/FEMALE
65%/44%

LIFE EXPECTANCY
47 yrs

0-5 MORTALITY RATE
139 per 1,000

POP. PER DOCTOR/NURSE
25,000/8,333

MEASLES VACC. COVERAGE
25 %

NO. OF REFUGEES/IDPs
6,000/500,000



Revolution, Rwanda, 1995

JUSTICE : A SAFEGUARD FOR THE FUTURE

The Rwandan Patriotic Front (RPF) continued to lead Rwanda's coalition government. Although a civilian administration was in place, the army retained a significant role in Rwandan life. There continued to be infiltrations of armed refugees in the border region. Almost 92 percent of the population work the land. However, war and genocide have devastated agriculture as well as the rest of Rwanda's economic and social infrastructure.

Access to health care in Rwanda is variable. The hundreds of thousands of displaced and dispersed are not always covered. Moreover, whole health districts need to be relaunched and health structures rehabilitated in the aftermath of the genocide in 1994. In the past year, MSF has been active in Gisenyi, Ruhengeri, Gikongoro, Cyangugu, Butare, Kibuye, Byumba, Kibumba and Gitarama. MSF's policy is to give support to locally-run health centres. National staff are registered with and paid by the Ministry of Health, but MSF tops up their salaries. Local health care workers are supervised by MSF nurses and doctors. Other than basic health care, staff members focus on preventive medicine, such as immunisation and ante-natal care. MSF is currently trying to help health centres gain access to prisoners in need of medical assistance.

MSF supports the Kabutare hospital in Butare Province and five of the province's health centres. MSF also supports 10 health centres in Gisenyi and two in the capital, Kigali. In Cyangugu, MSF supports primary health care and provides training at the hospital level as well as in the health centres. Until the end of 1995, teams relaunched health districts, reference hospitals and dispensaries, and supported health centres in Gikongoro, Gitarama and Kibuye. In Nyagatare, MSF provides primary health care through health centres.

Working in the prisons

Following the genocide of 1994, the Rwandan government and the international community have promised to see justice done. A war crimes tribunal (like the one

for former Yugoslavia) was to be set up, evidence collected and suspects tried and judged. However, the trials have got off to a very slow start. Thousands of people languish in overcrowded, disease-infected prisons. Many have been incarcerated on dubious evidence. While the foremost advocates of the war crimes tribunal, MSF is concerned for the health and human rights of the prisoners. Teams run a 30-bed ward in Kigali hospital for referrals from Kigali prison. Care is provided by the hospital staff, with the support of local medical personnel and expatriate staff remunerated by MSF. AIDS is the number-one cause of death among prisoners. In Gitarama and Kibuye, MSF also organised a reference service for prisoners in 1995.

Children in focus

The population movements which accompanied and followed the genocide, separated thousands of children from their families. Many are now orphaned, but others are simply lost. MSF aims to reunite as many of them with their families as possible and to see that the others are well looked after.

One hundred children between 7 and 14 years of age were being held in Rwanda's overcrowded prisons. A more suitable re-education centre was refurbished in Gitagata to which MSF transferred the children in 1995.

Hundreds of unaccompanied children, mostly from the Goma refugee camps, have also been taken into the MSF reception centre in Gisenyi. So far, MSF has successfully reunited 73 of them with their

families. Four "family units" were set up in 1995, each comprising some 15 children supported by three Rwandan classroom assistants. The unaccompanied children are integrated into Rwandan society and the oldest go to school.

It is estimated that there are 400 street children in Gisenyi. In October 1995, MSF started a project to provide an overnight shelter for them. The project is being extended to include training activities with a view to their social reintegration.

Psychological support

In 1995, MSF launched a pilot programme in Ruhengeri. MSF teams worked in six clinics and three hospitals providing psycho-social assistance to people traumatised by the genocide. As this pilot project comes to an end in late 1996, MSF is preparing an enlarged and long-term programme of this sort for Gikongoro and Kibuye. Needs are great, particularly in Kibuye which was an area particularly marked by the genocide. In the first phase of the programme, MSF teams will target women who were raped and mutilated in the genocide. In order to reach these victims, MSF will be working with women's groups in the community. Clinic supervisors will also be trained. From the experience of the pilot project, MSF has seen that community participation is of paramount importance as it difficult for some of these people to see the need to

come in regularly for psychological counselling. In a second phase of the programme, MSF will train health personnel in Kigali schools, to identify traumatised children. MSF is already running a psychiatric programme through health centres in Gisenyi and Kigali for people suffering from psychosomatic illnesses resulting from trauma.

Assistance in transit camps

Health posts were set up in the Nkamira transit camp near Gisenyi and in Butare province, where MSF teams provide health care to returnees. In the first post, MSF is also in charge of the drinking water supply. Another transit camp in Niarushishi, with a capacity for 10,000 people was also set up. Owing to the low level of repatriation, there has not been much activity, except during the wave of forced repatriation from Zaire, when 15,000 people returned to Rwanda. In Gisenyi, the sporadic repatriation of Tutsi refugees from Masisi made it necessary to conduct a measles vaccination campaign during the year.

In early December 1996, an MSF team was expelled from Rwanda. MSF never received any satisfactory explanations for why this happened.

International staff: 111

National staff: 1429



Revelli, Rwanda, 1995



POP. IN YEAR 1994
42.6 m

POP. IN YEAR 2000
51.1 m

GNP PER CAPITA
220x USD

ADULT LITERACY RATE,
MALE/FEMALE
83%/61%

LIFE EXPECTANCY
52 yrs

0-5 MORTALITY RATE
186 per 1,000

POP. PER DOCTOR/NURSE
4,286/1,351

MEASLES VACC. COVERAGE
33 %

NO. OF REFUGEES/IDPs
1,724,400/225,000



P Dral, Zaire, 1995

A YEAR OF EPIDEMICS

President Mobutu Sese Seko's thirty year old regime continued to be accused of high-level corruption. Consequently, international aid is limited and conditional. In many regions of this vast country, there is a complete absence of health care. There were frequent reports about the military terrorising the population in Goma. Average inflation in 1995 was reportedly around 500 percent - a significant improvement compared to the previous year.

By early 1995, the medical situation of the Rwandan refugees in the Goma camps had improved considerably, which allowed MSF to make a sizeable reduction in manpower. By September 1995, with the emergency phase over, MSF decided to hand over its remaining activities in the camps to another aid agency. The organisation felt that, like the situation in Tanzanian camps, the negative effects of the aid far outweighed the positive. By then, humanitarian aid was only consolidating the power structure in the camps. An unacceptable situation had arisen, whereby the very leaders responsible for the genocide in Rwanda were manipulating the humanitarian relief and virtually holding the main body of refugees hostage. MSF finally suspended its activities in the Kahindo Camp in September 1995

and in the Katala Camp in October 1995. A programme to support Zairian medical structures was launched at the end of 1995 through ASRAMES, a local agency supported by MSF. The programme supplies 180 health centres and hospitals with medicines and medical material.

MSF is also working in the refugee camps around the southern city of Uvira. These camps are inhabited by some 100,000 Burundian and Rwandan refugees, many of whom are in poor health. Their number has continued to grow since January 1996, when thousands arrived having fled the violence in Bujumbura. Teams provide the refugees with medical assistance. MSF has also been working on the drinking water supply and sanitation.

Violence in Masisi

Throughout 1995 and 1996, ethnically motivated violence continued in the southeastern parts of the North Kivu region, notably Masisi. This unreported war has given rise to a death toll running into the thousands and may have displaced up to 250,000. The problem has been exacerbated by the presence of the Rwandan refugees in Goma who have turned Masisi into a resettlement enclave. MSF is very concerned by the plight of the innocent victims, particularly those displaced in the villages of Kichanga and the monastery of Mokoto. In May 1996, MSF reported that 3,000 displaced Tutsis were caught between the crossfire of the warring parties in this area. Earlier in the month, an estimated 100 were massacred in Mokoto where they were seeking refuge. MSF's team in the area is following the situation closely.

Support to health care

In Equateur, the Basankusu, Bolomba and Ingende, health areas function with MSF support. At the end of 1995, an agreement was reached on support for five additional areas in the region: Boende, Djolu, Befale, Bikoro and Monkoto.

In Shaba, MSF supports the Kasenga health area. In Kikula, in the Likasi area of Shaba, MSF is trying to help local authorities set up an urban health district, a job complicated by the presence of the internally displaced Kasai people from Southern Shaba. At the end of 1995, MSF again agreed to give support to five additional areas in the

region: Kilwa, Pueto, Sakania, Katuba and Kenia-Kamalondo.

In the aftermath of the project to provide care for the internally displaced people, a care project in the Mwene-Ditu health area was begun, the emphasis being on the pharmaceutical depot and the health centre.

MSF set up a non-profit organisation called Horizon Santé with a view to finding better-suited and more durable ways of supporting health areas. The programme supports four areas: Bagata, Masi-Manimba, Kikimi and Kasansa.

AIDS in Zaire

MSF runs an AIDS prevention programme in the capital, Kinshasa. At first the programme was aimed at the city's prostitutes, but it was later expanded to include members of other high risk groups. MSF is working in the field of HIV and AIDS with other NGOs. A project to write and produce an "AIDS for School Children" brochure (12-16 years) specifically adapted to the Zairian context was started in 1995 with the support of an anthropologist. In Lubumbashi, a similar programme concentrates on ensuring blood safety in nine major health centres.

Sleeping Sickness

In Kimpese, Lower Zaire, MSF launched a project to counter trypanosomiasis (sleeping sickness) in February 1996. This project will run for two years. In this area, MSF will also provide medical assistance for the 30,000 Angolan refugees who will be repatriated in August 1996 in M'Banza Congo and Uige. Similarly, teams will provide assistance to the Angolans to be repatriated from Kinshasa to Luanda. All refugees who are screened for trypanosomiasis and test positive will be provided with treatment, either in Zaire or back in Angola.

Nutritional Problems

In Kinshasa, MSF supported 30 feeding centres until January 1996, when the

project was handed over to a religious organisation. In Mwene-Ditu, the influx of internally displaced people and the shortages of traditional foodstuffs have resulted in high malnutrition rates (30 percent overall) and MSF brought in emergency reinforcements during the year.

Epidemics

The gradual deterioration of the health system in Zaire has led to low immunisation-coverage, resulting in major epidemics. In mid-1995, MSF ran programmes to counter huge epidemics of polio, measles, Ebola and cholera which had appeared at the same time. Massive vaccination campaigns against measles and polio in the big cities made it possible to improve the immunisation coverage. In mid-1995, MSF ran a huge immunisation campaign against measles and polio in Mbuji-Mayi, in eastern Kasai province. The second round of vaccinations took place in December. One million people were covered. There were 1,500 cases of cholera in the Shaba region in 1995. MSF provided medical assistance to the victims in cholera centres and upgraded water supply and sanitation for prevention purposes.



In an effort to provide reliable statistics on disease, MSF runs a common health information project with the agencies Fondation Damien and Memisa.

In order to enable a quick reaction to unpredictable emergencies, MSF has launched a national Emergency Team of two people who remain on standby.

International staff: 89

National staff: 878

EBOLA

Ebola haemorrhagic fever was first recorded in Zaire in 1972, but came into the public eye with the 1995 outbreak. Although the Ebola virus is dormant today, it is one of the most pathogenic viruses known to science, causing death in over 50 percent of clinically ill cases. It is often characterised by the sudden onset of fever, muscle pain, headache and sore throat, followed by vomiting, diarrhoea, rash and both internal and external bleeding. Diagnosis requires specialised laboratory tests on blood specimens and should be conducted under maximum containment conditions as transmission is through direct contact with the blood, secretions and semen of infected carriers. Health care workers are at extreme risk and must be well briefed. Suspected cases should be isolated and strict barrier nursing techniques practised. Patients who die from Ebola must be immediately buried or cremated. Any person who has had close physical contact with patients should be kept under strict surveillance with body temperature checked twice a day and immediate hospitalisation and isolation in cases of temperature rising above 38.3°C.

The natural reservoir of the Ebola virus is not yet known, therefore prevention is not a possibility. There is no specific treatment although severe cases require intensive supportive care as dehydration is frequent and intravenous fluids are required.



P Dral, Zaire, 1995

CHAD



POP. IN YEAR 1994
6.2 m

GNP PER CAPITA
210 USD

ADULT LITERACY RATE,
MALE/FEMALE
57%/29%

0-5 MORTALITY RATE
202 per 1,000

POP. PER DOCTOR/NURSE
33,333/50,000

FINANCIAL PARTICIPATION IN HEALTH CARE

In spring 1996, the electorate voted to introduce the parliamentary system into the constitution. The current president, Idriss Deby of the Mouvement populaire du salut (MPS) is expected to be re-elected. Although, strikes remained frequent, inflation stabilised, cotton production increased and oil exploration began.

The objectives of MSF's health care programme in Chad are three-fold: the rehabilitation of existing health care structures, the promotion of cost recovery and the provision of staff training and technical assistance in hospitals and local dispensaries in the provinces of Mayo-Kebbi and Moyen Chari.

The purpose of cost recovery is to encourage the local community to contribute financially to their health care with a view to taking eventual control of their own health care system. MSF first started a cost recovery initiative in Mayo-Kebbi seven years ago and set up another in Moyen Chari in 1994.

MSF's training programme on curative and preventive medical care started to show results during the year. Training placements for young Chadian doctors and medical students were arranged in several hospitals in the Mayo-Kebbi area.

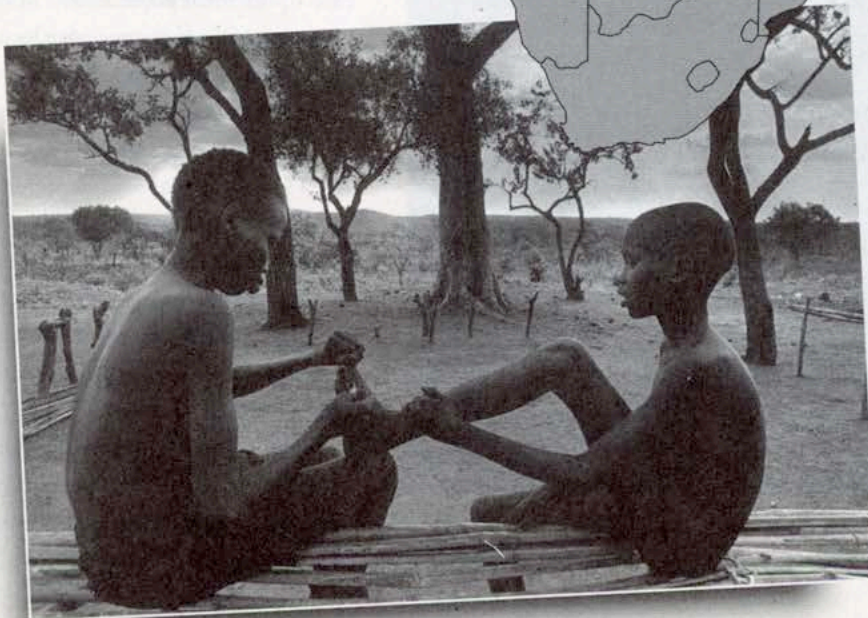
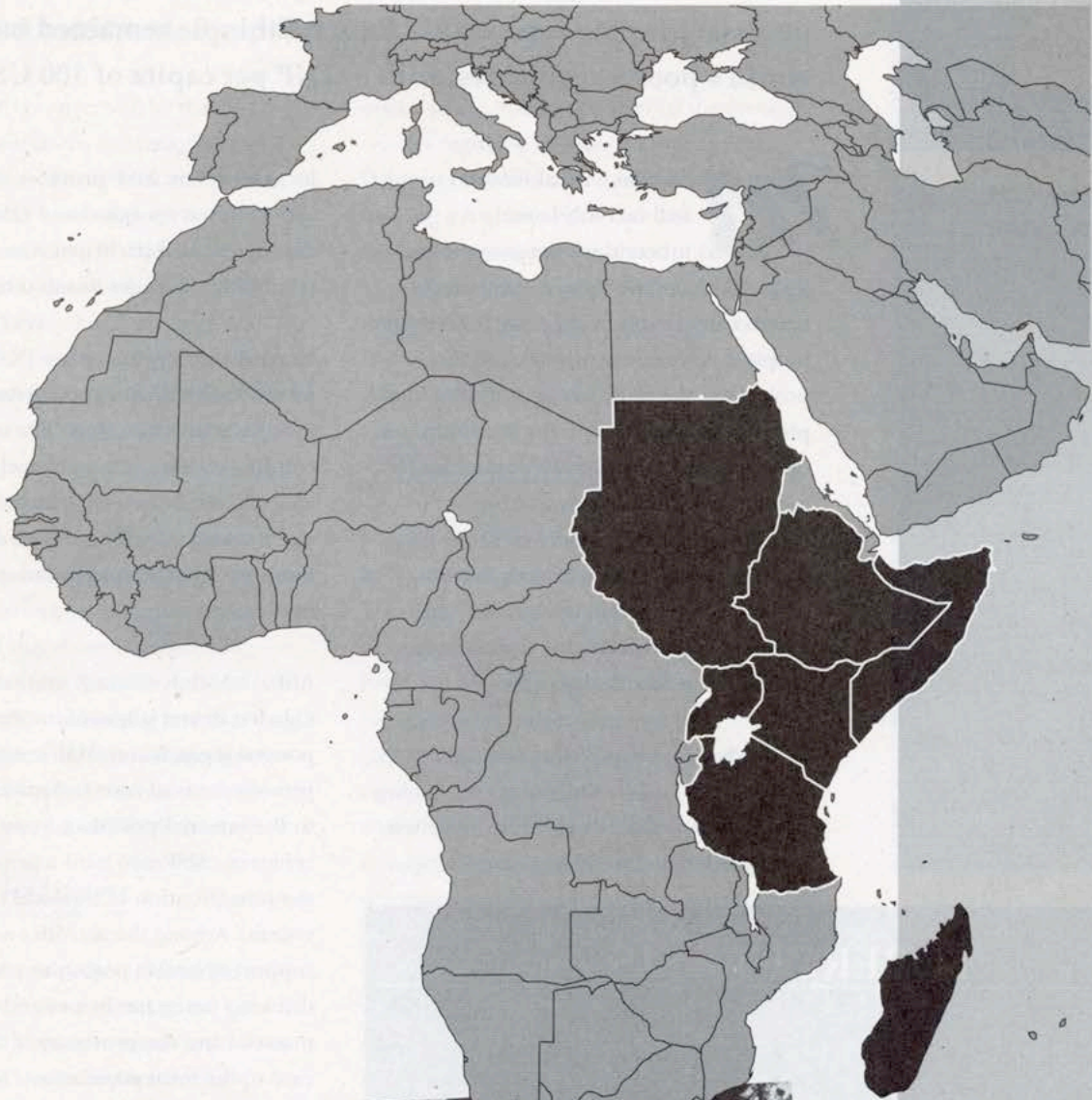
In 1995, the MSF-supported co-operative in the capital N'Djamena, which produces the vitamin-enriched flour Vitafort, produced 40 tonnes. By the end of 1996, the co-operative will be able to manage itself.

International staff: 21

National staff: 73

EASTERN AFRICA

AFRICA



G Turine, Angola, 1996



POP. IN YEAR 1994
53.4 m

POP. IN YEAR 2000
63.8 m

GNP PER CAPITA
100 USD

ADULT LITERACY RATE,
MALE/FEMALE
41%/21%

LIFE EXPECTANCY
47 yrs

0-5 MORTALITY RATE
200 per 1,000

POP. PER DOCTOR/NURSE
33,333/14,286

MEASLES VACC. COVERAGE
29 %

NO. OF REFUGEES/IDPs
348,100/200,000

LONG-TERM REHABILITATION CONTINUES

Fighting continued between the Ethiopian government forces and the armed opposition Oromo Liberation Front (OLF) in the Oromo region. Food shortages caused by insufficient rainfall continued to be one of Ethiopia's most serious problems. Food aid will be necessary for the foreseeable future. Ethiopia remained one of the world's poorest countries, with a GNP per capita of 100 USD.

MSF runs a rehabilitation project and recently launched a tuberculosis programme in Jijiga. The team works in a number of health centres and in the central reference hospital. Among the priorities of the project are the improvement of drug and pharmacy management, the establishment of a system of nursing care in the various communities in the area and the supervision of staff at the health centres. During the year, many existing health structures were rehabilitated and MSF resumed responsibility for the construction of three new health centres.

In Woldya, capital of Ethiopia's North Wollo region, MSF runs a surgical training programme which benefits four hospitals in North Wollo. In addition to training

local surgeons, MSF provides the hospitals with necessary surgical and other equipment and participates in the rehabilitation of the hospital buildings.

North Wollo's primary health care system receives extensive support from MSF in four health care centres. The teams there conduct training on issues such as anaesthesia, obstetrics, laboratory work and nursing care. There is an emphasis on mother and child health care and basic immunisation.

Afder, which is situated southwest of the Ogaden desert is one of the country's poorest areas, where MSF continues to provide medical care and other assistance to the internally displaced and to Somali refugees. MSF also runs a project aimed at the rehabilitation of the local health care system. Among the activities are the support of health posts, the provision of drinking water, medicines and other material and the provision of basic medical care to the local population. MSF team members train and supervise local staff, and special efforts are made to teach them how to prevent, diagnose and treat malaria.

From April to September 1995, MSF ran a feeding centre in the Ofa region in the southwest of Ethiopia, where the local population suffers from acute annual food shortages in the summer months. MSF relaunched this project in April 1996 with a view to running it until October.

International staff : 18

National staff : 214

TUBERCULOSIS

Tuberculosis (TB) kills more adults than any other infectious disease and presents a major challenge to international public health work. In 1995, it killed three million people. One third of the world's population is now infected and WHO believes that another 300 million people will become infected over the next decade. Coughing, sneezing, talking or expectorating pass the bacilli into the air where they can remain for hours and be inhaled by others. Only five to ten percent of those infected actually develop the disease to become contagious. Those with a weak immune system are most at risk, thus

explaining the close link between TB and HIV/AIDS.

The most efficient way to stop the spread of TB is by using a combination of drugs for a period of at least six months. Supervision is essential as the emergence of drug-resistant strains of TB result from incomplete or improper treatment. The available vaccine provides a high degree of protection against serious forms of TB in children and is recommended. In refugee settings, the risk of transmission may be increased by poor and overcrowded living conditions and malnutrition.

CHILDREN AT RISK

Albert Zafy, the leader of the Forces Vives coalition is Madagascar's head of state. Upon his election in 1993, he promised political and economic liberalisation. However, there has been little change, not least because of widespread popular opposition to economic reforms and half-hearted support from his own government.

MSF is concerned by the conditions in Madagascar's detention centres and prisons. Every week, MSF each week carries out medical and nutritional follow-up in seven of these centres. Conditions are deplorable. There is high mortality and morbidity. The prisons are overcrowded, unhygienic and insalubrious. Prison rations have been found to be insufficient and disease uncontrolled. MSF is also worried by the conditions faced by the detained minors who are often in what is known as preventive detention, where they remain for longer time periods than the law allows. The results of this abuse of justice are physical and mental ill health and poor growth rates. MSF is looking into the possibility of working with child judges in order to find a way to relax some of the detention regulations affecting minors.

Street children

The street children project in Antananarivo runs in collaboration with other aid agencies. MSF is trying to improve access to health care for street children through health centres and to supply medicine to these centres with the help of five local pharmacies and eleven local doctors. MSF's local partners also collaborate on a prevention programme to alert street children as to the hazards of sexually transmitted diseases (STDs) and AIDS which are spreading quickly because of the capital's developing sex industry. The programme benefits 3,500 children annually.

MSF has invested heavily in the problem of infant malnutrition in the capital. The team supports a network of 21 feeding centres which benefit 4,000 children a year, a network launched by the local

organisation, ASERN. MSF visits the feeding centres regularly in order to supervise and follow up the treatment. MSF also runs a training programme for national staff. A feeding programme was also launched in Morondava at the end of 1995 with a local agency. MSF also carried out a mother and child health care programme for a target group of 60,000.

Urban sanitation

In a poor quarter of the capital, inhabited by 36,000 people and regularly affected by flooding, MSF has developed a health and urban sanitation programme. The teams first focused on the health of the population by teaming up with local partner agencies to support local health centres, carry out epidemiological surveillance, train local health care workers, distribute health information on nutrition, diarrhoea and STDs. From 1996 onwards, MSF which was already working on the drinking water supply and upgrading the sanitation systems, began to support local efforts to dispose of waste, upgrade hygiene and introduce anti-plague measures.

Natural Disasters

In January 1996, MSF supplied drinking water and supported health structures following the Bonita Hurricane, which had a particularly devastating effect in the area surrounding East Fenoarivo. There were at least 4,000 medical consultations provided to the local population. MSF also set up an intensive feeding centre in Foulpointe which admits 200 children at a time.

International staff : 5
National staff : 69

MADAGASCAR



POP. IN YEAR 1994
14.3 m

POP. IN YEAR 2000
17.3 m

GNP PER CAPITA
220 USD

ADULT LITERACY RATE,
MALE/FEMALE
88%/73%

LIFE EXPECTANCY
56 yrs

0-5 MORTALITY RATE
164 per 1,000

POP. PER DOCTOR/NURSE
8,333/3,846

MEASLES VACC. COVERAGE
54 %

NO. OF REFUGEES/IDPs
n.a./n.a.



POP. IN YEAR 1994
27.3 m

POP. IN YEAR 2000
32.6 m

GNP PER CAPITA
270 USD

ADULT LITERACY RATE,
MALE/FEMALE
82%/62%

LIFE EXPECTANCY
56 yrs

0-5 MORTALITY RATE
90 per 1,000

POP. PER DOCTOR/NURSE
20,000/9,091

MEASLES VACC. COVERAGE
73 %

NO. OF REFUGEES/IDPs
252,400/210,000

International staff : 40

National staff : 361

REFUGEES, NOMADS AND DISPLACED

Daniel arap Moi, leader of the ruling Kenya African National Union (KANU) has been president since 1978. The opposition is threatening to boycott the elections in 1997 if the government does not introduce electoral and constitutional amendments. Although sectorally diverse by African standards, the Kenyan economy remains dominated by agriculture which still accounts for almost 30% of GDP.

Since the outbreak of civil war in Somalia (1991) very large numbers of refugees have been coming into Kenya. Most came in early 1992 into the North East Province. In Dadaab, MSF provides primary health care services for an estimated 120,000 Somali refugees in three hospitals and 10 health posts in Ifo, Dagahaley and Hagadera refugee camps. MSF runs an anti-tuberculosis programme, monitors for cholera and vaccinates refugees against other endemic diseases. MSF has set up a network of community health workers and traditional midwives in the camp dispensaries. Nutritional activities in the camps include weight/size monitoring and infant hospitalisation.

The Turkana nomads

In Turkana, Northwestern Kenya, MSF runs health assistance and nutritional programmes for the nomad population still recovering from the devastating droughts of 1990 and 1992. There is also a structural support programme for the ten dispensaries in south Turkana covering over 60,000 people. MSF supplies drugs to health structures and provides medical training. A vaccination programme has also been launched. MSF now intends launching a nutritional programme which would consist of dry supplementary feeding for six months to support the general food distribution operation organised by OXFAM.

AIDS/HIV education and treatment

MSF runs an AIDS education programme in Nairobi's Kibira slums. There is a marked endemicity of AIDS in Kenya. MSF plans to start up a curative care programme for HIV-

positive patients. An estimated 60 percent of deaths among HIV-positive people in Nairobi are caused by a failure to diagnose curable diseases for early treatment. MSF is working to improve Kibira's health services, particularly for women and under fives. The main objective of the programme is to help create a functional health system which could be taken over by local authorities.

Displaced Persons

In Rift Valley, Western and Nyanza provinces, MSF runs seven mobile clinics and three dispensaries to provide medical assistance to displaced and impoverished populations. Until March 1996, MSF worked in six health districts in the Rift Valley. This included three health centres, (two in Eldoret and one near Nakur) as well as 33 mobile clinics offering access to curative and preventive care for about 150,000 people, most of whom were displaced. Other health care centres received MSF support. In collaboration with the Kenyan ministry of health, MSF runs training programmes for traditional midwives. MSF also runs a sanitation project in the area.

MSF focuses strongly on the population of Burnt Forest and the south of Eldoret (a former centre of ethnic conflict). Here, MSF activity covers about 13,000 displaced. In February troubles flared up again - 6,000 people had to flee the camps. They regrouped nearby in groups of five to ten families to confront eventual attacks. MSF remains present in this zone with its mobile clinic. There were two emergency operations following conflict in Nyanza province. MSF also launched three vaccination campaigns against measles.

MSF STAYS ON AFTER UN PULLOUT

In March 1995, the United Nations troops pulled out despite the fact that there was still no recognised central government. Fighting continued in Mogadishu between rival militias, especially those of General Farah Aideed in the south and Ali Mahdi in the north. With the impact of war on the rural economy and shortages of every conceivable commodity in the cities, the monetary sector functions from day to day.

MSF supported the creation of a medical reference structure in the Medina enclave providing medical equipment, drugs and training. In both Wardigle and Medina, anti-measles campaigns were launched by MSF and the authorities. More than 15,000 children were vaccinated in Wardigle and 12,000 others in Medina. As security conditions worsened, MSF pulled out of South Mogadishu in late 1995.

In North Mogadishu, MSF works in the Yaqshid district providing health services for an estimated 102,000 inhabitants and to another 5,000 in 13 displaced camps. The project is mainly concerned with improving health care for the displaced. MSF's assistance focuses on preventive and curative health care for the most vulnerable section of the population particularly children. Activities include measles vaccination and a cholera response programme. MSF's mobile team is particularly useful for providing relief to the displaced. Other activities include the distribution of medicine and medical material to health structures, the training of local staff and the chlorination of drinking water.

MSF works in Kismayo General Hospital which has in-patient facilities for an estimated 120,000 people. MSF provides staff salaries, drugs and training. The team runs programmes to combat tuberculosis and cholera. MSF also supports cataract surgery performed by the Christoffel Blinden Mission.

Working with Somali Nomads

Before the arrival of MSF, there were no functioning health structures in Jowhar and

Aden Yabal. The target group in Jowhar is a nomadic, mainly Muslim population. An MSF mobile team aims to improve both mother and child health care and paediatrics. The team trains local staff and has established a reference system. The Aden Yabal project is run by locals paid by MSF and supervised on a monthly basis. Activities include disease prevention, health care assistance and training for the purposes of handing over the project to national staff. A mobile team reaches an estimated 20,000 people.

Hospital support in Bardera

In January 1996, MSF also intervened in Bardera, a town of 26,000 inhabitants which straddles the Juba river between the Kenyan border and Baidoa. A nutritional survey carried out in November 1995 revealed 22.1 percent global malnutrition and 6.4 percent severe malnutrition. MSF supports Bardera Hospital's general health and nutritional programmes. In March 1996, MSF intervened during a cholera outbreak.

MSF's programme in the self-declared independent state of Somaliland was handed over to another organisation in May 1996. MSF still supports a hospital and six outpatient clinics.

SOMALIA



POP. IN YEAR 1994
9.1 m

POP. IN YEAR 2000
10.8 m

GNP PER CAPITA
120x USD

ADULT LITERACY RATE,
MALE/FEMALE
36%/14%

LIFE EXPECTANCY
47 yrs

0-5 MORTALITY RATE
211 per 1,000

POP. PER DOCTOR/NURSE
n.a./n.a.

MEASLES VACC. COVERAGE
35 %

NO. OF REFUGEES/IDPs
n.a./300,000

International staff : 22

National staff : 213



POP. IN YEAR 1994
27.4 m

POP. IN YEAR 2000
32.1 m

GNP PER CAPITA
480x USD

ADULT LITERACY RATE,
MALE/FEMALE
53%/28%

LIFE EXPECTANCY
53 yrs

0-5 MORTALITY RATE
122 per 1,000

POP. PER DOCTOR/NURSE
n.a./n.a.

MEASLES VACC. COVERAGE
76 %

NO. OF REFUGEES/IDPs
727,200/4,000,000

International staff : 40

National staff : 413



P Slavenburg, South Sudan, 1993

THE PROBLEMS OF LIMITED ACCESS

President Omar Hassan al-Bashir won the March 1996 elections. Fighting continued between the security forces and a split Sudanese Peoples' Liberation Army (SPLA). Political opposition was suppressed and a state of emergency maintained. External relations worsened, notably with the United States and neighbouring Egypt and Eritrea. As in previous years, the difficulty in gaining access to populations in need remained acute.

The thousands of displaced in Maridi, Western Equatoria began to return to Bor during the year. MSF teams working in the region's clinics continued to focus on the endemic problems of tuberculosis and onchocerciasis (river blindness).

In Upper Nile province, MSF works in Akobo, Leer, Duar, Nimne and Toich. In 1995, following large-scale fighting, some 30,000 people fled their villages along the River Sobat to nearby Akobo district. Akobo has also received a smaller number of displaced from Jonglei. MSF activities there include the improvement and management of the rural hospital, the implementation of the Expanded Programme for Immunisation (EPI) which targets more than 100,000 people, the introduction of a health and monitoring information system, an emergency preparedness programme and an anti-tuberculosis programme.

Tropical disease

In Bahr el Gazal, MSF set up a mobile project in 1995 covering two dispensaries west of Wau with a major programme for river blindness. MSF also worked in two dispensaries east of Wau which were burned down in the second half of 1995. The mobile programme was set up in order to cover a maximum number of people whose health care services had been badly affected by political instability. It was combined with a Guinea worm control programme.

Since 1988, MSF has been involved in the treatment of Kala Azar, a disease which has

claimed tens of thousands of victims in southern Sudan. The team treats patients in special clinics in Leer, Duar and Khartoum. MSF carries out research on the origin and spread of this disease, and gives support to other agencies working with Kala Azar patients.

The shantytowns of Khartoum

Over a million displaced people are living in wretched conditions in shanty towns around the capital Khartoum. The destruction of these shantytowns began in 1989. The displaced were then forcibly relocated to government-designated camps far outside the city. MSF provides aid in a number of these camps, which are virtually without any facilities. Besides giving information on health and hygiene and providing maternal and paediatric care, MSF sees to the provision of drinking water and sanitary facilities. In 1995, many displaced camps were demolished leaving thousands homeless. MSF opened a clinic and a feeding centre close to where the authorities destroyed the Angola camp.

MSF runs a dispensary for 30,000 displaced in Mayo. A feeding programme was launched for children. The second round of a mass measles campaign took place in August 1995. MSF provides assistance to 30,000 displaced in Wad El Beshir where it runs a dispensary. In 1996, an anti-measles campaign was launched. A dispensary was also opened in the El Salam Ondurman displaced camp and teams support another in Ondurman and in Djebel Aulia.

MSF also works in Meiram in Kordofan province, North Sudan, which is very close to the fighting. Meiram has a population of 25,000 people, of which 18,000 are displaced and have been benefiting from MSF assistance since January 1996. A clinic is providing health care to the displaced and the local population. A centre for the treatment of acute diarrhoea was set up in May 1996 and the team carried out a measles vaccination campaign in July 1996. In July 1996, MSF began to provide medical assistance in Dilling for an estimated population of 50,000.



P Slavenburg, South Sudan, 1993

RWANDAN REFUGEES IN FOCUS

The October 1995 elections were won by the ruling Chama Cha. A new government was formed by President Benjamin Mkapa. Tanzania is still host to 500,000 Rwandan refugees who fled in the wake of the genocide.

One of the biggest MSF interventions in recent years was launched in the refugee camps of Tanzania, Burundi, and Zaire during and after the Rwandan genocide in 1994. However, like in Goma, Zaire, the extensive project in N'Gara, Tanzania, became unsustainable after the initial emergency phase when it became clear that the camp leaders, many of whom participated in the genocide, were effectively holding the refugees hostage and controlling food distribution and other aspects of camp life. Under these circumstances, MSF decided to terminate its work in the N'Gara camps in August 1995.

During all of 1995, MSF still worked in the Rwandan refugee camps in the district of

Karagwe in Tanzania, where 57,000 refugees were distributed among the three camps of Murongo, Kagenyi and Rubwera. Assistance to the refugees first involved the screening of new arrivals, vaccinations and medical and nutritional assistance. In addition, a rigorous insecticide campaign was initiated by the MSF team to fight malaria, the most prevalent health problem in the camps which are located in a marshland. In the second phase there was much more emphasis on prevention and health education, mother and child health care, and prevention of HIV/AIDS and other sexually transmitted diseases. After the decision was made to phase out the project in early 1996, MSF began to focus on training programmes for Rwandan and Tanzanian health workers.

TANZANIA



POP. IN YEAR 1994
28.9 m

GNP PER CAPITA
90 USD

ADULT LITERACY RATE,
MALE/FEMALE
75%/50%

0-5 MORTALITY RATE
159 per 1,000

POP. PER DOCTOR/NURSE
24,880 / 5,470



POP. IN YEAR 1994
20.6 m

POP. IN YEAR 2000
24.6 m

GNP PER CAPITA
180 USD

ADULT LITERACY RATE,
MALE/FEMALE
70%/44%

LIFE EXPECTANCY
45 yrs

0-5 MORTALITY RATE
185 per 1,000

POP. PER DOCTOR/NURSE
25,000/7,143

MEASLES VACC. COVERAGE
77 %

NO. OF REFUGEES
286,500

THE CURSE OF THE TSETSE FLY

President Yoweri Museveni was re-elected in the May 1996 elections. Uganda's northern regions remained politically unstable, with armed clashes between the security forces and armed opposition groups supported by the Sudanese government. The economy remained burdened by payments on the foreign debt.

Trypanosomiasis Gambiense (sleeping sickness), the debilitating illness carried by the tsetse fly, is prevalent in northern Uganda. A centre in Adjumani, East Moyo, where MSF teams diagnose, screen and treat the disease, has been operational since the autumn of 1991. Over the past year, most patients have come from nearby Gulu where insecurity prevents MSF from launching a programme. Training of local staff began in early 1996 in preparation for the handover phase. Mobile teams continued to screen local populations in Adjumani until the beginning of 1996. The hospitalisation of sleeping sickness patients ended in June. MSF teams continued to supervise the work of local staff in West Moyo until November 1995. In Omugo, in the district of Arua, an MSF centre opened in September 1995. In the first four months, 2,219 patients were screened and 212 cases of sleeping sickness

detected. There are approximately 70 inpatients. Their number is expected to stabilise in the second half of 1996, when the teams will make the move from passive screening towards active screening.

In July 1995, MSF stepped up efforts to screen refugees for sleeping sickness. A fixed screening post was installed at registration points for new arrivals in the camps in Kator and Ogujebe.

Sudanese Refugees

Since August 1993, MSF has run a relief programme for Sudanese refugees in the border town of Koboko. MSF provides curative and preventive assistance in transit centres, which have held up to 120,000 refugees at any time. The relief programme mainly concentrates on the provision of supplementary food to undernourished children and the improvement of sanitary facilities. MSF has set up health posts in seven refugee camps. At the end of 1995, the UNHCR began planning to relocate the camp to a more permanent site.

In East Moyo, Northern Uganda, MSF provides medical assistance to thousands of Sudanese refugees. The MSF programme centres around four different activities: health promotion, curative services, local staff training and the handover of dispensaries to health authorities. With the planned closure of the camps, the stable health situation and the low prospect of a new influx of any great size from South Sudan, MSF is planning to hand over the programme. In East Moyo, given the resettlement of large numbers of refugees, MSF will focus more on long-term aid.

SLEEPING SICKNESS

Human African Trypanosomiasis (sleeping sickness) is found exclusively in the inter-tropical region of Africa (from 20° north to 20° south of the equator). WHO estimates that 55 million people in 36 African countries are at risk. This debilitating illness is caused by two types of parasite transmitted by the tsetse fly. Although the Trypanosoma gambiense only infects humans, the Trypanosoma rhodesiense shares its cycle with humans, cattle and wild animals. Without treatment, both types are fatal - the rhodesiense usually within a year, and the gambiense

within two to three years or more. Farmers, fishermen and hunters are the main victims as they are the most exposed to the tsetse fly.

Very limited research has been done in the past few years and treatment still relies on expensive drugs which have been around for a long time. Vector control methods include the use of tsetse-fly traps, requiring a very high level of community participation. As with malaria, population displacement can contribute towards reactivating latent trypanosomiasis foci.

SOUTHERN AFRICA

AFRICA



G Turine, Angola, 1996



ACCESS IMPROVES WITH CEASEFIRE

In February 1996 the two principal political and military groupings, National Union for the Total Independence of Angola (UNITA) and Peoples' Movement for the Liberation of Angola (MPLA) agreed to respect the ceasefire of November 1994. UNITA still controlled most of the Angolan territory, but almost none of the big towns. Exports plummeted to nothing apart from oil, public sector strikes were widespread and there was racing inflation.

Better security conditions in 1996 enabled MSF to extend its aid operations to 12 of Angola's 18 provinces. MSF's main objectives inside this war-ravaged country are to reduce malnutrition and improve access to health centres.

In May 1995, MSF relaunched an intensive feeding centre in Benguela town. Malnutrition once again soared in this area owing to its inaccessibility and the fact that inflation had pushed up food prices. At the beginning of 1996, there were 150 admissions per month, three months later this figure had almost tripled. MSF runs feeding programmes in almost every province. The most successful programme was the one carried out in Huambo town until April 1996. However, Huambo is a showcase area in that it is not heavily mined, is very accessible and has benefited from enormous outside investment. Food aid remains a necessity throughout the rest of the country and will most likely continue to do so for the foreseeable future.

MSF is launching, relaunching and working in health centres and hospitals throughout Angola. The country no longer has a functioning Ministry of Health and its public health service has been destroyed by years of war. Over the last year, MSF has managed to bring health services to areas where the population has gone without any health assistance for three, four and five years. The needs are enormous in war ravaged enclaves such as Kuito, where thousands of amputees await prosthesis. MSF manages the provincial hospital and almost all its services, including surgery. MSF provides medical assistance in health centres and hospitals in Luanda, Huila, Kaala, Benguela, Uige, Bié, Moxico, Kwanza Norte, Zaire, M'Banza Congo and Huila.

MSF runs training programmes for local personnel and ensures the supply of medication and medical material to health structures. Angola has one of the highest maternity-mortality rates in the world partly due to a lack of qualified personnel. In Cazenga in 1995, MSF started to implement a pilot project where the local population pays a fixed sum for the medical services in these health centres. The money is later shared amongst the Angolan medical staff.

A breeding ground for epidemics

Epidemics remain a problem in Angola given the inadequacies of the health services, food shortages and the inaccessibility of so many zones. During the rainy season, cholera cases regularly shoot up in Angola's capital, Luanda, often leading to epidemics. An MSF team is on permanent stand-by in Luanda to deal with such epidemics. MSF chlorinates water for a target group of up to 800,000 inhabitants.

In N'Dalatando, Kwanza Norte, in the northwest of Angola, trypanosomiasis (sleeping sickness) is endemic. Unfortunately, war has resulted in the isolation of many villages where up to 50 percent of the population suffer from this mortal illness. MSF teams treat this illness and provide training for local staff. In Maquela Do Zombo in Uige province, MSF opened a sleeping sickness centre in February 1996.

Near the Zairian border in Uige province, MSF provides medical assistance in a transit camp for Angolan refugees returning from Zaire.



POP. IN YEAR 1994
10.7 m

POP. IN YEAR 2000
13.1 m

GNP PER CAPITA
700 USD

ADULT LITERACY RATE,
MALE/FEMALE
56%/29%

LIFE EXPECTANCY
46 yrs

0-5 MORTALITY RATE
292 per 1,000

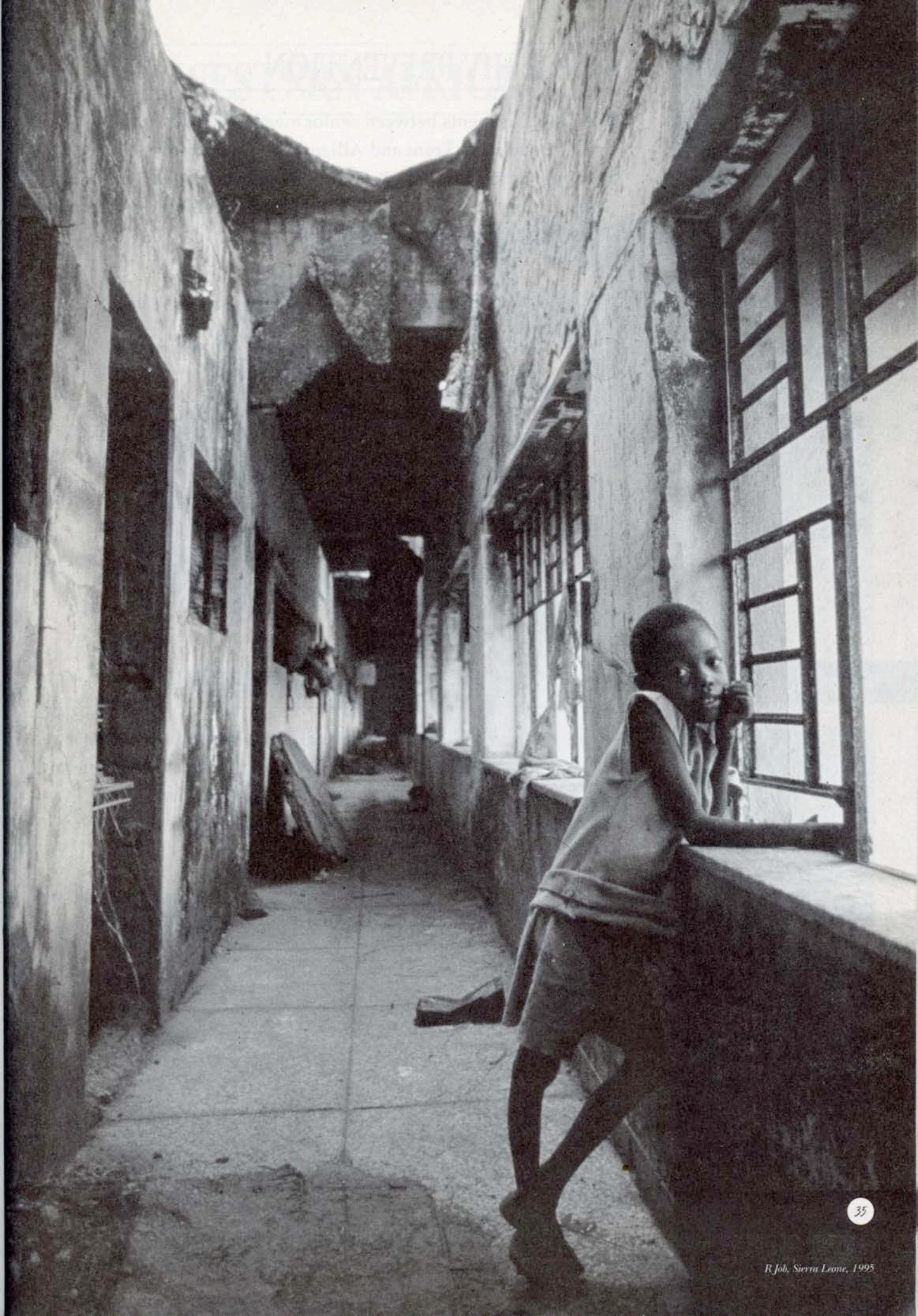
POP. PER DOCTOR/NURSE
25,000/ n.a.

MEASLES VACC. COVERAGE
44 %

NO. OF REFUGEES/IDPs
10,700/1,500,000

International staff : 86

National staff : 794



MALAWI



POP. IN YEAR 1994
10.8 m

GNP PER CAPITA
200 USD

ADULT LITERACY RATE,
MALE/FEMALE
69%/37%

0-5 MORTALITY RATE
221 per 1,000

POP. PER DOCTOR/NURSE
50,000/33,333

AIDS & HIV PREVENTION

Open disagreements between senior members of the ruling United Democratic Front and Alliance for Democracy threatened the future of the coalition. President Bakili Muluzi took concerted action in early 1996 to combat violent crime and get the fiscal deficit and inflation under control.

MSF runs an HIV/AIDS project in the Mwanza district in southern Malawi. The local population consists of approximately 180,000. Teams work in a 120-bed hospital and in 13 local health centres, ensuring that those already infected with HIV or other sexually transmitted diseases (STDs) receive appropriate treatment.

As is often the case in MSF-run HIV/AIDS projects, the emphasis is placed on prevention. The project mainly focuses on education in the local communities.

However, another important aspect of MSF prevention programmes is the training and supervision of medical and non-medical staff in the hospital and health centres.

A feeding programme which MSF ran in the Mwanza district closed in December 1995 as the number of admissions had dropped sharply.

International staff : 5

National staff : 94

MOZAMBIQUE



POP. IN YEAR 1994
15.5 m

GNP PER CAPITA
90 USD

ADULT LITERACY RATE,
MALE/FEMALE
52%/19%

0-5 MORTALITY RATE
277 per 1,000

POP. PER DOCTOR/NURSE
33,333/5,000

MINES - THE WAR AFTER THE WAR

The opposition, Resistencia Nacional Mocambicana (RENAMO) continued to undermine the authority of the government Frente para a Libertacao de Mocambique (FRELIMO). Economic problems gave rise to urban unrest. The GNP per capita in Mozambique remained very low, at 90 USD

The priority for MSF in Mozambique today is to assist the national authorities in the reconstruction of a basic health care system. Approximately 30 per cent of the country's medical structures were destroyed during the 16 year long civil war. MSF runs medical projects in the provinces of Manica, Zambezia, Gaza and Maputo.

One of the most devastating effects of the war are the landmines. MSF ran an awareness programme in the seven districts of Maputo province for populations at risk from mine accidents, which reached 200,000 people. It was terminated at the end of 1995, but MSF has assisted in the

creation of 84 local committees which are going to continue the work. During the year, MSF also identified 155 mine sites in the country.

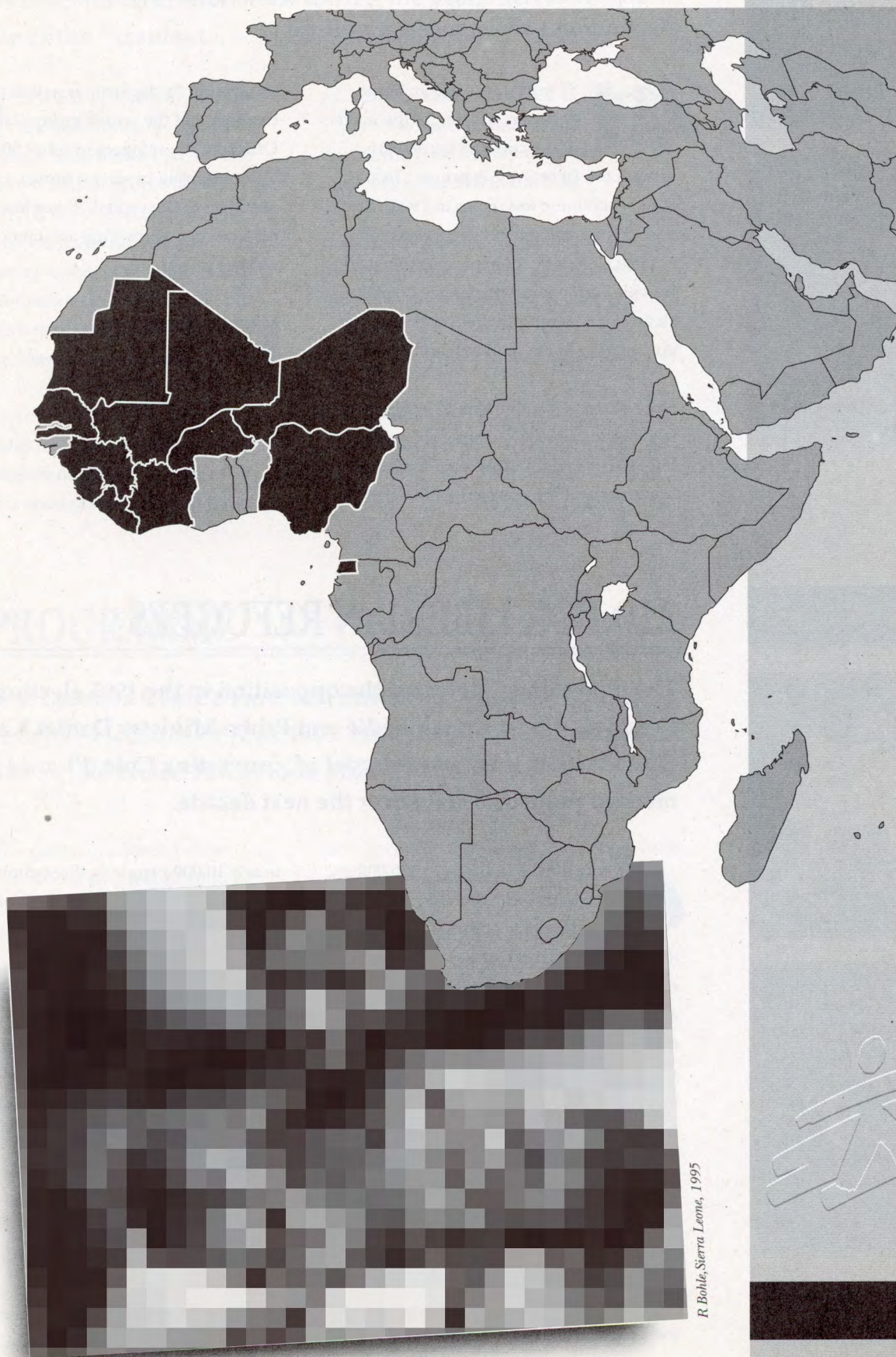
The project for the monitoring of food levels, food distribution and nutrition in the country's ten provinces continued. MSF's *Consolidated Information System* (CIS) has a team evaluating nutrition levels by collecting of pertinent statistics from 120 districts and in this way anticipating the likelihood of famine and drought.

International staff : 37

National staff : 468

WESTERN AFRICA

AFRICA



R Bohlé, Sierra Leone, 1995

BURKINA-FASO



POP. IN YEAR 1994
10.1 m

GNP PER CAPITA
300 USD

ADULT LITERACY RATE,
MALE/FEMALE
26%/7%

0-5 MORTALITY RATE
169 per 1,000

POP. PER DOCTOR/NURSE
33,333/10,000

ASSISTANCE TO THE TOUAREGS

Mr. Roch Marc Christian Kaboré, the prime minister, leads the Front Populaire (FP). There is a great deal of short-term and long-term economic migration, particularly to neighbouring Côte d'Ivoire and Ghana. Over 80% of the population of Burkina Faso depend on subsistence agriculture.

MSF works primarily in Soum province, situated in the north of the country, particularly around the Djibo area. A primary health care programme was set up in 1995. At the end of that year another team went in to combat a cholera epidemic and returned to provide curative and preventive care for the victims of a meningitis epidemic which appeared in Soum in March and April 1996.

Since March 1994, Burkina-Faso is host to tens of thousands of Touareg refugees who left Mali as a result of the resumption of hostilities and the massacre of the civilian

population by the army as well as the extremists of the armed group Ganda Koy. Officially, the refugees number 50,000. They are living in several provinces and in and around the capital. Since March 1996, MSF has been providing assistance in the refugee camps.

International staff : 9

National staff : 8

COTE D'IVOIRE



POP. IN YEAR 1994
13.8 m

GNP PER CAPITA
630 USD

ADULT LITERACY RATE,
MALE/FEMALE
44%/24%

0-5 MORTALITY RATE
150 per 1,000

POP. PER DOCTOR/NURSE
11,111/3,226

AID FOR LIBERIAN REFUGEES

The government defeated the opposition in the 1995 elections. President Henri Konan Bédié and Prime Minister Daniel Kablan Dunaca set themselves the goal of converting Côte d'Ivoire into a modern industrial state over the next decade.

Côte d'Ivoire is home to 330,000 Liberians who fled the civil war in their home country. These people do not enjoy refugee status and are still considered "visitors." Many live dispersed around the villages of the Tabou/Nigré region. However, in August 1995, a refugee camp for Liberians was opened in Guiglo, where MSF runs a dispensary and provides the refugees with medical and sanitation assistance. MSF also runs a medical programme with four health posts, one health centre and a therapeutic feeding centre.

In July 1995, a cholera epidemic broke out in Abidjan's Macca prison and soon after in the Guiglo and Tabou regions. MSF treated

nearly 10,000 people in three cholera camps and at several rehydration posts along the border.

In early 1996, MSF vaccinated 80,000 people against yellow fever in Tabou / Grabo. Shortly afterwards, a polio vaccination campaign was carried out for 2,300 children in Goson. This intervention was followed by a vaccination campaign against polio in February 1996 in the Goson region.

Côte d'Ivoire is also the base for MSF's activities in Liberia.

UPGRADING THE HEALTH CARE SYSTEM

Teodoro Obiang Nguema Mbasogo was re-elected president in February 1996. International observers described the elections as being unfair. Moreover, Equatorial Guinea changed both its Constitution and its electoral law during the year, increasing the mandate of the President.

MSF runs a project in the Bata district providing support to the local health care system. Approximately 20,000 people benefit from the project. Its main objective is to improve the health of the population by strengthening and developing the existing system. Mother and child health care is a special focus of MSF's efforts, and the aim is to bring down the high mortality rates in the area.

MSF has also helped to develop a health care management system and has launched a management training scheme

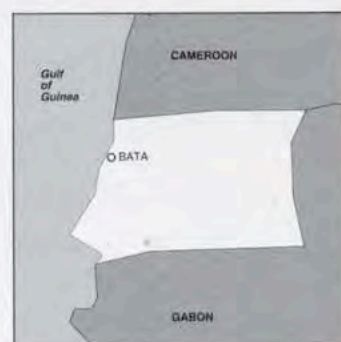
in Bata. Training courses for sanitation experts were successfully completed during the year, and led to greatly improved standards in the area.

Since the beginning of 1996, MSF has been preparing and developing a new project in Equatorial Guinea which focuses on health education in schools. The project will be operational in late 1996.

International staff: 1

National staff: 9

EQUATORIAL GUINEEA



POP. IN YEAR 1994
0.4 m

GNP PER CAPITA
340 USD

ADULT LITERACY RATE,
MALE/FEMALE
90%/68%

LIFE EXPECTANCY
48 YRS

MEASLES VACC. COVERAGE
44 %

TB PROGRAMME

President Lansana Conté's Parti de l'unité et du progrès won the Parliamentary elections of June 1995. However, an attempted coup d'état led by the armed forces took place in February 1996.

The civil war in Sierra Leone produced an influx of another 50,000 refugees in 1995 to

Gueckedou and the coastal region. MSF supports the facilities provided for the refugees by the government. Teams supervise and monitor the existing health care programmes and ensure adequate levels of nutrition.

In 1995, MSF's technical assistance programme in Upper Guinea included the relaunch of three hospitals and 30 health posts in four sub-prefectures. The programme came to an end in December 1995.

Tuberculosis treatment programmes run in Conakry, Mamou and Labé, benefiting

both the local populations and people from neighbouring prefectures.

MSF carried out emergency interventions in Guinea during a cholera epidemic in 1995. The epidemic was particularly acute in the five prefectures where MSF works: most notably in Macenta and Conakry. Teams also provided support to local health care authorities following cholera outbreaks in Kankan and Siguiri. MSF set up an emergency stock during the year, to be used for future cholera epidemics.

International staff: 29

National staff: 231

GUINEA



POP. IN YEAR 1994
6.5 m

GNP PER CAPITA
500 USD

ADULT LITERACY RATE,
MALE/FEMALE
45%/18%

0-5 MORTALITY RATE
223 per 1,000

POP. PER DOCTOR/NURSE
7,692/n.a.



POP. IN YEAR 1994

2.9 m

POP. IN YEAR 2000

3.6 m

GNP PER CAPITA

450x USD

ADULT LITERACY RATE,
MALE/FEMALE

49%/18%

LIFE EXPECTANCY

55 YRS

0-5 MORTALITY RATE

217 per 1,000

POP. PER DOCTOR/NURSE

n.a./n.a.

MEASLES VACC. COVERAGE

44 %

NO. OF REFUGEES/IDPs

120,000/1,200,000

International staff: 92

National staff: 1,303

MSF SUSPENDS PROGRAMMES IN LIBERIA

The civil war in Liberia, which is entering its seventh year, has devastated the country and its population of 2.5 million population. 150,000 Liberians have been killed, 700,000 are refugees and 800,000 are internally displaced. The ECOMOG peace keeping troops are neither keeping the peace nor protecting the population, while armed factions keep proliferating. The political system has collapsed and the economy is in a shambles. All basic services depend on external humanitarian assistance.

after seven years of providing humanitarian medical assistance to the victims of the war, MSF was

appalled by the abuse perpetrated against the civilians in April 1996 and by the lack of respect shown towards aid workers.

Consequently, MSF has withdrawn from all programmes and is only providing vital assistance in acute emergency situations.

Since December 1995, MSF has relaunched two health posts in Juahzon and Panama and a hospital in Greenville in the inaccessible Sinoe region. MSF also ran a hospital in Buchanan, Grand Bassa. MSF works in Upper and Lower Margibi. In Bong Mines, MSF reopened a dispensary, whereas in Bong and Nimba, teams constructed and renovated health structures. In December 1995, MSF launched a programme in Nimba centred around peripheral hospitals and dispensaries. Tapeta hospital was reopened by MSF in March 1996. MSF ran clinics and a hospital to the east of Upper Nimba for 130,000 people. A team also carried out a cross border operation from Macenta, Guinea, to support ten out-patient clinics and one hospital and another launched five clinics close to the Sierra Leonean border for 350,000 people.

Half of the 700,000 inhabitants of Monrovia were covered by two hospitals and twelve clinics, supported by MSF and a national aid agency, MERCI. In both the MSF-run hospitals of Swedrelief and Redemption, nearly 800 patients were admitted each month. MSF coordinated an ambulance system for the city and supported an AIDS programme.

In December 1995, MSF launched a vaccination programme to combat yellow fever for 1.5 million people. The campaign was launched in Monrovia, Bong, Margibi and Cape Mount provinces, although it was disrupted by fighting. A similar campaign for 90,000 was also carried out in Buchanan in November 1995 following an outbreak. In March 1996, a joint vaccination campaign against yellow fever and measles was launched in the Sinoe region covering 25,000. In Upper and Lower Margibi, MSF ran a vaccination campaign against yellow fever for 168,000 and opened cholera treatment centres. Several vaccination campaigns were also carried out in Greenville.

Assistance for the displaced

In Buchanan, there are 55,000 displaced persons, for whom MSF organised sanitation and the rehabilitation of shelters. Three health centres were set up inside the city and another outside. MSF also ran two mobile teams in the surrounding area. A team also lent its support to the Buchanan government hospital, the only reference hospital outside Monrovia. A cholera camp was constructed in October 1995. The project to assist the displaced in the capital was expanded to include a number of surrounding areas. In Cape Mount, MSF provided assistance and support to health structures for Sierra Leonean refugees.

In late 1995, a feeding programme was launched in Bong County with the creation of seven feeding centres. MSF also launched feeding programmes out of Greenville hospital.

Emergency activities in Monrovia

On 6 April, 1996, fighting erupted again in Monrovia and MSF felt obliged to withdraw its teams. MSF sent a sized-down emergency team back to the capital to address the most urgent needs. MSF support continued in Swedrelief and Redemption hospitals where national staff had continued to work during the worst of the fighting. A surgical team assisted the hospital staff in coping with the influx of war wounded, civilians and combatants.

Alongside other agencies, MSF provided medical and water/sanitation assistance in Greystone displaced camp. MSF set up a clinic, a cholera unit, dug latrines and organised water supply and waste disposal. Hundreds of cholera cases were treated. MSF provided medical assistance to the 200,000-strong population around the Barclay Training Centre.

MEASLES

Measles remains a major cause of childhood mortality throughout the world, especially in developing countries. Although it is contagious disease, its inclusion in the Expanded Programmes on Immunisation (EPI) since the 1970s has significantly contributed to reducing both morbidity and mortality rates in most countries. Nonetheless, WHO estimates that in 1993, there were 45 million cases and 1.2 million deaths from measles. There are wide regional variations in vaccine coverage: 19 countries, mainly in Africa, report below 50 percent coverage.

The current measles vaccine protects 85 to 95 percent of children when administered at over nine months. The vaccine may also reduce the severity of the disease if administered within three days of exposure. The clinical symptoms of measles are: a generalised rash

lasting three days or more, fever and either a cough, runny nose or red eyes. In all cases, fever must be treated, fluid intake increased, good oral hygiene encouraged, a prophylaxis given against conjunctivitis (eye ointment) and Vitamin A given to lower the mortality risks. Death from measles is often due to complications such as pneumonia, gastroenteritis, severe malnutrition and meningoencephalitis.

Many of the risk factors for the easy transmission and severity of measles are present in refugee settings: overcrowding, inadequate shelter, poor sanitation, lack of water, high prevalence of malnutrition, and vitamin A deficiency. However, WHO reports fewer measles epidemics among refugees since 1990 as a result of a combination of mass immunisations and early case management.

COMBATTING BLINDNESS IN MALI

A new political alliance between PARENA and ADEMA was announced in February 1996. At least 6,000 of the Touareg and Arab refugees who had fled to neighbouring countries returned to Mali voluntarily during the year.

In the eastern part of Mali, MSF runs a food distribution project. The 65,000 beneficiaries, who live by the Niger River, have had no harvest for two years, first because of armed conflict and then because of poor climatic conditions. MSF's aim is to help the local population relaunch agricultural activity.

MSF's ophthalmological project in Tombouctou has been so successful that the organisation has decided to launch a similar project to combat blindness in Koulikoro, 80 kilometers from Bamako.

In the Assongo district, near Gao in the north of the country, MSF helps rehabilitate the local health structures. The activities include distribution of medicines, training of local staff, provision of medical care, and logistical support.

In the second half of 1995, MSF intervened in Mali to assist the victims of cholera and meningitis epidemics. The teams provided both medical and logistical support.

International staff: 7

National staff: 8

MALI



POP. IN YEAR 1994
10.5 m

GNP PER CAPITA
270 USD

ADULT LITERACY RATE,
MALE/FEMALE
33%/17%

0-5 MORTALITY RATE
214 per 1,000

POP. PER DOCTOR/NURSE
20,000/5,882

VIRAL HAEMORRHAGIC FEVER

Viral haemorrhagic fevers (VHF) are caused by different viruses, some associated with arthropods and rodents. In humans, the infections are usually mild but may become severe or fatal, and some have led to devastating epidemics. Although each VHF has its own specific clinical profile, all show a tendency to bleed with the risk of severe haemorrhage and shock. They have high epidemic potential, high case-fatality rates

and are difficult to treat or prevent. The most common are yellow fever and dengue, and also include Lassa fever, Rift Valley fever and Ebola. Effective vaccines are available only for yellow fever and Rift Valley fever. In refugee situations, vector control can be very successful. Protection is absolutely essential for health staff and patients must be strictly isolated.

MAURITANIA



POP. IN YEAR 1994
2.2 m

GNP PER CAPITA
500 USD

ADULT LITERACY RATE,
MALE/FEMALE
47%/24%

0-5 MORTALITY RATE
199 per 1,000

POP. PER DOCTOR/NURSE
16,667/2,273

MALNUTRITION IN CAMPS

In October 1995, the Mauritanian government invited the 50,000 Mauritians expelled in 1989 to return from Senegal. Mining and fisheries account for almost all exports. Local food production is inadequate and droughts and locust attacks common.

MSF continues to run medical assistance and preventive care projects in the two refugee camps of Aghor and Bassikounoun. However, given the large repatriations of refugees to Mali at the end of 1995, MSF focuses on its assistance programme in Bassikounoun. Malnutrition continues to be a serious problem in the camps. In August 1995, the UNHCR and non-governmental organisations interceded with the WFP in order to re-establish a ration of 1900 kcal per refugee and day. In February 1996, MSF carried out a nutritional survey and active

diagnosis for malnourished refugee children in Mauritania.

In addition to its work with refugees, MSF answered a call from the Mauritanian government in early 1996 to provide badly-needed primary health care assistance in Nouakchott and Nouadhibou.

International staff : 5

National staff : 76

NIGER

A NEW EPIDEMIC

The south of Niger falls within the meningococcus meningitis belt. Epidemics tend to appear during the dry season which lasts from November to April. Following news of a new meningitis epidemic and a cholera outbreak, MSF sent a team to the affected districts in March 1996. Upon its arrival, the team learned that there had been a total of 6,956 cases of meningitis and 1,437 cases of cholera. MSF provided financial support and followed up on the cholera cases. However, as the national authorities appeared to have the meningitis in hand, the MSF team left after several weeks.

MENINGITIS EPIDEMIC KILLS THOUSANDS

In October 1995, Nigeria's Head of State General Sani Abacha, chairman of the military Provisional Ruling Council, announced a three-year transition to civilian rule. His announcement was widely considered too protracted. Nigeria continued to be criticised by Western governments for human rights violations during the year, particularly for the execution of author Ken Saro-Wiwa and others.

In February 1996, MSF launched a massive intervention in Nigeria following the outbreak of a meningitis epidemic in 17 northern states. A total of 50 million people live in the northern part of the country. This was the first time MSF intervened in a meningitis epidemic on this scale and in such a densely populated region.

The project objectives were both preventive and curative: to vaccinate 4.4 million people against meningitis and to treat people with symptoms in specially created treatment centres. In the three states where MSF was active - Bauchi, Katsina and Kano - 46,000 cases of meningitis and almost 5,000 deaths were registered between January and April 1996.

Early on, the MSF teams became aware that the meningitis was tied to a cholera epidemic, and that measles was also present in certain areas. Therefore, cholera treatment centres were set up immediately and rehydration treatment begun. In order to stem the measles epidemic, MSF sent 400,000 vaccines to Kano town on 12 March. This vaccination project began at the same time as the meningitis vaccinations. By 31 March, a total of 11,600 measles vaccinations were distributed to a target group of 125,000 children. Unfortunately, authorisations were not received for measles vaccinations elsewhere.

The emergency intervention in Nigeria ended in June 1996.

International staff: 20

NIGERIA



POP. IN YEAR 1994
108 m

POP. IN YEAR 2000
129 m

GNP PER CAPITA
300 USD

ADULT LITERACY RATE,
MALE/FEMALE
61%/39%

LIFE EXPECTANCY
50 yrs

0-5 MORTALITY RATE
191 per 1,000

POP. PER DOCTOR/NURSE
5,882/1,639

MEASLES VACC. COVERAGE
41 %

NO. OF REFUGEES/IDPs
6,000/n.a.

MENINGITIS

Meningococcal meningitis is a bacterial infection occurring globally. Some endemic countries have reported an increasing number of cases over the last decade. Countries in sub-Saharan Africa (the so-called meningitis belt) have experienced large outbreaks every 8 to 12 years, with intervals between major epidemics decreasing since the beginning of the 1980s. The possibility of a new epidemic cycle in the mid-1990s, seems to be confirmed by those epidemics reported in 1996 in Burkina-Faso and Nigeria.

Transmission is through direct contact, including respiratory droplets from the nose and throat of infected carriers. Most infections are subclinical and many of those infected become symptomless

carriers. The disease is characterised by sudden onset of intense headache, fever, nausea, vomiting, photophobia and stiff neck. Neurological signs include lethargy, delirium, coma and/or convulsions. Identification is mainly via laboratory tests of cerebrospinal fluid. Case fatality rate is between 5 and 15 percent if diagnosed early and given adequate therapy, but may exceed 50 percent without treatment. The most cost-effective and practical treatment is a single dose injection of chloramphenicol in oily suspension. Meningitis surveillance should be routine in every refugee situation and immunisation should start as soon as possible after the onset of an epidemic.



R Bohle, Nigeria, 1996

THE BLOODSHED CONTINUES



POP. IN YEAR 1994
4.4 m

POP. IN YEAR 2000
5.1 m

GNP PER CAPITA
150 USD

ADULT LITERACY RATE,
MALE/FEMALE
40%/14%

LIFE EXPECTANCY
39 yrs

0-5 MORTALITY RATE
284 per 1,000

POP. PER DOCTOR/NURSE
n.a./n.a.

MEASLES VACC. COVERAGE
46 %

NO. OF REFUGEES/IDPs
15,900/1,000,000

The civil war in Sierra Leone has lasted for five years. Parties in the conflict include the rural based rebel army the Revolutionary United Front (RUF) under the leadership of Corporal Foday Sankoh and the government army and many other factions, including Liberians and South African mercenaries fighting on the government side. Sierra Leone is one of the poorest countries in the world today, despite enormous natural resources such as diamonds, gold, ore and bauxite.

General Valentine Strasser was ousted by General Julius Maada Bio in a military putsch in January 1996, but was allowed to seek asylum in Guinea. Bio paved the way for a new democratisation process. In February and March 1996 free multi-party elections took place and a new civilian president was elected. In April, the new president, Ahmed Tejan Kabbah, was sworn in committing himself to fighting violence, greed and corruption. It is now hoped that the newly-installed government will be able to continue the recently initiated peace talks with the leader of RUF, Foday Sankoh. Unfortunately, it will not be easy to organise demobilisation on either side because neither the government nor the RUF control their poorly paid troops. Observers fear for the worst - with or without a peace agreement. It is highly likely that the many splinter groups will continue the war.

Huge population displacement

Since the outbreak of the civil war nearly two million of the estimated 4.4 million inhabitants have fled their homes and villages. Hundreds of thousands of civilians fled to neighbouring countries such as Guinea or Liberia (about 370,000), but most of them (about 1.6 million) have become displaced in their own country, especially in the bigger cities such as Freetown, Kenema, Bo and Makeni, where the local infrastructure cannot cope with the number of displaced. Before the war begun, Freetown had 250,000 inhabitants, but it now has 1.5 million. Kenema had 45,000 inhabitants before the war, but the current figure stands at 120,000. There may now be as many as 200,000 people in Bo, when before the war it had a population of 40,000.

Living conditions are precarious for the displaced. This, in combination with generally bad sanitary conditions, can easily lead to outbreaks of epidemics such as cholera. Despite the brokered ceasefire and although the displaced are living in pitiful conditions, only very few are ready to go back to their region of origin. Most of them fear that those rebels, who are still hiding in the bush and who are known to have committed atrocities, will not surrender voluntarily for fear of retaliation or punishment. The reintegration and demobilisation of soldiers will certainly be one of the most difficult tasks of the new government.

In the countryside many people were killed, tortured, mutilated, raped or forced to join the rebel troops. The conflict is therefore characterised by a total lack of protection of the civilian population and by grave human rights violations. Atrocities have been committed by all parties.

The destruction of the health care system

During the civil war most existing health structures were destroyed upcountry, and those not burned down were abandoned by their staff. Moreover, national health structures no longer work effectively due to the lack of motivation by the local staff who are poorly paid and equipped. In Kenema, for example, less than 50 percent of the capacity of the Government Hospital is being used at the moment. Reportedly, absenteeism among the health care staff is high. Health centres continue to function because the local staff buys drugs on the local market and sells them again to the patients. By doing so they can keep the health centre running.



R Job, Sierra Leone, 1995

Massive nutritional problems in Kenema

In August 1995, MSF started a feeding programme for refugees in and around the city of Kenema in the southeast of Sierra Leone because the intensity of fighting in this area had given rise to an emergency situation. Research showed that infant mortality in the city was six times the normal rate. MSF saw that there was a great shortage of medicines and medical material and the health-care system was no longer able to meet existing needs. Three feeding centres for malnourished children were opened. MSF also organised a vaccination campaign against measles.

Cholera in Freetown

MSF arrived in Freetown in April 1995. After having taken over a dispensary in the camp, the cholera epidemic which struck the country led MSF to undertake an extended programme. Teams helped the Ministry of Health to manage the problem and to install a hospital camp for the sick. Supplies of intravenous fluid for drips are available for the whole of the accessible area.

In conjunction with this, a referral hospital for the displaced persons was set up. It allowed these people to have access to care which they would have to pay for in any other facility in the country. Presently, two dispensaries for displaced persons are operating in two camps.

The internally displaced

In the Bo region, MSF operates eight health centres for the population affected by the war, which is mainly made up of internally displaced persons. Recently teams have been able to reach the populations of some towns in the surrounding area despite military activity. This allows us to cover a population of 90,000 people. More than 8,300 consultations are carried out each month.

This staff is also responsible for the region's referral hospital. A capacity of 120 beds allows teams to carry out war and general surgery as well as medical hospitalisations. As

in the dispensaries, medical equipment and medicine are provided by MSF. 350 hospitalisations and 750 consultations are carried out each month. The population covered is about 350,000 people.

The patients who are most severely affected by the cholera epidemic of last summer were also treated in a specialist unit attached to the hospital. Also, an immunisation campaign against measles allowed 70,000 children to be immunised in September 1995.

In the face of the huge influx into Bo of people fleeing the war, teams had to construct and organise camps. Water supply, sanitation and health care are provided by MSF. More than 30,000 people have found shelter in these facilities. One of the camps is a centre for discharged handicapped and mutilated victims and their families.

In May and June 1996, a cross-border immunisation campaign to combat measles and yellow fever was carried out in Vaclatum district. During this campaign, 10,200 people were vaccinated against yellow fever and 1,300 against measles.

International staff: 38 / National staff: 362

SIERRA LEONE



R Job, Sierra Leone, 1995

YELLOW FEVER

Yellow fever is an acute infectious disease that has caused many serious epidemics with high mortality rates, especially in western Africa. The disease also occurs in Panama and the northern region of South America. During epidemics, the mortality rate for non-immunised adults can exceed 50 percent. Transmission is mainly via a "jungle cycle" involving forest-dwelling mosquitoes and non-human primates. It enters the human chain when infectious mosquitoes feed on humans in the jungle who then return to urban centres (or refugee camps) and are bitten by specific domestic mosquitoes.

The disease is characterised by sudden onset of fever, chills, headache, backache, nausea and vomiting. The number of white blood cells is reduced, with possible

haemorrhaging, and jaundice. It is usually difficult to distinguish yellow fever from other febrile illnesses and there are many examples of epidemics recognised only several months after onset. Although there is no specific treatment, an effective vaccine is available and WHO recommends its use in the regular expanded programmes on immunisation in all countries at risk. In refugee situations, a mass vaccination campaign targeting everyone over four months should be started as soon as a single case is confirmed. Vector control comprises spraying shelters with insecticide and applying larvicides to the relevant mosquito breeding sites. Treatment is symptomatic but all patients should be kept in strict isolation and provided with mosquito nets to avoid transmission to others.

CHOLERA OUTBREAK

Abdou Diouf has been president of Senegal since 1981. He is also the leader of the Socialist party which has been in power since independence from France in 1960. Senegal's economy depends largely on agriculture and fisheries.



POP. IN YEAR 1994
8.1 m

POP. IN YEAR 2000
9.5 m

GNP PER CAPITA
750 USD

ADULT LITERACY RATE,
MALE/FEMALE
39%/19%

LIFE EXPECTANCY
49 yrs

0-5 MORTALITY RATE
115 per 1,000

POP. PER DOCTOR/NURSE
16,667/12,500

MEASLES VACC. COVERAGE
49 %

NO. OF REFUGEES/IDPs
73,000/n.a.

MSF launched a large-scale assistance programme in Senegal's Diourbel region at the end of February 1996 following news that the cholera which had first appeared in August 1995 in Dakar had spread there. The epicentres in Diourbel were the two cities of M'Baké and Touba where 3,180 cases were registered and two cholera camps immediately set up by MSF teams. MSF also set up oral rehydration points for referral of the sick and upgraded the sanitation systems and the water supply. Given the proximity of two major waterways, the Senegal and Saloum rivers, which could act as vectors for the disease, the two other suspected epicentres Saint-Louis and the Saloum islands were monitored by a mobile team. A quick and efficient emergency programme was needed because Touba is a Muslim place of pilgrimage and as such a centre for constant population movement.

International staff: 6

CAPE VERDE

MASSIVE CHOLERA EPIDEMIC

MSF carried out an emergency intervention in Cape Verde after the outbreak of an unprecedented cholera epidemic in 1995. The MSF intervention started in September 1995, when it was clear that the epidemic had spun out of the health authorities' control and had started spreading to islands which until then had remained unaffected. The MSF teams set up cholera camps and rehydration posts and started extensive water chlorination programmes. In addition, local staff received training on how to prevent, diagnose and treat the disease, how to control the quality of drinking water and how to set up safe sanitation structures. The MSF teams stayed until January 1996. In total, 20,000 Cape Verdians fell victim to the cholera epidemic.

CHOLERA

Cholera is an acute gastro-intestinal infection caused by the bacterium *Vibrio cholerae*. It has a short incubation period of one to five days and causes watery diarrhoea leading to severe dehydration and death if treatment is not provided rapidly. Vomiting occurs in most cases. However, less than 10 percent of the infected suffer moderate or severe dehydration and most never develop the full symptoms. Cholera is spread through contaminated water and food. Although, it is rarely transmitted from person to person, asymptomatic carriers often transmit the disease.

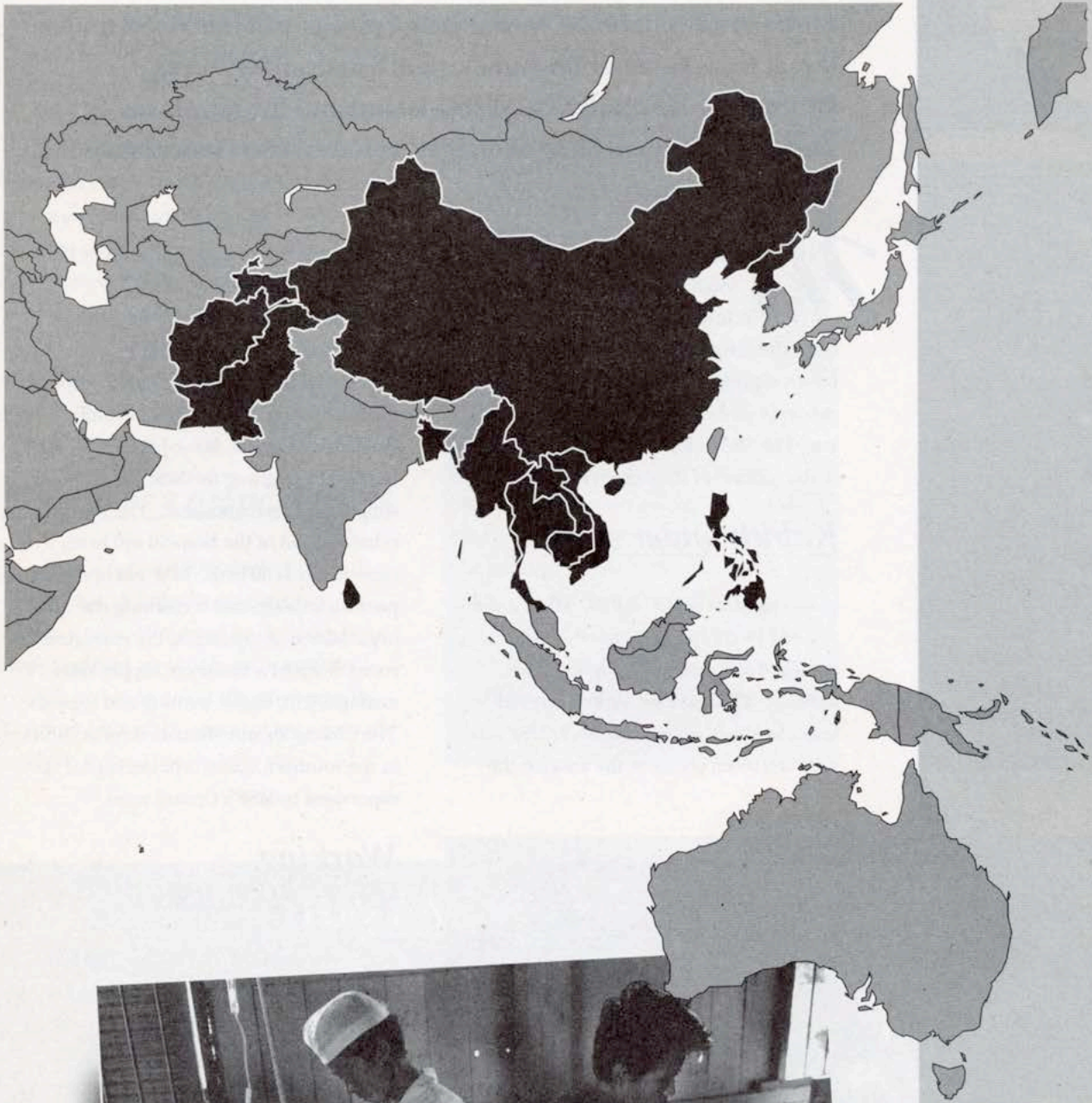
The world is presently facing its seventh cholera pandemic. This once began in Indonesia in 1961, spread across Asia and down through Iran and Iraq into Africa. It has now reached South America, where the disease is endemic, although this continent had previously been free of cholera for more than a century.

Most cholera cases can be treated with oral rehydration salts, but intravenous fluids are given to the vast majority (80-90 percent). In a community with no treatment facilities, case fatalities may be as high as 50 percent. Control

and prevention measures should be taken to ensure an adequate supply of safe drinking water, good food hygiene and hygienic disposal of faeces. Widely available vaccines provide only partial protection for a limited period. A two dose oral vaccine has become available in some countries, but it is too early to envisage the use in refugee situations where the doses are required one week apart and individual protection will be too late to prevent disease transmission.

R. Bohle, Senegal, 1996





J Vink, Cambodia, 1991





POP. IN YEAR 1994
19 m

POP. IN YEAR 2000
26.7 m

GNP PER CAPITA
280x USD

ADULT LITERACY RATE,
MALE/FEMALE
42%/11%

LIFE EXPECTANCY
43 yrs

0-5 MORTALITY RATE
257 per 1,000

POP. PER DOCTOR/NURSE
7,692/11,111

MEASLES VACC. COVERAGE
40 %

NO. OF REFUGEES/IDPs
19,100/450,000

MEDICINE IN THE WAR ZONE

One million Afghans have died in the war. In mid-1996, there were two million displaced persons in Afghanistan, six million Afghan refugees and another two million permanently disabled. The predominantly Tajik Jamiat-i-Islami forces of President Burhannudin Rabbani consolidated power, but remained under threat from General Rashid Dostam's mercenary forces, Gulbuddin Hekmatyar's Hezb-i-Islami and the new faces on the scene, the Taliban. Food shortages in Kabul were more acute than ever in 1995 and 1996.

MSF opened its first mission in Afghanistan just after the Soviet invasion on 27 December 1979, when the arrival of over 100,000 combat troops supported by considerable air power precipitated the whole country into all-out war. The Soviets left in 1989, just in advance of the collapse of the eastern communist bloc.

Kabul: under siege

In the war-torn capital Kabul, MSF runs the 230-bed Jamhuriat Hospital which has managed to function throughout the fighting. There are six Afghan surgical teams working around the clock. MSF also supports seven clinics in the area for the

city's internally displaced. In August 1995, MSF launched a health education programme for 100,000 school children which has since been successfully taken over by a local organisation. MSF also supports the burns wing of the Indira Gandhi Paediatric Hospital. Since June 1995, MSF has also been giving medical and technical support to Ghazni hospital. The recent rehabilitation of the hospital will bring capacity up to 60 beds. MSF has opened a paediatrics wing, and is ensuring the organisation of inpatients, the emergency room, hospital admissions, supply, stock management, wages, training and logistics. The Charasyab and Mohamed Agha clinics in the southern quarters of the capital are supervised by MSF's Ghazni team.

Working with those who fled

At the beginning of 1995, some 70,000 people fleeing the renewed onslaught on the capital ended up in an inhospitable stretch of desertland near the city of Jalalabad, where they found shelter in the Sharshahid refugee camp. MSF set up health posts and started a feeding programme. Children under five were vaccinated against measles and in November 1995 construction finished on a ten-mile pipeline for the supply of safe drinking water. At the beginning of 1996, MSF handed over part of the activities to the HealthNet International organization. On the other side of Jalalabad, MSF also works in Hadda with some 50,000 displaced. In 1995, MSF began a relief programme in the province of Uruzgan, an area controlled by the



M Van Bouwel, Afghanistan, 1993

Taliban, the most powerful rebel faction. The programme is mainly targeted at women, children and the poor.

Displaced persons, refugees and returnees

MSF runs a mission in the Sakhi refugee camp, in northern Afghanistan near Mazar-i-Sharif, which is a temporary home to 7,000 Tajik refugees. MSF manages health-care in the Sakhi camp and also provides support for a dispensary for 2,000 refugees in Taloquan. MSF teams also work with the displaced in Mazar-i-Sharif, Pul El Khumri, Baghlan and Kunduz. The displaced in these areas have been integrated into the local population. In this way, the clinics can also target local inhabitants. A community participation programme has been set up to provide for their needs in the most effective manner possible.

Emergency preparations

In unstable regions, MSF needs to be prepared at all times for emergencies. In Afghanistan, MSF provides drug stocks to dispensaries in areas of open or potential conflict and in all politically sensitive areas. Drugs and surgical equipment are also made available to local hospitals for war

emergencies in Mazar-i-Sharif, Pul El Khumri, and Kunduz. In the Taloquan hospital, MSF provides structural support. There are also two dispensaries in Kunduz and Khonabad in addition to the Kunduz programme.

International staff : 85

National staff : 526

PAKISTAN

FLOODING IN SINDH

MSF coordinates a large part of its programme in Afghanistan from its logistical base in Peshawar, Pakistan. However, in July 1995, an MSF team intervened in Pakistan's Sindh province following heavy rains. The Pakistani authorities run an emergency preparedness programme for this part of the country where flooding is an annual event. In 1995, MSF lent its support to the national programme by distributing medicine to combat malaria and providing plastic sheeting for temporary shelters.

HIV / AIDS

WHO estimates that 18 million people around the world have so far been infected by acquired immuno-deficiency syndrome (AIDS). There is presently no cure for AIDS. As those infected with human immuno-deficiency virus (HIV) and AIDS are often exposed to discrimination, health care workers involved in testing, patient information and counselling need to be made aware of the necessity for strict confidentiality. Mass screening must be avoided at all costs.

Some preventive measures can be taken against the two main routes of HIV contamination: sexual intercourse and blood. In refugee situations, this includes safe sex information, condoms, strict

criteria for transfusions, excluding all high risk groups from donating blood, limiting injections, ensuring proper disinfection, sterilisation and disposal of injection material and medical waste. It is difficult to prevent mother to child transmission of AIDS. There is a risk of contamination through breast feeding, but generally the benefits outweigh the risks.

AIDS treatments have very limited effect and the high cost is an obstacle. Treatment of the complications arising from AIDS (severe opportunistic infections and tumours) is symptomatic and palliative, and patients should be given appropriate psychological support.

BANGLADESH



POP. IN YEAR 1994
118 m

GNP PER CAPITA
220 USD

ADULT LITERACY RATE,
MALE/FEMALE
47%/23%

0-5 MORTALITY RATE
117 per 1,000

POP. PER DOCTOR/NURSE
12,500/20,000

International staff : 12
National staff : 318

BURMA



POP. IN YEAR 1994
45.6 m

GNP PER CAPITA
220x USD

ADULT LITERACY RATE,
MALE/FEMALE
88%/75%

0-5 MORTALITY RATE
109 per 1,000

POP. PER DOCTOR/NURSE
12,500/n.a.

50

FORCED REPATRIATION

The Bangladesh National Party (BNP) was returned to power in the February 1996 elections, with Begum Khaleda Zia as prime minister. However, opposition parties boycotted the elections which they claimed were rigged. Bangladesh remained among the world's poorest countries, with a predominantly agrarian economy.

One of MSF's main concerns in Bangladesh during the year was the issue of forced repatriation to Burma of refugees belonging to the Rohingya ethnic minority. So far, nearly 200,000 Rohingyas have been repatriated by the UNHCR. MSF claimed that the returnees may well face persecution in Burma. MSF and other international agencies carried out a survey in 1995, which showed that 65 percent of the refugees did not know that they could refuse to be repatriated.

In early 1996, 50,000 remaining Rohingya refugees were present in five camps. MSF teams work in the Gundhum I and

Nayapara camps. The activities carried out there include the prevention of common diseases as well as both medical and nutritional assistance. There is a special focus on mother and child protection and vaccination. In the Nayapara camp, MSF runs a feeding centre for malnourished children. In addition to medical relief, the MSF teams provide expertise on camp sanitation and water issues. Education is also an important aspect of the projects, especially the training of traditional midwives and community health care workers.

Between June and October 1995, MSF intervened following floods in Shibshar.

FOOD SHORTAGES IN RANGOON

The ruling military junta, the State Law and Order Restoration Council (SLORC), continued to resist pressure for democratic reform. 1996 saw political manifestations led by the previously detained Nobel laureate Aung San Suu Kyi.

The health situation remains precarious both for the urban poor and large segments of the rural population, and MSF's work in the country is focused on providing these groups with basic medical care.

In the outskirts of the capital Rangoon, MSF runs several projects in poverty-stricken townships, providing some 250,000 poor Burmese with basic medical care. These populations suffer an acute shortage of sanitary facilities, the water supply is inadequate, and hospitals and health care centres are ill-equipped. Malnutrition is a problem in the townships, and MSF runs two feeding centres in the Hlaingthayar district.

In the Arakan region in western Burma, MSF trains and supports local medical personnel, focusing on malaria prevention and treatment. Malaria is the country's most serious health problem. MSF is trying to open a similar project in the northern province of Kachin, with an additional focus on tuberculosis and AIDS.

International : 9
National : 154

A LONG WAY TO GO

Cambodia maintained its system of joint leadership with the two Prime Ministers Prince Norodom Ranaridh and Hun Sen. King Norodom Sihanouk remained one of the country's most important political figures. Sporadic clashes between the security forces and the armed opposition group Khmer Rouge took place during the year. In addition, tensions within the coalition government increased.

Cambodia's health structures, which were devastated by decades of war, are slowly being rehabilitated owing in great part to international aid. In certain areas, there is still poor access to health care. There is a lack of surgeons, anaesthetists, qualified laboratory technicians, and other specialised health staff in rural areas. The country's main health problems remain infectious diseases and war injuries. HIV and tuberculosis (TB) prevention are essential aspects of the MSF programme in Cambodia.

Assistance in provincial hospitals

Kratie had often been neglected by health authorities and aid organisations because of poor access and security. Even today, the province is only accessible by boat. MSF supplies the provincial hospital with essential medicines and medical material. Teams organise training courses for the local medical staff and support hospital management. In addition, a birth-control programme is being implemented and research carried out on the treatment of bilharziosis. Information on AIDS, on the increase in Cambodia, is considered important as is the distribution of condoms at a reduced price.

MSF also works in the Kompong Thom provincial hospital and surrounding health centres. Activities centre around the supply of medicine and medical material, support to the hospital management, training on sanitation and hospital hygiene, the creation of a blood bank with the ICRC, the continuation of the programme to combat TB and the construction of a 55-bed extension.

At the end of 1995, the numbers of IDPs in Battambang rose to nearly 43,000. The

provincial hospital is both a reference and training centre for all the districts of the province. Priorities are campaigns against TB and malaria, basic medical assistance, the supply of medicine and medical material, medical management and the training of surgeons. Technical support and support for medical supplies is ensured in the district hospital in Thmor Kaul and Rattanak-Mondol from the provincial hospital. Activities in the Kroch Chmar district include the training of medical and nursing staff, a TB programme, rehabilitation and construction and the upgrading of the water and sanitation systems.

MSF continued rehabilitating public health services in order to heighten standards of health care, notably in Siem Reap Provincial Hospital, in Sotnikom District Hospital and in Kravanh District Hospital in Pursat province.

HIV/AIDS infection

MSF launched a new programme in Stung Treng in November 1995. Objectives include rehabilitating health structures, supporting the provincial hospitals and reference hospital, diagnosing bilharziosis as well as active campaigning against AIDS and other STDs. MSF also runs a clinic in a poor suburb of Phnom Penh, where a specific STD programme is targeted at the local prostitute population.

Throughout the year, MSF has continued to run existing technical assistance programmes for public health services in order to heighten standards. Training programmes remain important especially the programme which has been running for several years for nurses specialising in anaesthesia and another for laboratory technicians.

CAMBODIA



POP. IN YEAR 1994
10 m

POP. IN YEAR 2000
11.6 m

GNP PER CAPITA
200x USD

ADULT LITERACY RATE,
MALE/FEMALE
48%/22%

LIFE EXPECTANCY
51 yrs

0-5 MORTALITY RATE
177 per 1,000

POP. PER DOCTOR/NURSE
n.a./n.a.

MEASLES VACC. COVERAGE
53 %

NO. OF REFUGEES/IDPS
n.a./55,000

International staff : 55

National staff : 343



R Oumer, Cambodia, 1995



POP. IN YEAR 1994
1,209 m

POP. IN YEAR 2000
1,285 m

GNP PER CAPITA
490 USD

ADULT LITERACY RATE,
MALE/FEMALE
87%/68%

LIFE EXPECTANCY
68 yrs

0-5 MORTALITY RATE
43 per 1,000

POP. PER DOCTOR/NURSE
n.a./n.a.

MEASLES VACC. COVERAGE
89 %

NO. OF REFUGEES/IDPS
287,100/n.a.



H. de Ribeauxcourt, China, 1996

One of the results of the shift towards a market economy has been a growing difference in wealth and income between certain regions of the country. There was a continuing flow of migrant workers from poorer areas to richer ones. Trade regulations and human rights issues continued to be a source of political tension between China and Western governments.

The economic reforms in China have had negative effects on the national health system, with decreasing medical coverage and a lack of epidemiological surveillance in many provinces.

Big Bone Disease

MSF continued to focus its activities in Tibet on the endemic and mysterious big bone disease, which stunts growth in children and make adults' joints swell up so much that they are unable to use their hands and in some cases are unable to walk. MSF has two physiotherapists in Tibet who teach village doctors how to ease joint pain and improve the mobility of their patients. Although it is not a cure, physiotherapy helps to relieve the pain. A study into the origins of the disease has been undertaken by several European universities and medical institutes to which MSF teams supplied data in 1995 and 1996. Indications are that the disease might be related to a lack of selenium in the water or a fungus which grows on barley grain in storage. In early 1996, the MSF team expanded its big bone disease-programme from Lhasa prefecture to include Shigatse and Lhoka prefectures.

Water Shortages

In Lhasa MSF runs an extensive sanitation programme. Water resources in Tibet are very scarce, especially in the winter, and MSF is advising the local population on how to channel water from mountain springs through pipes to village wells. The programme is also being extended to Shigatse and Lhoka prefectures.

Medical Assistance

In the rural areas of Lhasa prefecture in Tibet, MSF is running a medical assistance project, rehabilitating community clinics, and training township and village doctors. Because of the chronic lack of drugs in the area, MSF is providing one year's supply of essential medicines and encouraging health care staff to set up a revolving fund system whereby money received in payment for these drugs is used to buy new stocks.

MSF has launched a basic health care programme for the rural areas of Luzhou prefecture in Guangxi province, where eight million of the province's 44 million inhabitants live below the poverty line. Many ethnic minorities benefit from MSF's assistance.

Natural Disasters

MSF launched a relief programme following the flooding in Jiangxi province at the end of 1995. In January 1996, MSF also sent relief to Yunnan following an earthquake there. In the wake of the devastating snowstorms and freezing winter in Qinghai and Sichuan, MSF launched an international appeal to assist the Tibetan nomads who had lost most of their yaks and cattle. Assistance included barley, yak butter, blankets and medical kits. The distribution of relief supplies continued until the end of June 1996. In early July 1996, MSF intervened in Guizhou to assist the victims of China's worst floodings in half a century, which claimed hundreds of lives and left millions of people homeless.

International staff : 17

National staff : 34



F. Mathieu, China, 1992



H de Ribaucourt, China, 1996

FRENCH POLYNESIA

EFFECTS OF NUCLEAR TESTING

In July 1995, MSF sent a team of medical doctors to French Polynesia. The mission's aim was to investigate and evaluate the possible medical effects on the local population of French nuclear testing. Among MSF's findings were that: cancer statistics about the population of French Polynesia only exist for the last ten years and even recent information is incomplete; no official register exists on congenital malformations; medical follow-ups on populations at risk have not been carried out. MSF expressed concern over the apparent lack of concern on the part of the French authorities for the medical effects of exposure to nuclear radiation. While the French have carried out surveillance of the effects on the Polynesian environment, they have done no surveillance of the people at risk. French Polynesia has approximately 200,000 inhabitants.

MONITORING REPATRIATION

On 30 June 1997, the United Kingdom will hand over this colony to the Peoples' Republic of China. There are concerns that this will lead to a loss of civil and political freedom. Hong Kong has one of the world's highest GNP per capita rates.

at the end of 1995, 21,704 Vietnamese refugees remained in Hong-Kong. Of these refugees, only 1,479 were recognised as such. The rest are living in four detention centres while awaiting forced repatriation through the so-called Orderly Repatriation Programme (ORP). MSF is opposed to forced repatriation and is monitoring the ORP.

MSF is the only aid agency still working in all the detention centres. The teams run paediatric clinics and teach new mothers how to care for their children. There is an emphasis on newborns and under-fives. The health education provided by the teams centres around breastfeeding, family planning, hygiene and immunisation. A psychological

support program has also been launched to try and fight the often devastating effects of institutionalisation on the Vietnamese. In the detention centres, MSF also runs a methadone support programme to help heroin addicts come off the drug. The programme involves needle exchange and health education which focuses on the prevention of HIV/AIDS and other sexually transmitted diseases.

An MSF team also provides medical assistance to the Pillar Point refugee camp, the one open refugee camp for Vietnamese who either arrived before 1988 or who have been officially screened in as refugees.

International staff: 2 / National staff: 79

HONG KONG



POP. IN YEAR 1994
5.8 m

GNP PER CAPITA
18,100 USD

ADULT LITERACY RATE,
MALE/FEMALE
96%/85%

0-5 MORTALITY RATE
6 per 1,000

LIFE EXPECTANCY
79 yrs

LAOS



POP. IN YEAR 1994
4.7 m

GNP PER CAPITA
280 USD

ADULT LITERACY RATE,
MALE/FEMALE
65%/39%

0-5 MORTALITY RATE
138 per 1,000

POP. PER DOCTOR/NURSE
4,545/n.a.

International staff : 11

National staff : 31

POOR ACCESS TO HEALTH CARE

The communist Lao Peoples' Revolutionary Party continued to rule the country. The government took steps towards the establishment of a market economy and applied for membership in the Association of Southeast Asian Nations (ASEAN) during the year.

MSF is concerned by the Laotian state's dramatic reduction of spending on public health. The health care now available is uneven in quality, and large segments of the population have no access to it.

MSF works in the district health centres and the Champassak district hospital in Champassak province. At the health centre level, emphasis is placed on training and supervision. A birth control programme has been developed. In the hospital, MSF's activities include emergency blood transfusions with systematic HIV testing. Patients receive treatment for tuberculosis. Standard treatment lasts eight-months.

MSF also works in the provincial hospital in Saravane, covering nearly 65 percent of its budget. From March 1996 and onwards, the main objective was to put in place a cost recovery system before the hand-over in the summer of 1996 to an organisation specialising in development aid, Entraide Médicale Internationale (EMI). In the north-western province of Bokeo, MSF runs a similar project to that of Saravane, centred around the Houay Xay provincial hospital.

MSF also supervises preventive health care activities in the districts of Sanasomboun and Bachiang.

NORTH KOREA



POP. IN YEAR 1994
23.5 m

GNP PER CAPITA
970x-USD

LIFE EXPECTANCY
71 yrs

0-5 MORTALITY RATE
31 per 1,000

MEASLES VACC. COVERAGE
99 %

AID AFTER FLOODS

The communist Korean Worker's Party continued to rule North Korea. Kim Jong-Il did not appear to have the same political control as his late father and political predecessor, President Kim Il-Sung. The centrally planned economy declined further, with serious food shortages becoming apparent in early 1996.

In July and August 1995, large stretches of land were hit by heavy floods. In over half the country, much of the infrastructure was destroyed. Moreover, the harvest and a large part of the country's rice stocks were lost. After the disaster, the North Korean government made an historical first appeal for international humanitarian relief. In October 1995, MSF started a relief programme in three of the hardest hit areas - Pakchon, Huicon and Unpa.

MSF supplied medicines, medical material, blankets and high-energy biscuits to the flood victims. The team worked alongside

Korean doctors, supplying health centres with medical care, essential drugs, and basic medical and surgical equipment. Training seminars on the rational utilisation of health and sanitation kits were also held with local personnel. Special attention was paid to the screening methods and treatments used for undernourished children. The emergency intervention came to an end in early 1996.

International staff : 5

National staff : 8

HURRICANES DEVASTATE COAST

The government of President Fidel Ramos won a large victory in the 1995 elections. Negotiations with the communists remained stalled, while the peace negotiations with the Muslim separatists Moro National Liberation Front (MNLF) progressed. GDP growth in 1995 was 5.6 percent.



R. Job, Philippines, 1995

as the Philippines is in an area regularly affected by natural disasters, MSF launched the Emergency Preparedness and Response Programme (EPRP) for emergencies in the Philippines and neighbouring countries. In November 1995, two hurricanes caused serious damage in the provinces of Quezon, North and South Camarines, Cantanduanes and Negros Occidental. MSF distributed medical, logistical and sanitation assistance to the victims and in mid-1996 was participating in the rehabilitation of health centres.

MSF's socio-medical assistance programme for street children is continuing. Medical consultations are held in four different health centres in Quezon and Manila. Patients are also referred to the MSF health centres by other organisations.

MSF runs a specialised clinic in the centre of Davao for the diagnosis and treatment of AIDS and HIV infections. The team also distributes condoms as part of the prevention programme.

International staff: 3 / National staff: 17

PHILIPPINES



POP. IN YEAR 1994
66.2 m

POP. IN YEAR 2000
74.6 m

GNP PER CAPITA
850 USD

ADULT LITERACY RATE,
MALE/FEMALE
94%/93%

LIFE EXPECTANCY
66 yrs

0-5 MORTALITY RATE
57 per 1,000

POP. PER DOCTOR/NURSE
8,333/n.a.

MEASLES VACC. COVERAGE
87 %

NO. OF REFUGEES/IDPs
n.a./n.a.

INDONESIA

EARTHQUAKE INTERVENTION

In October 1995, an earthquake hit a large area on the western side of the Indonesian island Sumatra. Thousands of homes in a number of villages and towns were destroyed. MSF intervened in Sungai Penuh - one of the affected towns - providing victims with tents, blankets, plastic sheeting and some essential drugs. The intervention lasted two weeks.

WAR SURGERY



POP. IN YEAR 1994
18.1 m

POP. IN YEAR 2000
19.5 m

GNP PER CAPITA
600 USD

ADULT LITERACY RATE,
MALE/FEMALE
93%/85%

LIFE EXPECTANCY
72 yrs

0-5 MORTALITY RATE
19 per 1,000

POP. PER DOCTOR/NURSE
7,143/1,754

MEASLES VACC. COVERAGE
84 %

NO. OF REFUGEES/IDPs
n.a./850,000

International staff: 35

National staff: 56

Since 1983, the Sinhalese-dominated government of Sri Lanka and Tamil rebels have been at war. By the end of 1995, the security forces retained control of approximately half of the Jaffna Peninsula and towns and main roads in the east while the Liberation Tigers of Tamil Eelam (LTTE) controlled the Mullaitivu and Killinochchi districts in the north and large parts of the countryside in the east. The Sri Lankan economy is largely agricultural with a fifth of real GDP generated by this sector.

MSF works in the north and east of the country. These zones have been devastated by years of war.

Where the Sri Lankan Ministry of Health is absent, MSF tries to provide a basic health care system. Teams work in the hospitals of the region. In those villages where there is no access to hospitals, MSF mobile teams administer to the sick.

Emergency surgery in North and East

MSF runs a surgical and obstetrical programme on Mannar Island, situated off the northern coast of Sri Lanka, and the northern district of Killinochchi. Mannar is government-controlled and very difficult to reach as a result of the unstable situation in the area. Between 50,000 and 100,000 people rely on Mannar Hospital where an MSF team specialising in surgery and anaesthesia work.

In Vavuniya region, also in the northern part of the country, MSF surgeons and anaesthetists also work in the reference hospital which serves three districts. Most patients have come from troubled northern zones.

MSF also runs a surgical and paediatrics programme in the eastern part of the country, in Batticaloa Hospital. There are at least 200 operations carried out by MSF and more than 300 children admitted each month.

Massive displacement

At the end of 1995, hundreds of thousands of Tamils fled the northern peninsula of Jaffna, which is slowly but steadily being

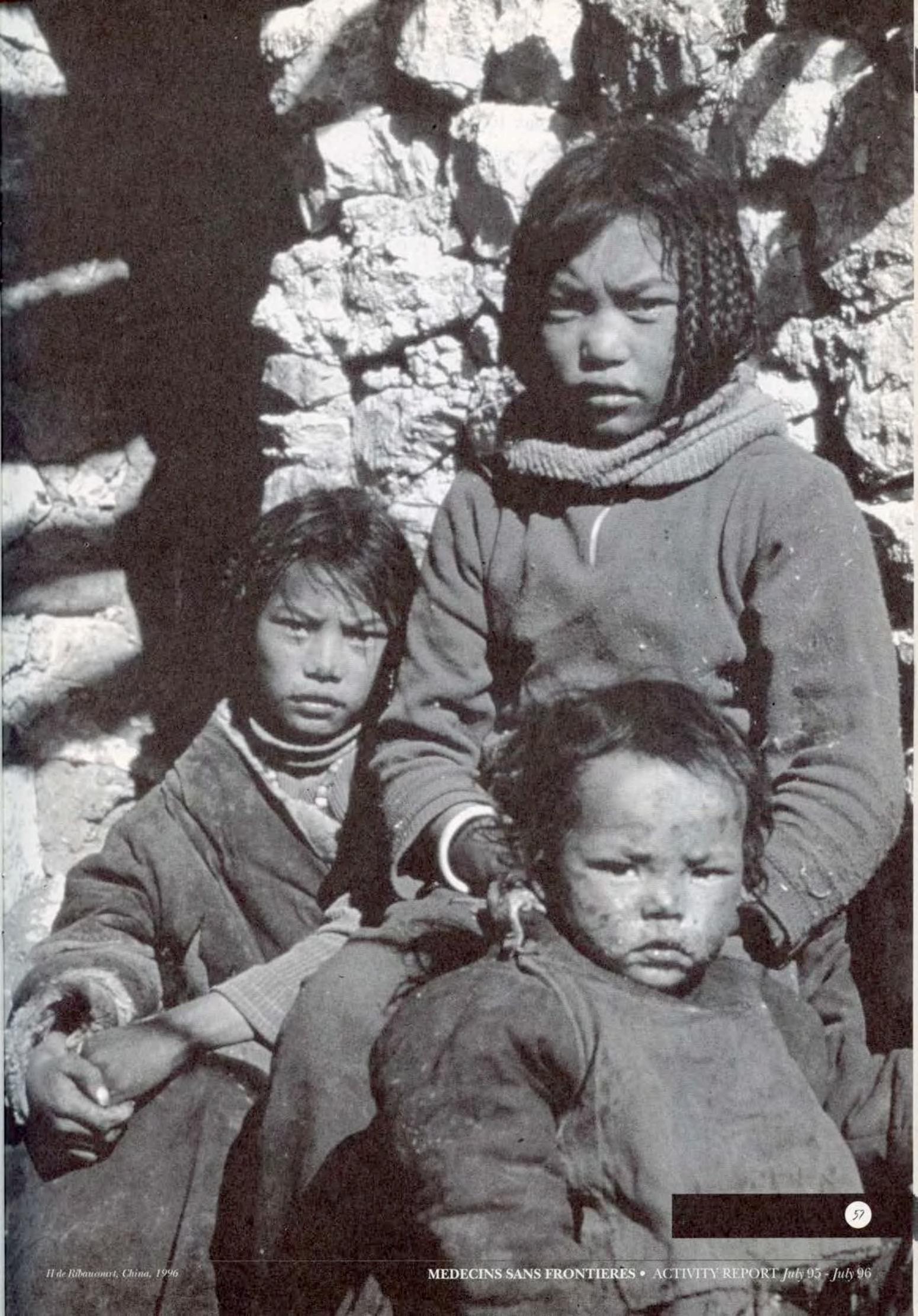
retaken by government troops. The relief effort for IDPs is centred in Kilinochchi, where MSF carries out a gynaecological and obstetrics programme. MSF is providing water and sanitation assistance to the welfare centres where displaced are gathered upon arrival from Jaffna. The workload in the hospital is rapidly increasing, but the Sri Lankan government has prohibited MSF from performing surgical operations here as Kilinochchi is in the LTTE zone. MSF continues obstetrics and referrals to Point Pedro and Vavuniya Hospitals.

MSF is the only agency working in Madhu refugee camp, which houses members of the Tamil minority who have returned from India. MSF also assists the displaced gathered in camps in both Madhu and Pallampidi as well as neighbouring villages. There are 50,000 people currently displaced in the region.

Point Pedro Hospital, is the only surgical hospital in the peninsula to deal with the needs of all the populations in the region. Surgical activity quadrupled in early 1996, from 180 to 700 operations a month. Staff from Jaffna hospital came to reinforce and help reorganise. MSF is in charge of surgery and anaesthesia at the hospital.



H Timmerman, Sri Lanka, 1995





POP. IN YEAR 1994
58.2 m

POP. IN YEAR 2000
61.9 m

GNP PER CAPITA
2,100 USD

ADULT-LITERACY RATE,
MALE/FEMALE
96%/91%

LIFE EXPECTANCY
69 yrs

0-5 MORTALITY RATE
32 per 1,000

POP. PER DOCTOR/NURSE
4,762/1,064

MEASLES VACC. COVERAGE
86 %

NO. OF REFUGEES
100,800

International staff : 26

National staff : 493

AID TO VIETNAMESE AND BURMESE REFUGEES

In July 1995, Prime Minister Banham Silapa-Archa formed a six-party coalition government. The Thai economy has gone from being agriculturally-based to one of the so-called "newly industrialising countries". GDP growth for 1995 was 8.6 percent, one of the highest in the world.

MSF provides medical assistance to 5,800 Vietnamese refugees in the Sikhui camp. Since 1995, the UNHCR and Thai government have started to push for their repatriation, however, the refugees have refused to leave as many still hope to be taken in by the United States. By late 1996, if they do not accept voluntary repatriation they may be forced to go back. In such a case, MSF will be present to see that the repatriation is carried out under the best possible circumstances.

On the Burmese border, MSF continues its mission to bring medical aid to members of the Karen ethnic group who fled Burma in 1983. In 1995, the military made incursions across the Thai border and harassed these people. The government decided to regroup the five camps to one less risky site - Maela where there were 25,000 refugees at the end of December 1995.

In 1995, the Mons, another ethnic minority who fled oppression in Burma, signed a cease fire with Rangoon. MSF has provided them with curative and preventive health care assistance since they first arrived. A repatriation programme was launched providing for complete repatriation of 6,950 Mon refugees by the end of March 1996. When the refugees return home, MSF will endeavour to provide them with assistance in their villages of origin which lie just across the border.

Assistance in the slums

MSF works in six slum communities alongside a Thai charity. The two largest slums are located near Bangkok's large rubbish dumps, and are inhabited by about 7,000 people. MSF runs a mother and child

health-care clinic in both slum areas offering primary health-care, with special emphasis on child care. MSF is also responsible for "youth" programmes operated in each slum. Their purpose is to run literacy campaigns, vocational training and sexual education for the young. A day centre has been set up, where children under the age of five receive health-care treatment.

MSF has also started up a mobile clinic programme offering mother and child health care to people living in four of the smaller slums. Health education is also provided.

Help for AIDS sufferers

MSF is an active member of a national association which promotes the prevention of AIDS and other STDs and works alongside three local agencies in Bangkok. Local aid agencies are responsible for the day-to-day management of shelters for AIDS sufferers, who have been ostracised by their families. MSF takes care of patient consultation and treatment twice a week in the shelters. MSF also supplies medical assistance at home for people with AIDS.

Collaborating with the government and other agencies, MSF has developed an intensive programme for information, education and training, so as to improve the quality of attention for HIV carriers and AIDS patients and their families, outside the hospital structure. Local staff is trained and supervised. Finally, in order to develop a viable health care system for patients at home, MSF has been training and supporting health care staff for more than a year with local volunteers in two districts.



R Ommet, Cambodia, 1993

HEALTH CARE IN ISOLATED COMMUNITIES

In late 1995, there were hopes for an end to the civil war. However, in early 1996, President Imamali Rakhmanov survived a coup attempt. The economy continued to be in a state of near-collapse.

MSF has been present in the very poor and inaccessible region of Pamir since 1993. Although the team continues to support the health structures, it is doing less active medical assistance in Pamir, but has been developing the partnership with national medical authorities. MSF focuses on the supply of medicine to health structures, the support for national vaccination campaigns and training programmes for national staff. The medical distribution programme covers 85 percent of the needs in this area. The training programmes focus on the correct use of drugs, particularly antibiotics and the

follow up on infectious diseases. In mid-1995, MSF organised and ran an anti-diphtheria programme.

A similar medical assistance programme was launched in the capital, Dushanbe in western Tajikistan, in October. In Dushanbe and Kourgan-Tuybe, training on the cold chain and vaccination strategies continued until mid-April 1996.

International staff : 6

National staff : 14

TAJIKISTAN



POP. IN YEAR 1994
5.9 m

GNP PER CAPITA
470 USD

ADULT LITERACY RATE,
MALE/FEMALE
99%/97x%

0-5 MORTALITY RATE
81 per 1,000

POP. PER DOCTOR/NURSE
350/210



POP. IN YEAR 1994
72.9 m

POP. IN YEAR 2000
82.6 m

GNP PER CAPITA
170 USD

ADULT LITERACY RATE,
MALE/FEMALE
95%/87%

LIFE EXPECTANCY
65 yrs

0-5 MORTALITY RATE
46 per 1,000

POP. PER DOCTOR/NURSE
247/1,149

MEASLES VACC. COVERAGE
96 %

NO. OF REFUGEES/IDPs
5,000/n.a.

MSF TARGETS STDs & AIDS

The Communist Party of Vietnam (CPV) remained the dominant force in the country. In July 1995, the United States restored diplomatic relations with Vietnam. In the same month, Vietnam joined the Association of Southeast Asian Nations (ASEAN). The government pursued its policies of economic liberalisation. While GDP growth was estimated at 9.5 percent in 1995, more than half the population continued to live in poverty.

In November 1995, MSF opened a clinic specialised in HIV/AIDS and other STDs in Nha Trang in southern Vietnam. According to government information, Nha Trang is the city hardest hit by HIV/AIDS and other STDs. The clinic focuses on providing treatment and support to high-risk groups such as prostitutes and drug addicts. In order to avoid stigmatisation, the clinic also offers general care and is open to anyone. MSF collaborates with local women's and children's organisations in its efforts to reach the target groups and increase their health awareness. A cost-recovery system whereby patients pay a small fee for treatment is in place. The goal is to make the clinic partly autonomous within three or four years.

Apart from the running of the clinic, MSF activities in Nha Trang include efforts to

prevent HIV/AIDS by improving the hygiene, the sterilisation methods and the monitoring of blood in the blood bank in the provincial hospital. MSF staff also carries out treatment of HIV/AIDS and other STDs in the Nha Trang dermatological hospital.

In Dabac in the north of Vietnam, an MSF team runs a technical assistance and health project, which includes training of local medical and other personnel. MSF runs courses on clinical examination techniques, diagnosis and treatment, hygiene and sterilisation, as well as laboratory techniques. In addition to training, MSF helped build and refurbish local health centres during the year.

International staff: 6

National staff: 16



T. Vostin, Chechnya, 1995



ARMENIA



POP. IN YEAR 1994
3.6 m

GNP PER CAPITA
660 USD

ADULT LITERACY RATE,
MALE/FEMALE
99%/98x%

0-5 MORTALITY RATE
32 per 1,000

POP. PER DOCTOR/NURSE
250/935

WORKING WITH THE HANDICAPPED

President Levon Ter-Petrosian's attention continued to be focused on a lasting peace agreement with Azerbaijan. A ceasefire was agreed upon in 1994, but the remaining Azeri fuel and energy embargo on Armenia has resulted in a severe lack of energy and water.

The Armenian health care system suffers from a lack of heating, water, drugs, equipment, and transportation facilities.

In Noyemberian, MSF's project centres around the district hospital, 9 dispensaries and 12 health posts. Provision of water, drugs and other medical supplies are in the focus of the project.

In Yerevan, MSF is trying to tackle the widespread problem of syphilis and other sexually transmitted diseases (STDs) by

improving laboratory tests and collaborating with local doctors specialised in dermatology/venerology.

In the hospitals of Vardenis, MSF's runs a project for the handicapped. Objectives there include the establishment of acceptable standards of living for the patients. In Gyumri, MSF runs another similar project for the institutionalised handicapped, particularly handicapped children.

International staff: 15

National staff: 54

AZERBAIJAN



POP. IN YEAR 1994
7.5 m

GNP PER CAPITA
730 USD

ADULT LITERACY RATE,
MALE/FEMALE
99%/96x%

0-5 MORTALITY RATE
51 per 1,000

POP. PER DOCTOR/NURSE
250/n.a.

REFUGEE ASSISTANCE

Elections took place in November 1995, strengthening the position of President Gaidar Aliev. The long-standing conflict with Armenia over the Nagorno-Karabach enclave remained unresolved. Despite a steep GDP fall, foreign investors showed considerable interest in the Azeri oil resources.

The presence of hundreds of thousands of internally displaced people and refugees from the disputed Nagorno-Karabakh enclave strained the country's health care system to breaking point.

In the districts of Chanlar, Fizuli, Agjabedi, Beylagan, Imishli, Sabirabad and Saatli and in the cities of Baku and Barda, MSF provides medical care and other assistance to local populations, the internally displaced, and refugees. Drugs and medical equipment are distributed among more than 85 hospitals and dispensaries throughout these areas. Training of local staff and rehabilitation of medical structures are other important MSF activities. Among the beneficiaries of these projects are

tens of thousands of internally displaced living in abominable conditions in railway carriages, tent camps and sports stadiums.

In the Nagorno-Karabakh enclave, MSF assists in the distribution of drugs and conducts training of health care workers in the use and management of essential medicines. The prevention of HIV/AIDS during transfusions, promotion of contraception, and improvement of hospital sterilisation methods and waste handling are other aspects of the work there. Special efforts are being made to provide psychological care for children traumatised by war.

International staff: 25 / National staff: 101

HEALTH CARE FOR ALL

The Christian Democrats, led by prime minister Jean-Luc Dehaene, continued to rule the country in coalition with the Socialist party. Major political issues during the year included budgetary planning in anticipation of European Monetary Union (EMU) and the planned tightening of immigration laws.

Despite the fact that Belgium has among the best health indicators in the world, MSF considered it worthwhile to intervene medically in Brussels in 1988. Activities have since expanded to include projects in Antwerp, Liege and Verviers. The work is focused on those population groups which do not figure in the national health statistics and those who live outside the social security system. Main beneficiaries are the homeless, certain immigrants, prostitutes and drug addicts.

The Elisa Centre in Brussels, which opened in 1988, provides free and anonymous HIV screening to the general public. Apart from testing, MSF staff also offers primary prevention of HIV/AIDS through information and personalised

counselling. MSF maintains confidentiality.

Medical care and social support is also provided in Brussels through mobile and permanent clinics. Similar projects run in Antwerp, Verviers and Liege.

Consultations are mainly carried out for the benefit of certain immigrants and asylum seekers. MSF also lobbies the government for the right to medical care.

A special project aimed at improving the health of drug addicts and providing support for those who wish to join methadone programmes started in 1995 in Brussels. MSF's staff also train general practitioners to care for drug addicts.

Staff: 10

BELGIUM



POP. IN YEAR 1994
10 m

GNP PER CAPITA
21,600 USD

ADULT LITERACY RATE,
MALE/FEMALE
n.a./n.a.

0-5 MORTALITY RATE
10 per 1,000

POP. PER DOCTOR/NURSE
298/131

DIPHTHERIA

Diphtheria is an infectious disease caused by a microbe spread from person to person by respiratory droplets from the throat. The disease breaks out two to five days later, affecting the tonsils, upper respiratory tract and heart. Symptoms are similar to those of tonsillitis, but diphtheria may result in damage to the heart and central nervous system and can end in a slow suffocating death. Treatment depends on the immediate administration of a diphtheria antitoxin and antibiotics, usually rendering patients non-infectious within 24 hours. However, five to ten percent of patients under treatment die.

Untreated, the disease claims even more lives and patients remain infectious for two to three weeks. Children and adults can be immunised.

Since 1990, a massive new epidemic has broken out in the newly independent states of the former Soviet Union, where recent large-scale migrations helped to spread the disease. Mass immunisation was either delayed or not carried out. The epidemic is now spreading into neighbouring countries, posing the threat of a global public health emergency.

FRANCE



POP. IN YEAR 1994
57.8 m

GNP PER CAPITA
22,500 USD

LIFE EXPECTANCY
77 yrs

0-5 MORTALITY RATE
9 per 1,000

POP. PER DOCTOR/NURSE
333/269

SLIPPING THROUGH THE NET

Jacques Chirac from the *Rassemblement Pour la République (RPR)* succeeded François Mitterand as president in the May 1995 elections. The proposed tightening of the immigration laws was among the main political issues during the year.

In Paris, MSF runs a clinic offering medical care to drug addicts. The aim is to decrease the risks to which this population is exposed, by offering free medical care and access to sterile material. A special kit designed by MSF (including condoms, sterile needles and syringes) is available and handed out free of charge. Mobile teams within Paris also distribute kits and condoms to the most marginalised population. Their aim is to establish contacts with this population, including drug addicts, who refuse to attend any public health structures.

A new programme has been launched to provide health care to children, teenagers and young adults from 6 to 25 years of age.

It also aims to reintegrate families into the social security system.

At the national level, owing to a law passed in 1992, access to health care improved for the excluded. MSF was able to close down its clinics in Lyons and Paris as the local authorities had adjusted and expanded the provision of medical care for the marginalised populations. However, MSF continues to run clinics in Marseilles and Lille where the law has not been enforced. MSF provides training for general practitioners and social workers and in nursing schools and hospitals.

Staff: 25

GEORGIA



POP. IN YEAR 1994
5.5 m

GNP PER CAPITA
580 USD

ADULT LITERACY RATE,
MALE/FEMALE
99%/98x%

0-5 MORTALITY RATE
27 per 1,000

POP. PER DOCTOR/NURSE
70/177

DIPHTHERIA & TUBERCULOSIS

Having survived an assassination attempt on 29 August 1995, Edvard Shevardnaze was an easy victor in November 1995's presidential elections. The prospects for sustained peace in Abkhazia and South Ossetia improved and there were signs of a renewed commitment to economic reform.

MSF's programme is carried out in six regions of Georgia: Abkhazia, Adjara, South Ossetia, Tbilisi, Khaketi and Samegrelo. The MSF medical distribution programme runs nationwide, directly and indirectly benefiting both local populations and the substantial numbers of refugees from the autonomous republics of South Ossetia and Abkhazia. Drugs are supplied to different kinds of health structures throughout the country. Inside the autonomous republics, MSF has also been involved in mass immunisation campaigns against diphtheria and the treatment for tuberculosis. In several regions, MSF also supports the 'cold chain'

which safeguards the refrigerated transport and storage of vaccines. Since May 1996, MSF has been analysing the situation in Tbilisi with regard to AIDS/HIV infection.

MSF has worked extensively in the field of water and sanitation in Georgia, either in areas where the water and sanitation systems have been destroyed by war, or those areas where the refugee population needs access to water. Teams are involved in the installation of chlorometers and the maintenance of reservoirs and pumps.

International staff: 29

National staff: 86

CHILDREN AND GYPSIES IN FOCUS

The Party of Social Democracy in Romania (PSDR) is expected to emerge as the largest party after the parliamentary elections scheduled for September 1996. The economy has suffered since the onset of transition to democracy in 1991.

MSF runs a socio-medical project in Transylvania specifically aimed at meeting the needs of underprivileged and socially excluded gypsies in the area. In 1995 and 1996, work was carried out in more than a dozen communities. The main objectives of the project are to provide the local population with medical care, health education, contraception, vaccinations, and essential drugs. Special emphasis is put on the monitoring of new-born babies. Sanitation, water, and hygiene issues are other important aspects of the project. Moreover, MSF works actively against the exclusion of gypsies from Romanian society, by trying to improve their access to schooling and literacy programmes.

Family planning constitutes an important part of MSF's work in Romania. An MSF team has set up an autonomous, reliable

and competitive system to supply contraceptives to all the public family planning offices. Romanian nurses and social workers are trained by MSF in basic family planning.

In addition to its own projects in Romania, MSF supports several programmes run by other organisations. Among the beneficiaries of these projects are street children, families and children affected by HIV/AIDS, and abandoned children in institutions.

A law was adopted in early 1996, aiming to improve the situation of children abandoned in institutions and hospitals. While MSF welcomed the new legislation it also expressed concern that it was not far reaching enough.

International staff : 2

National staff : 31



POP. IN YEAR 1994
22.9 m

POP. IN YEAR 2000
22.6 m

GNP PER CAPITA
1,100 USD

ADULT LITERACY RATE,
MALE/FEMALE
99%/95x%

LIFE EXPECTANCY
70 yrs

0-5 MORTALITY RATE
29 per 1,000

POP. PER DOCTOR/NURSE
552/535

MEASLES VACC. COVERAGE
91 %

NO. OF REFUGEES/IDPs
1,200/n.a.

ALBANIA

TRAINING OF NURSES

MSF carried out three projects in Albania in 1995. The distribution programme for medical material to health structures ran until September 1995, in parallel to MSF's collaboration with the national authorities on the cold chain. A second project aimed at lowering maternal and infant mortality rates and which involved the retraining of nurses and midwives in the districts of Berat and Tirana. This project was taken over by UNICEF in April 1996. Another project was carried out in the Ali Mahali mental hospital in Vlora, where the MSF team assisted with the care of the patients. MSF was concerned by the treatment of mental patients in the institution and tried to introduce new techniques for patient care. In December 1995, the project was handed over to a Dutch psychiatric hospital.



M Daniels, Romania, 1995



RUSSIAN FEDERATION :

International staff : 41

National staff : 156

POP. IN YEAR 1994
147 mPOP. IN YEAR 2000
145,6 mGNP PER CAPITA
2,300 USDADULT LITERACY RATE,
MALE/FEMALE
100%/98x%LIFE EXPECTANCY
68 yrs0-5 MORTALITY RATE
31 per 1,000POP. PER DOCTOR/NURSE
254/177MEASLES VACC. COVERAGE
88 %NO. OF REFUGEES/IDPs
50,200/490,000

CHECHEN CRISIS FAR FROM OVER

In June and July 1996, President Boris Yeltsin successfully fought off a concerted attack in the presidential elections from the Communist leader Gennadi Zyuganov. Mr Yeltsin's prospects would be boosted by a resolution of the Chechnya conflict which is unpopular at home and has done some damage to Yeltsin abroad. Unemployment continues to grow.

MSF has been running a programme for the homeless and the poor in Moscow. Teams provide patients with health care treatment and vaccinate them against disease. The success of this mission lies in the fact that MSF has found an effective way to reach its target group. Most of the consultations are carried out by a mobile team working out of a bus and mobile homes in three railway stations. There is also one permanent dispensary in the centre of the city. Emergency hospitalisations are organised with the Ministry of Health and in collaboration with Moscow hospitals. There are on average 3,000 consultations a month. Social consultations are provided at the dispensary. Services provided include aid for reintegration, information, "protection"

and clothes distribution. Teams also provide psychological consultations.

Tuberculosis programme in Siberia

MSF has launched a project to treat tuberculosis (TB) in the prison hospital in Mariinsk, Central Siberia. Overcrowding is a problem. There are 1,800 patients in the hospital which has a capacity for 700. In effect, all prisoners showing symptoms of TB are brought from the camps of Central Siberia to be treated here. However, the quality of treatment is poor. A large number of the patients leave without being properly cured and remain contagious. Teams are working on changing the protocols for treatment, medical supplies and improving hospital hygiene.

CHECHNYA

Despite the Peace Plan, the war in Chechnya continues. Since the beginning of the conflict in December 1994, it is estimated that 40,000 people have died. Thousands more are missing. In April 1996 alone, 25,000 new Chechen refugees arrived in Ingushetia and 20,000 in Dagestan. There are now around 110,000 Chechen refugees. No-one knows how many more people are displaced within Chechnya.

Support for health structures in Chechnya

From July 1995 to the end of June 1996, MSF was working in the Chechen capital, Grozny, and the districts of Vedeni, Nozajurt, Kurchaloi and Chatoy. As we go to press, all MSF operations in Chechnya, with the

exception of a sanitation programme in Grozny carried out by local staff, have been temporarily suspended owing to insecurity. MSF is presently talking to local authorities in an effort to find a way to relaunch the programme in more acceptable circumstances.

MSF has been working in the Chechen capital since the outbreak of the war. Activities centred around the Republic reference hospital, where an MSF team worked throughout 1995 and 1996. The team also carried out rehabilitation work on the hospital. MSF supplied the hospital and an additional nine polyclinics with medicine and medical material. MSF also monitored the proper use of medicine and supported the Central Pharmacy. During the winter of 1995/1996, MSF

stepped up its food distribution programme, supplying dry rations to hospitals, clinics, old peoples homes and orphanages. From January to March 1996, the team also distributed 1,400 hot meals to 30 distribution points. Another focus of the Grozny project was water and sanitation work. The team did some preliminary work on the damaged water supply system, while being involved in the water trucking initiative. MSF also distributed plastic sheeting, blankets, mattresses and hygienic products to the victims of war and returning refugees.

MSF worked in the rebel-controlled south east of Chechnya until April 1996. Activities centred around the supply of medicine and medical material to the Vedenno hospital and health structures in the Vedenno district. The MSF team renovated Vedenno Hospital and followed up on patient care. Relief goods were also distributed among the inhabitants of the town whose homes had been damaged or destroyed during heavy shelling. In 1996, MSF also distributed dry rations to the vulnerable populations.

From February 1996 onwards, MSF no longer had access to Nozajurt and Kurchaloi. In the former MSF had managed to rehabilitate the hospital. The team based in Daghestan had also donated drugs and equipment (including a generator and an incinerator) to the hospital. In Kurchaloi, MSF supplied medicine and medical material to health structures. MSF's medical distribution programme to the health structures in Chatoy came to an end in September 1995.

MSF's work with Chechen displaced

Most of the Chechen displaced are living in temporary sites in the neighbouring republics of Daghestan, Ingushetia and North Ossetia. In Chasavjurt, Daghestan, MSF provides medical and sanitation assistance in 50 community centres where Chechen refugees live. The team also gives logistic support to newly arrived convoys. MSF has mobile medical teams in the area who provide consultations to refugees and locals. The team provides water and sanitation assistance in the collective centres

and distributed dry food rations to the displaced in the winter of 1995/1996.

In Ingushetia, MSF runs a programme for the displaced which mainly revolves around assistance in the hospitals and in pharmacies. The MSF team is in charge of all displaced sites and has as its objective the idea of reducing them from 99 to 43. The first phase of vaccinations against diphtheria were carried out in 1995. MSF is preparing to launch a programme to combat rickets in the children of the displaced. There is also a hospital hygiene programme for the gynecological obstetrics ward in Nazran. Logistics is an important part of the programme, given the great needs for water and sanitation for refugees.

MSF provides medical assistance and supplies medicine and medical material to Oktiabrskoie Hospital in Prigorodny in North Ossetia. Teams work in a centre for the prevention and treatment of sexually transmitted diseases (STDs) and several local health centres. An important part of the programme is the supply of medicine and medical material to pharmacies for the displaced. In North Ossetia's Stavropol region, MSF provides assistance in chlorinated production for the infections hospital in Piatigorsk. MSF also provided emergency material to Zelinakoumsk, Piatigorsk, Stavropol during the hostage taking in Boudienovsk.

On 18 April 1996, as the G7 heads of states met to discuss the non proliferation of nuclear weapons, MSF issued a report on the systematic bombing and killing of civilians with conventional weapons which was continuing in Chechnya. MSF teams working in Chechnya, and with Chechen refugees in North Ossetia, Daghestan and Ingushetia reported that civilians were continuing to be targeted and villages flattened in the war campaign.

T Voeten, Chechnya, 1995



PEACETIME ACTIVITIES

The US government intensified its efforts to bring about peace in the countries of former Yugoslavia in the summer of 1995, inviting the presidents of Croatia, the Federal Yugoslav Republic and Bosnia-Herzegovina to a round table talk in Dayton, Ohio. A peace agreement was initialled on 21 November and signed in Paris on 14 December. Most of the negotiations focused on the dividing line between the Muslim/Croatian Federation and the Serb Republic.



A Kazimirovic, Gorazde, 1995

1995 was marked by the fall of the Bosnian enclave of Srebrenica. The MSF team provided medical assistance to the Bosnian people throughout the siege, only leaving on 21 July after the enclave had been taken by Serb forces and the deportations to central Bosnia had begun. 8,000 Bosnian men disappeared at this time and their lives are still unaccounted for, although there is increasing evidence that many of them were killed by Serb forces. In Kladanj and Tuzla, MSF workers took care of the newly-arrived refugees from Srebrenica. MSF teams distributed food,

covers and water. They also set up refugee centres where they provided medical care. MSF denounced the fact that the international community had failed to prevent the fall of a so-called "safe area".

In August 1995, Croatian forces carried out an onslaught on the Krajina, where they drove 200,000 Serbs from their homes. MSF teams set up way stations on the road between Banja Luka and FYR for those fleeing. The refugees were provided with food, water and medical assistance. In September another 100,000 Serbs were forced out following an offensive in north-western Bosnia. MSF responded by providing medical, water and sanitation assistance to the collective centres where the 100,000 Serbs gathered. During the autumn of 1995, thousands of Croats and Muslims who were pushed by the Serbs of Banja Luka to the borders, received medical care and water from the MSF teams.

International staff : 55

National staff : 167

BOSNIA-HERZEGOVINA

Medical distribution

MSF has been running a large-scale distribution throughout Bosnia-Herzegovina since the war began. While continually monitoring nation-wide drug availability, the MSF team supplies medical structures with badly-needed medicine and medical material. Teams also distribute family parcels, which contain food and hygiene products, to

12,000 health care workers, many of whom are unpaid. Thousands of hospital patients receive complementary food. Hygiene kits are sent to 30 medical structures on a monthly basis. MSF also built 85 incinerators for the main structures in Tuzla and Zenica.

MSF is still present in the last Bosnian enclave, Gorazde, where teams work in the surgical wing of the hospital. Rehabilitation



and sanitation work has already begun in several refugee centres. The team has also distributed 17,000 family parcels to the inhabitants of the enclave. A solidarity operation "Toys for Gorazde" was also launched in 1995.

Psycho-social programme

A psychological relief project is being run in Sarajevo for those who are still coping with the mental stress of living under siege conditions. Local aid workers were trained and deployed in five mental health centres. In addition, Sarajevans are given psychological counselling through a weekly radio broadcast. This project has been extended to Zenica.

In 1995, MSF ran a specific anaesthesia project in Mostar. A general medical

project is carried out in Maglaj which has also been combined with a physiotherapy project. In Maoca, 80kms from Tuzla, MSF was running a war trauma project in the district hospital. Since the ceasefire, the team has focused on redefining this hospital project. A surgical ward was built at the end of 1995 and a surgical team installed.

In 1995, MSF rehabilitated 54 structures including primary health care units (ambulancias), city pharmacies, hospitals, public kitchens and collective centres.

MSF supplies medicine and medical material to 33 dispensaries and 30 health posts throughout Eastern Bosnia, in the area controlled by Bosnian Serbs. MSF is supervising the rehabilitation of the Sokolac psychiatric hospital.

CROATIA

Aid to rebel refugees

Along the Dalmatian coast the psychological and social programme started by MSF in 1994 to assist the displaced persons and refugees from the Omis and Split regions continued to develop. MSF has trained 15 psychologists and social workers and is supporting the creation of a local specialist NGO. Already, 250 families have received counselling.

After the joint Muslim/Croat forces broke the siege of Bihac and took the Krajina, 25,000 Muslim rebels who had been fighting with the Serbs against the 150,000 other Muslims, fled from the pocket with their leader, Fikret Abdic. The rebels and their families were then blocked on a 4.5km road at Kupljensko. MSF intervened in the chaotic emergency phase with medical, water and sanitation assistance. The team took charge of health care for the population.

FORMER YUGOSLAVIA



FEDERAL YUGOSLAV REPUBLIC

Drug donations to Serbian health structures

The MSF team is still donating drugs to hospitals throughout Serbia. Until April 1996, MSF continued to distribute hygienic kits to 50 collective centres in Voivodine where 9,000 Serb refugees expelled from the Krajina had gathered. Since April 1993, MSF has been working in Kosovo, an area with a population that is 90% Albanian. Main activities include drugs

distribution to both the official structures of the Ministry of Health and ambulancias run by a local Albanian NGO called "Mother Teresa". MSF was also involved in the rehabilitation of official structures. Initial agreement was to cover the needs of 600,000 people living in two districts via official structures. MSF managed to support Mother Teresa ambulancias in other districts and now covers 80% of their needs by supplying 45 ambulancias out of 77. The MSF team also carried out two anti-lice and scabies campaigns in the first half of 1996.





POP. IN YEAR 1994
39.6 m

POP. IN YEAR 2000
39.8 m

GNP PER CAPITA
13,600 USD

ADULT LITERACY RATE,
MALE/FEMALE
97%/93%

LIFE EXPECTANCY
78 yrs

0-5 MORTALITY RATE
9 per 1,000

POP. PER DOCTOR/NURSE
262/246

MEASLES VACC. COVERAGE
90 %

NO. OF REFUGEES/IDPs
5,100/n.a.

FOCUS ON THE VULNERABLE

José María Aznar, leader of the conservative Partido Popular (PP) won a slim victory in the March 1996 Presidential election, over Felipe González and the Partido Socialista (PSOE) which had been in power since 1982. Spanish unemployment rates remained among the highest in Europe.

Despite good national health indicators and a generous social security system, the population groups that are excluded from Spanish health care grow larger every year. The seriousness of the problem made MSF intervene medically in Barcelona in 1994. The project focuses on vulnerable groups, such as certain immigrants, drug addicts, and alcoholics. Other main beneficiaries are Gypsy and Moroccan communities who live in isolation from Spanish society. An estimated 30,000 immigrants in need of health care reside in the department of Catalonia. Approximately 170,000 people in the area live in poverty.

The main project objective in Barcelona is to improve the health of vulnerable and excluded population groups, especially by preventing common diseases. The activities include providing medical assistance and prescribing medicines. Apart from the purely medical part of the project, MSF staff

conduct seminars and courses on sanitation issues and provide excluded people with information about how the health care system works and what legal rights they have to medical care.

By using a mobile clinic - a converted bus - the team moves around the city making regular stops at places that are easy access for the city's most vulnerable inhabitants. In addition to the bus, MSF works with small "flying" teams, often consisting of a nurse and a social worker. These teams visit the poorest parts of Barcelona and its surroundings, trying to identify and evaluate medical and social needs among the population.

All the medical care provided by MSF in Barcelona is free of charge, and the patients can remain anonymous.

Staff: 15



O Boe, Barcelona, 1995

TURKEY

AUTHORISATION DENIED

MSF worked in southeastern Turkey from mid-1995 to early 1996. The team left after being denied permission by the local authorities to continue its activities. During the intervention, MSF staff collaborated with a local Turkish organisation in supplying four dispensaries with essential medicines and equipment. MSF also intervened in Dinar after an earthquake shook the town and left thousands of families homeless in September 1995. MSF provided the victims with medical care, blankets, water, and sanitation structures.

CENTRAL *and* SOUTH AMERICA

AMERICA



R Job, Nicaragua, 1995





POP. IN YEAR 1994
7.2 m

POP. IN YEAR 2000
8.3 m

GNP PER CAPITA
760 USD

ADULT LITERACY RATE,
MALE/FEMALE
88%/71%

LIFE EXPECTANCY
59 yrs

0-5 MORTALITY RATE
110 per 1,000

POP. PER DOCTOR/NURSE
2,564/7,692

MEASLES VACC. COVERAGE
86 %

NO. OF REFUGEES/IDPs
n.a./n.a.

PREVENTING COMMON ILLNESSES

Bolivia continued to be plagued by political instability during the year. Conflicts between President Gonzalo Sánchez de Lozada's government and coca-growing farmers in the Chapare region led to frequent protest marches, hunger strikes and violence. Trade unionists also clashed with the government over issues such as declining wages, rising unemployment and a widening income gap.

Bolivia's health indicators remain among the worst in Latin America, with an average life expectancy of 59.4 years. The indigenous majority (the Quechua and Aymara Indians) are effectively excluded from many public services and often live in serious poverty.

MSF currently operates two long-term projects in the country: one in the Illampu district in the western part of the country and the other in the Mizque district in central Bolivia. Both areas are extremely poor, and have health indicators which are significantly worse than the national average. The projects aim to improve the health of local indigenous populations and prevent the most common illnesses, such as diarrhoea and respiratory problems. Training of local personnel is also an important element of the projects. With

increased knowledge about basic health issues, MSF hopes that community participation in the health care system will increase.

Approximately 115,000 indigenous people, most of them Aymara Indians, benefit from MSF's Illampu project. The project in Mizque reaches about 34,000 people, most of them small farmers belonging to the Quechua ethnic group.

Cholera is a major concern of both MSF's projects in Bolivia. The organisation dealt with several outbreaks in the period July 1995-July 1996. Such interventions were handled within the framework of the long-term projects.

International staff : 8

National staff : 23

MALARIA

Malaria is by far the world's most prevalent tropical disease. It kills more children than any other communicable disease (tuberculosis claims more adult lives). Although the geographical area affected by malaria has shrunk considerably over the past 50 years, it is becoming increasingly difficult to fight the disease. The disintegration of health services, armed conflicts and mass movements contribute to the spread of malaria, and refugees and internally displaced persons are high risk groups. WHO estimates that there are between 300 and 500 million malaria cases worldwide annually. Approximately 90 percent of those are found in sub-Saharan Africa, but northern South America and parts of Southeast Asia are also heavily affected by malaria.

Malaria is caused by parasitic protozoa of the genus Plasmodium which are transmitted by the female Anopheles mosquito. Treatment is with drugs, but resistance is increasing, making new drugs essential. However, the poverty of those most affected provides little incentive for the pharmaceutical industry to develop effective medicines against malaria. Recent research suggests a good possibility of an effective vaccine by the end of the decade. Preventive measures include the use of mosquito nets and insect sprays. Chemoprophylaxis can be given to high risk groups, such as pregnant women and severely malnourished children.

AID TO THE WEAKEST

Land redistribution continued to be a major focus of political conflict in Brazil. Dozens of landless peasants were killed by police in different parts of the country. As in previous years, urban violence remained a serious problem, especially in the slum areas of Brazil's. President Fernando Henrique Cardoso's financial plan (Plano Real) produced some positive results in 1995.

MSF's projects in Brazil seek to provide medical care to slum dwellers, street children, and other homeless people in major urban centres, and to indigenous peoples living in remote rural areas.

Poverty and Violence

As part of its work in urban areas, MSF has established a health post in one of Rio de Janeiro's most violent favelas (slum neighbourhoods) - Vigário Geral. Staff provide medical and psychological care for children and juveniles whose critical health situation is aggravated by the violent environment they live in. MSF has also helped to create a health cooperative for adults in the favela. Through a referral system, seriously ill patients can obtain access to appropriate medicines and specialist treatment.

In August 1995, MSF opened a health post in downtown Rio de Janeiro where approximately 1,000 people lived under a viaduct without electricity, water or sanitation. In May 1996, this population was forcibly relocated to an area called Vila dos Pinheiros. Soon after their relocation, 350 additional families joined the community there. MSF quickly set up a health post in Vila dos Pinheiros, providing the local population with basic health care.

Both in Vigário Real and in Vila dos Pinheiros, MSF distributes contraceptives to local residents and provides information and training on topics such as family planning, child care, and the prevention of sexually transmitted diseases.

In cooperation with local organisations, MSF staff provided street children in Rio de

Janeiro with medical and psychological support until late 1995. In October 1995, MSF started focusing its work with street children on the development of a referral system which gives these children access to specialist care.

Malaria Control

MSF runs two projects in remote areas of rural Brazil; one in the state of Roraima in the northeastern part of the country, and the other in the state of Amazonas which lies near the border with Peru and Colombia. Both projects aim to provide basic medical care to indigenous populations which have increasingly fallen victim to malaria, influenza and other diseases after the arrival of goldminers and other external groups into their traditional home areas.

The project in Roraima state focuses on malaria control, as malaria is the most prevalent and fatal disease in the area. Particular attention is paid to the training of local community health workers to diagnose and treat the disease. MSF provides microscopes, medicines and other logistical support to the Caso do Índio hospital. Direct medical care by MSF staff is only offered on an emergency basis.

In the Javari Valley area of Amazonas state, MSF works with an indigenous population which has suffered serious outbreaks of malaria in recent years. As in Roraima, the training of local people to diagnose, treat, and monitor the disease is a crucial element of the project. However, the logistical difficulties encountered by teams in the Javari Valley are more daunting. The area can only be reached by river, and the trip takes at least three to four days in good weather.

BRAZIL



POP. IN YEAR 1994
159 m

POP. IN YEAR 2000
175 m

GNP PER CAPITA
2,900 USD

ADULT LITERACY RATE,
MALE/FEMALE
82%/80%

LIFE EXPECTANCY
66 yrs

0-5 MORTALITY RATE
61 per 1,000

POP. PER DOCTOR/NURSE
847/3,448

MEASLES VACC. COVERAGE
76 %

NO. OF REFUGEES/IDPs
2,200/n.a.

International staff : 7

National staff : 25



POP. IN YEAR 1994
34.6 m

POP. IN YEAR 2000
37.8 m

GNP PER CAPITA
1,400 USD

ADULT LITERACY RATE,
MALE/FEMALE
90%/90%

LIFE EXPECTANCY
69 yrs

0-5 MORTALITY RATE
19 per 1,000

POP. PER DOCTOR/NURSE
1,064/2,632

MEASLES VACC. COVERAGE
87 %

NO. OF REFUGEES/IDPs
n.a./600,000

POVERTY AMID VIOLENCE

Allegations that President Ernesto Samper had accepted money from the infamous Cali cocaine cartel triggered a serious political crisis. The police, the military, and state-backed "death squads" were accused of hundreds of political killings and "disappearances." Several guerrilla groups remained active. The economic situation remained reasonably stable during 1995, but in early 1996 it began to show signs of decline.

Colombia's health indicators are good by Latin American standards, with low child mortality rates. However, poverty continues to be a serious problem both in rural areas and in the cities' extensive slums, where severe malnutrition is common especially among children.

MSF runs an assistance programme in the regional hospital in Buenaventura on the Pacific coast. MSF staff provides medical care in the paediatric and emergency wards and ensure the availability of equipment and essential medicines. Training and supervision are also important aspects of the programme.

Traditional Medicine

In the village Puerto Merizalde, three hours by boat from Buenaventura, an MSF team supports the local hospital medically and logistically. The beneficiaries of the project are approximately 20,000 people, most of whom live in acute poverty. MSF has also set up a mobile team which travels by boat to different villages in the area, offering basic health care, including vaccinations and odontological services. The mobile team provides local communities with information on health-related issues, such as sanitation, hygiene and nutrition. Diarrhoea, malnutrition, intestinal and skin infections, malaria, and respiratory problems are commonplace in the area.

One important aspect of the Puerto Merizalde project is the exchange of knowledge between traditional doctors and the MSF staff. The aim is to familiarise local

medical experts with Western medicine and to allow MSF to learn about local systems of traditional medicine.

In the towns of Silvia and Tierradentro, MSF runs two medical projects supporting which provides almost 49,000 indigenous people with medical care and training. One of the main goals there is to create a primary health care network in order to reduce morbidity-mortality rates. A special emphasis is placed on mother and child health programmes. The projects also include the rehabilitation and construction of local health clinics.

International staff : 8

National staff : 27



Q. Roser, Colombia, 1995

AIDS AWARENESS AND PREVENTION

President Fidel Castro maintained power despite increasing pressure for democratic reform. In March 1996, the US Congress passed the "Helms-Burton" bill, further tightening the long-standing embargo on Cuba. The number of tourists visiting Cuba increased by 75 percent in 1995, adding an estimated 1 billion USD to the country's economy.

Cuba still boasts one of Latin America's most comprehensive, equitable and effective health care systems. The system has helped to raise the average life expectancy in Cuba to 75 years, almost twenty years higher than the average in neighbouring Haiti. MSF's activities in Cuba are therefore not focused on basic health care.

In early 1996 MSF launched an HIV/AIDS awareness and prevention project in the capital city, Havana. The project was established in response to a notable rise in the incidence of sexually transmitted diseases (STDs) in recent years - a rise partly due to booming tourism and an associated increase in prostitution. Public education, especially among vulnerable groups such as prostitutes, is a key aspect of the project. MSF also began distributing some six million imported condoms during the year.

MSF operates sanitation and water chlorination projects in the country, from which approximately 2 million Cubans benefit. Much of the chlorination work has been concentrated in the Guantánamo area, the poorest part of the country. However, MSF provides training and basic materials for water chlorination in all of the country's provinces.

In addition to these long-term projects, MSF intervened in several emergencies during the year. In early 1996, MSF ran an assistance programme in a number of rural areas where a deadly virus was spreading through the "Aedes Albopictus," a mosquito of Asian origin. In order to prevent an epidemic, MSF organised initial fumigations of the affected areas and then provided the local authorities with the necessary equipment to continue the work.

International staff: 1 / National staff: 2

CUBA



POP. IN YEAR 1994
11 m

POP. IN YEAR 2000
11.4 m

GNP PER CAPITA
1,200x USD

ADULT LITERACY RATE,
MALE/FEMALE
95%/94%

LIFE EXPECTANCY
75 yrs

0-5 MORTALITY RATE
10 per 1,000

POP. PER DOCTOR/NURSE
332/180

MEASLES VACC. COVERAGE
93 %

NO. OF REFUGEES/IDPs
2,000/n.a.

COSTA RICA

PREPARING FOR EMERGENCIES

MSF runs a regional office in San José, Costa Rica, which facilitates the work of MSF teams in Central America and the Caribbean. One key responsibility of the office is the coordination of emergency interventions, mostly in the event of natural disasters but also in cases of armed conflict and epidemics. The office provides technical, logistical and educational support for MSF emergency teams, and maintains a stock of essential drugs and equipment. Between July 1995 and July 1996 the office coordinated several major emergency interventions in response to flooding, earthquakes, cyclones, volcanic eruptions and dengue fever epidemics in the area.

In addition to ensuring emergency preparedness, the office in San José is responsible for much of the organisation's official communication with government health ministries in the region. The office also gathers and processes information relevant to the health situation in the region.



Q. Roser, Colombia, 1995



POP. IN YEAR 1994
10.3 m

POP. IN YEAR 2000
12.2 m

GNP PER CAPITA
1,100 USD

ADULT LITERACY RATE,
MALE/FEMALE
61%/46%

LIFE EXPECTANCY
65 yrs

0-5 MORTALITY RATE
70 per 1,000

POP. PER DOCTOR/NURSE
4,000/7,143

MEASLES VACC. COVERAGE
66 %

NO. OF REFUGEES/IDP's
4,700/200,000

ASSISTANCE TO THE MARGINALISED

Alvaro Arzú of the conservative Partido de Avanzada Nacional won the presidential elections on 7 January 1996. Negotiations for a peace treaty between the government and the guerrilla movement Unidad Revolucionaria Nacional Guatemalteca (URNG) continued. Economically, Guatemala continued to be a divided country, with most of the wealth concentrated in the hands of a small elite, while the indigenous majority live in poverty.

The wide gap between rich and poor is reflected in the health of the population with large segments excluded from basic health care services. Among the groups most commonly excluded are the urban poor, refugees returning from Mexico, and rural indigenous populations living in isolated areas and in zones of armed conflict. These groups are the principal beneficiaries of MSF's projects in Guatemala.

Slum Clinics

MSF has worked with a local organisation, APRI, in slum areas of the capital, Guatemala City, for the last ten years. The main tasks there are the provision of medical care and sanitary support to local populations,

the training of health workers, and the distribution of essential medicines to local pharmacies. One especially vulnerable group which receives MSF support in Guatemala City is the population of El Basurero, a garbage dump where hundreds of families live and work recycling garbage.

During the year, MSF provided emergency medical care to the many poor residents of Guatemala City affected by a dengue fever epidemic, and carried out preventive programmes and epidemiological surveillance in the city.

In March 1996, MSF started working with a local organisation, Casa Alianza, to provide medical and psycho-social assistance to street children. MSF is proposing to start another programme inside juvenile detention centres.

Problems of Access

MSF works with the Ministry of Health training community health workers, assisting community pharmacies, rehabilitating health centres and providing safe drinking water and latrines.

Almost 15,000 indigenous people who formed an underground association: the Community of Populations in the Resistance (CPR) in the Sierra area of the country receive MSF assistance. Teams run a medical and sanitary project in an area only accessible by a two-day walk from the nearest road. As the medical training programme phases out, MSF continues to monitor the medical situation.



Ignasi de Juan-Creix y Breton, Guatemala, 1996

MSF runs a medical project in the Livingston and Fronteras municipalities of Izabal. Several of its villages are isolated for months at a time. Distribution of essential drugs, training of midwives, community healthworkers and nurses and rehabilitation of the primary health care system are priorities.

In Petén, several villages are accessible only by water, so the population does not benefit from health, education and other services for long stretches of the year. A primary health care programme is targeted at both the Ladino indigenous population and returning refugees.

In Todos Santos, MSF community health workers help to provide basic health care, medical education and logistical support to indigenous residents of 39 villages. Special emphasis is placed on cholera and HIV prevention, and several mini-clinics have been established.

In the Barillas municipality, MSF supports Guatemalan refugees returning from Mexico as well as the local population in 40 villages.

International staff : 85

National staff : 526

MEXICO

AID TO EARTHQUAKE VICTIMS

In October 1995, an earthquake registering 7.5 on the Richter scale shook the Colima and Jalisco area of southwestern Mexico, leaving some 60 people dead, 100 injured and 10,000 homeless. An MSF team went to the area to provide the victims with shelter, clean water, latrines and other logistical support. The team stayed in the area for seven weeks to deal with the effects of the first earthquake and of several smaller aftershocks.

DEVELOPING BASIC HEALTH STRUCTURES

The government of President Sixto Durán-Ballén faced widespread strikes and protests in late 1995 and early 1996. The border conflict with Peru appeared set to flare up again, but was avoided. Abdalá Bucaram won the second round of Presidential elections on 7 July 1996. Ecuador's economy suffered a sudden and dramatic decline during 1995.

access to health care in Ecuador is highly skewed, mirroring the unequal distribution of political power, education and other state services. For the indigenous majority, the general standard of health care is poor.

MSF works in the town of Cotacachi in northern Ecuador. The objective of the project there is to develop basic health care structures for the local indigenous population. Special emphasis is placed on improving the general health of women and children, providing vaccinations, and training of local staff. An additional goal of the Cotacachi project is to establish a primary health care system in which indigenous medical traditions are

combined with non-traditional medical practises. The local health teams which have been created are staffed by both traditional doctors and personnel trained by MSF.

In addition to the long-term project in the Cotacachi area, MSF carried out an emergency intervention in March and April 1996, in response to a series of earthquakes that hit the Cotopaxi area, 50 miles south of the capital city Quito. The initial earthquake, which registered 5.3 on the Richter scale, and several powerful aftershocks, destroyed thousands of homes and left at least 27 people dead. A snowstorm in the same area on 6 April killed dozens more.

ECUADOR



POP. IN YEAR 1994
11.2 m

GNP PER CAPITA
1,200 USD

ADULT LITERACY RATE,
MALE/FEMALE
90%/87%

0-5 MORTALITY RATE
57 per 1,000

POP. PER DOCTOR/NURSE
671/1,818

International staff : 1

National staff : 8



POP. IN YEAR 1994
7.0 m

POP. IN YEAR 2000
8.0 m

GNP PER CAPITA
370x USD

ADULT LITERACY RATE,
MALE/FEMALE
44%/38%

LIFE EXPECTANCY
56 yrs

0-5 MORTALITY RATE
127 per 1,000

POP. PER DOCTOR/NURSE
7,143/9,091

MEASLES VACC. COVERAGE
24 %

NO. OF REFUGEES/IDPs
n.a./n.a.

AID TO THE CONTINENT'S POOREST

A Presidential election, held on 17 December 1995, was won comfortably by René Préval, the candidate supported by former President Jean-Bertrand Aristide. The Haitian economy showed signs of a dramatic recovery in 1995. After recording a double-digit decline in 1994, Haiti's GDP grew by about 4.5 percent in 1995, and exports increased by more than 100 percent.

Haiti has one of Latin America's highest maternal and under-five mortality rates, and large parts of the population suffer from malnutrition. Life expectancy at 56.6 years is the lowest in Latin America. In recent times, the health situation in Haiti has been further aggravated by the fact that most international agencies stopped working in Haiti during the years of military dictatorship and extreme violence in the early 1990s.

Women and Children

In Saint-Marc, in the Artibonite department some 100 kilometres from Port-au-Prince, MSF runs a project based in the Saint Nicolas reference hospital. MSF works in the maternity ward, mainly with training, and supports the hospital with essential drugs. A surgical training programme was ended in January 1996. One part of the Saint-Marc project is purely logistical, and consists of repairing parts of the hospital buildings. In early 1996, the rehabilitation of a nearby drug depot started.

MSF also works in the northern town of Cap-Haïtien, in the country's second largest hospital. As part of this project, a feeding centre has been set up in association with the hospital's paediatrics ward, and two other feeding centres have opened in slum areas of the town. In addition to providing basic medical care, the MSF team in Cap-Haïtien trains local staff, supplies the hospital pharmacy with essential medicines, and runs a hygiene program. In February 1996, MSF set up a special project which aims to reorganise the working methods in the hospital's emergency ward.

Collecting Rain Water

In another project, based in the Grande-Anse province in the southeastern part of Haiti, MSF provides essential support to the Jérémie Hospital, the sole hospital providing services for a population of 620,000. MSF works in the hospital's surgery, internal medicine and post-operative wards, and provides administrative help to the hospital management. The central pharmacy also receives assistance from MSF, in the form of drugs, supervision of prescription methods and technical support. A cost-recovery system requires patients with sufficient funds to pay for their drugs. The money accumulated is placed in a special fund which covers the costs of medicines for those unable to pay. In addition to medical projects, MSF runs a sanitation programme in the Grande-Anse, with a focus on constructing reservoirs and ensuring safe collection of rain water.

One of MSF's projects - on Gonave Island, four hours by boat from the capital - was handed over to another international agency in the spring of 1996. During its presence on Gonave Island, MSF provided the population with basic health care, essential medicines and medical equipment. Special attention was given to improving the diagnosis and treatment of malaria and tuberculosis.

In early 1996, MSF collaborated with WHO and local counterparts in the creation of a central pharmacy in Hinche.

International staff : 20

National staff : 54

WORKING IN SHANTY TOWNS

The political scene was dominated by preparations for the October 1996 presidential elections, the first since President Violeta Chamorro's victory over the Sandanista's in 1990.

Access to health care for both the urban poor and many rural populations has declined in recent years, largely as a result of dramatic reductions in public spending.

In Managua, MSF helps to provide basic health care and medical equipment to approximately 180,000 people in shanty towns. MSF has also established four community pharmacies in the city.

In Wiwili, in northern Nicaragua, MSF participated in the creation of a locally run pharmacy, which became operational in late 1995. The team provides the pharmacy with its stock of medicines and ensures that drugs are properly used.

In Cua-Bocay in the northern part of the country, MSF helped provide 24,000 inhabitants with access to health care through the rehabilitation of two health centres and several health posts. Training, supervision and distribution of drugs and equipment are important elements of the project.

MSF also intervened to assist local populations in a wide range of emergency situations, including cholera and plague (leptospirosis) outbreaks, floods, drought, and volcanic eruptions.

International staff: 3

National staff: 16

AID TO THE NGÖBE INDIANS

Strikes and public demonstrations were frequent in Panama between July 1995 and July 1996. The economic policies of President Ernesto Pérez Balladares were heavily criticised by the trade unions, with the privatisation of state enterprises a particular target of protest. The Panamanian economy slowed down considerably during 1995, achieving GDP growth of just 1 percent.

In comparison with the rest of Central America, Panama enjoys relatively good health indicators. However, the general statistics tend to obscure the poor health situation of many of the country's indigenous peoples.

MSF runs a project in Soloy, district of San Lorenzo in the Chiriqui province. The project benefits approximately 18,000 indigenous people from the Ngöbe ethnic groups. These populations live in precarious conditions, and many suffer from malnutrition and infectious diseases. The principal goal of MSF's work in Soloy is to improve existing health care

structures. Special emphasis is placed on improving the health of women and children.

The MSF team works in the Soloy Hospital and in various small health posts in the area, where it runs a primary health care programme. A referral system has been set up through which seriously ill members of the local population can be referred from the health posts to the hospital. Supervision of local medical personnel and distribution of essential medicines and equipment are important aspects of the programme. The activities in Soloy also include an anti-tuberculosis campaign.

NICARAGUA



POP. IN YEAR 1994
4.3 m

GNP PER CAPITA
340 USD

ADULT LITERACY RATE,
MALE/FEMALE
63%/65%

0-5 MORTALITY RATE
68 per 1,000

POP. PER DOCTOR/NURSE
2,000/3,125

PANAMA



POP. IN YEAR 1994
2.6 M

GNP PER CAPITA
2,600 USD

ADULT LITERACY RATE,
MALE/FEMALE
89%/88%

0-5 MORTALITY RATE
20 PER 1,000

POP. PER DOCTOR/NURSE
562/1,064

International staff: 5

National staff: 12



POP. IN YEAR 1994
23.3 m

POP. IN YEAR 2000
26.1 m

GNP PER CAPITA
1,500 USD

ADULT LITERACY RATE,
MALE/FEMALE
93%/80%

LIFE EXPECTANCY
66 yrs

0-5 MORTALITY RATE
58 per 1,000

POP. PER DOCTOR/NURSE
1,031/n.a.

MEASLES VACC. COVERAGE
75 %

NO. OF REFUGEES/IDPs
n.a./480,000

PARAGUAY

AID BY BOAT AND PLANE

MSF carried out an emergency intervention in Paraguay in 1995. Heavy floods in early 1995 made tens of thousands of indigenous people flee their home valley and seek refuge on a small mountain plateau in the northeastern part of the country. MSF started its intervention in March 1995, when it was clear that diarrhoea and respiratory infections had started spreading on the plateau. Teams provided clean drinking water and basic health care to the internally displaced, and ensured that those seriously ill were brought to hospital. All transportation was carried out by boat and plane. The intervention ended in October 1995.

DRUG VIOLENCE AND ARMED CONFLICT

President Alberto Fujimori was re-elected in April 1995. The government's war against drug traffickers and coca growers continued. The 1995 border dispute with Ecuador flared up again in early 1996. Guerrilla groups remained active throughout the year. Peru's economic performance was stable, with GDP growth at 6 percent in 1995, with a similar increase predicted for 1996.

The wide gap between rich and poor in Peru means that current national health indicators tell little about the situation of the poor. Residents of urban slums, indigenous populations and the country's hundreds of thousands of internally displaced persons, generally live in poverty and are excluded from most public health services.

Basic Health Care

MSF runs three medical projects in rural Peru - one in the Ayacucho region, another in the Apurimac river basin and a third in the province of Satipo.

In each of these areas, MSF provides medical care, essential drugs and medical equipment, with a focus on the care of mothers and children. The activities also include

developing the water and sanitation facilities and providing local health workers with training. The main beneficiaries are internally displaced persons and Ashaninka Indians.

In Ucayali, in the Amazon jungle, MSF provides health care and trains local health workers in an area

plagued by both guerrilla- and drug-related violence. The MSF project focuses on the rehabilitation and construction of local pharmacies and sanitary structures. Among the main beneficiaries are local Shipibo Indians.

MSF runs two projects in the department of Loreto, providing over 80,000 people with medical care and support. The main goals of the projects are to strengthen the primary health care and sanitary systems, to train local staff, to increase community participation in health-related issues, and to lower the mortality-morbidity rates in the area. MSF has sought to establish a system of local health posts in the area. MSF also promotes the growing of medicinal plants in the area.

Aid to Urban Poor

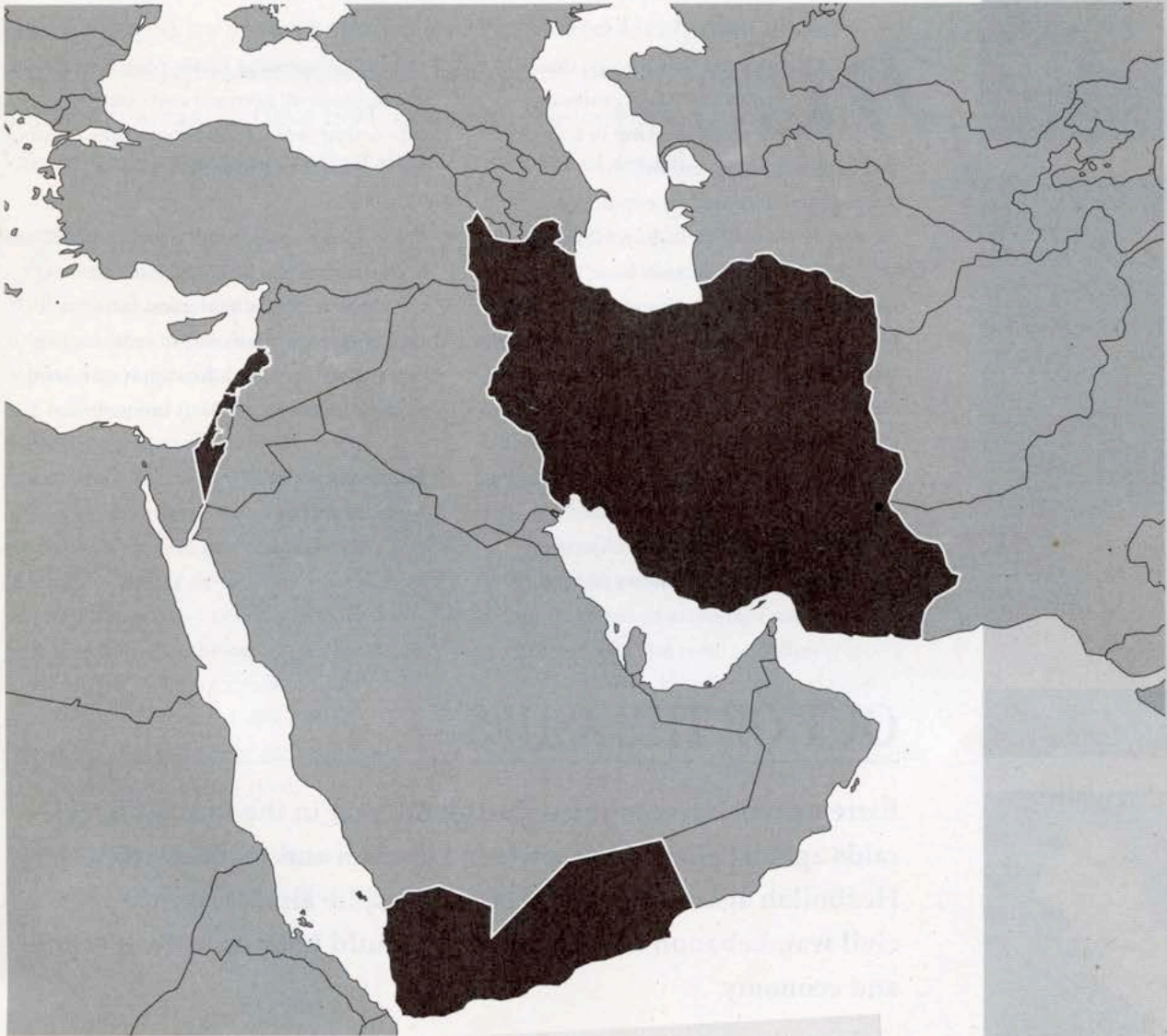
MSF works in three Peruvian prisons, two in Lima and one in Ayacucho town. Activities include the training of prison health workers and the provision of medical care, essential drugs and medical materials to prisoners.

In the shanty towns of the capital city, Lima, MSF runs a health programme in partnership with a local organisation. The project, which is based in 35 local schools, includes the provision of preventive care, tuberculosis screening, vaccinations and the training of health coordinators. The beneficiaries are not only students and teachers, but also their families.

An important part of MSF's work in Peru involves the provision of medical care in emergency situations, such as cholera outbreaks and natural disasters. In response to a cholera epidemic in Lima in mid-1995, MSF provided 14 hospitals and medical centres in the poorest neighbourhoods with medicines, logistical materials and training.

International staff: 14

National staff: 73



MSF, 1995



IRAN



POP. IN YEAR 1994
65.8 m

GNP PER CAPITA
2200x USD

ADULT LITERACY RATE,
MALE/FEMALE
72%/52%

0-5 MORTALITY RATE
51 per 1,000

POP. PER DOCTOR/NURSE
3140/1150

OPENING THE DOOR TO AID

Iran has remained largely isolated from the western world since the "Islamic Revolution" of 1979 led by Ayatollah Khomeini. The economy has suffered as a consequence, with hyperinflation of prices on basic commodities. Iranians must now pay for medical care.

MSF is the only foreign non-governmental organisation currently working in Iran. After two months of negotiations, the government accepted an exploratory mission in early 1995. In July, MSF received permission to start an assistance programme for Iraqi refugees, but due to bureaucratic delays, fieldwork did not begin until January 1996. The MSF team works in two camps, Sarvestan and Ibrahim Abad, each with approximately 2,500 refugees. MSF's activities consist mainly of improving the quality of existing curative and preventive care. The project objectives include reducing the number of hospital

referrals, improving family planning and gynaecological, prenatal and obstetric care, supporting vaccination programmes, and conducting a nutritional survey.

Other important aspects of the project are the rehabilitation of health care centres, the construction of sanitation facilities for the refugees, the training of local staff in sanitation issues, and the supply of essential medicines and material to camp clinics.

International staff: 1

National staff: 1

LEBANON



POP. IN YEAR 1994
2.9 m

GNP PER CAPITA
2,200x USD

ADULT LITERACY RATE,
MALE/FEMALE
94%/88%

0-5 MORTALITY RATE
40 per 1,000

POP. PER DOCTOR/NURSE
413/2,174

OUT OF THE ASHES

Extreme tension continued during the year in the form of Israeli raids against alleged terrorists in Lebanon and regular attacks by Hezbollah against targets in Israel. Despite almost twenty years of civil war, Lebanon has managed to rebuild both its infrastructure and economy.

After many years of medical work in Lebanon, particularly throughout the war-torn 1980s and early 1990s, MSF's long-term activities in the country were ended in December 1995. Local organisations had by then developed sufficiently to supply the population with basic health care and MSF's services were no longer needed.

However, during April and May 1996, when Hamas and Israeli armed forces exchanged deadly bombardments across the Lebanese/Israeli border, MSF again started working in the country. Thousands of Lebanese civilians fled their villages and

towns in the southern part of the country and MSF sent teams to the area to assist the displaced populations. Among the objectives of the emergency intervention were the distribution of medical and surgical material and medicine to different health centres and the upgrading of the living conditions in reception centres where displaced people gathered.

International staff: 3

TREATING BODY AND SOUL

PALESTINIAN AUTH.

The peace process with Israel, shaken both by internal troubles in the Palestinian movement and the assassination of Israeli Prime Minister Yitzhak Rabin at the end of 1995, continued. Yasser Arafat's election as president of the Palestinian Authority in January 1996 was followed by violent attacks by Hamas and Hezbollah, in response to which Israel tightened the security belt around Hebron and other areas. In June 1996, Benjamin Netanyahu, a recognised Likud hardliner was elected prime minister of Israel.



The efforts of MSF in the Palestinian Authority have focused on an area of growing awareness in humanitarian medical aid: the treatment of psychological trauma in areas fraught with tensions and conflict. Counselling for children and adolescents began in Gaza and the West Bank in 1994. In 1995-1996, MSF offered training in psychotherapy to a group of Palestinian professionals at the Mental Health Centre of Jenin. Preventive therapy was also developed to benefit groups identified as being at risk of trauma. Unfortunately, MSF's Palestinian partner in the project withdrew in 1995, and an evaluation of the future of the project was therefore started in early 1996.

nal centre of the organisation Terre des Hommes. The findings showed that a significant number of children were undernourished, and mothers were suffering from psychological problems. MSF also initiated a psychotherapy treatment programme, and the training of local personnel in collaboration with Terre des Hommes.

At the request of the Palestinian Ministry of Health, a project of preventive medicine was launched for the rural population around Hebron in 1996. Training of local health workers is one important focus of the project.

International staff : 6

National staff : 19

MSF carried out a medical evaluation in Hebron in 1996 together with the nutritio-

EGYPT

MSF IN CAIRO

In April 1996, MSF opened an office in Cairo. From this base, MSF provides medical and other assistance to vulnerable urban populations and maintains emergency preparedness in the Middle East. In addition to concrete interventions, the Cairo office fulfils the important task of gathering and analysing relevant humanitarian information about the countries of the Middle East. MSF hopes that this initiative will help the organisation understand and analyse regional emergencies.

INTO THE MOUNTAINS



POP. IN YEAR 1994
13.9 m

POP. IN YEAR 2000
17.1 m

GNP PER CAPITA
520x USD

ADULT LITERACY RATE,
MALE/FEMALE
53%/26%

LIFE EXPECTANCY
50 yrs

0-5 MORTALITY RATE
112 per 1,000

POP. PER DOCTOR/NURSE
4,348/1,818

MEASLES VACC. COVERAGE
45 %

NO. OF REFUGEES/IDPs
13,600/n.a.

In 1994, continuing differences between former North Yemen and South Yemen (officially united in 1991) erupted in a war, which was resolved by the middle of the year. Since early 1995, reunited Yemen has been reinforcing political and diplomatic links with neighbouring countries. However, it remained entrenched in a territorial dispute with Eritrea over the Hanish islands. The socialist opposition has been gathering strength in preparation for the March 1997 elections.

MSF worked in the national Expanded Programme for Immunisation (EPI) in South Yemen from 1986 to 1990. MSF left South Yemen in 1990 only to return to a reunited Yemen in 1991 where it currently runs a project in the mountainous area of Dhi Sufal. The project aims to improve the quality of health care at the district level. The team supplies essential medicines and provides the local population with primary health care, especially vaccinations and maternity care. Oral rehydration of children with diarrhoea is also an important aspect of the project. When MSF arrived, approximately 30 percent of the region's 130,000 inhabitants had no access to health care.

Apart from medical activities, the MSF team in Dhi Sufal also focuses on the construction and rehabilitation of local health care structures. Two new peripheral outreach centres were constructed during late 1995 and early 1996.

Training is another important aspect of the Dhi Sufal project. An education programme in sanitation for local staff was developed, and seminars and courses were conducted during the year. In order to ensure the sustainability of the project, it also includes a cost-recovery aspect whereby patients have to pay a small fee for consultations and medicines.

International staff : 4

National staff : 18



R Job, Yemen, 1992



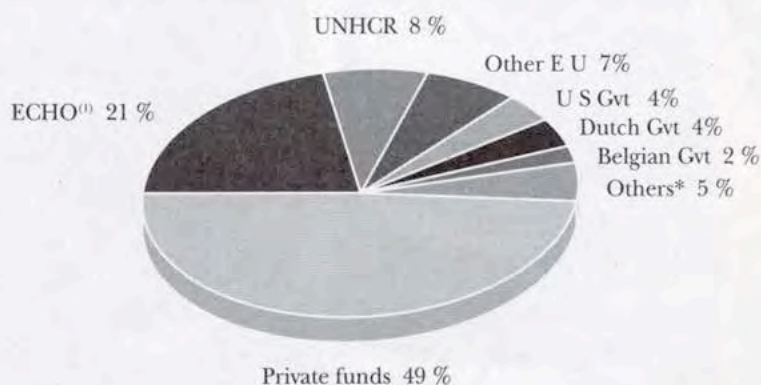
Médecins Sans Frontières is a private independent, non-profit organisation, with no political, economic or religious affiliations. MSF is comprised of 19 national entities. In 1995, 2 520 international staff worked in 70 countries around the world, collaborating with 12 000 national staff.

In order to carry out its operations, Médecins Sans Frontières receives contributions from private donors (individuals, corporations, foundations...), and also receives grants from international organisations and governments. This year, the organisation benefits from the support of more than 1.5 million active private donors.

The organisation's financial independence is guaranteed by the high percentage of private funding : MSF's objective is to raise 50% of its funds from private sources. MSF also encourages diversity in institutional funding.

MSF's income in 1995

TOTAL RESOURCES : 265 649 000 USD



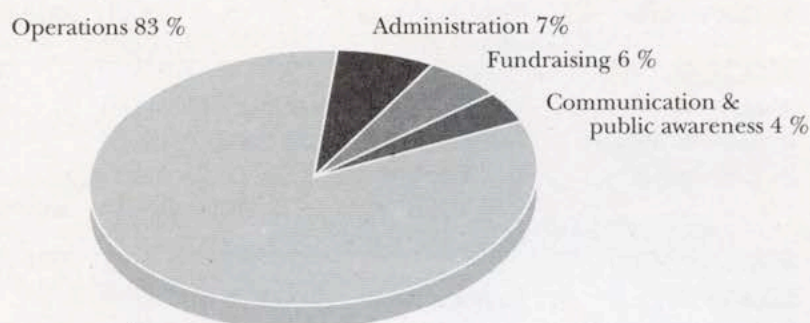
■ Private funds : 131 011 000 USD	■ United States Government : 10 316 000 USD
■ ECHO ⁽¹⁾ : 55 884 000 USD	■ Dutch Government : 9 474 000 USD
■ UNHCR : 21 830 000 USD	■ Belgian Government : 5 454 000 USD
■ Other European Union : 17 714 000 USD	■ Others* : 13 966 000 USD

* "Others" includes donor governments from Australia, Canada, Denmark, Finland, France, Germany, Greece, Hong-Kong, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland and the UK.

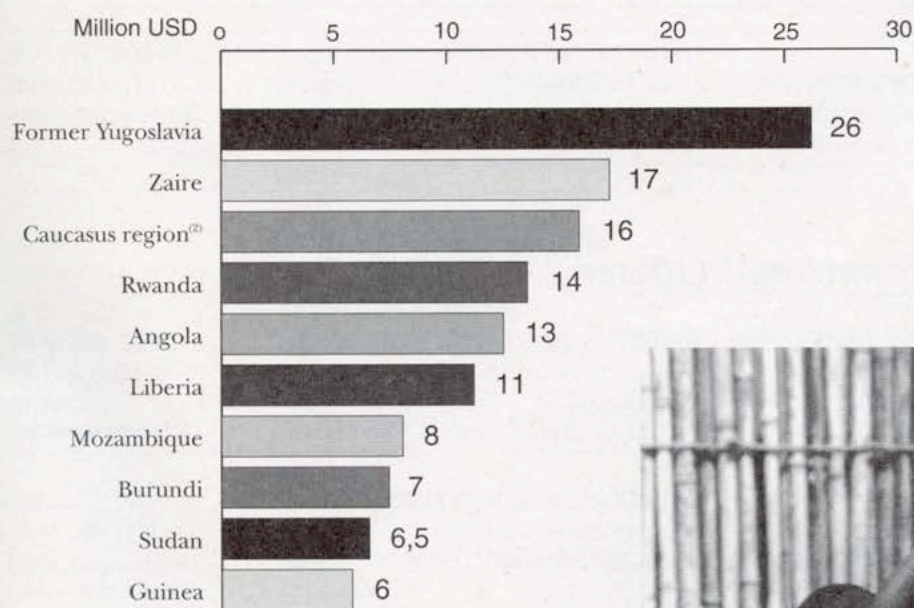
⁽¹⁾ ECHO is the European Community Humanitarian Office. UNHCR is the United Nations High Commissioner for Refugees

MSF's spending in 1995

TOTAL EXPENDITURE : 274 448 000 USD.



Breakdown of expenses per country : the ten largest recipient countries



P. Dral, Zaire, 1995

⁽²⁾ Caucasus region includes Armenia, Azerbaijan, Chechnya, Georgia.

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