

ACTIVITY REPORT

JULY 1996 - JUNE 1997



MEDECINS
SANS FRONTIERES



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photo Remco Bohle • Uganda

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Note on Statistics

The information presented in the fact boxes on individual countries in this report comes mainly from the UNDP - Human Development Report 1996 and l'Etat du Monde 1997.

Abbreviations

n.a. →	No information available
x →	Measurement that does not cover either the entire country or a whole calendar year
AIDS →	Acquired Immune Deficiency Syndrome
ICRC →	International Committee of the Red Cross
IDPs →	Internally Displaced Persons
NGO →	Non-Governmental Organisation
STDs →	Sexually transmitted diseases
TB →	Tuberculosis
UNHCR →	United Nations High Commissioner for Refugees

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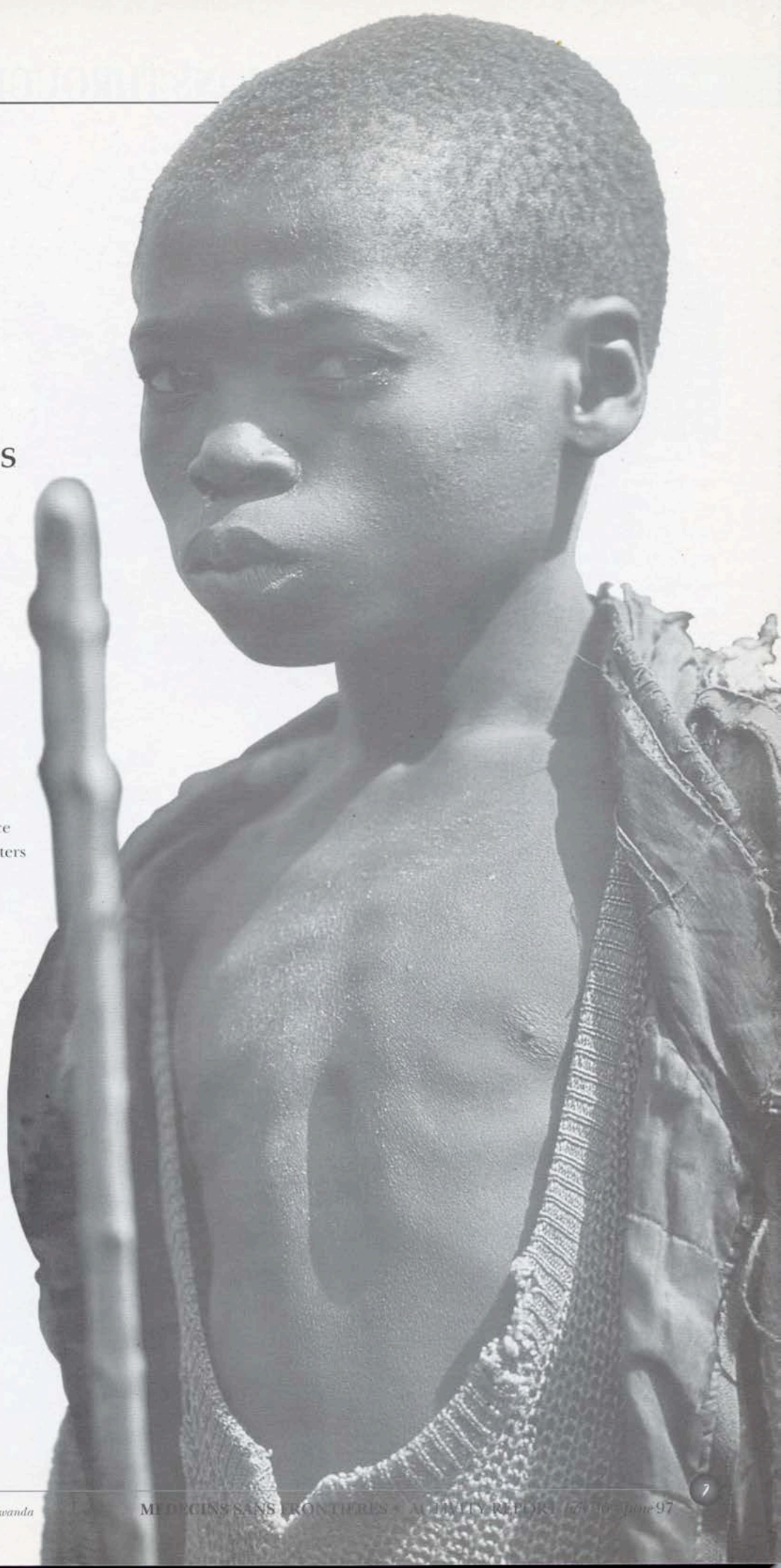
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photo Wim van Cappellen • Zaire

INTRODUCTION

This past year has been characterised by the increase in numbers of direct attacks on humanitarian organisations in war zones, notably in Chechnya, Burundi and Rwanda. Aid workers have suffered at the hands of looters, kidnappers and members of armed forces. Unfortunately, we have been forced to evacuate our teams from several areas for reasons of insecurity. We are alarmed by the growing lack of respect for the neutrality of humanitarian aid and the fact that some warring factions even perceive aid workers as parties to the conflict. On 20th June 1997, Ricardo Marques, a young doctor on his first mission for Médecins Sans Frontières in southern Somalia was gunned down as he left Baidoa hospital after his morning shift. We are outraged by this sad and senseless act and

will never accept that this is the inevitable outcome of our work in unstable regions. We are now striving to find ways to adapt to the new dangers in the field without compromising our humanitarian mission.

Despite our claim to be "Sans Frontières", in recent years access has all too often been barred to us by national authorities, armies or local warlords. The recent events in Africa's Great Lakes region are illustrative of our increasing difficulties in reaching victims. For several weeks, we were prevented from bringing medical relief to hundreds of thousands of refugees and displaced people in eastern Zaire. The border was closed off during the civil war. We urged the rebel force to reopen the border and called on the international community to put pressure on



photo Robert Maletta • Kenya

them to do so, but our cries fell on deaf ears. Médecins Sans Frontières laments the fact that few of the Rwandan refugees have received either protection or humanitarian assistance since then. We intend to continue to push for international respect for humanitarian law, one of the most fundamental tenets of which is that humanitarian organisations must be granted access to victims.

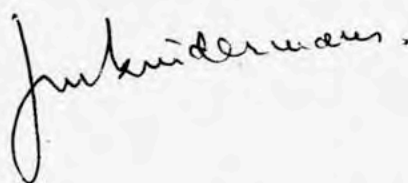
As members of the medical profession, it is impossible for us to distinguish between "good" and "bad" victims without denying our Hippocratic oath. All victims are worthy of and entitled to humanitarian aid. All sick people deserve to be treated. We know, of course, that many of the Rwandan refugees in eastern Zaïre were instigators of the genocide of 1994. We condemned their actions then, and have made repeated calls for the criminals to be separated from the main body of refugees. Since the genocide, we have remained fully committed to the work of the war crimes tribunal, because we believe that criminals must be made accountable for their crimes, particularly if reconciliation is ever to take place. However, we must also make it clear that although opposed to the notion of impunity and horrified by the manipulation of refugees by camp leaders, we want access to them all. We will always remain committed to providing the very humanitarian aid to which the refugees are entitled.

The phenomenon of the Burundian regroupement camps is another example of the sort of dilemmas we face today. The forced settlement of a population by the army is abhorrent to us. In Burundi, those who refuse to live in the camps are considered rebels and, therefore, are in danger of being killed. By providing medical assistance inside these camps we fear we might be giving our tacit support to what is, in fact, a military strategy. By avoiding them altogether - we shirk our duty as aid workers. Over this past year, we decided to provide essential medical assistance for the camp-

dweller. Our policy is to save lives, but to do nothing to set up long-term facilities in the camps. We are opposed to any initiatives which might contribute to their longevity and hope that this situation is temporary.

Although, our medical teams work in the world's foremost trouble spots, they also bring medical relief to victims in regions out of the glare of television cameras. Over this past year, Médecins Sans Frontières has worked in 83 countries throughout the world. The majority of these countries are not war zones, but areas in which civilians do not have sufficient health care coverage. Across the globe, our medical teams continued to carry our emergency medical relief programmes in the wake of epidemics and natural disasters, to pursue their longer-term efforts to stamp out endemic illnesses, to bring humanitarian relief to refugees, to provide post-war psycho-social counselling, to run AIDS awareness campaigns, to give nutritional assistance to malnourished populations, to focus on mother-and-child health care and to set up effective water and sanitation systems in order to prevent disease. In recent years, Médecins Sans Frontières has also stepped up its assistance to people living on the margins of affluent societies.

The very inhumanity displayed last year from Sierra Leone to Zaïre, Chechnya to Afghanistan only strengthens our conviction that humanitarian relief is needed. We are spurred on by our will to reach the largest number of people possible, while stressing the importance of individual patient care. It is, after all, the relationship between doctor and patient which lies at the very heart of the Médecins Sans Frontières movement.



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

26 YEARS ON : MILESTONES OF

20 December, 1971

A group of French doctors found Médecins Sans Frontières (MSF), the first non-military, non-governmental organisation to specialise in emergency medical assistance. Most of the founders have worked for the Red Cross in Biafra between 1968 and 1970. Their aim is to rectify what they perceive as the shortcomings of international aid: that it offers too little medical assistance and that aid agencies are overly reticent in the face of the many legal and administrative obstacles to the provision of effective humanitarian relief. The founders of MSF also distinguish themselves from other aid workers by their awareness of the role of the media in bringing the plight of populations to the attention of the general public.

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 - MSF's first big refugee programme. Teams provide assistance to refugees from Vietnam and Cambodia.

1978

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

1979

Thailand - MSF sends 100 volunteers to Cambodia refugee camps.

1980

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

MSF sets up its first operational centre outside France and thereby becomes an international organisation

1984

Ethiopia - extensive feeding programme launched for famine victims.

1985

Ethiopia - MSF denounces diversion of humanitarian aid and forced migration. The team 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 its biggest refugee programme ever following Gulf War. Teams provide assistance to Kurdish refugees in several countries.

A HUMANITARIAN MOVEMENT

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 population. MSF increases its activity in the field and alerts international opinion.
MSF launches its 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 triggering refugee emergency. Within a few weeks, MSF is providing emergency aid to 600,000 refugees in Rwanda and Tanzania.
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 agencies working 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, Zaïre. 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 - During the war, MSF is one of the only aid agencies to bring aid to the Chechen people inside the republic and to those who have fled to neighbouring republics

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 in Chechnya.
Sierra Leone, Burundi - MSF brings aid to the victims of war.
Zaire - Civil war breaks out. Rwandan refugee camps on the border attacked by the Alliance forces who wish to root out members of the former Rwandan army. This brings about the mass return of refugees from Uvira, Goma and Bukavu. However, many hundreds of thousands of the refugees flee into Zaire's interior where there are no facilities. MSF provides assistance where possible.

1997

Zaire - MSF fights for access to Rwandan refugees, many of whom perish.
Rwanda - Teams provide assistance to refugees during the repatriation from newly-renamed Congo

MSF CONCERNED BY

Médecins Sans Frontières is concerned by the increasing difficulties in treating patients suffering from tropical disease. While the incidence of kala azar, trypanosomiasis (sleeping sickness) and malaria rises steadily, the quality of some key drugs available in the developing world has plummeted. Médecins Sans Frontières is acutely aware that owing to war and poverty, many health services have deteriorated, are poorly staffed and function inadequately. However, this does not explain why patients in the developing world are, increasingly, endangering their lives when they go for treatment.

In recent years, drugs which can poison, such as diethylene glycol which has been used in the manufacture of paracetamol instead of the more expensive propylene glycol, have been circulating all around the developing world. The first example of this was in 1990, when 339 children in Bangladesh were admitted to hospital suffering from acute kidney failure as a result of ingesting these drugs - 70% eventually died. Potentially just as lethal, but more insidious in its progression, is the emergence in many developing countries of fake drugs and vaccines that contain little, if any, of the labelled active ingredient.

The problem of drug regulation

When a pharmaceutical company invents a drug, it is rewarded for this achievement by being granted a patent - the right to be the exclusive manufacturer. However, this patent will have a time limit, so that after a period of 20 years, the formula for the drug can be made available to all other drug companies. Consequently, the formula can be used by several manufacturers and fortunately, the price tends to drop. Adequate regulation of the drugs market is essential at this stage. In most countries of the industrialised world, following the expiry of a patent, a company wishing to produce the drug in question must prove itself capable of producing the drug correctly and only then is it granted a license. In some countries where regulation is very lax - licences are easy to come by.

photo B. Nefzuan • Rwanda

DRUG QUALITY

Seven years have now passed since the World Health Assembly first formally acknowledged the threat to public health posed by the existence of fraudulent and substandard pharmaceuticals. It is now generally accepted that the only viable recourse is to assist less developed countries in two ways: to help them organise small but effective national regulatory authorities and have a mandate to control both imported and locally manufactured products; and to create an efficient system for sharing between national authorities the information necessary to assure the quality of imported drugs and chemicals for producing drugs.

Particularly vulnerable to the tragedies that stem from the distribution of fraudulent products are countries with a rapidly expanding industrial infrastructure in which large numbers of newly established companies are competing, sometimes recklessly, to gain a foothold in the market.

When drugs are in danger of disappearing

However, in some cases, when a drug patent expires, other pharmaceutical companies have no interest in developing the drug to cure a tropical disease (such as trypanosomiasis) which is restricted to poor, under-developed countries when its manufacture is not particularly profitable. Worse still, the manufacturer is also within its rights to discontinue production of the drug if it wishes - with devastating results for people who have been stricken with a life-threatening illness.

There is also less research carried out on some of the most fatal tropical diseases. This is even more surprising given that trypanosomes, malaria, shigella, etc. are on the rise. Perhaps drugs companies are reluctant to pour money into research without being sure of a return on the investment. Since the 1940s, there has only been one drug available to treat sleeping sickness: melarsoprol. It is produced by one company, in relatively small quantities and is constantly at risk of being taken off the market.

What next?

Since the creation of Médecins Sans Frontières in 1971, we have built up a great

deal of experience in how to buy appropriate drugs at affordable prices and in adequate quantities. Today, our specialised purchasing centres deal with a limited amount of reliable drugs manufacturers. In the case of local purchase, which happens rarely, we send a pharmacist to the field to evaluate the performance of the drugs.

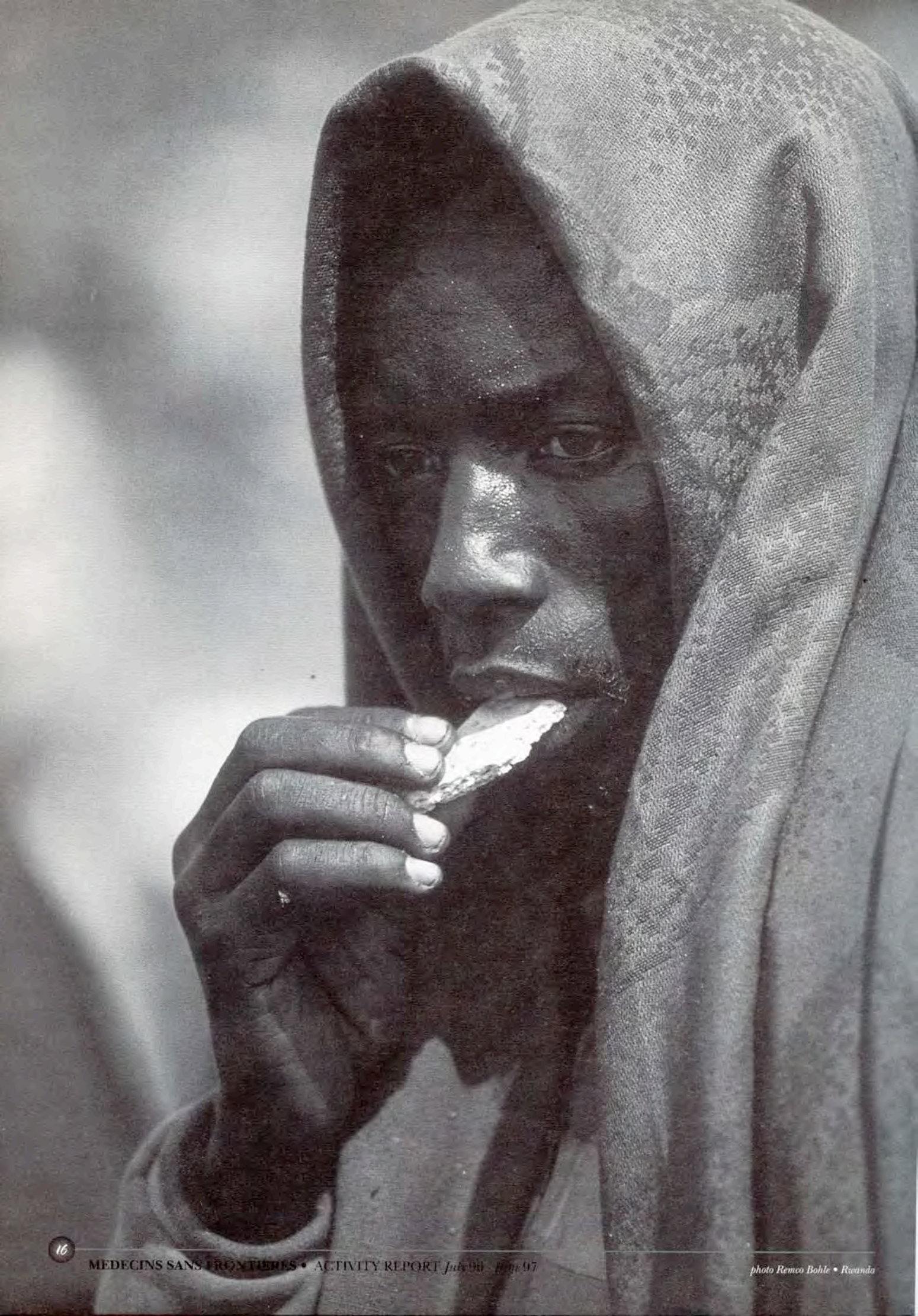
In recent years, Médecins Sans Frontières has achieved several of its objectives as regards drugs. Firstly, we have standardised the treatment of the most common diseases in order to ensure a continuous supply of essential drugs. Discussion with the International Narcotic Control Bureau has led to a simplification of international rules so that narcotics and psychotropes are made readily available during medical emergencies. Oily chloramphenicol, the simplest drug for the treatment of the epidemic form of meningitis, would have been discontinued had Médecins Sans Frontières not undertaken an effective lobbying campaign. We have also managed to bring down drugs prices by negotiating partnership agreements with certain drug companies.

Notwithstanding all our efforts, we are confronted with the results of the prevalence of phoney drugs in the field, and are acutely aware of the rise in tropical disease. We felt obliged to address this issue in a concerted fashion. Recently a special Drugs Unit was created within Médecins Sans Frontières. Not only does this working group examine practical issues such as drugs guidelines and drug use - but has a longer-term goal to lobby the drugs industry on a number of issues. We want the drugs industry to find a way to bring down prices and to get laboratories to start researching and developing treatments for tropical diseases. We also call for more clinical research and for the commercialisation of drugs which have been developed but which are being withheld for lack of a market. We also call for drug companies to renew their efforts to develop drugs, where development has been stalled for some time.



Dr. Myriam Henkens ■
International Medical Coordinator





CENTRAL AFRICA

AFRICA

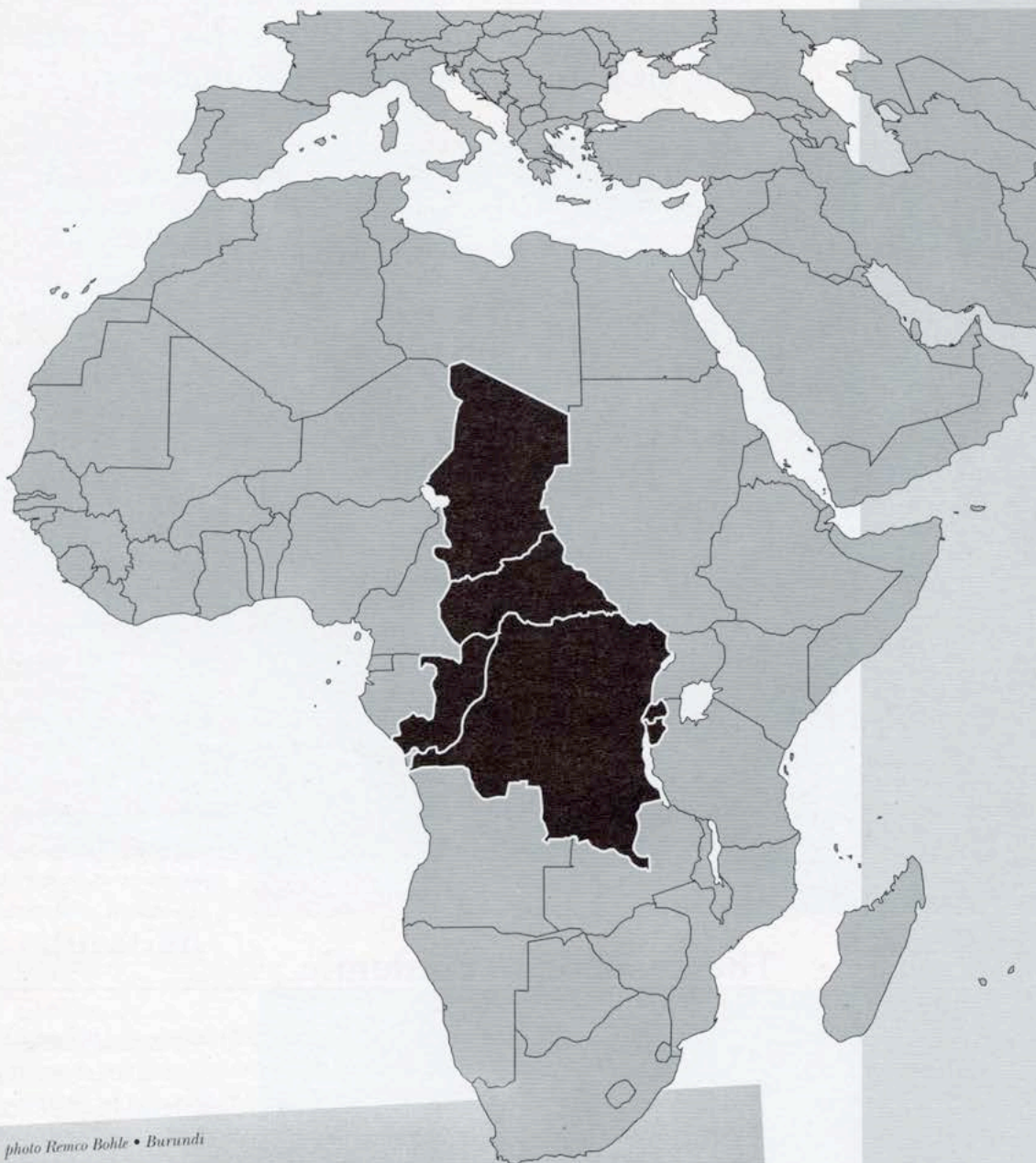
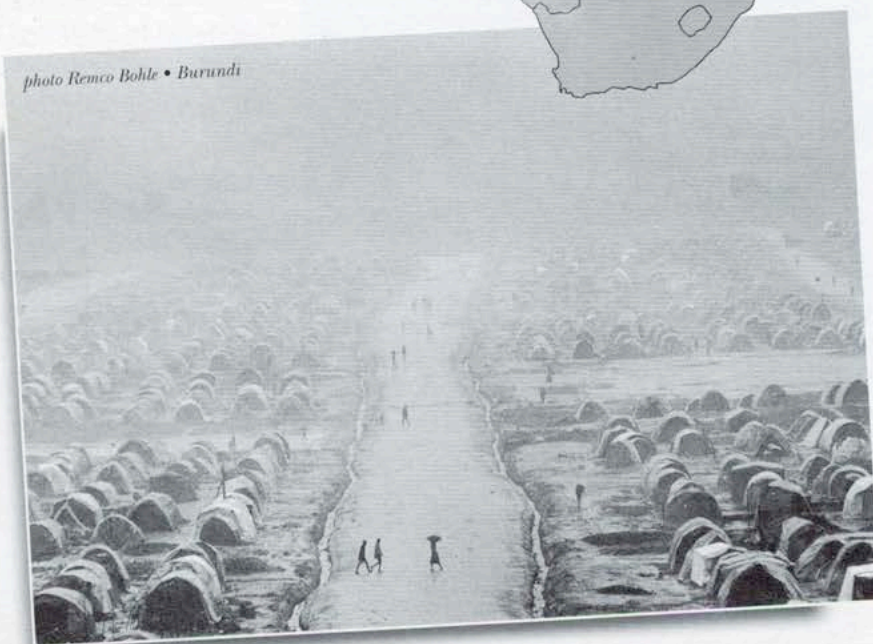


photo Remco Bohle • Burundi





Millions of people continue to die throughout the world each year from preventable disease, because they have not been vaccinated. Many of the diseases that were expected to have been eradicated by the end of the twentieth century continue to threaten large sections of the world population - diseases such as meningitis, polio, measles, yellow fever and diphtheria.



photo Remco Bohle • Nigeria

Vaccination is a priority for Médecins Sans Frontières. In every country where MSF works, it is involved in the Expanded Programme on Immunisation (EPI) which covers diphtheria, polio, tetanus, measles, whooping cough, TB and sometimes yellow fever. However, MSF also organises and participates in one-off mass campaigns following an outbreak of disease. In this case, outreach teams, screening centres and mobile teams are put in place. One or two sites are established for every 10,000 people. MSF almost always works with local personnel. One Health worker with two assistants preparing the equipment can vaccinate 350 persons per hour, or 2,000-2,800 per day. MSF also carries out preventive vaccination programmes in the case of major population displacement.

The onset of an epidemic

The declaration of an epidemic depends on the individual disease and the prevalence of that disease in a region. With yellow fever, one laboratory confirmed case is enough for an epidemic to be confirmed; with meningitis, more than 15 cases must be confirmed per 100,000 inhabitants per week for two consecutive weeks. A clinical diagnosis of a disease is often enough to start treatment, except in the case of measles. Vaccination campaigns are rarely launched before laboratory confirmation of specimens.



photo MSF • Uganda

VACCINATION

Setting up the programme



photo S. Brucher • Niger

Once the decision has been taken to launch a vaccination programme, the MSF team in place first estimates the size of the population and obtains a map of the area. The number of doses of vaccine ordered is based on the total population plus a 15% margin for expected loss. Vaccines must be kept within certain temperature ranges all the way from production to injection, so a "cold chain" must be established for the transport. Cool boxes and refrigerators (0-8°) are set up along the route, 24-28 hours in advance.

Registration materials, needles and vaccines need to be prepared. MSF has a standard vaccination kit for 10,000 persons, which includes a generator, refrigerators, cold chain transport material and injection supplies.

What is a vaccine

A vaccine is a special preparation of a substance which the body regards as foreign or dangerous and against which it produces an antibody. Vaccines can be used to stimulate the development of antibodies and thus confer active immunity against a specific disease or number of diseases. Vaccines are usually introduced into the muscles, although sometimes a light scratch on the skin is sufficient. There are even some oral vaccines available.



Public education

Diseases and epidemics are not only kept in check by treatment and vaccination, but also by education. MSF finds it helpful when local community leaders encourage the population to register for vaccination. Information on vaccination campaigns is ideally transmitted by television, radio and even by village megaphones. Local health workers and religious leaders are also encouraged to spread the word.

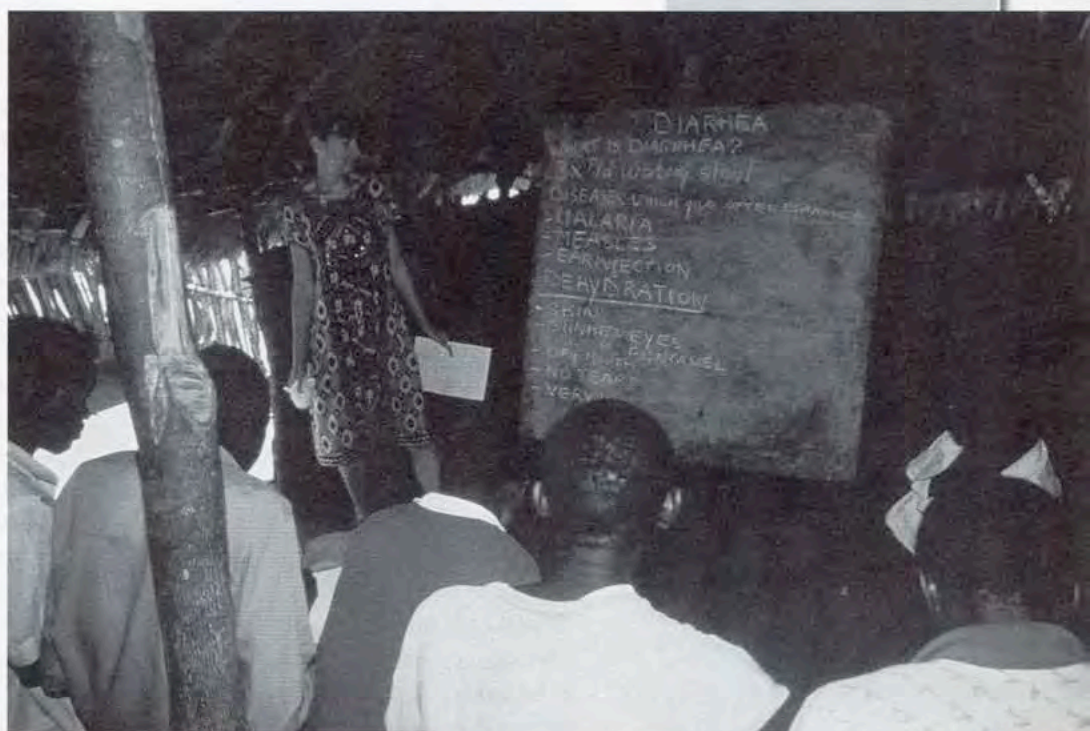


photo Marcel Wittebrood • Sudan



POP. IN YEAR 1996
6.3 m

GNP PER CAPITA
180 USD

ADULT LITERACY RATE,
MALE/FEMALE
47%/20%

LIFE EXPECTANCY
50 yrs

0-5 MORTALITY RATE
176 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
30%

International staff: 128

National staff: 782

MSF OPPOSES REGROUPEMENT

When Major Pierre Buyoya staged a successful coup d'état on 25 July 1996, the international community imposed a trade embargo on Burundi. The war between the armed forces and Hutu militias continued, with the victims largely innocent civilians. In several regions, the army has forcibly moved thousands of Hutus into what have become known as regroupement camps.

MSF's programme in Burundi now accounts for 60% of all health care in the country. The trade embargo is still in force, except with regard to humanitarian supplies such as medicines, drinking-water, sanitation equipment and refugee food. MSF assisted the populations of nine of Burundi's 16 provinces: Ngozi, Karuzi, Ruyigi, Kayanza, Makamba, Kirundo, Cankuzo, Gitega, and Bujumbura. Teams worked with local populations, the displaced, refugees and in the regroupement camps. In the Kayanza and Karuzi regroupement camps, MSF's policy is to save lives, but to do nothing to set up long-term facilities in the camps.

The repatriation of Rwandan refugees from Musinga, Ngozi and Kirundo took place in late 1996. In Ngozi, 250 Rwandans received regular MSF consultations. There was an increase in the number of violent incidents in the displaced camps, with incursions by armed bands on killing sprees followed by reprisals by the army.

MSF's activities in the health centres and hospitals

Throughout the country, teams worked in different wards of the district and provincial hospitals and in the province's health centres. MSF also supervised hospital staff and referred critically ill patients to reference hospitals. MSF also continued to work and supervise activities in the provincial health centres, which they supplied with drugs and where they ran training courses. In Kayanza, aid was provided to seven health centres, a district hospital and eight camps for the displaced. Vaccination campaigns were also carried out. Children received supplementary food rations in feeding centres in Muhanga, Rango and Musema Hospital. Musema hospital was rehabilitated and an ambulance service introduced for referrals. In September 1996, a marked rise in violence forced the evacuation of the MSF

staff to Ngozi, although they continued to supervise the programme from a distance. When Musema hospital and the four health centres were temporarily closed down for security reasons, the team kept on the mobile clinic.

In Kayanza, eight health centres benefitted from water and sanitation assistance. A surgical programme was launched in the provincial hospital and two new feeding programmes were opened. In Kirundo province, paediatric consultations were carried out in the orphanage. Medical assistance programme was also provided in Kirundo's provisional detention centre. When a meningitis epidemic broke out, MSF provided vaccination and treatment. Water and sanitation assistance was provided for the displaced, among whom, the team also distributed relief supplies.

Aid for the returnees

When Tutsi rebels seized eastern Zaire at the end of October 1996, around 20,000 Burundian refugees went home. Some returned to the Cibitoke, an area considered so dangerous that aid agencies dare not enter. Others arrived in the capital, Bujumbura, where MSF teams provided medical assistance and clean drinking water in the Gatumba and Gihanga transit camps. When these returnees were transported to Cibitoke by force, MSF denounced the UNHCR to the press and through diplomatic channels. Moreover, the transportation resulted in several deaths. An MSF team also remained in Bujumbura's displaced camps: Johnson and CNPK. At the end of 1996, MSF launched a project to support the re-opening of eight health centres in five districts of Bujumbura. MSF planned to run this project until the lifting of the trade embargo. MSF also supplied medicines and medical equipment to a hospital in the capital's notoriously violent Kamenge district.

REFUGEE INFLUX AS CIVIL WAR ERUPTS

In June 1997, fighting broke out in Brazzaville between President Pascal Lissouba's government troops and his opponent General Denis Sassou-Nguesso's so-called Cobras.

at the end of May 1997, thousands of Rwandan refugees fearing for their lives and many wishing to avoid repatriation to Rwanda fled into Congo/Brazzaville. The vast majority of these refugees were men. The presence of soldiers of the former Rwandan army and Interhamwes among them is indisputable. The authorities asked for their repatriation to Rwanda by the end of June, although MSF reported that many were too ill, exhausted and malnourished to travel.

By 28 May, MSF had installed a coordination team in Brazzaville and had teams in place in displaced camps in Loukolela/Liranga, Bilolo/Kintele and Njoundou. Once the fighting erupted in the capital, many of the inhabitants left for Kinshasa. There was also a massive displacement of populations in the

Bakongo areas. Heavy fighting meant that the MSF team had to be evacuated from Brazzaville by the second week of June. Since the beginning of hostilities, the International Committee of the Red Cross (ICRC) estimated that between 1,000 and 2,000 people were killed in Brazzaville during this period. At the beginning of July, an MSF team finally managed to start a medical and surgical programme in the capital's south side. MSF also supports Linzolo hospital, 30 kms to the west of the city.

When fighting broke out in Brazzaville, the UNHCR stated that there were approximately 18,000 Hutu refugees in the country. To date, MSF is providing medical assistance in two camps to the north: Njoundou and Loukolela where an estimated 8,000 to 10,000 refugees are living.

CONGO/Brazzaville



International staff: 4
National staff: 40

MSF FIGHTS SPREAD OF CHOLERA

On 8 August 1996, Idriss Deby of the *Mouvement Patriotique du Salut (MPS)* was sworn in for a second term as President. Chad's democratic process began in 1992.

MSF worked in Mayo-Kebbi where it supported health structures in five health districts. A similar project was launched in two of the four health districts in Eastern Logone. The objective of these projects were to support the development of the national health policy by upgrading supplies of drugs and medical equipment in health structures and improving the quality of health care staff. MSF also established a minimum package of health activities for health centres and district hospitals. A system to recover health service costs through a contribution from the population was also introduced. To compensate for the serious lack of qualified medical staff in Chad, MSF supplied the two prefectures with doctors to head up health districts and hospitals.

MSF provided primary health care assistance in Koumra, a sub-prefecture of Sahr. This involved the reorganisation of dispensaries and the hospital in order to upgrade curative and preventive health care for the 30,000 strong population. A surgical wing was added to Koumra hospital.

Teams supported the district authorities in case of epidemics. In 1996 and 1997, there were several serious cholera epidemics in Chad. In June, an outbreak in Njamena saw 5,000 people affected. MSF sent in a team and took charge of informing and educating the public, the staff, chlorinating wells and reservoirs and constructing rehydration centres. In May 1997, a new epidemic broke out in Njamena, Mayo Kebbi and five other southern prefectures. Once again, MSF launched a cholera relief programme.

CHAD



POP. IN YEAR 1996
6.3 m
GNP PER CAPITA
210 USD
0-5 MORTALITY RATE
202 per 1,000
POP. PER DOCTOR/NURSE
33,333/50,000
LACK OF ACCESS
TO DRINKING WATER
71%

CONGO

The Democratic Republic of Congo



POP. IN YEAR 1996
43.9 m

GNP PER CAPITA
220x USD

ADULT LITERACY RATE,
MALE/FEMALE
85%/65%

LIFE EXPECTANCY
52 yrs

0-5 MORTALITY RATE
186 per 1,000

POP. PER DOCTOR/NURSE
14,286/1,351

LACK OF ACCESS
TO DRINKING WATER
73%

International staff: 245

National staff: 1346



Photo: Evrim von Cappellen • Zaire

MSF DENOUNCES SYSTEMATIC ELIMINATION

On 15 May 1997, Laurent Kabila's *Alliance of Democratic Forces for the Liberation of Congo (ADFL)* finally took the Zairian capital of Kinshasa and within days, Kabila declared himself president of the newly renamed Democratic Republic of the Congo. Kabila's troops were accused of massacring Rwandan Hutu refugees and of denying them access to humanitarian aid. As many as 200,000 refugees have disappeared. Many of those who did not die of starvation and disease are thought to have been massacred.

Until the refugee crisis at the end of 1996, MSF's projects in Zaire had already been extensive. Not only, were teams working directly with Rwandan and Burundian refugees in Kivu but the organisation was in charge of 19 of the 306 Zairian health zones (specifically in Equateur, Shaba Bandundu and Kasai). In these zones, 2.5 million people received medical assistance. However, it is believed that only 80 zones were functioning when the war broke out in eastern Zaire at the end of 1996, given the disintegration of the Zairian health system during Mobutu Sese Seko's thirty year regime.

MSF also ran AIDS projects in Matonge and Lubumbashi, which involved the distribution of condoms and AIDS information. In Lubumbashi, there was a concerted effort on behalf of the team to improve the safety of blood transfusion. MSF ran a sleeping sickness project in Kimpese for 200,000 Angolan refugees. The programme came to halt in March 1997 as most of the Angolans returned. Although MSF had planned to set up a similar programme in Seke Banza, plans were dropped in the light of the changing political climate in Zaire.

MSF continued to run a special emergency pool to deal with crises in Zaire. In MSF, the pool is also known as the Pool d'urgence pour le Zaire or PUZ. In 1996 the PUZ provided assistance at the time of the cholera epidemic in Kinshasa and Mbandaka, and intervened following the Ndolo-airplane crash. MSF also launched a programme following the outbreak of monkey-pox in Kasai, where the PUZ worked alongside the Centres for Disease Control (CDC) of Atlanta.

Refugee camps attacked

Soon the refugee emergency in Zaire, became the focus of MSF's attention in Zaire as Kabila's troops steadily conquered the country province by province. It all began in October and November 1996, when the Alliance attacked the Rwandan and Burundian refugee camps along the Zairian border bringing about the mass return of the refugees from Uvira, Goma and Bukavu (as many as 600,000 to Rwanda and 60,000 to Burundi). However, many hundreds of thousands fled into the Zairian hinterland where there were no facilities ready for them. The refugee camps were targeted by the Alliance because many members of the former Rwandan Army and the Interhamwe had been living among the refugees, using the camps for cross-border operations and intimidating the majority of the camp population.

At the beginning of December 1996, a group of 80,000 refugees arrived on the Tingi-Tingi site on the road from Kisangani to Bukavu. Another 25,000 refugees gathered in Amissi. In Shabunda, there were 60,000 refugees. MSF intervened in Tingi-Tingi, setting up a hospital, feeding centres and isolation ward. Malnutrition was rife and in fact mortality actually rose to 4/10,000 a day in the month of February 1997 and to 10/10,000 for the under-five's. During this time, MSF has had only erratic and brief humanitarian access to the populations in danger in Zaire, i.e. Rwandan and Burundian refugees and displaced Zairians and affected Zairian residents. While access was allowed on the railway line South of Kisangani, it was systematically denied to other areas such as Masisi and West of Bukavu. The problem of access continued throughout the war.

OF REFUGEES

At the end of February 1997, humanitarian organisations were forced to stop assisting the 120,000 refugees of the Tingi-Tingi camp. As they fled towards Ubundu, they where attacked several times. Many died. Humanitarian agencies started gaining access to a remaining 80,000 from 31 March 1997. After this date, there were two main concentrations of people along the railway line. At Kesesa Bunda, there were some 55,000 and at Biaro a further 30,000. Large numbers of refugees were still scattered and hiding in areas like Shabunda and Masisi to where aid agencies had no access.

the health of these refugees was very poor, with the average number of deaths standing at between 80 and 100 per day. They suffered from many diseases including diarrhoea (with suspected Cholera cases among them), de-hydration, malnutrition and severe wounds to feet and legs as well as old gun-shot wounds.

Refugees start dying of malnutrition In March 1997, 85,000 Rwandan and Burundian refugees were found on the Kisangani-Ubundu axis, most coming from Tingi-Tingi and Amissi. Their health situation was catastrophic. One-third of the Biaro camp population (15-17,000 refugees) were considered walking corpses. 60% were malnourished, severely exhausted, they were suffering from cholera, malaria and diarrhoea. Medical and nutritional assistance was provided by MSF. MSF set up an emergency programmes in Kisangani and Lubutu: medical assistance for displaced Zairians at the level of hospital and transit centre of Kisangani.

From 20 April onwards, MSF's teams were no longer allowed in to the refugee camps. On 21 and 22 April, the camps were yet again attacked and more refugees fled. MSF brought out a report denouncing the systematic elimination of the refugees. MSF could only return to the sites a week later and then only for limited periods. The rebels imposed a delay of 60 days to the UNHCR for the refugee repatriation. The Alliance gave the UNHCR 10 days to evacuate the 35,000 refugees out of Biaro. MSF protested as the majority of the refugees were malnourished, sick and

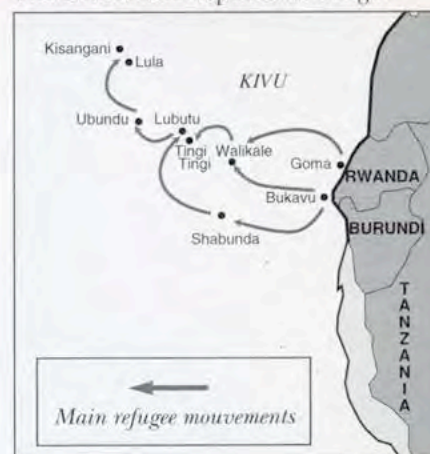
exhausted and in no state to move. MSF organised a transit camp in Lula with medical and nutritional structures. On 28 April 1997, the repatriations began. Many refugees had by this time fled to the borders of Congo and Angola and could not be reached.

MSF is opposed to forced repatriation of refugees, and was, in this instance, particularly horrified by the forced repatriation of the sick. MSF was also concerned that the monitoring of the returnees was not satisfactory in the Rwandan villages because of the current insecurity inside the country. MSF believed that those refugees who allegedly instigated the 1994 Rwandan genocide should not receive refugee status but should be brought to justice. Amongst the refugees in Zaire are tens of thousands of Burundians. For these refugees, MSF is opposed to their repatriation as it believes that their country is still too unsafe.

The refugees died in their thousands through massacres, illness and famine. By April 1997, there were many witnesses of attacks on refugee camps and massacres in the zones held by the rebel forces. The situation of both displaced Zairians and local populations in Kivu remained precarious as well. Yet, their exact numbers and locations remained largely unknown.

CONGO

The Democratic Republic of Congo



CENTRAL AFRICAN REPUBLIC

At the end of May 1997, MSF sent a backup team to the Central African Republic in order to prepare for a potential influx of Rwandan refugees from Congo-Brazzaville and to support the relief effort in the refugee camps. The team acquired three boats, which they sent down the Ubangui Chari river towards the Lukolela refugee camp. The plan was to bring assistance to isolated refugees all along the coast and, where necessary, transfer the sick. However, the team immediately ran into problems such as sand banks and low tides. At the end of June, MSF decided to transfer the backup team to Kinshasa.

photo Erwin Van Cappellen • Zaire



THE REFUGEES RETURN



POP. IN YEAR 1996
8 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

LACK OF ACCESS
TO DRINKING WATER
34%

International staff: 139

National staff: 1459

1996 and 1997 were marked by the repatriation of an estimated 850,000 Rwandan refugees from Zaire, Tanzania and Burundi. Guerrilla attacks increased followed by counter offensives by the Rwandan army. Insecurity forced many aid agencies to evacuate their teams. The humanitarian community was particularly horrified by the needless deaths of several aid workers. To date, 115,000 prisoners await trial for their part in the 1994 genocide.

MSF continued to work in the prefectures of Ruhengeri, Gisenyi, Kibuye, Cyangugu, Butare and Kigali. However, insecurity forced teams to leave several prefectures at certain times. MSF worked mainly in the area of rehabilitation and relaunching health centres and hospitals. Psycho-social programmes were also launched to heal some of the scars left by the 1994 genocide. In October and November 1996, medical and nutritional aid was also provided in three transit centres for returnees from Eastern Zaire. MSF teams also worked in more than 10 way-stations. The end of April 1997, saw the second wave of repatriations from war-torn Zaire. 500,000 refugees arrived, many of whom were malnourished and in poor health. MSF teams provided them with health care assistance in hospitals and health centres before they returned to the communes they came from. During the year, MSF also ran several programmes in Gisenyi aimed at minors and supervised the social reintegration of street children.

MSF continued to provide support for the health districts in Gisenyi and Butare. MSF's priority is to upgrade management structures and introduce some level of community participation in the financing of the health districts. MSF continued to advise on referrals and to provide medical assistance to prisoners in Kigali.

Both members of the current Rwandan army and the former Rwandan army are involved in open conflict in the country's western provinces. There were a series of incursions by members of the former Rwandan army from their

refugee camp base in Goma. In June 1996, the MSF team in Ruhengeri distributed enough drugs to the health centres to last them until October and then handed over the project to the Health Ministry. MSF had put together a local network of people and trained them in recognising and dealing with war trauma. MSF's psychological assistance programme in Gisenyi continued throughout this period. Here, the priority was training courses for local health care personnel in the recognition of trauma.

A similar programme was launched in Kibuye in September 1996 remained in operation. From November 1996 onwards, during a four-week training period, 18 health workers were trained in trauma recognition, psychological education and therapeutic interviewing techniques. Representatives of approximately 500 families from 70 communities were trained in trauma recognition, social skills and psychological education. Also in Kibuye, MSF teams provided assistance to 1,200 Zairian Tutsi refugees between November 1996 and March 1997.

In Cyangugu, MSF teams tried to upgrade community health assistance. There was a special emphasis on mother-and-child health care. MSF also launched the health district of Busenge including a hospital in collaboration with health authorities. Activities included the relaunch of surgical interventions, training of local staff, epidemiological follow-up and support in the management of intensive nutrition centres. There was a great deal of insecurity in this region in 1996, which meant that the programme could only be partially implemented. In March 1997, the team was finally evacuated for reasons of security. A new medical team returned in April to provide assistance in a district where many returnees arrived.



photo Erwin Van Cappellen • Rwanda

EASTERN AFRICA

AFRICA



photo Marcel Wittebrood • Sud-Sudan



ETHIOPIA



POP. IN YEAR 1996

56.6 m

GNP PER CAPITA
100 USD

0-5 MORTALITY RATE
200 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
75%

TANZANIA



POP. IN YEAR 1996

29.6 m

GNP PER CAPITA
90 USD

0-5 MORTALITY RATE
159 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
50%

RECONSTRUCTION AND REHABILITATION

Although there has been an increase in terrorist attacks carried out by Islamic fundamentalists, the crisis is largely over. Civil war, political tensions and drought are making way for reconstruction.

MSF continued to work in Jijiga, providing support to the reference hospital and 15 clinics.

Activities included training, rehabilitation, environmental health and medical supply. MSF provided health care services, including vaccination programmes, and tried to improve epidemiological surveillance. A system of cost recovery was implemented. A TB programme was also run from the hospital. From April to October 1996, MSF provided food aid and primary health care assistance in Ofa. When in August 1996, the River Awash flooded, MSF provided relief aid. MSF also provided food aid following the Oromo floods at the end of 1996 and the drought in the Somali/Ogaden region in March 1997. Logistical and financial support was given to the regional ministry of health in the southern provinces for a meningitis vaccination programme for 30,000. An

anthropological study was also carried out in Beni Shangui.

In Adis Abeba, MSF helped Health Aid Ethiopia (HAE) to reorganise and manage medical services. Activities included training and supervision. MSF also ran an STD/Aids prevention programme.

In Woldya, surgical training was provided for staff in four hospitals and four health centres received support. Since April 1997, MSF has supported the hospital in Dubti. In the Wag-Hamra region, MSF ran a water and sanitation project. Community participation was encouraged. The project was initially carried out in three areas, two of which MSF volunteers could only reach by foot or by donkey. Training was a priority.

International staff: 29 / National staff: 250

AID FOR REFUGEES

Following Burundi's coup d'état led by Pierre Buyoya in July 1996, Tanzania joined forces with neighbouring countries by enforcing an economic embargo with a view to encouraging them to restore democracy.

Tanzania is home to hundreds of thousands of refugees from Rwanda and Burundi. Last August, an additional 200,000 Burundian refugees and a few thousand Rwandan refugees arrived in Kigoma. They settled in camps in Kigoma, Kasulu and Kibondo. In November 1996 MSF was asked to intervene in a cholera epidemic in Kigoma and to be responsible for medically assisting 45,000 Zairian refugees in Kasulu district. This project was handed over to another aid agency in February at which time MSF agreed to relaunch Kasulu hospital. The relaunch of this hospital is a priority for the teams as there are more than 470,000 beneficiaries. There was a special focus on mother-and-child health care. In December 1996 MSF was present in the Kagera region during the forced repatriation of 500,000 Rwandan refugees.

Since August 1996, MSF has run a project to support the health care system in Mtwara district which benefits the local community, some 200,000 people. Its main objectives have always been to reduce mother-and-child morbidity and mortality, to improve access to health care and to promote community participation. All activities have been carried out in close coordination with local authorities.

International staff: 36

National staff: 91

DROUGHT AFFECTS NORTH

Severe drought has led to food shortages throughout the country but particularly in the north east. At the beginning of 1997, Daniel Arap-Moi finally declared that Kenya was in the throes of a nutritional emergency.

MSF has been active in solving some of the nutritional problems in Wajir, Turkana, Mandera, Garissa, Isiolo, and Marsabit following three consecutive droughts. In July 1996, following a nutritional survey carried out in Mayo, emergency food aid was launched in Mandera and at the beginning of December 1996, a similar programme was launched in Garissa. A second nutritional survey carried out at the end of December showed that 20% of the population was still suffering from acute malnutrition and 2.5% from severe malnutrition. In Garissa town, MSF opened one therapeutic feeding centre, two supplementary feeding centres and provided health care assistance to 80,000 people. A mobile team brought aid to isolated communities.

MSF continued to provide medical and nutritional assistance to some 120,000 Somali refugees in the camps of Ifo, Hagadera and Dagahaley. MSF supervised the hospitals and health posts and ran treatment programmes for cholera and tuberculosis.

In April 1997, a food aid programme was set up in Marsabit for what is largely a nomadic population. MSF also supported the hospital where severely malnourished children are being treated. MSF ran several feeding centres and carried out distributions of dry food rations for under-five year olds in some of the worst affected areas. In Mado Gashe, MSF opened a supplementary centre and set up a mobile team. Supplementary feeding ended in early July 1997 following the April rains.

Until the end of 1996, MSF continued its programme for the mainly nomadic population of Turkana who have suffered from increasing difficulties in reaching grazing areas because of insecurity and drought. Recent years have seen a marked deterioration of health facilities. As a result,

MSF vaccinated much of the population against disease and ran mobile clinics. MSF supervised activities in ten dispensaries and the Lodwar reference hospital. A supplementary feeding programme was run for 3,000 children in the Central and Lokori divisions.

MSF closed the Eldoret project in April 1997, as the conflict in the Rift Valley simmered down and health care needs subsequently dropped.

Assistance to AIDS patients

AIDS is a major health problem in Kenya's urban centres, notably Nairobi, where 17% of adults are HIV positive. MSF is particularly concerned by the fact that 60% of deaths of AIDS carriers are caused by diseases which can be cured relatively easily. The MSF teams in Kenya try to prolong the AIDS patient's life span by improving primary health care. An AIDS programme is run out of the Mathare 4B slum. In early 1997, a dispensary was built by the community and a health committee created to run it. In the capital's Kibera district, MSF also aimed to provide accessible health care services to the local population.

In November 1996, MSF opened a programme in Homa Bay, focusing on STDs, AIDS and tuberculosis. The team worked in the local hospital and tried to develop home care for AIDS patients. MSF helped transform the Nyarongi health post into a fully-fledged health centre and launched a sanitation programme in June 1997.

KENYA



POP. IN YEAR 1996
30.5 m

GNP PER CAPITA
270 USD

ADULT LITERACY RATE,
MALE/FEMALE
84%/66%

LIFE EXPECTANCY
56 yrs

0-5 MORTALITY RATE
90 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
47%

International staff: 118

National staff: 752



photo Robert Maletta • Kenya



POP. IN YEAR 1996
14.7 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

LACK OF ACCESS
TO DRINKING WATER
68%

LEGAL AID FOR IMPRISONED MINORS

President Albert Zafy was impeached by parliament in August 1996. The electorate returned former dictator Didier Ratsiraka to office in February 1997. In his victory speech, he said: "My victory is due more to the disillusionment of the Malagasy people towards the old regime than to their enthusiasm of me".

MSF assisted 4,000 street children in Antananarivo. Medical assistance was provided on a daily basis at two dispensaries. Consultations were provided free of charge by a network of doctors and pharmacists. There were also two mobile teams working at night. MSF also provided water and sanitation assistance in town. The distribution of information on AIDS is also a priority. Since 1994, alongside UNICEF, other aid agencies and the local authorities, MSF has run a network for children which promotes their rights.

In Antsirabe, Madagascar's second largest town, MSF launched a project in May 1997 for 1,500 street children and 2,000 homeless families who have little access to health care and protection. MSF was also committed to providing assistance for some of the social problems of these marginalised children. MSF helped to create a community lobby group to focus on issues such as child slavery, sexual and physical abuse and prostitution.

Children in prison

MSF continued to provide medical and legal assistance to institutionalised and

imprisoned minors. A total of 900 minors in eight institutions (two of which are detention centres attached to the capital's main prison) received MSF assistance. The team opened infirmaries and carried out nutritional surveys. MSF is

concerned by the fact that many of these young people have no access to health care and are living in an overcrowded insalubrious environment and that 90% of the minors remain in prison after their sentences have ended. The organisation lobbied actively against the paralysis of the legal system. The team followed up on many cases and has helped free 150 minors. MSF took part in round table talks on prison reform and helped set up of a commission for human rights.

MSF also provided health care and water and sanitation assistance for 50,000 slum dwellers in three districts of the capital. From September 1996 to March 1997, the team ran a campaign to eradicate the plague. This involved rubbish collection over a six month period in 12 of the most at-risk quarters of Antananarivo. MSF also provided support to health services treating patients suffering from the plague, and followed up on the cases in the reference hospital.

Hurricane Grette which hit the Southeast of Madagascar in January 1997 devastated the lives of 550,000 people. Crops were destroyed and infrastructure was damaged. Severe food shortages ensued. MSF launched a medico-nutritional programme targeting 3,000 severe and 5,000 moderately malnourished children. The team also distributed food rations and enough drinking water for 50,000 people. The nutritional situation in Madagascar is poor. At the end of February 1997, a nutritional survey showed that there was 17.5% acute malnutrition, of which 7.3% is severe. MSF opened three intensive nutritional centres and two health centres. 800 malnourished children were treated each day.

International staff: 27

National staff: 62



photo Sebastiao Salgado • Sudan

ASSISTANCE TO KHARTOUM'S DISPLACED

While Khartoum suffered from growing isolation on the international scene, the armed opposition managed to iron out its differences and make important gains. In January 1997, the *National Democratic Alliance (NDA)* launched an offensive on the east and north-east of the country, which resulted in casualties and population displacement, notably in Blue Nile province.

Thirty miles south of Khartoum, over 1.9 million displaced people and squatters live in wretched camps in the desert to which many were forcibly moved. The displaced and other migrants live in displaced camps, resettlement areas and unauthorised areas and MSF's medical assistance programme reaches the three groups. MSF provided medical assistance in the four official camps for the displaced: Omdurman el-Salaam, Wad el-Beshir, Mayo and Jebel Awlia el-Salaam where MSF works. The rest of the population live in what are known as "squatter" areas like the Angola camp, resettlement areas like Jebel Awlia Dar el-Salaam and of course in residential areas of Khartoum. Here, MSF focused on mother-and-child health care, training, health information and water and sanitation assistance. When the area south of Khartoum was seriously flooded in September 1996, the MSF team helped dig drainage canals at the the camps for the displaced. A programme was launched at this time to cure the numerous cases of severe diarrhoea.

In the transition zone closer to the front line, MSF brought aid to local populations and the displaced in Meyram and outlying villages. MSF assisted in several diarrhoea and measles epidemics. The programme in Abyei benefits 20,000 people and included the relaunch of the town hospital. Since October 1996, MSF has also provided assistance to the populations of South Kordofan and Dilling.

MSF and kala azar

In recent years, MSF has supplied drugs to the kala azar ward in Soba hospital, Khartoum. The organisation has also supported research into the diagnosis and treatment of kala azar. MSF ran a treatment centre in the village of Umm Kuraa in Gedaref state. During the wet season in 1996, the project was virtually cut off from the outside world. At the end of 1996, there was a strong surge

in the number of patients. MSF was also involved in kala azar treatment in Western Upper Nile. It continued to run the centre in Duar, which is only accessible by foot or by aircraft. Special kala azar clinics were set up in Leer, Duar and Niemne. The treatment centre in Toich, was moved to Mananganjan during the wet season. In October 1996, a new centre was opened in Langken.

In November 1996, MSF started a primary health care programme in Panyagor in Northern Bor. The team also tried to improve the supply of drinking water. The project aimed to encourage the return of refugees.

In September 1996, MSF opened a mission in Pochalla. The region was badly affected by floods in June and July 1996 which destroyed crops. MSF opened a health centre and carried out measles and polio vaccination programmes and trained local staff. Seeds, tools and survival kits were also distributed. However, the team had to be evacuated at the end of January 1997 for security reasons.

MSF programmes have been greatly cut back in Maridi-Mundri, as many of the displaced have settled or gone home. The tuberculosis and onchocerciasis (river-blindness) programmes continued. In Akobo, MSF focused on upgrading the rural hospital which it manages. The emergency preparedness programme and a tuberculosis programme continued.

The mobile programme continued in Bahr El Ghazal, where onchocerciasis is endemic. MSF also ran a Guinea worm control programme in this area. In March 1997, MSF launched a programme in Tonj county. The volunteers first set up a rural tent hospital in Maria-Lou where they provided medical assistance while the permanent hospital was being built.

International staff: 118 / National staff: 1146

SUDAN



POP. IN YEAR 1996
28.0 m

GNP PER CAPITA
480x USD

ADULT LITERACY RATE,
MALE/FEMALE
55%/32%

LIFE EXPECTANCY
53 yrs

0-5 MORTALITY RATE
122 per 1,000

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

WHAT IS KALA AZAR

MSF has been involved for many years in the treatment and study of the disease kala azar, which has claimed the lives of tens of thousands of people in southern and eastern Sudan. The disease, which affects the human immune system, is caused by a parasite. It is passed on to humans by sand flies. Once infected, the patient becomes feverish, loses weight and develops an enlarged spleen. As a result, his immune system weakens and he becomes highly prone to infections that, in 95% of the cases, result in death. With the drug Pentostam, kala azar patients can be restored to health in just a few months.



POP. IN YEAR 1996
21.2 m

GNP PER CAPITA
180 USD

ADULT LITERACY RATE,
MALE/FEMALE
72%/47%

LIFE EXPECTANCY
45 yrs

0-5 MORTALITY RATE
185 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
66%



photo Remco Bohle • Uganda

AIDS PROGRAMME CONTINUES

In May 1996, a large majority of the Ugandan population re-elected Kageta Yoweri Museveni as President. Since 1985 he has brought relative stability to the country, but in recent years, this stability is being disturbed from various quarters. Northern Uganda is made unsafe by rebels of the *West Nile Bank Front (WNBF)* and the *Lords Resistance Army (LRA)*.

Northern Uganda is very unstable. The population of Gulu is vulnerable as medical services have been badly affected by many years of terror perpetrated by the LRA. Health posts in the districts were not as well attended as they should have been because many of the roads leading to them were land-mined and vulnerable to rebel attack. At night time, to avoid attack, around 10,000 to 20,000 people gathered in churches or public buildings in the city centre. In January 1997, 400 civilians in the north-east were killed in a single attack. The presence of the rebel troops led to huge population movements towards the town and villages of Gulu and Kitgum. In Kasese and Kitgum, MSF brought assistance to those people displaced by the fighting.

In September 1996, MSF carried out a measles vaccination campaign. Conditions are such that there is a high risk of epidemics. In October 1996, MSF launched a water and sanitation programme in the heart of the city, and restored the water supply to the district hospital. At this stage, medical statistics were collected on a weekly basis. In this way, MSF was able to monitor the health situation. MSF staff paid particular attention to cases of bloody diarrhoea, cholera, bronchial infections, malaria, meningitis and measles. Moreover, the team set up medical facilities and built up emergency stocks.

Following the arrival of the Ugandan rebels from Zaire, MSF ran an emergency programme for the displaced from November 1996 to February 1997. MSF activities included assistance to medical structures, sanitation and the distribution of blankets and jerry cans. In January 1997, MSF launched a programme in Kitgum for 40,000 to 60,000 displaced people. When a cholera epidemic broke out, an MSF centre was set up in Kitgum hospital. A camp was also erected in town. MSF took

responsibility for sanitation and water supply. Local vaccination teams received MSF assistance and a measles campaign was carried out. MSF ran two dispensaries in the Kitgum and Palabek camps. Vaccinations were carried out twice a week. MSF also provided supplementary feeding programmes for children.

After an influx of Tutsi refugees in Kisoro in the south-west of Uganda, MSF donated medicines to St. Francis hospital in Mutelero as well as materials for sanitary facilities.

MSF's Aids programme

There is a high incidence of Aids cases in Northern Uganda. The Moyo Aids control Initiative (MACI) was set up by MSF and members of the local community. It became a Ugandan NGO in 1995. MSF continues to help MACI which focuses on information and education of the refugees and the local community. In Kampala, MSF joined forces with the Traditional and Modern Health Practitioners together against AIDS (THETA). The THETA programme consists of training and working with traditional healers. MSF is trying to set up a network of "informed" healers in Kampala.

Sleeping sickness

In Arua and Adjumani, MSF teams pursued a programme to combat trypanosomiasis (sleeping sickness). The project in Omugo was transferred to Arua in September when it became unsafe for the team to continue with its work there. At Arua hospital, MSF installed a specialist centre for combating sleeping sickness and used a mobile team to find the sick. Activities in Adjumani are in the process of being handed over to the authorities. Epidemiological surveillance of the illness was carried out in conjunction with Epicentre.

International staff: 41 / National staff: 324

POOR ACCESS TO HEALTH CARE

The seven year old civil war continues and there is still no recognised central government. Self-declared "Interim President" General Mohamed Farah Aideed died in battle in August 1996 and was succeeded by his son, Hussein. In early 1997, Hussein Aideed boycotted the Ethiopian-run peace talks in Sodere where 26 Somali factions agreed to establish the *National Salvation Council (NSC)* with a mandate to organise a transitional government.

MSF continued to run Kismayo hospital in the lower Jubba region of southern Somalia. This 240-bed hospital is the only working reference hospital between Mogadishu and Nairobi with the sole surgical facilities in an area inhabited by approximately 200,000 people. MSF also continued its tuberculosis programme in the hospital and MSF intervened following cholera outbreaks in southern Somalia: Doble, Afmadew and Dadachbula.

In Giohar, MSF teams focused on preventive care, organising vaccination campaigns, providing mother-and-child health care, health education, basic healthcare, rehabilitation, the distribution of medicines, the supervision of curative and preventive activities and training. Before MSF arrived, there were no functioning health care structures. In June 1997, MSF launched a tuberculosis project in Giohar. The Aden Yabal project, which has similar objectives, was handed over to local staff but is supervised regularly by MSF. The Mogadishu North project which provided health care assistance to the displaced included the distribution of essential drugs as well as staff training. Since January 1997, a cholera camp has been treating cases from Mogadishu North.

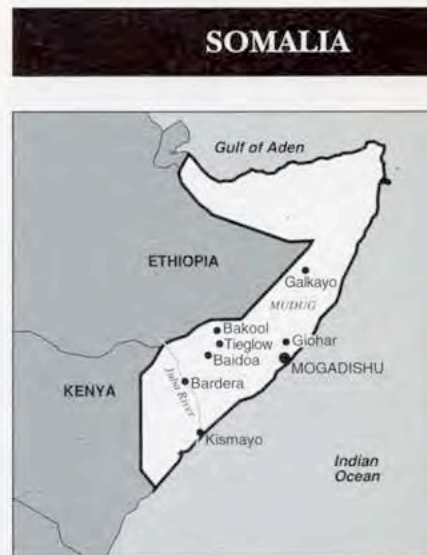
MSF also worked in Bardera, in the Gedo region. This town has been very badly affected by drought in recent years and is home to a large displaced population. MSF ran the 40-bed hospital. Volunteers were particularly active in the area of paediatrics and maternity wards. The team also ran the hospital pharmacy and laboratory and provided medical assistance in the out-patients clinic. Owing to severe food shortages, MSF ran a therapeutic feeding centre for children. Supplementary

nutrition was given to children as they were checked out. In April 1997, a cholera treatment centre was also set up.

Also at this time, MSF relaunched Baidoa hospital which had been more or less closed since the arrival of Aideed and his men in September 1995. In this reference hospital for 300,000 people, MSF focused on general medicine, the maternity and paediatrics wards, the emergency unit, the outpatients clinics, the pharmacy and the laboratory.

Tieglo, which is situated in the Bakool region had no functioning health service for over two years, when MSF opened a health centre in 1996. The local inhabitants asked MSF to run a low-key project as they did not want to attract the attention of militia groups. There was weekly supervision of the work of 12 Somali aid workers by an MSF nurse.

At the end of December 1996, MSF began supporting the hospital in Galkacyo, a town in Mudug province, central Somalia. Tuberculosis is endemic in the area.



POP. IN YEAR 1996
9.2 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.
LACK OF ACCESS TO DRINKING WATER
63%

International staff: 67
National staff: 440



photo MSF • Somalia

SOUTHERN AFRICA

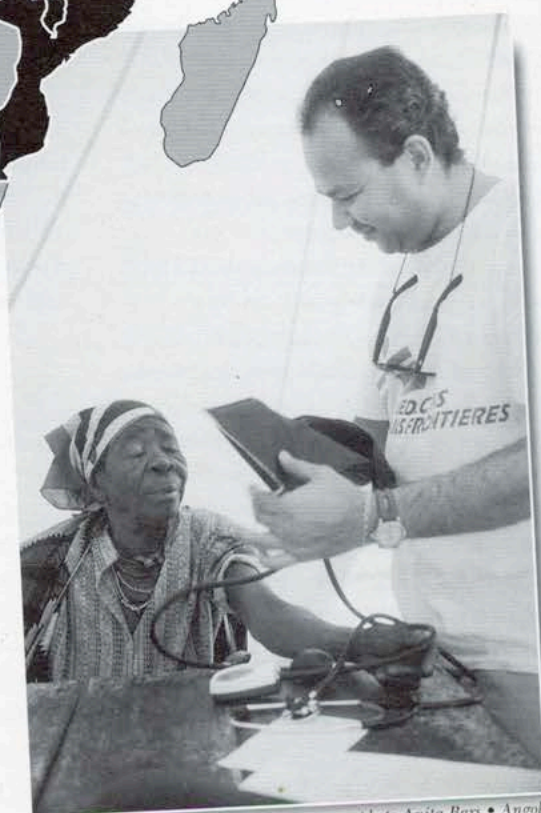


photo Anita Bars • Angola



MORE ACCESS TO HEALTH CARE SERVICES

A coalition government between União Nacional para a *Independência Total de Angola* (UNITA) and the *Movimento Popular de Libertação de Angola* (MPLA) was established on 12 April, 1997. The peace treaty still holds although it has not always been respected by both sides.

The Calandula project in Malanje province focused on the setting up of health posts, the rehabilitation of the hospital and the supply of essential drugs to 13 health structures in Calandula, Massango, Quela and Cacaluma. Training was also provided. The laboratory in Calandula was modernised, technicians trained and permanent vaccination centres set up. Polio and measles vaccination campaigns were carried out.

In M'Banza Congo, MSF began repairing the city's own water supply. Health care workers were trained and the central dispensary repaired and stocked with medicines. The team also opened a tuberculosis clinic and supported 12 health posts through training and supervision of health personnel, rehabilitation and distribution of medicines. In 1996, support was expanded to include a hospital and four small clinics in the district of Cuimba.

In Caconda, Huila province, the goal of MSF was to improve the quality of and access to primary health care in collaboration with the health ministry. The project included rehabilitation of health care structures, drug supply and training. In April 1997, a similar project was launched in Chicomba. The nutritional programmes in Quilengues and Caconda ended in late 1996. Seven health posts were opened and rehabilitated by the community itself.

In Huambo province, teams ran a medical programme in Kaala which included the relaunch of the reference hospital. MSF also works in four health centres in Gove. In Bie and Moxico, MSF provided basic health care to the population, rehabilitated the health care system and trained health care personnel. The project in Soyo came to an end in January 1997. Until then, MSF was supporting health posts in N'Zeto and Tomboco, training and supervising the medical staff, distributing medicines. MSF also built a dispensary in Tomboco hospital.

The sleeping sickness programme

In the province of Kwanza-Norte, MSF worked in N'Dalatando where it relaunched and supplied the laboratory, ran the sleeping sickness programmes in hospitals and carried out water and sanitation assistance. A team was also present in Quiculungo. MSF ran a 50-bed hospital and also provides external consultations. MSF screened for sleeping sickness in the surrounding region. In July 1996, MSF launched a programme in Maquela do Zombo to combat tuberculosis.

MSF then rehabilitated the maternity ward of the Malanje provincial hospital. A one-week seminar on maternity and paediatric care was organised for 20 nurses in M'Banza Congo.

In Benguela and Cubal, MSF focused on the problem of poor nutrition. MSF also worked in two health posts, vaccinated against measles and organised epidemiological surveillance. In Uige province, MSF ended the nutritional programme in January 1997. In Songo municipality, MSF focused on developing an efficient primary healthcare network which included the rehabilitation of health care structures, the provision of essential medicines and the training of local health care personnel. In February 1997, this programme was extended to Ambuila municipality and health posts in the area.

In Luanda, MSF ran two health centres with delivery rooms, trained health care staff and supplied medical equipment and drugs. MSF also kept a fleet of water trucks for the purposes of chlorination as a part of the emergency preparedness programme for cholera outbreaks. In the Cazenga district, MSF started a programme to implement a system initiating financial participation of the population in the health service. In 1996, the local staff in Luanda were trained in handling landmines.

ANGOLA



POP. IN YEAR 1996
11.1 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.

LACK OF ACCESS
TO DRINKING WATER
68%

International staff: 171

National staff: 1998

MOZAMBIQUE



POP. IN YEAR 1996
16 m

GNP PER CAPITA
90 USD

0-5 MORTALITY RATE
277 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
72%

HEALTH STRUCTURES OVERHAULED

Four years after the peace accords were signed, the role of aid agencies has changed. This was expressed symbolically by the end of the emergency period, officially announced on 31 December 1995.

In order to encourage population resettlement in Matutara in Tete province, MSF rehabilitated the district's health care structures, ran the health centre, trained local staff and helped build a rural hospital.

MSF provided technical support to health services in Chibuto, Gaza province. Activities included training and supervision of health care staff, technical assistance in the hospital, support to the national tuberculosis and immunisation programmes, water and sanitation assistance and the rehabilitation and construction of three health centres. MSF also tried to upgrade health coverage in 15 villages. Primary health care was provided in Chicualacuala. In Chigubo, MSF was involved in the construction of health structures. MSF also ran an AIDS awareness programme in the districts of Guja, Chibuto

and Xai-Xai. Training was provided for health care workers and support provided for a theatre group focusing on AIDS issues.

MSF also supported the health system in Matutuine, Maputo province. Objectives included improving the population's access to health services, with an emphasis on mother-and-child health care, and upgrading the management and efficiency of the health structures. Water and sanitation assistance was provided in Moamba. Solar energy systems were installed in five health services. Alongside Handicap International, MSF carried out information seminars on landmines.

The MSF-CIS Information System on Food Security was set up in 1992. Each month standardised data is gathered in 120 localities throughout Mozambique's 10 provinces.

MALAWI



POP. IN YEAR 1996
10.8 m

GNP PER CAPITA
200 USD

0-5 MORTALITY RATE
221 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
53%

INCREASING AIDS AWARENESS

In 1997, strikes almost brought public services to a standstill. The promises outlined in the government's Chatsika Report, which included plans for a salary raise for public officials, were not honoured.

Aids is a serious problem in Malawi. It is estimated that by the year 2000, 2 million Malawians will be infected with HIV. Out of a population of 10 million, there are 694,261 Aids sufferers. The most affected group aged between 20 and 40.

In July 1997, a campaign to increase awareness of the importance of sterilisation was launched by the team. In Mwanza district MSF has been running an Aids programme

since 1995. Much of the activities centre around prevention. However, in the hospital MSF has been running a confidential blood test. The team also provided a counselling service before and after screening. In January 1997, a similar programme was launched in Chiradzulu. MSF also launched an Aids programme in Thyolo in the south of the country, an area inhabited by 250,000 people.

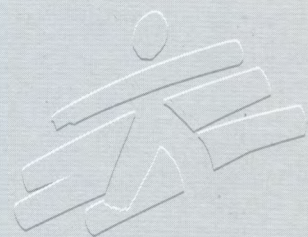
International staff: 12 / National staff: 30

WESTERN AFRICA

AFRICA



photo Remco Bohle • Nigeria



COTE D'IVOIRE



POP. IN YEAR 1996
14.0 m
GNP PER CAPITA
630 USD
0-5 MORTALITY RATE
150 per 1,000
POP. PER DOCTOR/NURSE
11,111/3,226

REFUGEES RECEIVE ASSISTANCE

Cote d'Ivoire is host to between 200,000 and 300,000 people who have fled the war in Liberia. However, as a result of repeated incursions by Liberian factions into the border region of Cote d'Ivoire, the authorities have installed a military zone and finally agreed, in February 1997, that the Liberian "visitors" needed refugee protection.

MSF carried out a medical and nutritional assistance programme for Liberian refugees in the Tabou sub-prefecture. The team also ran an intensive feeding centre in Tabou and in neighbouring Goson. MSF opened a dispensary in Goson. Activities included in and out-patient consultations and mother-and-child health care. MSF was also in charge of four health posts in the region, in Fété, Georgetown, Néro and Gnato. At all times the MSF team tried to be prepared for emergencies, particularly epidemics.

At the end of 1996, MSF set up a vaccination programme in Goson, Néro

and Georgetown and in January and February 1997 participated in the national polio vaccination campaign aimed at 6,000 of the region's children. At this time, MSF started to carry out an investigation into the high rate of acute malnutrition among under-five year olds in Tabou.

MSF finished a well-drilling programme in Tabou and the surrounding region in the spring of 1997.

International staff: 9

National staff: 189

GUINEA



POP. IN YEAR 1996
6.7 m
GNP PER CAPITA
500 USD
0-5 MORTALITY RATE
223 per 1,000
POP. PER DOCTOR/NURSE
7,692/n.a.
LACK OF ACCESS
TO DRINKING WATER
45%

AID FOR LIBERIAN REFUGEES

Since the coup attempt in early 1996, General Lansana Conté's presidency remains under threat. The region is also very unstable with ongoing conflicts in Liberia and Sierra Leone.

MSF participated in the programme which aimed to support and complement national health care structures. This programme has been ongoing since 1987. MSF also provided medical assistance to Liberian refugees. The refugees live mainly in open sites twinned with Guinean towns and villages. One of the problems facing the aid agencies is the identification and registration of the refugee population because they are so integrated into Guinean society. MSF's medical assistance to the refugees revolved around three main activities: the expansion and training of a network of around 30 health coordinators; supervision of health care assistance; and the publication of three monthly bulletins. MSF also supported the development of health services.

Since 1988, MSF has supported the national tuberculosis programme by supplying some of the medicines and laboratory equipment and supervising health centres in the prefectures of Mamou, Labe' and Conakry. There are a total of 3,500 patients in these centres.

The agency also provided primary health care in the prefecture of Mamou and ran a project to help prevent epidemics. MSF had responsibility for three health centres and supported the Mamou hospital when there were outbreaks of epidemics such as cholera, meningitis and yellow fever. At the onset of a cholera epidemic, MSF takes charge of training of local staff and educating the population in the application of hygiene measures, the distribution of chlorine and the organisation of treatment centres. MSF also supported the national immunisation programme for a total of 90,000 people.

PROGRAMME FOR THE BLIND

The mandate of Alpha Oumar Konaré, Mali's first democratically elected president, is expected to be renewed in 1997. Economic progress has been impressive since 1994.

One per cent of all Malians are blind as a result of curable diseases. Consequently, an ophthalmological project was launched at the primary level health centres. The first programme was launched in Tombouctou and the second in Koulikouro in September 1996. MSF trained nurses in the diagnosis and treatment of such diseases.

MSF ran a primary health care project in the southern region of Selingue. The organisation also helped the Malian government build several community health centres which serve 15,000 people. MSF also ran a primary health care project in the northern region of Ansongo. This project was aimed at both the nomadic population of the north and local inhabitants. MSF vaccinated the population using mobile teams. Aid workers were also involved in the rehabilitation of health centres, the maintenance of vehicles and

the supply of essential medicines. As is so often the case, training was provided for local staff. From May to November 1996, MSF distributed 300 tonnes of rice seeds and 1,000 tonnes of food produce to the population of Bourem which was suffering from food shortages.

A meningitis epidemic broke out at the end of 1996 and the beginning of 1997 in Bamako and, to a lesser extent in the regions of Kayes, Segou, Mopti, Sikasso and Tombouctou. MSF focused on direct medical assistance as the national authorities had the vaccination campaign well under way. MSF brought in supplies of oily chloramphenicol and trained health care staff. MSF also supplied vaccines and other medical equipment. At the same time, the western region of Kayes was also hit by a cholera epidemic in which MSF intervened.

International staff: 36 / National staff: 36



POP. IN YEAR 1994
6.2 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.

BENIN

From July to September 1996, MSF ran a campaign to prevent the spread of a cholera epidemic in Benin's Borgou department. Later in the year another MSF team returned to Benin to carry out a vaccination programme against yellow fever, in the Atakora and Borgou departments. The campaign ran for two months in the prefectures of Parakou, N'dali and Bimbereke. The team vaccinated 220,926 people which represents a coverage of over 90 % of the population targeted.

GABON

The ebola epidemic in Gabon which began on 13 February 1996, was thought to have ended on 21 November of the same year. However, there was an unexpected death from ebola on 18 December. MSF was asked to go in and help the national health authorities plan for a new outbreak. In January 1997, the team's first activity was to upgrade the isolation ward in Melen hospital. They also supplied protective material to hospitals in Libreville, Owendo and a hospital and 11 dispensaries in Booué. In February 1997, MSF participated in the training programmes for local staff and distributed medical kits to them. MSF also participated in the awareness programme in Booué which was, in fact, the source of the epidemic. The team also supported supervision and refresher courses for the paramedics and designed a new emergency kit to be used in the event of a new epidemic.



POP. IN YEAR 1994
2.9 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.

LACK OF ACCESS
TO DRINKING WATER
60%

WARLORDS HOLD POPULATION HOSTAGE

In theory the war is over. The Abuja II accords of August 1996 would seem to confirm this. However, the gun still rules and MSF has all but given up hope of gaining access to the victims of terror. Of the 3 million strong population before the war, an estimated 150,000 were killed between 1989 and 1996. The question on everyone's mind is whether the leaders of the three main factions will be able to live with the results of the July elections. Or whether they will lead to all-out war?

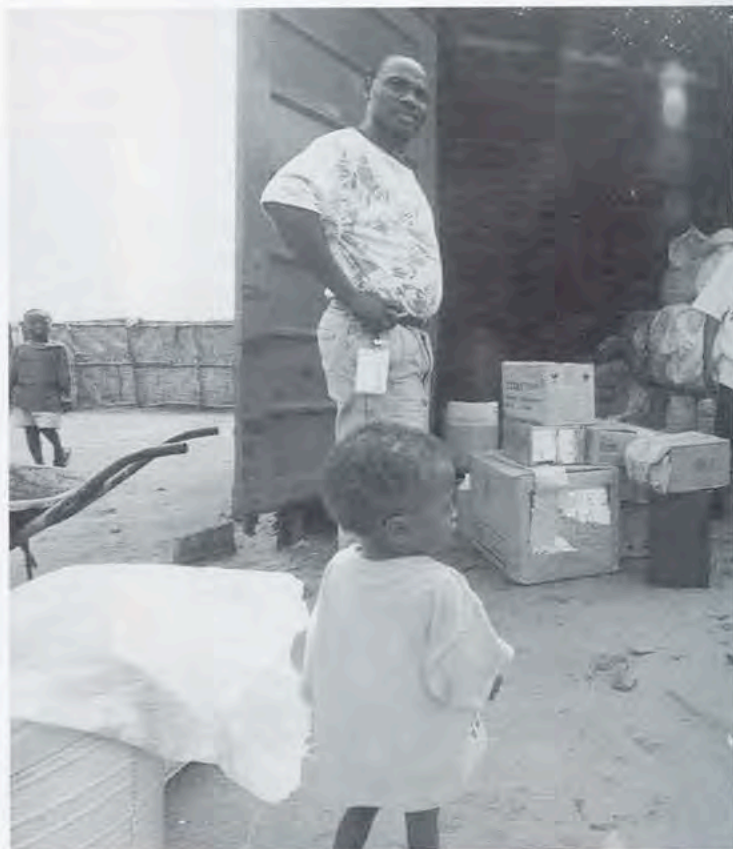
In mid-1996, MSF decided to suspend most of its relief operations in Liberia and to intervene only in cases of acute, life-threatening situations. This decision was made in the face of the ongoing violence and insecurity. Access was nigh-on impossible until September 1996, when MSF was able to bring badly needed food aid to isolated communities. In Monrovia, armed gangs engaged in the whole-sale looting of homes and offices of foreign relief agencies, using the loot (cars, computers, food and medicines needed to treat the wounded) for combat purposes. Aid in this case had become counter-productive. The ECOMOG peace-keeping troops consistently failed to keep the peace and protect the population.

Between 800,000 and a million people live in Monrovia. MSF was responsible for war surgery in two hospitals, Swedrelief and Redemption. These hospitals have the only in-patient facilities available to the general public. Since the violence of April 1996, MSF has supported these two hospitals. However, at the end of 1996, rates of malnutrition were so high inside Monrovia that several nutritional programmes were launched. There is also a therapeutic feeding centre and a team of community health workers who carry out outreach operations.

A nutrition survey carried out in July revealed that nearly 30,000 children under

BURKINA FASO

MSF continued its primary health care programme in Soum province for a target population of 100,000. Assistance is provided in ten of the province's health centres. The team has also launched a programme to combat epidemics. Training courses are provided for health care workers. There are 25,000 Tuareg refugees from Mali living in three of the country's provinces. MSF provides primary health care assistance in the camps.



five years of age were showing signs of moderate or severe malnutrition. MSF opened three therapeutic feeding centres and 10 supplementary centres where dry rations were distributed. By April 1997, MSF was running only one therapeutic centre and ten supplementary centres as the nutrition problem had improved greatly.

In September 1996, MSF finally reached the town of Tubmanburg, located 70 kilometres to the north of Monrovia, where the 35,000 inhabitants had been cut off from aid and at the mercy of warring factions for a period of seven months. To its horror, the team found the community literally starving. MSF immediately distributed 4,000 food rations, opened four food kitchens and three feeding centres. A mortality survey carried out retrospectively showed that 15.7% of the total population and 36.4% of under-fives died during the four last months, principally from malnutrition and diarrhoea. Once the nutritional emergency was over, MSF left Tubmanburg.

In the period from January to August 1996, both Bong and Marghibi had also been virtually cut off from aid as a result of the violence. Due to the limited supply of food

from Monrovia, the inhabitants could no longer afford to buy food supplies and were forced to forage for edible roots and fruits in the jungle. MSF considered the situation so serious when it managed to get back in September 1996, that it immediately launched an intensive feeding programme. Along the 70 kilometre road leading from Gbanga to Kakata, five feeding centres and clinics were opened where some 5,000 children were nursed back to health. The MSF team operated from Man in neighbouring Côte d'Ivoire. In the clinics, MSF treated patients suffering from malaria, diarrhoea and acute respiratory infections. At the beginning of 1997, malnutrition levels finally dropped. During the same period, a measles epidemic broke out in Margibi. MSF ran a vaccination campaign. In total, 14,034 children between 6 months and 15 years were covered.

International staff: 72

National staff: 1616



photo MSF • Liberia



photo Dirk Bogaert • Liberia

EQUATORIAL GUINEA

MSF supported the health care system in Bata, with an emphasis on mother-and-child health care. The team collaborated with authorities who were trying to set up an effective management system for the health service. MSF ran the programme out of La Libertad health centre. Activities included immunisation and health education as well as work in the laboratory and pharmacy. Each month more than 1,000 people were treated. The MSF volunteers also provided primary health care assistance in neighbouring villages. Eight village councils collaborated with the team and have helped create community health committees. MSF also supplied water and provided sanitation training for workers. Great efforts were made to improve sanitation and hygiene in schools. An intensive health education programme was run for teachers, school children and their families.



POP. IN YEAR 1996
2.2 m

GNP PER CAPITA
500 USD

ADULT LITERACY RATE,
MALE/FEMALE
48%/25%

LIFE EXPECTANCY
51 yrs

0-5 MORTALITY RATE
199 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
n.a.

HELPING URBAN MIGRANTS

As Mauritania becomes more stable, many refugees in Senegal are returning. Opposition leaders are, however, demanding that the government encourage the return of the black population which was expelled in 1989.

In Mauritania, MSF provided assistance to the Moorish and Tuareg refugees from Mali since 1991. At the height of the refugee crisis there were 25,000 in two camps. MSF ran a full health care assistance programme for the refugees. The team focused on mother-and-child health care. There are only 7,000 Malian refugees left in M'Berra camp in Bassikounou. In June 1997, after the final UNHCR repatriation, MSF ended this mission.

In October 1996, MSF opened a health care programme in the Toujounine district of Nouakchott where 5,000 displaced families arrived following floods in October 1995. The majority of the inhabitants are migrants from rural areas and are very

poor. Since their arrival in the capital many have suffered greatly from changing to a sedentary lifestyle from a nomadic existence. More than 100,000 people benefit from MSF's primary health care programme. Activities include maternity health care, vaccination, laboratory work and X-rays.

MSF also ran a health centre in Saada in the Boudhida region where flood victims received assistance. Activities centred around vaccination and nutrition programmes, consultations and work in the pharmacy. MSF participated in the national polio vaccination campaign and carried out a local vaccination campaign against measles.

International staff: 23 / National staff: 164

photo Pep Colas • Mauritania



photo Remco Bohle • Nigeria

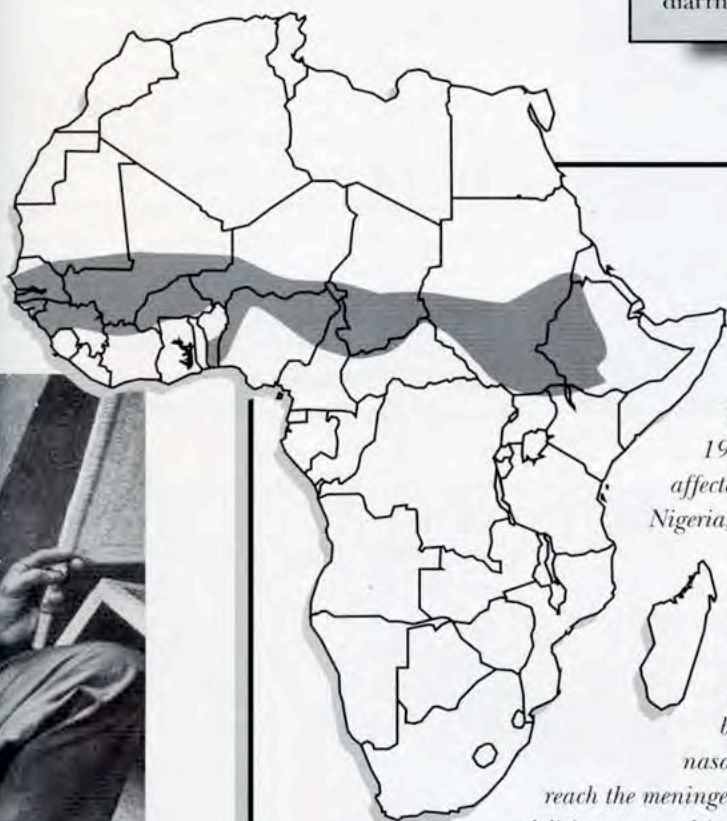


NIGER

At the beginning of March 1997, MSF launched a medico-nutritional programme following reports of serious food shortages. Activities focused on: relaunching health centres in the Tanout and Mirriah regions; giving logistical support to vaccination programmes; relaunching nutritional centres in Zinder. Health surveillance was carried out for the displaced of Zinder, Mirriah and Guidilouni. Here, MSF also monitored nutrition levels.

NIGERIA

Following the large cholera epidemic intervention of April/May 1996, an exploratory mission was dispatched in July 1996 to assess the extent of the problem. An aid programme was then launched in Borno and Bauchi states to assist the Ministry of Health in case management, hygiene education and water sanitation activities. This intervention was completed by August 1996. An emergency preparedness and response (EPR) project was launched in December 1996 with two major components: training in EPR skills across the country; participation in investigations into outbreaks. In March 1997, MSF launched an urban slum pilot project in Lagos, which focused on the control of diarrhoea diseases. Activities included the provision of water and sanitation facilities to schools and markets, hygiene education and case management of diarrhoea diseases both at home and in selected health facilities.



THE MENINGITIS BELT

The meningitis zone in Africa was defined by Lapeyssonnie in 1963 as the "cerebrospinal meningitis belt". The countries first affected were, from west to east: Burkina-Faso, south Niger, north Nigeria, north Cameroon, south Chad and the north of the Central African Republic. However, this geographical region with a high frequency of the disease, ranging from meningococcus to full-blown meningitis has spread considerably towards the west (Senegal) and the east (Sudan). Meningitis epidemics occur every year to a greater or less degree. The bacteria is transmitted by air. The dryness of the air, which produces an irritation of the nasal mucous membranes, allows the bacteria to settle and then to

reach the meninges (membranes lining the brain and spinal cord) leading to delirium, convulsions, even coma. It is a seasonal disease, beginning in November or December and always linked to the harmattan south-blowing wind that produces very fine dust. Epidemics end in April with the arrival of the rains. The epidemic threshold is set at more than 15 cases per 100,000 persons per week for two consecutive weeks. Immunisation campaigns are most efficient if they are begun early and are as comprehensive as possible. They should begin before the peak of the epidemic is reached, which is reckoned to be between four and eight weeks after the threshold is passed. Apart from preventive measures, treatment consists of a single dose injection of chloramphenicol in an oily suspension.

SIERRA LEONE



POP. IN YEAR 1996
4.5 m

GNP PER CAPITA
150 USD

ADULT LITERACY RATE,
MALE/FEMALE
43%/16%

LIFE EXPECTANCY
39 yrs

0-5 MORTALITY RATE
284 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
66%

SURGICAL PROGRAMME IN FREETOWN

On 25 May, 1997, the Sierra Leonean army quickly joined by the *Revolutionary United Front (RUF)* overthrew President Ahmed Tejan Kabbah's regime. The coup was unexpected and particularly disappointing given that the government had signed a peace accord with the rebels the previous December. In February 1997, a civilian government was elected. After five years of civil war, there were some hopes that the violence would end despite the ongoing tension inside the country.

Since the beginning of the war five years ago, around 10,000 people have lost their lives and nearly a third of the population of 4.5 million has fled. Much of the fighting of the past years has been a struggle for control of the eastern regions. Here, there are rich natural resources, including diamond and bauxite. Tens of thousands of people fled to cities such as Bo, Kenema, Makeni and Freetown. Due to the extreme insecurity, food and medicines had to be flown in or transported by trucks travelling in convoy.

Before the coup d'état in May, MSF was working in Freetown, Bo and Kambia and had just launched a programme to take charge of two clinics in Kono District, and to support the hospital and mobile clinics.

Since the coup d'état, MSF's main activity has been a surgical programme run by aid workers in the Connaught hospital. MSF also began to assess the public health situation in the capital. However, until the

end of May 1997, MSF ran clinics for Freetown's displaced population in the Grafton and Clay Factory camps. The project in the Clay Factory camp, consisted of a water trucking programme and lending support to the camp's clinic. Initially there were approximately 8,000 displaced. Following the coup d'état, there was a further influx of 6,000 to 10,000 people mainly from the other camp which is located outside town. MSF relaunched its sanitation programme and once again began to supply drugs and medical equipment to the camp clinic. The other camp was emptied by the authorities.

There have been so many cholera outbreaks in Sierra Leone in recent years that MSF ran a cholera preparedness programme. Teams maintained cholera camps in Freetown, Bo and Gondama.

MSF focused on improving accessibility to primary health care for the southern population, both the displaced and local inhabitants. In Bo district, MSF worked in five displaced camps until the camp population returned to their places of origin and seven clinics in and around the

GAMBIA

In April 1997, MSF intervened during a meningitis epidemic in Gambia. The team provided direct health care assistance to the country's six administrative regions and focused on prevention in the four regions to the west. Drugs and medical equipment were supplied to health structures and an epidemiological survey was carried out. The programme ended in June 1997.

GHANA

From March to May 1997, MSF intervened in a meningitis epidemic in Ghana. The team helped the Ministry of Health vaccinate the population against the disease. MSF focused on three districts: Bulsa, west Mamprusi and Gushiegu/Karagaz, vaccinating 150,000 people. Two direct medical assistance programmes were also run in Bawku and Mamprusi and MSF brought in supplies of drugs to treat the disease. The organisation also carried out epidemiological surveillance.

city of Bo. MSF also rehabilitated and managed the Bo governmental hospital. In Pujehun District, MSF reopened the hospital and ran five clinics. In Bonthe District, MSF ran two clinics. A programme was also starting in Moyamba District at the time of the coup d'état. In the Southern province, MSF had also launched a water and sanitation programme.

After the peace accords of November 1996, and because many rebels had been flushed out of the area, displaced people started returning to their villages. MSF launched a rehabilitation programme for health centres and health posts in three districts of the province and distributed blankets, soap and cooking utensils to camps for the displaced and vulnerable in nearby villages. MSF also provided many displaced people, in Freetown, with resettlement packages of cooking utensils to take back with them to their villages of origin.

Other activities in Sierra Leone include a vaccination campaign against measles and yellow fever. In the summer of 1996 in the north of Kailahun (the only programmes in the RUF zone). MSF was unable to pursue its plans to run a medical programme in one of the city hospitals and was forced to leave the area. When cases of whooping cough were reported by staff in the Koribondo clinic, MSF launched a

vaccination campaign for the Jima Bagbor Chiefdom.

At the time of the coup d'état, MSF was also in Kambia, where the team focused on vaccination. Other than helping the authorities overhaul the national immunisation campaign, MSF ran a cholera preparedness programme and was carrying out training for health care workers.

International staff: 55 / National staff: 418

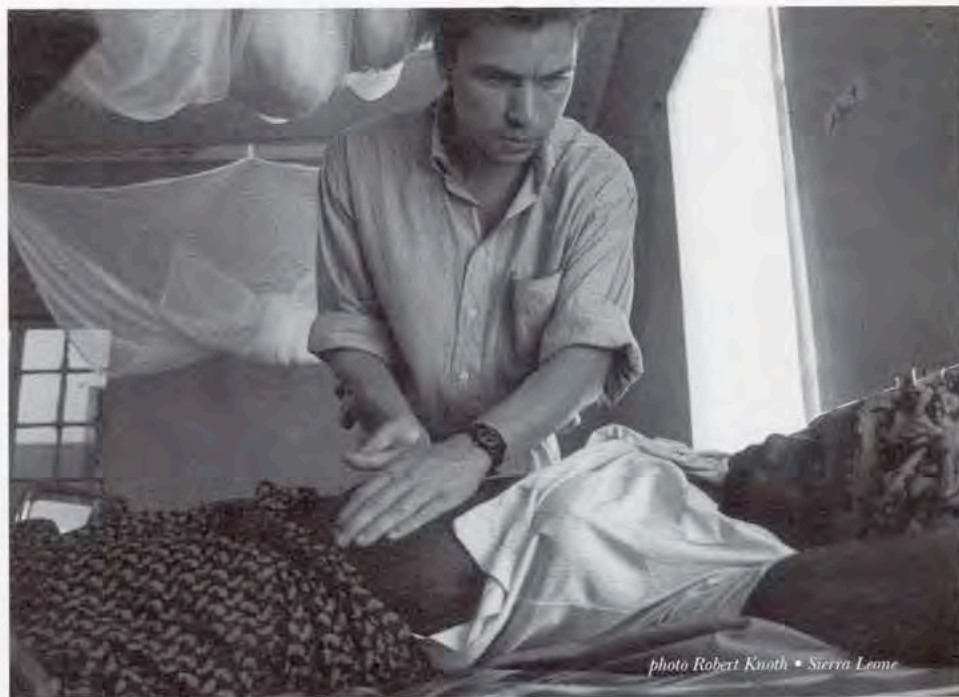


photo Robert Knott • Sierra Leone

TOGO

A serious meningitis epidemic broke out in the northern regions of Togo at the end of 1996. The epidemic reached its peak at the end of January and the beginning of February 1997. There were 1,887 recorded cases, of which 274 died over a twelve-week period. MSF worked to improve patient care in Dapaong hospital, to which it supplied oily chloramphenicol. The team also carried out a vaccination campaign for 150,000 people in the town of Dapaong and in the prefectures of Oti and Tandjoare. Once again, MSF supplied medicines and medical equipment. Epidemiological surveillance was carried out.

CAMEROON

Cholera is a recurring problem in Cameroon, particularly the area around Lake Chad. In June 1996, there was a serious outbreak in the north of the country. MSF decided to intervene in Kousséri, Garoua and Maroua, which are all poor areas where health structures have little in the way of medicines and medical equipment. From mid-July to the end of September 1996, MSF trained local health care workers to disinfect wells and health centres. The team also distributed rehydration salts, drips and antibiotics as well as other supplies to cholera centres. MSF worked in close collaboration with local and provincial health authorities. In total, 1,500 people received treatment.

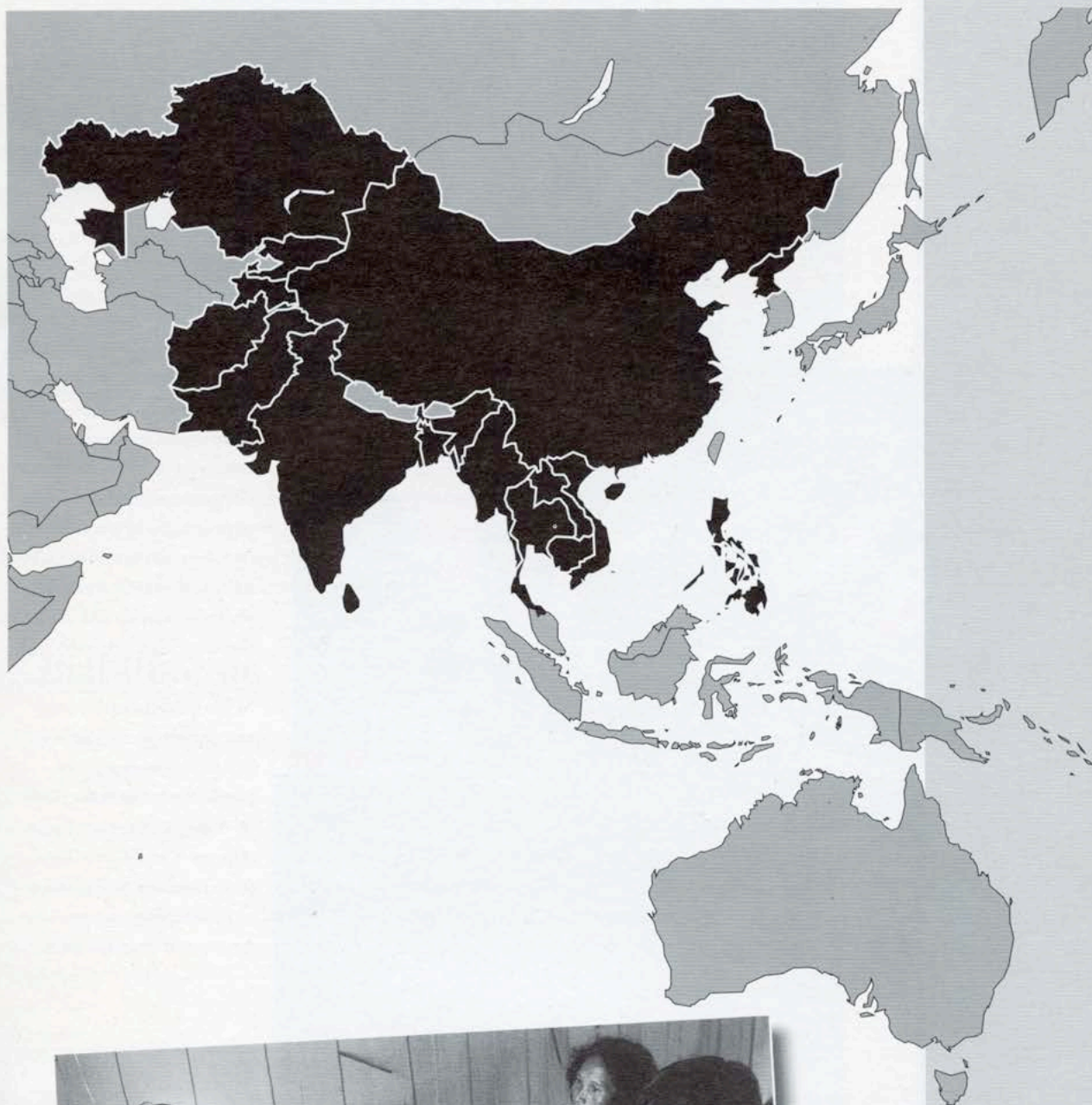


photo John Vink • Cambodia





Over the past 25 years, MSF has built up its expertise in bringing relief to the victims of natural disasters. These sort of disasters include earthquakes, hurricanes, floods, snow-storms and volcanic eruptions. Logistical support is paramount as the priorities are access to the victims, the distribution of relief supplies, food and temporary shelter, repairs in the water supply and electrical systems as well as maintaining radio communication. In order to provide populations with basic materials to get through the first phase of a disaster, MSF has developed more than 150 specialised medical and non-medical kits.

Rapid response



photo R. Job • Philippines

Earthquakes, floods, hurricanes and volcanic eruptions and other potential disasters can devastate an entire region within days, or even hours or minutes. Some disasters are predictable, like seasonal storms or flooding, but others come with little or no warning. MSF operational centres are always on the alert for potential emergencies, particularly in those parts of Asia and the Caribbean

where disasters are yearly events. MSF set up offices in both the Philippines and Costa Rica, where personnel and stocks are on regular emergency stand-by. Often, national authorities will call on aid agencies for help. As the first 48 hours are crucial, in a disaster, once a distress signal is received via national contacts, press or other emergency warning systems, relief can be dispatched with hours.

Transport and distribution

Over a 48-hour period, MSF teams are able to load and send a full cargo plane to its destination. Getting materials to major airports or ports is only the first step. Medical, nutritional and logistical supplies must then be taken to the scene of the disaster. MSF's logisticians arrange for their transport in trucks, which can be hired locally. MSF teams then often become involved in the national or local authorities distribution programme for the victims who will often need water, food, blankets and temporary shelter.





photo R. Job • Philippines

When natural disasters result in numerous injuries, MSF will always arrange for swift treatment of the wounded. Frequently, there are few injured people, but the damage to the infrastructure has brought normal medical activities in the area to a standstill. In this case, MSF will provide consultations to the population during the emergency phase. Over a longer period of time, disease can set in because of contaminated water, food shortages or exposure to the elements. In order to ward off outbreaks, vaccination campaigns are sometimes launched.

Rehabilitation

Once the emergency phase is over, rehabilitation of the infrastructure can begin. Longer-term assistance and technical support may be needed to repair roads and building or to find interim solutions for replacing livestock and crops which have been destroyed.



photo R. Job • Philippines



photo R. Job • Philippines





POP. IN YEAR 1996
20.0 m

GNP PER-CAPITA
280x USD

ADULT LITERACY RATE,
MALE/FEMALE
45%/13%

LIFE EXPECTANCY
43 yrs

0-5 MORTALITY RATE
257 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
88%

International staff: 64

National staff: 737

HEALTH CARE FOR WOMEN A PRIORITY

Although the ultra-religious Taliban movement seized Kabul on 27th September 1996, and proceeded to take control of three quarters of Afghan territory, the north remained in the grip of a loose coalition made up of three warring factions. Since then, the Taliban have made serious attempts to make inroads in this region. Afghan women continue to suffer terrible discrimination.

MSF's main priority in Afghanistan is to promote health care for women and children who are most at risk from exclusion. Given that the country is so unstable, emergency preparedness is also a priority as is emergency aid. Moreover, the Afghan health care system is in tatters. Most medical professionals have left the country and training programmes are non-existent. Numerous hospitals and clinics have been destroyed or are otherwise out of commission, while in the absence of a central government supplies of equipment and essential drugs are sporadic if they materialise at all.

Caring for refugees and local populations

In Northern Afghanistan MSF focused on making primary health care accessible to the whole population including refugees, the displaced and returnees. In Takhar, in the north-east of the country, MSF

supported health posts in four districts. MSF was also responsible for training and staff supervision as well as medical supply. This project began in August 1996.

MSF also continued its programme in Mazar-i-Sharif. The clinics in Sakhi, Kamaz and Shamarq refugee camps were opened to local populations. New clinics were set up in collaboration with regional health authorities. A community participation scheme with a health committee for each clinic was introduced to most of the structures. MSF also paid a financial incentive to the medical staff. MSF continued to run an emergency preparedness programme. Teams supported dispensaries in areas of open or potential conflict. Donations of drugs and surgical equipment to local hospitals receiving the war wounded took place in Taloqan, Charikar and Manaima. Taloqan hospital also received structural support for the surgical wing.

In Hazarajat, a clinic for in-patients was opened, and an MSF team worked there alongside Afghan staff. Major rehabilitation work was carried out with a view to its opening in 1997. This hospital will be fully supported by MSF.

As the Taliban militants made their way towards Kabul last autumn, they seized the town of Jalalabad. The international MSF team was temporarily evacuated to Pakistan for fear that government troops might carry out a counter-attack. Local MSF staff continued their work in the clinics, although initially many of the women among them stayed at home. Once the Taliban indicated that they did not object to women's labour in the health-care sector, they went back to work. A partition wall was built to separate male and female patients. In December 1996, the programme in New



photo T. Voeten • Afghanistan

Hadda was handed over to HealthNet International, as was the Emergency Preparedness programme.

In addition to the provision of medical relief for refugees and displaced persons, MSF worked on the improvement of mother-and-child care. The team also checked out medical facilities and needs in this particular field in the eastern province of Nangahar. This survey, too, was handed over to HealthNet.

Targeting health care for women and children

Health statistics for women in Afghanistan are grim: a high percentage of mothers die during childbirth (Unicef estimated their number at 640 to 100,000 live births). A quarter of all children die before the age of five of easily preventable diseases. The figures are even more dramatic in Orúzgán, one of the most isolated provinces in southern Afghanistan.

In 1995, MSF started a programme specially targeted at improving health care for women and children. Most families in Orúzgán are Pathans. Women are not allowed to go outdoors unaccompanied and may be seen only by men of their immediate family. Because there are few female doctors and nurses, women have almost always been excluded from any form of health care. The only help they can resort to is that given by traditional midwives, who exist in every village community. MSF therefore decided to train this group of women in the area of hygiene and health information. It also appointed Afghan doctors to clinics in the towns of Tarín Kowt and Dehrawod. The team had to negotiate constantly with the religious leaders of the Taliban about the project's progress.

MSF has always collaborated with the Afghan relief organisation AHDS, which, it is hoped, will eventually take over the programme. Together, MSF and AHDS rehabilitated two destroyed hospitals and ten health posts in the area.

When fighting broke out in the north-west of Afghanistan in November 1996, thousands of people fled to Herat. More than 8,000 displaced people descended on

Shahadai camp, situated four miles outside the city. A heated marquee served as a clinic and was visited daily by some eighty to a hundred patients. The most frequent diseases were bronchial infections and diarrhoea. The camp is exposed to icy cold winds and the temperature often drops to way below zero. Many displaced persons had no other clothing than what they were wearing. Besides setting up primary health care facilities, MSF also provided training and supervision of local medical staff and carried out a measles vaccination programme. It gave technical support for the improvement of the water supply and sanitary facilities in the camp.

In March 1997, MSF ended its technical support programme for Kabul's Jamhuriat Hospital but has decided to stay at Karte Seh hospital in the south of the country. The organisation also supported six clinics where assistance was provided to the displaced of Kabul and continued to evaluate care in the burns unit at the Jamhuriat and Indira Gandhi Hospitals.

Over the past year, MSF stepped up its activities in Ghazni province. Teams continued to support the provincial hospital, and most particularly the paediatrics wing which opened and where teams work to improve the standards of general medicine. In March 1997, a tuberculosis programme was launched. In Gardez, Paktia province, MSF supported the reference hospital. The full range of services were provided, with an emphasis on paediatrics. Saraab health centre in Hazarajat was opened in November 1996. External consultations are provided as well as immunisation programmes.

The continuing problem of landmines

In 1997, MSF felt spoke out about the effects of mines in Afghanistan. They kill and injure civilians on a daily basis, they prevent the use of large areas of vital land, and they prevent the return of refugees and internally displaced people to their homes. Those particularly at risk are kuchis (nomads) who travel widely across the country, and shepherds. The MSF report Living in a Minefield (MSF, May 1997) documents the current mines situation in Afghanistan by looking at the demining and mines education programmes. MSF supports the governmental ban on the production, possession, transfer, and use of landmines which is to be signed in Ottawa at the end of 1997. MSF is also pushing for more funding for demining programmes and increased funding for rehabilitation projects for the victims of mines.



photo M. Van Bouwel • Afghanistan

BANGLADESH



POP. IN YEAR 1996
120.4 m
GNP PER CAPITA
220 USD
0-5 MORTALITY RATE
117 per 1,000
POP. PER DOCTOR/NURSE
12,500/20,000
LACK OF ACCESS
TO DRINKING WATER
17%

BURMA/Myanmar



POP. IN YEAR 1996
46.5 m
GNP PER CAPITA
220x USD
0-5 MORTALITY RATE
109 per 1,000
POP. PER DOCTOR/NURSE
12,500/n.a
LACK OF ACCESS
TO DRINKING WATER
62%

MSF CONCERNED FOR FATE OF ROHINGYA

While Bangladesh wants to "solve" the problem of the Rohingya refugees, Burma is reportedly refusing to allow them back in. Between 10 to 15,000 new arrivals have not received refugee status.

Since late 1991, members of Burma's Rohingya ethnic minority have been crossing into Bangladesh. Although they repeatedly claimed to have fled persecution, most have already been repatriated by force. MSF continues to assist the remaining 20,000 and has made preparations for new arrivals.

They live in four camps around Cox's Bazaar. In the Nayapara camp, where 11,500 of them are staying, MSF runs an outpatients clinic, a hospital, feeding centres and a diarrhoea treatment centre. Mother-and-child care and vaccination programmes are also provided. MSF is responsible for part of the camp's water supply. The sanitation facilities are maintained by the refugees. MSF has trained health workers and traditional midwives. This will be the last camp to close down. MSF

also carried out a similar programme in Gundhum which closed in late 1996. Those Rohingya who have not received refugee status are living dispersed throughout the hills in the Cox's Bazaar region. They have no access to the state's health services.

MSF has also provided assistance to the Bengal population following the tornado in Tangail of 13 May 1996 which killed 525 people and left 75,000 homeless. Almost all existing sanitary facilities were destroyed. A water and sanitation programme was carried out for the 6,000 inhabitants of six villages of the district. From August to October 1996, MSF intervened in the Shibchar Thana area of Madaripur state. The programme was prompted by severe flooding. To prevent cholera, two outpatient clinics were opened and a mobile medical team set up.

MEDICAL ASSISTANCE FOR SLUM-DWELLERS

Rangoon rejects the UN's latest denunciation of its administration for human rights abuse, characterising it as western prejudice. Aung San Suu Kyi says that from a Buddhist point of view, the denunciation is justified.

Burma has been ruled by a military junta, the State Law and Order Restoration Council (SLORC), since 1988. The 1990 election victory of the National Democrat Party (NDP), led by Nobel Prize winner Aung San Suu Kyi, has not been recognised by the junta.

In Burma, MSF gives medical aid to the population of townships around the capital, Rangoon, and to deprived ethnic minorities and other inhabitants in Rakhine state. The cornerstones of these programmes are general health care and malaria control.

From 1988 on, hundreds of thousands of Rangoon residents were forcibly relocated to make room for government-sponsored projects. In 1993, MSF started an aid programme for these township dwellers. The main medical problems include diarrhoea,

bronchial infections, sexually transmitted diseases (STDs) and malnutrition. Hospitals, outpatient clinics, and health posts were supplied with drugs and medical supplies. The team set up an adequate water supply and sanitary facilities, and instructed local health workers in the use of essential drugs. In Hlaing Thayar, MSF opened two mother and child care clinics and two feeding centres for children.

Rakhine state is inhabited by a relatively large Muslim population called the Rohingya. Here, MSF launched a malaria-control programme. The team installed equipment in 22 laboratories for a quick and accurate diagnosis of malaria. 25 lab assistants were trained in malaria microscopies, and health workers were given training in the treatment of fever and malaria. MSF also supplied antimalarial drugs.

PROGRESS ON HEALTH CARE REFORM

On 30th March, 1996, four grenades were thrown into a crowd of peaceful demonstrators, in front of the parliament building in Phnom Penh. They were protesting against the judiciary's lack of independence. The event confirmed that Cambodia's fledgling democracy is under threat. Nevertheless, significant progress is being made by the Ministry of Health in restructuring the national health care system.

For several years now MSF has given assistance to the Cambodian Ministry of Health to overhaul the health care system. MSF teams are working in the provinces Stung Treng, Kratie, Siem Reap Oddar Meanchey, Pursat, Banteay Meanchey, Battambang, Kompong Cham and Kompong Thom, and in the capital Phnom Penh.

In these provinces MSF helps the Ministry of Health in the practical implementation of the Health Reform, and more specifically in the organisation of the so called "operational health districts", which are being designed to provide basic health care for target populations of between 100,000 and 200,000 people. MSF is directly involved in the creation of 8 of these model districts in Cambodia's remotest areas, where numerous landmines, extremely bad road conditions, lack of bridges and banditry complicate access. With the Khmer Rouge defections in 1996 for the first time "their" populations in Banteay Meanchey (Phnom Malai), Battambang and Pursat, have now suddenly become accessible! MSF is actively involved in the organisation of the integration of their health care into the provincial health care systems. As there has never been any vaccination in these areas, this is one of the priorities.

Also in Banteay Meanchey MSF's attention was drawn to a group of 10,000 displaced persons lingering on the Thai border, many of them former returnees from the border camps that have not succeeded to create a new living after their repatriation in 1993. MSF established a temporary health centre for this vulnerable group, in Nong Chan, that in the future will be taken over by the Ministry of Health.

As part of this Health Reform, there is much to be done in the organisation of

disease control programmes, such as malaria, tuberculosis, dengue, bilharzia and STD-AIDS.

The people living along the Mekong River and suffering from Bilharzia were given a mass treatment, while further investigations are ongoing to find out where the disease has spread. A result of the mass treatments in Kratie in 1995 and 1996, the prevalence of bilharzia in certain villages was reduced from 75% to 15%.

In all 8 provinces where MSF is present, MSF is organising the "social marketing" of condoms, i.e. the sale of condoms at many places against a subsidised price. The revenues are used for health education activities and aids prevention. Sexual Transmitted Diseases are an enormous problem in Cambodia that MSF tries to tackle by establishing STD clinics providing effective treatments, especially for prostitutes and their clients. More and more AIDS cases are appearing and MSF is trying to organise AIDS care for the first patients in hospitals and as Community Based Care. Many patients are rejected or severely discriminated by their environment.

Both national training programmes in the National School for Health Cadres (ECCS), supported by MSF, continued in 1996: the anaesthetist-nurses programme, and the laboratory programme.

1996 was the year of floods in many countries in Asia, and also in Cambodia. For many weeks in September and October large parts of the country were inaccessible. Part of the rice crop was destroyed and thousands of people were temporarily displaced. MSF was involved in the distribution of relief goods for the affected populations.

International staff: 47 / National staff: 267

CAMBODIA



POP. IN YEAR 1996
10 m

GNP PER CAPITA
200x USD

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

LIFE EXPECTANCY
52 yrs

0-5 MORTALITY RATE
177 per 1,000

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



photo Benno Neelmann • Bangladesh

CHINA



POP. IN YEAR 1996
1,221 m

GNP-PER CAPITA
490 USD

ADULT LITERACY RATE,
MALE/FEMALE
88%/70%

LIFE EXPECTANCY
68 yrs

0-5 MORTALITY RATE
43 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
54%

INDIA

MSF provides financial assistance to the Indian aid organisation Share and Care. A project to combat polio has already helped 255 children. The agency also organises nursery care for small children in the slums of Madras. In mid-November 1996, the Indian state of Andhra Pradesh was hit by a cyclone. An exploratory mission revealed that local relief activities met the existing needs. MSF therefore limited itself to the distribution of drugs to a hospital.

CHINA OPENS THE DOOR TO AID

As liberalisation continues to make China one of the fastest growing economies in the world, free access to medical services is being eliminated. The disintegration of the old system has had particularly grave consequences for rural China. Medical expenses have skyrocketed while wages have increased only marginally. Until recently, it was unthinkable that foreign organisations would provide aid in China. Not until the extreme flood disaster in 1995 did the Chinese accept the assistance offered by MSF.

Since late 1995, MSF has been operating in the province of Yunnan, in the deep south of China. 25 of China's 56 minorities are located in Yunnan, where health is extremely poor at the local level. Doctors with only limited training have little if any equipment or medical supplies. MSF concentrated on the collection of medical data and the building up of local contacts. The team also distributed medical supplies to a hundred village clinics and ten hospitals and gave additional training to village doctors about the treatment and registration of a large range of diseases.

From July to September 1996, MSF teams intervened following the floods in South China.

Although, annual floods are a part of life in this part of China, the 1996 flood was on an unprecedented scale, with the river Yangtze overflowing its banks everywhere.

According to official figures, the flood killed 1,509 people and caused material damage for 100 million others.

MSF provided aid in direct collaboration with the local Red Cross. MSF teams were involved in the relief effort in eight different provinces in the south of the country - Guianxi, Hubei, Hunan, Jiangxi, Anhui, Guizhou, Kunming, Zhajiang. In the north of the province of Guangxi, an MSF team found itself cut off by the rising water for two days. Rubber dinghies were used to rescue thousands of people from the upper floor of apartment buildings that were under water up to the fourth floor.

After the initial emergency phase, which mainly involves the distribution of supplies, MSF's focus was shifted towards the prevention of epidemics. Water sources had been polluted by the flood waters. The creation of an alternative water supply and the construction of emergency toilets was therefore essential once the water level began to go down. MSF continued to support the stricken areas up to the second week of September by installing mobile clinics, distributing medicines, supplying drinking water and distributing emergency supplies (such as plastic sheeting) for the displaced.



photo MSF • China



photo MSF • China

MSF's primary health care programme for the rural areas of Luzhou prefecture in Guanxi province continued. The programme includes the introduction of a list of essential medicines and a fixed price per illness, the creation of patient files with a filing and archive system, the rehabilitation of buildings, financial management at the clinic, bonuses for doctors to compensate for loss in reduction of prescription prices. The team also organised drinking water distribution to 11,000 people in Guosol canton.

MSF in Tibet

MSF's big bone disease programme is run in Lhasa, Lhoka and Shigatse prefectures. This is the backbone of the Tibet mission. MSF trains village doctors in physiotherapy which does provide some relief for this endemic and somewhat mysterious disease. There is currently no cure for big bone disease. This past year has seen the continuation of the ambitious research project in partnership with two Belgian universities which will lead to a pilot prevention project. The preliminary results of this study into the origins of the disease point to an iodine and selenium deficiency, as well as a micro-fungal contamination of barley grains. MSF's drinking water supply project was also extended to Lhoka and Shigatse.

MSF's medical programme continued in the counties of Lhundrup and Nyemo. In the summer of 1996, 28 "village clinics"

were built with the help of the local population. MSF teams provide training courses for local staff and supervise activities in the clinics. The team is currently making plans for the launch of a cost recovery initiative.

In May, MSF launched a programme for 200,000, mainly nomadic people living in Yushu prefecture in the north of Tibet. The inhabitants of this immense area have little access to health care. MSF is in the throes of setting up a programme to provide support to the health care system, specifically by training local health care staff and supplying medical supplies to health care services. The team is currently rehabilitating two clinics in Nangquian county and setting up a revolving fund for medicine.

International staff: 41 / National staff: 228

What is Big bone disease

There is currently no cure for big bone disease, an endemic and mysterious illness which stunts growth in children and makes adults' joints swell up so much that they are unable to use their hands and in some cases are unable to walk. MSF helps to ease the pain of sufferers with physiotherapy. This past year has seen the continuation of the research project in partnership with two Belgian universities which will lead to a pilot prevention project. The preliminary results of this study into the origins of the disease point to an iodine and Selenium deficiency, as well as a micro-fungal contamination of barley grains.

KIRGHYZIA

Since Kirghyza gained its independence from the Soviet Union in August 1991, the health sector has suffered greatly. In Osh, MSF supports those health services which provide medical assistance to patients suffering from sexually transmitted diseases. The team works in collaboration with health authorities and local health care staff. It supplies the health services with medical supplies, works on improving hygiene and sterilisation methods and is trying to upgrade existing laboratories. MSF hopes to extend the STD programme to three dispensaries in the district.

HONG KONG



POP. IN YEAR 1996
6.2 m
GNP PER CAPITA
18,100 USD
POP. PER DOCTOR/NURSE
n.a./n.a.
0-5 MORTALITY RATE
6 per 1,000

LAOS



POP. IN YEAR 1996
4.8 m
GNP PER CAPITA
280 USD
0-5 MORTALITY RATE
138 per 1,000
POP. PER DOCTOR/NURSE
4,545/n.a.
LACK OF ACCESS
TO DRINKING WATER
59%

CONTINUING LOBBY FOR BOAT PEOPLE

On 30 June 1997, the British colony Hong Kong was returned to China. MSF is concerned about the fate of the Vietnamese refugees and non-refugees.

MSF has loudly criticised the UNHCR's Orderly Repatriation Programme (ORP) since the outset. However, as the date for the hand over approached, the vast majority of the refugees had, in fact, returned to Vietnam. MSF wants an acceptable solution to be found and one that does not include forced repatriation of refugees. To date, there are 1,300 refugees without a country to resettle into and 3,000 illegal aliens who will not be receiving refugee status.

The MSF team intends to stay with the Vietnamese refugees and illegal aliens until the last of the camps closes. Tai A chau detention centre closed in September 1996, and Whitehead camp in June 1997. MSF continues its work in Pillar Point refugee camp. The programme reaches both groups of Vietnamese. MSF's priority in Hong Kong is to monitor the situation of the Vietnamese and the ORP.

Medical care is second on the list of priorities and given the likelihood of camp closure in the foreseeable future, it is being phased out. MSF is determined to continue its medical programme until the very end. The team continues to provide its Well Baby Service, whereby MSF volunteers run paediatric clinics and teach new mothers how to care for their children; and specifically the under-fives. Vaccination is still an important part of this programme.

The trauma of years spent behind barbed wire with an uncertain fate, has driven many Vietnamese to take drugs. MSF's Harm Reduction Programme (HARP) which provides a needle exchange for drug users in camps continued. In the near future, the service will be extended to include Hong Kong nationals.

International staff: 6 / National staff: 60

RELAUNCHING THE HEALTH SERVICES

It has been eight years since the end of communism in Laos. Many of the state's public services need to be overhauled. Health care structures are dilapidated and insufficiently supplied with medicines.

In Champassak, MSF is helping relaunch the province's health system by dividing the whole province into into operational health districts. MSF continued to supervise health services in two districts. The cost recovery system initiated by MSF has taken off and has permitted health structures to keep up supplies of medical equipment and drugs. MSF tried to ensure good basic health care at every level of the system and focused on weekly training courses for health workers. At health centres, MSF carried out what is known as a birth-spacing programme. MSF opened an operating theatre in Champassak district hospital and trained a surgeon. Finally, MSF became involved in a pilot project to collect health data. Medical supervision was carried out in the districts of Sanasomboune and Bashiang.

Following a flood and heavy rainfall in August/September 1996, MSF launched an emergency aid programme in nine of the worst affected districts. Teams distributed seeds, tools and rice.

In April 1997, MSF opened a mission in Sekong province, a very inaccessible zone where health care coverage is poor. The team started to support the provincial health authorities, provide technical assistance to the provincial hospital and Sekong hospital. In Kalum and Dakchung, MSF supported health care in the district hospital and the health centres.

MSF left Saravane in July 1996, but remains in touch with the organisation Entraide Médicale Internationale (EMI) which is collaborating with the local health authorities to upgrade the health system. The programme in Bokeo has ended.

TUBERCULOSIS KILLS THOUSANDS

In Kazakhstan there has been a dramatic decline in public investment in health services. Tuberculosis has become a major health problem as have diseases caused by pollution.

According to the most recent survey, 50,000 people contract tuberculosis (TB) each year, 3,000 of whom die. Another serious health problem is caused by the enormous level of pollution, a result of the abuse of chemical products and nuclear testing.

In Aksi Hospital, which is located to the north of Almaty, MSF launched a three-year pilot project to combat tuberculosis in 1996. MSF is providing medical treatment for the patients. The team also trains local health personnel, who have not been able to brush up on their skills for many years. In the

southern region of Chimkent, a similar project started in the summer of 1997 (this includes support for an Aids prevention programme). There have been 4,000 cases of registered TB cases by health staff using outdated methods. There has been no other international aid presence in the region.

The project consists of rehabilitating a specialised dispensary unit, 100kms north of Chimkent; retraining health staff on WHO protocols; the latest methods of diagnosis and a preventive approach which is adapted to HIV/AIDS. A mobile follow-up system was also to be implemented.

KAZAKHSTAN



International staff: 6
National staff: 6

NORTH KOREA

At the end of April 1997 an exploratory team went to North Korea which was facing an imminent famine. MSF had worked before in North Korea, following the dramatic floods at the end of 1995, and has since been trying to find a way to provide aid assistance in a country where food shortages can often be acute. Permission was requested to launch an emergency programme. This was not given, however, the authorities did allow a MSF team to supervise food distribution in January 1997.



photo Bern. Foubert • Hong Kong



photo Bern. Foubert • Hong Kong

PHILIPPINES



POP. IN YEAR 1996
68.4 m
GNP PER CAPITA
850 USD
0-5 MORTALITY RATE
57 per 1,000
POP. PER DOCTOR/NURSE
8,333/n.a.
LACK OF ACCESS
TO DRINKING WATER
16%

UPGRADING THE HEALTH CARE SYSTEM

Progress has been made in talks with separatists. The leader of the Muslim group the *Moro National Liberation Front (MNLF)* was installed as leader of the autonomous Muslim region.

Unlike most other years, there was no major natural disaster in the Philippines in 1996. However, MSF keeps open an emergency preparedness programme in Pinatubo, Pampanga province.

The team continued its project for street children in Quezon and Manila. This was carried out in collaboration with the government and other aid agencies. The team provided medical consultations, immunisation programmes and health education for these children.

In Davao, MSF ran a project at a clinic to try and combat STDs. Over the course of a year, there was a slight increase in the number of sex-

workers attending this clinic. Other services provided include the full range of gynaecological programmes for female sex-workers. MSF also tried to promote the use of condoms, held group discussions on safe sex and ran a telephone "hotline".

International staff: 4 / National staff: 40



photo R. Job • Philippines

VIETNAM



POP. IN YEAR 1996
74.5 m
GNP PER CAPITA
170 USD
0-5 MORTALITY RATE
46 per 1,000
POP. PER DOCTOR/NURSE
247/1,149
LACK OF ACCESS
TO DRINKING WATER
62%

RELIEF AFTER THE TYPHOONS

The Politburo of the Communist Party controls both the electoral process and the executive. The president suffered a serious stroke, triggering intense speculation about his possible successor.

As a result of typhoon Frankie at the end of July 1996 and typhoon Willy at the end of September 1996, MSF launched two emergency projects in three Vietnamese provinces: Ninh Binh, Thai Binh and Ha Tinh. This included the distribution of medical supplies. A water and sanitation programme was also carried out for the health centres.

In July 1996, a medical programme was launched in the Delta region with the objective of improving access to health care.

Another programme was launched in Can Tho province, in March 1997. Here, the team brought support to a community health care centre in the district of Long Tuyen.

Although the health assistance project for the Da Bac district in the north of the country came to an end in December 1996, the STD prevention project in Nha Trang in the south continued.

International staff: 10

National staff: 100

WAR SURGERY CONTINUES

The war continues in Sri Lanka, with the Tamil Tigers continuing to attack army bases and suicide attacks being carried out regularly. 1996 saw the fall of the towns of Jaffna and Killinochchi to the government army.

MSF has been working in Sri Lanka throughout the war. Teams work on both sides of the front line. In July 1996, the MSF team left Killinochchi when it fell to the government army and most of the population fled. MSF protested vigorously when the hospital came under fire. Soon, the last hospital in the area controlled by the Liberation Tigers of Tamil Eelam (LTTE) stopped functioning.

MSF then set up a new hospital programme in Mallavi, 33 miles to the south. Two health posts in the region around Mallavi stayed in close contact with MSF, referring patients who needed gynaecological, obstetric, surgical or paediatric care. Given that the government's restrictions on the supply of drugs and medical material were severe, it did not take long before the hospital's stock of medical supplies was depleted. MSF lodged a vigorous protest in Colombo against this obstruction of humanitarian aid. Throughout the year, supplies continued to come in only sporadically. In Mallavi, the team helped the local staff improve surgical techniques and treatment. In the busiest periods, thousands of patients received treatment at the hospital. MSF continued to run the cleaning and refuse disposal services of the hospital.

Difficult access to health care

After the fall of Killinochchi in 1996, there was an increase in the number of attacks and acts of sabotage carried out by the Tigers on the island of Mannar, which was already controlled by the army. At the island's hospital, the MSF team continued its work. Unfortunately, a large segment of the population of Mannar (the island and the mainland) had difficulties reaching the hospital because of the fighting. Once a week the MSF team visited the Pessalai health centre, situated further away on the

island, for urgent surgical consultations. However, the problems of access to both Mannar and Vavuniya have been solved as the road was opened by the army in February 1997.

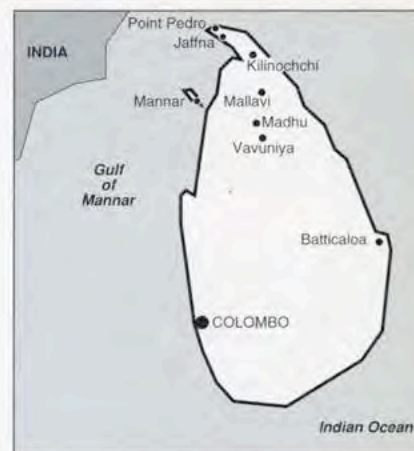
MSF was in charge of surgery and paediatrics in Batticaloa hospital. The team also ran a mobile clinic for the surrounding villages. In Vavuniya Hospital, which is the reference centre for the northern region, MSF ran both the surgical and anaesthetics ward. There were an average of 230 surgical operations each month. In Madhu, MSF continued to work with the Tamil refugees who returned from India in 1990. The team also supported the displaced camps in Madhu, Pallampidi and neighbouring villages.

The attacks on positions in the Jaffna peninsula have brought about the destruction of the hospital, which is the reference centre for the whole peninsula, and have resulted in the massive exodus eastwards in the direction of Point Pedro. However, Jaffna hospital was rebuilt by the health authorities and in April 1997, MSF sent in a team to work there.

International staff: 113

National staff: 367

SRI LANKA



POP. IN YEAR 1996
18.3 m

GNP PER CAPITA
600 USD

ADULT LITERACY RATE,
MALE/FEMALE
93%/86%

LIFE EXPECTANCY
72 yrs

0-5 MORTALITY RATE
19 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
47%

PAKISTAN

For many years, MSF's projects in Afghanistan have been coordinated from the Pakistani city of Peshawar. When southern Pakistan was flooded in September 1996, MSF dispatched a team to assess the situation. They decided to donate medicines to the affected population but, not to launch an emergency programme as devastation was not on a big enough scale to warrant it.



POP. IN YEAR 1996
60.2 m

GNP PER CAPITA
2,110 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

LACK OF ACCESS
TO DRINKING WATER
14%

International staff: 27

National staff: 376

AIDS PROGRAMME UP AND RUNNING

In the general election of November 1996, the *New Aspiration Party (NAP)* won more seats than any other party. Its leader Chavalit Yongchaiyudh assembled a six party coalition.

The problems that face MSF in Thailand are the lack of medical staff, particularly in rural areas, and the fact that private health services are booming in the cities, thereby draining human resources. The Aids epidemic is at an all time high. The total number of full-blown Aids cases in 1996 could number 70,000 (which happens to be the total number of hospital beds in the country)

In Bangkok, MSF provides direct medical care for Aids patients at home, trains care givers, works in close cooperation with the major reference hospital, networks with local NGOs, produces medical records and trains local NGOs. A pilot project in Chiang Mai, northern Thailand, was launched in order to promote and encourage community care for those infected with HIV and their families. In this area, there is the highest incidence of HIV in the country.

In October 1994, MSF opened a health care centre in the town of Chiang Mai and also started working in two subdistricts training local health care staff as well as volunteers. The project attempts to show the importance of a taking a global approach to health care. This includes psycho-social, nursing and medical care. As hospitals are overburdened, MSF promotes the reference system. The health centre staff attends seminars and conferences and plays an important role in building up a community support network. There is a weekly radio programme broadcast by one of the counsellors. Since October 1996, a programme to promote home care for Aids patients has begun in Surin province. It is carried out in strict collaboration with a Thai agency BAN-NET.

In collaboration with health authorities as well as local and community NGOs, MSF works in two sub-districts of Chiang Mai and a city slum. Training is an essential aspect of the programme. Home care plays a big part but this means that follow up can be

difficult. Nursing and counselling is provided.

Refugee assistance programmes

Throughout 1996, MSF continued its assistance programme for the Karen refugees in five camps in Mae Sod. At the beginning of 1997, some of these camps were attacked and burned down on the Burmese side of the border, causing chaos inside the camps. During the attacks, MSF teams ensured that the refugees were receiving adequate medical assistance. Since then the programme has returned to normal and damaged buildings have been repaired. There were more attacks on the Karen populations living in Tenasserim, Burma which led to new arrivals in Thailand. MSF successfully lobbied the Thai government for more access to the refugees.

Since the peace accord between the SLORC and the Mon State Party in 1995, and their consequent return to Burma, MSF has sent teams, throughout 1996, into Burma to check on their welfare. However, since January 1997, MSF has not been allowed into Tavoy district. It is unclear whether or not the peace accord is solid.

Throughout 1996, MSF continued to provide assistance to the remaining Vietnamese refugees in Sikhui as they prepared to return to Vietnam. MSF teams provided medical and psychological assistance to the refugees until the sites were closed



ASSISTANCE FOR THE ISOLATED

In February 1997, an agreement was signed between the government and opposition foreseeing power sharing and the return of refugees. Anti-Russian attacks and hostage-taking are still regular occurrences.

MSF provides support to the health care system of the isolated and somewhat inaccessible region of Pamir by supplying medicines and medical equipment, supporting the vaccination programme and vaccination campaigns, distributing nutritional supplements, and training health care staff. MSF has withdrawn from several districts and is concentrating its aid programme in three target districts chosen on the basis of the level of motivation of the health care personnel. MSF provides medical supplies to all of Pamir's health services. However, MSF has handed over the responsibility for two districts to another aid agency. Supplies are flown in via Osh, Kirghizia.

MSF participated in the diphtheria vaccination campaign in October 1996 and the polio vaccination campaign in April 1997. The team also provides support for the national immunisation programme in

three districts by running training courses and advising on vaccination schedules. Food shortages and lack of variety of foodstuffs are noticeable from the prevalence of rickets and people suffering from a disease caused by a lack of vitamin A. During the biannual vaccination campaigns for polio, vitamin A and vitamin D pills are distributed to under-fives. MSF places a great deal of emphasis on training programmes.

At the beginning of 1997, MSF opened a mother-and-child health care programme in Kolkhozabad district, situated in the south-west of the country. MSF's target population is made up of 50,000 women and children.

In the capital, Dushanbe, MSF spent several months at the beginning of 1997 trying to halt the spread of a typhoid epidemic.

International staff: 23 / National staff: 61

TAJIKISTAN



POP. IN YEAR 1996
5.9 m

GNP PER CAPITA
470 USD

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

LIFE EXPECTANCY
70 yrs

0-5 MORTALITY RATE
57 per 1,000

POP. PER DOCTOR/NURSE
350/210



photo MSF • Thaïlande



24

CENTRAL and SOUTH AMERICA

AMERICA

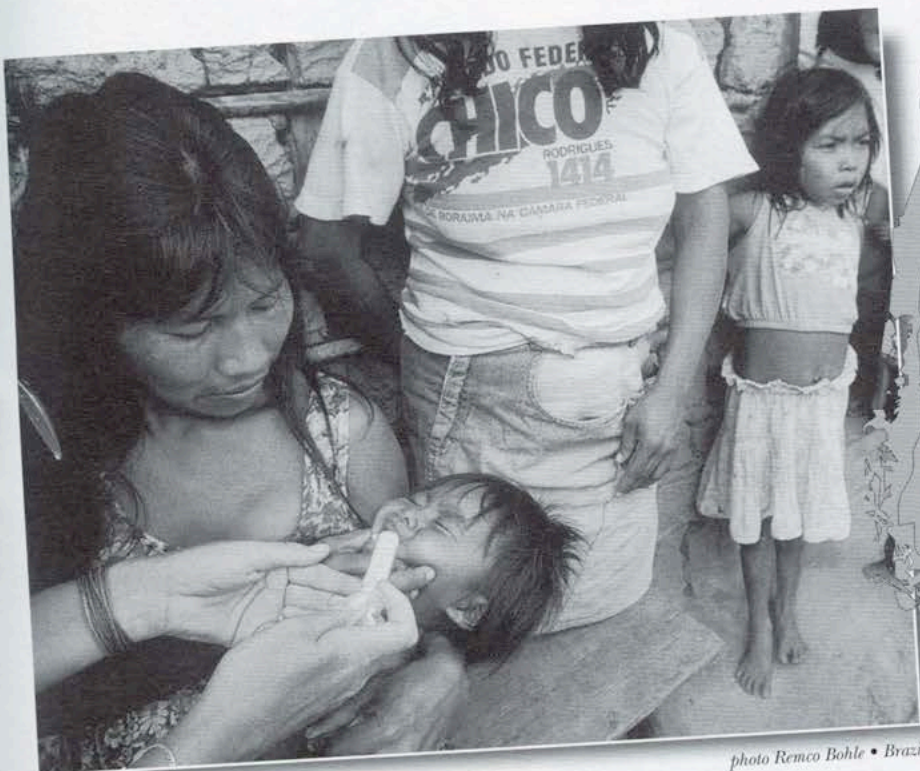
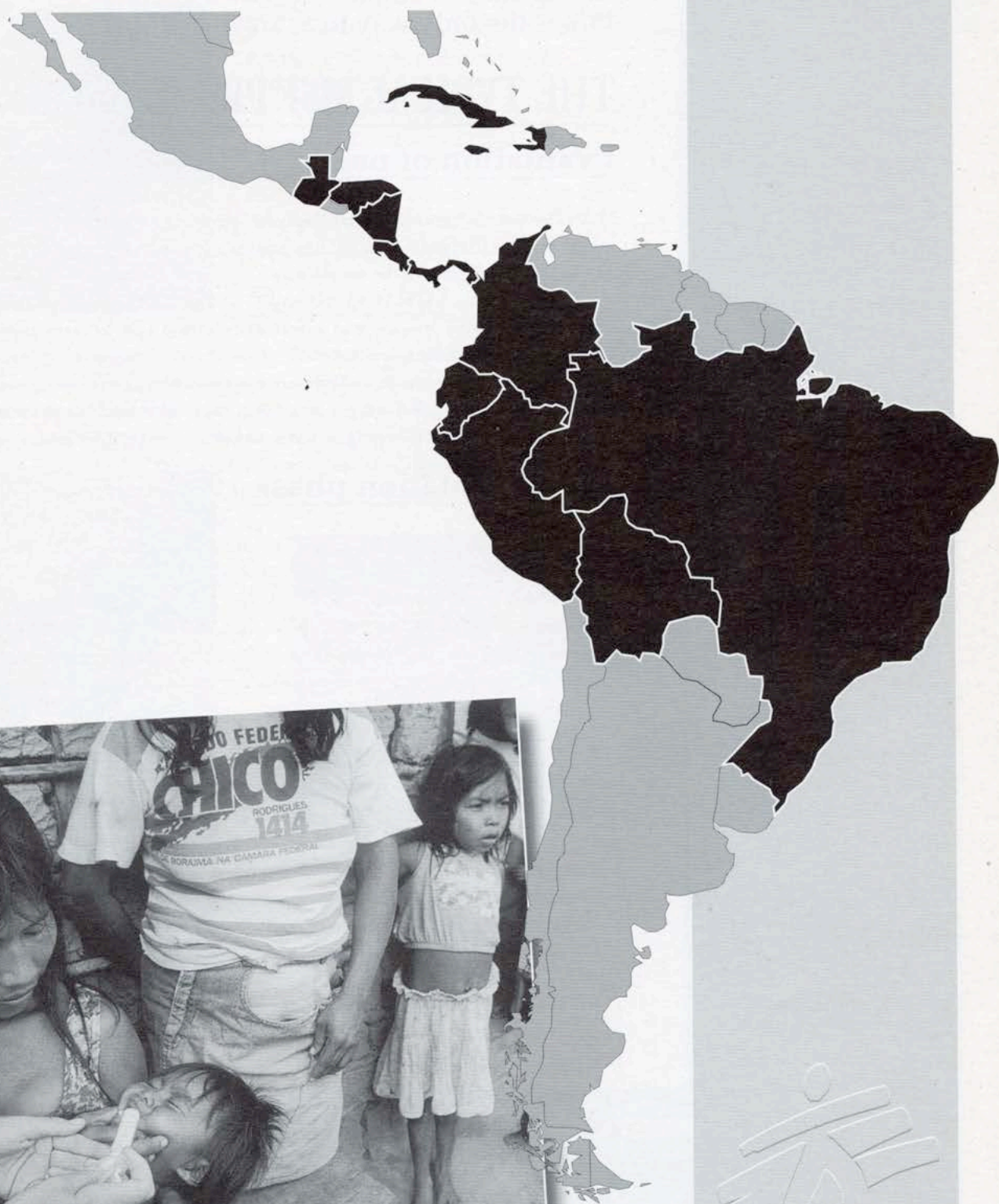


photo Remco Bohle • Brazil



Water and sanitation programmes, including vector control, are crucial aspects of Médecins Sans Frontières' medical assistance both in emergencies and in the longer-term. Although MSF sends technical experts to the field, the participation of members of the local community is also encouraged as experience shows that this is the only way to achieve lasting results.

THE TYPICAL MSF PROGRAMME

Evaluation of needs

MSF's assistance programmes often focus on upgrading water and sanitation because by raising hygiene levels and ensuring that water is not contaminated, MSF can prevent disease and improve the health of the community.

When MSF first sends its water and sanitation experts to a project area, they carry out a survey on the environment, evaluate the socio-cultural or religious requirements of the community, check the quality and efficiency of the public health facilities and estimate sanitation needs. MSF also makes contact with the local authorities and to enquire about national requirements for setting up water and sanitation programmes.

Implementation phase

Water:

Water is an essential element for the survival of individuals, for the prevention of numerous contagious diseases and in order to maintain adequate health levels. If the affected population has little access to water, it is essential to set up a water supply system in sufficient quality and quantity close to surface or ground water (rivers, lakes, springs) or rain catchments (wells). It is only then that the water can be stored, disinfected and purified before distribution. In emergency situations, MSF requires that each individual receive 15 to 20 litres of water per day. In non-emergency situations, the requirements are even higher.

Sanitation:

As in the case of water, the poor treatment of waste represents a source of illness. It is, therefore, essential that latrines and waste disposal systems be created. During the first days of an emergency, one latrine or trench is needed for every 50-100 persons. This should be rapidly increased to one for every 20 persons or family. Latrines should be no closer than 5 metres to a shelter and no further away than 40 metres.



photo MSF

Disposal of waste and increasing public hygiene awareness are the next priorities. Run-off rain water and waste water need to be monitored. Solid waste needs to be

disposed of - ideally using waste collection teams and a landfill system. One garbage container for every ten families should be placed within 15 metres of shelters. Medical waste must be incinerated and dead bodies need to be disposed of in a manner acceptable to the population. Disease vectors including insects and rats must be exterminated.

The importance of hygiene education



Where necessary, MSF will provide training courses on hygiene to local staff so that they can raise awareness on hygiene in the community.

Vector control

The main vectors for disease are mosquitoes, lice, flies, fleas and rodents. MSF aims at finding ways to control the spread of insects and rodents (usually by improving hygiene). Insecticides are used sparingly by MSF because many vectors have developed a resistance to those chemicals and also, their harmful effects on humans have been well documented. Many diseases are transmitted by insects. Mosquitoes are responsible for the spread of malaria, Japanese encephalitis, dengue fever and yellow fever. Flies transmit trypanomiasis and onchocerciasis. The plague is spread by lice which live on rats, typhus by fleas and encephalitis by ticks. MSF focuses on attaining acceptable levels of environmental hygiene. However, the main thrust of vector control is prevention: information and education.



photo Jet Belgraver • Peru

Water related health risks

In extreme cases of lack of water, life is simply not possible. Complete dehydration leads to death. Less extreme shortages also have an impact on the health status of a population. Many dermatological and ophthalmic diseases are directly due to lack of hygiene such as scabies, trachoma and conjunctivitis. Lack of personal hygiene and washing of clothes encourages the proliferation of lice which are disease vectors. They transmit louse-borne typhus and recurrent fever. A lack of hygiene, particularly of hands and food result in what are known as the "dirty-hand diseases". They include diarrhoea and dysentery, cholera, typhoid and paratyphoid fevers, hepatitis A, poliomyelitis and various helminth diseases.

However, many other types of problems are caused by poor water quality, whether chemical or biological. Although the possible presence of toxic substances in water is something which must be borne in mind, most infectious diseases transmitted by water are linked to the pollution of water by the excreta of humans or other animals (from the sick or from healthy carriers). One last category of water-related diseases is those with an insect vector which develops in or lives near to water, for example malaria, dengue, yellow fever and onchocerciasis.

The Ocotal project

In mid-1996, MSF launched a water and sanitation project for the 80,000 inhabitants of the town of Ocotal and two neighbouring villages in Nicaragua's north-western department of Nueva Segovia. This is an area which was devastated by the twenty-year long civil war, and to which, in recent years, refugees and displaced people have returned in their thousands. When MSF arrived, uncontaminated water was available at the town water treatment plant, but it was prohibitively expensive for most people. The population was, thus, more susceptible to potential outbreaks of diseases such as cholera and other kinds of diarrhoea. In the surrounding rural area, the situation was even worse with a complete

lack of sanitation facilities and little access to drinking water. The MSF team, working alongside members of the local community, set about constructing efficient water supply systems, water treatment facilities, latrines and incinerators. MSF promotes health education initiatives in local communities, schools and the health centres. In the surrounding countryside, MSF is focusing on two villages where needs are greatest. The project is set to run until the end of 1998.

BOLIVIA



POP. IN YEAR 1996

7.4 m

GNP PER CAPITA

760 USD

0-5 MORTALITY RATE

110 per 1,000

POP. PER DOCTOR/NURSE

2,564/7,692

LACK OF ACCESS
TO DRINKING WATER

45%

COLOMBIA



POP. IN YEAR 1996

35.0 m

GNP PER CAPITA

1,400 USD

0-5 MORTALITY RATE

19 per 1,000

POP. PER DOCTOR/NURSE

1,064/2,632

LACK OF ACCESS
TO DRINKING WATER

13%

AID FOR THE AYMARAS AND THE QUECHUA

On 1 May 1997, the majority of the Bolivian electorate voted for former dictator General Hugo Banzer Suarez in the presidential elections.

MSF teams work to bolster and develop the health system of Illampu district, which is mainly inhabited by Aymaras Indians. The objective of the programme is to improve health coverage. There is, however, a special emphasis on mother/child health care. The project includes an ongoing education programme for local health workers, the rehabilitation of 21 health posts as well as a Reference Hospital and the promotion of community participation. The beneficiaries of this programme number almost 140,000.

A similar project is run in Mizque, in the department of Cochabamba where teams are trying to organise an effective local health care system and to improve health services. There are 45,000 inhabitants in Mizque district, most of whom are Quechua Indians.

An important aspect of both these projects is that MSF has set up pharmacies financed by a revolving fund for the supply of medicine and medical material.

International staff: 6 / National staff: 60



CARING FOR VICTIMS OF URBAN VIOLENCE

The political agenda in Colombia over this past year continued to be dominated by accusations that the Cali drug cartel financed the 1994 election campaign of president Ernesto Samper.

In Cali's Agua Blanca district of Cali, MSF launched a maternal and reproductive health care programme for adolescents as well as a health care programme for victims of violence.

MSF's programme supporting the hospital and health centres of Puerto Merizalde came to a close in March 1997. It is now the hospital itself which organises health visits and training for mobile teams. MSF supports Buenaventura Hospital and provides training in the emergency room and neonatology unit.

In October 1996, MSF started a project in the Northwest of Colombia, in Tierralta, Urabá-Cordobés. Owing to frequent violence between guerrillas, paramilitary groups and the national army, certain areas have become very isolated and lack

adequate medical services. MSF wants to help build up a minimum health structure by training health workers and supervising them for a fairly long period. In collaboration with these health workers, the organisation is also setting up a registration system and trying to improve the availability of drugs and medical supplies.

MSF supports the creation of a rural primary health care network in the municipalities of Silvia and Paez, in the upper Tierradentro zone. MSF has been involved in rehabilitation work and the implementation of preventative health care. Close to 50,000 people benefit from these projects. Until the end of May 1997, MSF was also been involved in a project to improve food security in Tierradentro.

International staff: 14 / National staff: 51

MSF COMBATS MALARIA

Half of the 150 million Brazilians are living below the poverty line. The central government now wants to put the burden of nearly all public expenditure on the shoulders of the regional governments. As a result, the poor now stand to lose their social benefits as well. Already abominable, the position of the native peoples will only get worse.

The recent surge in the rate of deforestation in Amazonas is reason for concern as the tropical rain forest is the lifeblood of several native peoples. The arrival of goldminers and farmers has had a devastating effect on the native populations. Many have died from diseases previously unknown to them, such as influenza and malaria. The changing environment has created a breeding ground for the malaria mosquito. The Yanomami Indians are still suffering greatly from malaria six years after the goldminers were expelled.

MSF provides health care to a number of threatened native peoples in Brazil. The team gives acute medical care, but also a great deal of training, refresher courses and supervision so as to make the Indians less dependent on non-Indian doctors.

MSF also works in Boa Vista, Roraima province. Here again, native Americans make up fifteen per cent of the population. Among other things, the team provided primary health care and information on how to treat the most common diseases. MSF also paid a great deal of attention to advocacy, drawing the world's attention to the plight of the Yanomami. The programme was later extended geographically to include an area Northeast of Boa Vista which is home to other native peoples, such as the Macuxi, Wapixana, Tuarepang, Patamana, Ingariko and Wai-Wai. Here, more than fifty Indian microscopists were trained and supervised. More than three hundred members of native Indian groups were trained as health workers, each of them operating in his own home area. Malaria-related deaths have now become very rare in MSF's area of operation, thanks to the malaria diagnosis networks.

MSF has also been running a project in the Javari valley, where another malaria epidemic among Indians led MSF to start

an aid programme. A project similar to that of Roraima was set up. The first step consisted of setting up a network for the diagnosis and treatment of malaria by training eight Brazilian microscopists. A network of local health workers are being trained in prevention and treatment of the main diseases.

MSF's urban projects

Another important part of MSF's programme in Brazil, is the project in the capital, Rio de Janeiro, where teams focus their efforts on improving health care in the shantytowns which are known as the favelas

In Vigario Geral, MSF runs a healthcare centre for children and adolescents. The favela is geographically isolated from any public system and strongly controlled by drug traffic. MSF has set up a health cooperative to which it provides psychological and social support. In Vila dos Pinheiros, MSF provides assistance to a homeless population living under bridges while waiting for state housing. These people receive health care and psychological and social support. Medical support is also given to five street children's institutions



photo Jet Belgraver

BRAZIL



POP. IN YEAR 1996
159 m

GNP PER CAPITA
2,930 USD

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

LIFE EXPECTANCY
66 yrs

0-5 MORTALITY RATE
61 per 1,000

POP. PER DOCTOR/NURSE
847/3,448

LACK OF ACCESS
TO DRINKING WATER
13%

International staff: 9

National staff: 46

CUBA



POP. IN YEAR 1996
11.0 m
GNP PER CAPITA
1,200x USD
0-5 MORTALITY RATE
10 per 1,000
POP. PER DOCTOR/NURSE
332/180
LACK OF ACCESS
TO DRINKING WATER
6%

INFORMATION ON STDS

Fidel Castro signed the common declaration drawn up after the Ibero-American summit in November 1996 which rejects the USA's Helms-Burton Act punishing companies investing in Cuba and which promotes the idea of modern pluralist democracies.

Since the spring of 1996, MSF has run an aid programme in Havana, the objective of which is the prevention of sexually transmitted diseases (STDs) and the provision of information on STDs to young people between the ages of 15 and 24. A second objective is to encourage the use of condoms. The team first started a training programme for nurses treating venereal diseases in the five districts of Havana where syphilis, gonorrhoea and HIV occur most frequently. Three different information brochures, 180, were distributed among young people. Health instructors, students and radio and television journalists received training on HIV/AIDS issues as well as information on other venereal diseases. MSF distributes condoms among the groups most at risk and sells others for a nominal sum. In

1997, an AIDS information and training centre was set up. The information programme for prostitutes and other high-risk groups continues.

MSF also runs a water and sanitation programme which focuses on improving access to clean water in the provincial capitals and contributing to a decrease in the regular diarrhoea outbreaks. In practice this means the distribution of sprays, evaluation of de-lousing methods, monitoring of the projects, support to the manufacture of national products such as ceramic filters and rain water tanks as well as support to water disinfection in the zones most affected by hurricane Lilly.

International staff: 4 / National staff: 22

ECUADOR



POP. IN YEAR 1996
11.4 m
GNP PER CAPITA
1,200 USD
0-5 MORTALITY RATE
57 per 1,000
POP. PER DOCTOR/NURSE
671/1,818
LACK OF ACCESS
TO DRINKING WATER
29%

MORE COMMUNITY PARTICIPATION

On 7 July, 1996, the populist leader Abdalá Bucaram Ortiz beat Jaime Nebot Saadi in the presidential elections. In February 1997, he was impeached for mental incapacity.

MSF first went to Ecuador in January 1996 to start a project in Cotacachi and intervened in Cotopaxi province in April 1996 following an earthquake whose epicentre was in the city of Pujili. MSF now runs a project focused on family and community health for the indigenous populations of Cotacachi in Imbabura province. The project also aims to promote community participation in order to establish a self-sustainable project, in various ways such as the creation of a revolving fund system for essential drugs. In co-ordination with the Ecuadorian Ministry of Public Health, MSF tries to unite traditional medicine with modern know-how to improve coverage for the Quechua population of Cotacachi. There is also a special focus on mother/child health care and training for

local staff. As many as 15,000 benefit from this project.

International staff: 2 / National staff: 9

COSTA RICA

Since 1993, there is an MSF office in San José. This office facilitates the operations of all MSF sections in Central America and the Caribbean. The MSF officer in San José provides logistic and technical support and maintains official contacts with the various governments in the area. In addition, he is responsible for the exploration and coordination of new emergency situations (natural disasters, epidemics, conflicts) in Central America and the Caribbean.

ASSISTANCE FOR RETURNEES

Thirty-six years after the civil war began, on 29th December 1996, a peace agreement was signed by Alvaro Arzu Irigoyen's government and the guerrillas of the *Unidad Revolucionaria Nacional Guatemalteca (URNG)* in Guatemala city.

Since 1986, MSF had worked in the slums of Guatemala city. In 1994, it was decided that this work should be phased out. MSF helped create a local NGO APRI which took over the project in 1996. MSF is now very focused on the problems faced by children in the capital and was involved in the creation of a day care clinic for young people in the 14-20 age bracket. MSF has taken responsibility for the medical and psycho-social programmes. MSF gives medical, psychiatric and legal support to 500 under-sixteens in six detention centres. Teams also give social and medical support to minors in the Lomas and Santa Faz slums inhabited by 60,000 people. MSF is in the process of setting up a crèche for 120 under fives. Unlike traditional crèches the places would rotate every three months. MSF also runs a medical programme in "El Basurero" (the rubbish dump).

of Populations in the Resistance (CPR) in the very inaccessible North Sierra area. However, MSF still supports their health care authorities for reference cases.

MSF runs a programme in the department of Huehuetenango in the isolated villages of the districts of Todos Santos and Barillas district. Here, it was seen that health structures were inadequate to cope with local populations and the large numbers of returnees from Mexico. Particular attention is paid to mother child health care. A primary health care programme focusing on community participation and community organisation through voluntary health care agents trained and followed up by MSF. The programme for the Promoteurs Ruraux de Todos Santos finished in December 1996. Supervision is foreseen for the two years to come. The training and supervision programmes for traditional midwives and sanitation will continue until 1998.

The Barillas programmes have been extended for three years - until September 1999 so as to better complete sanitation coverage in the northern region. Following the peace accords, many more refugees are expected to arrive.

MSF runs a primary health care project in the municipalities of Livingstone and San Luis whose general objective is to improve the health of the population. Training courses are also provided for local staff. There are over 30,000 beneficiaries, many belonging to the Quekchi ethnic group living in the municipalities of Izabal and Petén, where MSF also supports the local authorities efforts to upgrade health care.

In 1996, the construction of health posts in Mario Méndez and La Reinito was finished. MSF continued to run training programmes for health care staff, particularly traditional midwives. Health care and sanitation assistance was provided for returnees from Mexico in El Tumbo, Entre Rios and Santa Amelia. The project ended at the end of January 1997, 23,000 returnees and locals having benefited.

The teams stopped giving direct medical assistance to the 15,000 displaced native Americans who were part of an underground association: the Community

GUATEMALA



POP. IN YEAR 1996
10.6 m

GNP PER CAPITA
1,100 USD

ADULT LITERACY RATE,
MALE/FEMALE
61%/47%

LIFE EXPECTANCY
65 yrs

0-5 MORTALITY RATE
70 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
38%

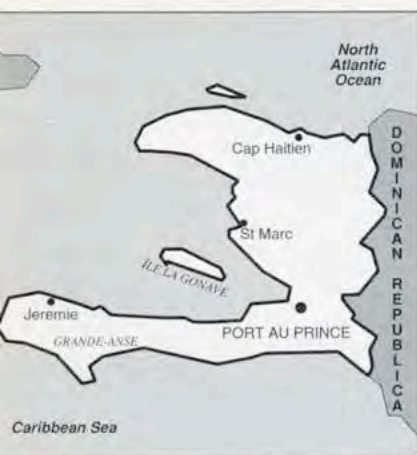
International staff: 26

National staff: 70

photo Michel Zuecker • Guatemala



HAITI



POP. IN YEAR 1996
7.1 m
GNP PER CAPITA
370x USD
0-5 MORTALITY RATE
127 per 1,000
POP. PER DOCTOR/NURSE
7,143/9,091
LACK OF ACCESS
TO DRINKING WATER
72%

AID IN THE SHANTY TOWNS

President René Prével's government ministries have been called inept and there has been controversy over the police force which has been involved in 50 contested killings.

In Saint-Marc, in the Artibonite department some 100 kilometers from Port-au-Prince, MSF runs a project based in the Saint Nicolas reference hospital. The health sector is in poor shape as it suffers from the extremely centralised management of resources. MSF provides training, supervises medical assistance and supplies essential medicines. Teams have also been involved in the rehabilitation of health structures. Volunteers support and supervise community dispensaries and focus on mother/child health care. The drugbank in Saint-Marc is now in proper working order and is supervised by MSF. MSF and the directors at provincial, district and hospital level have jointly elaborated a new project. This project aims at installing an integrated health system including the three municipalities MSF currently works in, in three to five years time.

MSF also provides surgical and administrative support for Jeremie Hospital in province of Grande Anse. Before the arrival of MSF, there was no surgical wing for a population of 600,000. The sick had to travel for nine hours to receive treatment. The journey was dangerous and expensive.

A programme in the slums of Port-au-Prince is being launched. The slums are now overflowing with people who arrive in the 1970s as a result of a massive rural exodus - the most famous of these shanty towns is Cité Soleil which includes 250,000 people. The team is providing medical assistance and water and sanitation. MSF's work in Justinien Hospital in Cap-Haïtien came to an end in November 1996.

International staff: 20 / National staff: 95

HONDURAS



POP. IN YEAR 1996
5.6 m
GNP PER CAPITA
600 USD
0-5 MORTALITY RATE
54 per 1,000
POP. PER DOCTOR/NURSE
1,266/4,545
LACK OF ACCESS
TO DRINKING WATER
35%

TACKLING THE AIDS EPIDEMIC

Honduras has registered 6,000 AIDS cases since 1985 which is in fact 58% of all the cases registered in Central America.

In December 1996, MSF's teams intervened in San Pedro Sula following Hurricane Marc and the catastrophic flooding. MSF worked in three dispensaries: Monterrey, Urraco and Riviera Hernandez providing services for 50,000 people. In February 1997, MSF launched a medical distribution programme for 10,000 people in Brus Lagunas, Cocobila, Plaplaya and Palacios.

In the "Nahuaterique" Bolson, which is effectively an enclave territory, a medical project was launched in March 1997. The decision to recreate a new border has forced 5,000 Salvadorians to change nationality. There are tensions in the area and the population is very dispersed which complicates access to health care. MSF works in three health centres in the main enclave: Nahuaterique, El Carrizal and El Zancudo which cover a target group of

4,000 people. Close to the main enclave, MSF also provided aid to 13,000 people in five health centres Santa Elena, Yarula, Llano de Maco, Sabanetas and Cabanas.

Since May 1997, MSF has been providing urban health care in El Carrizal, in Honduras's capital Tegucigalpa. The programme's aim is to improve access to health care over a period of four years. The project includes the construction and equipment of a health centre with in-patients capacity, sanitation facilities, technical support in management and assistance, creation of an epidemiological information network and a pharmacy managed by the community. An ongoing sanitary education programme, essentially on AIDS, is being implemented as well.

International staff: 13

National staff: 41

AID FOR RETURNEES AND DISPLACED

Arnoldo Aleman Lacayo was elected president in October 1996. His liberal government is trying to negotiate with the Sandanistas on how to compensate those who lost property during the civil war.

MSF ran two technical assistance projects and one emergency project in 1996. The support project for the health services of the shanty

towns of Managua continues as does the rehabilitation project for the health care structures and staff training in the Cua Bocay region, Jinotega Department, in the north of the country. A food aid,

healthcare and medical aid project in the Laguna de Perlas area on the south Atlantic coast was launched after Hurricane Caesar, which hit the country at the end of July 1996.

Since September 1996, MSF supports health services in Nueva Segovia, in the Northwest of the country. The team is active in three municipalities: Ocotal, Quilali, Murra. the project includes the training of health care agents and midwives, water and sanitation, the development of an efficient primary health care system, epidemiological surveillance and the setting up of community pharmacies. The project benefits 15-20,000 returnees from Honduras, 20,000 displaced persons and 25,000 locals.

International staff: 13 / National staff: 68



photo R. Job • Nicaragua

PRIMARY HEALTH CARE FOR THE NGOBE

With only two and a half years to go before the Panama canal is returned to the state, The government is already foreseeing economic losses as a result of the closure of the US military bases.

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 group. This population lives 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 health posts to the hospital. Supervision of local medical personnel and distribution of essential medicines and equipment are important aspects of the programme. MSF places a lot of emphasis on the importance of training health care workers. MSF also rehabilitated, and in some cases, built, health facilities. However, this activity is now over. The team also built a foot-bridge on the Hacha River in the district of San Lorenzo.

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



photo Q. Roser • Panama

NICARAGUA



POP. IN YEAR 1996
4.5 m

GNP PER CAPITA
340 USD

0-5 MORTALITY RATE
68 per 1,000

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

LACK OF ACCESS
TO DRINKING WATER
42%

PANAMA



POP. IN YEAR 1996
2.6 m

GNP PER CAPITA
2,600 USD

0-5 MORTALITY RATE
20 per 1,000

POP. PER DOCTOR/NURSE
562/1,064

LACK OF ACCESS
TO DRINKING WATER
17%



POP. IN YEAR 1996

23.5 m

GNP PER CAPITA

1,500 USD

ADULT LITERACY RATE,
MALE/FEMALE

93%/81%

LIFE EXPECTANCY

66 yrs

0-5 MORTALITY RATE

58 per 1,000

POP. PER DOCTOR/NURSE

1,031/n.a.

LACK OF ACCESS
TO DRINKING WATER

40%

International staff: 25

National staff: 107

MSF TARGETS YOUNG PEOPLE

The hostage crisis was resolved by a military commando attack in April 1997. The operation resulted in 17 casualties including 14 members of the rebel group itself, the Movimiento Revolucionario Tupac Amaru (MRTA), two soldiers and one of the remaining 72 hostages.

The health programme in 38 schools in the capital's shanty towns continued as did the AIDS project also in Lima, which includes support for the reference hospital and laboratory. MSF provided full health coverage for those between five and 19 years of age in the Villa el Salvador district. Priorities include the care of pregnant teenagers, young tuberculosis patients and child victims of violence. MSF runs public health information programmes in schools and within parent associations. TB diagnosis is carried out in conjunction with a local organisation.

Bringing aid to native American populations

MSF also runs a programme to improve access to health care in the Masisa and Iparia regions of Amazonia with an emphasis on training and water and sanitation assistance. In Pucallpa, MSF intervened following a malaria outbreak.

In Requena and Ucayali provinces, in the Loreto region, MSF continued to run two primary health care projects. The region presents huge logistical difficulties in that it is so extensive and is crossed by six rivers. MSF teams travel to and from villages in the "Igara Uka" house-boat. In Requena, MSF focuses on mother and child health care, training, sanitation support and the creation of a revolving fund system for essential drugs. The Ucayali project supports the local primary health care system, particularly as regards mother-and-child health care. Both projects promote community participation.

The relief programme for the Ashaninka ethnic group and the displaced of Ayacucho continued. MSF operated in six of the eleven districts benefitting 100,000 people. Local health workers were trained and supervised and medicine stocks and medical supplies in the clinics were replenished. In two of the regions, training was provided for the creation and maintenance of basic drinking-

water and sanitary facilities. MSF continued to target displaced persons in the Apurimac basin. In the health posts, MSF provided health care assistance and training.

The 50,000-strong population of Satipo province, including 15,000 Ashaninka Indians, is living in conditions of squalor and privation. MSF provides primary health care, with an emphasis on mother-and-child health and training, in three provincial districts as well as two Ashaninka communities. In 1996, health workers and traditional midwives were trained in obstetrics. The team regularly visited 68 health posts, distributing medicines and medical supplies, monitoring the general health situation and treating the sick. As a result of renewed guerrilla activity, twelve communities were temporarily cut off from aid.

Medical aid in prisons

Until the end of 1996, MSF provided specialist help in two prisons, Chorrillos Maxima Seguridad in Lima and Ayacucho prison. The medical staff was given additional training and essential medicines and medical materials in short supply were supplemented. The prison project was set up in consultation with the International Red Cross (ICRC). The ICRC gives individual support to prisoners and handles transport, visits by relatives and the provision of extra food. A new project started in January 1997 which provides for the training of 60 auxiliary nurses in 15 prisons. This project will directly benefit 40% of the country's total prison population. Their basic medical material will also be provided by MSF.

Following the earthquake in Nasca, located in the Peru's Andean region; at the end of 1996, MSF supported health care structures, carried out epidemiological follow up and distributed blankets, jerrycans and household implements for about 10,000 people. In total, 20,000 earthquake victims were treated with special MSF kits.



photo Russell Sacks • Azerbaijan



ARMENIA



POP. IN YEAR 1996
3.7 m
GNP PER CAPITA
660 USD
ADULT LITERACY RATE,
MALE/FEMALE
99%/98x%
0-5 MORTALITY RATE
23 per 1,000
POP. PER DOCTOR/NURSE
250/935

AZERBAIJAN



POP. IN YEAR 1996
7.5 m
GNP PER CAPITA
730 USD
ADULT LITERACY RATE,
MALE/FEMALE
99%/96x%
0-5 MORTALITY RATE
38 per 1,000
POP. PER DOCTOR/NURSE
250/n.a.

AID FOR THE HANDICAPPED

Levon Ter-Petrosian was re-elected president on 22 September 1996. The legitimacy of the presidential elections were questioned by international observers, and were even met by violent street riots in Yerevan.

MSF is the only humanitarian agency still working in Armenia since the earthquake in 1988. The health system is highly centralised, prohibitively expensive and lacking in basic medical materials.

In Yerevan, MSF cared for patients suffering from syphilis and gonorrhoea. This assistance included the supply of medicine for these infections, the provision of tests and laboratory material as well as technical assistance for the elaboration of a new national health policy for the treatment of sexually transmitted diseases (STDs).

MSF's work in Giumri in an institution for physically and mentally handicapped children came to an end at the end of 1996 as did its work in the Vardenis

psychiatric hospital. Teams then focused on the STD project in the Shirak region (360,000 inhabitants). MSF also aims to upgrade the health services in Noyemberian. This is MSF's way of monitoring the impact of health reforms and developing intervention methods in the Commonwealth of Independent States (CIS).

NAGORNO-KARABAKH

Armenia declared war on Azerbaijan in 1992 over the enclave of Nagorno-Karabakh which has an ethnic Armenian population. The war resulted in numerous casualties and great population upheaval. A cease-fire was finally declared on December 1994 and it has been generally respected by all parties. However, there has been no progress in negotiations between Armenia, Azerbaijan and Nagorno-Karabakh. MSF was working inside the enclave until November 1996 which was when the team finished reorganising the distribution and supply of essential medical supplies from the central pharmacy in Stepanakert.

HELP FOR IDP's

The arrival of the 700,000 Azeris have caused a total breakdown of public services in Azerbaijan.

MSF provided medical assistance to refugees, the displaced and local populations alike. In the districts of Chantlar, Sabirabad, Saatli, Imishli, Beylagan, Agjabedi and Fizuli and the cities of Baku and Barda, the number of health structures receiving support dropped dramatically. There has been integrated support given to governmental health facilities in six displaced camps. This entailed the distribution of medical supplies; basic repairs to health structures, training for medical workers, a health education programme in the camps and support given to the laboratories. In addition, MSF opened a dispensary next to the railway station where the displaced live.

MSF also worked in Sumgayt, a depressed industrial area inhabited by a local

population of 200,000 and a displaced population of 50,000. In 1996, teams launched a medical and sanitation programme in favour of the displaced and marginalised. A book distribution service was also carried out for midwives. The team also maintained emergency medical supplies.

MSF continued to provide health care for the under-fives and women of childbearing age. This programme is a continuation of existing MSF activities in Khanlar and Baku. Eleven clinics were provided with a basic store of medical supplies and visited weekly by an MSF team. The organisation is concerned with issues such as primary health care for children, birth control and obstetrics. Malnourished children received supplementary food rations.

BELGIANS DEMAND CHANGE

In August 1996, it was discovered that several missing children had fallen victim to a paedophile known to the Belgian police. This was followed by a string of corruption and fraud scandals.

MSF's programme in Belgium has now entered its tenth year. It was launched because in Belgium, like in so many other European countries, significant numbers of people suffer from problems of exclusion, unemployment, homelessness and loss of social rights. There is a growing number of people without access to health care.

In Brussels, MSF continued to run the Elisa centre, which provided free and anonymous HIV testing for the general public. AIDS information and counselling were also provided.

Medical care and social support was also brought to several districts in the capital by means of a bus staffed by MSF volunteers. This project was run in partnership with Pharmaciens Sans Frontières. MSF

consultations were also provided at centres in Antwerp, Verviers and Liege. Immigrants and asylum seekers made up the main body of patients. MSF also lobbied 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 trained general practitioners to care for drug addicts and to carry out HIV testing including pre and post-counselling.

staff : 6



photo Roger Job • Belgium

MEDICAL CARE FOR ADDICTS

On 1 June 1997, early elections were won by the Socialists who started to govern in coalition with the communists and Greens.

In Paris, MSF runs a clinic offering free medical care and access to sterile material to drug addicts. A special kit designed by MSF (including condoms, sterile needles and syringes) is available and handed out free of charge. Mobile teams are also in place. Their aim is to establish contacts with this population, including drug addicts and prostitutes, who refuse to attend any public health structures. Of those attending the clinic, 70% are homeless or in temporary housing, 80% of the women are prostitutes, 50% have been in prison and 16% are HIV positive. The health care programme for children, teenagers and young adults continued. The programme includes free consultations, vaccinations and house calls. It also aims to reintegrate families into the social security system.

MSF continues to run clinics in Marseilles and Lille where the law passed in 1992 which guarantees access to health care for everyone has not been enforced. MSF lobbied the health authorities on behalf of those who are falling through the net. MSF is trying to find a way for the excluded to benefit from third party insurance for their health care assistance. MSF provides training for doctors and social workers and in nursing schools and hospitals. In February 1997, MSF opened a new programme offering social and legal assistance to foreigners and refugees. The objective is to inform people about their rights and denounce discriminatory practices. MSF is now working on the issue of the right to asylum in Europe.

Staff : 20

BELGIUM



POP. IN YEAR 1996
10 m
GNP PER CAPITA
21,600 USD
ADULT LITERACY RATE,
MALE/FEMALE
99%/99%
0-5 MORTALITY RATE
7 per 1,000
POP. PER DOCTOR/NURSE
298/131

FRANCE



POP. IN YEAR 1996
58 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



International staff: 40

National staff: 524

CROATIA

MSF's refugee assistance programme in the Kupljensko camp was finally closed down on 20 August 1996 when the last of the refugees left. In Split and Omis, MSF supported the Melina Tarras family therapy centre. These centres were set up by Croat counsellors who worked with MSF. After a transitional period, the region of Eastern Slavonia is expected to be incorporated into the Republic of Croatia in 1997. Here, MSF ran a medical distribution programme and a team member visited five health centres and 22 clinics in the Srem region, as well as a health centre and 12 clinics in Baranja. In addition, the team started a mobile clinic for the elderly and vulnerable.

On 14th September 1996, the first post-war elections were held in Bosnia and Herzegovina. The results were, not surprisingly, in favour of the established nationalist parties who gained majorities in their respective areas. There has been no noticeable progress regarding the reunification and constitution of a united and multi-ethnic Bosnia. The country is still divided into the Republika Srpska and the Croat-Muslim Federation. 30% of Bosnians are in exile.

MSF teams are active throughout the Croat-Muslim Federation and the Republika Srpska. Activities are diverse and other than direct medical assistance, they include a great deal of rehabilitation of health structures; physiotherapy and occupational therapy, supplementary food distribution for the the handicapped and the elderly, water and sanitation, training courses and refresher courses for Bosnian medical staff and collaboration with medical institutes. The distribution programme to health structures throughout the country was phased out at during 1997.

In Bosnia, MSF has been working in the field of mental health since 1994. In Sarajevo, MSF was of the first foreign aid organisations to engage in such activities. In 1996, the sixth counselling centre was opened in the former Bosnian-Serb part of Sarajevo (Vogosca). Largely deserted by the Bosnian-Serbs, Vogosca became the new settlement area for the displaced of Zepa and Srebrenica. MSF's objective is to give mental health support to all people who suffer the psychological consequences of the war. The Sarajevo programme is managed by local staff. MSF provides support and overall supervision. In 1996, the local counsellors who were trained by MSF gave treatment and support to 3,000 people. The data gathered in this programme are analysed by the University of Utrecht. The first analysis reveals a significant improvement in the mental health of the patients.

The Sarajevo mental health programme has been extended to Central Bosnia. A total of 30 counsellors from Zenica, Travnik and Vitez were trained over a period of three months to identify and give support to people suffering from Post Traumatic Stress

Syndrome and other war related mental health problems. After the training course, they were used to staff four counselling centres and four mobile teams. In both of these programmes, people from all ethnic backgrounds are employed. A similar programme was launched in Gorazde in September 1996. Once again, there is an emphasis on the training of local staff. The team is also in the throes of setting up an efficient reference system for severely disturbed patients.

MSF has also rehabilitated Sokolac psychiatric hospital in order to improve the patients' quality of life. MSF provided occupational therapy and has tried to help the hospital once again become self-sufficient as regards food stocks.



photo Alain Kazinierakis • Bosnia

AID FOR THE POPULATION OF KOSOVO

The outbreak of demonstrations following the cancellation of the election results could pose a serious problem for the regime in place in Serbia. It may be the biggest mistake of Slobodan Milosevic's political career.

MSF is concerned by the poor health care situation in Kosovo, an area inhabited mainly by ethnic Albanians. Here, MSF runs three programmes which focus on improving access to quality health care in the health structures, the supply of medicines and medical equipment, the provision of training courses and epidemiological surveillance.

It has been estimated that in Kosovo only 40% of the population has access to clean water, as springs and wells are often polluted. The water and sanitation situation is so catastrophic that in July 1996 MSF launched a water and

sanitation programme. MSF provides support to the populations of several villages trying to overhaul their water distribution systems.

In September and November 1996, MSF took part in a polio vaccination campaign. As many as 70,000 children of the 230,000 vaccinated were not even registered as the Albanians refuse to deal with official Serb structures

FOCUS ON THE VULNERABLE

The territorial integrity of Georgia is tenuous as the populations of Abkhazia and South Ossetia are still calling for independence.

For the past few years, much of MSF's work in Georgia hinged on drug distribution. However, MSF now provides a more long-term approach. The last of the distributions took place on 1 April 1997. In September 1996, MSF launched a primary health care project in the districts of Tchalendjika in Samegrelo and Telavi in Kakhetia. Teams monitored access to health care through a network of health centres, polyclinics and reference hospitals.

Health-care reforms in Georgia have given rise to new serious problems for vulnerable groups, as medicines and medical care are no longer free. From May 1996, MSF set up a dispensary in Kobuleti, where medicines, consultations and medical check-ups were provided for free for a period of one year.

MSF also carried out scurvy and ringworm information campaigns at schools. In July

1996, MSF handed over its cold chain programme to an agency. MSF supported four blood transfusion centres with blood tests and transfusion centres. In December 1996, these projects were handed over to the national Aids centre.

MSF works in health centres throughout Abkhazia. A dispensary was opened in the capital, Sukhumi, with the objective to provide free health care and social assistance. The drug distribution programme continues in Abkhazia. MSF's anti-tuberculosis programme continued, with consultations in the treatment centre and in Sukhumi prison. MSF also provides vaccinations in collaboration with UNICEF and has worked on water and sanitation programmes in Sukhumi.

International staff: 35

National staff: 123

FYR



International staff: 32

National staff: 300

GEORGIA



POP. IN YEAR 1996
5.5 m

GNP PER CAPITA
580 USD

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

0-5 MORTALITY RATE
21 per 1,000

POP. PER DOCTOR/NURSE
70/177



POP. IN YEAR 1996
147 m

GNP PER CAPITA
2,300 USD

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

LIFE EXPECTANCY
68 yrs

0-5 MORTALITY RATE
26 per 1,000

POP. PER DOCTOR/NURSE
254/177

HELPING THE HOMELESS

The war in Chechnya ended in August 1996. The Russians, defeated, have withdrawn all their troops. On Monday 27th January, the Chechens called an election. They chose as their leader a committed Chechen nationalist, but one who appears committed to communicating with the Russians - Aslan Maskhadov. It will take years for Chechnya to recover from the brutality of the military intervention.



Photo R. Job - Russian Federation

In Moscow and St. Petersburg, MSF runs socio-medical assistance programmes for the homeless. Most of Moscow's homeless live in the railway stations. They are particularly vulnerable to diseases such as tuberculosis and dysentery. Respiratory diseases are also widespread. Medical consultations are carried out by mobile clinics. Counselling is provided at the MSF dispensary. MSF also distributes information and monitors legislation.

The incidence of HIV/Aids in Russia is rising dramatically, in particular among IV drug users. As drug use often takes place within the confines of home and in small private circles, it is very difficult to reach this target group. So far, the Russian approach towards HIV/Aids has mainly focused on mass mandatory testing. This approach is expensive and does not help HIV/Aids prevention.

In 1996, MSF started preparations for a large scale Aids prevention programme.

This was done in close cooperation with the health authorities and a Russian NGO and with the support of several international experts. The preventive programme is intended to serve as a model for others likely to be adopted for long-term use by the local authorities and Russian NGOs. There are three main aspects to MSF's programme: a mass media campaign to promote safe sex among young people, outreach programmes for IV drug users (informing them of the hazards of sharing needles and the dangers of injecting certain home-made drugs) and the distribution of information among health professionals.

MSF runs an anti-tuberculosis programme in the Mariinsk prison hospital in central Siberia. There, MSF has taken responsibility for 300 patients. The team is faced with many problems not least of which is that the patients are suffering from a strain of TB that is resistant to most drugs. MSF is studying a possible solution to this problem with the World Health Organisation (WHO) and the Tropical Institute of Medicine in Antwerp.

BULGARIA

In February 1997, huge demonstrations led to the downfall of the Socialist government which was made up of former communists. Following a transition period, the new government, controlled by the Democratic Forces (UFD) is now in place. Owing to the huge economic crisis, health services are lacking in medical supplies. MSF opened a distribution programme for health services in the Bulgarian regions of Targoviste and Kjustendil in early May. The programme was to run for a six-month trial.

MSF in Chechnya

In August 1996, Chechen forces retook Grozny and retook control of the autonomous territory. A cease-fire was eventually established. Russian troops withdrew in November. MSF relaunched its activities in September by supporting the central maternity hospital in Grozny, hospital no. 3, and five polyclinics, and by continuing with the water distribution programme. Barely a month afterwards, three team members were violently abducted. The team was evacuated.

The Chechen refugees are being provided with medical and logistical assistance in Dagestan, Xasavjurt and the region. The aim is to improve their living conditions. (MSF checks that all the refugees have access to clean water, gas and electricity. The teams have also rehabilitated the reception centres. The water distribution system was overhauled in the town of Xasavjurt..

MSF returned to Chatoï in September 1996 where it worked on relaunching medical activities in the hospital and the district health centres. Other activities included supplying medicines and medical equipment to the hospital and health centres, management of medical supply, the rehabilitation of the hospital building,

upgrading the water distribution system and the rehabilitation of the dispensary at Itum Kale.

Activities in Ingushi and North Ossetia

In Ingushi, MSF continues its programme in favour of the conflicts in Chechnya and Prigorodny. Activities include the supply of medicines and medical equipment to five pharmacies servicing refugees, assistance in the hospitals, health and logistical support in several refugee camps and displaced camps. MSF also launched a programme to eradicate rickets in the refugee and local populations.

In North Ossetia, MSF's programme also benefits displaced and refugee populations, who are mainly made up of Ingush returnees and South Ossetian refugees from Georgia (The Russian/Georgian border cuts the Ossetian nation in half). MSF supports the reference hospital at Prigorodny. Teams also provide medical supplies to health services, ensure access to health care, provide sanitation assistance, where necessary, and monitor living conditions. A tuberculosis programme was launched in June 1997.

International staff: 50

National staff: 275

RUSSIAN FEDERATION



ALBANIA

Albania is perhaps the poorest of the former communist bloc countries in eastern Europe. MSF has run various programmes within the country in recent years. In mid-September 1996, Albania was hit by a polio epidemic to which MSF responded by helping the country's Ministry of Health vaccinate three million people over the period of a month. When the financial pyramid schemes collapsed at the end of 1996 and the country disintegrated into chaos, MSF returned to gather information and monitor the situation. It soon became clear that emergency assistance was no longer necessary and the teams left.



photo MSF • Chechnya

ROMANIA



POP. IN YEAR 1996
22.7 m
GNP PER CAPITA
1,100 USD
0-5 MORTALITY RATE
29 per 1,000
POP. PER DOCTOR/NURSE
552/535

PROTECTING CHILDREN

MSF is concerned by the lack of legal protection for Romanian children. The number of institutionalised under-three-year-olds now stands at 11,000 and the overall number of minors at 60,000.

photo David Verberck • Romania



MSF is very concerned by the plight of children in Romania. In 1994, MSF decided to help create a local organisation which would protect children's rights. MSF provided technical and financial support to this organisation which is called Noi de Assemenea (or "We too"). MSF donated logistical material, a city apartment and has agreed to continue support for a two-year period. This was done in collaboration with SONGE (Soutien aux ONG de l'Est et au Sud), an MSF satellite organisation.

Other activities include a truancy prevention programme, running an information and health education centre, a physiotherapy programme in orphanages in Roman and Pietra Neamt, and in Pietra Neamt Hospital. The organisation also focuses on the integration of institutionalised children into the national school system

MSF runs a health and social assistance programme for the gypsy community of Transylvania. The aim is to improve living conditions by fostering self-help, creating, sustaining and encouraging involvement in community development. As many as 400,000 people in this community are unemployed. There are three main aspects to the programme: social assistance and education; health care and family planning; and sanitation and hygiene. MSF also lobbies local as well as national authorities on behalf of this community and has provided support for the creation of an Association which will represent the whole community.

International staff: 8

National staff: 30

ITALY

The project in Italy began in October 1996. Intervention is carried out at camp for gypsies, which houses around 1,300 people, "casilino 700", which is located in Rome. This is the city's largest gypsy camp with almost no facilities. Consequently, the MSF team provides the necessary water and sanitation assistance. The aid workers also carry out medical consultations, vaccinations and training programmes for the health care workers.

MSF TARGETS THE EXCLUDED

José-Maria Aznar's government has continued its privatisation of large state enterprises. Employer associations and trade unions finally agreed on a social pact. However, unemployment figures remain the highest in the European Union.

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 led to MSF intervening medically in Barcelona in 1994. The project focuses on vulnerable groups, such as illegal immigrants, drug addicts, and alcoholics. Other important beneficiaries are gypsy and Moroccan communities who live on the margins of 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.

By using a mobile clinic - a converted bus - the team moves around the city making regular stops at places that are easy to 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 medical care provided by MSF in Barcelona is free of charge, and the patients can remain anonymous.

staff: 5

The main objective of the project 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.

SPAIN



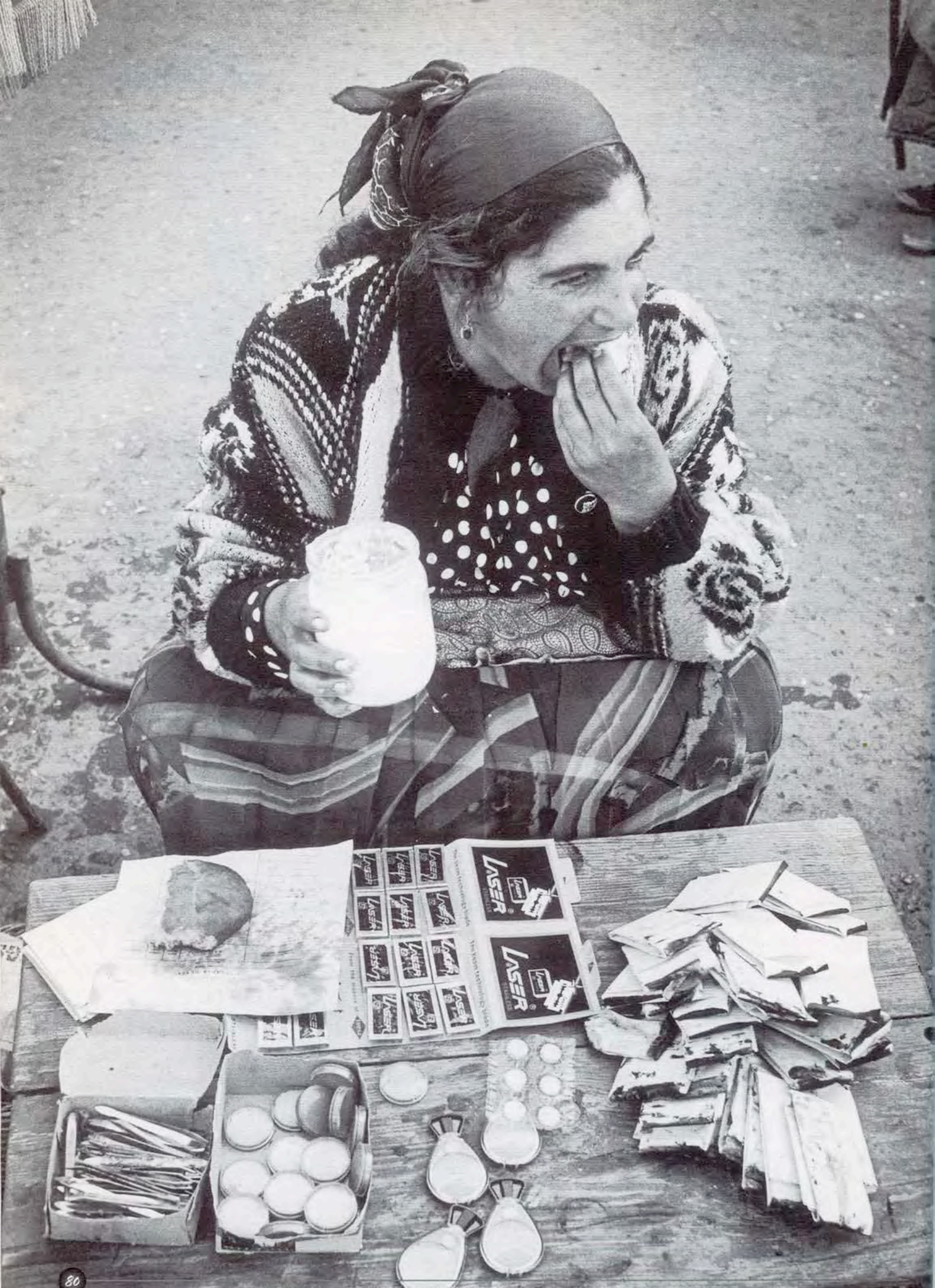
POP. IN YEAR 1996
39.2 m
GNP PER CAPITA
13,600 USD
0-5 MORTALITY RATE
8 per 1,000
POP. PER DOCTOR/NURSE
262/246

LUXEMBOURG

In January 1997, a help network was launched, by the magistrates of the Youth Tribunal, for minors suffering from drug addiction. The network is run by Jugend an Drogenhëllef, Jongenheem and MSF. This project also targets young people with behavioural problems, where perhaps drug abuse is recreational rather than a full-blown addiction. Assistance is provided by a mobile clinic. Psychological counselling is provided for individuals and family groups.

photo Rachider Belkhadem • Spain





NORTH AFRICA *and* MIDDLE EAST

MIDDLE EAST

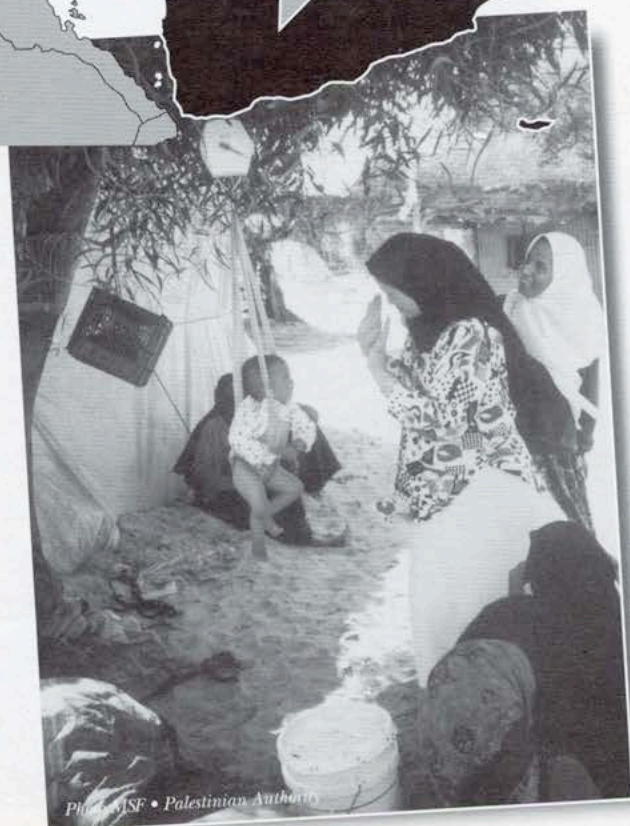


Photo: MSF • Palestinian Authority



IRAN



POP. IN YEAR 1996
67.2 m

GNP PER CAPITA
2200x USD

ADULT LITERACY RATE,
MALE/FEMALE
75%/56%

LIFE EXPECTANCY
67 yrs

0-5 MORTALITY RATE
51 per 1,000

POP. PER DOCTOR/NURSE
3,140/1,150

LACK OF ACCESS TO DRINKING WATER
16%

MSF STEPS UP REFUGEE ASSISTANCE

On 25th May 1997, a moderate Muslim cleric, Mohammed Khatemi won a landslide victory over the candidate of the arch-Conservative religious establishment. Iran is home to two million refugees most of whom are Afghan or Iraqi Kurds or Chi'ites. MSF is the only international aid agency working in the country.

at the beginning of 1996, MSF set up a refugee programme in south-west Iran. MSF provides medical and sanitation assistance for Iraqi refugees in the camps at Shahid Behesti and Ibrahim Abad. In November 1996, MSF teams started to provide assistance to Afghan refugees living close to Mashhad. MSF supports a health centre in the northern suburb of Gohlshar and tries to improve access to health care for the 5,000 refugees living in the village of Ghorgi. MSF monitors the nutrition of the children.

In September 1996, following conflict among factions in Iraqi Kurdistan, 70,000 new refugees crossed the border into Iran and were settled in camps in three provinces in the north-west (Kermanshah, Kurdistan and west Azerbaijan). MSF provided medical and sanitation assistance until January 1997.

In February 1997 MSF provided logistical support in the wake of an earthquake to the population of Bojnurd near the Turkmen border.

International staff: 33 / National staff: 230

ALGERIA

Insecurity and violence were daily realities in Algeria where the conflict between the government and Islamic fundamentalist groups continued. MSF collaborated with an Algerian medical association which targeted women in Es Senia, a poor district of Oran. In 1996 and 1997, MSF sent supplies of medical equipment and drugs to Oran, the area around Algiers and several other towns.



DECENTRALISING THE HEALTH CARE SYSTEM

The North/South conflict is presently at a standstill, but there is still a great deal of internal instability and tension with neighbouring countries. The elections of April 1997 were won by the incumbents.

In the mountainous area of Dhi Sufal, in the Ibb governorship, MSF continued its programme aimed at improving the quality of health care at district level for a population of 135,000 inhabitants. The programme hinged on four activities: rehabilitation, drugs supply, health information and improving the quality of health care. The team was working towards the decentralisation of the health care system and introduced an adapted cost recovery policy. MSF is currently phasing out its activities in this area but will continue to support the health

care system. Similar programmes are underway in El Hazm district and in Aden.

MSF teams also intervened in Shabwa following a flood emergency in summer 1996. MSF aid workers overhauled the water distribution system in five hospitals and distributed medicines and medical equipment in the face of a diarrhoea epidemic.

International staff: 12

National staff: 10

YEMEN



POP. IN YEAR 1996
14.5 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



photo Roger Job • Yemen

EGYPT

A day care centre for street children opened in Cairo in March 1997. MSF is responsible for the health of the children attending the centre and trains outreach aid workers. The team also distributes health information. The organisation is presently negotiating the launch of an integrated medical assistance project targeted at the deprived urban population of Bassatin. The Cairo office is also used to facilitate emergency preparedness in the Middle East. From here, the team gathers and analyses relevant humanitarian information on countries in the region and carries out exploratory missions.



MOTHER-AND-CHILD HEALTH CARE

When Prime Minister Benjamin Netanyahu approved the construction of an estimated 2,600 housing units in the Har Homa neighbourhood of south-eastern Jerusalem, the Palestinian Authority warned the Israeli government that this decision could have grave consequences for the peace process. The decision was seen as a violation of peace accords and an attempt to populate Arab land with Jews. Building started on 19 March.

MSF runs a mental health programme in Hebron which provides psychological support for people who have lived through the worst of the intifada. The programme is aimed at strengthening the mother-and-child bond in the families receiving treatment. It is also targeted at former detainees.

MSF aid workers support a network of primary health care activities in the district and have rehabilitated and equipped 16 so-called health rooms. These rooms have been supplied with medicines and medical equipment. MSF has also trained 20 community workers. The programme is currently expanding outside Hebron.

In October 1996, an emergency programme for the hospitals in the West Bank was carried out following a new outbreak of violence between the Israeli army and the Palestinian population since the opening of a tunnel under El-Aqsa Mosque in Jerusalem. MSF supported health care services in the West Bank, pushed to the extreme by the arrival of many injured people.

International staff: 11 / National staff: 45

LIBYA

- Around 260 Palestinian refugees, expelled from Libya in 1995, have been stranded in a no man's land at the Libyan border near Salloum. Here, they were prevented from travelling on to the Palestinian Authority. Israel has not given them clearance to return and Egypt is slow to grant visas to non-resident travellers who have no final destination arranged. MSF provides them with medical, sanitation and logistical support and lobbies on their behalf. Following their refusal to return to Libya, they were forcibly driven back across the border by the Libyan authorities in April 1997. There was no international monitoring.

MSF supported the launch of a programme focusing on preventive medicine in the rural community in the district of Hebron. There are 40,000 beneficiaries of this programme.

LEBANON

350,000 Palestinian refugees live inside the Lebanese border. Half of these refugees have lived here since 1948. Their situation was not helped when the Oslo accords signed between Israel and the Palestinian Authority made no provision for them. MSF opened a new mission in Lebanon in November 1996. The programme in the Qada district of Akkar in northern Lebanon aims at upgrading primary health care services. This is part of the national health programme. The team focuses on organising epidemiological follow up, providing training courses to improve nursing and mother/child health care and encouraging the use of essential drugs.



photo J. Bridle • Libya



**MEDECINS
SANS FRONTIERES**



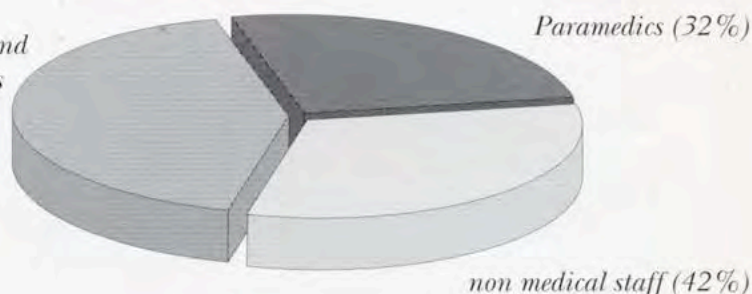
MSF FACTS AND FIGURES FOR 1996

Médecins Sans Frontières is a private independent, non-profit organisation. The international movement is represented by 19 national sections.

Aid Workers in the field

- **National staff :**
 - 15,000
- **International staff :**
 - 2,418 departures
 - 1,131 fieldposts

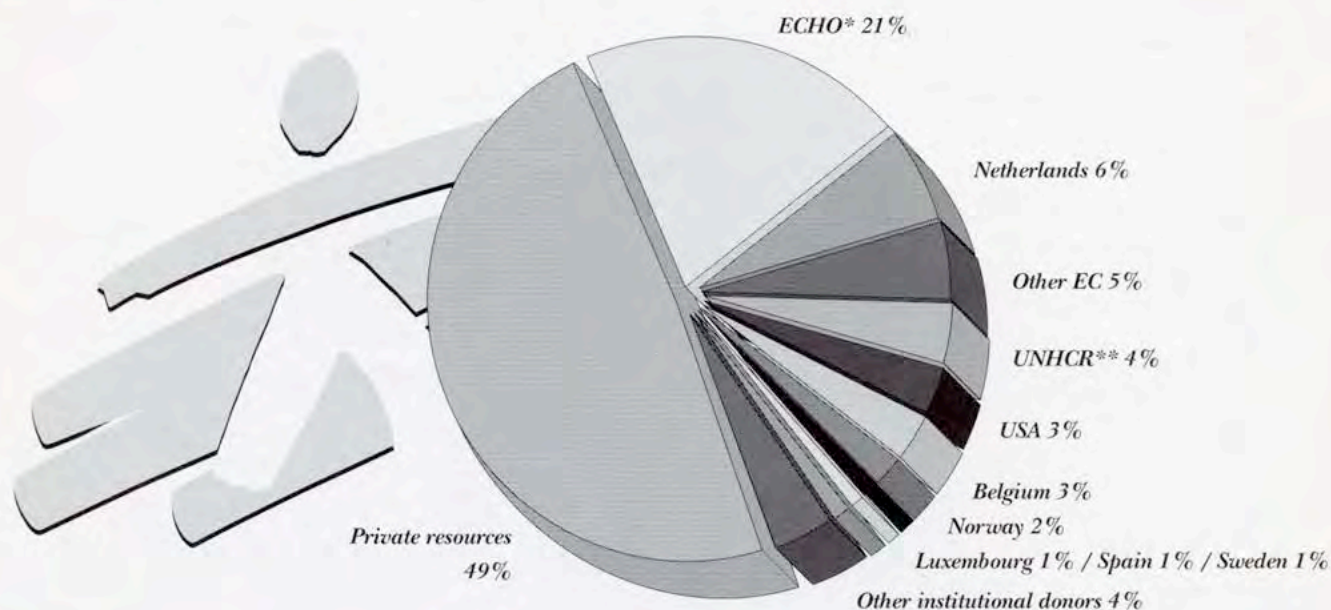
*Doctors and
specialists
(26%)*



MSF'S INCOME

Total Resources : 252 million USD

In 1996, 49 % of MSF's total resources were provided by private donors (individuals, corporations, foundations,...). This high percentage of private funding, which is provided by more than 1.5 million active private donors, guaranteed the organisation's financial independence. MSF also received grants from international organisations and governments which represented 51% of its total resources. MSF also encourages diversity in institutional funding.



The other institutional donors include the governments of Australia, Austria, Canada, Denmark, France, Germany, Greece, Hong Kong, Ireland, Japan, Switzerland, United Kingdom, the World Bank, various UN agencies, etc...

* ECHO is the European Community Humanitarian Office

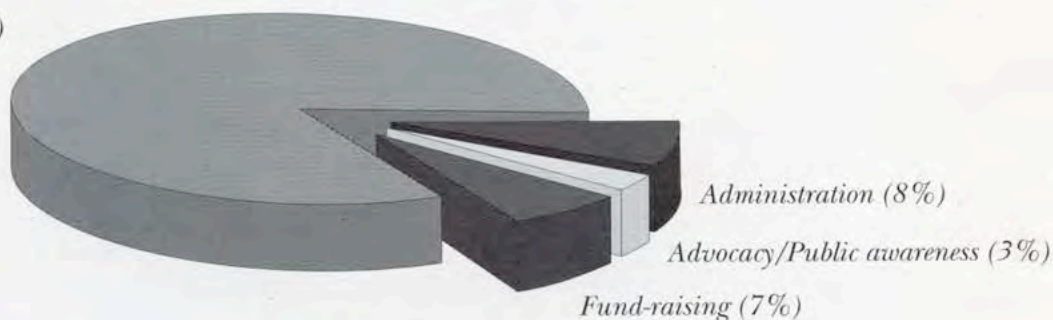
** UNHCR is the United Nations High Commissioner for Refugees

How was the money spent ?

Total expenditure : 251 million USD

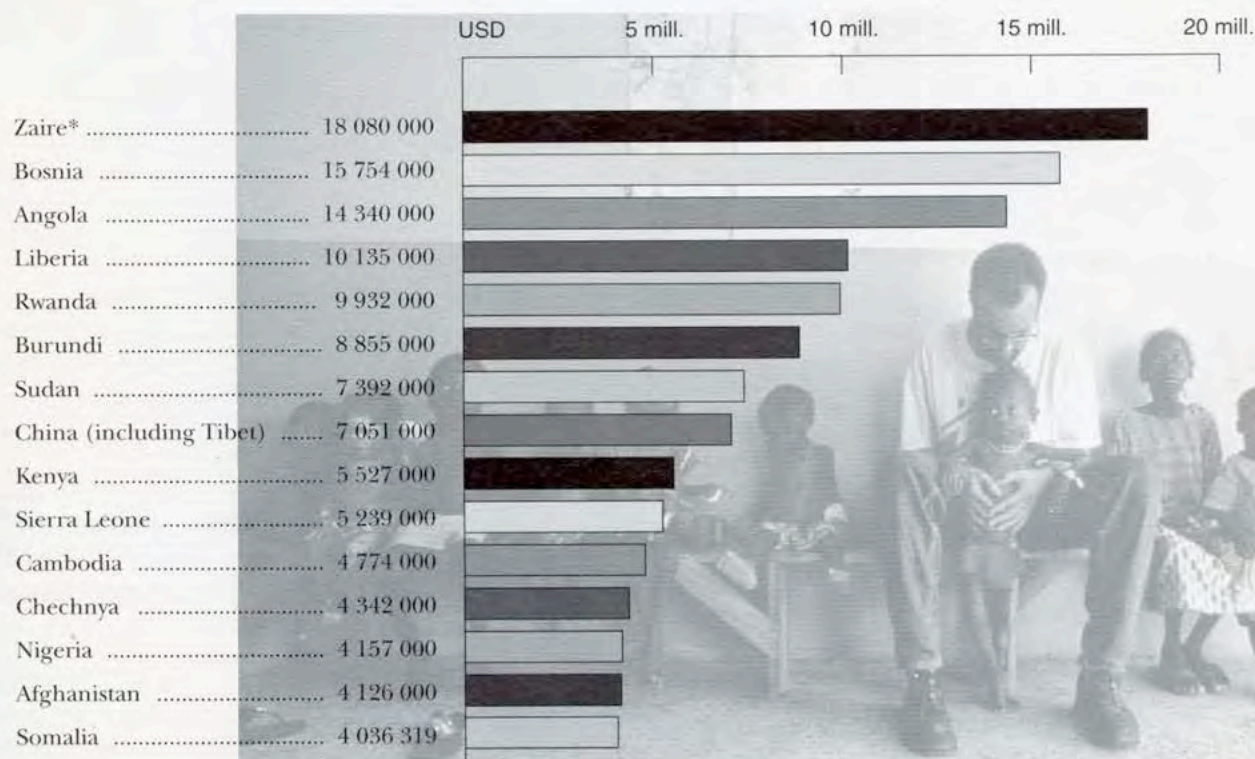
MSF aims to provide medical and humanitarian aid to people in crisis situations. Besides giving medical aid, MSF also regards it as its responsibility to report gross human rights violations observed by its staff. In 1996, 82% of expenditure went towards medical assistance and 3% towards bringing the victims humanitarian situation to the attention of the world community.

Operations (82%)



WHERE DID IT GO ?

This is the list of the 15 countries where MSF's budgets are highest



* includes programmes for Rwandan refugees since renamed Congo

photo Roger Job • Sierra Leone

Note : These figures are based on the financial statements of all 19 sections of Médecins Sans Frontières, which have been audited nationally. MSF's accounting covers the 1996 calendar year. However our Activity Report covers the period July 1996 - June 1997.

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 SWITZERLAND

"We had one baby whose heart was beating at half the normal rate. I really thought it would die and told people to keep it warm and feed it. The next day it was alright - it just felt a bit like a miracle. Another baby was born in one of the feeding centres recently and they called it MSF boy!"

**MEDECINS
SANS FRONTIERES**

"I don't believe that war should be a way of resolving conflict, but aid groups have to be present and make sure people in a bad situation get care. If you want to promote peace and fellowship, how better to do it than to attend to peoples' basic needs?"



photo H. de Ribaucourt • Burundi

"I have fallen in love with this country. It's so clear to me that human needs are the same the world over - these people love to dance, sing, joke and fall in love just like the rest of us"

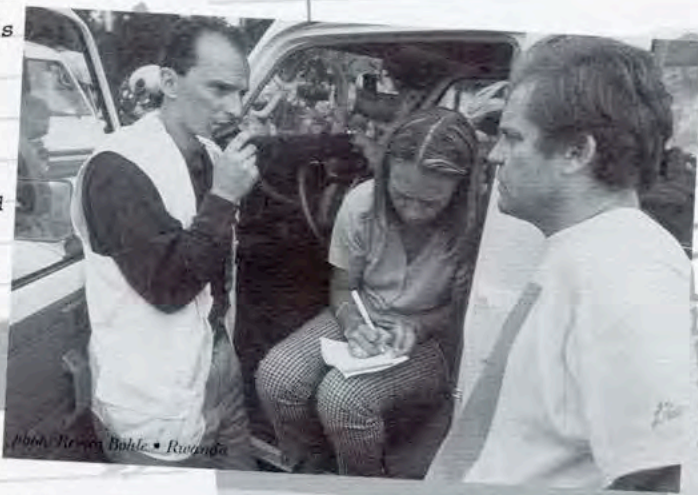


photo Pierre Bahle • Rwanda

"Tomorrow might be a big day, or another day of disappointment and anger. I expect now that the leaves are off the trees at home. They are still hanging on here, but just. So too, I'm afraid is my spirit".

"This is the first time I have felt so out of touch with my former life. But I'm very happy here - its like landing on the moon and tumbling into the open arms of a big family. So I am isolated in one sense but really quite at home in another"

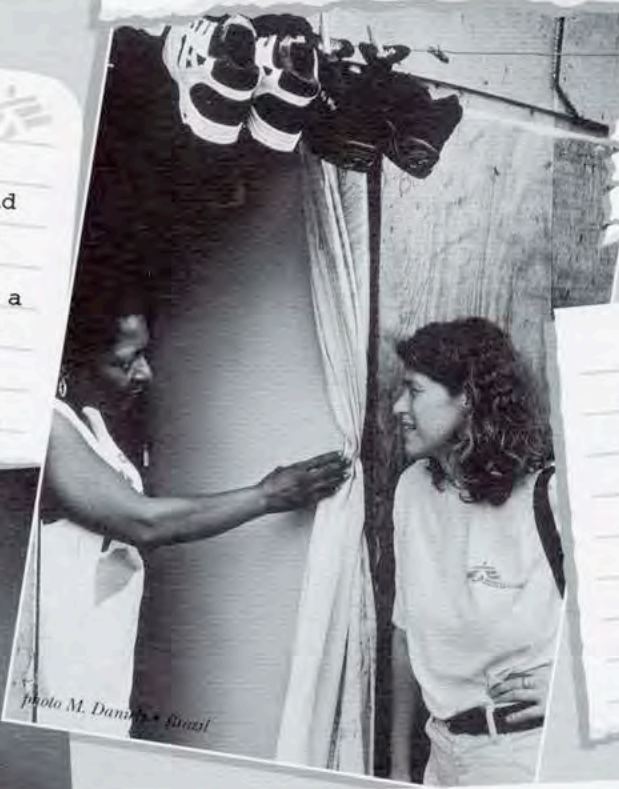


photo M. Daniels • Brazil

"I am sitting in my 'Tukul'. Its a Sunday morning and all is peaceful. You can hear the children talking, the roosters crowing and the priest speaking to a group of people gathered for Mass".

"The children run up to touch my hand - each kneeling as he or she does so, then they screech in delight as they run off having felt a 'musunga' (white person's) hand. The smaller children are scared stiff of white people and they cry hysterically if approached".

"I am having a short holiday shortly....I really cannot wait to walk outside without constantly looking to see where the line of fire is and listening for 'noise'. I think the biggest adjustment will be the absence of a VHF radio strapped permanently to my hip!"

"Cattle are the dearest possession of the Nuer people. Conversation this morning tends to the number of cattle my father and uncles must have at home. They fail to understand that I have no cattle. Although they do not show contempt for my misfortune, my manhood is suspect".

"The men of our village are often addressed by names that refer to the form, colour of hair, or breed of their favourite oxen. I have been granted the name Kwerol: bi ox of red body with white face and foreleg. It was one of a thousand or so appropriate names and its is appropriate I suppose"

THE CHARTER OF MEDECINS SANS FRONTIERES

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

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