



ACTIVITY REPORT



**MEDECINS
SANS FRONTIERES**



ACTIVITY REPORT

JULY 1997 - JUNE 1998

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ABBREVIATIONS

AIDS:	Acquired immune deficiency syndrome
HIV:	Human immunodeficiency virus; the cause of AIDS
IDP:	Internally displaced person
MOH:	Ministry of Health
STDs:	Sexually transmitted diseases
EPI:	World Health Organisation's expanded programme on immunisation
TB:	Tuberculosis
INGO:	(International) Non-Governmental Organisation
DOTS:	Directly Observed Treatment, short course therapy
MCH:	Mother-and-child healthcare
WHO:	World Health Organisation

SOURCES USED FOR STATISTICAL INFORMATION

- A. ETAT DU MONDE 1998 (71.01)
- B. WORLD DEVELOPMENT REPORT 1997 (71.02)
- C. HUMAN DEVELOPMENT REPORT 1997 (71.02)
- A = Pop. in year 1997
- A = Life Expectancy
- A = 0-5 mortality rate
- A = Pop. per doctor
- B = GNP per capita
- C = Lack of access to drinking water



photo A. Ericson - Zaïre

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photo P. Lowe - South Sudan

THE WORLD / JULY 1997 - JUNE 1998

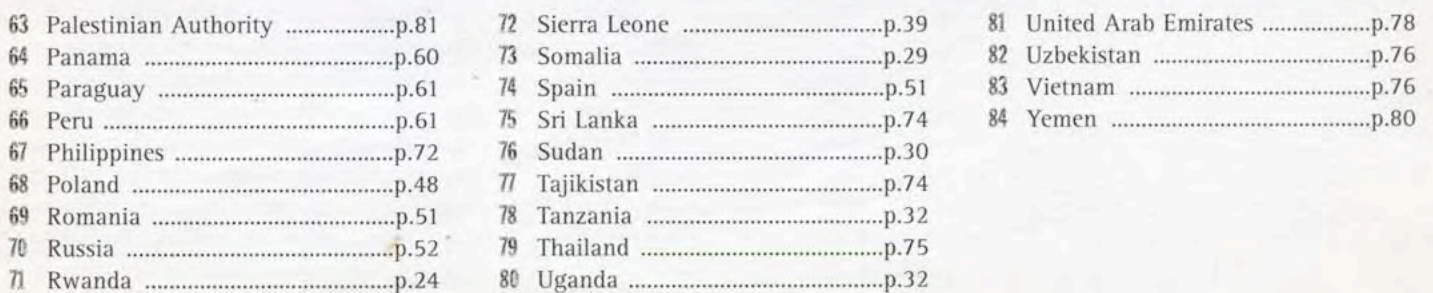




photo R. Bohle - South Sudan



In this summer of 1998 a new famine is hitting Sudan, threatening the lives of hundreds of thousands of people. Médecins Sans Frontières has been working in the affected areas for a number of years and was therefore able to raise the alarm

several months earlier that preventive action needed to be taken or else famine would inevitably arrive. This is only the most recent example of the specific nature of Médecins Sans Frontières' mission in which medical action and "témoignage" (advocacy) are inextricably associated. As doctors, we provide care and assistance, but our responsibility in crisis situations goes further than this. First, we must provide information on the situation of populations in danger so as to raise awareness and mobilise as many people as possible and thus ensure the most adequate response to their needs. And when it is in the interest of the victims themselves, we must reveal the root causes of their situation. Merely providing medical care may seem inadequate when populations are facing famine, violence and other forms of degradation. We must therefore go further and insist on respect for medical ethics, international humanitarian law and basic human rights. How do we go about doing this? We inform our usual

partners and the public at large (in the country of intervention or on a more international level); we discuss and negotiate with the local authorities as well as those who might play an influential role in other countries. This is what we mean by witnessing or advocacy, an aspect of our work that is always linked with our medical activities in the field and thus guarantees the legitimacy and credibility of what we say. And witnessing is not limited to conflicts and catastrophes, although these are the situations in which it is usually most visible; it is also essential in more stable contexts. There have been several examples over the course of the past year to illustrate our insistence on this practice. Just over a year ago, we denounced the "disappearance" of 200,000 people in the Democratic Republic of Congo following the break up of the refugee camps in Kivu at the end of 1996. Although questioned at first, this shocking reality was confirmed by the United Nations Investigation Team, although its members were not given full access or freedom of movement to carry out their research. Our own research among surviving refugees confirmed that successive violence had been carried out not only against fighting men, but against all age groups and both sexes without distinction. We will continue to battle against impuni-



photo R. Bohle - Rwanda

ty. In Afghanistan the Taliban government issued a decree in September 1997 forbidding women from entering the main hospitals in Kabul. This decree is directed towards both patients and those caring for them and denies all access to hospital care, particularly surgery, for women. Working in Kabul, we have refused to accept a form of discrimination that directly contradicts medical ethics. Together with other non-governmental organisations (NGOs), we protested to the local authorities and issued warnings to countries and donors actively involved in Afghanistan. There was a slight improvement in the situation which, unfortunately, proved short-lived when all NGOs were expelled from Kabul in July 1998. In Madagascar we provide care for some 5 to 10,000 street-children in Antananarivo, where they are rejected by society in general. Working first with magistrates, the police and doctors, we have progressively raised awareness of this issue in a programme that culminated in an exhibition and debate during which the children and government ministers found themselves side-by-side. In addition to providing medical care for them, the fact that the people of Madagascar are now taking these children into consideration at all is encouraging for their future. In Brazil the same objective of reintegrating those

excluded from health care is at the heart of our work in Rio de Janeiro. Médecins Sans Frontières has set up a health centre in the favela of Vigário Geral, which had no public health structure whatsoever. As the result of raising awareness among the municipal authorities and disseminating information through the local press, this centre has now been taken over by a local NGO with financial support from the municipality. The people of the city have thus begun to accept responsibility for a problem which is their own. In the north of France a system for distributing free medical assistance penalised the most disadvantaged fringe of the population. The conjunction of a number of different activities (spreading information, petitions, recourse to an administrative tribunal) has led to the reinstatement of the right to free and unlimited access to medical care for 160,000 people. These examples illustrate what we understand by our responsibility as doctors. Although they are few in number, the successes we have achieved confirm our belief in the path we are following: to provide care for populations in danger, and act as witness on their behalf in order to help them to improve their state of health and recover their dignity.

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



photo C. Sacré - Rwanda



photo M. Dehaspe - Kenya

27 YEARS ON... MILESTONES

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 population to the attention of the general public.

1972

Nicaragua : intervention following earthquake

1974

Honduras : long-term mission in the wake of 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 Cambodian 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. An MSF 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 are set up in Eastern Europe following the collapse of the Communist bloc.

Armenia : earthquake relief

1990

Liberia : MSF brings assistance to inaccessible areas.

1991

The flight of the Kurds : MSF launches biggest refugee programme following Gulf War. Teams provide assistance to Kurdish refugees in several countries.

Somalia : MSF sends emergency aid to the victims of the civil war.

Former Yugoslavia : MSF launches mission in the war zone.

MSF awarded European Human Rights Award and Philadelphia Liberty Medal.

1992

Somalia : Civil war and famine decimate the population. MSF increases its activity in the field and alerts international opinion.

Bosnia-Herzegovina : MSF denounces ethnic cleansing and crimes against humanity.



photo R. Job - Sierra Leone



photo T. Voeten - Afghanistan

OF A HUMANITARIAN MOVEMENT

1993

Somalia : MSF denounces the methods of the United Nations troops in Somalia which violate the very humanitarian principles by which they are supposed to operate.

Burundi : Following attempted coup d'état, vicious round of killings begin which triggers refugee emergency. Within a few weeks, 180 MSF volunteers are providing emergency aid to 600,000 refugees in Rwanda, Tanzania and in Burundi itself.

MSF receives Nansen medal for its work amongst the world's refugees.

1994

Bosnia : work continues during the siege of Gorazde

MSF team and the International Committee of the Red Cross are the only humanitarian presence in the enclave. **Rwanda** : Genocide begins. MSF takes out all but its most experienced staff and works with the wounded in extremely difficult circumstances. MSF calls on the International community to intervene in the genocide.

One million refugees fleeing the Rwandese Patriotic Army (RPA)'s advance, arrive in the small town of Goma, Zaire. Within days, thousands are dying of cholera. MSF collaborates on water distribution system, launching biggest cholera programme to date.

1995

Bosnia : MSF is the only international presence during fall of Srebrenica enclave. **North Korea** : MSF intervenes following floods.

Chechnya : During the war, MSF brings aid to the Chechen people inside the republic and on the borders of 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.

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

Zaire : Civil war breaks out. Rwandese refugee camps on the border attacked by the Alliance forces who wish to root out members of the former Rwandese 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 healthcare facilities and they must fend for themselves. MSF provides assistance where possible.

1997

Democratic Republic of Congo : MSF fights for access to Rwandese refugees, many of whom are massacred and die of starvation and disease. MSF issues reports tracing the fate of the refugees and on human rights abuses suffered. **North Korea** : MSF is one of the few international organisations to gain access to this closed country. MSF distributes medicines to health centres and hospitals in three provinces.

Afghanistan : MSF teams continue their work. In Kabul, MSF successfully pushes for a reversal of a Taliban edict excluding women from emergency health care, but the access of women to healthcare remains difficult. Gaining access for them is MSF's priority.

1998

Rwanda : MSF calls for a Commission of Enquiry into the role of the French government in Rwanda's genocide (March 1998).

South Sudan : MSF launches emergency operations and appeal for famine victims. In early March there were 808 malnourished children in MSF feeding centres, at the end of June there were 7,000 in nine feeding centres. MSF's newly created food unit sets up an air-bridge to carry out food distribution.





In this activity report our work is described on a country-by-country basis so that readers may reach a more detailed understanding of how we react within a given context and may more easily follow up on their specific interests. However, we also aim to present an overall image of our interventions. It is Médecins Sans

Frontières's mission to assist certain categories of populations, as a result of which we are confronted with specific problems and challenges that require our organisation to maintain a capacity to respond adequately. By analysing the activities of all sections combined in 1997, project by project, we have been able to characterise them more exactly and more accurately pin-point the populations to which they are addressed. Since its creation in 1971, Médecins Sans Frontières has been known mainly for its work in emergency situations. Although this remains the reality, the world itself has changed and the resources and techniques used by MSF have had to be modified and improved. These natural evolutions enable us to assist an ever wider variety of populations.

The number of projects dealing with conflicts and their consequences represent around 20% of the total. The populations concerned are the direct victims of wars, as well as refugees and the growing numbers of displaced persons. Other projects can also be assimilated to crisis interventions in the sense that they are of limited duration, their evolution is not easily foreseen, and the programmes connected with them require frequent adaptation and reorientation. These projects are aimed at populations with poor access to health care, or none at all, in the context of conflict

(although outside the combat areas) or in post-conflict situations. They also include the victims of disasters (such as earthquakes, floods, etc.) or of epidemics (cholera, meningitis, measles, etc.). Altogether, these projects respond to acute situations and correspond to the image of our action that has held true for a long time. They represent about 55% of all our work.

The other populations that we address are those with insufficient access to health care, but in more stable situations, those confronted with problems that have developed over the course of recent years: new or recrudescing endemic diseases (such as AIDS and tuberculosis), and those who are victims of the phenomenon of social exclusion. This last category, present in rich countries as well as in poor ones, is constantly growing and includes people living on the margins of society in large towns and cities, street-children and minority groups.

What can we do to help these populations? In more than two-thirds of our projects, our activities are concerned with health centres and hospitals, and entail direct contact with the patient and the direct involvement of volunteers in providing care, both curative and preventive. In parallel to this, 25% of our projects are primarily composed of support, supervisory activities, and a similar proportion is comprised of training aimed at ensuring that the activities will continue after our eventual withdrawal. Finally, if our work is mainly medical, it is complemented by water and hygiene activities, which are aimed at overall improvements to health and are present in over 20% of our projects.

MSF INTERVENES IN EAST AFRICAN CHOLERA EPIDEMIC

The cholera epidemic in East Africa over the last 12 months was the first to be seen in East Africa as a whole. Since the beginning of last year, there have been over 170,000 cases of cholera in the region, resulting in over 7,000 deaths. Increased rainfall and flooding due to El Niño are likely to have been a catalyst in the spread of cholera in a region where the rural population has increased dramatically over the last 10 years. With population increases comes overcrowding, poor hygiene and sanitation and water shortages. Such environments are ideal for the spread of cholera.



photo R. Job

Over half of the reported deaths have been in Tanzania. The cholera problem in Tanzania dates back to the last century. The latest cholera outbreaks here began in 1977, where the origin of the disease was traced to a merchant travelling from the Middle East. A local man with whom the merchant stayed died of cholera within 3 days. By the end of the year, 135 people had died. This number of deaths remained constant until last year, where it shot up to 2,231.

From Tanzania, the epidemic spread to Kenya and Mozambique, then on to the other Eastern countries. The cholera epidemic was recognized in June 1997. By March 1998, 14 countries were affected*. During this period, Médecins sans Frontières teams were working with local authorities in all of these countries to treat patients and prevent further spread of the epidemic. The severity of the epidemic varied from country to country, depending on the geography of the country which sometimes made it very difficult to reach the populations at risk, and the level of existing healthcare which at best is inadequate and at worst non-existent.

Cholera is caused by the bacterium *Vibrio cholerae* and is spread by contaminated water and food, and by personal contact. Initial symptoms of diarrhoea appear within five days of infection, often with

vomiting, and it is the dehydration and loss of electrolytes resulting from these symptoms that leads to illness and in the most severe cases, death.

Generally speaking, the treatment of patients with cholera is relatively straightforward. Ninety per cent of cholera cases seen world-wide are mild, and a simple solution of oral rehydration salts is sufficient. But the situation in East Africa was bad. 'Almost half of the people we treated in East Africa had severe illness, requiring treatment with intravenous fluid replacement', explained Dr Marc Gastellu, Director of the Medical Dept. in MSF France.

In the worst cases, death can follow within hours of infection and a rapid response is therefore vital. It is for this reason that MSF developed comprehensive cholera kits. Developed over 10 years ago during the cholera epidemic among refugees in Malawi, these kits contain all the necessary medical supplies for setting up a fully operational treatment centre within a matter of hours.

To prevent the spread of cholera, an adequate supply of drinking water and basic hygiene and sanitation is all that is required. MSF logisticians and water and sanitation experts worked in collaboration with local workers to improve access to good quality water for vulnerable populations. In more remote areas, mobile teams made regular deliveries of water, soap and



photo R. Job

medical supplies, at the same time informing people as to the ways in which cholera spreads. Such awareness campaigns were a key factor in controlling the epidemic. By alerting people to the cause of infection and the importance of seeking treatment as soon as symptoms develop, the risk of further spread has been minimized.

An upsurge in the epidemic was feared with the onset of the rainy season in March. The hard work over the last year helped to avoid this. However, outbreaks have been recorded in the Great Lakes region, confirming earlier predictions of spread from the East to central and southern regions. Médecins sans Frontières continue

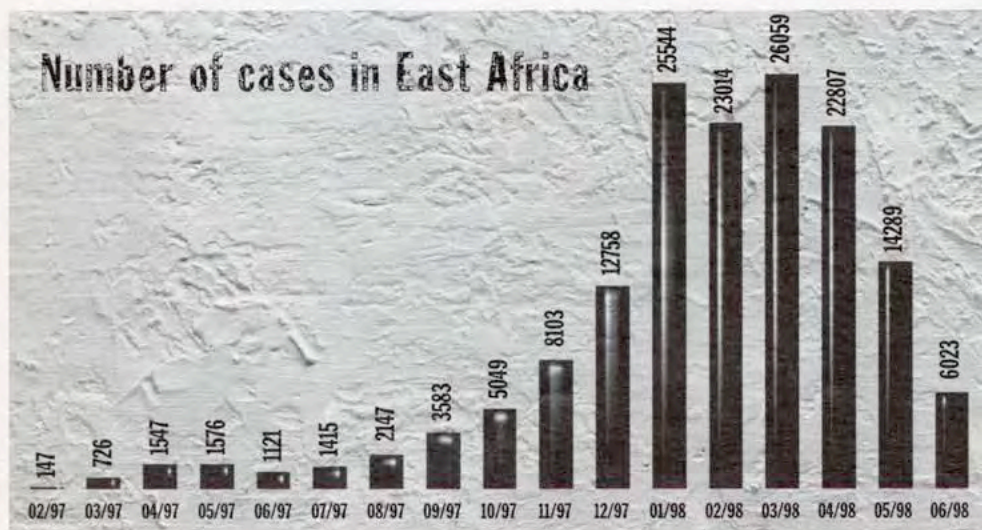
to survey these regions. By mapping the development of new cases, the spread of cholera can be predicted to a certain extent and contingencies set up in advance. The continued training of local health workers and provision of vital medical aid have contribute greatly to reducing the number of deaths from a disease which has been claiming human lives for over 2000 years.

* All data cited up to 28/07/98.

** Tanzania, Kenya, Mozambique, Uganda, Djibouti, the Democratic Republic of Congo, Somalia, Malawi, Ethiopia, Burundi, Zimbabwe, Zambia, Chad and the Comores Islands.

† MSF publishes comprehensive reference guidelines for intervention during cholera and other epidemics.

Nathan Ford



MSF FACES GROWING PROBLEM OF DRUG RESISTANCE

In spite of the many successes in medicine this century, infectious diseases continue to be the greatest health problem for developing countries. Bacteria, viruses and parasites are responsible for nearly half of all reported deaths in these countries.

The discovery of antibiotics was one of the most important advances in the fight against infectious disease. Hundreds of antibiotics have been developed since Alexander Fleming discovered penicillin in 1929.

However, the subsequent misuse of antibiotics has engendered widespread drug resistance. Fleming first noticed the antibacterial effects of penicillin when working with *Staphylococcus aureus*. Seventy years on, this bug is causing widespread illness. It is resistant not only to penicillin, but to almost all common antibiotics.

Drug resistance is a result of natural selection. The more an antibiotic or anti-parasitic drug is used, the more pressure there is for resistant bacteria to evolve. This is much more of a problem in the developing world. Where in the industrial world, most antibiotics are available only by prescription, in the developing world they are found on the local market. Moreover, these countries lack sophisticated epidemiological surveillance. The emergence of drug resistance is rarely monitored, and these countries are therefore incapable of defining appropriate drug policies.

The increase in the number of tuberculosis cases in recent years is partly due to the emergence of multidrug-resistant bacteria. In the MSF tuberculosis project in Mariinsk, Siberia, over one third of patients are infected with multidrug-resistant TB bacilli. These patients cannot be cured by the usual drug regimens. Second line drugs are expensive, difficult to manage, have varied success and, in some cases, serious side-effects.

African Sleeping sickness is treated with melarsoprol. The MSF sleeping sickness project in Uganda has experienced resistance

to melarsoprol in one in five patients. The best alternative drug, eflorinthine, is no longer manufactured.

Outbreaks of dysentery have recently been afflicting the African continent. The *Shigella* bacteria causing the disease have rapidly developed resistance to classical drugs such as nalidixic acid. One of the few effective alternative drugs, ciprofloxacin, is frequently found on the local market place in developing countries. The uncontrolled use of ciprofloxacin is likely to lead to resistance, and alternative drugs will be needed.

There are between 300 and 500 million cases of malaria each year. Over 2 million people die. Most are children of the African continent. In the last 10-15 years, resistance against the traditional anti-malarial drug, chloroquine, has become commonplace. Even the newer drugs such as fansidar and mefloquine are losing efficacy against the malarial parasite in more and more parts of the world. In spite of the fact that 40% of the world population are at risk from malaria, research for new anti-malarial drugs does not appear to be a priority for the pharmaceutical industry.

These diseases are almost exclusively a problem of the developing world. In these countries drugs are often not available, if available often not accessible and if accessible often misused. There has been very little research and development of new drugs for tropical diseases. No radically new antibiotics have been discovered since the introduction of quinolones in 1961. When new drugs are produced by developed countries, price dictates that for the most part this is where they will stay.

Francine Matthys and Nathan Ford

STREET-CHILDREN

A UNIVERSAL AND GROWING PROBLEM

Children and adolescents end up on the streets for a number of reasons, but hardly ever out of choice. They have almost always experienced physical (often sexual) violence in their families or in the institutions entrusted with their care. Having lost touch with their families and abandoned any chance of schooling, they become members of a marginalised population for whom prostitution may be the only way of surviving and drugs offer the only respite. They are ignored by society at large, deprived of their legal and moral rights to protection and denied access to public health systems.



photo R. Job

When MSF intervenes on their behalf, it is in order to give them back a sense of their physical integrity, dignity and self-respect and encourage their re-integration into society. Programmes are already running in many countries (e.g. Nicaragua, Peru, Madagascar, Egypt, Occupied Territories) and other possibilities are being explored (e.g. China and Bangladesh). A first approach is usually to offer medical help, which includes information and other activities geared at prevention (e.g. against HIV/AIDS and addiction to drugs, alcohol, etc.), and then social and legal assistance to re-establish their rights, including access to existing health systems. Through experience, MSF has also learned that psychological help is generally crucial if these children and adolescents are to have a chance in the future. However, it is never the intention of MSF to force their re-integration; their freedom of choice must always be respected.

Street-children are generally perceived as a threat to public order - actual or potential delinquents, although there is a distinction to be made between delinquency as a way of survival and delinquency as a way of behaviour. They are often rounded up and held under "preventive detention" in closed institutions, sometimes prisons or juvenile detention centres. Here, the most vulnerable are at risk from exposure to more hardened, very often criminalised, peers: a destructive experience at every level. In

these situations, MSF is also prepared to work inside such institutions. Although this may first mean providing a medical presence for individuals, legal and social welfare assistance is also made available, and teams press for improvements in overall living conditions while simultaneously advocating against incarceration as a response to this problem and in favour of genuine protection for juveniles. This may mean lobbying for existing laws to be respected or, indeed, changed. MSF does not believe that "anything" must be better than life on the street.

Sometimes advocacy may be carried out very discreetly, particularly where abuse is occurring in officially-run institutions. Sometimes it is very public and the MSF name is directly linked to national campaigns. In some countries, it is extremely difficult to get either the authorities or the general public to acknowledge that there is a problem of any scale. Just raising the issues - for example, by holding an exhibition in the main station of Tananarive, Madagascar in December 1997 - may already be a big step forward.

For the street-children themselves, MSF's presence is a reassurance, and often a very visible one when it takes the form of mobile teams on foot or using converted buses to work in the streets themselves. Indeed, this kind of proximity is essential. Street-children do not hold their health as a priority and sitting wai-



photo R. Job

ting for them to present themselves in clinics is not the best way of making contact. MSF has to be there where they are likely to gather, even if this means being around drug dealers. Once the first contact is made with MSF, they know that they have someone reliable to whom they can turn, an experience most have previously never had. For many of them, that is as far as it can go. They have been on the streets since such a young age that no alternative seems a realistic possibility. Others may start out spending increasing amounts of time in the streets, perhaps to escape violent situations at home, but still have the possibility of a family to whom they periodically return. Some of this group may be prevented from becoming

fully fledged street-children if they can be reached in time.

MSF operates all its street-children programmes with local staff of the country concerned and always collaborates closely with local organisations working on behalf of street-children, or helps to set up such groups. In some cases, MSF's intervention is purely to provide medical consultations in existing night shelters or day centres for street children (such as in the Philippines and Brazil), but the collaboration may develop into a coordination on aspects such as lobbying for reforms or into a partnership of synergies that makes a global approach possible.

Alison Marschner



CENTRAL AFRICA

A F R I C A



NUTRITIONAL PROBLEMS EMERGE

Although the government announced peace and reconstruction for 1998, rebel groups and the army maintain pressure on the civilian population, violence continues and no political solution is in sight. However, international pressure and the need to get people back to work, led to half the "regroupment" camps being dismantled by the end of 1997.

POP. IN YEAR 1997
6.2 m

GNP PER CAPITA
160 USD

LIFE EXPECTANCY
44.6 yrs

0-5 MORTALITY RATE
120 per 1,000

POP. PER DOCTOR
0.06 per 1,000

LACK OF ACCESS
TO DRINKING WATER
41%



photo M. Wittebrood

MSF is responsible for drugs supplies in Kayanza province and for surgery in the provincial hospital. In Makamba province, a team provides support for surgery and anaesthesia in the hospital, and ensures drugs supplies, medical supervision in 21 health centres and epidemiological monitoring. In Kirundo province, where the situation has been improving, MSF started to reduce similar support provided to 15 health

centres and by February 1998, the only remaining responsibility in the provincial hospital was for Caesarean sections.

MSF continued to manage the 50-bed Kinyinya hospital, Ruyigi province, until its hand-over to the MOH at the end of 1997. A team still provides staff training, particularly in surgery. Surgical support and drugs supplies continue for the provincial hospital here and in Cankuzo province, where the maternity department is also supported. The health centres in Cankuzo are also supported. District health programmes are conducted in Ruyigi, Ngozi and Karusi provinces, as well as surgery in the 220-bed Ngozi hospital (the fourth largest in the country). MSF provides support to two health posts in Ruyigi; one in an orphanage and the other in a transit camp for returnees (Gisuru).

In Bujumbura, MSF's support for a hospital emergency department involved volunteers in caring for scores of injured civilians following an attack near the airport at the start of 1998. A team is also working in a transit camp for returnees in near-by Gatumba, on the border with the Democratic Republic of Congo.

International Staff: 54
National Staff: 441

The health situation is deteriorating because of insecurity, population displacements, the continuing economic embargo, lack of access to health care for those unable to pay and transport difficulties for medicines and sick patients. MSF has been present in eight of the country's 15 provinces on behalf of an estimated 2.3 million people (37% of the total population). The main activities were support for surgical services in provincial hospitals, drugs supplies and technical assistance from expatriate medical staff and emergency health care for the displaced and returnees.

Many new nutritional programmes opened in 1998 in response to the deteriorating food situation, particularly in the war zones. Supplementary feeding was initiated in four IDP sites in Nyanza-Lac and Vugizo, Makamba province, in December 1997, and a therapeutic feeding centre for 250 children was added in February 1998. MSF has taken over a nutritional programme in Karusi province for 150 severe cases and 1,500 moderately malnourished. Nutritional programmes are also running in Matongo, Kayanza province, and in Cankuzo province. A feeding centre for the IDP population in Kamenge (Bujumbura province) covered 300 severely malnourished in May 1998. The centre had to be extended to cope with the growing numbers.



POST-EMERGENCY PROGRAMME

A UN force has now replaced the previous inter-African force monitoring implementation of an agreement to end social unrest caused by CAR army mutinies, including that of June 1997 leading to the displacement of 20-30,000 people.

MSF supplied emergency assistance during the June 1997 mutiny and remained to carry out a 12-month post-emergency programme in health centres in the Petevo, Yapele, La Kouanga and Bimbo areas of Bangui. The overall objective is to improve access to health care for the target population of 236,882 working in close collaboration with the MOH. The current project aims to improve the quality of preventive and curative care with a special emphasis on mother-and-child health, the management of drug supplies and the running of the pharmacy, as well as the health information system.

The project also provides support for EPI, the laboratory and the out-patients department of each centre. The community will work together with MSF to improve the physical structure of the health centres. The team will also give training on specific subjects in consultation with the regional health director. Support is being given to emergency preparedness and in late 1997, MSF assisted the MOH in managing a cholera outbreak.

International staff: 6
National staff: 12

CENTRAL AFRICAN REPUBLIC



POP. IN YEAR 1997	3.3 m
LIFE EXPECTANCY	48.3 yrs
0-5 MORTALITY RATE	100 per 1,000
POP. PER DOCTOR	0.04 per 1,000

ACCESS TO HEALTHCARE A PRIORITY

The elected government has remained in place despite an armed opposition operating in the Lake Chad region and in the east of the country. Although Chad had a record cotton harvest in 1996-97 and looks forward to oil revenues starting in 2000, cereal crops are insufficient and there are repeated epidemics of cholera and meningitis.

MSF's long-term programme in Mayo-Kebbi now extends towards Eastern Logone (covering 20% of the total population). A similar programme is underway in the Koumra district of Sahr prefecture (pop. 177,000). The objective is to provide support to the health system for

preventive and curative care by ensuring supplies of drugs and medical material, and setting up a cost recovery system for health centres to become self-financing. Every effort is made to guarantee access to medicines is guaranteed, as well as quality in health care. Infrastructure is being constructed and rehabilitated and ongoing training provided for health workers. Emphasis is placed on the importance of working in partnership with local health professionals to ensure long-term sustainability. In collaboration with local NGOs, education programmes were started covering AIDS and other health matters, and family planning advice is available when requested. MSF also provides technical assistance in support of EPI.

MSF worked with the MOH in response to a meningitis epidemic that began in early 1998. A team provided logistical and technical support for mass vaccinations. While assisting with this, four MSF expatriate staff were held hostage for several days by members of an armed opposition force.

International staff: 26
National staff: 164

CHAD



POP. IN YEAR 1997	6.5 m
GNP PER CAPITA	180 USD
LIFE EXPECTANCY	47 yrs
0-5 MORTALITY RATE	123 per 1,000
POP. PER DOCTOR	0.03 per 1,000
LACK OF ACCESS TO DRINKING WATER	71%



photo A. Kazmierakis

NO IMPROVEMENT FOR HEALTH CARE

President Kabila's government is neither stable nor consolidated and the eastern regions remain in a state of complex conflict. For the civilian population, this means a situation of generalised crime and violence and no improvements for health and education.

MSF works in the provinces of North and South Kivu, Bas Congo, Equateur, Katanga, Eastern Kasai, Kinshasa and Orientale, where many health structures are not functioning, particularly in areas with vulnerable populations, including large numbers of IDPs and refugees. Support to health centres includes supplies of essential drugs, medical and logistical material, staff training and assistance with preventive activities such as vaccinations, prenatal care and condom distributions. Essential medical support in Kalemie and Katana (Kivu) continued until the end of 1997.

MSF runs comprehensive STD/AIDS programmes in Kinshasa, and in Lubumbashi, where the focus is on safe blood transfusions. An AIDS leaflet directed at teenagers is produced and distributed through schools. Teams are also involved in sleep-

ing sickness programmes in Bas Congo and Equateur, where a hospital and health centre are being extensively rehabilitated. MSF is helping to set up a nation-wide epidemiological surveillance system and a water-borne diseases prevention programme has begun in Eastern Oriental.

Since July 1997, MSF has intervened in one meningitis emergency (Tembo) and eight cholera outbreaks in Bas Congo, Goma, Bukavu, Bunia, Katanga and Kisangani. A treatment centre was set up in Kisangani outside a closed military camp for some 4,000 soldiers aged 8-20 held for "re-education" in extremely poor conditions. MSF advocated strongly for the eventual closure of this camp.

International staff: 43
National staff: 308



POP. IN YEAR 1997
47 m

LIFE EXPECTANCY
52 yrs

0-5 MORTALITY RATE
95 per 1,000

POP. PER DOCTOR
0.07 per 1,000

LACK OF ACCESS
TO WATER
58%

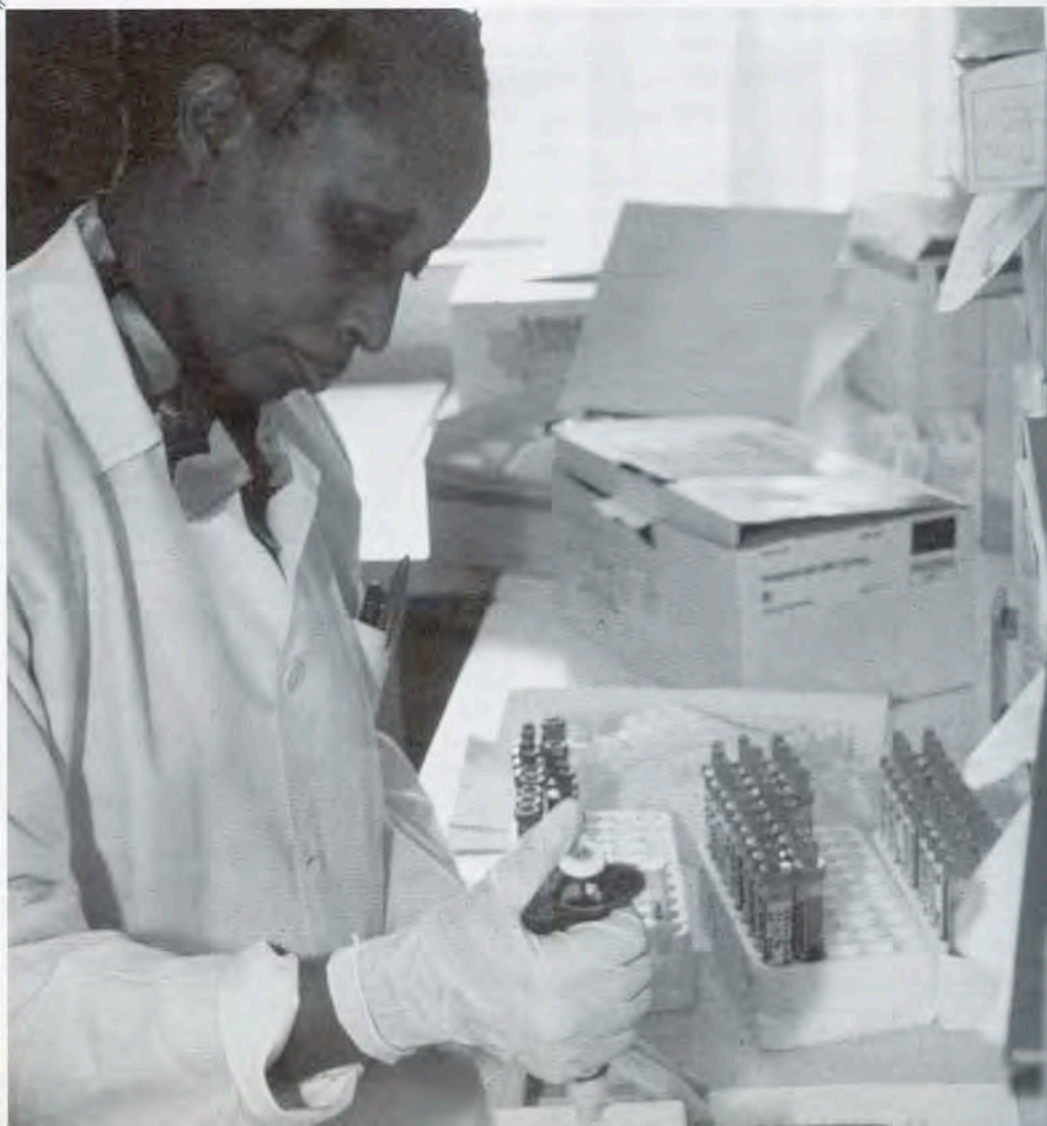


photo Ph. Revelli

PROGRAMME DRAWS TO A CLOSE



photo B. Neelman

POP. IN YEAR 1997
2.6 m
LIFE EXPECTANCY
51.5 yrs
0-5 MORTALITY RATE
89 per 1,000
POP. PER DOCTOR
0.27 per 1,000

On 15 October, after five months of fighting, General Sassou-Nguesso defeated government troops supporting President Lissouba and declared himself president.

As hundreds of thousands were displaced by the fighting, MSF provided emergency assistance in the form of temporary health posts, feeding programmes and supported four health centres on the northern and southern outskirts of the capital, and another six health centres and a mobile clinic further north on the Lefini river. A team carried out measles vaccinations in Gamboma and Oyo. In Kinkole, across the border in the Democratic Republic of Congo, MSF supplied water to an estimated 25,000 Brazzaville refugees.

In the capital's Makelekele hospital, MSF supplied surgical kits, re-organised the surgical department and installed a water supply system. Despite difficulties in obtaining drugs and medical material, Makelekele functioned throughout the war. Afterwards, the team introduced treatment

protocols, rationalised prescriptions and set up a central pharmacy. Some support was also given during the war to Linzolo and Kinkala hospitals. Two MSF volunteers equipped with medical and logistical material provided support for Pointe Noire cholera centres during an outbreak beginning in February.

MSF provided medical, nutritional and sanitation assistance to 15,500 Rwandan refugees grouped on sites in Loukelela, Ndjoundou and Liranga. As only Loukelela could be reached by plane, food, drugs, medical and logistical equipment were brought by boat from Bangui in the Central African Republic.

MSF remained in Congo-Brazzaville until end-April 1998, gradually scaling down activities as large numbers of IDPs and refugees began returning home.



RWANDA

INSECURITY JEOPARDISES AID

Much of Rwanda's health infrastructure was either destroyed or badly damaged during the period of killing and destruction that began in April 1994. The medical services are understaffed because a large number of trained staff were killed, fled the country or are held in overcrowded prisons in deplorable conditions. In the northwest, the Rwandan army is failing to secure the region against armed groups, and civilians are still being targeted.

MSF's objective in Rwanda is to give medical and nutritional assistance to refugees, returnees, IDPs and the general population by providing qualified expatriate, regional and local staff. In some

but new returnees and those with very low incomes are exempted. In Bushenge (pop. around 162,000), the focus is on establishing the district health team and committees and setting up a district pharmacy. Other activities

are similar to those in Kabutare. Water and sanitation evaluations are carried out in clinics in both places. A programme to renovate health centres and houses accommodating hospital medical staff began in January 1998.

MSF cares for around 450 unaccompanied children while tracing the families from whom they were separated during the 1994 exodus or the mass repatriations in

November 1996. Although several hundred children have been successfully reunited with their families, when this is impossible, and many of the children were so young that they are unable to contribute useful information, MSF places them with foster families. As the two centres near Gisenyi in which they were being held were in very insecure areas, MSF succeeded in evacuating some of them to another centre in the town itself in March 1998. Others were taken to Gitarama.

Another Gisenyi programme assisting street-children was taken over by a local organisation in March 1998. MSF suspended the training and supervision provided for a Gisenyi psychological assistance programme in November 1997 because of the high level of insecurity.

MSF has medical responsibility for two camps for Burundian refugees: Musange, near Butare, and Kibangiara, in Cyangugu province.

International staff: 17
National staff: 100



POP. IN YEAR 1997

5.5 m

GNP PER CAPITA

180 USD

LIFE EXPECTANCY

47 yrs

0-5 MORTALITY RATE

139 per 1,000

POP. PER DOCTOR

0.04 per 1,000



photo R. Bohle

areas team members substitute for missing health staff and in other areas they provide technical assistance, training, supervision, etc. For various periods until the end of 1997, MSF provided medical screening and/or other assistance for returnees in Gisenyi (Petite Barrière and Nkamira transit camps), in Kigali (the airport and Runda transit camp), in Cyangugu (Musange transit centre) and on the Tanzanian border (Nyakarambi transit camp).

The district health programmes continue in a collaboration with district medical directors and hospital directors that fully implicates MSF in all planning, budget allocations, supervision and decision-making in regard to the revolving drug fund. MSF provides drugs for prisons in the districts in which we work (two in Kabutare and two in Cyangugu) and ensures that lock-up prisoners receive medical care at local clinics. In Kabutare (pop. around 350,000), the programme has developed towards training for health and supervisory staff, and improvements in health care emphasizing vaccination, maternal health, STD/AIDS control and epidemiological data collection. A revolving drug fund has been introduced,

EASTERN AFRICA

A F R I C A



DIJIBOUTI

In November 1997 MSF responded to a request from the MOH to assist with a cholera epidemic resulting from severe flooding and a poor sanitation system in the town itself. A team was quickly in place and re-organising one of the two cholera treatment centres, where improvements in the quality of patient care succeeded in lowering the case fatality rate from 5.6% to 1%. In addition, oral rehydration points were set up in three of the five town health centres, detection techniques were improved and health education messages were disseminated. As the hospital did not have the capacity to treat severely malnourished children discharged from the treatment centre, support was also provided for the paediatrics department. After the peak of the epidemic had passed in the town, the team assisted the local partners to prepare for the next one that may occur and carried out a nutritional survey before withdrawing in March 1998.

ETHIOPIA



KALA AZAR OUTBREAK

Although Ethiopia entered a new phase in its development, the population still has huge needs. Regionalisation complicates relations with the health authorities.

In Afar state (pop. 500,000), MSF provides technical assistance to Dubti referral hospital. In Amhara state (pop. 2 million), a surgical training and technical assistance programme terminated in March 1998. A district health programme in Jijiga

ward for the successfully functioning TB programme. Emergency assistance was given during a cholera outbreak in Jijiga beginning in March 1998.

MSF is improving peripheral and health centre services in Degeha Bur (pop. 900,000), where locally displaced people are resettling. A water project aims to ensure water and food stability for 25,000 people in remote Wag-Hamra region, Amhara state. In Salamago district, South Omo state, MSF works to make local hospitalisation a possibility for the isolated population of 15,000. Assistance for 20,000 refugees in Shekole Camp, near Asosa, includes wells, latrines and training for community health workers.

In October 1997, MSF responded to an outbreak of kala azar in Tigray state. The team based in Humera hospital supplies the treatment drug, assists in diagnosis and treatment, helped set up a special clinic for ambulatory patients and is now setting up a laboratory and training technicians and medical staff.

In Addis Ababa, MSF is involved in AIDS prevention and treatment programmes for STDs.



photo M. Dehasse

region (pop. 400,000) aims at improving peripheral health services and the hospital. Construction activities include a 40-bed TB

International staff: 21
National staff: 255

POP. IN YEAR 1997
58.2 m
GNP PER CAPITA
100 USD
LIFE EXPECTANCY
47,5 yrs
0-5 MORTALITY RATE
119 per 1,000
POP. PER DOCTOR
0,03 per 1,000
LACK OF ACCESS
TO DRINKING WATER
75%

FLOODING & EPIDEMICS WREAK HAVOC

The worsening political and social situations are severely affecting the health services: deteriorating buildings, demotivated staff, no response to the growing problems of AIDS and TB. Those most affected live in urban slums or the under-resourced northern and eastern provinces.

In Nairobi's slums, MSF focuses on AIDS and primary health care. In Kibera and Dandora (pop. 300,000), comprehensive AIDS programmes provide home-based care with community participation while two health centres and a referral hospital are supported. In Kibera, MSF also develops an urban health project based on a clinic constructed with community help and supplies organisational, material and technical expertise for treatment, prevention and health promotion. MSF also supports Mathare community dispensary and has provided training for 36 traditional midwives.

In November 1997, MSF closed nutritional programme in Garissa and Marsabit. In Marsabit, 22 supplementary feeding centres for moderately malnourished children and three therapeutic centres for severe cases helped save 2,000 children and a further 5,000 were vaccinated against measles.

Kenya hosts a large refugee population, mainly from Somalia and South Sudan. Funding cutbacks limited activities in Dadaab camp (pop. 120,000) in 1998 to epidemiological surveillance, preventive care and a nutrition programme. This includes support for nine health posts and Hagadera referral hospital with its operating theatre and therapeutic feeding centre. In February 1998, emergency interventions were carried out on behalf of 1,500 IDPs from Likoni and another 12,000 in Laikipia and Njoro. This consisted of measles vaccinations, drugs supplies and water and sanitation support.

In Homa Bay (Nyanza province), MSF targets a population with an estimated HIV incidence between 30 and 40%, as well as high TB rates. A three-year programme reinforces the national TB programme, improving blood transfusion security, and providing training and supervision in the treatment of STDs. Close by, Nyarongi dispensary has been upgraded into a health centre. The team works with the community to protect water points and provides training for traditional midwives.

Flooding and epidemics

A water and sanitation project was running successfully in Wajir district, Northeastern Province to help offset the

effects of drought when the area was hit by catastrophic flooding in October 1997. MSF responded to escalating mortality rates caused a malaria epidemic and severe malnutrition due to the exacerbated food situation. Teams provided supplementary and therapeutic feeding programmes for



photo M. Deliasse

under-fives and pregnant women and tackled the epidemic by opening a special unit in the local hospital, operating six mobile clinics and implementing a vector control programme. In Mandera, floods in early 1998 forced the extension of a nutritional programme covering 62,000 people to include therapeutic and supplementary feeding centres and general food distributions. In Nyanza province, MSF mounted a large-scale emergency intervention to counter a lengthy cholera epidemic that began in June 1997, but spread extensively. Teams in seven provinces had treated over 30,000 patients by end-May 1998, when the outbreak had begun to decline. In June, MSF still retained responsibility for cholera activities in Western province and monitored the situation in the other six, already handed back to the MOH.

International staff: 33
National staff: 183



POP. IN YEAR 1997
28 m
GNP PER CAPITA
280 USD
LIFE EXPECTANCY
54 yrs
0-5 MORTALITY RATE
71 per 1,000
POP. PER DOCTOR
0.05 per 1,000
LACK OF ACCESS
TO DRINKING WATER
47%



photo R. Job

ISLAMIC REPUBLIC OF COMORES

The first case of a cholera outbreak in the Comores islands, northwest of Madagascar, was registered in Grande Comore in January 1998. As heavy rains hit the islands, the number of new cases rapidly increased. MSF sent in an emergency team at the request of the MOH and set up cholera camps in two hospitals and a health centre. This consisted of organisational and technical back-up on the medical side, and logistical help included setting up an isolation area in each hospital, building latrines and washing areas, and ensuring waste collection and incineration, water supplies, etc. In April, MSF extended into prevention work consisting mainly of disinfecting contaminated households and raising awareness of sanitary measures to prevent infection. By mid-May, the number of registered cases had risen to around 3,800. The outbreak has been almost entirely limited to Grande Comore.

MADAGASCAR



CHILDREN NEED LEGAL PROTECTION

The deteriorating socio-economic situation has seriously affected even the most basic health care. STD prevalence is very high and Madagascar is on the verge of an HIV/AIDS explosion.

In Antananarivo, MSF works to improve access to health care for 4,000 street-children and children in institutional care, as well as around 400 women and children in a detention centre. In areas where children congregate, MSF has instituted 24-hour mobile paramedical teams identifying problems, providing health education and protection, and directing them towards a network of private doctors, treatment centres, pharmacies, a referral hospital and contact points in the main markets. Protection for abused children is strongly emphasised, as well as the application of a children's rights charter. The team ensures that children in institutional care or detained are monitored from a legal and social point of view. Awareness of street-children is being raised among institutions, ministries and municipal bodies. In 1998, MSF is also beginning to introduce psychological care into the programme. Another project encourages children to act more positively.

MSF also works on behalf of homeless families in Antananarivo, providing emergency night-time care via mobile para-medical teams. A sanitation programme in Ankasina shantytown (pop. 36,000) was handed over to a local NGO in December 1997. MSF was providing latrines and access to adequate supplies of clean water as well as hygiene education and disease prevention.

At the national level, MSF is actively involved in developing strategies responding to public health problems such as malnutrition and the prevention and control of epidemics.

International staff: 5
National staff: 60

POP. IN YEAR 1997
15.3 m

GNP PER CAPITA
230 USD

LIFE EXPECTANCY
56.5 yrs

0-5 MORTALITY RATE
93 per 1,000

POP. PER DOCTOR
0.12 per 1,000

LACK OF ACCESS
TO DRINKING WATER
68 %

COMPLETE DEPENDENCE ON HEALTH CARE ASSISTANCE

Ordinary Somalis continue to wait for their leaders to negotiate peace, if not for the whole country, at least for Mogadishu. The only public health care available depends on NGOs and UN agencies.

MSF continues to work in Kismayo hospital, the only functioning hospital with surgical facilities for a target population of 250,000. Programmes cover paediatrics, orthopaedics, surgery, TB and therapeutic feeding as well as out-patient consultations and training for medical staff. The team also provided consultations in an IDP camp outside Kismayo until its nomadic occupants moved on in March 1998. Although it is hoped to reach a sufficient level of hospital administration and medical management to run the hospital with only minimal input from international staff, there is a major lack of human resources. Many qualified Somali doctors and surgeons remain as refugees rather than return to this unstable country. Logistics, maintenance and financial administration have, however, been successfully handed over to local staff.

MSF is present in the north of Mogadishu, the divided capital, supporting

child clinic, an out-patient dispensary, an emergency ward and a district network of health posts.

A new approach aimed at avoiding the exploitation and extortion so often associated with Somalia is being tried out in Galkayo, Northeast region. This involves keeping the number of MSF local staff to a minimum and insisting that they remain the employees of the regional administration, rather than MSF. Instead of paying salaries, MSF supports the rehabilitated hospital, which re-opened in February 1998, with drugs, essential equipment, and training in diagnosis, treatment protocols and hospital management. A specialist provided training in cholera prevention and treatment prior to the start of the cholera season at the end of 1997.

Floods and cholera

MSF began an emergency intervention in November 1997 in response to floods that rendered some southern parts of the country inaccessible except by air. Teams provided consultations in Kismayo IDP camp and in small dispensaries in Jamame, Marere and Harquesa, three flooded villages in the Jubba valley. A cholera treatment centre set up in January 1998 in Mogadishu North had treated 2,169 cases by April. MSF also intervened when the cholera epidemic hit Middle Shabelle. The team took charge of epidemiological monitoring, and referrals to Jowhar hospital as well as setting up oral rehydration points in the district. The Kismayo team provided urgently required medical material for cholera treatment in Ras Chiambone village, 14 hours by boat from Kismayo. In the same area, MSF reacted to a suspected measles outbreak in March by establishing data collection points and intensifying the routine immunisation programme. A mass immunisation against measles was carried out in Jowhar district in May and June.

International staff: 22
National staff: 383



photo K. Bernstein - Somalia

a health centre offering out-patient consultations, mother-and-child health care and health education. MSF is in charge of the year-round chlorination of Mogadishu's main wells in Yashid district. In Jowhar, an MSF team focuses on primary health care. Activities include EPI, mother-and-child health, out-patient consultations, health education and epidemiological monitoring. In Aden Yabal, MSF runs a mother-and-

POP. IN YEAR 1997
9.8 m
LIFE EXPECTANCY
47 yrs
0-5 MORTALITY RATE
122 per 1,000
POP. PER DOCTOR
0.07 per 1,000

SUDAN

CRISIS IN SOUTH SUDAN



By May 1998 it was estimated that 930,000 people in South Sudan were facing a crisis situation due to two successive poor harvests, displacement and years of war. Global malnutrition rates of 30-40% had been established in pockets of Bahr el Ghazal and Western Upper Nile, indicating a serious situation. Teams were running nine feeding centres in early June and had admitted 5,000 children. Another poor harvest is anticipated due to late rains, indicating the need for at least one more year of significant food support.

MSF'S activities in South Sudan

Panarou, Upper Nile, was the focal point of a kala azar epidemic in the south that killed thousands. A recent assessment with Medair established a need for medical services and relief distributions, but only mobile interventions were considered possible. MSF completed a first distribution of 5,500 mosquito nets while Medair ran a mobile health clinic, but insecurity forced both teams to evacuate.

Until April 1998, MSF supervised TB, kala azar, brucellosis and nutritional programmes run by national staff in a health centre in Duar region, Western Upper Nile. As the security situation deteriorated, staff fled and MSF moved further south setting up 13 primary health care units between Ler and Nimne (target pop. 244,000) and conducting nutritional monitoring. In the first month a supplemental feeding programme admitted 751 children, of whom 265 were severely malnourished. Meanwhile, kala azar, TB and referral services continued in Ler during this period. Unfortunately, both teams had to evacuate on 29 June, due to insecurity spreading to Ler town. Although services had been handed over to the national staff, by 30 June the population had fled. Further east, MSF provides kala azar and referral services in Jaibor and Lankien for a target population of approximately 150,000.

Teams working in Akobo and Wangding counties (pop. 100,000), where many have suffered severely from the fighting, support Akobo's 68-bed district hospital and provide mobile activities in three primary health care units in Akobo district and two in Wangding. A water and sanitation programme began in January 1998 to drill ten boreholes. The primary health care programme expanded to Kaikuny and Watt districts in April. Two new health care units are being built to cover the basic needs of an estimated 50,000 people.

In September 1997, MSF began renovating Kajo Kaji hospital, providing essential equipment, training and relaunching activities in the rebuilt laboratory. Emergency prepared-

ness is also important. Assistance to IDPs in Maridi and Mundri counties focused on endemic disease control, managing a 48-bed rural hospital and TB treatment. This also covers measles vaccinations, training for traditional birth attendants and a primary health care centre in Bari camp, primary health care units in Kuluwe and Lacha camps and emergency preparedness for further IDP influxes. Up to 300,000 people benefited from these programme, which closed in March 1998 as other NGOs are now present and improvements have been made.

Assistance in Bahr el Ghazal

MSF has been working for four years, on and off, in the rebel-held areas of Bahr el Ghazal. In Tonj county, a team running a rural hospital in Marial Lou serving a population of 150,000 people provides out-patient consultations, including mother-and-child health, surgical, paediatric and maternity services. Mobile clinics offer EPI and out-patient services to the pastoralist community during the dry season, and there is support for five primary health care units.

Four teams offer primary health care and assistance in combating endemic diseases in Wau, Gogrial and Aweil East counties. A measles immunisation programme targets all under-fives. MSF monitors health and nutrition among IDPs and local populations and prepares for emergencies. A training project for community health workers in Mapel began in November 1997 and aims to train 15 people in the first year.

MSF's activities in the Jonglei region are also managed by the South Sudan mission. The team which supports a health centre and six primary health care units in Panyagor, close to the front-line, has often had to be evacuated. As many of the target population live in the region's swamps for food and security reasons, mobile health staff were recently trained and dispatched there to meet health needs. A 1998 water programme focusing on remote IDP settlements has drilled nine new boreholes and renovated three existing wells since January. The team

POP. IN YEAR 1997
27.3 m
GNP PER CAPITA
480 USD
LIFE EXPECTANCY
51 yrs
0-5 MORTALITY RATE
85 per 1,000
POP. PER DOCTOR
0.9 per 1,000



photo R. Job



photo R. Job

concentrates on training local staff in basic health, EPI, mother-and-child health and laboratory work.

MSF's activities in North Sudan

MSF's activities in four official camps housing some of the 1.9 million IDPs around Khartoum cover dispensaries, medical consultations, mother-and-child health, water and sanitation. A therapeutic feeding centre operates in Mayo camp. MSF advocates against forced displacements and helped persuade the authorities relocating 400 families in September 1997 to distribute cards entitling each family to a plot of land and secure access to health care and water.

With a dramatic increase in the potentially fatal disease kala azar in Umm Kurra, Gedaref state, since September 1997, the two MSF treatment centres predict a rise in patient numbers from 3,261 patients in 1997 to 10,000 in 1998. MSF provides blood testing, treatment and consultations in support of local health organisations battling the disease in South Sudan.

In neighbouring Blue Nile state, an undeclared cholera epidemic that killed hundreds at the beginning of the 1997 rainy season was only discovered in September. MSF donated a cholera kit for future emergency

use and a programme began in February 1998 supporting national agencies assisting up to 25,000 IDPs.

MSF's mission in North Sudan is also responsible for the administration of the programme in Dilling, South Kordofan, where MSF supports three health centres providing consultations, epidemiological surveillance, training, ante-natal care, distributions of drugs and medical material, and sanitation. A recent hospital programme aims to improve hygiene, sterilisation, water and sanitation. MSF also runs a health centre with some in-patient facilities in Meyram, West Kordofan, focusing on out-patient consultations, vaccinations, growth monitoring, in-patient and emergency care. Supplementary and therapeutic feeding activities are also provided. A sanitation programme runs in the town and three mobile clinics cover surrounding villages.

In May 1998, MSF started a programme providing curative services in Wau's civilian hospital, EPI and drugs distributions. Additional services had to be set up following a dramatic rise in the number of people returning to the town after fleeing in January.

International staff: 58
National staff: 414

TANZANIA



POP. IN YEAR 1997
30.8 m

GNP PER CAPITA
90 USD

LIFE EXPECTANCY
50.5 yrs

0-5 MORTALITY RATE
86 per 1,000

POP. PER DOCTOR
0.03 per 1,000

LACK OF ACCESS TO WATER
50%

photo MSF - E

CHOLERA OUTBREAK FOLLOWED RAINS

Although health planning is good, including a decentralisation project, implementation is impeded by the lack of economic resources and epidemic outbreaks.



Tanzania faced cholera epidemics throughout 1997 and the first half of 1998 following torrential rains. MSF teams organised and supported cholera treatment camps in Kigoma, Dar-es-Salaam, Mtwara and Zanzibar. Activities included supervision, training local health personnel, drugs and medical material, an epidemiological monitoring system, and a water and sanitation programme. In mid-May 1998, heavy rainfall disrupted Dar-es-Salaam's water system and another cholera outbreak occurred.

MSF is developing long-term projects improving access to health care in Mtwara

and Kigoma districts. In Kigoma, where support for the 138-bed reference hospital in Kasulu covers 126,300 refugees and 391,000 Tanzanians, activities include maternity, mother-and-child health, patient consultations, surgery and a pharmacy. Other projects focus on epidemiological warning system, water and sanitation, and emergency preparedness. In Mtwara district (pop. 197,700), support to three 15-bed health centres and 29 dispensaries covers training, mother-and-child health, drugs and medical supplies,

construction, refurbishment and equipment of health structures and an epidemiological monitoring system.

In May 1998, in response to a malaria outbreak, a project began in Kagera district to improve early and effective treatment of uncomplicated cases at village level, and case management for severe cases, and to reduce morbidity, especially among under-fives.

International staff: 16
National staff: 70

UGANDA



POP. IN YEAR 1997
20.2 m

GNP PER CAPITA
180 USD

LIFE EXPECTANCY
41 yrs

0-5 MORTALITY RATE
122 per 1,000

POP. PER DOCTOR
0.04 per 1,000

LACK OF ACCESS TO WATER
62%

SLEEPING SICKNESS ENDEMIC IN NORTH

The north and west of the country continue to be unstable as a result of attacks by rebel groups. There are an estimated 400,000 internally displaced people.

MSF implements AIDS programmes in Adjumani and six districts of Kampala with an emphasis on prevention. In Karamoja hospital, Pokot county, a team is renovating buildings, providing primary health care support for 40,000 Pokots returning from Kenya, training personnel and supporting the management team.

Medical relief was provided to 70,000 IDPs in Kitgum (North Uganda) throughout 1997, and continues in Bundibuyo (Southwest Uganda) with assistance to 60,000 IDPs and support to the hospital and 13 dispensaries.

MSF focuses on trypanosomiasis (sleeping sickness) in Omugo, Moyo and Adjumani in the north of the country, with a target population of 400,000 people. This

disease is endemic to Uganda and has become one of the country's major health problems. The programme covers a treatment centre in Omugo that also carries out active detection. In Adjumani and Moyo, MSF is integrating trypanosomiasis-related activities into the health system and collaborating with the local authorities in Moyo to monitor the global situation in North Uganda.

An emergency intervention ran for several months after the MOH solicited MSF's help in fighting the cholera epidemic that broke out in December 1997. As of May 1998, 29,300 patients had been treated.

International staff: 35
National staff: 213

WESTERN AFRICA

A F R I C A



BENIN



POP. IN YEAR 1997
5.5 m
LIFE EXPECTANCY
53.7 yrs
0-5 MORTALITY RATE
90 per 1,000
POP. PER DOCTOR
0.06 per 1,000

TEAMS TREAT CASES OF BURULI'S ULCER

Benin has no national health system. There is a lack of trained staff and modern equipment and preventive medicine is not widely practised.

In September 1997, MSF began a project in Benin targeting an infectious disease known as Buruli's ulcer, caused by the development of a bacteria (*Mycobacterium ulcerans*) in the cutaneous tissues. BU affects a mostly young, rural population and appears to be spreading in West Africa, yet is little known to either medical personnel or the public. No medication seems to be successful and the most effective treatment is surgical removal and skin grafts. In collaboration with the Benin health authorities, MSF is setting up a specialised treatment centre integrated into Lalo health centre in Mono department (pop. 767,854), the region most affected by this disease. A specialised ward will offer hospitalisation for up to six months, although it is hoped that early diagnosis will reduce the time

required. Training is given to nursing staff carrying out the very specific treatment required and to community health workers spreading information encouraging sufferers to come for treatment in the very early stages. MSF ensures the availability of the necessary drugs, medical and teaching materials, transport for patients and nursing supervision.

The research aspect is conducted in collaboration with Antwerp Tropical Medicine Institute and aims to develop ways to reduce patients' suffering and fight the frequently occurring osteomyelitis for which amputation is the only treatment.

International staff: 2
National staff: 10

BURKINA FASO



POP. IN YEAR 1997
10.7 m
GNP PER CAPITA
230 USD
LIFE EXPECTANCY
46.5 yrs
0-5 MORTALITY RATE
103 per 1,000
POP. PER DOCTOR
0.03 per 1,000
LACK OF ACCESS
TO DRINKING WATER
22%

HEALTHCARE FOR NOMADS

Health coverage is poor for much of the mainly agricultural and pastoral population of Burkina Faso and epidemics are frequent.



photo A. Durrant - Guinée

In the health district of Djibo, Soum province, in the north of Burkina Faso, MSF collaborates closely with the local authorities in a programme constructing and rehabilitating infrastructure, providing material, and setting up depots of essential medicines for the largely nomadic popula-

tion. MSF also ensures training and supervision for health workers and installs community health workers and traditional midwives. Another programme in the capital, Ouagadougou, is directed towards 600 street-children. A mobile team is working to improve their access to health care and to set up a reference system towards existing medical structures. The team, working in partnership with local organisations, encourages these bodies

to take on responsibility for the youngsters. The programme also has a social content directed towards reinserting the children into society.

International staff: 4
National staff: 10

EQUATORIAL GUINEA

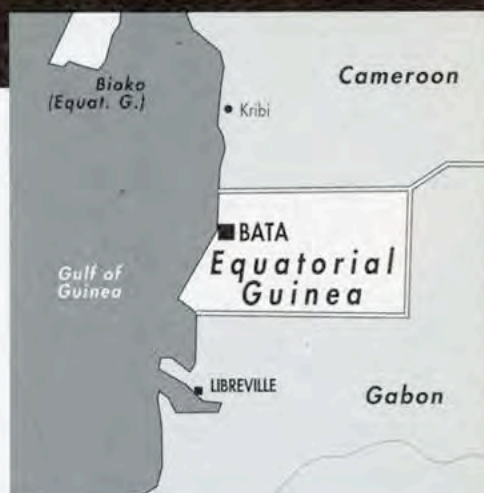
HEALTHCARE DETERIORATES

General Teodoro Obiang Nguema's regime continues to violate human rights. The health care system has deteriorated greatly since Spain withdrew assistance in 1994.

MSF continues to develop projects aimed at improving access to health care for the rural and urban population of Bata (target pop. 30,000). Activities in a health centre and in eight dispensaries include mother-and-child health, EPI, organisation and supervision of out-patient consultations, running a pharmacy, technical assistance, implementation of a health information system, and water and sanitation activities. MSF is also involved in a school health programme in cooperation with another INGO, Education Without Borders. This project targets 1,100 children and 25 teachers in nine schools in the northern part of Bata. Activities include training teachers in regard to health matters, developing a "Hygiene and Health" module for inclusion in the curriculum for the teacher training college

and "Health Education" didactic modules for primary school children. Educational facilities are also being renovated, which includes the construction of wells and latrines, and the installation of equipment.

International staff: 5
National staff: 25



POP. IN YEAR 1997
410,000
LIFE EXPECTANCY
48 yrs
0-5 MORTALITY RATE
117 per 1,000
POP. PER DOCTOR
0.28 per 1,000

photo MSF-E

NUTRITIONAL AID FOR REFUGEES

Ivory Coast has been a refuge to huge numbers of Liberian refugees during the long years of war. Now, they are beginning to return home.

MSF continues intensive feeding programmes in the 24-hour centre in Tabou, receiving an average of 100 children monthly, and a small day centre in Gozon health centre. The supplementary feeding programme for refugees in Gozon is also maintained. On the medical side, way stations were opened in the border area, monitoring refugee numbers and acting as vaccination points. In the Gozon 24-hour health centre, MSF ensures EPI, a monthly average of 3,500 consultations, 50 hospitalisations, 400 antenatal consultations and around 50 births. MSF is also in charge of four health posts, providing out-patient consultations and vaccinations for an isolated population. A cholera camp is installed in Tabou ready to function as and when required.

A cholera intervention was again required in July 1997 in an Abidjan detention centre where overcrowding (5,000 detainees are held in a facility foreseen for 1,500), and insufficient food and drinking water encourage the disease to spread. MSF has now started a longer-term project aimed at improving the nutritional status of detainees and their access to health care.

International staff: 9
National staff: 130

CÔTE D'IVOIRE



POP. IN YEAR 1997
14.0 m
GNP PER CAPITA
660 USD
LIFE EXPECTANCY
52 yrs
0-5 MORTALITY RATE
91 per 1,000
POP. PER DOCTOR
0.09 per 1,000

GUINEA



POP. IN YEAR 1997	7.5 m
GNP PER CAPITA	550 USD
LIFE EXPECTANCY	44.5 yrs
0-5 MORTALITY RATE	134 per 1,000
POP. PER DOCTOR	0.13 per 1,000
LACK OF ACCESS TO DRINKING WATER	45%

MEETING NEEDS OF REFUGEES

Guinea remains stable despite civil wars in neighbouring Liberia and Sierra Leone causing huge influxes of refugees.

MSF supports the health system in four prefectures in the eastern region where refugees live as neighbours with the local population. A team assists in immunisation campaigns and community-based condom distributions. Training is given to personnel managing epidemics, to anaesthetists and to those themselves involved in training nurses. Another programme focuses entirely on around 100,000 Liberian refugees in three of these four prefectures, monitoring general health, epidemic outbreaks and nutritional status, and immunising in response to a rise in the incidence of measles and whooping cough. MSF has an influential voice in decisions related to refugees, e.g. care for the most vulnerable and repatriations.

In Mamou prefecture, treatment in four health centres is being improved through

supplies of drugs to treat TB and kits for dealing with epidemics. A further three health centres and two TB detection centres are being constructed or rehabilitated, and training is provided in nursing care and in fighting epidemics. MSF supports the national TB programme in extending its coverage and integration into primary health care.

At the beginning of June, MSF was working in seven camps (total pop. 92,000) for recent arrivals of Sierra Leonean refugees fleeing deliberate attacks on the civilian population. Teams were providing water and latrines, vaccinations, health posts and, in three camps, therapeutic and supplementary feeding.

International staff: 6
National staff: 36

LIBERIA



POP. IN YEAR 1997	2.2 m
LIFE EXPECTANCY	39.4 yrs
0-5 MORTALITY RATE	200 per 1,000
POP. PER DOCTOR	0.11 per 1,000

POST-WAR HEALTH SYSTEM IN SHAMBLES

On 19 July 1997 Charles Taylor won through the ballot box what he had been unable to achieve through seven years of war: the presidency of Liberia.



photo R. Job

In the post-war situation, MSF adjusted its strategy to focus on reconstruction of the health system. In Monrovia, MSF has complete responsibility for the 165-bed Swedrelief hospital, while support to Redemption Hospital was phased out over a three-month period ending in September 1997. An MSF team continues to run a therapeutic feeding centre, but the supplementary feeding programme closed at the end of January 1998.

In Bong and Margibi counties, MSF teams are in charge of two health centres, each providing 2,500 consultations monthly, as well as nutritional and supplementary feeding. Medical and logistical support is provided to the county referral hospitals in Maryland (Harper), Bomi (Tubmanburg) and Lofa (Voinjama). Prior to MSF's intervention, the hospitals covered only a minimum level of medical activities. This support includes staff training, supplies of drugs, medical and non-medical equipment, management and supervision support, building renovation work, and improvements in water and electricity supplies.

In April 1998, MSF began preparing a site in Kolahun for 50,000 Sierra Leonean refugees. Medical and nutritional screening are given to refugees on their arrival and the team also provides supplementary and therapeutic feeding, sanitation and emergency water supplies.

International staff: 26
National staff: 680

HIGH INCIDENCE OF BLINDNESS

Mali's population of ten million is among the poorest in the world. The country's natural geography makes it subject to a large number of infectious and parasitic diseases.

In March 1998, an MSF mobile team concluded a three-month project aimed at improving immunisation cover for under-fives among 50,000 semi-nomadic people in Ménaka. Working in partnership with the MOH, EPI covered the main diseases. A much longer term project based in Bamako is projected for the whole country, again in partnership with the authorities. This comprises epidemiological monitoring, management of epidemics, immunisation and case-handling.

In Ansongo, in the northeast, MSF's efforts to strengthen the health system include support for training and supervision among health teams, supplies of essential drugs and rehabilitation of a peripheral health centre. In Koulikoro, eye care is integrated into primary health care and support provided for training and supervi-

sing medical and paramedical staff in ophthalmologic techniques in an effort to combat the high incidence of blindness arising from curable diseases. On the prevention side, the project aims to inform and raise awareness among a population of 1.733,000.

The Sélingué project in the southwest provides support for revitalising district health centres and creating community-based health centres. Training and supervision is again an important part of the project, which also ensures supplies of essential drugs and rationalisation of the cost-recovery system and health management in the region.

International staff: 13
National staff: 36

MALI



POP. IN YEAR 1997	11.1 m
GNP PER CAPITA	250 USD
LIFE EXPECTANCY	46 yrs
0-5 MORTALITY RATE	159 per 1,000
POP. PER DOCTOR	0.05 per 1,000

NEW IMMIGRANTS NEED AID

Maaouya Ould Taya had an easy return to power in the presidential elections in December 1997. The political situation is calm and the economic outlook has improved.

MSF is involved in a three-year programme in Toujounine, a recently settled neighbourhood lying ten kilometres from the centre of Nouakchott, the capital. The impoverished population of 79,686 is composed partly of migrants from rural areas escaping drought and famine, and partly of families displaced by floods in 1995. MSF's objective is to improve access to health care for both the local population and IDPs. The team is involved in a variety of activities aimed at improving primary health care, especially for women and children under five, ensuring that health structures meet national standards, supporting health service management and improving access to water and sanitation facilities. This includes the rehabilitation of the two existing health centres, the construction and equipping of a health post, and the installation of supplementary feeding units in the health centres. The team also trains personnel and provides education for the

population in regard to health and hygiene. On the sanitation side, the quality of drinking water is monitored periodically. This was particularly important between end-August and November 1997, when there was a significant increase in acute diarrhoea with the suspicion that cholera was present.



International staff: 5
National staff: 7

MAURITANIA



POP. IN YEAR 1997	2.3 m
GNP PER CAPITA	460 USD
LIFE EXPECTANCY	51.5 yrs
0-5 MORTALITY RATE	101 per 1,000
POP. PER DOCTOR	0.06 per 1,000

NIGERIA



POP. IN YEAR 1997
115 m

GNP PER CAPITA
260 USD

LIFE EXPECTANCY
50.3 yrs

0-5 MORTALITY RATE
84 per 1,000

POP. PER DOCTOR
0.19 per 1,000

MSF VIGILANT IN MENINGITIS BELT

Health services are inadequate for the population of 100 million. Consequently, infant and maternal mortality rates are amongst the highest in the world.

MSF is based in Lagos, from where it operates an emergency preparedness and response programme for epidemic outbreaks that is directed towards the whole country. This is necessitated by the increased incidence of infectious diseases such as meningitis, yellow fever and cholera. There are strong indications that these diseases may take on epidemic proportions. The programme's capacity was increased by the opening of an office in February 1998, in the northern city of Kano, which is situated in the Nigerian part of the "meningitis belt" stretching across a significant part of sub-Saharan Africa. MSF is organised and equipped to intervene in epidemic outbreaks whenever necessary.

A diarrhoeal diseases control programme continues in Amukoko (pop. 320,000), a poor slum area of Lagos, where MSF also supports a clinic. The programme's objective is to reduce the morbidity and mortality caused by diarrhoeal diseases, a major health problem throughout the country. MSF provides treatment for diarrhoeal diseases in public and private health centres as well as via community health workers. On the preventive side, the team focuses on schools and market places where it is building latrines, ensuring water supplies and providing health education.

International staff: 5
National staff: 17

NIGER

Three consecutive years of bad harvests led to an emergency medico-nutritional intervention by MSF in March 1997, in Tanout, Zinder department in the north of Niger. Focusing on feeding programmes for moderately and severely malnourished children, MSF provided training and supervision for personnel and was involved in the construction or renovation of shelters for supplementary and therapeutic feeding activities. The team's assistance also included vaccination and logistical help. By the end of June 1998, the feeding centres were operating independently.

GUINEA BISSAU

By the end of June 1998, between 200,000 and 300,000 people fled Bissau city as result of the conflict which broke out on June 7 between troops loyal to president João Bernardo Vieira and insurgents. There has been a huge displacement of populations towards the cities located along the main routes of the country. An MSF team arrived on 18 June to launch a medical programme. This is an area where cholera is endemic, and the lack of drinking water, food and medicines could lead to epidemic outbreaks and malnutrition.

photo S. Brucher - Niger



SURGICAL PROGRAMME CONTINUES

Although the Nigerian-led ECOMOG force overthrew the military junta in February 1998 and secured the return to power of President Kabbah, many parts of the country remain insecure and fighting continues. The previous nine months of almost total blockade aggravated the steady decline in the health system.



Southern Province
MSF is providing support in eight clinics and one hospital in Bo, two clinics in Bonthe, and in one hospital and six clinics in Pujehun. All of these clinics function with both MOH and MSF staff. In spring 1998, MSF began to reduce its involvement in the actual running and management of Bo hospital to concentrate on providing medical supplies, basic logistics, financial incentives to staff and training for maintenance staff.

photo Grossman

Since the coup d'état in May 1997, MSF has been running a surgical programme at Connaught Hospital in Freetown for war-related cases. The hospital received large numbers of wounded during the February 1998 ECOMOG advance on the capital and performed 15-20 emergency operations daily. Since April, casualties resulting from mass exactions against the civilian population in the east and northeast of the country reached Freetown and required surgery at Connaught (58 on 26 April). Many, including children, had suffered amputations at the hands of armed groups (70 out of 225 by end-May). MSF is protesting strongly against this practice of terror against civilians.

Also in Freetown, MSF provided medical, logistical and sanitation assistance in the IDP camps at Clay Factory (pop. 7,000) and Kossoh Town (pop. 2-3,000) throughout 1997. Emergency stocks are held in preparedness for a cholera outbreak.

Two MSF staff were kidnapped and held for a fortnight in February when taking medicines and water and sanitation equipment to 10,000 displaced persons east of Freetown. They were able to give medical assistance to displaced persons in the area in which they were held captive. Otherwise, the programmes in and around Freetown have continued during the emergency situation.

Financial incentives are essential in a situation in which staff receive little or no salary. A cholera camp is also maintained in Bo. The programmes at Bo and Pujehun hospitals continued with local staff under "remote control" during the emergency as the insecurity forced MSF teams to evacuate.

MSF gives logistical support and provides financial incentives to staff in the effort to re-start EPI in most areas of Southern province where it had been suspended for over a year.

Northern Province

In Kambia district, traditionally the bread basket of Sierra Leone, the MSF therapeutic feeding programme experienced an increasing number of admissions from December 1997, clearly indicating a rise in the level of malnutrition (50 children at the end of April). A further supplementary feeding programme covers 400 children. Other programmes have had to be postponed because of the continued fighting and Kambia continues with local staff under "remote control" during the emergency.

International staff: 26
National staff: 323



POP. IN YEAR 1997
4.3 m
GNP PER CAPITA
180 USD
LIFE EXPECTANCY
34.4 yrs
0-5 MORTALITY RATE
195 per 1,000
POP. PER DOCTOR
0.07 per 1,000
LACK OF ACCESS
TO WATER
66%



photo Grossman



SOUTHERN AFRICA

A F R I C A



ANGOLA



POP. IN YEAR 1997
11.2 m

GNP PER CAPITA
410 USD

LIFE EXPECTANCY
46.5 yrs

0-5 MORTALITY RATE
124 per 1,000

POP. PER DOCTOR
0.04 per 1,000

LACK OF ACCESS
TO DRINKING WATER
68%

COMBATING INFECTIOUS DISEASE

Prospects for the peace process look bleak as armed attacks intensified during the first months of 1998. The health service remains in ruins after almost 30 years of war.

The major objective of MSF's extensive activities in Angola is to rehabilitate and strengthen the health-care system in two-thirds of the provinces. The support provided to provincial and municipal hospitals varies according to size and need and may extend to supervision of all wards, as in the 300-bed hospital in Kuito. The assistance given to literally dozens of clinics and health posts focuses on general and mother-and-child health and includes activities such as training, TB projects, supplies of drugs and medical material, and management support. MSF also carries out nutritional surveys and runs feeding programmes such as those in Caala and Cubal hospitals. Vaccination programmes are another important aspect. MSF vaccinated around 30,000 people in Camacupa district, Bié province, in April 1998 in response to a meningitis outbreak.

Teams carry out essential work building new health facilities and renovating others (e.g. a new paediatric unit in Maquela and the conversion of Songo health centre into a hospital, both in Uige province). Water and sanitation teams are involved in projects in several provinces, including two centres in Kwanza Norte province

(Ndalatando and Quiculongo), where a sleeping sickness programme covers over 500,000 people. Active screening is also carried out in surrounding villages producing a significant increase in the number of patients treated.

International staff: 109
National staff: 484



photo R. Job

MALAWI



POP. IN YEAR 1997
10 m

GNP PER CAPITA
170 USD

LIFE EXPECTANCY
42 yrs

0-5 MORTALITY RATE
148 per 1,000

POP. PER DOCTOR
0.02 per 1,000

LACK OF ACCESS
TO WATER
63%

HIV INFECTION THREATENS YOUTH

Malawi has one of the highest incidences of AIDS in Africa, which it targets under a national prevention programme that began in 1992.

HIV/AIDS is the main focus of MSF's interventions in Malawi. Teams in Mwanzi, Chiradzulu and Thyolo districts (pop. around one million) are involved in treatment and prevention. MSF renovated the hospital and a number of dispensaries in Thyolo, and initiated a primary health care programme.

Lacking sterile and transfusion material, and providing no STD treatment, the country's impoverished hospital structures encouraged HIV transmission. MSF therefore trains hospital staff in hygiene and sterilisation techniques, supplies protective and other medical material, and training in its use, and monitors blood collections and transfusion practices. Drugs are provided to treat the opportunistic infections affecting AIDS sufferers and condoms supplied. Other AIDS-related hospital activities inclu-

de training supervision and teaching staff to offer psychological support. Prevention activities cover incinerator construction, improving health structure sanitation facilities, and drilling boreholes for health centres and local communities to reduce the incidence of water-borne diseases and improve access to safe water. "Anti-AIDS clubs" are formed to propagate prevention messages, and high risk groups are particularly targeted to persuade them to modify risky sexual behaviour.

MSF made an emergency intervention in March 1998 in Blantyre and Thyolo in response to a cholera epidemic. MSF was also asked to assist in an outbreak of plague.

International staff: 11
National staff: 52

IDPS & RETURNEES NEED ASSISTANCE

Although the ruling Frelimo party and the Renamo opposition have not resolved all their differences after 15 years of war, the government is working hard to exploit the country's natural resources and attract international investment.

MSF provides financial support for health personnel, supervision and drugs and medical material for seven health centres in Mutarara district, Tete province (pop. 185,000) and has built six houses for their nurses. In Mutarara hospital, the team began constructing a surgical block, surgical ward, delivery room and maternity ward. Elective surgery and Caesarian sections began in two operating theatres after renovations had been completed in April 1998. In Mututuine district, Maputo province, MSF has almost completed a project improving access to health care for IDPs and returnees. This included assistance to Belavista's health centre and six health posts with maternity facilities. There are 55 beds in all. MSF assists in the training of health staff, mother-and-child health, consultation supervision, and the construction and equipping of health structures.

In Gaza province, MSF's provides assistance in Chibuto district hospital and five health centres, as well as to PI and mother-and-child health teams (target pop. 170,000). This includes technical assistance, training for traditional birth attendants, the

construction of latrines and renovations to MOH health structures destroyed during the war. Health education in relation to STD/AIDS, malaria and diarrhoea is promoted via a theatre group. Water and sanitation (wells, latrines, rubbish pits, chlorinating) is an important aspect of MSF's work in N'gauma and Mandimba districts, Niassa province (target pop. 146,000 - half of whom are returnees from Malawi). Here again, a theatre group is promoting health education.

A cholera emergency

A cholera outbreak began in August 1997 in Maputo. When 1,000 new cases were registered in one week in November, the authorities called for international help. MSF responded immediately. In February 1998, cholera gradually spread northwards to the provinces of Sofala and Zambezia, where MSF also intervened. More than 40 volunteers took part in interventions that lasted until the end of May. MSF flew in a planeload of logistical equipment and medical supplies, including huge quantities of Ringer lactate, the product used to rehydrate patients, and set up 16 cholera camps. An important aspect of the work was the prevention of new cases. This involved the chlorinating of water supplies, waste disposal arrangements and hygiene education. MSF treated 35,000 patients over the six-month period.

MSF-CIS

The MSF Consolidated Information System was set up in 1992 and collects information on the health and nutritional situation throughout the country. This is a joint project now implemented by MSF's sister organisation, AEDES (European Association for Development and Health). The objective of the information-gathering is to enable national and international agencies to assess the severity of nutritional problems and food availability in order to define future priorities and actions required. Negotiations are underway to hand this project over to the government department dealing with natural disasters.

International staff: 19
National staff: 92



POP. IN YEAR 1997
18 m
GNP PER CAPITA
80 USD
LIFE EXPECTANCY
46 yrs
0-5 MORTALITY RATE
118 per 1,000
POP. PER DOCTOR
0.03 per 1,000



photo R. Job



EUROPE

JULY 97-JUNE 98



ARMENIA



POP. IN YEAR 1997
3.7 m
GNP PER CAPITA
730 USD
LIFE EXPECTANCY
71 yrs
0-5 MORTALITY RATE
25 per 1,000
POP. PER DOCTOR
3.83 per 1,000

photo R. Job

MODERN FAMILY PLANNING NEEDED

Despite a complicated and fairly volatile internal political situation, Armenia has had a peaceful twelve months. Changes introduced under a reform programme for the disintegrating health service have badly hit vulnerable groups.



ALBANIA

MSF focused on improving primary health care in the districts of Ballsh, Telepene and Permes in the south of the country, where the situation had deteriorated to the extent that many people were crossing into Greece for medical treatment. The current objectives are to improve the standard of equipment in the health centres, renovate the buildings, supply emergency drugs and renewable material, provide training in sterilisation and disinfecting techniques and support management. In June 1998, MSF responded to the influx of some 10,000 refugees in the Tropoje district of northern Albania by setting up a reception tent/way-station for them on a remote mountain side near the border. In order to anticipate the possible impact that the influx may have on the existing health structures, MSF has implemented a health data collection system. Most refugees have been housed with host families. MSF and OXFAM carried out a survey of the refugees' health as well as the water and sanitation conditions in this area.

MSF teams worked in the Noyemberian region until the end of 1997 increasing access to health care for the population with drug distributions, training in prescription techniques and data collection. An extended family planning programme covering three northern districts was launched in February 1998. Contraceptive methods are proposed to women of reproductive age in preference to the previous Soviet-style response: abortion. In Yerevan and in Gyumri, Shirak region, teams are involved in STD/AIDS activities including STD detection, updating treatment techniques in a specialised hospital, blood screening and information.

In Vardenis and Sevan psychiatric hospitals, MSF provides occupational therapy,

nutritional follow-up, management support and renovation work to improve long-term living conditions for patients. MSF set up a network for all those involved in this field to increase awareness of the need to humanise care for psychiatric patients and help reform their present legal status.

A street-children project in Yerevan focuses on children removed from the streets and placed by local authorities in two reception centres. Psychological assistance is provided for 400 children annually as well as material assistance (drugs, clothes, hygiene products) and training for personnel. MSF is again trying to humanise a situation in which abuse has occurred and is fully implicated in a national debate about street children.

NAGORNO-KARABAKH

Although Nagorno-Karabakh remains a potential flashpoint, both Armenia and Azerbaijan are influenced by a desire for a peaceful resolution of the conflict over the enclave, which is geographically and historically part of Azerbaijan but with a population now exclusively Armenian. MSF is working with patients in a TB hospital in Stepanakert, which is being renovated by the team. DOTS treatment is given free of charge. With an emphasis on passive detection, training is provided for medical and paramedical personnel both in DOTS and in sputum analysis. The target is to achieve an 85% cure rate for new TB cases annually.

AZERBAIJAN

LARGE DISPLACED POPULATION AT RISK

Reforms to rationalise and privatise the health system complicate access for the most vulnerable, including 700,000 internally displaced people from Nagorno-Karabakh.

MSF targets medical assistance to over half a million vulnerable people in Sumgayt region, including a large number of IDPs. This includes four free dispensaries, assistance to government health structures and raising awareness of prevention and treatment for common diseases. In several districts in Central Azerbaijan, where IDPs are widely dispersed, often living with local families, a team helps to train primary health staff and establish a vaccine cold chain. Training in reproductive health care is provided for gynaecologists and midwives, as well as management support in rationalising drug use. MSF set up a dispensary in Imishli and trains laboratory technicians with an emphasis on malaria identification. STD smear identification training was introduced in February 1998.

MSF implements a programme in six districts in the northwest, close to the border

with Nagorno-Karabakh. A team trains medical staff and midwives in family planning methods and works to improve the immunisation programme, including the establishment of an effective cold chain, in order to strengthen the weak links in existing MOH public health initiatives. A drug distribution programme covering 80 health facilities in these districts concluded in December 1997.

MSF assists the MOH and UNICEF with vaccination management and works with other NGOs and UN agencies to persuade the government to implement a national TB programme. MSF has run seminars and put together a manual on antibiotic management.

International staff: 17
National staff: 124



POP. IN YEAR 1997	7.6 m
GNP PER CAPITA	480 USD
LIFE EXPECTANCY	71 yrs
0-5 MORTALITY RATE	33 per 1,000
POP. PER DOCTOR	3.89 per 1,000

DRUG ADDICTS NEED HEALTH CARE

MSF targets the increasing number of unemployed, homeless and destitute people excluded from social protection and without access to health care, including drug addicts and illegal immigrants.



photo MSF - B

A mobile clinic offers medical-social consultations in Brussels, and from centres in Antwerp, Verviers and Liège, providing access to basic care and social welfare for the marginalised. The team refers those requiring further help for tests and hospitalisation. This project is being extended during 1998 to focus particularly on publicising the plight of the marginalised among the general public and advocating on their behalf through political, institutional and media contacts. MSF is working to ensure the implementation of the December 1996 decree regarding illegal immigrants which requires medical services to provide them with urgent medical assistance.

In partnership with a local association, another medical-social project targeting drug addicts among the marginalised offers methadone substitution and needle exchange, testing for HIV and hepatitis B and C, and facilitates contact with the welfare services. There is no state institution working on behalf of this group.

Staffing: 10
(including 30/40 unpaid volunteers)

BELGIUM



POP. IN YEAR 1997	10.2 m
GNP PER CAPITA	24,710 USD
LIFE EXPECTANCY	76.4 yrs
0-5 MORTALITY RATE	8 per 1,000
POP. PER DOCTOR	3.7 per 1,000

In 1998, MSF will close the Elisa Centre providing free anonymous HIV testing and information for those unable to address official structures directly, and psychological support to people identified as HIV positive and to their families. This 10-year-old project has successfully demonstrated the need for such facilities throughout the country and MSF is now working to convince the authorities to set them up within the health system.

BOSNIA-HERZEGOVINA



POP. IN YEAR 1997
3.6 m
LIFE EXPECTANCY
72.4 yrs
0-5 MORTALITY RATE
15 per 1,000

photo A. Kazimierakis

PSYCHO-SOCIAL PROBLEMS PERSIST

The military presence of NATO troops supposed to implement the Dayton Accords continues to ensure a precarious peace in Bosnia as the emergency situation comes to an end and physical and social rehabilitation begins.



CROATIA

Eastern Slavonia was reintegrated into Croatia on 15 January 1998 after two years of a UN-monitored transitional administration. Two MSF mobile teams provided curative health care to elderly and vulnerable populations in 12 remote villages in the region until March 1998. This was gradually phased out after a survey in November 1997 indicated a gradual improvement in health services. Prior to the closure of each clinic, the teams provided information and encouragement to patients to register in the state-run system. For many of the elderly, the teams had provided an important psychological support in the post-conflict situation.

Although the main drug distribution programme was gradually decreased, MSF continued to provide insulin and related materials to diabetic patients until the end of 1997. A mobile team also monitored access to health care by conducting a regular dialogue with health facilities, pharmacies and patients, passing on information about problems experienced locally and highlighting issues with the local authorities, and national and international organisations.

MSF continued to provide psycho-social care until the end of 1997 to 10 counselling centres set up in Sarajevo and Central Bosnia. They were then handed over to another organisation with the aim of eventually integrating them into the state-run

health system. Under MSF, the centres had treated approximately 8,750 clients. The centres are all staffed by local counsellors for whom MSF has provided continuing training, including visits by international experts in Post-Traumatic Stress Disorder. A mental health programme is still continuing in Gorazde, where MSF is attempting to meet the growing demands of institutions such as schools and homes for the elderly. Support also continues for Sokolac psychiatric hospital in Republika Srpska where MSF has now set up various activities, including group therapy sessions and social work with the families of patients.

International staff: 12
National staff: 55

POLAND

In July 1997, Poland was hit by torrential rains that caused the death of at least 80 people over several days and forced tens of thousands to flee their homes. MSF sent assistance to Wroclaw, one of the worst affected cities, where 15,000 were made homeless. As the lack of clean water made sterilisation extremely difficult, MSF distributed dressings, disposable gloves, needles, syringes, transfusion sets, jerry cans and disinfectant to nine hospitals. MSF also trained 60 child psychologists and other mental health professionals in dealing with post-traumatic stress disorder over a three-week period in August. They, in turn, trained another 60 people, including teachers and psycho-social workers, and so on until the end of the year when 300 had been trained. MSF also established a system of community-based mental health centres to which people could turn for help in coping with their flood-related psycho-social problems.

FRANCE

SOCIAL AND LEGAL AID FOR FOREIGNERS

Several laws were drafted in 1997 that directly concern the people for whom MSF is working. They deal with the rights of foreigners to enter and reside in France, access to health care and the problem of exclusion.

An MSF medical centre in Paris continues to offer free consultations to intravenous drug addicts. MSF promotes the distribution of its free kits (sterile material, disposable syringes and condoms) as the only way to lower infection risks. Team members assist addicts in their approaches to administrative and medical authorities and there is regular contact with hospitals in order to improve access for them and ensure equal treatment. Mobile teams provide information, and distribute kits and condoms among the most marginalised addicts living (and often prostituting themselves) in the streets.

The MSF medical centre in Marseilles provides consultations for many denied access to health care (2,100 in 1997). The

social and legal support also available has already resulted in residence and work permits and health care access being granted to around 40 foreigners previously without official papers, many seriously ill. MSF organised a petition in Northern France that successfully reinstated access to health care for 160,000. As this right has not yet been fully implemented, the MSF medical centre in Lille continues to offer consultations. The Paris team also offers information and support to foreigners in regard to their social and legal rights and intervenes with the authorities when these are not respected and discrimination is experienced.

MSF staffing: 32
(including 20 unpaid volunteers)



POP. IN YEAR 1997
58.3 m
GNP PER CAPITA
24,990 USD
LIFE EXPECTANCY
78 yrs
0-5 MORTALITY RATE
7 per 1,000
POP. PER DOCTOR
2.95 per 1,000

BULGARIA

The MSF mission was set up mid-May 1997 following an exploratory mission launched at the request of the transitional government. The regional hospitals and several municipal hospitals in the particularly needy provinces of Targoviste and Kjustendil (pop. 320,000) are kept supplied with drugs and basic medical material that is either bought in Bulgaria or brought in from other European countries. MSF takes charge of the transport, storage and distribution. The team also advises the hospitals on the management of their pharmacies. Priority is given to ensuring availability of the most commonly required drugs and material with a particular focus on the needs of vulnerable groups.

ETHNIC ALBANIANS TAKE FLIGHT

In 1998, a small radical movement known as the Kosovo Liberation Army took control of several villages in Drenica and Srbica. The KLA is seeking complete independence from the rest of Yugoslavia. The Serb army and a strengthened police force have been deployed in the rebel zone. Both sides are becoming increasingly violent.

MSF involvement remains concentrated in Kosovo where 90% of the inhabitants in Kosovo (1.8 million) are ethnic Albanians. Support continues for the ethnic Albanian NGO, Mother Theresa, the most reliable access to primary health care available. MSF distributes and monitors drug supplies and medical material to 40 clinics as well as to 15 official health facilities. Training is also provided for doctors and nurses of the Mother Theresa association. Since the armed conflict worsened in the spring of 1998, MSF has put two mobile medical teams in place covering the Drenica and Metohija regions. During the month of June, MSF's two mobile teams have provided 3,500 consultations.

Working with both Albanians and Serbs, the team is also trying to counteract the high incidence of infectious diseases such as polio

and TB and low rate of vaccination coverage. A support programme for EPI in 13 districts is improving the technical capacity of vaccination teams by supplying training and equipment, and encouraging vaccination among the population. A water and sanitation programme carries out rehabilitation work in ten villages in order to improve hygiene standards and thus reduce the risks of infection.

The mass arrival of up to 12,000 Kosovars in Montenegro has been contained because the vast majority have been invited to stay with host families. However, MSF has someone in place monitoring their health and laying the groundwork for any future influx.

International staff in Kosovo: 9
National staff in Kosovo 21

FEDERAL YUGOSLAV REPUBLIC



POP. IN YEAR 1997
10.3 m
LIFE EXPECTANCY
71.7 yrs
0-5 MORTALITY RATE
21 per 1,000

GEORGIA



POP. IN YEAR 1997
5.4 m

GNP PER CAPITA
440 USD

LIFE EXPECTANCY
73 yrs

0-5 MORTALITY RATE
23 per 1,000

POP. PER DOCTOR
5.50 per 1,000

EMBARGO HITS HEALTH SERVICES HARD

Although the economy is improving and UN-sponsored negotiations work towards resolving disputes with South Ossetia and Abkhazia, the political situation deteriorated sharply in February 1998 following an assassination attempt against President Shevardnadze and the kidnapping of UN personnel.

MSF works inside South Ossetia and Abkhazia, and on the Georgian side of the border with Abkhazia. The economic blockade imposed by Russia on the two would-be republics has impoverished their health services. The overall objective is to reduce soaring TB levels by introducing WHO protocols, renovating TB hospitals in Sukhumi (Abkhazia) and Tskhinvali (Ossetia), and drugs distributions.

In Abkhazia, 3,000 vulnerable people (mainly elderly, excluded Georgians and Russians without families) receive free medical consultations and drugs from an MSF dispensary and two social workers make home visits. A similar programme runs for vulnerable groups in Ossetia.

In Tchalendija, on the Georgian border with Abkhazia, a project to improve access to health services throughout the district includes health education, management training, pharmacy management, health structure renovations and maintenance, the quality of care and the health information system. The team also gives technical assistance and assists with vaccination programmes. Support focuses on two hospitals, a polyclinic and eight health centres.

An education and information programme in Zugdidi (Georgia) for the general



photo MSF - E

population and health personnel aims to improve access to primary health care. This includes specialised workshops and a teaching video. Efforts are also being made to improve and rationalise the drugs distribution system outside the main towns in this region.

International staff: 18
National staff: 114

ITALY



ASSISTANCE TO ROME'S GYPSIES

There are an estimated 5,000 Gypsies living in camps around Rome, many of whom are refugees. Their long-term presence is linked to recent events in the countries of Eastern Europe.

MSF works with around 1,500 Gypsies living in one of many unauthorised camps that have grown up around Rome. Prior to MSF's intervention in November 1996, the camp, known as Casilino 700, had no water or sanitation and no health care. Now, the municipal authorities in Rome have been persuaded to provide four tanks containing a total of 24,000 litres of water and to place rubbish containers from which collections are made at regular intervals. MSF has itself set up 70 latrines and offers free medical consultations. These are given in a mobile home moving between the different groups that have established themselves in the camp

according to their country of origin. The local health authorities now come to give vaccinations, but mothers have to take their children to the official centre for the second shot. The MSF team makes sure that they understand the importance of vaccinations and organises their transport to the centre. Transport is also organised to another centre giving antenatal consultations. In spring 1998, MSF started a training course for community health workers in order to involve the community more fully in promoting health education.

Staffing: 15

HEALTH & PSYCHO-SOCIAL CARE FOR HOMELESS

The "shock therapy" carried out by the coalition government in 1997 did nothing to aid a deteriorating health system suffering from shortages of drugs and equipment, an underpaid medical staff, an abnormally high infant mortality rate and a rise in the incidence of TB and meningitis.

In December 1997, MSF handed over a socio-educational support programme for 14 Rom (Gypsy) communities in Transylvania to Wassdas a Rom-Romanian NGO set up by MSF. An extensive evaluation carried out among the 2,600 Roma benefiting from the programme had confirmed a significant overall improvement in the level of social integration, a considerable increase in the number of children attending school, greater use of medical facilities, higher vaccination coverage and growing acceptance and use of contraceptives. MSF produced a guide for social workers, local authorities, NGOs, etc. based on the experience gained in working with this marginalised group. A survey was also produced, in collaboration with Cluj-Napoca university, demonstrating the

generally negative way in which the Roma are perceived and highlighting the importance of developing a national policy for them.

MSF now focuses on the increasingly large numbers of homeless, particularly migrants from other provinces. A centre, opened in December 1997 under an agreement with the MOH, provides medical consultations, showers and psycho-social counselling, and also organises food distributions throughout the winter. MSF is active in lobbying national and local authorities and the Romanian people in order to highlight the problems of the homeless.

International staff: 1
National staff: 10

ROMANIA



POP. IN YEAR 1997
22.7 m
GNP PER CAPITA
1,480 USD
LIFE EXPECTANCY
69.5 yrs
0-5 MORTALITY RATE
24 per 1,000
POP. PER DOCTOR
1.86 per 1,000

photo S. Van Praet

GREECE

Between November 96 and January 98, 4,800 people attended an MSF polyclinic in Athens and a smaller one in Thessaloniki. They are intended for those excluded from Greek society, economically and/or socially, mainly immigrants (representing 10% of the population). Whenever possible, MSF ensures their referral to state-run health services. The clinics provide primary health care including antenatal care, dental emergencies and drug prescriptions. Advice on social rights, (e.g. school registration) is intended to raise awareness and encourage integration. A December 1997 decree allows illegal immigrants to register for residence and work permits, but requires medical check-ups. As the decree is open to misinterpretation, MSF works to ensure that those suffering from life-threatening diseases will not be expelled to a country where no treatment is available but allowed to remain "for humanitarian reasons" and that work permits will not be refused to those suffering from a treatable infectious disease.



SPAIN



POP. IN YEAR 1997
39.7 m
GNP PER CAPITA
13,600 USD
LIFE EXPECTANCY
77.3 yrs
0-5 MORTALITY RATE
8 per 1,000
POP. PER DOCTOR
4.1 per 1,000

AIDING THE "FOURTH WORLD"

Although the economic situation is improving, Spain has the highest unemployment rate in Europe. A large number of people are living on the margins of the welfare state.

MSF has been developing a socio-medical project for the marginalised population of Barcelona known as the "Fourth World" since 1994. The target population is around 8,000 people, mainly drug-addicts, the elderly on low incomes, illegal immigrants and homeless. The team organises and supervises out-patient consultations and treatment in a mobile clinic with fixed stops in areas of easy access for the targeted population. The clinic acts as a first point of contact with the ultimate aim of integrating these people into the existing health and social welfare systems. During the winter of 1997-1998, "Operation

Cold" was launched to target the homeless, a difficult group to reach as they have no base. Consultations were organised every evening at city shelters for the homeless by an MSF doctor and nurse. This strategy made it possible to follow up on the health situation of those assisted and take the necessary steps to integrate them into the health and social services. There is a syringe exchange programme and condoms are distributed in order to prevent the spread of STD/HIV/AIDS. General health information is also provided.

MSF staffing: 5

RUSSIA



POP. IN YEAR 1997
148.1 m

GNP PER CAPITA
2,240 USD

LIFE EXPECTANCY
66.5 yrs

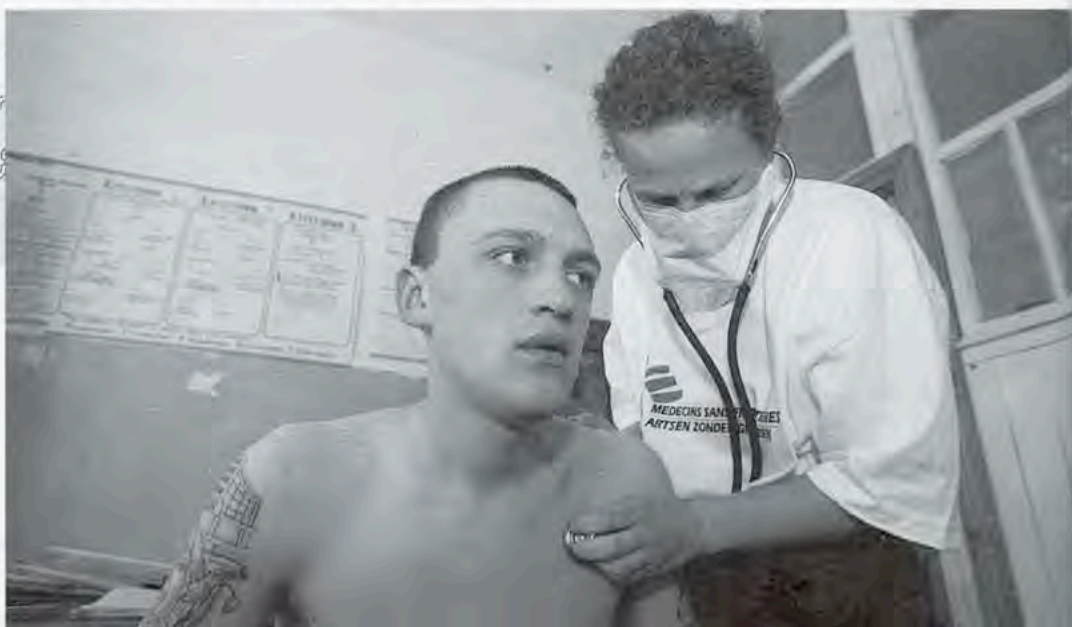
0-5 MORTALITY RATE
22 per 1,000

POP. PER DOCTOR
4.5 per 1,000

photo R. Job

FIGURES FOR HOMELESS SOAR

There continued to be a decline in the overall level of health care, including a steady rise in TB and STD/HIV/AIDS rates. The numbers of homeless already excluded from the minimal social welfare system continued to swell.



LUXEMBOURG

MSF runs a psycho-social and therapeutic project to assist minors with drug-taking habits likely to lead to addiction or those with behavioural problems who also use addictive substances. Together with two other local organisations, MSF has put together a team of experienced psychologists using a family-based approach. Much of the work consists of training staff in homes and holding centres for juveniles in dealing with drug-related problems. For example, reception centres that normally refuse minors taking psychotropic and other potentially addictive substances may be persuaded to do so if they can turn to MSF to provide training and specialised help when necessary. MSF's intention is to "coordinate" a network of existing organisations so that juveniles with drug-related problems do not fall through the net. In addition, MSF encourages the justice system to consider alternatives to residential sentences for such minors, including referring them and their families to MSF for consultations. However, MSF remains completely independent of the justice system and does not report to it - a point that is stressed to all potential beneficiaries of the programme.

MSF continues to work on behalf of marginalised and vulnerable groups in Moscow and St. Petersburg to improve the situation of the homeless and limit their exclusion from the health services. It is very easy to become homeless in Russia and although precise numbers are difficult to ascertain, there are estimated to be as many as 100,000 in Moscow and around 50,000 in St. Petersburg. MSF offers them free medical consultations, vaccinations and health education, ensures a referral system to hospitals for treatment, promotes hygiene and access to available services, and provides clothes when necessary. Free consultations with social workers aim to encourage their reintegration into society, give information about the different services available and guidance in approaching the authorities. MSF also organises general awareness campaigns focusing on the plight of the homeless.

TB rates soar

TB has reappeared to become a major scourge in Russia. The incidence rate varies from region to region, but Siberia appears most affected with a rate twice the national average. This is largely due to a prison population of over one million crammed into overcrowded and insalubrious prisons in which TB spreads rapidly (30% of TB patients in Siberia are ex-prisoners). MSF works in Mariinsk prison hospital in Central Siberia housing well over twice the number of patients it was intended for. Smear positive cases are specifically targeted as they are the most contagious. MSF instituted DOTS

and trains prison medical staff in its correct use. A similar programme opened in Novokuznetsk prison hospital in June 1998. An important element of this programme is raising public awareness about the prison TB epidemic and its consequences for the general population in order to encourage the authorities to take adequate measures to confront the problem.

An HIV/AIDS programme in Moscow includes a mass media awareness campaign, prevention work among injecting drug users, and training and information for health professionals. MSF also advocates for reform on HIV/AIDS prevention and other policy issues.

Chechnya

An MSF team continued to assist refugees from Chechnya sheltering in neighbouring Ingushetia until an MSF expatriate volunteer was kidnapped in July 1997, when work was terminated here and in Chatoi hospital in Chechnya itself. He succeeded in escaping after 15 weeks, but the worsening security situation also brought to an end MSF's involvement in North Ossetia and Dagestan. MSF keeps a close eye on the situation and is ready to intervene again in case of need. This falls under the emergency preparedness plan for manmade and natural disasters, which is an important function of the Moscow office.

International staff: 17
National staff: 85

CENTRAL AND SOUTH AMERICA

A M E R I C A



BRAZIL



POP. IN YEAR 1997
161 m

GNP PER CAPITA
3,640 USD

LIFE EXPECTANCY
66 yrs

0-5 MORTALITY RATE
47 per 1,000

POP. PER DOCTOR
1.18 per 1,000

LACK OF ACCESS
TO DRINKING WATER
27%

MALARIA & MALNUTRITION POSE THREAT

Land reforms in favour of mining and lumber interests, and a policy to resettle people from the overpopulated Northeast, have had a disastrous effect on Amerindian groups and small farmers.

As settlers have pushed the indigenous people off their lands, they have been forced into great poverty. There have also been large displacements of dispossessed peasants to the periphery of big cities, swelling the already huge numbers living rough or in favelas (slums). MSF works on

improve the distribution system for essential drugs and medical material, train community health workers and microscopists and establish a health monitoring system. MSF promotes inter-institutional working groups and indigenous organisations with a view to the eventual hand-over of these activities to the Brazilian authorities and local NGOs.

The total number of beneficiaries from this project is less than that of most MSF projects, but as no other organisation is working with this threatened group advocacy is an important element.

Rio de Janeiro

The favelas are rife with gangs of drug traffickers and the inevitable consequences that have led to an official policy of violent police raids. MSF tries to counter these problems of urban violence and social exclusion by an approach that aims both to improve health and to act as an interlocutor between the public authorities and the excluded. A pilot project on STD/AIDS prevention brings MSF into partnership with public authorities and local community groups in 15 favelas. The project provides a "condom bank", information/education and a link-up with the public health system treatment available for STD/AIDS.

In Vigário Geral favela (pop. 12,000), MSF has set up a health post providing primary medico-psycho-social care for children and adolescents, and a health co-operative for adults. In order to reach a level at which this can become autonomous, MSF is running a community management training programme for 17 participants from five favelas. MSF also continues to provide access to health care through five projects for street children. In Costa Barros favela, MSF runs a social integration programme for 1,000 re-housed families previously living under bridges and in transit shelters. Using a health-oriented approach, MSF encourages them to formulate and seek solutions to their problems.

behalf of both Amerindians in rural northern areas and marginalised groups in Rio de Janeiro.

Risk of extermination

As a result of their past isolation from common diseases and a failure to implement the national health system on their behalf, the Amerindian population of northern Brazil is at very high risk from, for example, malaria and the effects of malnutrition. Indeed, large numbers have already died among a group that is already comparatively small (0.2% of the total population).

MSF works on behalf of the Yanomamo and Javari groups in Roraima and Javaria states to reduce the five main causes of mortality, increase immunisation coverage,



photo M. Daniels



photo MSF - Bolivia

International staff: 52
National staff 17

BOLIVIA

BETTER HEALTH COVERAGE REQUIRED

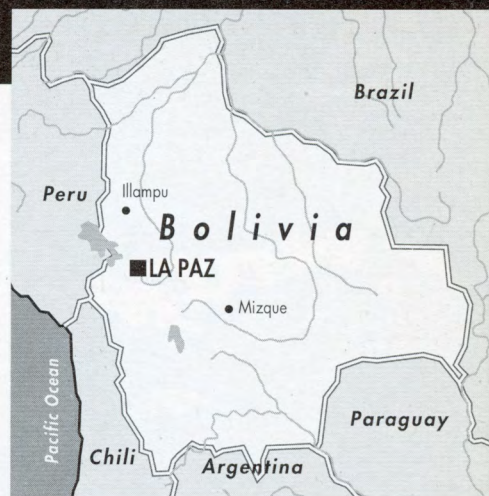
The former dictator, Hugo Banzer, returned to power in August 1997. The decentralisation of healthcare continues. Rural areas have suffered most owing to the lack of trained health care workers.

Since 1987, MSF has been carrying out projects in Bolivia that aim to improve access to health care for the indigenous populations. At present, MSF is running two long-term projects. In Illampu, the Aymara Indians are targeted via support to three hospitals, six health centres and 17 dispensaries. In Mizque, assistance is provided to the Quechua Indians via a hospital, four health centres and several dispensaries. Activities in both projects include mother-and-child health, training for traditional midwives and community health workers, the renovation and equipment of health facilities, drugs supplies and logistical assistance to the national vaccination programme. In total, over 180,000 people are assisted by these two projects.

In May 1998, MSF began a three-month emergency intervention in Beni and Pando, two departments in the north of the country following severe flooding that affected some 6,000 families. The main activity was the distribution of drugs and non-food items.

International staff: 8
national staff: 16

POP. IN YEAR 1997	7.6 M
GNP PER CAPITA	800 USD
LIFE EXPECTANCY	59.4 YRS
0-5 MORTALITY RATE	75 PER 1,000
POP. PER DOCTOR	0.43 PER 1,000
LACK OF ACCESS TO DRINKING WATER	34%



AID TO SCATTERED COMMUNITIES

Violence still dominates the mortality and morbidity statistics in Colombia where the population is subject to the vagaries of the armed forces, guerrillas, paramilitary groups and drug traffickers.

MSF is extending its work in the extremely violent Urabá region to cover a further 40,000 people. Many are victims of violence, including IDPs and indigenous peoples, traumatised by their experiences and with little or no access to basic health care. Mobile health brigades travelling in dug-out canoes provide emergency aid and basic medical care to scattered communities along the Atrato river. They also assess their mental health and the state of the health system, and are setting up an early warning system.

Projects in Silvia and Tierradentro, Cauca Department, aim to improve the rural indigenous population's access to health care. Activities include mother-and-child health, vaccination programmes, supplies of drugs and medical material and training for community health workers, traditional birth attendants and nursing assistants, as well as the construction, refurbishment and equipping of healthcare structures.

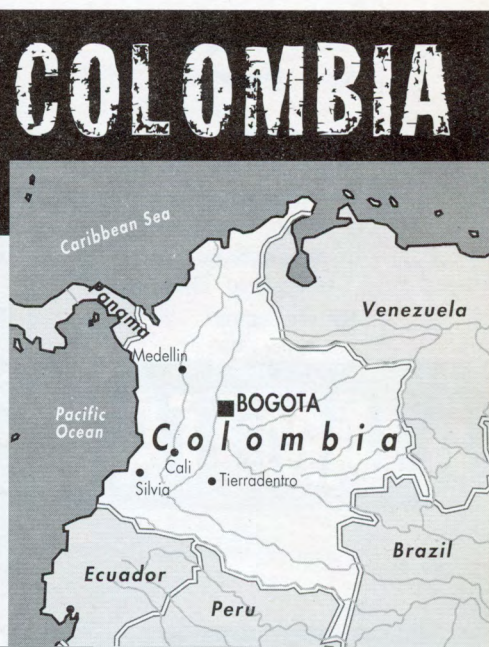
In the marginalised and violent Agua Blanca district of Santiago de Cali, MSF runs a rehabilitation healthcare programme for victims of violence, including psychological assistance. This includes a home visit system for recently discharged or chronic patients, physiotherapy, educational programmes for victims, their families and

professionals, and for schools, where the focus is on prevention. MSF continues an integrated reproductive and maternal healthcare programme aimed particularly at adolescents. This provides a range of pre-natal, post-natal and family-planning services, including psycho-social care and a support group for very young mothers.



In mid-1998, MSF launched an urban health project in the slums of Bogotá.

International staff: 9
National staff: 24



POP. IN YEAR 1997	36.5 M
GNP PER CAPITA	1,910 USD
LIFE EXPECTANCY	69.7 YRS
0-5 MORTALITY RATE	28 PER 1,000
POP. PER DOCTOR	0.95 PER 1,000
LACK OF ACCESS TO DRINKING WATER	15%

CUBA



POP. IN YEAR 1997
11.0 m

GNP PER CAPITA
1,200 USD

LIFE EXPECTANCY
75.3 yrs

0-5 MORTALITY RATE
10 per 1,000

POP. PER DOCTOR
5.19 per 1,000

LACK OF ACCESS
TO DRINKING WATER
6 %

photo MSF - E. Ecuador

AIDS/STDS COUNSELLING REQUIRED

Cuba looks to tourism to boost an economy still suffering from the abrupt removal of Soviet subsidies reinforced by the effects of the Helms-Burton bill.



COSTA RICA

The MSF Regional Office for Emergencies based in San José, set up to provide a more efficient response to emergencies, covers all of Latin America and the Caribbean. The main objective is reactivity and appropriate response to disasters in co-ordination with affected communities and local authorities. The second objective is disaster preparedness and prevention through collaboration with local authorities, regional and international organisations. The meteorological phenomenon El Niño has been monitored closely and crucial information obtained from analyses was shared with MSF teams in the region and with headquarters in Europe. MSF also maintains a stock of emergency material in Costa Rica to facilitate rapid interventions in the region.

STD/HIV/AIDS are a priority for MOH policy in 1998. MSF advocates prevention and works with the authorities to set up an information and counselling centre in Havana that also provides training and education for health staff. MSF also donates condoms to local posadas (bars) and distributes them at concerts. Another project established a self-help/support group for AIDS-infected people in 15 municipalities of Havana. This includes the production of three manuals aimed at people with HIV/AIDS, their friends, families, and doctors. In September 1997, a similar project was launched for the province of Santiago de Cuba, where there is a high incidence of STD.

In order to reduce the incidence of diarrhoeal diseases by increasing access to clean water, MSF runs a water and sanitation

programme in Jose Martí district of Santiago de Cuba and a rainwater collection project for rural communities in Granma. Another project aims to reduce the incidence of intestinal parasites among communities in Cuba's mountainous regions and a pilot project supports the production of domestic filters to improve water quality.

MSF intervened in response to a dengue fever outbreak in the south of Cuba in July 1997 by donating spraying equipment and insecticides for vector control. MSF collected epidemiological data and was involved in a training and awareness programme among the general population.

International staff: 5
National staff: 19

ECUADOR

HEALTHCARE SERVICE LACKS RESOURCES

The health service is under-resourced and around 20% of the population only has access to traditional medicine.

MSF has been working in Cotacachi since January 1996. The objective is to improve access to health care for the rural ethnic minority of 15,000 people excluded from the national health service for cultural, geographic and economic reasons. The project aims to create a complementary healthcare service, integrating traditional and western medicine, and linked with MOH services. However, the continuous political crisis affecting all Ministries has made collaboration with the MoH very difficult. Activities developed include training for community sanitation and health personnel, mother-and-child health, the construction and equipping of a health training centre, and logistical support to MOH vaccination programmes.

In March 1998, MSF launched a three-month emergency intervention in Guayaquil to assist the population affected by floods resulting from the "El Niño" phenomenon. Five mobile brigades travelled to the affected communities to provide medicines and basic health care. In early June, MSF extended the intervention to assist

with a cholera outbreak that began when water levels fell.

International staff: 7
National staff: 36



POP. IN YEAR 1997
11.6 m
GNP PER CAPITA
1,400 USD
LIFE EXPECTANCY
69 yrs
0-5 MORTALITY RATE
50 per 1,000
POP. PER DOCTOR
1.3 per 1,000
LACK OF ACCESS TO DRINKING WATER
32%

photo MSF - E. Guatemala

SUPPORT FOR STREETCHILDREN

With public health expenditure well below the average for Latin America, only 34% of the population has access to health care and water-related diseases are common.

In Guatemala City, MSF continues to provide medical and psychological assistance in a day centre for adolescent street-children. MSF also ensures that adolescents in five detention centres have access to appropriate medical and psychological care and that their legal rights are respected. MSF encouraged the setting-up of a medical nursery for under-fives to help deal with large-scale problems of malnutrition, poor physical and mental health and mistreatment in the shantytown of Lomas de Santa Fez. Parents are kept closely involved so as to help them resolve family problems and improve child-rearing abilities. STD/HIV/AIDS prevention programmes are underway in the shantytowns of Milagro and Mezquital.

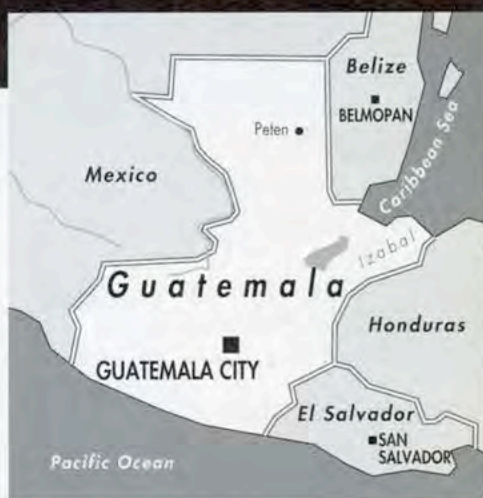
In March 1998, MSF completed a community health programme to improve

access to health care for the rural population in Izabal district. This included training, supervision and support for healthcare workers and traditional midwives, encouragement for using plants in traditional medicines and support for an independent system making basic medicines available at low prices. Other activities covered mother-and-child health, health education, the organisation and supervision of vaccination programmes, and water and sanitation projects (latrines, drains, waste collections).

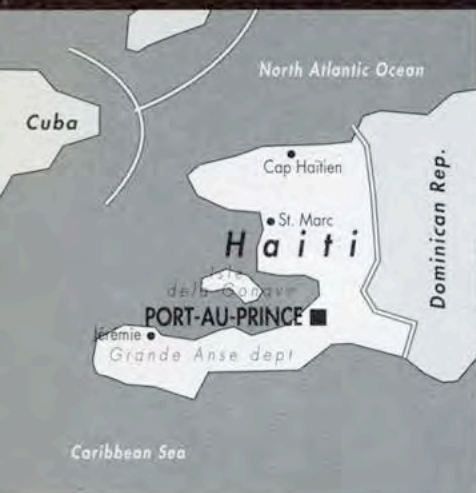
MSF provides medical support as part of three processing programmes underway for refugees returning to Peten.

International staff: 17
National staff: 88

GUATEMALA



POP. IN YEAR 1997
10.9 M
GNP PER CAPITA
1,340 USD
LIFE EXPECTANCY
65 YRS
0-5 MORTALITY RATE
48 PER 1,000
POP. PER DOCTOR
0.44 PER 1,000
LACK OF ACCESS TO DRINKING WATER
36%



BASIC HEALTHCARE & SANITATION NEEDS

Haiti remains heavily dependent on external aid. The only state-run hospital was paralysed by a doctors' strike for 25 days in August/September until Aristide intervened.



photo A. Kazinierakis

POP. IN YEAR 1997
7.3 m
GNP PER CAPITA
250 USD
LIFE EXPECTANCY
54.4 yrs
0-5 MORTALITY RATE
89 per 1,000
POP. PER DOCTOR
0.09 per 1,000
LACK OF ACCESS
TO DRINKING WATER
72%

In the face of structural problems within the health system itself, MSF's overall objective in Haiti is to ensure regular access to quality health care and basic sanitation for the most marginalised sections of the population. Great care is taken to ensure that the projects undertaken will be sustainable in the long term.

In six poor quarters of Port-au-Prince, dispensaries, public water fountains and latrines are being built or rehabilitated and support is given to dispensaries by instituting management committees, supplying essential medicines through a community pharmacy and training health workers. Assistance is also provided for setting up community health units for the 100,000 people living there.

In Jérémie, the focus is on guaranteeing access to surgical services for the population of Grande Anse department, improving care for women undergoing difficult births and ensuring that isolated rural communities have access to clean drinking water. In Sud department, training is provided for 10 logistician-administrators and a network is being set up to handle medical-surgical emergencies. In Saint-Marc, Desdunes and Grande Saline (pop. 200,000), financial and training support is given to the local health office for the implementation of an integrated health system focusing on mother and child health, essential drugs supplies, emergency preparedness, training and rehabilitation work.

International staff: 15
National staff: 29

HIV/AIDS PROGRAMME TARGETS YOUTH

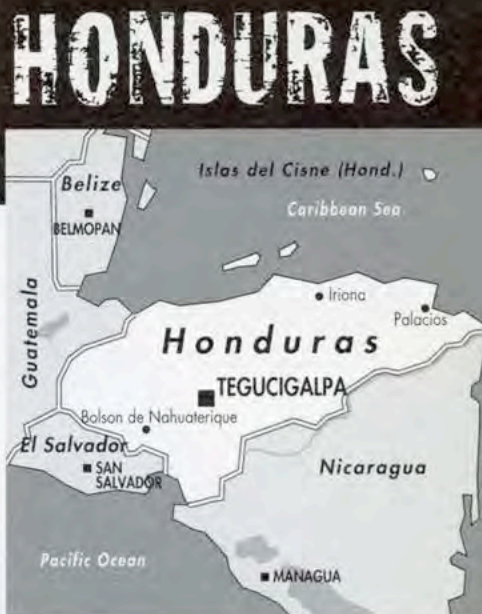
Many isolated areas have very poor access to health care, and the country has the highest incidence of AIDS in Central America.

MSF supports seven health posts in and around Bolson de Nahuaterique covering 15,000 people, including 1,500 Salvadorians remaining after a negotiated settlement with Salvador redrew the frontier in Honduras' favour in 1992. MSF relaunched health structures, assists with training and organising auxiliary health personnel, and encourages community mobilisation to improve access to health care. In Iriona, Colon department, a similar programme covers five health structures serving a very isolated population.

An urban health project in El Carrizal quarter of Tegucigalpa (pop. 110,000) aims to increase health care access by constructing a health centre providing in- and out-patient consultations and a maternity ward, supporting staff training, setting up a community pharmacy, and providing drugs and medical material. Other activities include mother-and-child health, vaccination programmes and an epidemiological monitoring system. A cost-recovery system will be implemented for both the health centre and pharmacy following a "health-care economy" survey carried out between March and June 1998 to discover how much people are prepared to pay for medical assistance. AIDS prevention is tackled through a continuing education programme.

Honduras is the base for a regional STD/HIV/AIDS programme that began in May 1998 and also covers Nicaragua and Guatemala. The general objectives are to train health staff on prevention and case management and to reach young people by training teachers and organising activities with students and parents.

International staff: 13
National Staff: 9



POP. IN YEAR 1997
5.8 m
GNP PER CAPITA
600 USD
LIFE EXPECTANCY
68 yrs
0-5 MORTALITY RATE
43 per 1,000
POP. PER DOCTOR
0.21 per 1,000
LACK OF ACCESS
TO DRINKING WATER
13%

photo MSF - E

HURRICANE PAULINE STRIKES SOUTH

Confident that new health reforms will transform the current health system, the government is reluctant to accept outside assistance. This is particularly the case in regions of unrest in which there are major groups of indigenous peoples, such as Chiapas.

Although MSF had no projects in Mexico when Hurricane Pauline struck the south coast province of Oaxaca in October killing more than 400 and making 300,000 homeless, human resources from the team in Guatemala and pre-positioned emergency stock from Costa Rica were soon on hand in the province of Oaxaca. As 90% of the wells on which the rural population depend for drinking water were contaminated by the consequent flooding, MSF responded to a government request for assistance in providing emergency water supplies and in disinfecting wells in the affected areas. The structures at the most basic level of health care were most affected: at least 300 of the 600 casas de

salud (rural health posts) were severely damaged and medical material destroyed or rendered unserviceable. MSF provided kits containing simple diagnostic equipment, medicines and medical supplies for two months. Excerpts from the MSF manual for health workers describing correct use of drugs, basic sanitation, diarrhoea, cholera, dengue and malaria were also included. Subsequent to this two-month intervention, the environmental health service of the MOH asked MSF to work with them on the development of an emergency preparedness manual.

International staff: 5



POP. IN YEAR 1997
92.7 M
LIFE EXPECTANCY
71.5 YRS
0-5 MORTALITY RATE
34 PER 1,000
POP. PER DOCTOR
1.64 PER 1,000

NICARAGUA



POP. IN YEAR 1997
4.2 m
GNP PER CAPITA
380 USD
LIFE EXPECTANCY
66.1 yrs
0-5 MORTALITY RATE
52 per 1,000
POP. PER DOCTOR
0.58 per 1,000
LACK OF ACCESS
TO WATER
47%

photo R. Job

HEALTH SERVICES NEED SUPPORT

The provision of medical services in Nicaragua is poor. As state hospitals lack medicines, even in emergencies the poorest have to buy from private pharmacies.



health centres/posts, training local personnel and ensuring community pharmacies, was completed in December.

In Managua, MSF continues to provide technical and financial support for primary health care and medical equipment, and for establishing community pharmacies ensuring access to reasonably priced quality drugs. Medicines are supplied from Managua to public health structures and other NGOs outside the capital. MSF works with national and local organisations on these urban programmes.

In August, a new programme began targeting the growing number of glue-sniffing street-children. A mobile team works in Managua's main markets, where this group tends to congregate, and basic health care is provided in a number of public and private institutions. Training is given to team members and educators working with the partner NGO. MSF also supports groups working to raise awareness of this issue and persuade public opinion that restrictions should be placed on the sale of these glues and their toxic content replaced by a non-addictive substance.

International staff: 5
National staff: 20

MSF has a well-established programme supporting health services in the Nueva Segovia department in Northwest Nicaragua. This includes community pharmacies (partial cost recovery) for the 70,000 inhabitants of Ocotal, Murra and Quilali, and training for midwives and health educators (including STD/HIV/AIDS). There are also clean water and hygiene (latrines and waste disposal), and health education (including in schools) projects. The El Cua Bocay project, refurbishing

PANAMA



AID FOR THE NGOBE

Despite continuing economic growth, the majority of Panamanians are not content with their government's policies. The health system does not receive adequate investment and many do not have access to health care.

MSF works in indigenous areas that are not included in MOH statistics when overall health indicators are published and are not fully covered by public health care programmes.

In March 1998, MSF concluded a project in the Soloy area, San Lorenzo district, that had been running since 1993. The project had achieved its aim of improving access to health care for 18,000 members of the Ngobe ethnic group living locally. Based in a hospital and nine health centres and health posts, a team provided technical assistance, the organisation and supervision of vaccination programmes, the organisation of epidemiological monitoring and

medical referrals. Building and rehabilitation work was also carried out in these health structures.

International staff: 3
National staff: 5

POP. IN YEAR 1997
GNP PER CAPITA
LIFE EXPECTANCY
0-5 MORTALITY RATE
POP. PER DOCTOR
LACK OF ACCESS TO WATER

2.7 M
2,750 USD
73 YRS
25 PER 1,000
1.24 PER 1,000
7%

FOCUS ON VICTIMS OF VIOLENCE

Peru, one of the most impoverished countries of South America, experiences widespread terrorism and guerrilla activity and now suffers from the compounded physical and economic effects of El Niño. Although MOH cover is improving, most of the population has no access to basic health care.

MSF focuses on displaced populations and returnees in remote communities in the Andes mountains and adjacent jungle areas, which are geographically isolated, suffer cultural and ethnic discrimination and are affected by violence resulting from political unrest and contraband trading. Teams work on behalf of 150,000 people in the departments of Ayacucho, Huancavelica, Junín and Cuzco, training community health workers, including traditional birth attendants, in order to upgrade the quality of care, and providing management support to the MOH at the local level. Additional support is provided during immunisation campaigns. In 1997, health structures were renovated and supplied with basic drugs and medical material. Water and sanitation support was also given.

MSF provides primary health care, focusing on mother-and-child health and training, to 50,000 in Satipo province, including 15,000 members of the marginalised Ashaninka ethnic group. Originally operating in three provincial districts and two Ashaninka communities, the project was extended in September 1997 to the Rio Tambo region. A similar project on behalf of a further 55,000 people operates since June 1997 in Acobamba and Angaraes provinces, Huancavelica department, and there is another in Rio Apurímac.

MSF continues to run several long-term projects in Amazonas, a vast area crossed by six rivers presenting huge logistical challenges. Teams visit villages with a houseboat. In Ucayali province, activities include training health staff for indigenous communities, mother-and-child health, construction, refurbishing and equipping health structures, and logistical support for MoH vaccination programmes. MSF is also involved in creating a community pharmacy and a project to provide wells. A similar project was completed in Requena province and handed over to a local NGO in January 1998.

Targeting AIDS

Health and sexual education directed towards children and adolescents in the marginal urban district of Villa el Salvador, Cono Sur, aims at reducing the growing incidence of STD/HIV/AIDS and very high TB levels, as well as unwanted pregnancies, violence and child abuse. Medical and psy-

chological consultations are also provided and a network of agencies and institutions is being established to co-ordinate referrals.

Another project, implemented with a local NGO, raises community awareness and knowledge of HIV/AIDS, particularly



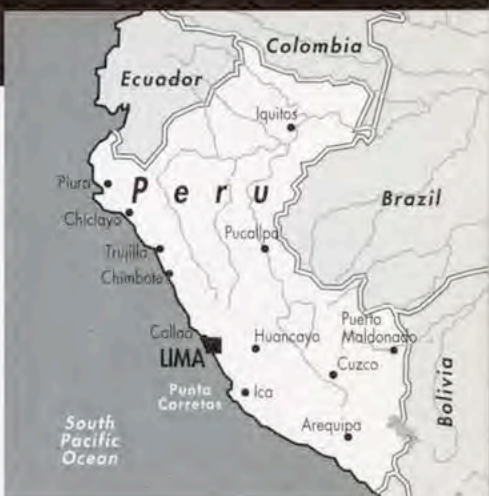
photo MSF-E

among adolescents, in Villa el Salvador and two districts of Cono Sur. Activities include street and school education programmes, and a televised counselling programme. Four Cono Sur districts are targeted in another HIV/AIDS programme assessing pregnant women aged 15-24 and counselling those at risk, HIV-positive and AIDS patients.

El Niño-related cholera outbreak

Exceptionally heavy rains caused extensive flooding, which led to a cholera outbreak in coastal areas from Lima northwards that so far affected around 30,000 people. An emergency intervention began in March 1998 and was still required at the beginning of June, when another outbreak occurred in Iquitos.

International staff: 17
National staff: 70



POP. IN YEAR 1997
24 m
GNP PER CAPITA
2,310 USD
LIFE EXPECTANCY
66.7 yrs
0-5 MORTALITY RATE
55 per 1,000
POP. PER DOCTOR
0.52 per 1,000
LACK OF ACCESS TO WATER
40 %

PARAGUAY

An MSF emergency team intervened in Paraguay in January 1998 with a three-month mission on behalf of around 30,000 people, mainly from among the poorest members of the population, made homeless by floods. MSF donated drugs, medical supplies and plastic sheeting and ran training courses for a selected number of community health workers, who then passed on information to those affected. A water and sanitation project provided pumps and built latrine and shower units. The team concentrated on camps for the homeless in Asunción, Concepción, Alto Paraguay and Pilar, where material could only be brought in by boat.



CENTRAL AND EAST ASIA

A S I A



AFGHANISTAN



POP. IN YEAR 1997

20.8 m

LIFE EXPECTANCY

43.5 yrs

0-5 MORTALITY RATE

163 per 1,000

POP. PER DOCTOR

0.14 per 1,000

LACK OF ACCESS

TO DRINKING WATER

88%

WOMEN REFUSED BASIC HUMAN RIGHTS

The Taliban movement remains in control of two-thirds of Afghanistan and only the northern provinces are held by the different factions of the Northern Alliance. Fighting continues to destabilise the area as the Taliban pushes for control over the whole country.

Although most Taliban-held areas are relatively stable, the humanitarian situation is deteriorating. Women are denied equal access to health care. MSF targets women, children, minorities and victims of the conflict in Taliban and non-Taliban areas. The overall objectives are: preventive and curative primary health care with a complete minimal package of activities, essential drugs and quality-controlled prescriptions; a surveillance system and emergency preparedness enabling an adequate and timely response to the medical consequences of emergency humanitarian needs in the region; advocacy for equal access for women to quality medical assistance as well as their right to practise as medical professionals; to increase international awareness both in regard to this issue and to the estimated ten million landmines scattered throughout the countryside.

In Oruzgan, one of the most isolated and traditional provinces in the south, MSF implements a primary health care programme focusing on women and children in partnership with a local NGO. MSF runs two comprehensive health centres (each averaging 80 female patients daily) and 12 basic health posts. As women's movements are culturally restricted in this remote area, MSF trains traditional birth attendants in hygiene and health education, and the clinics' staff is made up of Afghan women. To achieve this, the team has to negotiate constantly with Taliban leaders. In October 1997, public amputations were carried out on two men at Tarin Kowt bazaar by doctors sent by the MOH to set up a surgical programme. MSF deplores such activities.

MSF continues to provide medical, and water and sanitation services to approximately 12,000 IDPs in Shaidai camp who fled the fighting in Badghis province. In Ghuriani, a district west of Herat, MSF started a primary health care programme together with a local NGO. This includes a kitchen garden project showing how vegetables can be grown and used for nourishing meals. The high prevalence of malnutrition in Afghanistan is due more to lack of education than lack of food.

In Kabul, MSF supports four clinics and the 50-bed Karte Se hospital in regard to

consultations, in-patient care, mother-and-child health, vaccinations and a basic laboratory. The team fights to defend the right of local female doctors to work in the hospital. Support also continues in the 16-bed paediatric burns unit in Indira Ghandi hospital. MSF's work in Kabul is frequently complicated by Taliban interference, including threats to team members.

Following a detailed analysis of nutritional activities in Ghazni, the team is introducing modifications to feeding programmes based in the hospital and a new strategy for mother-and-child health in areas surrounding the town. The TB treatment programme started in April 1997 can now treat 120 people. MSF supports a 10-bed unit in Sarab clinic, Hazarajat province opened in November 1997, and another clinic opened near Gardan dewal in April 1998. Drugs were supplied to several clinics in Hazarajat as the year-long Taliban blockade continues.

In Taloqan, close to the frontline, MSF supports the 40-bed hospital with a medical and surgical programme and financial incentives for staff. An operating bloc has been built. The effectiveness of the training was proven not only when they assisted in Rostaq hospital in the earthquake emergency (see below), but also after an air attack on Taloqan caused several deaths and injured more than 60 civilians in May 1998.

Taloqan serves as a base for support to a clinic in Pul I Khumbri, Baghlan province, serving IDPs from Kabul, and for four clinics and the emergency department of Kunduz hospital. When a measles epidemic broke out around Kunduz in April 1998, the team responded immediately with a mass vaccination of 100,000 people.

In Maimana, Faryab province in the west, MSF is carrying out a preventive medicine programme including vaccinations in the clinics and a mass measles vaccination campaign. Training is provided for traditional birth attendants and support and drugs are supplied to four clinics.

An earthquake and other emergencies

At the beginning of February 1998, a powerful earthquake hit around 30 moun-



photo T. Voeten

tain villages in the province of Takhar, in Northeast Afghanistan, killing an estimated 4,000 people. MSF teams already present in the area were the first outsiders to arrive on the scene. They helped the most urgent cases in the hospital in Rostaq, the centre of the stricken area, and then went into the mountains searching out and evacuating the wounded to hospitals. The terrain and heavy snowfalls combined to make an already remote area almost impossible to reach. The emergency lasted for six weeks. A second and even more powerful earthquake struck the region at the end of May killing between 3,000 and 5,000. As it happened during the day, many lives were spared. An MSF team arrived the next day to coordinate the medical assistance to the wounded.

Emergency aid was provided for war victims in Panjshir province and further north between August and November 1997. Two volunteers intervened to relaunch and support health structures in the area, but had to withdraw for security reasons throughout the winter. A team responded immediately to flooding in 15 villages in

Northeast Afghanistan in April 1998 with distributions of plastic sheeting and covers for 6,500 homeless people, and followed up with measles vaccinations for 100,000 people. Such emergencies demonstrate the advantages of having MSF teams already in place to respond immediately. A less fortunate result of their proximity to the frontlines is that they are sometimes obliged to remain in their bunkers for days at a time, or even to make temporary withdrawals, and it can be extremely difficult, sometimes impossible, to get supplies through the fighting and winter snows. The team supporting four clinics in Mazar-i-Sharif distributed a three-month supply of drugs before having to withdraw in March because of the fighting. They returned six weeks later. Expatriate support can only be provided in summertime to a 20-bed clinic opened by MSF in Penjao (Hazaradjat).

International staff: 32
National staff: 60

BANGLADESH



POP. IN YEAR 1997
120 m
GNP PER CAPITA
240 USD
LIFE EXPECTANCY
55.5 yrs
0-5 MORTALITY RATE
91 per 1,000
POP. PER DOCTOR
0.08 per 1,000
LACK OF ACCESS
TO DRINKING WATER
17%

FORCED REPATRIATION CONTINUED

Repatriations to Burma reduced the number of Rohingya refugees so that only two camps remained in Cox's Bazaar.



photo J. Vink

July 1997, refugees boycotted food and medical care for two months. MSF is firmly opposed to forced repatriation and

In Nayapara camp MSF continued its aid programme for the refugees. This involved supplementary feeding and healthcare for pregnant and breast-feeding women and children under ten, including antenatal services and family planning. Vaccination, laboratory services, staff training and health education for refugees were also provided with the objectives of preventing, controlling and curing common diseases, improving the nutritional status and ensuring hygiene and safe drinking water. Following forced repatriations in

advocated on their behalf.

As refugee numbers declined, MSF expanded its activities towards the local population. Two health centres were set up in Cox's Bazaar district, serving a population of 50,000 people, to provide curative and preventive health care to local people. As this district is particularly susceptible to cyclones, the team is prepared to respond quickly by dispatching first aid kits.

International staff: 7
National staff: 140

BURMA (MYANMAR)



HEALTH SERVICE FAILS ETHNIC MINORITIES

Although, US and other Western countries continue to impose sanctions against the repressive military-led government in an effort to persuade it to free elections, Myanmar was granted ASEAN membership in November 1997.

Two new townships (pop. 250,000) have been formed in the Yangon (Rangoon) area. These are intended for people who have been forcibly displaced and relocated in an attempt to isolate insurgents from their population base. MSF is providing mother-and-child clinics and feeding centres in an attempt to decrease mortality in this group. The team is also ensuring supplies of essential drugs, as well as clean water and sanitation. AIDS, a fast-growing problem in Myanmar, is being countered here and in Rakhine and Kachin states by activities including education programmes, STD screening, therapy and promotion of the use of condoms. Two other programmes underway in parts of Rakhine and Kachin

states focus on controlling malaria through diagnosis, treatment and education with a particular focus on pregnant women and under-fives. Another two programmes beginning in other parts of Rakhine are intended to decrease morbidity and mortality among the most disadvantaged and to strengthen their coping mechanisms for the future. In order to meet these objectives, MSF is setting up village health systems that should reduce the incidence of communicable diseases and malnutrition rates, increase immunisation coverage and improve antenatal care and contraceptive advice.

LARGE SCALE HIV EPIDEMIC

National defence and security are the main priorities of the government, which has yet to make the important investments in health and education expected by the international community. The unstable situation in the west and north of Cambodia delaying planned refugee repatriations from Thailand was exacerbated after the death of Pol Pot in April 1998.

MSF has been working in Cambodia since only weeks after the Vietnamese withdrawal in September 1989. Teams are distributed throughout many parts of the country and their contribution represents a crucial element in the reconstruction of the health system. The following is an overview of the extremely large range of activities carried out over the past twelve months.

MSF has been the very active partner of the MOH for a number of years, assisting it to carry out its health reform programme. Teams are working in the provinces and the districts of Stung Treng, Kratie, Siem Reap Oddar Meanchey, Pursat, Banteay Meanchey, Battambang, Kompong Thom and Kompong Cham, as well as in the capital, Phnom Penh. MSF continues to provide assistance for refugees and IDPs. This takes the form of cross-border operations targeting camps in Thailand and the setting up of transit camps for returnees in Cambodia.

MSF is helping to get seven operational health districts underway, each one covering between 100,000 and 200,000 inhabitants. Although the reforms provide a boost to the MOH, they also conflict with the vested interests of bureaucrats at the Ministry of Finance and in the offices of the provincial governors, who would prefer to retain their roles as the intermediaries in the management of health budgets.

As Cambodia opened up to the outside world, it rapidly fell victim to a large-scale HIV epidemic. MSF is doing a great deal towards AIDS prevention by introducing a range of general precautions in the hospitals and by widespread distributions of condoms. MSF distributed more than 1.7 million condoms in 1997 on the basis of the "social marketing" principle. MSF teams are also ensuring medical and psycho-social care for those affected by AIDS and treatment for patients suffering from STDs. The training provided to medical and paramedical staff is another important aspect of this care and treatment approach.

In Phnom Penh, MSF is supporting home-based TB treatment through the use of the DOTS method and is implementing a national training programme for laboratory

technicians in the Technical School for Medical Care. MSF is also providing technical assistance for the implementation of a national programme to control a type of bilharzia called schistosomiasis mekongi in direct collaboration with WHO and the Basle Institute of Tropical Medicine.

International staff: 53
National staff: 30



POP. IN YEAR 1997
10.3 m
GNP PER CAPITA
270 USD
LIFE EXPECTANCY
52 yrs
0-5 MORTALITY RATE
116 per 1,000
POP. PER DOCTOR
0.10 per 1,000



photo Pellegri



REDUCED FUNDING FOR HEALTH

While a Western lifestyle is catching on in the big cities, economic reforms have resulted in drastic reductions in funding for health, welfare and education that have particularly affected the rural areas. Here, the public health system has collapsed and, in a country in which natural disasters are both frequent and severe, an estimated 500 million people have no access to safe drinking water.

In China, as elsewhere, MSF targets marginalised minorities. They can be divided into four groups: many of the 56 ethnic groups, some seriously affected by HIV, STDs, TB and malnutrition; drug users and prostitutes (both are illegal activities); the poor who do not have access to health care services and education.

Yunnan province (home to 36 ethnic groups)

Here, MSF is working to improve the health services provided to the rural counties of Xichou and Xundian (pop. 120,000) through training and supervising village doctors. A water and sanitation programme is underway in three villages in Xichou aimed at improving and protecting existing water systems, constructing biogas plants and increasing health and hygiene awareness. HIV/AIDS and STDs are targeted in the floating population of an estimated 300,000 in Kunming with the focus on education, medical care and advocacy.

Sichuan province

An HIV/AIDS/STD programme began in spring 1998 in Liangshan prefecture in the mountainous area of Sichuan bordering Yunnan, aimed at the Yi minority, drug addicts and prostitutes and the floating population. Many Yi come into contact with drugs and are infected with HIV when they seek work in the city. Their village communities are quite unprepared for dealing with this problem, as are the local health authorities. The intention is to increase knowledge about these diseases through training health workers and educating the population, as well as providing medical care for STDs and an advocacy effort aimed at changing official and general attitudes towards those affected. Another focus is on physiotherapy treatment and training for local doctors dealing with sufferers from Kashin-Beck ("big bone") disease among ethnic Tibetans living here.

Guangxi Autonomous Region

MSF is collaborating with the provincial health authority to renovate existing hospitals in rural areas and construct new ones, provide medical equipment for hospitals and for clinics staffed by village doctors, and train health care personnel. The team is also

setting up and implementing a collective insurance system aimed at meeting the national requirement to make health structures semi-autonomous. At the beginning of 1998, a celebration was held in Guosui township, Xincheng county, to inaugurate the completion of a new water pipeline. Neighbouring villages are being connected up to this network, which will supply clean drinking water for 12,000. Water and sanitation activities are also planned to accompany a medical programme in Lüzhou, Rongshui county, which includes construction of a referral hospital in Gongdong. Completed mid-1998, the hospital includes a small surgery unit and medical equipment supplied by MSF. MSF plans to continue drinking water supply projects in Xincheng and Shanling counties for another two years.

Qinghai province

A primary health care programme is underway in Nangqian county, Yushu prefecture, one of the poorest in Qinghai with a large dispersed Tibetan ethnic population. Training is being given to village and clinic doctors focusing on the main endemic diseases and renovation work has been completed in the county hospital and township clinics.

Emergency relief targeting a total of 80,000 people affected by severe snow storms was also organised in Yushu county. Food aid was distributed and medical kits provided to village and township doctors. Treatment was required for snowblindness, frostbite and diarrhoea.

An emergency programme was carried out in Hebei province following an earthquake in January 1998. The MSF team handled the procurement and transportation of essential antibiotics and monitored their distribution among the most needy 412,000 homeless survivors suffering from acute respiratory infections. MSF also provided emergency relief early in 1998 to Tibetans living in Yushu prefecture of Qinghai province suffering as the result of heavy snowstorms.

Hong Kong

The assistance programme for interned Vietnamese refugees ended in March 1998. MSF successfully advocated for a number of severely ill refugees to remain in Hong Kong



photo Fr. Mathieu

and others were allowed entry to some Western countries after the June 1997 hand-over to China.

The Autonomous Region of Tibet

The MSF team continues to train doctors and physiotherapists in the treatment of Kashin-Beck ("big bone") disease in Lhasa, Lhoca and Shigatse. Research is an important part of the programme for this presently incurable disease. Training sessions are held for doctors and medical supervisors on subjects such as the introduction and use of essential drugs, respiratory tract infections and diarrhoea, as well as sterilisation and hygiene in clinics. The drugs "revolving fund" cost recovery system has been suc-

cessfully implemented in two counties of Lhasa prefecture in order to guarantee the maintenance of sufficient drug supplies. The water and sanitation programme, now in its third year, is progressing successfully in collaboration with the village communities who are receiving clean water, and basic hygiene and health education. There have been 50,000 beneficiaries so far.

An MSF team made emergency distributions of antibiotics, snow-blindness and frost-bite medicines in Nagqu prefecture of Tibet, following exceptionally bad snowfalls last winter.

International staff: 42
National staff: 85

POP. IN YEAR 1997
1.2 bn
GNP PER CAPITA
620 USD
LIFE EXPECTANCY
68.5 yrs
0-5 MORTALITY RATE
44 per 1,000
POP. PER DOCTOR
0.94 per 1,000
LACK OF ACCESS
TO DRINKING WATER
54%

INDONESIA



TACKLING DROUGHT

The economy has been severely affected by the crisis in Southeast Asia. President Suharto left office in May 1998.



photo J. Bridle

INDIA

Although not physically present in India, MSF provides financial support to the Indian agency, Share and Care, for their work on behalf of around 250 under-fives suffering from polio and 175 children living in a Madras shantytown. The head of an MSF team based in Sri Lanka visits the projects twice a year in a supervisory capacity.

MSF trucked around 11 million litres of water to Gununk Kidul district in the Yogyakarta province of Java from early December 1997 to mid-January 1998 when rain ended the drought caused by El Nino. This project was implemented under the emergency plan submitted by the local authorities to central government. In March, an MSF project began to build or upgrade 520 water tanks for the most vulnerable members of the population, along with improvements to the water pipe network.

MSF supplies medical assistance to fire- and drought-affected areas in Irian Jaya province. Drugs and medical material are given to the MOH and MSF is involved in supervising storage and utilisation (decentralised distribution). A health education programme is implemented in close collaboration with the MOH, and MSF will also assist with epidemiological and nutritional monitoring.

Drought was also the reason behind MSF assistance in constructing 50 community-based water pumps in Central Lampung district of Lampung province in Sumatra, where 25 villages (pop. 100,000) lacked drinking water. The first part of this project began in March. A training programme on pump construction and maintenance started later. A health and sanitation programme to reduce outbreaks of endemic disease was introduced in close collaboration with the local authorities.

LAOS

HEALTH SERVICE NEEDS BOLSTERING

With the socio-economic indicators among the lowest in Southeast Asia, less than 20% of the largely agricultural-based population have access to even the poor quality of care offered by the public health structures.

MSF provides technical assistance to energize the health structures in the provinces of Champassak, Sekong and Bokeo. Teams work alongside local personnel and collaborate with district and provincial authorities to improve health services. Activities include basic curative and preventive care in health centres, medical training and preparation of treatment protocols. Medical activities are organised and supervised at district level, including EPI, an epidemiological surveillance system, and health information for villagers. A revolving fund for essential drugs is being developed to ensure stock replacements, as well as a cost recovery system. MSF's work is greatly appreciated by the authorities.

Management support is given to the provincial health service, and technical support to provincial hospitals and health centres, in Sekong province where the

population is mainly composed of underprivileged minority groups. MSF completed and translated a clinical and therapeutic manual, which was presented to the MOH with a view to its eventual use as a standard reference. An MSF economist worked with a national committee on the preparation of a guide to the practical implementation of a rolling fund for essential drugs and implementation of five provincial pilot projects.

In April 1998, MSF began a six-month assistance programme for four villages for lepers following the second consecutive year of flooding that ruined crops and resulted in serious food shortages.

International staff: 11
National staff: 19



POP. IN YEAR 1997
5 m
GNP PER CAPITA
350 USD
LIFE EXPECTANCY
51 yrs
0-5 MORTALITY RATE
97 per 1,000
POP. PER DOCTOR
0.22 per 1,000

RADIATION & POLLUTION POSE HEALTH RISKS

The Kazakh people are at risk from high levels of radiation resulting from nuclear weapons production and testing, and heavy industrial and agricultural pollution.

MSF activities in Kazakhstan focus on TB detection, treatment and prevention in order to reduce mortality and morbidity rates. MSF implements the DOTS method to ensure patients comply with treatment, thus reducing the high risk of drug resistance, and aim for a cure rate of 85%.

In Aksy, the MSF-equipped laboratory is fully operative. Extensive renovation and maintenance work (electricity, heating, water supplies and sewage work) was carried out in the hospital, which has been severely affected by health service administration changes. A new TB laboratory was provided for the dispensary in near-by Illy. MSF supplies medical equipment and TB drugs to both places. Laboratory technicians are trained and supervised in the sputum examination method.

A further TB and AIDS-prevention project is underway in a region 100 kilometres north of Shymkent (target pop. 55,000), where MSF has renovated, re-equipped and supplied a 40-bed TB centre and trained laboratory staff. The team co-operates closely with the health authorities in implementing passive case detection and treatment using DOTS.

In March 1998, MSF began working in the 135-bed TB ward in Nova Kazalinsk, Kizil Orda Oblast (pop. 610,000), concentrating on hygiene, sanitation and improvements to the laboratory, as well as training in DOTS.

International staff: 7
National staff: 21

KAZAKHSTAN



POP. IN YEAR 1997
16.8 m
LIFE EXPECTANCY
67.7 yrs
0-5 MORTALITY RATE
34 per 1,000
POP. PER DOCTOR
3.94 per 1,000

KYRGHIZIA



POP. IN YEAR 1997	4.5 M
LIFE EXPECTANCY	67.7 YRS
0-5 MORTALITY RATE	39 PER 1,000
POP. PER DOCTOR	3.3 PER 1,000

HEALTHCARE NEEDS REVAMPING

The health ministry is unable to undertake singlehandedly the drastic institutional overhaul required by the health system. It has therefore initiated the MANAS "plan", financed by various external bodies, to assist in health structure reforms.

MSF continues to implement a programme, integrated into the MANAS plan, responding to the alarming increase in STDs, particularly syphilis. There was a recorded rise of 700% between 1993 and 1996 in the Osh region alone. This is mainly a training programme directed towards dermato-venerological specialists in order to improve the biological diagnosis of STDs, as well as the drugs supply and treatment available, which is being brought into line with WHO protocols. Prevention and information activities focusing on STDs and AIDS are targeted at high risk groups (drug addicts, prostitutes, prisoners, young people) and the population in general. The programme is being

carried out in collaboration with 16 health structures dealing with STDs in the Osh region. Some renovation work is also being done and equipment supplied for a laboratory in Osh and an outpatient consultation room in Osh general hospital.

As there is a low incidence of AIDS for the moment (only 17 recorded cases in 1997), MSF hopes that a continued expansion of preventive action will keep numbers down in a part of the world with a generally high incidence.

International staff: 4
National staff: 11

PHILIPPINES



POP. IN YEAR 1997	69.3 m
GNP PER CAPITA	1,050 USD
LIFE EXPECTANCY	66.3 yrs
0-5 MORTALITY RATE	40 per 1,000
POP. PER DOCTOR	0.12 per 1,000
LACK OF ACCESS TO WATER	16 %

MSF TARGETS THE EXCLUDED

Although health care is theoretically free to everyone with a fixed address, all patients have to pay for drugs, x-rays and laboratory tests, and the homeless and street-children are excluded altogether.

WEEKLY consultations and treatment are available to street-children in five clinics set up in centres run by partner organisations in poor districts of Metro Manila, as well as in Molave prison for juveniles. The clinics, equipped by MSF and supplied with basic drugs, receive up to 600 children monthly. General health and

15 mentally-handicapped street-children.

In Davao, commercial sex workers, their partners and other high risk groups are targeted by an STD/AIDS programme, with partners and clients encouraged to attend a clinic set up by MSF. Although initially free of charge, a very limited cost recovery system was set up early in 1998, responding both to the request of patients themselves concerned to protect their dignity and MSF's decision to reinforce this as a health issue through a relatively symbolic financial participation. Prevention includes information and condom distributions, both in the clinic and by a team working directly in the streets and bars, which also advertises the clinic's existence.



photo R. Job

STD/AIDS education is given during consultations, or in the streets themselves and training is offered to para-medical personnel and social workers at the centres. Another Manila project assists a home for

An Emergency Preparedness and Response team was withdrawn in May 1998 as most objectives had been achieved including preparation of a manual for local NGOs. A new project in Sulu trains nursing personnel and distributes drugs to rural health centres.

POPULATION SUFFERS FOOD SHORTAGES

North Korea is one of the last bastions of communism. The agricultural sector faces significant structural problems and industrial activity has almost come to a standstill since the collapse of the eastern bloc, yet military expenditure remains disproportionately high. This situation, compounded by the effects of two years of flooding, has severely affected the nutritional status of the population.

It was this combination of factors that instigated MSF to start working in July 1997 in three southern provinces, South Pyongan, North Hwanghae and Kangwon, and, in spring 1998, in North Hamgyong, the first time a foreign aid organisation had been allowed to visit this northern province. MSF had previously intervened in North Korea after very severe floods at the end of 1995 and in early 1997. This time, the major needs were recognised as both nutritional and medical. In fact, there is a very high number of hospitals and medical doctors, but they rely on herbal medicine as medical material and Western medicines have been in short supply for years.

MSF supplied drugs and medical material to around 300 provincial, county and local health structures in each of the four provinces concerned. Korean doctors were trained in the use of these drugs, some of which were quite unknown to them (e.g. paracetamol, cotrimoxazole, amoxycilline). Part of MSF's guide to essential drugs was translated into Korean (covering 13 basic drugs for clinics and health centres and about 60 drugs for hospitals). They were also given information on simplified clinical diagnostic techniques as there was no functioning laboratory. In the three southern provinces, support was given to 30 district hospitals (each averaging 150 beds) and 150 clinics and health centres. In the northern province, support covered 17 district hospitals and 68 clinics and health centres. MSF teams set up around 40 therapeutic feeding centres in county and paediatric hospitals (for children of less than 80% weight-for-height) and trained many hundreds of health personnel to assess children by the weight-height method.

Although MSF has not directly observed people dying of famine, not all of the country is accessible to outside NGOs and thousands of children have required therapeutic feeding. In addition, all visits outside

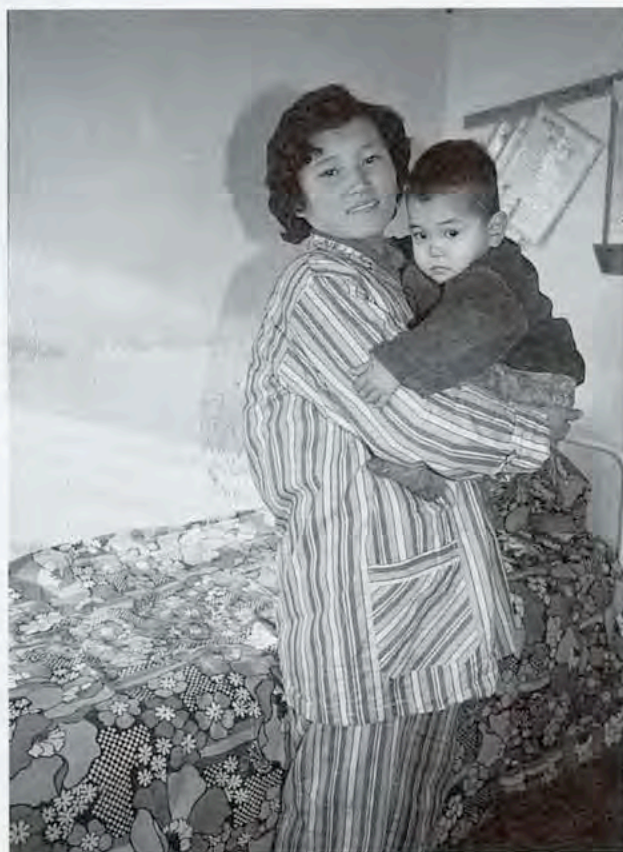


photo M. Wittebrood

the capital, Pyongyang, and all contacts with the population are very strictly controlled by the authorities and the lack of reliable empirical data (anyway treated as state secrets) has made it extremely difficult to measure accurately the extent and severity of the malnutrition problem in order to confirm or deny the claims made. MSF has consistently requested greater access to the population and freedom to carry out nutritional surveys and strongly encourages donors and all other INGOs working in the country to take a common stand in this regard.

As this report was being finalised, MSF was reviewing the extent of its intervention and considering a more limited and specific involvement that would concentrate on a medical approach and nutritional support for vulnerable groups (e.g. institutions for orphaned children).

International staff: 13
National staff: 17

POP. IN YEAR 1997
22.5 m
GNP PER CAPITA
9,700 USD
LIFE EXPECTANCY
71 yrs
0-5 MORTALITY RATE
24 per 1,000
POP. PER DOCTOR
2.70 per 1,000

SRI LANKA



POP. IN YEAR 1997	18.1 M
GNP PER CAPITA	700 USD
LIFE EXPECTANCY	72 YRS
0-5 MORTALITY RATE	18 PER 1,000
POP. PER DOCTOR	0.15 PER 1,000
LACK OF ACCESS TO WATER	43%

VICTIMS OF WAR & EMBARGO

As Sri Lanka celebrated 50 years of independence in February 1998, fighting continued between government troops and the LTTE force also known as the Tamil Tigers, seeking autonomy for the Tamil people.

MSF works in both government- and LTTE-held territory. A major problem is a military embargo that includes drugs and medical materials. MSF therefore advocates strongly for sufficient medical supplies to continue its work.

MSF is responsible for surgery, paediatrics and gynaecology/obstetrics in Mallavi hospital with 132 beds (and 80-100 patients on the floors). This is the referral centre in Vanni region for an estimated 450,000 civilians and lies only 12-15 kilometres from the main battlefield. Another team runs surgery and anaesthesia in Mannar hospital, serving around 300,000 civilians. Both teams also deal with large numbers of civilian war-wounded. MSF is in charge of surgery and paediatrics in Batticaloa hospital (3,400 interventions annually) and had

charge in Jaffna until May 1998. Surgery and anaesthesia are also run by MSF in Vavuniya hospital, the largest referral centre in the northern region (2,200 surgical interventions annually).

MSF expanded its work in the Tamil IDP camps in Madhu and neighbouring villages where a supplementary feeding programme was required to deal with rising malnutrition levels. Teams provide preventive and curative activities from a 27-bed rural hospital and mobile clinics. Another mobile clinic set up to serve Tamils in villages around Batticaloa is functioning well (51,000 consultations annually).

International staff: 37
National staff: 126

TAJIKISTAN



POP. IN YEAR 1997	5.9 m
GNP PER CAPITA	470 USD
LIFE EXPECTANCY	67.2 yrs
0-5 MORTALITY RATE	56 per 1,000
POP. PER DOCTOR	2.36 per 1,000

PSYCHIATRIC CARE NEEDS OVERHAULING

A major breach of the peace agreement occurred in March 1998 with a significant clash east of Dushanbe between government and opposition forces.



photo R. Job

the lack of specialists and the less than minimal investment. Focusing mainly on these two hospitals, MSF began distributing drugs, setting up patient care programmes and training staff supervisors. Building renovations are underway and food, bedding and clothes are supplied. The first major goal was reached with a dramatic fall in mortality rates over the past winter. MSF is expanding this programme and preparing to hand it over to the local staff and authorities.

In September 1997, MSF started an emergency programme for about 1,500 patients in mental health institutions after an August assessment revealed alarmingly high mortality rates (up to 30-40%) in the two largest psychiatric hospitals, one near Dushanbe and one in the north of the country. The mental health service is particularly in need of support because of the negative bias remaining from Soviet times,

In spring 1998, a programme began in the Karategin Valley providing drugs for rural health posts and preparing for an EPI by establishing a cold chain for vaccines and training for health staff, and by mobilising the community. It is hoped to reduce both the morbidity and mortality rates in this region.

International staff: 8
National staff: 45

HOME CARE FOR HIV/AIDS SUFFERERS

The disastrous economic situation in Southeast Asia has hit Thailand particularly badly resulting in cutbacks that affect the most vulnerable.



photo J.-L. Orban



In Surin province, MSF is developing a medical programme for people living with HIV/AIDS. This includes home care and setting up a network of people and organisations dealing with HIV/AIDS. A training programme began recently to improve the quality of health care offered to patients.

Along with TB, HIV/AIDS is the focus in

Chiang Mai province, with a strong community-based approach. MSF provides training in HIV/AIDS counselling, nursing care for patients in an MSF-run care centre and at home, and activities related to prevention. In Bangkok, home-based care for people with AIDS targets marginalised groups such as the very poor, women, children and migrant workers. MSF offers support, training and assistance in developing new strategies to NGOs, AIDS support groups and public health authorities, all of whom appreciate MSF's grassroots experience in this area.

International staff: 24
National staff: 18

POP. IN YEAR 1997	59 m
GNP PER CAPITA	2,740 USD
LIFE EXPECTANCY	69 yrs
0-5 MORTALITY RATE	32 per 1,000
POP. PER DOCTOR	0.23 per 1,000
LACK OF ACCESS TO WATER	11%

MSF has been assisting displaced populations fleeing the dictatorial Myanmar regime since 1984. Over the past year, MSF supported Karen refugee camps, particularly Mae Sod, which were subjected to a number of attacks over recent months. Similar support is provided to a very cramped Karen camp in Ratchaburi. In Surin province, MSF ran an emergency operation between July and October 1997 on behalf of Cambodians displaced by the fighting. This evolved into refugee assistance when they fled into Thailand. A team in Sangklaburi provides cross-border support to Mons refugees who returned to Burma in 1995 and are now IDPs.

VIETNAM



POP. IN YEAR 1997
75.2 m
GNP PER CAPITA
240 USD
LIFE EXPECTANCY
65.2 yrs
0-5 MORTALITY RATE
42 per 1,000
POP. PER DOCTOR
0.44 per 1,000

RESPONSE TO TYPHOON LINDA

The economic opening to the outside world that began ten years ago is beginning to bear fruit, but at the expense of the rural population as the government's capital investment programme puts peripheral health services at risk.



photo D. Wilson

The STD/AIDS project in Nha Trang continues successfully. The team targets prostitutes and intravenous drug users, the high-risk groups in this popular resort attracting foreigners. The MSF-run clinic, providing mainly STD/AIDS preventive and curative care, records 900 consultations monthly. The programme is expanding its prevention work towards reproductive-age females in general using an increased range of resources, including a telephone information line and school presentations.

Further south, in Can Tho, MSF supports a renovated community health centre providing a range of medical services, but recently focusing on antenatal care and gynaecology. STDs are also treated and an epidemiological study is underway prior to launching a more comprehensive STD programme.

MSF responded to an official appeal for help when South Vietnam was hit by Typhoon Linda in November 1997. A post-emergency programme in Ca Mau province is repairing damage to health structures in four districts and supplying them with drugs and medical material. Mosquito nets are distributed and water points chlorinated in order to prevent disease. As Ca Mau is criss-crossed by rivers, assistance for the affected communities has to be brought by boat. MSF ran a short-term relief programme in 14 health centres in Bac Lieu province until April 1998. The team gave 200 consultations daily and conducted medical, epidemiological and nutritional monitoring.

International staff: 10
National staff: 34

UZBEKISTAN



POP. IN YEAR 1997
23.2 m
LIFE EXPECTANCY
67.5
0-5 MORTALITY RATE
47 per 1,000
POP. PER DOCTOR
3.54 per 1,000

ENVIRONMENTAL DISASTER AFFECTS HEALTH

This region is the setting for one of the world's greatest environmental disasters, but the implications for human health are largely overlooked.

With the introduction by the former Soviet Union of a cotton industry into an inappropriate environment and poor water management practices in general, an environmental disaster has occurred: the drying up of the Aral Sea and gross deterioration of water, land and air qualities further upstream. This region, including areas of Turkmenistan and Kazakhstan, has one of the highest levels of anaemia in the world and possibly the worst TB situation in Europe and Central Asia. Acute respiratory infections (ARIs) and diarrhoeal diseases are the main causes of morbidity and mortality among children.

While international attention targets the environment, MSF targets five million people in the Aral Sea region. The focus is on TB patients in Muynak and Kungrad,

where MSF implements a DOTS pilot programme, and on reducing life-threatening complications for anaemic pregnant women during delivery in the districts' maternity hospitals. The team also works with health staff responsible for diagnosing, treating and monitoring ARI and diarrhoeal diseases. Improvements are being made in water supplies and sanitation in the health facilities.

MSF implements an epidemiological data system to improve MOH disease monitoring and health information systems. Operational research is beginning to promote greater understanding and acknowledgement of the health implications of this disaster for the region's populations.

International staff: 9
National staff: 25



EGYPT



POP. IN YEAR 1997
63.3 m
LIFE EXPECTANCY
63.6 yrs
0-5 MORTALITY RATE
67 per 1,000
POP. PER DOCTOR
0.76 per 1,000

HEALTH PROBLEMS OF STREETCHILDREN

Increasing poverty in the countryside has produced large-scale migrations to Cairo and the towns of Upper Egypt. Cairo in particular experiences chaotic informal development and lacks resources to meet even the basic needs of new arrivals.

The number of street-children rose dramatically in recent years, many having untreated diseases. MSF collaborates with a local partner in an effort to have them officially acknowledged and given legal protection. The team offers medical consultations in a Cairo drop-in centre and provides laboratory tests and medicines, as well as training for local staff. Although the increasing number of children come for clothes, food and to wash, they soon discover the MSF dispensary. Their main health problems are respiratory infections, parasitosis and trauma. Whenever required, MSF seeks to have them admitted to hospital. The team also provides health education focusing on STD prevention and the dangers of drug addiction.

In Cairo's Bassatin district, an MSF team worked through a health centre and locally-based groups improving access to health care, including reproductive health, for the most impoverished inhabitants of a slum area. Unfortunately, registration problems interrupted the project at the end of 1997, although part was taken over by the MOH. In Manshiet el Nasr district, work continues to improve the horrific conditions of 30,000 rubbish collectors living in intimate proximity to rubbish and pigs. This is a community development project targeting health and hygiene awareness and integrating various health-related services.

International staff: 4
National staff: 8



photo Ph. Degrauwe - Egypt

UNITED ARAB EMIRATES

MSF opened an office in Abu Dhabi in 1994 in response to an invitation from the UAE, and a second branch was opened in Dubai in 1998. The objectives are: to promote awareness of humanitarian ethics and promote understanding of the Arab world; to provide information on MSF's activities world-wide, but particularly in the Middle East, South Asia and North and Sahelian Africa; to recruit medical volunteers and to conduct private fund-raising.

REFUGEE ASSISTANCE REMAINS PRIORITY

Iran hosts one of the largest refugee communities in the world: approximately 2.2 million, most of whom are Afghan and Iraqi Shiites and Kurds. Only five percent live in official camps.



photo X.V.D.S.

MSF's assistance to refugees in Khorassan province continues to focus mainly on Gulshahr, close to the Afghan border in the northeast. MSF supports the health clinic serving the population of 100,000 Afghans and Iranians and operates mobile clinics among refugees living in the most under-privileged parts of Gulshahr (Gorgh, Hemat Abad and Al Tymor). Since July 1997, a team of 12 Afghan volunteers trained by MSF is providing a health education programme that makes it possible to evaluate the refugees' health status and their access to care. School visits are also included in this programme. The team ensures referrals to other levels of health care and follow-up on patients, and also supplies drugs, medical material, family planning and training.

In November 1997, an MSF team began a medical programme among 30,000 Iraqi refugees and a community of 40,000 Afghans in Khuzestan province, in the Southwest. A private clinic was opened in Ahwaz in February 1998, in collaboration with an Iraqi organisation, which should improve access to preventive and curative care for the refugee population. The programme includes building renovations, recruitment of local medical staff, preventive, curative and family planning activities,

referrals, supplies of drugs and medical materials and management of the pharmacy. A sanitation project is also running.

International staff: 8
National staff: 40



photo X.V.D.S.

POP. IN YEAR 1997
70 m
LIFE EXPECTANCY
67.5 yrs
0-5 MORTALITY RATE
43 per 1,000
POP. PER DOCTOR
0.32 per 1,000
LACK OF ACCESS
TO DRINKING WATER
10%

LEBANON



POP. IN YEAR 1997
3 m

GNP PER CAPITA
2,660 USD

LIFE EXPECTANCY
68.5 yrs

0-5 MORTALITY RATE
34 per 1,000

POP. PER DOCTOR
1.86 per 1,000

HEALTHCARE FOR REFUGEE CHILDREN

Peace accords between Israel and Palestine took little account of 356,000 registered Palestinians in Lebanon (and another 60,000 who are unregistered). Many have no access to health care.



In February 1998, MSF began working in Al Hamshari Hospital, run by the Palestinian Red Crescent in Saïda (Sidon) in South Lebanon, which targets the Palestinian population of two refugee camps (around 90,000 people), particularly children under 15 (39% of the pop.). The objectives are the creation of paediatric and neonatology services and a referral system towards them. The team also aims to set up a health monitoring system and a continuing training programme for hospital staff. An MSF paediatrician works beside local paediatricians and an MSF nurse pre-selects local nurses for specialised training. Both volunteers are involved in paediatric training and have set up a course covering resuscitation/intensive care, anaesthesia and paediatrics for the nurses' training school attached to the hospital.

International staff: 2
National staff: 3

YEMEN



POP. IN YEAR 1997
15.7 m

GNP PER CAPITA
260 USD

LIFE EXPECTANCY
55.5 yrs

0-5 MORTALITY RATE
92 per 1,000

POP. PER DOCTOR
0.9 per 1,000

MSF REACHES ISOLATED COMMUNITIES

Peace now prevails in Yemen. However, economic reforms initiated in March 1995 continue to make life difficult for the population and the public health sector is accorded an increasingly lower share of the budget.

MSF completed a five-year project in Dhi Sufal supporting the authorities in establishing a district health system including cost sharing and health information. MSF continues to participate in district health council meetings, district supervision and the preparation of drug orders, as well as technical advice regarding medical and administrative activities. The team provides furniture and equipment not otherwise available for the most recently completed health centre and organises activities there (job descriptions, national treatment protocols, pharmacy management tools, health information, etc.).

A five-year programme began in August 1997 to develop and improve primary health care services for the population of 82,000 in mountainous and remote Hazm Al

Udayn district, Ibb governorate. A district health care system is being established on the basis of experience gained in Dhi Sufal district. The Al Hazm health centre is now being turned into the district referral centre. Current activities include supplies of drugs and equipment, organisation, improving the quality of care and implementation of a cost-sharing system. A similar five-year programme is now running in Aden. However, this is set in an urban context, covering 12 health facilities (polyclinics, health centres, health units) and targeting a population of 370,000. Current work includes renovations, equipment, organisation, drugs supplies, evaluations and training.

International staff: 8
National staff: 24

PSYCHOLOGICAL SUPPORT CONTINUES

The Israeli government further colonised the Occupied Territories resulting in a dead-locked peace process and heavy clashes between the Israeli and Palestinian communities.

A psychological support programme to mothers and malnourished children continues in Hebron district at two levels: home visits in villages and therapeutic activities in facilities set up by MSF within nutritional support centres run by the INGO, Terre des Hommes. Psychologists also train community health workers and centre staff to recognise when psychological support might be needed in a mother-child relationship. It has taken two years for this work to gain acceptance within the very traditionally religious culture of Hebron. In January 1998, MSF initiated an academic research programme based on this work focusing on a clinical approach to the typical interactive patterns existing between the mother and malnourished child.

Also in Hebron district, the first primary health care project (16 health posts built and equipped and 19 new community health workers trained) was handed over to the MOH in February 1998. A second project then began to renovate the 50 so-called health posts that already exist and to upgrade the skills and training of 53 community health workers. The principal aim of these projects is to improve health conditions in the community with a particular emphasis on preventive medicine and mother-and-child health. This is being achieved through establishing treatment protocols, supplying basic drugs, developing the management of the pharmacy system at the district level, establishing a referral system and implementing a health information system. Community health workers are trained to set up and implement control systems in regard to pregnancy, growth in healthy children and immunisation, including anti-tetanus and detection of those at risk. They also learn to organise health education and to use home visits for the early detection of problems.

The Ministry of Social Affairs set up a rehabilitation centre for former detainees in 1996 in support of 7,000 people, of whom 4,000 live in Hebron. It was recognised that most were suffering psychologically as a result of their detention. Since March 1997, MSF promotes psychological help for ex-detainees requiring it and trained a psychological counsellor. The team has

drawn up a list of ten questions for social workers at the rehabilitation centre to use to identify those in need of help. This support is now being extended towards their families as well.

MSF has an ongoing programme in five villages in the Gaza strip aimed at the physically handicapped, numbering 2,706 out of a total population of 66,158 - a high percentage for a developing country. The programme is based on a specific rehabilitation plan for each individual and activities aimed at their social integration. It seeks to secure their access to health services and participation in community activities while promoting the principle of equal opportunities.

As tensions increased in the autumn of 1997, MSF ensured supplies of emergency kits for the main hospitals on the West Bank.

International staff: 16
National staff: 22



POP. IN YEAR 1997
1.9 m
LIFE EXPECTANCY
67 yrs
0-5 MORTALITY RATE
40 per 1,000



photo Marlène Stafilidou

MSF FACTS

MEDECINS SANS FRONTIERES is a private, non-profit international organisation. It is represented by nineteen national sections in Australia, Austria, Belgium, Canada, Denmark, France, Germany, Greece, Holland, Hong-Kong, Italy, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland, the UK and the USA.

Local staff: 10,000
International staff: 2,354
Fieldposts in 1997: 1,218

AID WORKERS IN THE FIELD

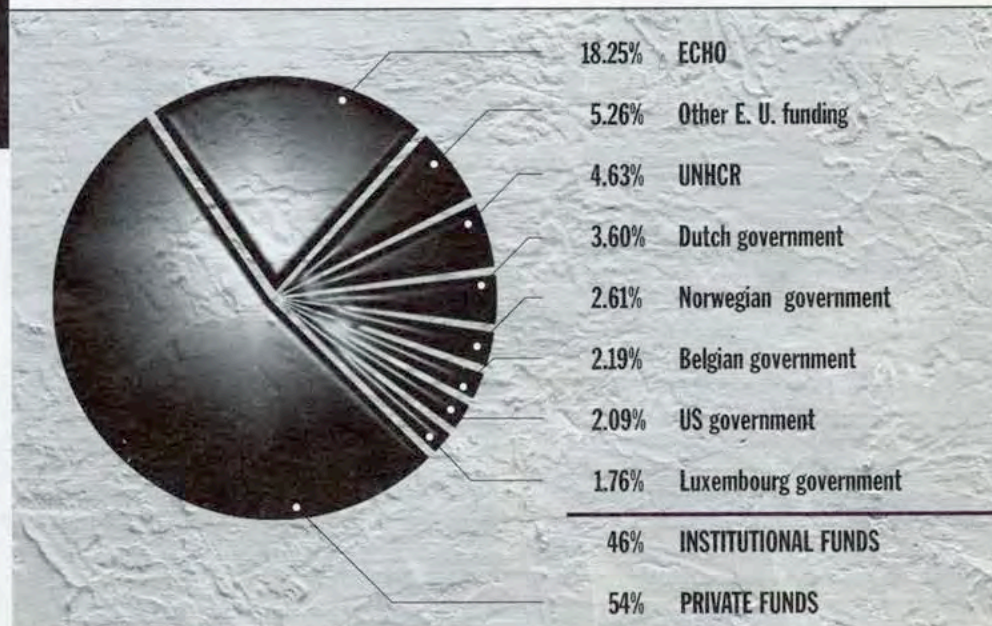


Total income:
231 million USD

In 1997, 54% of MSF's total income was provided by private donors (individuals, corporations, foundations...) -as opposed to 49% in 1996.

Grants from international organisations/agencies, and governments represented 46% of MSF's resources.

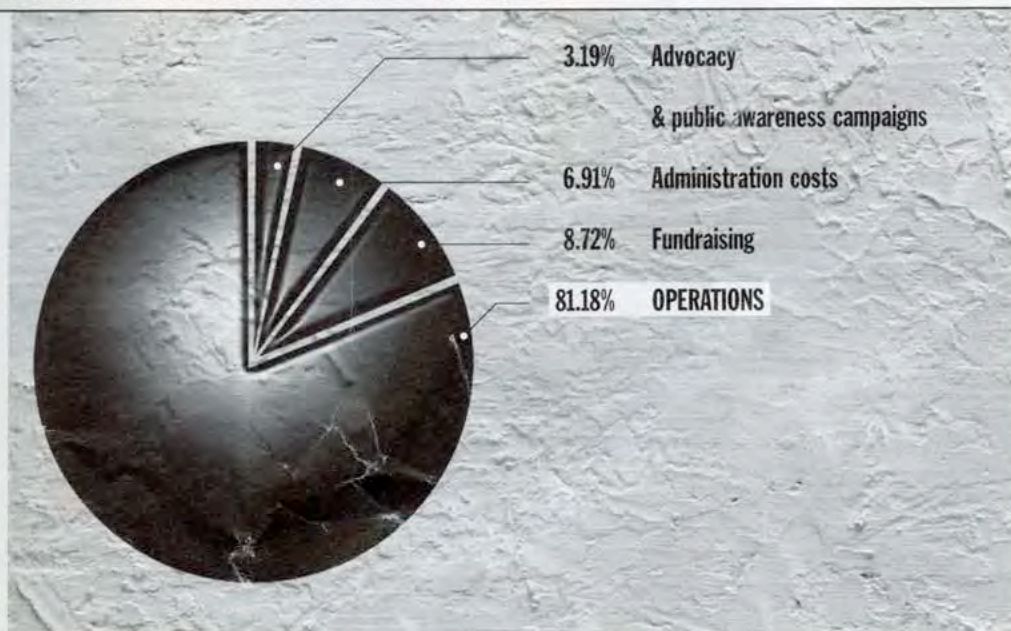
MSF'S INCOME



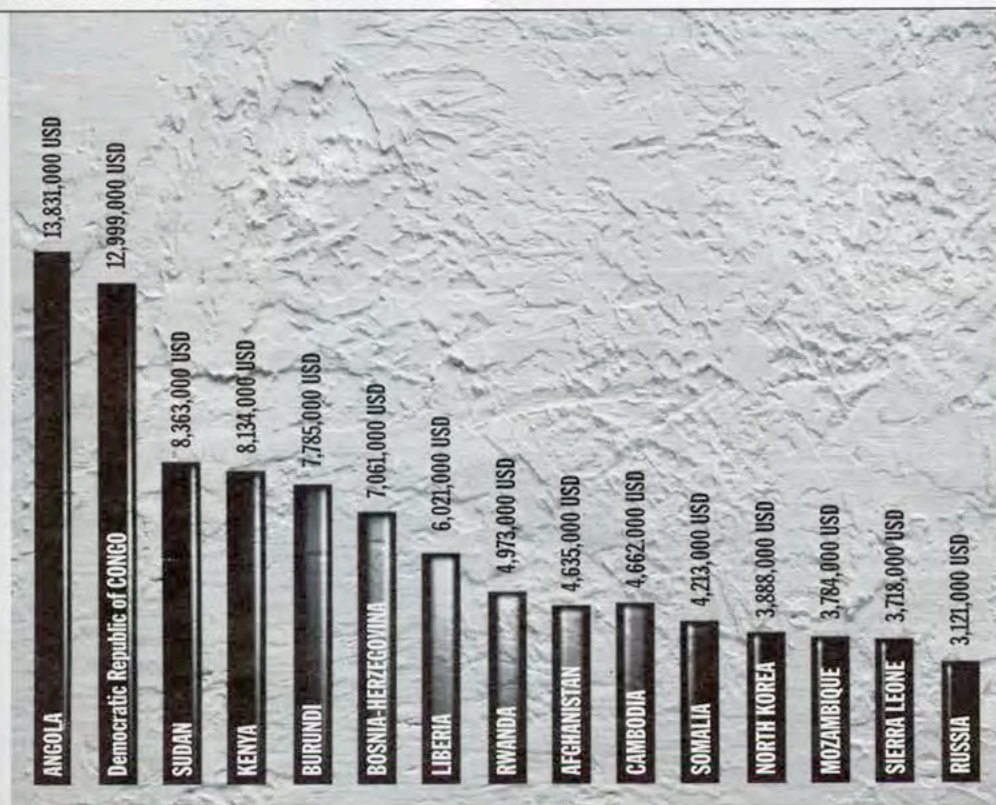
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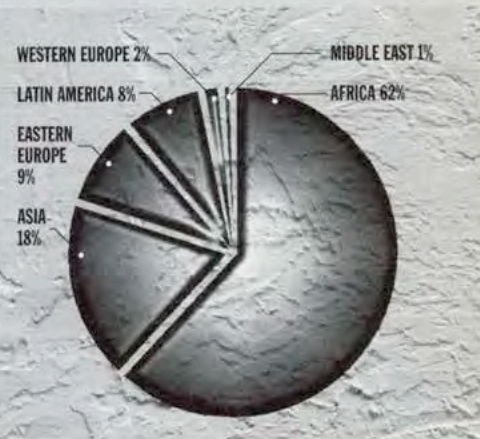
HOW WAS THE MONEY SPENT?



WHERE WAS THE MONEY SPENT?



Total expenditure:
228 million USD



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- › 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 neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance and demands full and unhindered freedom in the exercise of its functions.
- › Médecins Sans Frontières' volunteers undertake to respect their professional code of ethics and to maintain complete independence from all political, economic and religious powers.
- › As volunteers, members are aware of the risks and dangers of the missions they undertake, and have no right to compensation for themselves or their beneficiaries other than that which Médecins Sans Frontières is able to afford them.