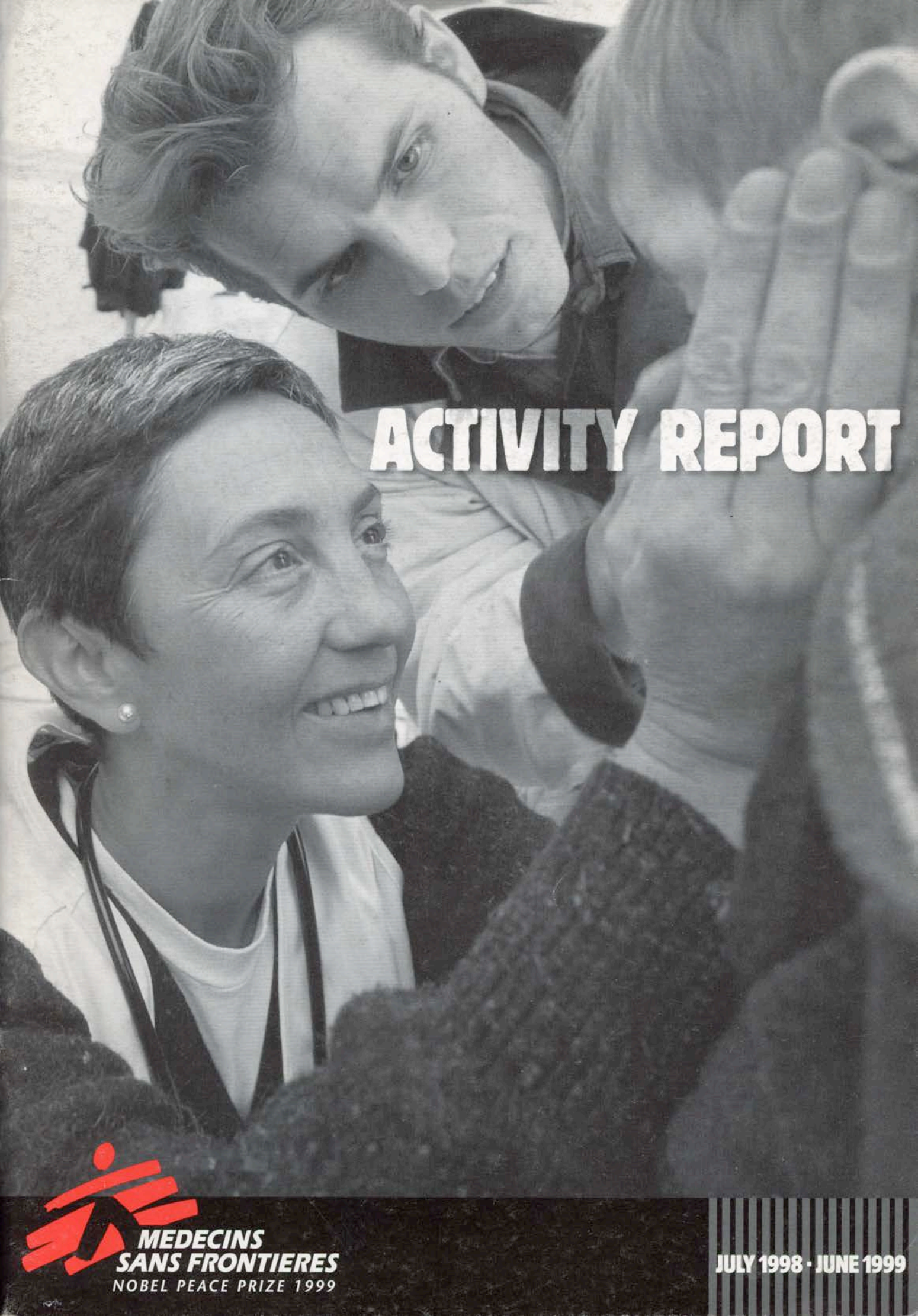




ACTIVITY REPORT



**MEDECINS
SANS FRONTIERES**
NOBEL PEACE PRIZE 1999

JULY 1998 - JUNE 1999



ACTIVITY REPORT



JULY 1998 - JUNE 1999



Editor

Iseult O'Brien

Photo editor

Barry Sandland

Production Assistant

Stéphanie Soufflet

Contributors

Odilon Couzin

Laure Delcros

Kathryn Dinh

Nathan Ford

Jean-Marie Kindermans

Polly Markandya

Alison Marschner

James Orbinski

Barry Sandland

Stéphanie Soufflet

Thanks to

Véronique Arpigny

Jan Brigou

Anne Decortis

Amaia Esparza

Paola Ferrara

Eric Goemaere

Anne Guibert

Mar Padilla

Myriam Hekens

Anne-Thérèse de Jamblinne

Malini Morzaria

Marjorie Piovani

Evelien Schotsman

Bas Tielens

French version

Anne Decortis

Spanish Version

Pilar Petit

Dutch Version

ISO Translation

Italian Version

De Falco Translations

Elena Mazza

Cover photograph

Roger Job

Graphic design

Debie graphic design

Printed by

Bietlot

ABBREVIATIONS

AIDS :	Acquired Immune Deficiency Syndrome.
DOTS :	Directly Observed Treatment Short course chemotherapy.
EPI :	World Health Organisation's expanded programme on immunisation.
HIV :	Human immunodeficiency virus : the cause of AIDS.
ICRC :	International Committee of the Red Cross.
IDP:	Internally Displaced Person.
MPLA :	Peoples' Movement for the Liberation of Angola.
NATO :	North Atlantic Treaty Organisation.
NGO :	Non-Governmental Organisation.
OSCE :	Organisation for Security and Cooperation in Europe.
STDs :	Sexually Transmitted Diseases.
UNHCR :	United Nations High Commission for Refugees.
WHO :	World Health Organisation.
UNITA :	National Union for the Total Independence of Angola.



photo R. Job - Sudan

CONTENTS

- 6** MSF Missions throughout the world
- 8** Introduction
- 10** MSF milestones
- 12** MSF Campaigns for Access to Essential Medicines
- 14** MSF Focuses on Growing Problem of Tuberculosis
- 16** What is Big Bone Disease?
- 18** A Scientific Approach to "Témoignage"
- 20** Sudan Relief : MSF Calls For Change
- 22** Kosovo : Aid Under Siege Once Again
- 26** MSF goes WWW

MSF PROGRAMMES

- 27** Africa
- 45** Europe
- 55** America
- 65** Asia (including the countries of the Middle East)
- 80** MSF Facts and Figures for 1998
- 82** Contact Names and Addresses



MSF MISSIONS THROUGHOUT THE WORLD



1	Afghanistan	p.66
2	Albania	p.46
3	Algeria	p.28
4	Angola	p.28
5	Armenia	p.46
6	Azerbaijan	p.47
7	Bangladesh	p.66
8	Belgium	p.47
9	Benin	p.29
10	Bolivia	p.56
11	Bosnia-Herzegovina	p.48
12	Brazil	p.57
13	Bulgaria	p.48
14	Burkina-Faso	p.29
15	Burma	p.67
16	Burundi	p.30
17	Cambodia	p.67
18	Central African Republic	p.30
19	Chad	p.31
20	China	p.68
21	Colombia	p.58
22	Congo (Brazzaville)	p.31
23	Costa Rica	p.58
24	Côte d'Ivoire	p.32
25	Cuba	p.59
26	Democratic Republic of Congo	p.32
27	Ecuador	p.59
28	Egypt	p.33
29	El Salvador	p.60
30	Equatorial Guinea	p.33
31	Ethiopia	p.34
32	France	p.49
33	Georgia	p.50
34	Guatemala	p.60
35	Guinea	p.35
36	Guinea-Bissau	p.35
37	Haiti	p.61
38	Honduras	p.62
39	India	p.68
40	Indonesia	p.69
41	Iran	p.69
42	Italy	p.51
43	Kazakhstan	p.70
44	Kenya	p.36

45	Kyrgyzia	p.70
46	Kosovo	p.49
47	Laos	p.71
48	Lebanon	p.71
49	Liberia	p.37
50	Luxembourg	p.51
51	Macedonia	p.52
52	Madagascar	p.37
53	Malawi	p.38
54	Mali	p.38
55	Mauritania	p.39
56	Mexico	p.62
57	Mongolia	p.72
58	Montenegro	p.49
59	Mozambique	p.39
60	Nicaragua	p.63
61	Nigeria	p.40
62	North Korea	p.72



photo R. Job - South Sudan

THE WORLD / JULY 1998 - JUNE 1999



63	Palestinian Authority	p.73
64	Panama	p.63
65	Papua New Guinea	p.73
66	Peru	p.64
67	Philippines	p.74
68	Romania	p.52
69	Russia	p.53
70	Rwanda	p.40
71	Sierra Leone	p.41

72	Somalia	p.41
73	Spain	p.53
74	Sri Lanka	p.75
75	Sudan	p.42
76	Tajikistan	p.75
77	Tanzania	p.43
78	Thailand	p.76
79	Turkmenistan	p.76
80	Uganda	p.43

81	Ukraine	p.77
82	Uzbekistan	p.77
83	Vietnam	p.78
84	Yemen	p.78
85	Zambia	p.44



photo R. Job - Kosovo

INTRODUCTION

Reviewing our activities during the course of the past year provides an opportunity to examine the difficulties that we have encountered in implementing them. The objective of humanitarian action is to assist and protect populations in danger, with those most under threat given highest priority. Our presence is obviously a necessary condition if we are to achieve this. Recently, despite all our efforts to ensure adequate security for our teams, the insecurity present in some conflicts has often prevented us from maintaining this presence. Thus, in Sierra Leone, although we were able to return to Freetown in February 1999, most of the country remains inaccessible. The development of the conflict in Angola considerably reduced the possibility of access in many different areas and Congo (Brazzaville) was cut off completely for a number of months while countless acts of violence were taking place. Nonetheless, we are encouraged by the fact

that we have been able to maintain a presence over the past twelve months in countries such as Algeria and the eastern part of the Democratic Republic of Congo.

In the Balkans, during the Kosovo war, we were able to help the refugees who had been deported to neighbouring countries. It was particularly difficult to ensure protection for them because of the lack of any registration process. The situation was further complicated by the presence of a huge political-military arsenal, which made independent action by humanitarian organisations a particularly delicate task. Yet throughout this period, those most in need of assistance and protection were the exhausted and abandoned people who remained inside Kosovo itself. However, we might well ask ourselves whether humanitarian assistance would have genuinely helped the civilian population which was being eliminated or deported by the Serb regime during

the course of its war. In this type of situation those in authority often "conceal" some groups of people and "select" others to receive assistance from humanitarian organisations. And while all this was happening, humanitarian aid was being used as a propaganda tool in the battle over information that was an integral part of this war. How, therefore, could real protection have been provided for those who needed it most? In this kind of context humanitarian organisations seem unable to serve the best interests of the populations to which they are committed.

Other examples show that geographic access in itself is no guarantee of genuine humanitarian action. In Sudan, during the course of 1998, part of the country was inaccessible (Nuba Mountains, Western Upper Nile, etc.) as a result of the Khartoum government's control over the relief flights intended to bring aid to these areas. However, in Bahr-el-Ghazal, where the needs were immense, we were able to ensure a regular presence from spring onwards despite the many logistical constraints common to this region. MSF decided to speak publicly about the famine in order to draw the world's attention to what was happening and increase the volume of aid. In the end, this reached an adequate level to meet the identified requirements. However, as was so symbolically demonstrated in Ajiep, thousands of people continued to die close to distribution centres. Despite all our efforts, we were unable to reach many of the most vulnerable. The principle reason for this failure resulted from the method of distribution that was imposed on us. This gave a lower priority to the displaced, although the people in this group, by its very nature, are the most vulnerable. It was, therefore, logical that MSF should publicly call for the aid system to be changed in order to ensure that a real humanitarian intervention could prevail: independent and increased control over distributions and freedom to evaluate needs.

North Korea demonstrates how the restrictions placed on humanitarian action in a situation unrelated to conflict can still have a major and negative effect on the most vulnerable, even when MSF volunteers are able to work in a state of relative security. Confronted with this different type of famine situation, we undertook programmes covering aid distributions and the reinforcement of the health services in the four provinces to which the Pyongyang government had granted us access. Nevertheless, the attendance rates in the health centres and feeding centres were

low in relation to the catastrophic situation. Rather than continue to work blindly, dependent only on "guided" visits, we wished to concentrate our activities on the most vulnerable groups (the homeless, orphans, etc.). Faced with this official refusal to allow us to distribute food and medical material to those most in need, we had to leave the country. As we were unable either to conduct independent evaluations of the needs or to control distributions, the nature of the aid that we were offering was at risk of becoming totally separated from its humanitarian objectives. Used for other ends, some of which were already responsible for the condition in which the most vulnerable found themselves, such aid could even have become more harmful than beneficial. Thus, witnessing the situation of this population in danger became the only way in which we could defend their rights. We are still trying to reach some of them today by other means, but obviously on a very reduced scale.

It is, therefore, clear that a physical presence and access to populations are not synonymous with real humanitarian action, which must seek to care for and protect the most vulnerable. Faced with all these difficulties, which are not new to us, we always try to be present. Confronted with such realities, we must make a judgement and then act. This is a delicate exercise and it has to be conducted in situations in which no distinct line can be drawn between civilians and combatants, beneficiaries and manipulators of aid, etc. We therefore fight for our right on the spot to conduct our activities in conformity with our objectives and our principles and we endeavour to remove the obstacles that are placed in our path. The conditions are rarely ideal and – fortunately also rarely – the external constraints may be such that our assistance no longer serves the best interests of the population and we decide to suspend our activities.

This is why it is of prime importance to have the greatest possible margin of independent manoeuvre in regard to our ability to assess and to act. However, we cannot claim this degree of independence for ourselves if we do not also hold ourselves liable to account for our activities, as well as the difficulties we meet in performing them and how we deal with these. Such transparency is necessary if those who provide essential support for our activities are to continue to have confidence in us.

*Dr. Jean-Marie Kindermans
Secretary-General*



28 YEARS ON... MILESTONES OF

photo J. Vink - Kurdistan

photo R. Job - Rwanda

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 Zaïre.

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.

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



photo R. Job - Nicaragua

photo R. Bohle - South Sudan

A HUMANITARIAN MOVEMENT

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, MSF collaborates on the biggest cholera programme to date.

Angola : MSF continued to work in the besieged Quito enclave. During months of shelling, medical, surgical and nutritional assistance was provided by the team who were working in deplorable conditions in order to bring relief to the population of 300,000.

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.

Burundi : MSF is opposed to the numerous "regroupment" camps to which large sections of the population have been forcibly settled. The organisation decides to provide only essential medical assistance to the camp dwellers, but to do nothing to set up long-term facilities in these camps.

Zaire : Civil war breaks out. Rwandese refugee camps on the border attacked by the Alliance forces who wish to root out mem-

bers of the former Rwandese army. This brings about the mass return of refugees. However, hundreds of thousands flee to areas where there are no health-care facilities. 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 pushes for a reversal of a Taliban edict excluding women from emergency health care, but the access of women to health-care remains difficult.

East Africa : MSF intervenes in a cholera epidemic of an unprecedented scale.

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.

1998

South Sudan : MSF launches emergency operations and large-scale appeal for famine victims. From the outset, there are problems with the relief effort. Although the famine of 1998 was foreseen, the humanitarian response from all the aid agencies present (including MSF) was insufficient.

The relief took too long to arrive and much of it was misappropriated. Many of the most needy were overlooked by those who controlled the food distribution.

Honduras, Nicaragua and Guatemala : Over the last weekend of October a hurricane of unprecedented force hit Central America. In total, 7,000 people were registered dead and another 10,000 reported missing. Two million people were estimated to be in need of immediate relief. MSF teams, already working in the region, reinforced their aid effort by sending 100 tons of drugs and medical material to the affected areas.

1999

South Sudan : MSF voices its concern that the UN relief programme Operation Lifeline Sudan (OLS) has become overly institutionalised and asks for its workings to be reviewed.

Angola : the peace accords signed in 1991 and renewed in 1994 are no longer respected. Civil war has resumed. Bringing relief to the victims of Angola's war remains a priority for MSF.

Sierra Leone : In February, an MSF surgical team returns to Freetown after a two month absence from the capital due to widespread fighting and insecurity. MSF has worked in several regions of Sierra Leone since the coup d'état of May 1997.

Kosovo : During NATO attacks on Serbia, MSF provided humanitarian assistance to refugees in Albania, Macedonia and Montenegro. Following the ceasefire in June, MSF supported health structures to prepare for the return of refugees.

MSF CAMPAIGNS FOR ACCESS TO ESSENTIAL MEDICINES

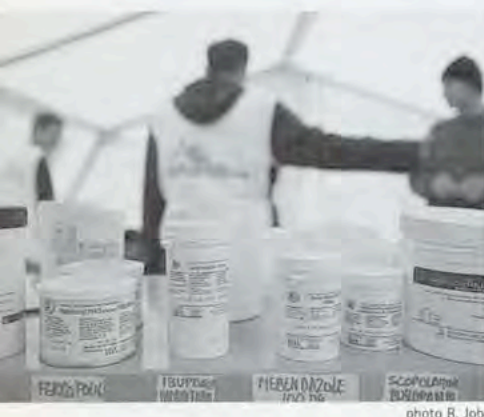


photo R. Job

Millions of poor people die every year from infectious diseases because the medicines that could cure them are too expensive. For other diseases there is no treatment: no effective medicine exists and nobody is looking for one. In the pharmaceutical market profits are put before human lives and life-saving medicines are nothing more commercial products. MSF is campaigning for change to ensure that disadvantaged populations get the medicines they need.

Despite the progress made by twentieth century medicine infectious diseases are still the leading cause of death in developing countries. New diseases have emerged that have reversed progress made over the years: AIDS for instance has lowered life-expectancy for many developing countries. Tuberculosis and diphtheria were once considered under control, but the number of cases is increasing as bacteria develop antibiotic resistance and medicines that were once effective become redundant. In MSF's TB programme in Siberia over a third of patients are infected with multidrug-resistant TB bacilli and the only treatments that are effective are expensive, difficult to manage, have limited success and in some cases severe side-effects.

More bacteria are becoming resistant to antibiotics, yet no medicine for use against tropical diseases has appeared since the development of quinolones in the 1960s. 'The majority of tropical medicines were developed over 40 years ago and many no longer work' says Dr. Bernard Pécoul who is leading the MSF campaign. 'Millions of lives are put at risk every year and almost nothing is being done to change the situation.' A look at the new medicines produced over the last years confirms this worrying trend: of the 1,200 new medicines brought onto the market between 1975 and 1997, only eleven directly target a tropical disease. Between 1935 and 1970 the pharmaceutical industry made a vital contribution to the fight against endemic tropical diseases, when the market for medicines was driven by colonial or military interests such as the American involvement in South-east Asia. 'Since then', says Dr Pécoul 'manufacturers have clearly lost interest in conditions that

affect poor countries, concentrating on more profitable products designed to meet the needs and purchasing power of the industrialized world.' In addition, regulations that must be complied with before authorisation to market a medicine can be obtained increase the cost of clinical development, and when a promising medicine is found for the treatment of a tropical disease, the manufacturer often decides not to market the drug, knowing it would be too expensive for the patients.

Counterfeit and poor quality medicines

The quality and effectiveness of medicines have been declining over the past years, particularly in the poorest countries that rarely have the necessary resources to apply international standards to the production and quality control of medicines. Moreover, these standards are sometimes applied less strictly in developed countries when the product is for export. The number of counterfeit products on the market has also risen. MSF teams encountered this problem during a meningitis vaccination campaign in Niger in 1995, where some 88,000 doses contained no active vaccine. The consequences for many were undoubtedly fatal.

Fluctuations in production

Second-stage African sleeping sickness is treated with a 40-year-old, arsenic-based drug that doesn't always work and can be fatally poisonous. A more effective medicine was developed in 1985, but was soon withdrawn from the market. The producers decided that it was not commercially viable, leaving the 300,000 people who suffer from African sleeping sickness without a life-saving medicine. Medicines for the treatment of bacterial meningitis and leishmaniasis



photo R. Job

have also begun to disappear from the market. These medicines were discovered in the 1950s and 1960s and are no longer used by developed countries.

Prohibitive cost

Reasonable pricing of essential medicines could enable these countries to make the most of their money, but developing countries have to spend as much as over half of their total health budget on medicines. *Shigella dysenteriae* type 1 is a highly contagious form of dysentery that causes death in 5 to 15 per cent of cases if left untreated. The bacteria rapidly developed resistance to traditional antibiotics, and new medicines are ten-times more expensive. This is just one of many examples: the majority of people suffering from meningitis, respiratory tract infections, diarrhoea or AIDS cannot afford the commonly available drugs or vaccines that help treat these diseases and prevent their spread.

Global trade and access to medicines

Laws governing import of medicines and patent protection of new discoveries are subject to increasing globalization, and there is much concern over the negative impact on public health. The World Trade Agreements determine what can be done in terms of production and importation of medicines. It is therefore vital that the implications of these agreements are fully understood, particularly by developing countries where access to medicines is major factor in the fight against infectious disease.

Prospects are far from encouraging. Unless steps are taken to change the current situation, MSF doctors and other health workers in the developing world will very shortly be left without medicines, or be forced to treat patients with old, expensive medicines of poor efficacy. As a medical organisation operating 400 medical programmes in 80 countries, MSF must defend the right to health care of marginalized populations.

Nathan Ford

MSF FOCUSES ON GROWING PROBLEM OF TUBERCULOSIS

Tuberculosis is currently one of the biggest health threats to the world's population. It is estimated that over 9 million people will be infected by the year 2005¹. Of these, 95% live in developing countries. Last year, between 2-3 million people died from TB. Almost all of these deaths occurred in low-income countries. Little wonder it is often called "the disease of the poor".



photo G. Calton/MSFH - Uzbekistan 1998

TB thrives in conditions of insufficient lighting and ventilation, particularly attacking people who are weak due to an inadequate diet. The spread of TB in recent years is for many countries the result of economic crisis and the subsequent disintegration of health care services.

The collapse of the former Soviet Union which began in the late 1980's marked not only a radical change in the political composition of the region but also medical care and the health of the population. The former Soviet Union (FSU) had an extensive and centralised TB control system. During the fall of the Soviet Union, this system began to lose its capacity to keep the spread of tuberculosis under control. At the same time, declining living standards resulted in an increase in the number of people at risk of contracting TB, such as the homeless and unemployed.

The result is that TB is now the number one health problem in the FSU. In Russia in 1991, there were 34 new cases of TB per 100,000 people; by 1998, this figure had risen to 80 new cases per 100,000. In the prison population of Russia, where there is massive overcrowding and poor living conditions, the situation is even worse. Today, at least 110,000 of Russia's prison population have TB. In other parts of the FSU the figures are just as alarming. This year in Kazakhstan, 91 new cases of TB have been officially recorded per 100,000 people, and a similar incidence has been recorded in the Republic of Karakalpakstan, Uzbekistan. In comparison with a country such as Belgium, these figures for Kazakhstan and Karakalpakstan are nine times higher for the same period. The same grim picture can be painted for almost all countries in the FSU.

So what can be done in such a situation where most governments in the FSU have little money and resources to tackle such a vast and urgent problem? MSF has been attempting to respond to this question by implementing pilot programmes in the region. In 1995 a team began work in a prison hospital in Siberia. Colony 33 Prison Hospital was built for about 750 patients, but has been treating more than 1,600 patients at a time.

When MSF started its pilot project in the hospital - which treats prisoners with TB from 26 surrounding prisons - patients were dying at a rate of 2-3 per day. By the end of 1998, this figure had been reduced to 2-3 per month. MSF has been involved in implementing and training the hospital staff in "DOTS" (Directly Observed Treatment Short-course) - a World Health Organisation (WHO)-recommended TB control strategy in use in over 50 countries world-wide.

DOTS is designed to cure TB and reduce its transmission, prevent multi-drug resistant (MDR) TB and lower costs for TB patients. This treatment involves the patient taking a course of medication every day, and being strictly observed to ensure full compliance with this regimen. Without such compliance, a patient may not be cured. Poor compliance also contributes to the growing resistance to TB drugs. Implementing DOTS is necessary to start with but it will not be enough: 22% of patients appear to be resistant to the two main anti-tuberculosis drugs- rifampicin and isoniazid, a figure high enough to predict that a standardised DOTS treatment without sensitivity testing will produce more resistant strains. MSF has been supplying anti-TB medication, assisting the hospital in improving the living



photo G. Carlton - Uzbekistan

A PROFILE

There is a girl of 27 years living alone in a house in Siberia. She has short punk-style brown hair and green eyes. She looks much younger than her age. Her pyjamas have holes in them, her slippers are torn, and she is quite malnourished.

A few years ago, this girl was caught trying to steal, and sentenced to more than one year in prison. After completing her sentence, she was released.

Now the girl is back in prison, again for theft, but this time she faces a much more serious sentence. A few months ago the girl was found to have multi-drug resistant tuberculosis or MDR TB. It is suspected that the girl contracted MDR TB during her first time in prison. Now she must live alone in a house in the prison known as the "chronic department". When the girl found out she had MDR TB and was segregated, she cried for a week and refused to eat. Now she eats a little and tends to the small garden inside the metal fence which encircles the house. She only has human contact with the people who bring her high energy milk, multivitamins and food; and with MSF staff. She has problems breathing. The girl is still awaiting further test results to confirm her MDR TB status. At present, there are no means to treat MDR TB in the prison.

In 6 months the girl is due to be released. With a mortality rate of more than 50% for those who have MDR TB and are not treated, the girl will go home with little chance of survival.

There are thousands of cases like this one across the CIS, but behind each statistic lies the human tragedy.

conditions and nutrition of patients and providing supplies and equipment for the laboratory. MSF now works in two regions of Siberia – Mariinsk and Novokuznetsk – screening for and treating TB in several prisons and two prison hospitals. MSF is also carrying out TB pilot projects in Kazakhstan, Uzbekistan, Georgia, Nagorno Kharabagh and Turkmenistan. The aim of MSF's TB pilot projects is to demonstrate a model for TB control that can be replicated throughout each country where the organisation works. By training local staff in DOTS techniques MSF is establishing a framework for how TB can be treated in the region.

TB will only be brought under control if the problem is addressed at all levels. MSF has been working with governments and national TB institutes in the places where it works, so that these countries will adopt DOTS as part of their national TB policies. The question of large-scale funding of such projects is being addressed by MSF through contact with various international bodies such as the Council of Europe.

A major problem that all people working with TB face is the growing resistance to TB drugs. The collapse of the health system in the FSU meant that many people were not able to complete their TB treatment adequately: drug supply was increasingly irregular, drugs became too expensive and a breakdown in the

co-ordination and information flow among health professionals led to incorrect treatment.

In some regions of the FSU, this has now resulted in alarming proportions of MDR TB. In Kazakhstan, 10 to 12% of all recorded TB patients have MDR TB; in the prison population of Mariinsk the number of MDR-TB cases is 22%. Treating MDR-TB requires medicines that are not widely available and can be 100 to 250 times more expensive than regular TB treatment. The cure rate is substantially less.

To address the problem of MDR TB in Siberia, MSF has just begun implementing the DOTS Plus treatment strategy. The organisation is working on the problem of how to reduce the huge costs of medication for such treatment (\$8,000/patient) and establishing a system for easily identifying those patients who have MDR TB. It is planned that this work will be replicated in other MSF projects in the region.

The challenge for treating TB in the former Soviet Union is to establish treatment models which work effectively in the region, that can be sustained in the long-term and replicated on a wide scale. The tragedy is unfolding, and where there is capacity for organisations such as MSF to intervene, there is a strong obligation and responsibility to do so.

(1) Who

Kathryn Dinh



This Tibetan man fell victim to Big Bone Disease as a child. His arms are shorter than the normal length and his painful joints so badly deformed that movement is restricted to as little as 30 degrees.

WHAT IS BIG BONE DISEASE?

Big Bone disease is a painful bone disorder that causes stunted growth in children. It can make arm and leg movement so painful that sufferers can no longer work. In China alone it affects between two and three million people. However, the cause of the disease is unknown. Most doctors in the West have never heard of Big Bone Disease.

'When I first arrived in Tibet in June of 1992' says Françoise Mathieu who heads the MSF Big Bone Disease Programmes, *'I was to stay for six weeks. I knew nothing about Tibet and never guessed that I would end up staying there for eight years.'* MSF began working in Tibet in 1991, providing mother and child health care. The MSF doctors very quickly noticed the large number of patients coming to the community clinics with complaints of elbow and knee pain. The joint bones of some patients had grown excessively, making normal movement impossible. *'After observing so many people affected by a disease we had never heard of before, I began to work with local doctors to help alleviate the pain of BBD sufferers'*, says Françoise.

Big Bone Disease is a chronic disease that destroys bone cartilage of the limbs, resulting in stunted growth, arthritis-like pain and restricted movement of the arms and legs. It affects people in a remote crescent-shaped region stretching over Tibet and the rest of China, North Korea and Siberia. Most people in this area subsist through farming, but those with Big Bone Disease often find it extremely difficult to control the movements of their joints or hold a tool firmly enough to be able to plough the land, sow seeds and harvest crops. Some cannot even walk. For the individual, the pain that comes with Big Bone disease is constant; in the poor rural communities of Tibet, where the disease can affect as many as 80 per cent of the population, it can have serious social and economic consequences.

With the support of the health office in Lhasa Françoise, herself a physiotherapist, started up a physiotherapy programme to treat sufferers of Big Bone Disease. The mixture of massage, mobilization of the joints and home exercises

for the patient proved successful. The treatment reduced the pain and patients regained their ability to work. MSF then opened a physiotherapy clinic and began a training programme for local health workers. Six years on, MSF have opened almost 60 physiotherapy clinics throughout Tibet and trained 90 local doctors.

The causes of Big Bone Disease are unknown. *'It appears from the medical literature that three risk factors are associated with the disease'* explains Françoise. *'Selenium deficiency, the presence of fungi in grains, and certain organic matter in the drinking water.'* MSF is carrying out ongoing research into the causes of the disease. This work began in 1995 in international collaboration with different institutes and universities. The first results of research carried out by MSF were published in high-profile international medical publications. *'Following our findings, MSF began a preventive programme distributing selenium supplements, providing of clean drinking water and encouraging farmers to use fungicide and dry their grain'*, says Françoise. The programme started last year and will monitor the effects through the physical development of 1,000 children in 22 villages over three years.

In January, MSF and the Chinese Ministry of Health organized a two-day symposium in Beijing. The symposium succeeded in bringing together world experts in growth disorders, introducing them to the disease and stimulating collaboration in the search for prevention and cure. *'It could take up to ten years before a decline may become visible'* Françoise admitted. Total eradication will take much longer. For now, many Tibetans continue to struggle with the daily effects of the disease.

Nathan Ford



A SCIENTIFIC APPROACH TO “TÉMOIGNAGE”*

photo J. Vivik - Bangladesh

MSF finds itself working more and more often in situations with high levels of violence. This has required the organisation to implement new tools and adapt existing ones in order to respond adequately to the needs of the populations with which we work. An interesting example can be seen in epidemiology, a branch of medical science that deals with the incidence and transmission of disease in populations, and one in which MSF has acquired much experience and developed a strong reputation. By adapting its methods of epidemiological survey and analysis, MSF is now able to obtain quantitative information about human rights' violations against populations in situations of violence.

The first such survey was conducted in the vastly over-crowded prison of Gitarama, Rwanda, in 1995, and succeeded in drawing the world's attention to the extent of that drama. MSF has implemented the technique on several other occasions since then. More recently, MSF has used the services of Epicentre, an epidemiological research centre based in Paris with which it has developed a close collaboration.

The unseen massacres in the forests of Congo

Although the return at the end of 1996 of half of the million plus Rwandan refugees from the camps in Kivu (in the Democratic Republic of Congo) were the focus of world attention and figured nightly on our television screens, the other half were ignored or conveniently forgotten – but not by MSF. The results of an epidemiological survey carried out in July 1997 in Ndjoundou, in Bas Congo province, provided proof that they had been systematically massacred.

The 3,121 refugees who had reached Ndjoundou (normal population around 500) were receiving food, medical and sanitary assistance from MSF. The stories they told of their 1,500-kilometre journey led to a decision to make a statistical documentation of their experience. A total of 266 families were selected by random sample out of a base of the “enlarged family” units registered for food distributions. The survey took place over a five-day period. Detailed questioning of one member of each family covered background information and the travel history of all members since leaving Kivu. The events documented included deaths, “disappea-

rances", repatriation and spontaneous return. The most significant fact revealed by the data was that only 17.5% of family members reached Ndjoundou. The others could be accounted for as follows: disappearances: 59.5%; killings: 19.7%; other: 3.3%. Between 1 October 1996 and 31 May 1997, the crude mortality rate was 15.5 per 10,000 persons per day; the comparative infant-juvenile rate was 18.2. The mortality rate, mainly the result of armed attacks, was probably under-estimated as deaths were only recorded if confirmed by the person interviewed.

As a result of this survey, MSF was able to back up its témoignage with statistical proof of a kind that could justifiably be used to extrapolate evidence of the fate of tens of thousands of Rwandan refugees in the forest of Congo. This was especially important in view of the Congolese government's refusal to grant free access to refugees to a United Nations human rights investigation team.

Mutilations and amputations in Sierra Leone

Following a violent upsurge in the fighting in Sierra Leone's protracted civil war at the beginning of 1999, the MSF surgical team in Connaught Hospital in Freetown carried out a one-day systematic survey of patients on 14 February in order to document civilian casualties. A standard and anonymous questionnaire was drafted to identify the cause of each admission. Of the 284 patients interviewed, the study focused on 215 who had been wounded during fighting since the beginning of the year. Of these, 43% were female and 23% were under 15 years old. The results showed that 57.2% had received gun shot wounds, 30.2 had blade injuries. The remainder was suffering from the effects of shells, bombs, burns and other injuries. According to the stories told by patients, 79.1% had been intentionally wounded. These included 63 people who had suffered either full or partial amputations of limbs. As most of the violence could be shown to have occurred between 19 and 20 January, it is very likely that specific orders had been given for these attacks. As statements were obtained only from those lucky enough to survive, it is feared that the level of brutality described by the patients must have resulted in many more mutilations that are unlikely ever to be recorded. This survey offered irrefutable proof that civilians were being directly targeted.

Forced Displacement of Kosovars

Epidemiological surveys of Kosovo refugees were carried out at the end of April 1999. One was conducted among the 100,000 or so refugees hosted by, or renting accommodation from, local families in Kukes, Albania; another covered Rosaye, in Montenegro, where 3,000 (out of

a total of over 10,000 refugees) were living in three disused factories. Apart from providing necessary information to determine the most urgent needs among these people, the intention was also to obtain detailed information on the causes and duration of their exodus from Kosovo and to evaluate the impact of the abuses, physical and psychological, with which they were confronted.

A sample of households living in Kukes was obtained using a two-stage random technique (100 apartment buildings were selected and then two apartments from within each of these). Detailed information was obtained for 1,510 of the 1,572 people in the sample. The detailed information received from the 197 households interviewed (average size: 7.7) showed that 70% had left their homes as the result of threats by the Serbian armed forces. At least one family member was reported as absent from 34% of households; 60% of these were males aged between 15 and 54. Out of a total of 141 missing persons, 22% went missing during the exodus and 8% were forcibly separated from their families. Assuming that the approximately 90,000 other refugees in Kukes suffered in a similar way to this sample group, the number of deaths attributed to intentional violence could range from 200 to 600. In absolute numbers, there may be at least 2,000 missing persons among the Kukes refugees whose fate remains to be discovered. A similar number of families were chosen, again by random sample, from among refugees living in disused factories in Rosaye. An analysis of the replies produced comparable results.

males aged between 15 and 54. Out of a total of 141 missing persons, 22% went missing during the exodus and 8% were forcibly separated from their families. Assuming that the approximately 90,000 other refugees in Kukes suffered in a similar way to this sample group, the number of deaths attributed to intentional violence could range from 200 to 600. In absolute numbers, there may be at least 2,000 missing persons among the Kukes refugees whose fate remains to be discovered.

A similar number of families were chosen, again by random sample, from among refugees living in disused factories in Rosaye. An analysis of the replies received produced comparable results. In addition, almost half of the families in Rosaye had had their identity papers seized before being allowed to leave Kosovo.

From these examples, it is clear that the use of proven epidemiological methods to obtain data enables MSF to offer solid statistical evidence to back up its témoignage on behalf of populations in situations of violence.

Alison Marschner



photo UNHCR - Macedonia

"The French term is retained here as it encompasses all shades of meaning in regard to MSF's commitment, as expressed in its mission statement: 'to provoke a social and political reaction that recognises the rights and the needs of populations in danger': discreet testimony, open advocacy, outright denunciation.

See MSF/Epicentre report: Histoire des réfugiés rwandais ayant fui les camps du Kivu, Zaïre, de septembre 1996 à juin 1997, September 1997. See MSF report: Sierra Leone mutilations: Un mois d'activités à l'hôpital Connaught de Freetown, May/June 1999.

See MSF/Epicentre reports: Exode Massif du Kosovo: Enquête au sein de la population Kosovar réfugiée à Rosaye, Monténégro, 27 April 1999, and Rapid needs assessment among Kosovar refugees hosted by Albanian families and assessment of human rights violations committed in Kosovo, 29 April 1999.

SUDAN RELIEF: MSF CALLS FOR CHANGE

The 1998 famine in Sudan produced the highest malnutrition rates MSF has ever seen and revealed the inadequacies of the international relief framework of Operation Lifeline Sudan.



photo A. Durrant

The civil war in South Sudan, which began over 40 years ago in 1956, is the longest running conflict in Africa. With over two million lives lost, the vast majority among civilians, it has also been responsible for the greatest number of deaths. The war between the Khartoum government and the rebel groups in the south of the country is not clear-cut. Although religion and ethnic identity are the main points of contention, the picture is confused by the extreme fragmentation of the parties involved as they have split into various factions and alliances, as well as the involvement of various militia groups pursuing their individual interests. Economic factors such as the right to exploit oil and water reserves also play an important part. All this has subjected the people of Sudan to a chronic war interspersed with periods of acute famine.

MSF has been working in Sudan since 1985 and some of its sections are members of the coalition of UN agencies and NGOs that established a pioneering relief programme in 1989 known as Operation Lifeline Sudan (OLS). OLS was intended to initiate constructive change through negotiations for access to the most vulnerable groups combined with the delivery of humanitarian aid. OLS operates under a tripartite agreement signed by the government, the rebel movements and the UN. It delegates and recognises a role for the humanitarian wings of the rebel movements in the organisation of relief supplies. This is in itself a dubious practice as it is in their nature to continue to promote the political and military interests of their movements. The unfortunate reality is that by breaking or manipulating the OLS agreement, the government and other warring parties have consistently and successfully denied humanitarian access to many regions of both North and South Sudan (the Nuba Mountains, the Blue Nile and Western Upper Nile). This breach of the access agreement played a critical role in limiting the humanitarian response to

the 1998 famine, particularly in the Bahr el Ghazal region.

Although an early warning system predicted significant food shortages in Sudan for 1998, it did not foresee the scale of the famine that hit Bahr el Ghazal and other parts of Southern Sudan. However, despite the forecast of an almost certain famine, the humanitarian response – including that of MSF – was grossly inadequate in regard to both timing and the amount of aid required. Although OLS intervention achieved some positive impact in certain parts of Sudan, MSF was in a position to estimate the real extent of the tragedy in Bahr el Ghazal. In May 1998 we were therefore compelled to draw the attention of the world's media and donor governments to the undeniable and overwhelming level of suffering. The essential priority was to save as many people as possible.

However, even where there is geographical access and relief agencies are present with adequate resources, effective humanitarian is not guaranteed unless the volunteers and the resources are directly targeted towards the most vulnerable. The failure to do this in Sudan last year explains why the impact of the response was greatly reduced and the enormous suffering continued for far too long. It also revealed the weaknesses in the application of humanitarian principles in a context – in this case a well-established system – in which aid agencies are prevented from independently assessing needs and setting the priorities for food distributions.

The worst situation arose in the town of Ajiep and highlighted the problem. Over 100,000 people had sought refuge in the Bahr el Ghazal region from the fighting in Wau, Gogrial and Aweil in January 1998. A quarter of this number was present in Ajiep, as a partial ban on essential relief flights at that moment did not extend to this area. The partial ban meant that flights were only allowed to land in selected



photo A. Durrant

places. Therefore Ajiep, with the highest concentration of vulnerable and malnourished displaced persons, was the largest famine pocket in Bahr el Ghazal. Although no military action impeded access to Ajiep and considerable food relief was available despite very considerable logistical constraints, MSF nutritional surveys showed that malnutrition rates remained extremely high over many months. Indeed, MSF was eventually facing malnutrition at rates that we have never previously seen – and they may well have been even higher in those places to which we did not have access. In July over 80% of under-fives in Ajiep were malnourished and mortality was almost thirty times higher than the internationally recognised critical level. By October, after over five months of emergency food relief, more than half the children in Ajiep were still malnourished and it is estimated that at least 3,000 people died there during this period.

Two major factors are mainly responsible for these appalling statistics. First, the displaced were most often excluded from food distributions. This arose from the distribution system itself. According to the OLS agreement and established practice, food relief in Bahr el Ghazal was controlled by the local authorities and the humanitarian wings of the rebel groups, (in this case the Sudan Relief and Rehabilitation Association, or SSRA), and not by the humanitarian organisations in the field. It was these groups that set the priorities and the main beneficiaries tended to be local residents rather than the most vulnerable: the

displaced who had already been forced from their homes by war and hunger.

The second factor was the straightforward diversion of food aid by the rebel groups and their humanitarian wings. An investigation in August 1998 by a joint task force of OLS, SSRA and SPLM (Sudan People's Liberation Movement) representatives confirmed that the local authorities and other groups were operating a systematic taxation system on all food distributed. However, it was impossible to estimate the scale of the diversion and its impact on the population as we were also prevented from setting up a systematic post-distribution monitoring system.

The ultimate conclusion to be reached from the experience of this terrible famine is that the OLS system, which has been in place for the past ten years, has become overly institutionalised and must be overhauled. Indeed, the inadequacies of the OLS framework significantly contributed to the inability of the humanitarian organisations to reach the most vulnerable because they were not permitted to carry out independent needs' assessments (including estimating population numbers), to control distributions or to conduct post-distribution monitoring. At the beginning of 1999 MSF therefore called for radical changes to the OLS and hopes that these will eventually be implemented.

*Dr. Jean-Marie Kindermans
Secretary-General*

KOSOVO : AID UNDER SIEGE ONCE AGAIN

The principles, roles and responsibilities of humanitarian action were challenged at a fundamental level during the 1999 Kosovo crisis. In the face of brutal state-planned crimes against humanity inside Kosovo, MSF confronted NATO's direct involvement in humanitarian action, an uncertain role for UNHCR, the lack of humanitarian protection inside Kosovo, and the relationship of NGOs to state funders who were at war. These were key questions in a political and military crisis where humanitarian action was essentially apart of military and political strategy. It was against these challenges, and toward the primary challenge of acknowledging and restoring the dignity of people and relieving the suffering of war, that MSF tried to steer a course through the Kosovo crisis.



photo R. Job

MSF has had extensive on-the-ground involvement in the Kosovo region since 1993. In Kosovo itself, systematic attacks and massacres against civilians were clearly evident since the attack by Serb special police units in Drenica early in 1998. Kosovo Liberation Army (KLA) attacks also occurred through 1998 and 1999, and over 200,000 civilians were displaced inside Kosovo during this period. In October 1998 MSF spoke out against the deplorable conditions that internally displaced persons had to endure, and the beating and killings of ethnic Albanian doctors working with us in Kosovo. With the failure of the Rambouillet talks in mid-March 1999, and as the Milosevic government amassed thousands of military and paramilitary personnel at the Kosovo frontier, monitors from the Organisation for Security and Cooperation in Europe (OSCE) were pulled out of Kosovo on 20 March. As Milosevic's forces escalated further attacks on Ethnic Albanian villages in Kosovo, without UN Security Council approval, NATO began a bombing campaign on 24 March designed ostensibly to bring Mr. Milosevic back to the bargaining table. The bombing action then, was not a UN intervention, but an intervention of NATO and its member states. As violence and insecurity

escalated, it became impossible to provide humanitarian assistance or protection, and on 29 March MSF was forced to withdraw its last remaining expatriate staff from inside Kosovo. With the onset of NATO bombing, Mr. Milosevic only accelerated his campaign of systematic terror and forced migration, and as the bombing campaign itself intensified, over an eleven week period more than 800,000 people were forcibly expelled from Kosovo.

Within days of the bombing, MSF had teams in Macedonia, Albania and Montenegro providing humanitarian assistance for the largest and fastest efflux of refugees in Europe since the Second World War. For those making it across the border, the most common medical issue was physical exhaustion and psychological trauma due the inhuman campaign of brutality that people had endured in Kosovo. MSF quickly provided direct medical care, established mental health programs, and provided shelter, water, sanitation, and epidemic monitoring in the region.

But the humanitarian effort during what is now called the Kosovo crisis was not just about technical service to meet the immediate physical needs of refugees. While the 800,000 refugees certainly had needs, those people



photo R. Job

who remained trapped and brutalized inside Kosovo were completely without humanitarian protection.

During the crisis, NATO member states - the richest states in the world and the traditional financial and political supporters of the UNHCR - shifted their attention and resources to direct political and military action in the region, effectively sidelining the UNHCR as the lead UN humanitarian agency. Effective registration of refugees - a fundamental first step to protecting their political rights as refugees - became all but impossible. As the lead UN Agency in this setting, UNHCR had the legitimate responsibility of setting humanitarian priorities around assistance and protection, and ensuring that these are implemented. Here, MSF lobbied internationally, insisting that UNHCR not be side-lined by the political and military interests of NATO and its member states.

Within days of bombing Kosovo and Serbia, NATO and its member states gave logistical support toward the humanitarian effort. Given the size and speed of the humanitarian need,

this was necessary- as in many other circumstances this decade- but risked extending to a defacto control of independent and impartial humanitarian efforts. Seeing the public relations advantage toward their home-publics, NATO and its member states began building refugee camps in the region. Either directly or in collaboration with NGOs, they also wanted to manage those camps. Yet despite the disproportionate financial cost to NATO, in Albania for example, only a small proportion of refugees were actually housed in NATO-built camps. The vast majority were accommodated privately in the homes of Albanians, or scattered throughout the country in make-shift camps and collection centers.

By assuming a so-called humanitarian role, NATO was trying to improve its public image. However, not only did NATO violate fundamental humanitarian principles, many of its actions were incorrect, so that in some cases sites were poorly selected, and camp-layout and water and sanitation services had to be re-done according to correct UNHCR standards.

EZALD: A YOUNG 15-YEAR-OLD GIRL: (12TH APRIL, 1999)

"The village was surrounded by policemen; we were at home. There were soldiers everywhere, as far as the forest. A hand grenade was thrown in the direction of our house, and it landed just in front of me. My hand was wounded and I lost a lot of blood. We managed to escape along the river, through the forest and then along the road. Soldiers were posted every ten meters along the road. Once we had crossed the border, I was taken to the Italian camp (and from there onto Kukes hospital to get some X-rays done). My identification papers were confiscated at the border."

AN OLD MAN, FORCED TO LEAVE ON 28TH MARCH 1999, TELLS HIS STORY:

"I left my home about a year ago after soldiers burnt down some houses in my village and occupied others. Me and my family were staying with friends on the 28th of March when once again the Serbs drove us out. We carried on to Voinic where my wife has relatives and from there on to Tushila. At 11 in the morning the village was surrounded. We took refuge in a school but after an hour we gave ourselves in as there was no escape; a man walked out of the school waving a white flag. Men were separated from women and children. Some policemen and soldiers wore masks, others didn't. They let women, children and the elderly go. I was taken in an armored vehicle to the barracks and then some soldiers began to beat me up. One soldier recognized me and told the soldier to stop. Then another came, an officer, and said that all men had to be killed. They took our money and jewelry from the women who were also there. I tried to defend myself, saying that I spoke Serbo-Croat very well, that I'd worked all over Serbia, that they shouldn't be doing this, that they must have families of their own. I showed them my retirement papers to prove that I had no more money. They let us go, ordering us to go to Klina. We walked for 2 days and 2 nights. I still have no idea where my two sons are. Near Betsa soldiers opened fire on 4 young people. I didn't know them but they came from Shtupel. There were two brothers and two sisters from the same family; they were on the edge of the road with injuries to their legs, feet and upper-body. Their father was with them".

MSF refused to collaborate with NATO or its member states on refugee camp management, and unequivocally refused funding from NATO member states. Why? Because as actual parties at war in the conflict, they could not be seen as impartial supporters of humanitarian action, and collaboration of this kind could put the security of refugees at risk. This was born out when Serbian forces began shelling into Albania in regions where camps had been set up. Early on and repeatedly in the crisis, MSF publicly called on NATO to not mix military and humanitarian objectives and principles.

As the bombing campaign intensified, NATO's public relations increasingly focused on the work NATO was doing outside Kosovo for the refugees. In contradiction to this, MSF systematically surveyed and publicly released the stories of people leaving Kosovo; their experiences of rape, massacre and torture, and the beaten, killed, abandoned or lost family members remaining behind. In one survey conducted in Montenegro at the end of April, 28% of refugees had left at least one member behind in Kosovo, and 10% had wounded, killed or missing family members. At the height of the bombing and NATO's public relations campaign, MSF publicly called attention to the 'forgotten' people still inside Kosovo in the hands of the Milosevic government- those without humanitarian protection or assistance.

The actions of MSF aid workers and hundreds of national staff in the region provided direct medical assistance to people in need. Just as importantly, MSF also took strong public positions and lobbied internationally to demand humanitarian protection of people in Kosovo; to ensure access to refugees; for improved conditions for Kosovars displaced to Macedonia or seeking refuge in other neighboring states; for people's right to protection and political asylum, and for their right to not have to suffer the further indignity of being forcibly expatriated to a third country of asylum against their will.

By the end of June 1999, the Kosovo crisis was not over simply because the NATO campaign had ended, or because the refugees returned to Kosovo. By June, the majority of ethnic Albanian refugees had returned. Despite the presence of thousands of UN mandated troops, retribution-killings of Kosovar Serbs began, and tens of thousands of Serbs left Kosovo by the end of June. The

RAKENIC: A 47-YEAR-OLD WOMAN TELLS HER STORY (30TH MARCH, 1999):

"We were forced to leave by the Serbs, demanding money if my husband wanted to leave with the tractor. Since my husband is almost deaf, he didn't hear, so the Serbs said that if he didn't obey they were going to give him "another operation" (he'd just had an ear operation), gesturing that they were going to cut his throat; they took him away."

She has not heard from him since. Her identification was confiscated at the border.

crisis in the region continues into an uncertain future. With the massive reconstruction effort under way inside Kosovo, and the political uncertainty of the region, MSF continues to be present providing mental health programs, direct medical assistance and infra-structural rehabilitation, water and sanitation, epidemic monitoring, and of course, monitoring the humanitarian situation for both ethnic Albanians and Serbs.

For some, NATO's humanitarian war signaled the "the end of humanitarianism". However, as with Somalia, Rwanda, the former Yugoslavia and other conflicts around the world, for MSF Kosovo can only be yet "another chapter" in the struggle to preserve and assert the right to independent and impartial humanitarian action. Kosovo was and remains a monumental challenge to humanitarianism as we know it. In such settings, humanitarianism is not about political or military victories, but about relieving the human suffering of war, and acknowledging and acting to respect basic human dignity in the face of political failure and uncertainty. For MSF, beyond media or Western political interest, this was and is the challenge of humanitarianism both in Kosovo and around the world.

*Dr. James Orbinski
President of
International Council*





MSF GOES WWW

MSF and the internet are no strangers to each other. Since the organisation began exploring the possibilities of internet presence over a year ago, MSF has taken a further leap forward with the development of the international site (www.msf.org). And, if the past few months alone indicate the possibilities for the future, the internet is about to open up a series of new opportunities for MSF to develop its presence and influence.

Internet development also extends to MSF's national sites run by the different operational and non-operational centres - 18 in total. There are currently 14 active national sites and more are expected to open. The national sites provide information more specific to their operations, including local events, fundraising and human resource management.

MSF has always pursued an active communications policy and maintains a strong relationship with journalists who cover humanitarian disasters. The mainstream media provides essential benefits by making MSF's name and its work known to a wider circle. However MSF is not always able to keep control of the message. MSF also produces magazines, reports and other publications for donors and decision-makers. But the financial cost of publishing makes it expensive to update information as often as MSF would like. The worldwide website is now providing MSF with an opportunity to bring fresh and regular information to more people while retaining full editorial control. The internet complements MSF's other communications activities.

With the internet, MSF is able to provide comprehensive coverage of field activities as they are carried out. Details of MSF involvement in emergencies can be brought to the public immediately and then updated daily - or even hourly. MSF internet coverage of events in Kosovo, Liberia, Turkey and East Timor has brought MSF recognition from the Financial Times, the British Medical Journal, CNN and BBC.

The internet is providing a stunning range of possibilities for all our areas of activity. Human resources and fundraising departments have already begun to explore the possibilities, and communications is benefiting from the opportunity for anybody to register with MSF and receive regular updates on our activities throughout the world, delivered directly to their e-mail address. It also means MSF can reach our supporters - from schoolchildren to retired professionals. This means that we can establish contact with the next generation of MSF supporters, sponsors, volunteers and enthusiasts, and develop a rapport and dialogue with them at a cost that is so minuscule as to become all but irrelevant.

MSF's worldwide web operations will be extended over the next year. Electronic archiving and site development means field staff will be able to stay abreast of MSF activities or retrieve archived material to assist them in their work. This should help to remove the sense of isolation sometimes experienced in field projects and strengthen the sense of MSF as a community.

There is no shortage of possibilities for internet development within MSF because technological progress is moving so fast. However the real development will come from MSF itself. As always with new technology, its effectiveness lies in the resourcefulness of those within the organisation who see the opportunities and embrace the challenge in order to bring it further into the new realm of communication.

Barry Sandland
International Website Editor

OTHER MSF SITES

AUSTRIA (German)

149.148.83.8/msf

BELGIUM (Dutch/French)

www.msf.be

CANADA (English/French)

www.msf.ca

DENMARK (Danish)

www.malaria.dk/msf/index.html

FRANCE (French)

www.paris.msf.org

GERMANY (German)

www.aerzte.ohne.grenzen.de

HONG KONG (Chinese)

www.enmpc.org.hk/msf/

ITALY (Italian)

www.msf.it

JAPAN (English/French/Japanese)

www.japan.msf.org/

LUXEMBOURG (French)

www.gms.lu/~msf

NORWAY (Norwegian)

www.leger-uten-grenser.no

SPAIN (Spanish)

www.barcelona.msf.org/

SWEDEN (Swedish)

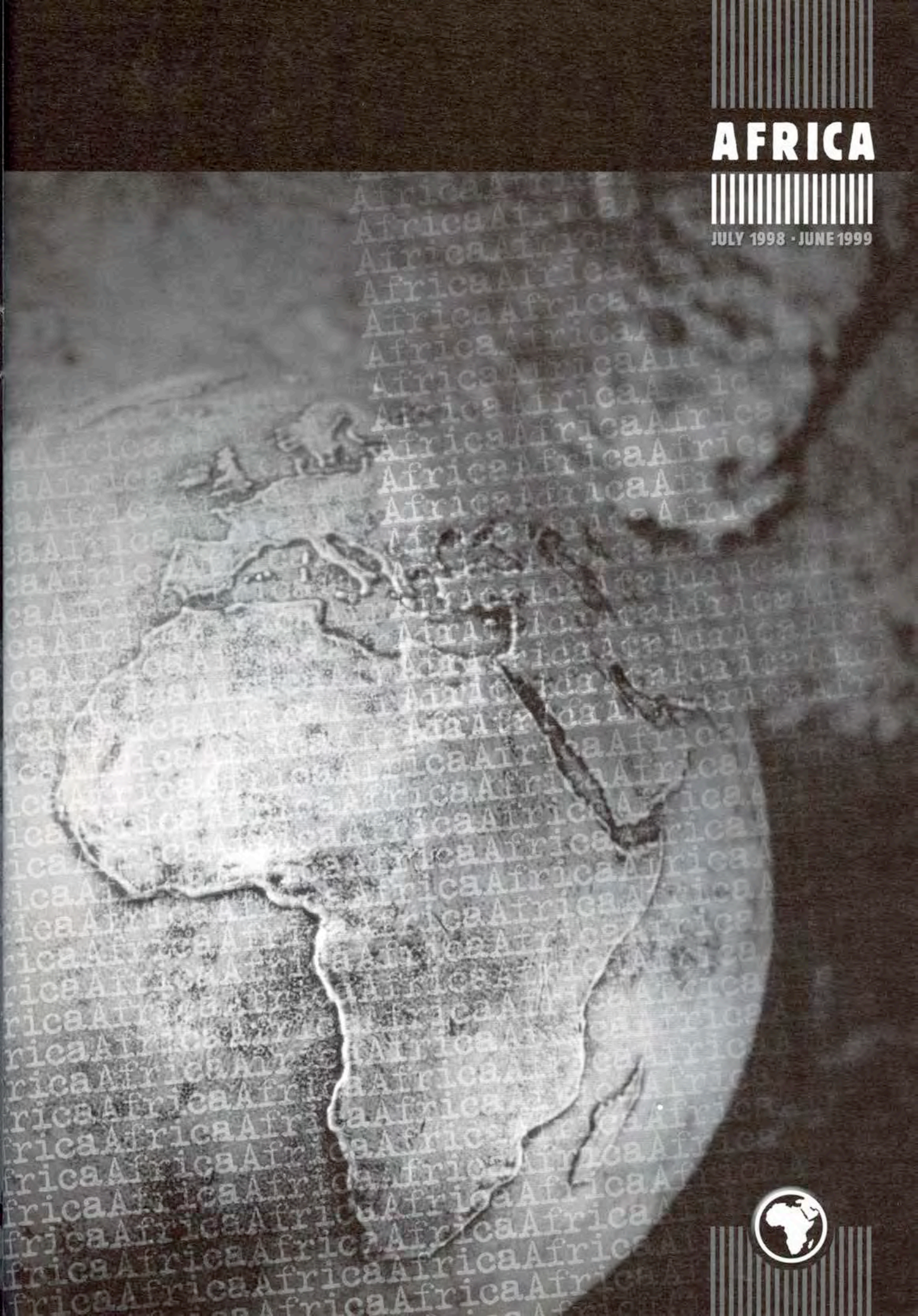
www.stockholm.msf.org

UNITED ARAB EMIRATES (English)

www.dubaicity.com/msf/

USA (English)

www.dwb.org/



AFRICA

JULY 1998 • JUNE 1999



ANGOLA

MALNUTRITION ON THE INCREASE AS WAR RESUMES



Fighting broke out between the rebel group *UNITA* and the Angolan army (*MPLA*) in the summer of 1998. By December, it was clear that a new civil war had begun.

MSF has been present in Angola since 1988 working in a minimum of nine provinces at a time. It is one of MSF's biggest missions. Owing to the renewed conflict, malnutrition is widespread once again and MSF is focusing on providing nutritional assistance to resident and displaced populations in many provinces. Vaccination is also a priority because of endemic diseases such as measles and meningitis.

province, MSF phased out its technical assistance to the Catholic Hospital's tuberculosis centre. In July 1998, following the outbreak of a meningitis epidemic; MSF ran a mass anti-meningitis vaccination campaign in the towns of Caála, Ekunha and Huambo. In Luanda, MSF participated in a large-scale polio vaccination campaign. A cholera prevention programme was also carried out from March to May 1999.

► International staff : 61



photo MSF

ALGERIA

The presidential elections which were held in April 1999 were boycotted by six of the seven candidates. The new president, Abdelaziz Bouteflika, has made many gestures towards re-establishing peace. In the aftermath of his election, an amnesty was declared for prisoners of the *Front Islamique du Salut (FIS)* the political party which won the elections in 1991 but was prevented from taking power by the army. In July 1999, Algeria hosted the conference of the *Organisation of African Unity (OAU)*, the first international meeting of its kind in Algeria in ten years. MSF runs three programmes in Algiers : a mental health training course which promotes new method-tools for counselling, a programme to promote alternative caring methods for child minders in nurseries and an exchange programme for technical and professional workers in the psycho-social field. *Songes*, an aid agency created by MSF, supports Algerian associations. MSF helps rehabilitate health care structures and provides regular medical donations. MSF also provides assistance to Algerians in France.

In Cubal, Benguela province, a nutritional centre is run out of the town's catholic hospital. MSF also provides support to the municipal feeding centre. Nutritional assistance is also provided in Caála, Huambo province, where MSF intervenes in the government hospital. MSF was forced to evacuate from Cuito, Bié province at the end of 1998 because of the fighting. Between January and March 1999, a team was able to return where it carried out a surgical programme. However, in March security conditions were such that MSF was forced to reduce its team. MSF continues to run two nutritional centres in Chitembo and Camacupa. In N'Dalatando in Kwanza Norte, MSF runs a long-term programme to combat trypanosomiasis (sleeping sickness). In Cubal, Benguela

In the capital, Luanda, MSF is phasing out its supervision of two health centres. However, in Luena in Moxico province, MSF runs a mother and child health care programme. Teams also run a primary health care programme in Bibala and Camacupa in Namibe province and another in Huila province. However, security has made it difficult for MSF to reach Huila in 1999. Insecurity in Malange has forced MSF teams to evacuate on several occasions. Nutritional assistance is now a priority and although MSF was running three feeding centres in early 1999, the programme had to be suspended in April. MSF supported the provincial hospital in Zaire province until insecurity forced the teams out in December 1998. Support continues for a health unit in Mbanza Congo.

CASES OF BURULI-ULCER MULTIPLY

In September 1997, MSF began a project in Benin targeting a little understood infectious disease known as *Buruli-ulcer (BU)*. It was first diagnosed in 1988 in the region around Zou. It has since been diagnosed in various parts of southern Benin.

No known medication seems to cure this disease which is caused by the development of a bacteria in the cutaneous tissue. It appears that many of those who suffer from it in West Africa and some parts of Asia live close to stagnant water. Until now, amputations and large skin excisions have been generally the only solutions offered to patients.

Most of the cases of BU are found in the Lalo region of Mono. In 1997, MSF set up a treatment centre in Lalo town. Skin grafts are carried out by surgeons who treat patients as if they were suffering from severe burns. Patients are treated here over a period of one to eight months during which time they must be hospitalised. Surgical interventions began in November 1998. About 20 to 30 patients/months are treated. The treatment is effective if BU is diagnosed in the early stages.

MSF sees the need to train Beninese doctors to treat this emerging disease. In 1998, they financed a one-month training course for a Beninese doctor in the burns unit of Brussels' Nederoverheembeek Hospital.

MSF is also training nurses and other local health care personnel in the early diagnosis of BU and urging them to refer patients immediately to the MSF centre. MSF collaborates on BU research with the Institute for Tropical Medicine in Antwerp, Belgium. The current concern is to find effective medication to treat BU.



- National staff : 25
- International staff : 2

BENIN



BRINGING AID TO OUAGADOUGOU'S STREETCHILDREN

Since the summer of 1998, MSF has been assisting streetchildren in the capital, Ouagadougou in collaboration with local agencies. The main objectives are to improve their access to health care and psycho-social assistance.

MSF is teaching basic medical skills to the *ainés*, a group of older children who have emerged as leaders. MSF is in the throes of setting up a referral health network and also a network of people in town who the children can turn to in times of need (e.g. street vendors and other town dwellers).

For the future, MSF would like to explore the different categories of streetchildren. There are three main types : those who are totally homeless, those who have a home

but who spend most of their time on the streets and those suffering from drug addiction and alcoholism. MSF is also investigating the growing problem of child prostitution.

In Soum, MSF volunteers helped staff in 10 health centres combat epidemics by providing training in the diagnosis of disease, in upgrading the quality of prescriptions and in the effective management of medical stocks. This programme drew to a close in May 1999.

BURKINA-FASO



- National staff : 15
- International staff : 3

BURUNDI

PRIMARY & EMERGENCY HEALTH CARE



Since 1993, government troops and rebels have been at war. The western part of the country is currently the most affected. Peace negotiations have so far led nowhere. The economic embargo was finally lifted in early 1999.

In the western province of Kayanza, MSF carries out medical supervision in the provincial hospital and health centres. MSF runs a therapeutic feeding centre in the southern town of Matongo and distributes supplementary rations.

In Makamba, an MSF team runs a surgical programme for the war wounded in the province's main hospital. MSF also supplies medicine to 22 provincial health centres.

tors patient care in the 50-bed Kinyinyo hospital and provides logistical backup.

In Karusi, MSF works in an 80-bed referral hospital and seven health centres, providing surgical support, supplying medicine and supervising nursing care. MSF runs a therapeutic feeding centre which will soon be reintegrated into the paediatrics ward. MSF supports the provincial health centres' feeding programmes. In the poor, isolated province of Cankuzo, MSF carries out a surgical programme in the 120-bed hospital. In the newly reopened 50-bed hospital in Muroro, MSF supervises health care and completes its medical supply. MSF also trains health care staff and traditional birth attendants for eight health centres. Following a nutritional survey in August 1998, MSF continued to run nutritional programmes out of eight provincial health centres.

In central Bujumbura, MSF runs a centre for the wounded as many people are afraid to go to hospital for treatment. Many patients have been wounded in the fighting which continues sporadically in the city. MSF treats cases where possible and refers the more serious injuries to hospital. MSF also runs a therapeutic feeding centre in the city. Since July 1998, MSF has intervened in several cholera emergencies throughout Bujumbura province and in neighbouring Bururi province. MSF has been able to intervene more effectively because of the emergency response centre it set up in the capital.



photo A. Bertran

In the eastern province of Ruyigi, MSF is in the last phase of its programme to support the health care system since 1994. MSF teams have worked in the referral hospital and nine health centres. The team has reintegrated a feeding centre into the paediatrics ward of the hospital and is running several feeding programmes out of the health centres. MSF moni-

► International staff : 24

CENTRAL AFRICAN REPUBLIC

MOTHER AND CHILD HEALTH CARE ASSISTANCE



In the new parliamentary elections called in December 1998, the incumbent President Ange-Félix Patassé managed to retain control of the government.

Regional instability continues to affect the population, the vast majority of whom live in great poverty and have little or no access to health care. In May 1999, MSF launched a project supporting three maternity wards in Bangui. This project targets 99,000 women and their future new-borns and will run for three years. The main focus is on technical assistance, management and rehabilitation. MSF intends to build or rehabilitate surgical theatres inside the maternity wards.

In January 1999 MSF gave medical assistance to refugees coming from the Democratic

Republic of Congo (DRC) in a transit camp located in Bangui Port. By February, MSF finally managed to support the nearest health structures in Zongo and Libengue towns inside DRC, a boat-ride away.

In March 1999 a rise in meningitis cases was reported in those northern parts of the country bordering Chad and Cameroon. An MSF exploratory mission saw cases of meningitis but nothing to indicate an epidemic or the onset of one. The organisation donated chloramphenicol to health structures in the affected regions.

► International staff : 3

LARGE-SCALE HEALTH CARE PROGRAMME

MSF has been present in Chad since 1981, where teams run a large scale assistance programme which benefits 11% of the 6.5 million strong population. Although the country continues to lack qualified health professionals, the situation is improving. At the end of 1999, 33 doctors and 125 nurses will qualify for the first time in 12 years.



Photo A. Kazmierak

MSF's long-term programme in the southern region of Mayo Kebbi now extends towards neighbouring East Logone. 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. MSF runs seven district hospital programmes where surgery is carried out and works in 12 health centres. MSF also supports laboratories in 36 health centres. The team

supervises health posts and carries out clinical follow up. MSF also provides medicine and medical material to pharmacies.

A team intervened in a meningitis outbreak in southern Chad from February to March 1999. MSF had vaccinated several districts in 1998, including 2,000 Sudanese refugees. MSF prepares for foreseeable emergencies such as epidemics and is helping coordinate inter-border cooperation on cholera in Cameroon and Chad.

MSF provides primary health care assistance in the densely populated southern district of Koumra in the Sahr prefecture. This project started in 1995. Here, the team deals with many endemic illnesses such as malaria, diarrhoea, bleeding diarrhoea, respiratory infections and schistosomiasis, which is a disease caused by infestation of the body with blood flukes. MSF has built dispensaries and rehabilitated Koumra Hospital, where it opened a new surgical wing. MSF supplies medicine and medical material to health structures in Koumra and oversees health care training. A cost recovery system is now in place.

CHAD



► International staff : 30

FIGHTING RESULTS IN FOOD SHORTAGES

Since December 1998, Congo (Brazzaville) has been once again plunged into a civil war which has resulted in the displacement of 50,000 in the north of the capital where today more than 26,000 live on 18 sites in precarious sanitary conditions.

MSF's main focus today is nutritional assistance. MSF opened a feeding centre in Brazzaville in early May which caters for young and old. There is an average of 80 new arrivals each week. MSF returned to Brazzaville's Makélékélé Hospital in 1999 where it had worked during and in the immediate aftermath of the civil war in 1997.

It was almost unrecognisable, overgrown with weeds and abandoned

grenades. In May, MSF finally returned to the hospital to carry out an assistance programme providing backup to the emergency room, the paediatrics wing and the outpatients department.

Given the difficult living conditions for many of the displaced, it came as no surprise that there were cases of cholera diagnosed in Brazzaville city. From 1 February to 28 April, the University Hospital registered more than

100 cases, of which 15 were untreatable with antibiotics. 42% came from the displaced sites, and 58% from other parts of the city. Fortunately, the outbreak never reached epidemic proportions. Following a government request, MSF set up a cholera treatment centre in the hospital. MSF has been involved in the rehabilitation of this hospital and has provided training to nurses and has supplied medicine and medical and logistical material to the hospital.

On 8 March 1999, there were almost 27,000 displaced on 18 sites in the northern quarters of Brazzaville and as many again living with host families; *The International Committee of the Red Cross (ICRC)* and the Federation of the Red Cross have taken charge of all the sites. MSF has provided water and sanitation assistance for the 7,000 displaced living in the Kimbanguiste and Salvation Army camps.

CONGO (BRAZZAVILLE)



► International staff : 3

DEMOCRATIC REPUBLIC OF CONGO

MSF INVESTS IN HEALTH DISTRICTS



Since August 1998, Congo has been the scene of conflict with more than 19 armed groups waging war on its soil.

MSF supports 19 health districts in the territory held by president Laurent Kabila and is relaunching 18 in the rebel-held zone. Constant attention is being paid to the danger of elevating the quality of care to a standard which cannot be sustained by local means. More community involvement will be needed.

Following the outbreak of fighting in August 1998 in the capital, Kinshasa, MSF lent its support to 16 city health structures taking care of the wounded. Backup was also given

region and provides medical and sanitation assistance to 15,000 Angolan refugees. MSF continues to support local health care in eastern Congo. This includes the reconstruction of devastated clinics, the distribution of medicine, mother and child care and water and sanitation assistance. The objective of MSF's AIDS/STD programme is to limit the transmission of HIV by improving care and carrying out a national information and education campaign. Treatment is provided through specialised centres but is also integrated in the

horizontal programmes in health districts. Counselling and education are priorities. In four health districts in Equateur province, MSF is involved in active screening for trypanosomiasis (sleeping sickness), supervision of patient care, supply of medicine and vector control. MSF has created an emergency pool of MSF volunteers who focus on accelerating and improving the organisation's reaction to medical and other crises. MSF has intervened in polio, measles, meningitis and cholera campaigns. In



photo Ph. Revelli

to four hospitals, mainly in the form of medical supply and electrical and sanitation work. MSF also carried out a similar emergency programme in Lubumbashi. Security was so poor at this time that MSF teams were forced to evacuate from Kisangani.

MSF works in two hospitals in the Bas Congo

1999, MSF ran a mass measles vaccination campaign for 50,000 children in Nsona-Mpangu and Kimpese. MSF provided water and sanitation assistance following an outbreak of Marburg fever in April and May 1999 and also provided nutritional assistance in Kisangani at the same time.

- National staff : 185
- International staff : 30

CÔTE D'IVOIRE

BRINGING AID TO PRISONERS



The enforced cost recovery programme introduced in 1990 has had a poor effect on the population's access to health care in both rural and urban areas. In the countryside, health coverage continues to be very poor.

Since 1997, a team has been running a medico-nutritional programme in the La Maca prison in the capital Abidjan. Overcrowding is a major problem in La Maca. The prison was built for 1,500 people and yet there are currently 6,000 inmates (or a third of the country's prison population). MSF runs a nutritional centre for 200 malnourished adults and gives medical consultations to the prisoners. The level of hygiene and the quantity of clean drinking water improved owing to MSF's water and

sanitation activities. This is not the first time that MSF has brought humanitarian assistance to the prison. In 1991 and 1995, there were interventions following cholera outbreaks.

MSF also runs a medico-nutritional programme for the Liberian refugees living along the banks of the Cavally River in the southern Tabou region.

- National staff : 50
- International staff : 7

PROJECTS AT CROSSROADS

Elections in March 1999 brought no surprises as the incumbent regime claimed an overwhelming victory. Although the economy should be buoyant, owing to petrol reserves, basic services and public structures such as the health care system continue to deteriorate.

After a promising pilot phase, MSF has been preparing and negotiating a health education programme on a nation-wide level in cooperation with another international agency; *Educación Sin Fronteras* (Education Without Borders) as well as the Ministry of Education. Progress is limited as administrative procedures and

people begin to adopt healthy and hygienic lifestyles from an early age. Educational facilities are also being renovated, with an emphasis on the construction of wells and latrines. MSF teams are also trying to improve access to health care for the urban and rural populations living in and around



photo G. Almerdona

bureaucracy appear to be crippling the project. Activities would include developing and publishing a teacher's manual for health-education, training teachers about health matters, developing a "Hygiene and Health" module for inclusion in the curriculum for teacher-training college and introducing health education as a subject for primary school children. MSF believes that it is important that

Bata. The estimated target population is 30,000 people. The teams' main activities are carried out in a health centre and eight dispensaries and include the management and supervision of mother and child health care, vaccination programmes, water supply and the construction of latrines.

EQUATORIAL GUINEEA



- National staff : 31
- International staff : 3

EGYPT

There are between 60,000 and 200,000 children living rough on the streets of Cairo. MSF runs an assistance programme with the primary objective of improving their access to health care. Alongside two Egyptian doctors and health workers from a local association, MSF runs a health centre four days a week. Medical consultations are carried out in a dispensary where free medicine is supplied by MSF. The team is also trying to improve streetchildren's access to hospitals, accompanying individual children where necessary. A sexually transmitted disease (STD) prevention drive has also been launched and MSF tries to educate children on the dangers of drugs.



- ▶ National staff : 70
- ▶ International staff : 25

Since May 1998, Ethiopia and Eritrea, which became independent in 1993, have been at war. Eritrea lays claim to the area around Badme and Shirao

Following the fighting which ensued when Eritrea invaded the Badme region in May 1998, a large number of Ethiopians and Eritreans were displaced from their homes. MSF started an emergency aid programme for the displaced and Ethiopian refugees from Eritrea. When war broke out, MSF launched an emergency programme in the area, where teams had been already running a hospital programme to combat kala azar. Medical care and

benefit of four hospitals. The programme involves practical training for surgeons and surgical nurses, the supply of surgical equipment and the renovation of operating theatres. MSF also supports the public health system in North Wollo. Here, a team works out of Woldya Hospital and four health centres. The programme focuses largely on training health care workers, providing a referral service, supplying medicine and medical equipment and renovating health structures. In the northeastern Afar region, MSF has also introduced surgery in the region's only hospital which is located in Dubti. Training for hospital staff is provided at all levels. In the capital, Addis Abeba, MSF runs an AIDS programme and supports AIDS and STD control in 13 health centres. MSF targets sex workers and focuses on providing education and raising awareness on AIDS and STDs in the community. Part of this programme also aims at improving family planning. In the Somali region, MSF has been running a tuberculosis (TB) treatment programme in Jijiga since 1997. There are currently 1,110 patients enrolled in the programme which is based on the Directly Observed Treatment Short course chemotherapy (DOTS) strategy. Unfortunately, the programme is at risk because of insecurity. In Degahbur, MSF runs a health and rehabilitation programme for health centres. MSF supplies drinking water to health structures which service both sedentary and nomadic populations. Here too,



photo R. Job

water and sanitation assistance was provided in three locations for 3,000 people. MSF helped local authorities relocate the hospital and its patients to a more secure area.

In Central Tigray, a latrine construction programme was launched to facilitate the integration of 40,000 displaced in Adigrat town. MSF supported surgical services in Mekelle Hospital.

In Central Ethiopia, MSF ran a malaria control programme. In the South-West, water and sanitation assistance was carried out by the team for 12,000 Sudanese refugees. A new kala azar project was launched in the south. In November 1998, MSF organised a kala azar workshop in Addis Ababa, which was attended by participants in MSF projects in northern and southern Sudan and Ethiopia, as well as by representatives of local organisations and WHO.

In Woldya, the capital of North Wollo, MSF runs a surgical training programme for the

security problems have forced the team back to Jijiga for long periods.

Since May 1996 MSF works on developing water supplies for people living in isolated and inaccessible Wag-Hamra in the western Amhara region. MSF also trains villagers on judicious methods of storing and using water and on other health issues. The programme now incorporates several dozen villages. MSF has set up water and sanitation committees in the villages to ensure the longevity of the programme.

The Salamago Health Development Project evolved as a response to the plight of three tribal groups living a precarious existence in the south west of Ethiopia. The project involves the construction of health posts, redynamising health programmes, facilitating the training of health workers and traditional birth assistants (TBAs). Health care assistance is being provided to isolated villagers for the first time in over 20 years.

MSF SUPPORTS NATIONAL TB PROGRAMME

Since 1988, MSF has supported the national programme to combat tuberculosis (TB) by supplying medicine and laboratory material to health structures.

The national TB programme covers the whole country and is run out of 33 anti-tuberculosis centres in 33 prefectures. The government has adopted the *Directly Observed Treatment Short course chemotherapy (DOTS)* strategy to combat TB. This is the most effective currently available because it reduces the numbers of patients who become multi-drug resistant. MSF supports the govern-

There are an estimated 400,000 Sierra Leonean and Liberian refugees in Guinea today. Although many of the Liberians are being repatriated, the number of Sierra Leoneans has increased. As many as 160,000 arrived in Guinea after the attack on Freetown at the end of 1998. The UNHCR set up a camp for them in Gueckedou South where MSF provided medical assistance. However, they had to



ment initiatives in the western prefectures of Mamou and Labé where there is a population of 2.5 million. MSF is also involved in the rehabilitation and the direct supervision of the TB treatment centres in these prefectures as well as in the capital. In Conakry, other than the city TB control centre, MSF supervises 16 satellite centres which bring medical care to people living on the outskirts of the city. This project aims at screening and treating the greatest number of patients possible.

MSF has a 12 year history of trying to re-energise the health system of Guinée Forestière. Results have been mixed. MSF continued to work in N'zerekore Hospital until the end of June 1999 at which time the project drew to a close. MSF is currently reflecting on possibilities for future assistance in this region.

be moved because of rebel attacks on the camp from across the border. MSF also provides medical assistance in the Forecariah region Southeast of Conakry, to 55,000 Sierra Leonean refugees. After the attack on Freetown, 15,000 new refugees also arrived in this area. Once again there were rebel incursions in these border camps and the refugees had to be moved. MSF provides primary health care and water and sanitation assistance.

GUINEA



- ▶ National staff : 300
- ▶ International staff : 18

GUINEA-BISSAU

In June 1998 there was an attempted *coup d'état* against the president João Bernardo Vieira followed by several months of armed conflict between forces loyal to the president and the military Junta.

Up to 300,000 people fled the capital Bissau at this time. MSF opened an emergency mission inside the country to help the civilian victims of the unrest, providing assistance to rural and urban populations and to the displaced. Activities included support to surgical referral centres, basic health-care for the displaced, vaccination against measles, water and sanitation activities, epidemiological surveillance and emergency preparedness. These activities continued until the end of 1998.

In February 1999 the fragile peace structure imploded, and the fighting in the capital Bissau resulted in newly displaced people. Emergency activities were renewed, this time coinciding with a meningitis epidemic which affected most of the country. The entire country was vaccinated between February and May 1999, with 95% coverage. Since early June, Vieira has been living inside the Portuguese Embassy as diplomats and the transitional government deliberate on whether or not he should be allowed go into exile in Portugal or be made to stand trial in Guinea Bissau. The emergency mission is over and plans for closure are underway.



- National staff : 180
- International staff : 21

An estimated 1.4 million Kenyans were infected with HIV in 1997. At this time MSF set up a comprehensive AIDS programme in the Nairobi slums which focuses on the provision of home-based care with community participation.

MSF also runs an AIDS and TB programme in Homa Bay, western Kenya. The objective is to reduce HIV transmission and to provide care to AIDS and TB patients. In the local hospital, MSF has set about improving hygiene, making blood transfusions more safe and improving water supply. MSF intends to start anonymous screening for HIV.

climate phenomenon in early 1998 and the propensity for large parts of Northern Kenya to succumb to drought, MSF created a post-flood emergency programme in the Northern part of Mandera district. Here, MSF's mobile clinics provided basic health care services. The team supervised vaccination, closely monitored the nutritional status of the population, and helped the



photo R. Job

In Nairobi's Kibera slum, MSF runs activities at Ushirika dispensary with community participation. The programme includes consultations, vaccination, mother and child health care, training of the clinic staff, health education, and the setting up of an early warning system for epidemics. MSF also supports a community run dispensary in a slum in Matharé district which covers a population of 40,000.

Following the floods provoked by El Niño

Health ministry set up an early warning system for identifying epidemics. The project drew to a close in October 1998. From June to December 1998, MSF also carried out emergency nutritional assistance for the mainly nomadic population in 15 feeding centres in Marsabit and Samburu districts. MSF intervened when shigellosis broke out in Samburu in October using mobile teams.

From June to November 1998, MSF also carried out emergency nutritional assistance through feeding centers in Mandera district. From November 1998, MSF continued closely monitoring the nutritional status of the population. In May, MSF relaunched activities in a feeding centre and seven distribution points.

Kenya hosts a large refugee population mainly from Somalia and South Sudan. Health and nutritional assistance are provided to 110,000 refugees in Dadaab refugee camp in Garissa district.

photo R. Job



MSF RELAUNCHES HOSPITAL PROGRAMMES

Relaunching the health care system has been difficult in Liberia because of a lack of funds and a desperate lack of human resources. There are only 77 Liberian doctors in the whole country.

MSF provides medical and logistical support to the 60-bed Harper Hospital in the eastern province of Maryland. The team oversees consultations and vaccination activities, mother and child health care and laboratory work. MSF is also rehabilitating the hospital and supplying medicine and medical material and has relaunched the hospital surgical programme. At the end of 1998, MSF closed Swedrelief Hospital in Monrovia but continued to work in the capital in Redemption Hospital. MSF also runs programmes in four clinics linked to the hospital in Montserrado county. MSF provides incentives to staff and helps with the management. Another programme runs in the hospital in Tubmanburg, Cape Mount. However, activities in Voinjama hospital, Lofa County are currently on standby following looting and insecurity in April 1999.

Although most of the 700,000 refugees have been repatriated, there are still many displaced communities inside the country. In February 1998, renewed fighting in neighbouring Sierra Leone result-

ed in the arrival of 30,000 refugees in the north. MSF set up a refugee camp in Kolahun. Activities focus on the provision of drinking water and water and sanitation assistance. MSF also provides nutritional assistance for the most vulnerable refugees.

In 1998, MSF ran a primary health care programme covering five counties including Monrovia. In Bong and Margibi counties, MSF teams support four clinics and prepare for emergencies such as cholera.



LIBERIA



- National staff : 500
- International staff : 17

photo R. Job

FOCUS ON PLIGHT OF CHILDREN

In Madagascar, 74% of the population live under the poverty threshold. Marginalised populations such as street children, the institutionalised and detainees have little access to health care.

In the capital, Antananarivo and in Antsirabe, MSF runs programmes targeting 6,500 children living on the streets. MSF is setting up a network of health care professionals in order to improve their access to health care. MSF legal experts are pushing for the authorities to respect children's rights. Psychological and psychiatric assistance are provided to those who need it. At night, MSF runs mobile teams on the streets of the two cities. In the capital, MSF targets 700 minors living in seven institutions and the city prison. Assistance is also given to 230 female prisoners. Once again, MSF focuses not only on finding ways to ensure adequate access to health care for the target group but MSF legal experts are also working on behalf of individual child prisoners. MSF pushes the courts to bring a backlog of cases to trial so that all those children in preventive detention can be taken out of an environment so detrimental to their development. MSF carries out a similar programme on a smaller scale in Antsirabe. In Morondava on the western coast, MSF has been running a project to combat STDs and

AIDS since September 1998. As AIDS prevention is a priority, raising awareness about transmission is an essential part of the programme. MSF intends to provide logistical and technical assistance to the laboratories in Morondava hospital with a view to limiting HIV transmission.

Since 1997, MSF is relaunching basic health care structures including two referral hospitals in the southern district of Betioky, an area inhabited by 164,000 people. MSF trains staff, supervises hospital care, manages medical stocks, rehabilitates buildings and has set up a health information system. MSF's main focus is improving mother and child health care. In Ambovombe in the deepest south, MSF is part of an effort to run an early warning system for nutritional emergencies. MSF has recruited a Madagascan doctor to participate in an initiative run by the European Union and the AEDS agency, to plan for such emergencies. MSF also forms part of an emergency committee which focuses on how best to respond to catastrophe, whether it be a nutritional emergency or a natural disaster.

MADAGASCAR



- National staff : 15
- International staff : 3

MALAWI

MSF COMBATS GROWING AIDS PROBLEM

Life expectancy in Malawi is 57 years, but is expected to fall to 36 years by 2005 because of the AIDS epidemic.

Since 1994 MSF has run a programme to combat STDS and AIDS in Mwanza district. In 1997 this was extended to include Chiradzulu district. This preventive and curative programme focuses on providing assistance to health centres, hospitals and schools targeting the sick, the young, prisoners and sex workers. MSF is also helping ensure the safety of blood transfusions. MSF also runs an AIDS prevention programme in Thyolo district where one in four people is HIV positive. The team distributes information on AIDS and raises awareness on how to prevent its spread among the sections of the population most at risk. MSF also trains health workers, traditional healers

and counsellors in dealing with people infected with the HIV virus. MSF monitors the quality of home-based care provided to AIDS patients by community groups. In 1999, MSF intervened during a cholera epidemic in all its project sites in southern Malawi as well as in the capital Blantyre by setting up cholera camps and providing water and sanitation assistance. MSF continues to provide water and sanitation assistance in Thyolo district in an effort to ward off disease. MSF supplies drinking water to health centres, maternity wards and neighbouring villages. Incinerators and latrines have been put in place.



- National staff : 63
- International staff : 11

MALI

PLANNING FOR EPIDEMICS

MSF helps the government prepare for epidemics such as meningitis, measles, haemorrhagic fevers and diarrhoea by carrying out epidemiological surveillance.

MSF also supplied the medical emergency stock in Bamako. MSF has rehabilitated the infectious disease wing of the Bamako hospital. In collaboration with the government, MSF is launching a media information campaign on meningitis. A pilot programme was launched in the Southwestern region of Kayes which has a population of 1.3 million inhabitants divided into seven health districts. Here, MSF focuses on preparation for epidemics on a local level. Activities include epidemiological surveillance, storing medical supplies and the distribution of information on infectious disease.

In Koulikoro, to the north of Bamako, MSF combats debilitating eye conditions which can result in blindness. MSF provides support for training and supervising medical and paramedical staff in ophthalmological techniques. Training is provided in the diagnosis and treatment of diseases such as xeroma and trachoma. In order to raise awareness in the population, MSF organises dramatic representations in community centres which deal with subjects such as eye hygiene. MSF runs a primary health care programme in the southern region of Yanfolilia-Selingué which targets a population of 60,000. Since 1997, MSF has reorganised the local health centre and has created several community centres. The community now participates in the costs of health care. MSF targets a preventive and curative health care programme at the 78,000 inhabitants of Ansongo in Northern Mali. Since the Tuareg rebellion in the first half of the 1990s, the development of the health care sector has been slow. Seven dispensaries have been identified for medical support, and partial or total rehabilitation. Mobile teams have organised rounds of vaccination for a population which has not been vaccinated in years. MSF also organises information and education seminars. As the system of cost recovery which has been introduced in the southern regions is not viable in the north, MSF is studying other ways of helping the health service become self-sustaining.



- International staff : 10



photo MSF

HEALTHCARE FOR URBAN AND ISOLATED POPULATIONS

Rural migration continues to the urban centres, mainly Nouakchott and Nouadhibou. Consequently, the primary health care system needs to be strengthened particularly with regard to mother and child health care.

MSF continues to run a primary health care programme for inhabitants of Toujounine, lying 10 kilometres from the centre of the capital Nouakchott. This programme was first launched at the end of 1996 and is now in a transitional phase aimed at providing a health care system that meets the populations needs. The team's objective is to improve access to health care for both the local populations and the displaced. The team is involved in a variety of activities aimed at improving health care, and most particularly mother and child health care : training in pre/post-natal care, vaccination, nutrition, and health-care management. In March-April of 1999 MSF launched a nutrition and vaccination programme in the central region of Tagant,

whose population has long been subject to minimal attention in, among others, the health-sector. In april a measles outbreak affected the region, calling attention to the need for improvement in the health-information system (this concern resurfaced in May 1999 when meningitis cases were detected in the southern regions of the country).



- National staff : 5
- International staff : 6

photo M. Serti

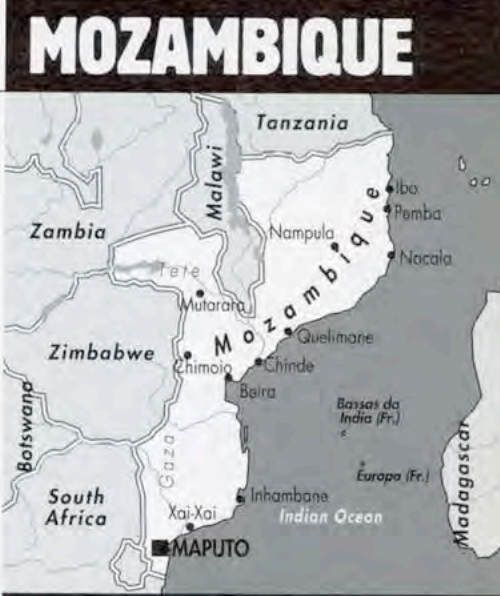
ASSISTANCE DURING CHOLERA EPIDEMIC

Until April 1999, one of MSF's priorities in Mozambique has been the organisation of a large-scale emergency assistance programme to combat a nationwide series of cholera outbreaks.

There have been several massive outbreaks since August 1997. MSF has intervened in six out of Mozambique's 10 districts. Teams have set up more than 150 cholera camps to treat victims of the disease and have implemented water and sanitation programmes to prevent new outbreaks. Water and sanitation remains a priority for MSF, given the ongoing threat of cholera. In Zimpeto, an urban area on the outskirts of the capital Maputo, MSF runs a low cost sanitation programme in collaboration with national and local health and water authorities. The main objectives of this project are to improve living conditions, to demonstrate the link between water-health and sanitation and to change the behaviour and practices of the community. MSF participates actively in the Mozambican government's decentralisation initiative for the public health system. In Mandima and N'gaúma, in the isolated northern district of Niassa. MSF supports two health centres and 11 health posts. The objective is to improve

primary health care and mother and child health care and to improve vaccination coverage. MSF supplies medicine and medical material, trains health workers and provides health care at the community level with the help of 150 local activists and health workers trained by MSF.

MSF supports the rural hospital programme in Mutorara, in the western district of Tete. While a new hospital is being built, MSF is providing technical and medical support to the district which includes 11 health posts and clinics and a health centre setting up rehabilitation and sanitation activities. MSF is also in the throes of launching a water and sanitation programme in order to bring drinking water to the communities. Until August 1998, MSF also ran a project supporting the health system in the southern district of Matutuine. The MSF Consolidated Information System was set up in 1992 and collects information on the health and nutritional situation throughout the country.



- National staff : 40
- International staff : 13

NIGERIA

MSF INTERVENES IN CHOLERA EPIDEMIC



The densely populated west African country Nigeria is often plagued by epidemics, notably meningitis as it is located on the so-called meningitis belt.

In 1998, as part of an emergency preparedness and response (EPR) programme, MSF trained over 200 monitoring and evaluation officers in 11 northern states, to monitor, report, control and respond to outbreaks. As the impact of the programme was seen to be limited, in 1999, the EPR programme was reduced in its scope and now covers only Kano state. MSF now focuses on job training at the hospital and laboratory surveillance. A cholera epidemic broke out in the last weeks of March 1999 in and around the northern city of Kano. MSF set up five oral rehydration therapy units (ORTs) as well as a cholera treatment centre in the local hospital. In the space of eight weeks, 2,379 patients were treated, 39 of whom died. At the end of May, however, an unprecedented number of serious cases continued to be registered. Treatment was hampered by a nation-wide strike of government personnel with the result that nursing staff in the cholera treatment centres abandoned their

work - and their patients. Since all government medical personnel were on strike, the cholera treatment centre also had to deal with an influx of non-cholera patients, a number of whom died. MSF trained health educators in the field of cholera prevention and distributed literature explaining the causes of cholera and the ways to prevent it. The MSF team also provided health information to water vendors, who supply the drinking water for more than half of all Kano households.

In early April 1999, there was a meningitis outbreak in the north-eastern state of Yobe. MSF set up vaccination teams and vaccinated more than 7,800 people in isolated villages in the state. MSF investigated several measles outbreaks in May which resulted in the launch of a curative programme. MSF also runs a water-borne disease-control program in Amukoko, a Lagos slum which has a population of 320,000.

- National staff : 10
- International staff : 69

RWANDA

HEALTH CARE IN THE DISTRICTS



MSF is providing general health care assistance in several districts. Widespread insecurity in the regions bordering the Democratic Republic of Congo (DRC) still prevents MSF reaching certain populations in need.

In the southwestern province of Cyangugu, MSF provides assistance in nine health care centres and one hospital in the district of Bushenge. The traditional range of health care services includes consultations, mother and child health care, vaccinations and training. In Bushenge, MSF is helping implement a cost recovery programme initiated by the local authorities. An estimated 162,000 people

benefit from this programme. MSF's programme in the southern province of Butare which has been running since before the genocide, is finally drawing to a close. Here, MSF has worked in a health district, providing similar services to those it provides in Bushenge with one notable addition - that is the surgical training MSF provides to doctors. An estimated 340,000 people benefit from this programme.

In January 1999, the insecurity in the border region diminished and MSF finally managed to return to Ruhengeri where a team launched a nutritional programme. MSF set up a feeding centre in Ruhengeri hospital and two others in Janja and Mataba. Malnutrition has since fallen and the programme will have probably end soon.

MSF is also exploring the possibility of launching a mental health programme. The Rwandan population has still not come to terms with the genocide which destabilised Rwandan society. MSF is trying to rebuild confidence between Rwandan and International agencies such as MSF.

MSF is also reflecting on its own place in Rwandan society today and in the future.



benefit from this programme. In Nyagatare, near the Congolese border, MSF provides assistance to a camp of several hundred people, all of whom are either refugees or retur-

photo R. Bohle

- National staff : 250
- International staff : 15

WAR SURGERY A PRIORITY

At the end of 1998, heavy fighting resumed in Freetown and the campaign of terror against civilians continued.

The rebels have since been forced out of the capital but still control many of the roads and towns in the surrounding area. It is estimated that there are 50,000 newly displaced people as well as 54,000 new arrivals in Liberia and 70,000 in Guinea. Since the coup d'état in May 1997, MSF has run a surgical programme at Connaught Hospital in Freetown for war-related cases. On 31 January, MSF relaunched the programme after a month-long evacuation. In April and May, the team witnessed a severe rise in the number of mutilated patients. MSF continues to protest against the cruel acts directed towards civilians.

MSF has also been running a surgical programme and an outpatients wing in Brookfields Community Hospital since February 1999. The team is in charge of hospital management and provides health care support to four clinics: Rocupa, Lumley, Goderich and Hastings. MSF also provides medical follow up in a displaced camp in Freetown.

Many of the patients are amputees who have been treated by MSF in Connaught Hospital. A team supplies water to two other camps for the displaced.

Since the renewed fighting, MSF was forced to evacuate from Moyamba, a district which lies to the south of the capital Freetown, where a new medical programme had begun. In the Northern Province, MSF works in Kambia and Portloko districts where MSF runs a dry feeding programme in eight clinics for under-fives, provides water and sanitation assistance and supplies drinking water to the community. MSF also supports Kambia hospital on an ad hoc basis. During the worst of the fighting in January, MSF ran the programme from its base in Guinea.

In the Southern province MSF continues to provide support to six clinics and the district hospital in Pujehun, eight clinics and the district hospital in Bo, and two clinics in Bonthe. Many of these structures have been rehabilitated by MSF.

SIERRA LEONE



- National staff : 150
- International staff : 48

TUBERCULOSIS SUFFERERS RECEIVE CARE

For more than a decade, Somalia has been in a permanent state of civil war. Several peace conferences have been held over the past years but fighting actually appears to have intensified in some areas. Access to health care remains a problem.

In the southern town of Kismayo, MSF provides support to the outpatients department and tuberculosis (TB) ward of the 280-bed hospital. Each year, 120,000 outpatients and 10,000 TB patients benefit from the services provided. Kismayo Hospital is the only one functioning in the whole of South Somalia. MSF's presence also permits a quick and efficient response to emergencies including the endemic cholera, malnutrition problems, the displaced and floods throughout the Kismayo area. In the northeastern city of Gaalkayo, MSF has refurbished and equipped Mudug Regional Hospital. In collaboration with the local community, MSF is setting up a professional management and administration system. Training has been provided for general hospital staff as well as for laboratory technicians and pharmacists. MSF has launched a service for the prevention and treatment of contagious diseases such as cholera and measles. MSF has

also introduced a new policy for use of medicines and diagnosis and treatment practices. The feasibility to start up a TB-programme is being monitored. However, due to the unstable health structure in Northeastern Somalia, this is unlikely in the foreseeable future. In North Mogadishu and the districts of Giohar Mahaday and Aden Yabal (Middle Shabelle), MSF runs primary health care programmes through a network of 12 health centres. Activities include the organisation and supervision of the health care service including consultations for all age groups, dressings and minor surgery, antenatal and postnatal curative and preventive care, vaccination, nutritional screening, health education, training and medical supplies. MSF also runs an early warning system for epidemics and is responsible for the Cholera Treatment Centre in North Mogadishu.

SOMALIA



- National staff : 389
- International staff : 22



- National staff : 1,438
- International staff : 124

The chronic emergency in Sudan, which centres around war, the use of food as a weapon by the warring parties and bad harvests, reached crisis point in the spring of 1998 with the onset of one of the most devastating famines ever to hit the country.

The famine resulted in an estimated 60,000 deaths many of which were preventable. Aid agencies faced many obstacles including limited access to the affected populations owing to insecurity and a government imposed flight ban, the diversion of aid by warring factions as well as many other logistical constraints.

The Khartoum government and the *Sudanese Peoples' Liberation Army (SPLA)* finally

MSF responded to cholera outbreaks in Eastern Upper Nile near the Ethiopian border in April by establishing treatment centres but these were closed and evacuated due to insecurity in May.

MSF runs programmes in West and South Kordofan which is a transitional region between North and South Sudan.

In Dilling, MSF supports three dispensaries and the referral hospital.

In Meiram, where there are tens of thousands of displaced people from Bahr El Ghazal, MSF provides health care and nutritional assistance.

By the end of 1998, it appeared that the famine had been brought under control.

MSF continued the nutritional programme but shifted its attention from the emergency to the causes of the famine.

The main lobbying efforts for MSF focused on the targeted distribution of food rations by the *World Food Programme (WFP)* and the fact that the displaced populations were being denied food rations by local community leaders. Further fighting and insecurity in Sudan may still result in another nutritional crisis before the next harvest in October 1999.

In Khartoum, MSF provides assistance in five camps for the internally displaced.

The displaced are thought to number one million.

The programme comprises activities in three primary health care clinics, two health centres and a feeding centre.

MSF runs two Kala Azar treatment centres in Gedaref state and treats around 5,000 patients each year.

At present a comparative drug trial is being done to introduce a generic drug which would reduce treatment costs to 15% of the current level.

In February 1999, MSF launched a large-scale mosquito net distribution programme in an effort to tackle both Kala Azar and malaria.

Around 160,000 bed nets were distributed and training on public health and education provided.

MSF also runs similar programmes in Eastern and Western Upper Nile.

Since January 1999, MSF has supported the health ministry in its successful efforts to tackle a meningitis epidemic, which broke out in the west of the country and moved to the east. There have been three main activities : patient care, vaccination and epidemiological surveillance.

The sleeping sickness programmes continues in Ibba, Western Equatoria.



photos R. Job

agreed to a cease-fire mediated by the United Nations.

In mid-July 1998. The famine hit hardest in the province of Bahr El Ghazal where MSF launched nutritional programmes for adults and children in Panthou, Ajak, Tieraliet, Ajiép, Thiek, Panliet, Achongchong, Mapel, Wau and Bararud. MSF was also active in the Lakes and Jonglei region where primary health care programmes were complemented with emergency nutritional activities.

The team which had launched a nutritional programme in Leer in Western Upper Nile were forced to evacuate in July due to insecurity. At the end of January 1999, pro-government militia raided the village of Bararud. This resulted in the deaths of 10 civilians, including one MSF national staff member. MSF teams evacuated from this area three times over a six month period due to the nearby raids by government supported militia.

COMBATING EPIDEMICS

The effects of El Niño climatic phenomenon has given rise to longer and more intense droughts in this part of Africa. It is estimated that three million Tanzanians are undernourished as a result.

From December 1997 to September 1998, in the wake of the cholera outbreak in the western region of Kigoma and the capital, Dar-es-Salaam, as well as Mtwara and Lindi on the east coast, MSF teams launched an emergency preparedness programme for future epidemics. Health care staff received training from MSF and a health information system was set up.

From May to November 1998 intervened in a malaria epidemic in the Nshamba division of Muleba district in the Northwestern region of Kagera. The team hospitalised patients suffering from severe malaria, trained

health care staff in dealing with the symptoms and upgraded the referral system. There are currently 300,000 refugees from Burundi and the Democratic Republic of Congo (DRC) living inside Tanzanian borders. In August 1998, MSF set up a transit camp in Kigoma for incoming refugees from the Democratic Republic of Congo. Activities included camp construction, medical consultations, in-patient services and support to neighbouring refugee camps. MSF also runs community health care programmes in the western districts of Kigoma and Kasulu and the Southeastern Mtwara district.

TANZANIA



- National staff : 100
- International staff : 43

RELIEF FOR VICTIMS OF SLEEPING SICKNESS

Although peace has been restored to most of Uganda, ongoing attacks carried out by the *Lord's Resistance Army* in the north and the *Allied Defence Forces* in the Southwest have resulted in major population displacements.

MSF has run a programme to combat the tropical disease trypanosomiasis. This disease, also known as sleeping sickness, is passed by infected Tse Tse flies and is characterised by fever, wasting and sluggishness. MSF's programmes run in Omugo in the Northeastern district of Arua and in Moyo and Adjumani in the extreme north of Uganda. MSF screens for the disease and provides treatment. Currently, MSF and its collaborators are trying to identify the causes of resistance to treatment and through the MSF campaign to push for access to medicines, MSF hopes to ensure a reliable future supply of efficient medicine. MSF teams regularly bring assistance to the displaced in the highly insecure Bundibugyo district. In April 1999, MSF provided emergency assistance to 15,000 newly displaced in Bundibugyo town including a mass vaccination campaign against measles. The team also set up water points and supplied drinking water to the displaced sites. Unfortunately, insecurity forced MSF to evacuate after several weeks.

MSF also runs an integrated health programme close to the Kenyan border in Moroto district. There has been a great deal of ethnic violence in this area over recent years which has led to population displacement and a deterioration of the health services. MSF's objective is to improve the general health status of the semi-nomadic Pokot ethnic group, through a sustainable and integrated health system. MSF is rehabilitating and upgrading the Amudat Health Centre.

Since the project started in 1997, clean drinking water has been made available at the Health Centre, a new tuberculosis (TB) ward has been built. There are also 70 hospital beds, one-third of which are occupied by people suffering from Kala Azar.

MSF continues to help combat Uganda's serious AIDS problem via two Ugandan agencies. MACI promotes changes in behaviour in order to prevent AIDS and changes in attitude towards AIDS patients. THETA seeks collaboration between native healers and health workers for the development of prevention and treatment strategies and the establishment of a referral system between the traditional and "modern" health systems.

For most of 1998, Uganda was in the grip of a cholera epidemic, with more than 46,000 cases reported between December 1997 and September 1998. Working closely with the health ministry, MSF intervened in 40 of Uganda's 45 districts. The epidemic was brought under control during the spring and summer of 1998 and all activities were wound up in September 1998.



photo MSF-S

UGANDA



- National staff : 121
- International staff : 26

ZAMBIA

INFLUX OF CONGOLESE REFUGEES



- National staff : 40
- International staff : 8

Refugees fleeing fighting between rebel forces and the Congolese army in the Democratic Republic of Congo (DRC)'s Shaba province began arriving in Kaputa in northern Zambia on 5 March 1999. To date there are 15,000 of them inside Zambian borders. There is, however, a potential for another mass arrival as long as DRC remains unstable.

MSF works in the Kaputa and Mwange refugee camps where teams provide medical care and water and sanitation assistance. In both camps, MSF runs health clinics where refugees can come for consultations. The most common diseases are diarrhoea, malaria, respiratory infections, skin infections and intestinal parasites. Those in need of hospitalisation are referred to the Kaputa Health Centre. MSF also set up a cholera isolation ward in Kaputa in the early days of the refugee crisis in order to ward off an epidemic.

In Kaputa camp, MSF also vaccinated 4,400 children against measles. The Mwange camp was set up to take in the overflow of refugees from Kaputa. MSF was involved from the start in the site planning and site development.

An MSF team was present in Zambia at the time of the refugee influx where they had been helping authorities cope with a cholera epidemic since February 1999. MSF donated medicine and water and sanitation materials and trained health care staff in their use.

photo R. Böhle



photo R. Böhle

EUROPE

JULY 1998 • JUNE 1999



ALBANIA

MASSIVE REFUGEE AID PROGRAMME



The NATO attacks on Serbia began at the end of March 1999. In the space of the three months, 430,000 ethnic Albanians fleeing ethnic cleansing in Kosovo had come and gone, placing enormous strains on an already insufficient health care infrastructure.

photo R. Job

MSF first worked in Albania in 1981. Prior to the refugee crisis, MSF opened an emergency ward and an intensive care unit in the hospital in Fier, southern Albania.

Here, MSF is assisting the health ministry in developing a long-term health care programme. When the refugees started flooding across the border in late March and early April 1999, MSF provided medical aid and water and sanitation assistance in camps, collective centres, hospitals and health posts throughout the country. Finally MSF built and ran a camp in Kukes close to the Kosovo border from where counsellors also provided psychiatric assistance to refugees.



Although the refugees returned en masse in June, MSF remained in Albania, where reduced teams provide medical aid and water and sanitation assistance in villages in the more remote regions of the country.

ARMENIA

ASSISTANCE FOR STREET CHILDREN



In Yerevan, MSF runs a programme to help street children become reintegrated into society. Homelessness is outlawed in Armenia and the children can be rounded up by the police and sent on to one of many institutions where living conditions are notoriously harsh.

MSF works with street children in two institutions in Yerevan. When the team first arrived in the referral centre at Zeitoun, it was shocked by the large numbers being sent unnecessarily to psychiatric hospitals. Today MSF's Armenian psychologists assess the children individually in order to identify where they will do best. Some are referred to the Vartachen re-education centre where MSF works. Here, MSF is responsible for about 70 young people from 10 to 18 years of age. The team has improved living conditions and runs weekly counselling sessions for 33 children. As none of the children are orphans, MSF tries to help them reforge links with their family and return to education. Last year, MSF established an STD Information Centre in Yerevan. The centre offers advice for those who visit in person, and also operates a free, anonymous information telephone line. MSF is also working in STD prevention in Gyumri - providing STD

consultations and treatment. In this region, MSF has also set up a system for safe blood transfusions.

In eastern Armenia, MSF is working to improve conditions for patients in psychiatric hospitals in Sevan and Vardenis. This work has involved the improvement of staff/patient relations, hygiene and living conditions, as well as the introduction of therapeutic activities. Nutritional assistance has been provided and a referral service is being set up. MSF is setting up a network of local mental health professionals in order to improve the quality of mental health care.

In the northern Tavush region, MSF is working to implement the national project on family planning. In Noyemberian, Ijevan and Berd, MSF targets women of a reproductive age. MSF provides technical assistance to a network of approximately 55 hospitals, polyclinics, dispensaries and health posts.

► International staff : 22

IMPROVING ACCESS TO HEALTH CARE

Reforms to rationalise and privatise the health system complicate access for the most vulnerable, including 845,000 displaced people from the Nagorno-Karabakh war.

In the industrial Northwestern region of Sumgayt, MSF targets medical assistance to over half a million vulnerable people, ten percent of whom are displaced. Teams provide primary health care assistance, with a focus on mother and child health care, in four MSF dispensaries where 3,000 people receive treatment each month. MSF also provides technical assistance and medicine and medical material to governmental referral health structures. MSF runs training programmes on vaccination and the management of the cold chain in five paediatric polyclinics and three maternity wards. Since 1996, MSF and the health authorities have run a scabies control programme. Health education is also an important part of the programme. MSF focuses on distributing information about the preven-

tion of common diseases and reproductive health care. Information seminars are also held by the dispensary staff. In the Southeastern regions of Imishli, Fizuli and Saatli, activities include the provision of primary health care to vulnerable people, public health education, reproductive health care training for gynaecologists and midwives, the treatment and prevention of sexually transmitted diseases (STDs), a malaria programme, emergency medical preparation for disease outbreaks such as diphtheria and plague, rehabilitation and vaccination. The programme targets the 268,000 inhabitants of the region, a quarter of whom are displaced. Until April 1999, MSF ran an immunisation programme in six districts of Northwestern Azerbaijan. In close collaboration with the Ministry of Health, MSF reorganised the vaccination system, trained health care workers in vaccination techniques and assisted in improving and setting up cold-chain facilities. MSF also ran a programme to promote better mother and child health care and family planning for 75,000 women. In collaboration with a government agency, MSF is working on finding ways to improve malaria detection. The organisation also participates in a tuberculosis forum attended by non-governmental organisations and UN agencies which is pushing for the implementation of a national programme to combat the disease. MSF is active in the area of reproductive health and has recently published a manual on contraception. An MSF survey on STDs was carried out in May 1999.



photo A. Givadyelov

EXCLUDED FROM HEALTH CARE

In Belgium, MSF targets the most marginalised members of society. Immigrants, homeless, asylum seekers and refugees receive social, medical and legal aid. Medical consultations are provided to those who have fallen through the social security net.

Since 1988, MSF has been providing anonymous and free AIDS tests in Brussels' Centre Elisa. Up to 3,000 tests are carried out each year. Those diagnosed as being HIV positive are put in touch with social services. They and their families are offered psychological counselling. MSF is bringing doctors and social workers together to find ways to provide more care for drug addicts. A methadone programme is underway.

In collaboration with *Pharmaciens Sans Frontières*, MSF runs clinics in several cities for people who have no access to social and health care assistance. The project also aims to ensure

access for each patient to a system of social protection. 7,000 medical and social consultations are provided each year for a population of $\pm$ 2,300 patients of 70 different nationalities (85% foreign). The Belgian project is also active within the "Mouvement National pour la Régularisation des Sans-papiers et des Réfugiés". The "Mpore" project was set up when the resident Rwandan community called on MSF for help in managing the post-traumatic stress undergone by genocide survivors. Group therapy and individual counselling is provided in Brussels and Liège by a Rwandan psychotherapist.

AZERBAIJAN



- National staff : 80
- International staff : 16

BELGIUM



- National staff : 50
- 50 medical and non-medical volunteers

BOSNIA

TREATING PSYCHOLOGICAL SCARS OF WAR



- National staff : 12
- International staff : 6

photo A. Kazmirakis

Since the Dayton accords were signed in December 1995, the peace process has proceeded slowly. The return of refugees has been problematic owing to the ongoing ethnic tension between the Bosnian, Croat and Serb communities.

Since July 1996, MSF has run a mental health assistance programme in Gorazde. MSF trains Bosnian mental health professionals to treat the many people still suffering from the experience of living through the war. The team is now setting up a psychological rehabilitation centre in Gorazde together with psychologists working in Sarajevo and other parts of Bosnia as well as with the health ministry. The centre will cater for the needs of young

and old. More than 150 patients have been treated already. MSF also provides support to community networks (schools, women's associations, etc.) capable of identifying people who need extra help in coming to terms with trauma and loss so that they can be referred to mental health structures where necessary. In collaboration with Sarajevo university, MSF is training a Bosnian psychologist in order to help the Bosnian health ministry pursue its activities. In Tuzla and Pale, MSF runs a family medicine programme which focuses on facilitating access for families to first-line medical services. MSF is encouraging people to see general practitioners before resorting to specialists. The team runs training programmes for Bosnian health care staff in the rational use of medicine and is identifying other cost-effective methods of organising health care services for the benefit of all.

Since the end of August 1998, almost 22,000 Kosovar refugees have arrived in Bosnia as well as another 3,000 members of the Sandjak ethnic group who fled Serbia during the first half of 1999. MSF works in four camps and is monitoring transit centres. In these sites, MSF monitors and provides primary health care and carries out water and sanitation assistance. The team runs a mobile health clinic for the refugees. In Republika Srpska, MSF runs a mobile clinic, supports local health care structures and carries out the distribution of hygiene products. In the eastern part of the republic, MSF distributes medicines to health structures.



BULGARIA

NEW PROJECT TO COMBAT SYPHILIS



- National staff : 4
- International staff : 2

The health system in Bulgaria is organised around big hospitals and a network of polyclinics where almost all medical attention is specialised. Access to primary health care has become a problem in this country where there is one specialist for 63 inhabitants.

The MSF programme was set up in 1997 during the worst of the economic problems resulting from the transition to a market economy. The effect on the hospitals was devastating. MSF started distributing medicine and medical material to 10 hospitals in the Targovichte and Kjustendil regions. From September 1998 onwards medicines were also distributed to four hospitals in the Montana region. These 14 hospitals cover a population of one million people. MSF also provides technical support to medical management and is foreseeing the computerisation of the pharmacies in seven big hospitals to help manage their stocks.

MSF has been running a pilot project to combat syphilis and other sexually transmitted diseases since July 1998. The programme was launched in response to the revelation that over an eight year period, the number of cases of syphilis had increased from 378 cases in 1990 to 2520 in 1998. In Bulgaria, syphilis treatment is lengthy and expensive. Since July 1998, MSF has set up a new project in six hospitals based on a new and cheaper protocol. MSF is focusing on the importance of training health care professionals to respect the confidentiality of their patients. The team is also providing AIDS education and distributing condoms.

KOSOVO

In February 1998, Serb police started attacking villages inhabited by ethnic Albanians. By the end of March 1999, as many as 300,000 Kosovars had been driven out of their homes. When the NATO attacks started in late March 1999, MSF was present in Kosovo, where teams were running a mobile medical programme for the displaced. Another team was also in the throes of launching a mental health programme for this group of people. MSF's mobile teams were assisting the displaced during most of 1998. However, in September and August, the attacks intensified and MSF stepped up its activities for hundreds of thousands of ethnic Albanians fleeing police attacks. The aid community in Kosovo ran 23 mobile clinics to cover half the population, with

visits to villages every two weeks. MSF continued to donate medicine to *ambulancias* (basic health posts). When war was declared, MSF teams were forced to evacuate for security reasons but launched programmes for the deportees in Montenegro, Albania and Macedonia. In April 1999, MSF published a report describing the deportation process and how the identity cards and belongings of the Kosovars were being systematically destroyed. The report also included witness testimony from the ethnic Albanians arriving in Montenegro, Albania and Macedonia.

KOSOVO & MONTENEGRO



MONTENEGRO

During the ethnic cleansing in the spring of 1999, an estimated 65,000 Kosovars were deported to Montenegro. Some were taken in by Montenegrin families, others went to live in displaced camp. MSF provided assistance to between 15,000 and 20,000 in Rozaje and 13,000 in Ulcinje. MSF activities included the setting up of shelters, rehabilitation and installation of water points, distribution of relief supplies including food rations for the collective centres, support to health structures and the collection of witness testimony. Later on, MSF participated in the setting up of displaced camps in Ulcinje.



photo R. Job

IMPROVING ACCESS TO HEALTH CARE

MSF exerted an exceptional lobbying effort in regard to a bill on universal health cover, which should eventually allow free and direct access to health care to almost six million disadvantaged people.

A programme devoted entirely to this project began in October 1998 aimed at testifying to the difficulties faced by certain groups in obtaining medical assistance and influencing the contents of the bill itself. A large number of MSF's proposals were finally accepted by the National Assembly, which voted in favour of the bill in June 1999. An MSF unit specialised in social and legal matters has continued to assist foreigners living in France with the information and support in completing the necessary formalities. Medical and social activities on behalf of drug addicts in Paris have been integrated into a medical centre run by MSF and opened

to a wider public. Mobile teams have continued to pursue their objectives in regard to reducing infection risks by distributing sterile material (condoms, syringes, etc.) distributors were also installed in front of pharmacies. Mobile teams have also been set up to go out and meet young people hanging around in the streets and tell them about the medical-social centre.

Another medical programme has been initiated for children and young adults in the Wazemmes area of Lille. Consultations for adults are also available in the MSF centre. In Marseille, MSF is also helping to improve the regional health care network.

FRANCE



► MSF staff : 30



In October 1998, MSF resumed its TB programme in the autonomous republic of Abkhazia after an absence of six months.

In the Central TB Hospital in the capital, Sukhumi, MSF set up a laboratory with supplies and equipment, carried out rehabilitation and participated in an internal reorganisation of the hospital. MSF has now begun screening and treating patients in the hospital. It is also providing training for hospital staff in *Directly Observed Treatment Short course (DOTS)* chemotherapy, as well as refresher courses in hygiene and sterility. The orga-

handed over to Ossetian doctors and social workers.

MSF's TB programme is achieving good results with an 85% cure rate for the newly affected. MSF runs information seminars for doctors and is raising awareness in the community on TB issues. In May 1998, MSF started its programme on reproductive health in the Georgian capital Tbilisi and in January 1999, opened an information centre for reproductive health issues.

► International staff : 24

photo J.B. Cunillera



nisation is evaluating the regional polyclinic system in order to create a thorough system of follow-up treatment of TB patients. MSF is involved in assisting vulnerable people through primary medical distribution to health posts across Abkhazia. Medical and social assistance is targeted at 3,000 people who have suffered during the conflict.

In the autonomous republic of South Ossetia, MSF runs a medical distribution programme for 14 health structures in Tshkinvali. MSF's medical and social assistance programme for the 2,000 most vulnerable people in this area is being

In the Zugdidi district of western Georgia, MSF runs an assistance project for those displaced by the Abkhazian crisis. This includes medical supply, rehabilitation of medical structures and training health care staff.

DRUG ADDICTION AMONG MINORS

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 Jugend an Drogenhölle and Jongenheem, 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. MSF also runs an outreach programme and refers addicts for treatment in existing clinics and hospitals. Over the past year, the network has managed to inte-

grate more doctors into the programme, including doctors who work in schools. Forty-eight patients were treated for drug addiction in 1998 of whom 14 were heroine addicts under 18-years of age. 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.

LUXEMBOURG



► Staffing : 3 psychologists

ASSISTANCE IN ROMAN GYPSY CAMPS

There are several hundred thousand gypsies in Italy today, the vast majority of whom are from other countries. Since 1996, MSF has been working in Casalino 700, a camp located on the outskirts of Rome. There are a thousand camp dwellers.

MSF is trying find ways to combat the marginalisation of the camp population which live in poverty and isolation and are caught in a spiral of sickness, unemployment, drugs, violence and prostitution. The team is also trying to help the community take responsibility for their camp and to manage it more effectively. MSF's mobile team provides consultations three times a week. Ante-natal care is provided to pregnant women. Families receive regular medical visits. MSF is also training social and health care assistants and gathering epidemiological information. Upgrading the deplorable hygiene conditions is a priority for MSF. Since the project started in

September 1996 - MSF provides logistical assistance in order to improve the hygienic conditions in the camp (installation of cisterns, construction of latrines and septic tanks). MSF also provides social and legal assistance to the camp dwellers, who need to put their papers in order or to the mainly Bosnian refugees who wish to apply for temporary resident permits. MSF lobbies on behalf of the residents of Casalino 700. It has taken a stand against the police authorities' habit of regularly evicting sizeable portions of the camp population. MSF is also asking for explanations for why the city authorities have decided to move the camp in June 1999.

ITALY



photo F. Scianna - Magnum

MACEDONIA



- National staff : 150
- International staff : 40

MACEDONIA CRACKING UNDER THE BURDEN OF REFUGEES

At the end of March 1999, over 250,000 ethnic Albanians were driven into Macedonia. During the first chaotic days, both the Macedonian government and people went to great lengths to provide a temporary haven for the refugees. But under the surface, ethnic tensions are simmering and the economy has started to fall apart.

Macedonia already had a significant population of ethnic Albanians before the massive deportation of Kosovars. As of late March, more and more were forced into Macedonia from Kosovo. Initially, the government was very reluctant to receive the refugees, afraid that the ethnic balance would tip over. For many days, a large group was out in the open at the border near Blace, unable to move back or forth, cut off by police from aid supplies. Later camps were set up in Stenkocic, Cegrane and other places. MSF constructed

field hospitals in the largest camps, checked the health of newly arriving refugees, prepared for potential epidemics and started mental health programmes to help people cope with their traumatic experiences. In the transit camp at Blace, MSF provided and maintained toilets and washing points.

Meanwhile the majority of refugees found shelter with families. These people needed help with their access to health and emotional traumas as well. In Debar district, MSF supported local clinics and launched a

mental health programme. In Tetovo, MSF also initiated a training programme for counsellors, in close collaboration with the Macedonian Ministry of Health. For its work in the crisis, MSF decided to decline any funding from governments who had a military involvement in the conflict.

photo UNHCR / LeMoynne



ROMANIA



HELPING THE HOMELESS

MSF runs a programme for up to 3,000 of Bucharest's homeless population, about half of whom are migrants from other provinces.

The assistance programme for Bucharest's homeless started in 1997 when an MSF team provided mobile medical care on the streets of the capital. In 1998 MSF opened a centre for homeless people providing a broad spectrum of medical and social care. Collaboration with the Romanian ministry of health has been progressing since and now MSF is creating a medical network for homeless people involving Bucharest's hospitals.

MSF collaborates with the local aid agency, Casa Ioanna, which runs a night shelter with temporary beds. MSF also lobbies national authorities and the Romanian society in order to highlight the problems of homelessness.

- National staff : 5
- International staff : 1

TB TREATMENT IN SIBERIAN PRISONS

Tuberculosis (TB) has once again become a major health threat in Russia. The incidence rate in Siberia appears to be twice the national average. This is largely due to a prison population of over one million living in overcrowded and insalubrious prisons.

Since 1995, MSF has worked in prison hospitals in Siberia, implementing Directly Observed Treatment Short course (DOTS) protocols for the treatment of TB. MSF runs treatment programmes in prison hospitals in Mariinsk and Novokuznetsk. MSF is also involved in the supply of medicine and medical material, rehabilitation work, the distribution of blankets and sheets and the provision of high energy milk to at least seven other prisons. MSF trains Russian health care staff treating the disease and raises public awareness about the prison TB epidemic in order to encourage the authorities to take measures to tackle the problem. Today in Russia, more than 14,000 people have been registered as HIV-infected, 80 per cent of whom are drug users. The number of injecting drug addicts is estimated at 1 million by the Russian authorities. MSF is focusing on this target group by training governmental and non-governmental health professionals in setting up prevention programmes. So far, a total of more than 130 people from 41 regions have undergone such training. In addition, MSF is providing information through contacts with drug users in the streets of Moscow and through in-patient centres. The organisation also conducts safe-sex campaigns through the Russian media together with its Russian partner NGO FOCUS. Furthermore it translates and distributes relevant HIV/AIDS/STD information in printed and electronic form to over 400 NGOs throughout

Russia in close cooperation with the Russian NGO AIDS Infoshare. MSF continues to work in Moscow to improve the situation of the homeless and limit their exclusion from health services. There are an estimated 100,000 homeless people in Moscow. MSF offers 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 where necessary. Free consultations with social workers are also provided and MSF organises general awareness campaigns to focus on the plight of people living on the streets.

MSF recently handed over a similar project to the St Petersburg authorities. MSF will continue to support this project by supplying medicines and medical supplies until the end of 1999.

RUSSIA



- National staff : 55
- International staff : 11

photo R. Job

HELPING THE FOURTH WORLD

The Fourth World project is the name of MSF's socio-medical project for the marginalised population of Barcelona. This project has been in existence since 1994.

MSF targets around 8,000 people, most of whom are intravenous drug users, illegal immigrants, the homeless and all the people with no access to the Public health and welfare services. Elderly people who live on low incomes also come to MSF for health care assistance. The team organises and supervises medical visits in a mobile clinic which makes regular stops in areas of easy access for the target population. The ultimate aim is to reintegrate the patients into the existing health and welfare systems.

There is a syringe exchange programme and condoms are distributed in order to prevent the spread of sexually transmitted diseases (STDs) and the HIV virus. General health information is also provided.

SPAIN



- Staffing : 5 volunteers



AMERICA

JULY 1998 - JUNE 1999





Decentralisation of the health system continues. Rural areas are particularly vulnerable owing to the lack of trained health workers. MSF currently works in Mizque, in the high valley region and since March 1999 in the Chimore municipality in central Bolivia, having phased out of the Illampu health district in western Bolivia towards the end of December 1998.

In Mizque, MSF focuses on supporting and developing the health system in the rural areas inhabited by native Americans of the Quechua ethnic group. An estimated 38,000 Quechua live in these areas. Activities include mother and child health care, training of health workers,

tives at the municipal level also involve mother and child health care, construction and rehabilitation of health posts and health centres, and large-scale water and sanitation assistance in the primary schools as well as the installation of water hand pumps for a total of 2,550 families.

- National staff : 31
- International staff : 8



photo M. Daniels

In addition to ongoing mid and long-term development programmes, MSF intervened in the departments of Beni and Pando in the summer of 1998 in response to the flooding brought on by the El Niño climate phenomenon in the Bolivian Amazon Region. Mobile teams staffed by medical and non-medical personnel provided medical consultations and distributed medical supplies to health posts and health centres. The relief aid programme reached over 6,000 displaced families who were supplied with blankets, water containers, personal hygiene products, mosquito nets, etc. Alongside the Bolivian health ministry, MSF combated the acute malaria problem by training technicians to fumigate over 6,000 homes infested with mosquitoes. MSF continues to monitor general changes in weather patterns (flooding and drought) and epidemiological developments throughout the country.

construction, re-equipment and rehabilitation of health posts and health centres as well the provision of logistical support to the government vaccination campaigns etc. In Chimore, the 3,000 members of the Yuracare and Yuqui indigenous groups have been substantially outnumbered since the late sixties by the migrant Quechua population. This community is made up of an estimated 20,000 people. MSF's objec-

HELP FOR URBAN VICTIMS OF POVERTY & VIOLENCE

In Brazil the gap between public and private health is infinite, with the public sector offering poor quality and minimal access for health care to the poor. No where is this more evident than in the urban slums of Rio de Janeiro.

Over the past four years MSF has set up a co-operative health post in the Vigário Geral favela (slum). The final phase of this programme is now under way. MSF is preparing the staff and the community to take over this project. As a result of the health interventions of MSF, the team in Rio have also developed a dental health game for children.

seminars, activities to increase awareness and a referral service. A common activity in all these projects is management training for community leaders. MSF also runs a network of health professionals who give free consultations for public patients. In collaboration with the Brazilian government and several local organisations which

BRAZIL



- National staff : 22
- International staff : 17



To counter problems of urban violence and social exclusion and with the aim to improve health, MSF continues to act as an interlocutor between the public health authorities and socially excluded populations.

MSF has recently opened two new urban health programmes, one in the Costa Barros favela, where MSF run a public health centre for a population of 40,000 inhabitants, in conjunction with the health ministry. The second in the neighbouring Portus favela, where MSF is running an alternative integrated family health programme, as a pilot study with the health ministry, to try and introduce alternative, more complete health care strategies for the poor in Rio. MSF also runs a social integration programme in these areas. A STDs/AIDS prevention project has brought MSF into partnership with public authorities and local community groups in 22 favelas. Here MSF runs condom banks, information

aim to protect the interests of the Indian population, MSF has been working for some years to improve health facilities in a number of remote areas in Brazil. Owing to changes in their living environment, some brought about by the incursions of gold miners, the Indian population in the Javari, Yanomami and Tefe regions have come into contact with all kinds of diseases, such as malaria. MSF is training health workers and microscopists. At the end of 1998, a project was started in Tefe on the banks of the Meio Solimões river, with the objective of setting up a system of medical facilities in collaboration with the population, as has been done in other areas.

COLOMBIA

HELP FOR VICTIMS OF VIOLENCE



Cali is one of the most violent cities in the world. On average, there are six murders a day.

MSF works in Agua Blanca, which is the biggest slum area in the city inhabited by 145,000 people. MSF runs two projects targeting youth. In the Cali slums, only three out of 10 male youths reach the age of 30 and many others fall victim to non-fatal lesions. They often receive little rehabilitation or psychological assistance and often live in such fear of their attackers that they hide themselves away. MSF provides medical and psychological home care to inju-

MSF also carries out water and sanitation activities, health education and is setting up an early warning system for epidemics. MSF also focusses on providing advice and information to the displaced.

In northern Colombia, MSF provides medical assistance to isolated communities. From project bases in Apartado, Monteria and Barranco Bermeja, MSF teams travel by boat to villages where mobile teams treat patients and train communities in malaria prevention.

- National staff : 26
- International staff : 18



photo M. Goldwater

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 coordination 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.

red people and their families. MSF is also planning to provide psychosocial assistance for adolescents considered "at risk".

MSF also focuses on the provision of reproductive health care for adolescents, as 34% of pregnant women in Cali are under 19 years of age. MSF promotes the use of family planning and provides sex education targeting health structures and schools.

Pre and post-natal care is provided by the team working out of one health centre. However, MSF also has contacts with other health centres where volunteers work with and alongside local institutions and other agencies.

MSF runs an urban health programme for marginalised slum populations in San Cristobal, Malvinas and Soacha in Southeast Bogota. Using mobile teams, MSF offers curative medical care, vaccination programmes and mother and child health care assistance.

This is an extremely insecure area where guerrilla warfare has been waged for thirty years, leading to high mortality rates and population displacement. MSF provides psychological support to the displaced population of Monteria.

On Monday, 25 January, the west of Colombia was hit by an earthquake measuring 6 on the Richter scale, which left its mark on at least twenty cities. The city of Armenia and its surroundings was worst affected. The number of deaths were estimated at more than 1,000. MSF ran an emergency aid programme in the towns of Tebaida and Calarca, providing medicines, surgical supplies, clean drinking water and shelter. Moreover, MSF provides primary health care and surgical support. In this region MSF was able to reach about 80,000 Colombians. Psychological support was also provided with a focus on group sessions.

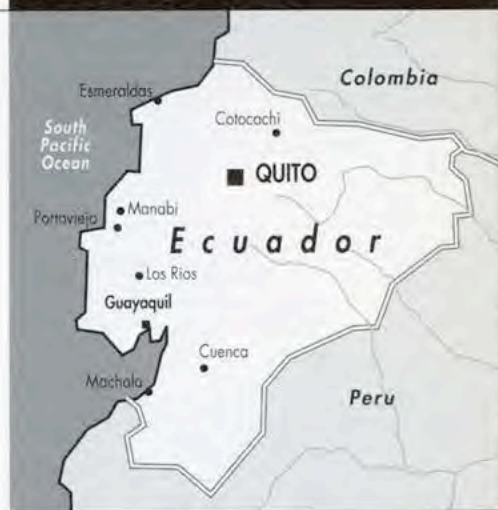
EL NINO AFFECTS THOUSANDS

The newly elected president, Jamil Mahuad, brought the territorial dispute with Peru to an end by signing a peace agreement in October 1998. In the same year the "El Niño" climate phenomenon contributed to worsen an already bad economic situation by devastating 8,200 homes and part of the road network.

MSF has been in Ecuador since January 1996, running a primary health care project in the northern canton Cotacachi, an area inhabited by native Americans. The project closed in December 1998 because the Ministry of Health refused to honour its commitment to train medical assistants. From March to September 1998 MSF's mobile teams provided basic medical assistance to the population affected by El Niño in the provinces of Guayas, Manabí and Los Ríos. A total of 30,000 people benefitted from this project.

MSF launched a primary health care project on 15 July 1999 in the province of Sucumbios, which borders the Colombian Putumayo region and Peru. It will run for two years. Activities include technical assistance and medical supervision, the relaunch of health centres and health posts and basic rehabilitation. MSF is working in two cantons: Putumay and Shushufindi. This project targets 200,000 people, most of whom are Ecuadorian as well as more than 50,000 displaced Colombians, many of whom live along the river bank.

ECUADOR



- National staff : 43
- International staff : 16

FOCUS ON AIDS PREVENTION

Although Cuba has a well organised healthcare system staffed by qualified medical professionals, economic hardship has meant that healthcare structures lack material resources.

In 1997, MSF helped the Ministry of Health set up a national information and co-ordination centre for the prevention of HIV infection and other sexual transmittable diseases. From the centre in Havana, MSF has organised information campaigns, trained people in the provision of information and worked on encouraging social acceptance of the use of condoms and on co-ordination between AIDS prevention programmes and programmes focusing on the control of other sexually transmittable diseases (STDs). Attention has also been given to better medical treatment of HIV/AIDS infected people. By June, the centre was functioning independently but MSF continues to collaborate with its staff on an outreach programme for high risk groups in Havana and supports nation-wide self-help groups of people living with HIV. In Santiago de Cuba, An AIDS/STD prevention programme targets mainly the adolescent and youth population, as well as prostitutes and vulnerable groups within the tourism industry. Working with a multidisciplinary team of Cuban professionals, MSF analyses the populations' understanding of AIDS/STDs and focuses on changing attitudes in the community. Activities also include training community healthcare workers, running awareness campaigns and ensuring access to condoms. An information and counselling centre was established in the centre of Santiago. Preparations are underway to extend/replicate this programme throughout the remaining eastern provinces.

MSF also runs a project for water and sanitation in the José Martí district in order to improve conditions for drinking water distribution and waste disposal and to reduce water-borne disease. Vector control following a mosquito plague which broke out in July 1997 ended in August 1998. MSF's main objective was to avoid the transmission of dengue and haemorrhagic fever. Teams fumigated buildings, distributed information on prevention methods and car-



ried out epidemiological surveillance. MSF also carried out a water project in the community of Rio Cauto in Granma, and another involving the production of domestic water-filters in Baracoa in Guantanamo. Following the destruction Hurricane Georges left in its wake in September 1998 in the eastern provinces, a programme was launched to prevent epidemics transmitted by water, as well as the prevention of dengue and haemorrhagic fever.

CUBA



- International staff : 5

photo H. Franz

GUATEMALA

MSF ACTIVE IN EMERGENCIES



The vast majority of Guatemalans live in poverty and only 34% have access to health care. MSF runs urban and rural programmes, accompanies returning refugee communities and intervenes frequently in emergencies.

Following the devastation caused by Hurricane Mitch in early November 1998, MSF teams provided assistance in Guatemala City, Escuintla and Izabal. Activities included medical consultations, cholera prevention, epidemiological surveillance and logistical support. During the second half of 1998, MSF intervened in the north of Guatemala City and

overcrowded detention centres for minors between 12 and 18 years of age, MSF's objective is to improve living conditions in the centres for the 5,000 detainees and to ensure their access to health care. In the impoverished slums of Lomas de Santa Fez, MSF provides assistance to an estimated 1,100 families living alongside railway tracks. MSF teams run a medicalised nursery in the Casa del Patojo. They provide psychological support for mothers and children and help strengthen the mother/child bond. MSF also carries out home visits.

Until the end of 1998, MSF provided aid in four urban slums of Guatemala City, three of which are situated on the city's rubbish dump. MSF provided sanitation assistance, water supply and constructed two community halls and rehabilitated the health centre.

MSF runs several projects to control the spread of HIV/AIDS/STDs. Projects run in two metropolitan townships of Guatemala City: Milagro and El Mezquial and in the country's second largest city, Quetzaltenango. Activities include the distribution of information, raising awareness and training staff in techniques for better dealing with STDs. MSF has supplied medical equipment to many clinics and laboratories.

MSF runs a community health and sanitation project in Barillas in the Southwestern province of Huehuetenango. The aim of the project is to provide primary health care and basic sanitation services to the 54 most isolated villages in the north of the country. In the fourth quarter of 1998, MSF launched a support programme for the health district of Livingston in Izabal, in order to improve the population's access to health care. The project involves the division of Livingston into Livingston and Frontera. MSF teams focus on organisation, planning and management of Frontera. They are trying to improve mother and child health, water and sanitation, vaccination coverage and are training health care workers.



photo T. Donozo

the region around Peten during several cholera outbreaks. Teams provided support to epidemiological surveillance, provided water and sanitation assistance, screened for cholera, set up cholera units, retrained health workers, provided health information and supplied medicine and medical material to health structures. Following flooding in San Marcos in October 1998, MSF provided support to health structures and set up temporary shelters.

In Guatemala City, MSF focuses its project on marginalised children and adolescents. MSF helped create an aid agency called APRI which provides sanitation assistance and carries out health education. In collaboration with a local NGO, Casa Alianza, MSF set up Rescate, a day centre which provides medical assistance to a thousand street children each year. The team also raises awareness on the plight of these children. Until April 1999, MSF helped hospital staff upgrade patient care and hygiene in the paediatric service of San Juan de Dios hospital.

Until February 1999, MSF intervened in five



photo T. Donozo

► International staff : 13

EL SALVADOR

When El Salvador was struck by Hurricane Mitch on 31 October 1998, MSF set up an emergency programme in the country. This involved the supply of 50 health centres and five hospitals and the installation of drinking-water and sanitation facilities in ten villages. MSF also provided accommodation for the stricken population. In 1999, MSF continued its drinking-water and sanitation programmes and ran a health campaign in the western and eastern parts of the country within the framework of the national reconstruction programme.

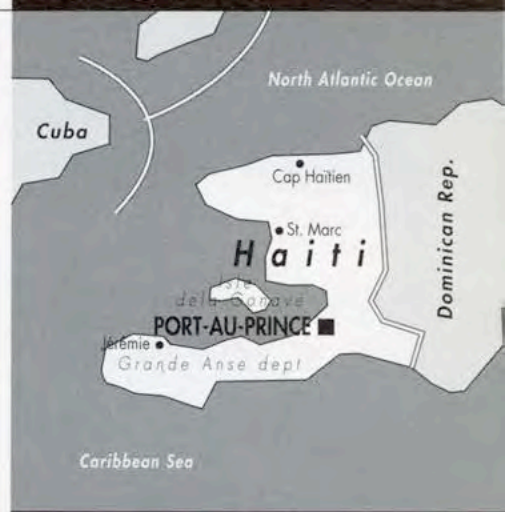
BASIC HEALTHCARE & SANITATION NEEDS

Political instability has had a devastating effect on health structures which lack human and material resources. Haiti remains heavily dependent on external aid.

In the Sous-Rail district of the capital Port-au-Prince, MSF renovated a dispensary and organised the supply of essential medicines. MSF is trying to do the same for a dispensary in the Delmas commune but the lack of government has an impact on decision making at all levels and progress is slow. In Sapotille, Cité Simon and Bois Neuf districts, MSF is focusing on increasing the number of latrines. MSF has supplied the materials and supervises the work. This is a priority for the schools as well as the poorer urban residential areas. Five water fountains have been installed in the Warf Jérémie commune to improve access to safe drinking water.

MSF also provides support to Saint Marc Provincial Hospital and surrounding dispensaries (the set up of a health district). MSF supplies medicine and medical material for anaesthesiology and surgery. There is also a large programme of rehabilitation for the hospital and the peripheral dispensaries. Until September 1998, MSF worked in the Southwestern town of Jérémie in the Grande Anse department. Teams renovated the hospital and trained nurses. The focus was on guaranteeing access to surgical services, improving care for women undergoing difficult births and ensuring that isolated rural communities have access to drinking water.

HAÏTI



- National staff : 37
- International staff : 9



photo M. French/MCC

HONDURAS

EMERGENCY PROGRAMME IN WAKE OF HURRICANE



In November 1998, Hurricane Mitch wreaked havoc on Honduras destroying almost 70% of the infrastructure and the agriculture. This has been devastating for the population which was already one of the poorest countries on the continent.

Following Hurricane Mitch in November 1998, MSF launched an emergency programme for the affected population in the capital, Tegucigalpa, and the Cortes, Atlantida and Colon regions. Activities included the donation of medicine, water and sanitation activities, vector control to prevent outbreaks of malaria and dengue fever, strengthening the epidemiology

MSF provides training for health care workers, is involved in renovation work and organises and supervises health centres and pharmacies.

A similar programme is underway in the inaccessible Cusuna area, in Northeastern Colon department, where MSF provides aid to the former slaves known as the Garifunas who have been living on this part of the

► International staff : 33



photo G. Sanchez

MEXICO

Having completed a three-month intervention on the Oaxaca coast after it was struck by Hurricane Pauline in October 1997, MSF opened an office in Oaxaca in October 1998, with a view to starting a primary health care project. A project was launched in March 1999 in the Mixteca region of Oaxaca. The team will provide primary health care to the indigenous population, who had almost no access health care when MSF arrived. The project is aimed at some 17,000 people living in 60 dispersed communities. The team's main focus is to restore a primary health-care system which can function independently. In the first few months of 1999, MSF trained six doctors, six health promoters and 10 nurses to run the project. The project will be handed over to the health ministry after two years.

gical early warning system, as well as the system for nutritional surveillance and an evaluation of the risk of contamination of chemicals in the southern region of Choluteca.

By the beginning of January 1999, the post-emergency phase had begun in the southern province of Choluteca where the hurricane had displaced thousands of people when the river overflowed devastating the area. Local authorities set up two sites for the displaced where MSF launched medical and sanitation assistance. MSF also supports health centres in Choluteca town and a hospital in neighbouring San Lorenzo.

MSF provides assistance in and around Bolson de Nahuaterique covering 15,000 people, including 1,500 Salvadorians who remained following a negotiated settlement with Salvador which redrew the border in Honduras' favour in 1992. MSF works in eight dispensaries and supports the Marcala referral hospital.

coast for 200 years as well as to the ladinos who live in the interior. A total population of 10,000 benefit.

In February 1998, a regional coordination unit to prevent spread of AIDS and STDs was created in Tegucigalpa. In May 1998, MSF initiated a HIV/AIDS programme in Tegucigalpa and La Ceiba. The programme aims to contribute to the reduction of HIV transmission amongst the marginalised populations and to improve the clinical and psychosocial attention given to patients. In Tegucigalpa, MSF runs an urban health care project in the El Carrizal Barrio to improve access to health care for the population. Activities includes the construction of the health care centre with maternity ward, organisation and supervision of activities such as vaccinations, mother and child health care, health education mainly on AIDS, the construction of a pharmacy and training for health workers.

POST-EMERGENCY RELIEF

Following the devastation caused by Hurricane Mitch in November, 1998. MSF launched large-scale relief programme.

In Western Nicaragua, MSF has provided post-emergency assistance in the departments of Nueva Segovia, Chinandega, León, Managua and Jinotega. Teams provide medical assistance and water and sanitation relief. Since early November, MSF has brought assistance to 20,000 displaced people living in 10 camps, including the Nueva Vida camp in Managua. MSF also brings assistance to rural communities and carries out epidemiological surveillance. Teams support health structures and monitor the nutritional status of the population.

In the east of Nicaragua, MSF teams work in an area inhabited by 35,000 members of the Mesquito and Mayanga indigenous groups. Following the hurricane, floods destroyed many houses, health posts, harvests and water facilities. MSF repaired and improved the water and sanitation facilities, distributed 30,000 zinc sheets for shelter, re-equipped health posts and carried out a nutritional survey covering about 40,000 people. MSF has also distributed 7,000 mosquito nets and provided health education in 13 schools.

MSF teams run an assistance programme for Managua's streetchildren. At night time, Mobile medical teams provide assistance on the streets of the capital. The first objective is to ensure the children are in good health, the second to reunite them, where possible, with their families. Team members are also able to

provide them with psychological assistance and legal advice. MSF is currently trying to establish a welcome centre for these children and plans are afoot to run an awareness campaign. Also in the capital, teams run a primary health care programme in the slums of sectors 1 and 2. The objective is to improve the population's access to health care. From Managua, MSF continues to run and provide support to rural pharmacies. MSF has a well-established programme supporting health services in the Nueva Segovia department in Northwest Nicaragua. More recently, MSF opened the casa materna in the municipality of Quilali. Here, high-risk deliveries can be carried out. It is also from this base that MSF helps the local community promote women's rights. The Casa Materna is in the process of becoming a fully independent organisation.

Since February 1999, MSF is active in the autonomous South Atlantic region of Nicaragua. Teams run a water and sanitation project in the city of Bluefields. An AIDS/STD prevention and control project is also carried out in Bluefields as well as the municipality of Corn Island. In the municipality of La Cruz in Rio Grande, MSF runs a project to rehabilitate health care structures destroyed by Hurricane Mitch.

NICARAGUA



- National staff : 167
- International staff : 19

MSF BRINGS AID TO INDIGENOUS PEOPLES



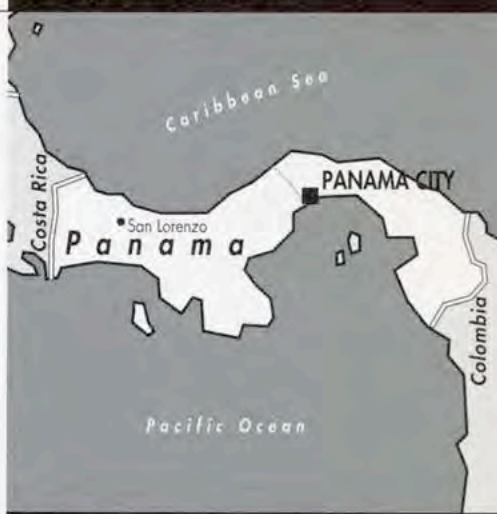
photo N. Isenard

An estimated 8% of the population of Panama is made up of indigenous peoples. MSF is working in the heart of the northern Panamanian region inhabited and governed by native Americans from the Ngobe-Bugle ethnic groups.

MSF provides technical support to a health care network in the district of Kankintu in northern Panama. Today there are only two health centres but in the future there will be five. MSF is focusing on the relaunch of primary health care services in this district which has been greatly neglected.

MSF is providing training to health staff, community health committees, community health promoters and traditional midwives. Several health posts are two days walk away from the referral Health centre. Referral is thus carried out by boat.

PANAMA



- National staff : 12
- International staff : 4



In 1998, Peru was severely affected by El Niño. Damage to the infrastructure, agriculture and fishing industry has been estimated at 7,500 million dollars and has affected the livelihoods of some 400,000 people.

MSF is supporting primary health-care services in the remote areas of Peru that used to be made unsafe by the activities of the armed groups *El Sendero Luminoso* (The Shining Path) and the *Movimiento Revolucionario Túpac Amaru* (MRTA) during the eighties. In the isolated districts of Masisea and Iparia in the

MSF has used the media to reach the largest number of young people possible. In Villa El Salvador, MSF provides medical, social and psychological assistance to pregnant adolescents and abused children. MSF has opened a consultation centre within a hospital where family planning assistance is also provided. MSF is also seeking to improve the medi-

- National staff : 70
- International staff : 26



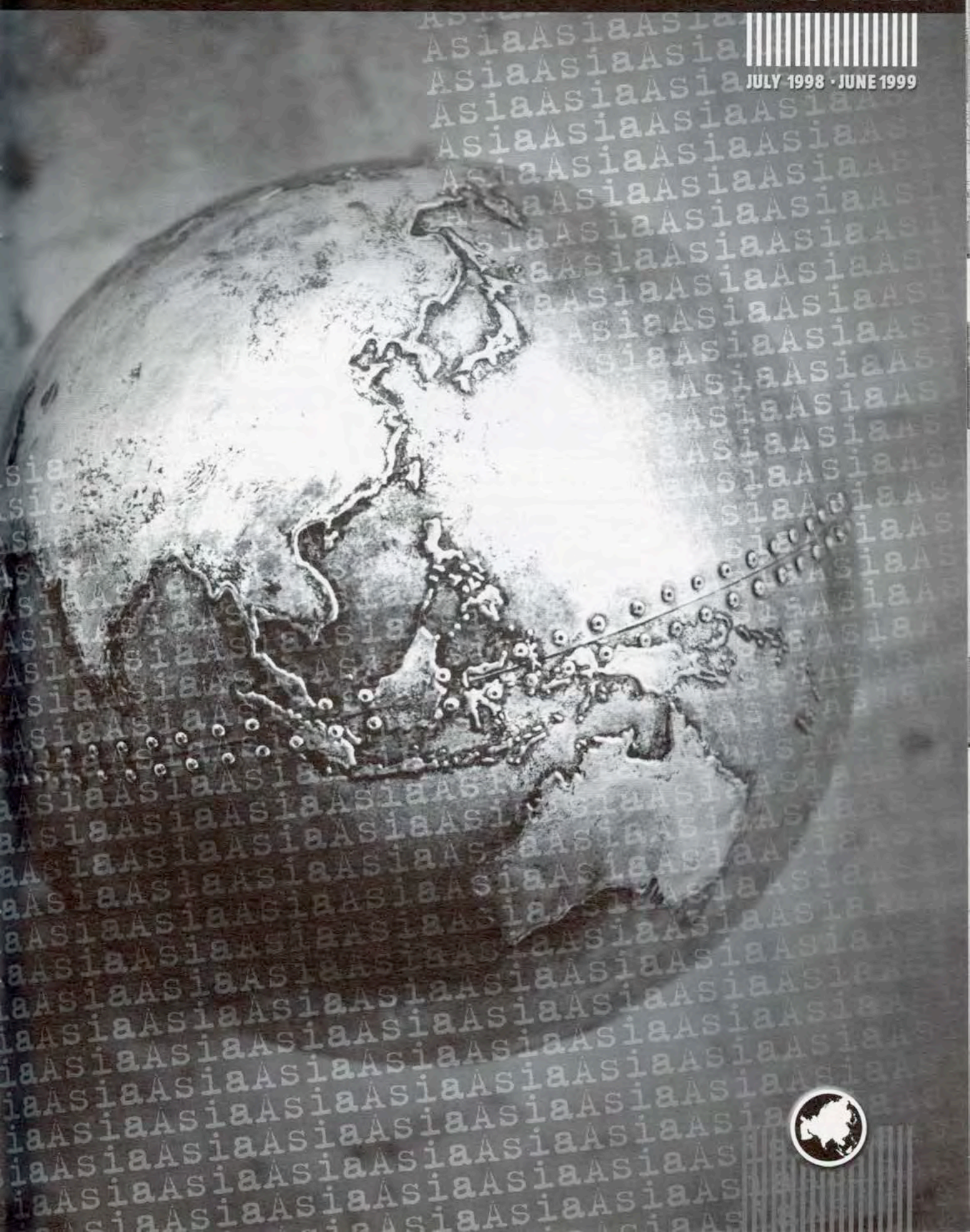
photo S. Streble

Amazonian forest, MSF trains health agents and traditional mid-wives. In Ucayali province, MSF ran a primary health care programme until March 1999 and intervened during a cholera epidemic in September and December 1998. Health and sex education is directed towards children and adolescents in four marginal districts of Cono Sur: Villa María del Triunfo, San Juan de Miraflores, Villa El Salvador and Chorrillos with a view to preventing the spread of HIV and AIDS. MSF raises awareness on the risk of AIDS and the importance of safe sex among the young in schools and community centres with a presentation known as the *Feria del Sida* (AIDS Festival). MSF has also helped create a character known as Super Condom who goes to discotheques at night and distributes condoms and raps about safe sex.

cal situation inside several prisons in Peru including the country's largest penal institution in Lima where the population of 6,600 grossly exceeds its capacity of 1,500.

ASIA

JULY 1998 • JUNE 1999



AFGHANISTAN

FOCUS ON MOTHER & CHILD HEALTH CARE



The fundamentalist Islamic Taliban movement has taken most of the country, except for the north-eastern provinces. MSF works in both Taliban-controlled and Alliance-controlled areas although poor security has meant several evacuations over the past year.

Ensuring good mother and child health care is a priority for MSF. For cultural reasons, Afghan women are reluctant to be seen by male doctors and often do not have the option of seeing a woman doctor as there is a lack of female health care staff. MSF cooperates and supports the work of a local aid agency running a network of maternal and child health clinics in the Kandahar and the central province Oruzgan. In the eastern pro-

Badghis Province, MSF is helping the displaced return to their areas of origin by setting up basic health facilities in an area where there is otherwise no health care. In the northern provinces of Balkh, Baghlan, Kunduz, Takhar, Faryab and Bamian where tens of thousands have been displaced by the conflict, MSF runs preventive and curative medical programmes out of 20 clinics and one hospital with an average of 30,000 consultations a month. MSF aims to respond rapidly to emergencies, whether they be natural disasters or the results of conflict. In January 1999, MSF opened a new mission in the poor, isolated north-eastern region of Badkhashan. MSF focuses on strengthening medical services in two clinics and improving the populations' access to health care. In the neighbouring Panjshir region, MSF supports two hospitals and four clinics for preventive and curative health care. Since July 1998 when all agencies were expelled from Kabul by the Taliban, MSF has resumed its activity in only one clinic but is ready to react to any emergency, if MSF's independence is guaranteed. In June 1999, because of a new outbreak of cholera in Kabul, MSF was elected to be the operational lead agency in terms of hospital case management, in cooperation with *Save the Children Fund (SCF)* and the ministry for health. Antany Hospital is intended to be the main referral center for adults. Here, MSF set up and supports a 60-bed female and male cholera ward.



photo T. Voeten

vince of Ghazni, MSF continues to support the 80-bed provincial hospital and a tuberculosis programme. From Ghazni and Kabul, support is given to two clinics in Hazarajat. In Western Afghanistan, MSF is working in Herat Province with a local aid agency with whom over a three year period MSF will help develop health care facilities focusing on health care for women and children for a total of 150,000 people in three districts. Also in Western Afghanistan, in

► International staff : 38

BANGLADESH

SURVIVING THE FLOODS



In Bangladesh, 1998 was dominated by a flooding disaster, which submerged two-thirds of the country and lasted for three months.

Following the floods, there was an outbreak of cholera and other diarrhoeal diseases among the population. MSF supported the work of local aid organisations. Makeshift cholera centres were set up following an outbreak, while five mobile medical teams were treating patients in isolated areas for other diseases. In the capital, Dhaka, MSF, in close cooperation with CARE, organised basic health care services in five centres for flood victims. An immunisation campaign against measles was also launched from these centres. In Cox's Bazar, the south-east of the country, MSF is still providing aid (curative and preventive health care, health education, immunisation, ante-natal care, therapeutic and supplementary feeding) to the Rohingya, Muslims who fled Burma en masse in the

early nineties to escape the repression they suffered in their country. Most have since returned to Burma. MSF spoke out against the many forced repatriations. Repression continues in Burma and the remaining caseload of refugees is reluctant to return. Alongside human rights organisations, MSF is monitoring the situation of the Rohingya refugees in Bangladesh. All relevant facts are brought to the attention of the international community. MSF also provides health care assistance in the district of Cox's Bazar. MSF runs two dispensaries, one of which opened in Shamlapur in September 1997 and the other in Sonarpura in June 1998. Each dispensary covers 20,000 people. The main illnesses encountered by MSF teams are diarrhoea, malaria and respiratory infections

► National staff : 130
► International staff : 12

FOCUS ON WOMEN AND CHILDREN

Over the past year, MSF has focused on the vaccination and treatment of pregnant women and young children in the new shanty towns that have sprung up around the capital.

In Rangoon, special attention has been given to malnutrition, the prevention and treatment of cholera and dengue fever and the fight against AIDS as well as other sexually transmittable diseases. Among minority groups in the states of Rakhine (west) and Kachin (north), MSF's main endeavours concerned the fight against malaria, tuberculosis and AIDS. (In 1998, among other things, MSF treated some 40,000 children against malaria). In the state of Rakhine, the organisation is also doing an experiment to teach minorities to take care of their own health needs.

HIV/AIDS is a rapidly growing problem in Burma and is being given far too little attention. In collaboration with local actors and artists, MSF has developed information material. This has been translated into six languages and is now being distributed on a large scale. In addition, MSF is stimulating the distribution and marketing of condoms.

BURMA



- ▶ National staff : 300
- ▶ International staff : 10

CAMBODIA'S SECOND CHANCE

Cambodia is crawling out of the deep pit it had fallen into because of political turmoil in mid 1997. The new government has been given a second chance to start the necessary reforms.

MSF first started working in Cambodia only weeks after the Vietnamese withdrawal in September 1989. Medical teams are now based in many parts of the country and through their concerted efforts, MSF is contributing substantially to the reconstruction of the Cambodian health system. The development of these health services is slowed down by the extremely low salaries of medical personnel who earn US\$ 10 a month, a fraction of what they need to live on. In fact the Ministry of Finance keeps full control of the health budgets, as in the old days. The management of human resources also requires modernisation, with the introduction of evaluations and incentives. Pilot projects that address these issues are already showing promising results.

The needs in what were formerly *khmer rouge* areas are enormous, as their leaders had kept the people prisoners for more than twenty years. MSF started to work in Anlong Veng, their last head quarter to fall into government hands. The HIV epidemic is the fastest growing in south east Asia. An estimated 180,000 people are infected with the virus. To reduce infection, MSF runs Sexual Transmitted Disease (STD) clinics. In public hospitals MSF introduces so called "Universal Precautions" that aim to reduce hospital based transmission of HIV by providing training in sterilisation techniques, etc. As the disease is new in Cambodia, AIDS patients face severe discrimination. MSF supports the Preah Bat Sihanouk

Hospital in Phnom Penh, which functions as the national referral hospital for AIDS patients. Tuberculosis is estimated at around 4.5 per 1,000 people, one of the highest rates in the world. MSF provides technical assistance to the national TB centre CENAT. Activities include support to the home-based Directly Observed Treatment Short course chemotherapy (DOTS) programme and assistance to provincial supervisors in several provinces.

CAMBODIA



- ▶ National staff : 292
- ▶ International staff : 55

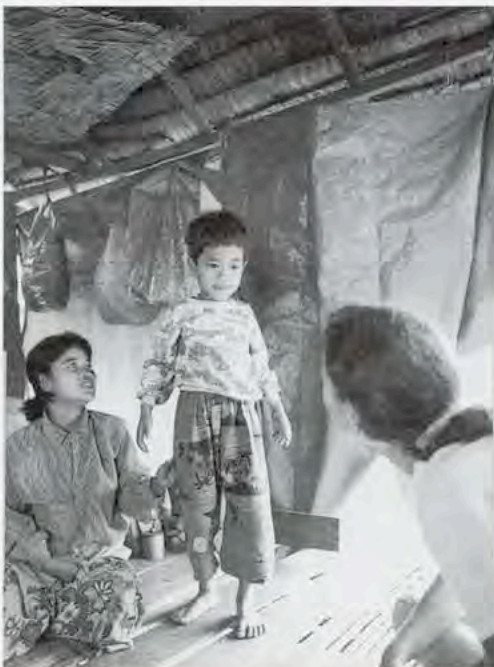


Photo J. Barning

CHINA

MSF PREVENTS ONSET OF WATER-BORNE DISEASE



Rapid economic growth and the privatisation of medical care in China means millions of people - especially in poorer and ethnic minority rural areas - continue to lack access to basic health care, safe drinking water, and well-trained medical personnel.

The floods of 1998 were the largest in China for over 50 years, affecting hundreds of millions and killing over 4,000 people. MSF intervened in five affected provinces, distributing chlorine for water disinfection, basic medicines, jerry cans and blankets to displaced people living in makeshift shelters. MSF has a number of projects ensuring

of Qinghai Province, MSF is training village and township doctors, rehabilitating clinics and a Mother and Child Hospital, running an iodine survey and collecting other medical data.

MSF is also working to prevent specific diseases in China. In both Tibet and neighbouring Sichuan, MSF continues to run a Kashin-Beck (also known as "Big

photo K. Van Lohuizen/Agence VU

- National staff : 81
- International staff : 28

INDIA

MSF LAUNCHES TB PROGRAMME

Although not working in India at the time, MSF was granted the prestigious 1996 Indira Gandhi Prize for Peace, Disarmament and Development for its overall humanitarian action worldwide. This opened the doors for MSF to launch a programme in India.

In 1998 an exploratory mission was carried out to assess the health situation in India and identify the more acute health needs. The conclusion was that there was a severe problem of tuberculosis (TB) in urban areas especially in Mumbai (formerly Bombay) which has a population of 14 million. In February 1999 an MSF team went to Mumbai to set up a programme to treat TB. A team is currently working within the framework of the *Revised National Tuberculosis Control Programme (RNTCP)* together with the local Ministry of Health and a local aid agency. The programme aims to support and help both public and private health sectors -with the collaboration of the local communities- in the implementation of the *Directly Observed Treatment Short course (DOTS)* strategy. The DOTS strategy is implemented within the framework of the RNTCP and has been adopted by the government of India following the recommendations of the World Health Organisation (WHO). MSF has committed itself, for an initial period of three years, to running an innovative pilot programme which is designed to be duplicated in other parts of the country at a later stage. By June 1999, MSF had also opened an office in New Delhi. The office is to be used for the purpose of representation and maintaining close contacts with government authorities.



both a supply of water and adequate hygiene awareness to prevent the spread of water-borne disease. In Tibet, MSF is constructing wells, catchments, and taps for over 50,000 people in more than 170 villages. In Yunnan Province, MSF is helping villagers build their own catchments and conducting health and hygiene awareness programs in four minority villages. Medical training in more remote areas is another priority for MSF. In five poor townships in Rongshui Miao Ethnic Autonomous Area, Guangxi, one such MSF programme combines doctor training with the rehabilitation and construction of new hospitals. In ethnic Tibetan areas

Bone Disease") project, which both treats this debilitating joint disease with physiotherapy and searches for the causes of this still mysterious disease affecting three million people in China alone. On the Burmese border in Yunnan province, MSF started a Tuberculosis control program for two extremely poor ethnic minority counties where TB is endemic.

BRINGING AID TO THE DISPLACED

Economic crisis has contributed to the outbreak of ethnic and religious conflict throughout the country.

Following the religious clashes in Ambon in the Molucca Islands in January 1999, MSF teams brought relief to 20,000 displaced living in 24 regroupment camps in Ambon city. MSF worked principally on emergency sanitation. From March 1999 onwards, MSF also implemented environmental health care assistance for the Muslim population who had fled Ambon Island to take refuge in their ancestral home in Butan, southeast Sulawesi. In early March 1999, ethnic conflict broke out in Sambas, Kalimantan. As many as 35,000 ethnic Madurese fled to 12 regroupment sites in Pontianak, West Kalimantan where MSF set up an assistance programme. Since March, half the displaced have moved back to Madura, their ancestral home. In May, MSF also set up an assistance programme for 20,000 displaced in Tual in the Kai Islands following another religious clash. MSF helped the authorities launch emergency measles vaccination. MSF's project in Kupang, West Timor, aims to

reduce sexually transmitted diseases (STDs) and the transmission of the HIV virus. Today, MSF works in schools, dispensaries and prisons raising awareness on the prevention of AIDS and STDs. MSF also runs a radio discussion programme. In May 1999, MSF opened a mission in East Timor where there is a population of between 50 to 100,000 displaced people. In the clinics in Baucau and Liquisa, MSF runs a primary health care programme with mobile medical teams in operation. In Dili, MSF is setting up a hospital referral service. During the summer of 1998, MSF provided emergency malaria treatment to 20,000 people in the Jayawijaya district of Irian Jaya (the other part of the island of Papua New Guinea). Here, MSF runs a community health training programme. In 1998, some 800,000 people benefited directly and indirectly from MSF's water supply projects in Lampung and Yogyakarta. MSF also continues its water supply project in Western Java.

INDONESIA



► International staff : 23

AID TO AFGHAN AND IRAQI REFUGEES

Today, Iran is playing host to two million refugees, making it the country with the largest refugee population in the world. Most are of Afghan and Iraqi origin and have been living inside Iran's borders for many years.

MSF is one of the few international aid agencies providing humanitarian assistance to the refugees. It is estimated that 95% of the refugees live outside the camps. These are the refugees that MSF teams assist. The priority is to improve their access to health care. Given that natural disasters are also frequent in the region, MSF is always prepared for the onset of emergencies - such as earthquakes.

In Gulshar, in the northern suburb of Mashad, the MSF team brings aid to a health centre from where 100 medical consultations are carried out each day. MSF staff work inside the centre, and supply medicine and medical material to it. MSF also runs mobile medical teams in neighbouring areas. 80,000 Afghan refugees are targeted by this programme, of whom more than 40% are residing illegally on Iranian territory. Since July 1997, more than 15 Afghan volunteers trained by MSF have been providing a

health education programme for the refugees. They carry out home visits. MSF also gives talks in schools on the prevention of disease. An MSF team was also working with Iraqi refugees in Khozestan province until November 1998. The team provided medical assistance in a primary health care centre in the city of Ahwaz. The project has since been handed over to an Iraqi agency.

IRAN



► National staff : 40
► International staff : 4



photo XVID.S - MSF

KAZAKHSTAN

TB CONTROL AND TREATMENT



- National staff : 30
- International staff : 8

Tuberculosis is a major public health problem in Kazakhstan with an incidence rate of 100/100,000. MSF runs a tuberculosis control and treatment projects in the Ily and Balkash districts, North of Almaty and another in the Baidebek region of Southern Kazakhstan Oblast (SKO). MSF will also be extending its Aral Sea project to Kazakhstan in the second half of 1999.

Since August 1998, Directly Observed Treatment Short course (DOTS) chemotherapy protocol of the World Health Organisation is accepted by the government. However, MSF introduced DOTS treatment in Kazakhstan as early as 1996 when a TB programme was launched

in the Aksy Hospital covering the districts of Ily and Balkhasch and Kapjigai city. MSF rehabilitated the hospital, which has since become the regional referral hospital. MSF has also put in place three new laboratories in order to improve screening for TB. The MSF programme in Aksy targets a population of 190,000. Treatment lasts six months and is made up of a two-month period of hospitalisation, followed by four months of treatment at home. Patients go to their local health centres for their medication. Five people are diagnosed with tuberculosis in SKO every day, and at least one person dies daily from TB. MSF now targets a population of 150,000. In Baidebek region, patients were first taken onto DOTS treatment in December 1997. MSF teams work out of Shimkent Hospital which was entirely rehabilitated in August 1998. MSF makes regular visits to all villages covered by their programme to identify and follow the progress of patients in the second phase of treatment. Staff in the health centres try to trace the defaulters and encourage them to return to finish their course because incomplete treatment results in greater risks for TB infection and increased drug resistance. Training of local medical staff, and public health education are priorities.



photo: M. Dehaese

KYRGHIZIA

MSF COMBATS GROWING PROBLEM OF STDs



MSF launched its current health care programme in Kyrgyzia in the southern region of Osh in 1996 when it had become evident that sexually transmitted diseases (STDs) were on the increase.

The MSF team helps staff in 16 clinics and hospitals screen and treats STDs. Particular attention is given to syphilis sufferers as cases have tripled over the 1990s. MSF also supplies medicines and medical material where needed. In Osh General Hospital, MSF has equipped the outpatients department and has also helped staff renovate the laboratory. MSF has launched a training programme for specialists in sexually transmitted diseases to improve their diagnostic methods and the quality of treatment.

Prevention and information is an important part of this programme. MSF is also organising activities to help raise awareness about AIDS and STDs in the community. The team targets drug addicts, prostitutes and prisoners.

- National staff : 20
- International staff : 4

MSF ASSISTS RELOCATED VILLAGERS

Over the last few years, the government has been gradually relocating thousands of villagers in northern Laos from the mountains to the plains. However, they have suffered from epidemics such as measles and malaria and they have had difficulties adapting their rice-cultivation to a different altitude. Consequently, there have been food shortages.

MSF provides technical assistance to strengthen the health structures in the southern provinces of Champassak (Districts of Champassak and Khong) and Sekong and the northern province of Bokeo. Teams work alongside local health workers and collaborate with district and provincial authorities to improve health services. Activities include basic curative and preventive care in health centres, medical training and the preparation of treatment protocols. MSF is also carrying out rice distribution as the level of malnutrition is alarming. The northern province of Sekong which was created in 1984 is one of the poorest. Each of the four districts has a population of 15,000 people, most of whom are from ethnic minorities. Other than MSF's support to provincial health management and the provision of technical support to the provincial hospital, MSF lends its support at every level to the health services of the isolated

Kalum and Dakchung districts. During the last months of 1998, the MSF team in Bokeo, in coordination with the provincial health authorities, carried out emergency assistance in response to outbreaks of malaria and diarrhoea in the displaced and resettled communities.



► International staff : 19

AID FOR RESIDENT POPULATION & PALESTINIAN REFUGEES

The 350,000 Palestinian refugees living in Lebanon enjoy no political, economic or social rights. Their fate will not even be examined under the Oslo accord until the final phase of negotiations. Half their number live in camps.

Since February 1998, MSF works in the southern town of Saïda helping to strengthen the paediatric wing of Hamshary Hospital. This hospital, which is run by the Palestinian Red Crescent Society, mainly covers the population of two refugee camps, notably Lebanon's biggest camp Ain el Hilweh (60,000 people). In February 1999, it also became a referral centre. MSF paediatricians work alongside Lebanese and Palestinian specialists, including a Palestinian paediatrician. An on-call system has been established. A paediatrics nurse is training five nurses to work on the paediatrics wing. In several villages in the southern Nabatiyeh region, which border on the Israeli-occupied area, MSF runs a community-based mental health programme. Volunteer counsellors are being trained in front-line villages to provide psycho-social education for their communities

and individual support and counselling. MSF is also providing, through a Lebanese agency, a district-level referral service. MSF has also trained and equipped first aid teams in eight front-line villages.

In the southern district of Jezzine, which has been cut off from the rest of Lebanon due to occupation by the Israeli-backed South Lebanon Army (SLA), MSF focuses on supporting emergency medical services. MSF's anaesthetist and surgical nurse work alongside Lebanese medical staff in the Jezzine government hospital. MSF has supplied emergency equipment for the ambulances of the Lebanese Red Cross and trained local paramedics in its use. MSF is also running a one-year qualification training course for nursing aides in order to establish a pool of nurses with at least basic training.



► International staff : 10

MONGOLIA

NEW AIDS PREVENTION PROGRAMME



On 1 March 1999 MSF launched a new AIDS prevention programme in Mongolia. The present AIDS epidemics in the neighbouring countries of Russia and China are a great source of concern to the authorities. The programme will draw largely on the expertise which MSF has built up over the past few years with a similar kind of programme in Russia.

A model campaign is being developed for combating the spread of AIDS, in close collaboration with the Mongolian ministry of health and a Mongolian partner organisation. The provision of information to health care personnel in the areas of AIDS/HIV and

with intensive support, both on the spot and from Moscow. The team is based in the Mongolian capital, Ulan-Bator.

- International staff : 8
- International staff : 3



photo K. van Lohuizen

NORTH KOREA

In 1998, MSF ran a medical and nutritional programme in four provinces: Southern Pyongyang, Northern Hwangae, Northern Hamyong and Kangwon. The country was suffering from major food shortages and a lack of medicines. MSF supplied medicines, gave information about their use, set up feeding centres and trained health workers in diagnosing and treating malnutrition among children. Of the four provinces where MSF was allowed to operate under the contract, teams were barred access to several regions for "security reasons". MSF's work was obstructed by the authorities' continually and it became almost impossible for the teams to work. In September 1998, MSF had to withdraw as the authorities did not want to discuss a new Memorandum of Understanding. MSF withdrew its teams in protest. MSF believes that there are severe nutritional problems in North Korea, but is not convinced that the international relief effort is directly benefiting all the victims. MSF would re-launch an aid programme in North Korea if its independence were guaranteed.

other sexually transmitted diseases will also be improved. In collaboration with a Russian partner organisation, MSF will set up an AIDS information centre and train health professionals on pre and post HIV test counselling. The team in Mongolia is almost entirely composed of Russian staff who have gained experience in the AIDS prevention project in Russia. The coordinator of the safe sex campaign in Moscow will also provide the team



photo K. van Lohuizen

MSF TACKLES CHILD MALNUTRITION

The Palestinian people have suffered from the non-compliance of the Netanyahu government with the terms of the Wye Peace Accord and the growth of Israeli settlements on the West Bank and the Gaza Strip. They have also been affected by the management problems of the Palestinian Authority.

In 1996, MSF carried out an evaluation on child malnutrition in Hebron district which showed that depression linked to political, socio-economic and cultural conditions had affected some mothers' ability to feed and look after their children.

In collaboration with the Swiss agency Terre des Hommes, MSF set up a mental health programme to support mothers and children in need of psychological assistance. MSF main objectives are to re-establish or strengthen the mother/child bond so as to prevent malnutrition and the consequences of malnutrition (psychological disorders, developmental delays, mental and physical handicaps and even death) and to train a Palestinian counsellor to take over psychological activities.

In March 1997, MSF launched a project to bring assistance to former detainees suffering from psychological disorders as a result of detention and ill-treatment. MSF first concentrated its attention on the 3,200 former detainees registered in the rehabilitation centre of the Ministry of Detainees and Free Detainees

affairs (MDA) of Hebron District. Over a two year period, MSF trained a psychological counsellor who now runs the service by herself, under the clinical supervision of an MSF psychologist. Building on its experience, MSF is now extending its programme to benefit other former detainees in the West Bank.

A new stage in MSF's primary health care program in Hebron district was launched in 1998. MSF built/rehabilitated and equipped 52 village health rooms (HR), bringing to 68 the total number of HR reorganised by MSF in the area since 1996. To staff these health rooms, MSF has concentrated its efforts on the training of 52 community health workers, who have received a comprehensive upgrade of their medical skills through a one year course. They are now able to conduct the preventive work needed at village level (mother and child health care, immunisation, health education, home visits, etc.) under the supervision of the ministry of health and the MSF team. An emphasis has also been put on the accuracy of data collection at the village level and its analysis.

PALESTINIAN AUTHORITY



- National staff : 8
- International staff : 6

POST-WAR ASSISTANCE IN BOUGAINVILLE

In 1989 war broke out on the island of Bougainville between the independence movement the Bougainville Revolutionary Army and the Papua New Guinea government. Until the cease-fire was called in January 1998, MSF had difficulties gaining access to the island.

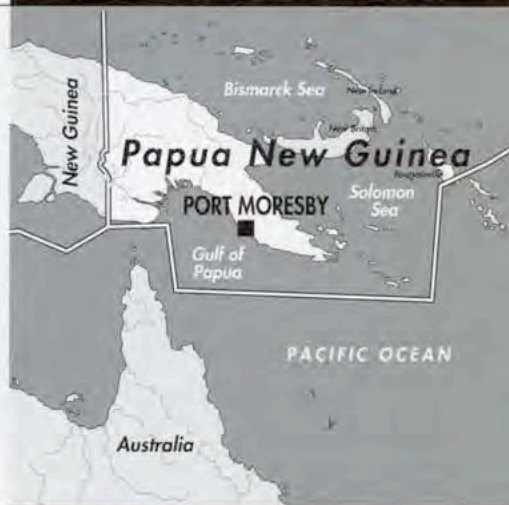
Over 10 years of war, health posts, clinics and hospitals on the island deteriorated and are in need of extensive rehabilitation. In 1998, MSF launched a health care programme out of the Buin health centre, in the Telei district. The main objective is to provide health care to the district which is inhabited by 70,000 people. This health centre is in the throes of being upgraded to a referral hospital. MSF teams have already helped the local health authorities rehabilitate the health centre.

The main disease treated is malaria which is also endemic in this region. MSF also provides support to the health centre, runs a referral service and trains health care workers. MSF also tops up the government supplies of medicine to health structures in Bougainville. MSF is helping the health authorities identify more

effective ways of ensuring medical supply in the long-term

MSF intervened in the main island of Papua New Guinea during the second part of 1998 following the devastating tsunami (tidal wave) of 17th July. This natural disaster resulted in the deaths of 2,200 people, the displacement of 10,000 and the total destruction of Aitape village and the area around Sissano on the northern coast. The displaced regrouped in eight different sites. MSF assisted with the set up of temporary dispensaries. The team also vaccinated against disease and provided water and sanitation assistance. This included the construction of wells and water tanks. MSF managed all medical donations, took responsibility for the cold chain and carried out epidemiological follow up. Only 2,000 of the displaced have been resettled so far.

PAPUA NEW GUINEA



- International staff : 7

PHILIPPINES

HEALTH CARE FOR STREET CHILDREN



- National staff : 42
- International staff : 6

There are estimated 50,000 to 75,000 children living on the streets of Manila. MSF targets the most marginalised of them all and provides them with medical, social and legal assistance.

A mobile medical team works five days a week, providing health care assistance to children from six to 15 years of age. MSF teams also work out of four city clinics where free consultations, medicines and vaccinations are provided. Those who need more medical attention are referred to the city hospitals. Interactive education sessions on themes such as emergency care, STDs, AIDS, drugs, hygiene and nutrition are organised

on the behalf of streetchildren is a priority. MSF also runs a project in one of Manila's many slums. Paradise Village is inhabited by 15,000 people living on six hectares of marshland. In collaboration with a local agency, LinGap, MSF cleans the sewage pipes and insulates them. MSF has been involved in the construction of a bridge on the canal which is located alongside the slum. It has built access roads and is providing health education to the community

In July 1998, MSF closed most of its large-scale health-care programme in the south-western archipelago of Sulu in July 1998 because of political insecurity. The health care service in this area continues to be monitored by MSF and the team continues to supply medicine and medical material to health structures. Since 1995, MSF has run an STDs-HIV control project in Davao in the southern Philippines. This is currently being re-evaluated. Philippines is often affected by natural disasters and the past year has been no exception. At the beginning of November 1998, MSF intervened in the provinces of Catanduanes and Camarines Sur following Typhoon Loleng. MSF organised emergency medical distributions and contributed to the rehabilitation of health centres. At the begin-

photo E. Tomika/MSF



ing of March 1999, MSF carried out emergency assistance following flooding in the southern Caraga region. In February 1999, 75,000 people were displaced following clashes between the army and the *Moro Islamic Liberation Front (MILF)* in Maguindanao and Cobatabo. MSF provided emergency kits to 30,000 displaced.

by the team. The team also makes regular medical visits to detention centres and temporary regroupment centres. Two teams of outreach social workers spend four days a week working with the children and referring those who need assistance to the appropriate centre. MSF also follows up on the welfare of children who have been reunited with their families. MSF provides many different kinds of legal assistance to street children including to those detained in adult jails. Advocacy

AID TO ISOLATED & DISPLACED COMMUNITIES

Since 1983, the Sinhalese-dominated government of Sri Lanka and the Tamil rebel army, Liberation Tigers of Tamil Eelam (LTTE) have been at war. MSF has been one of the few international medical agencies to work inside the country on both sides of the front-line since 1986 and has been present throughout.

MSF intervenes in the north (Jaffna, Vavuniya, Mannar, Kilinochchi and Mullaitivu districts) and in the east (Batticaloa and Trincomalee) supporting the health care service and filling hospital posts for the many specialists who have fled the war. Years of guerrilla warfare have damaged the public health care service, which although free of charge and properly run, is desperately lacking staff and medicine and medical materials. The many groups of people who find themselves living in LTTE-held zones have been isolated by war and have little access to health care structures. Until the end of June 1999, MSF provided assistance to people living in Madhu in Mannar district, which was in rebel hands until the end of March 1999. Of the 64,000 people living there, the vast majority are displaced. MSF runs mobile clinics in the area around Batticaloa town where 200,000 people live in LTTE-controlled territory. In many of the government hospitals in the north and east of the island, there is a serious lack of doctors and paramedical staff. During 1998 and 1999, MSF has supplied many of the big hospitals with staff, namely: Batticaloa Teaching Hospital, Vavuniya Base Hospital, Jaffna Teaching Hospital, Mallavi PU and

Mannar Base Hospital. In Batticaloa, Jaffna and Mullaitivu districts, MSF has sent surgeons to carry out operations on war wounded and has hired surgical nurses. MSF teams try to upgrade the health care provided in the northern and eastern hospitals by focusing on hospital hygiene and sterilisation. Many of the hospitals also lack medicine and medical material, which MSF provides. In Puthukkudiyiruppu and other parts of the north, MSF is also running an anti-malaria campaign in collaboration with the government and is supporting public health activities, focusing primarily on ante-natal and child health care.



- National staff : 155
- International staff : 37

photo H. Timmermans

MSF REHABILITATES MENTAL HOSPITALS

Since an MSF survey in 1997 found that widespread illness and high mortality rates in Tajik mental hospitals were linked to appalling living conditions, MSF has focused on upgrading them.

MSF has rehabilitated the country's two largest mental hospitals, one in the south of the country and one in the north. MSF has also rehabilitated a number of mental health dispensaries in the north and south.

Medicine, food, clothing and household supplies have been distributed among 15 mental hospitals throughout Tajikistan. A training programme for nursing staff in the psychiatric institutions has also been launched, which focuses on patient care.

A primary health care programme is carried out in the Karategin Valley in central Tajikistan. Activities have included the distribution of medicine and medical material to rural health posts and training for health care staff. MSF first started working in the isolated eastern region of Pamir in 1991. The initial activity centred around the supply of medicine and medical material to health structures. Then the

programme was expanded to include vaccination and the distribution of vitamin A and D. Since 1996, MSF has transferred many activities to the Aga Khan Foundation which runs a long-term distribution programme in this region. From August 1998 to April 1999, MSF supervised medical care in the hospitals and clinics of the Rushan and Shugnan districts, with particular emphasis on the management of the pharmacies and the rational use of medicine by the health care staff. In November 1998, MSF carried out medical distributions to all health structures in the districts. A team also intervened following the outbreak of anthrax in Rushan, and a typhoid fever epidemic in Kholog in late 1998. At this time, an evaluation of the health structures in Kholog was carried out. MSF now plans to relaunch vaccination in the whole province and to provide technical support to the departments of infectious disease in Kholog hospital.



- National staff : 74
- International staff : 11

THAILAND

CONCERNS FOR REFUGEE PROTECTION



Since the financial crisis in southeast Asia began, a more severe policy towards refugees is visible in many parts of Asia. MSF is concerned that forced repatriations may begin in the near future.

MSF has been providing assistance on the Burmese border to Karen and Mons refugees since 1983 and 1992 respectively. MSF works in three refugee camps in the Mae Sot region and one in Ratchaburi as well as in a refugee camp in Sangklaburi which has been relocated inside the Burmese border following the ceasefire in 1995. MSF provides medical assistance, trai-

cines. MSF also started working in four clinics in 1998.

The programme to assist people living with HIV/AIDS in the eastern province of Surin began at the end of 1996. This includes home care and the creation of support networks. MSF trains health care staff and an MSF doctor sees HIV/AIDS patients in Surin Hospital, where he works alongside Thai health care staff.

- National staff : 58
- International staff : 19



photo St. van Praet

TURKMENISTAN

NEW TB PROGRAMME

MSF's Aral Sea programme started in Uzbekistan. The programme is now being expanded to cover isolated communities living in three of the former Soviet oblasts in Uzbekistan, Kazakhstan and Turkmenistan.

In May 1999, MSF launched a tuberculosis programme in Turkmenistan. The pilot programme in the former Soviet oblast of Dashowuz to treat tuberculosis using the DOTS (directly observed therapy short course) method is running smoothly and the team was able to put to good use the lessons learned in a similar programme in the Uzbek oblast of Karakalpakstan. Dashowuz is inhabited by 200,000 people. A representation office will be opened in Ashgabat with possible logistics support for the region.

ning for health care staff and monitors epidemics such as malaria and cholera which are endemic in this region. The financial crisis has also resulted in more difficulties for people with AIDS and their families. In Bangkok, home-based care for people with AIDS targets marginalised groups. MSF offers support, training and assistance to community hospitals and local aid agencies and is a key member of a local NGO campaign known as "Access to Treatment", which is linked with MSF's international campaign on the issue of access to medi-

MSF would like to start using this approach in more health structures around the province.

The MSF nurse makes home visits to follow up on patients and to help them remain in their communities. HIV/AIDS sufferers are often rejected by Thai society. The team also tries to diminish the risks of mother to child transmission of the HIV virus.

AIDS PREVENTION AND CARE IN UKRAINE

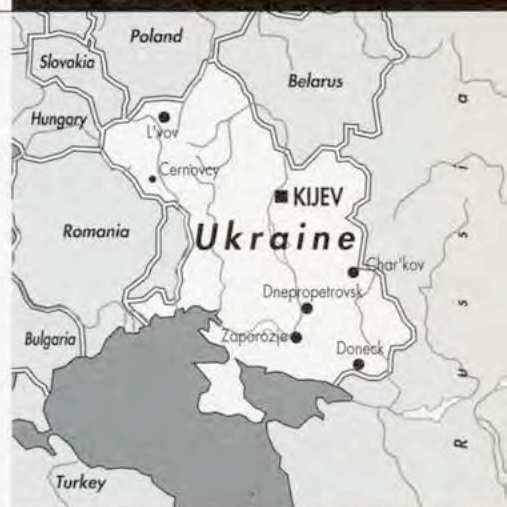
The aids problem in Ukraine is the worst in the whole of the Commonwealth of Independent States (CIS). At the end of 1997 UN AIDS agency and the World Health Organisation (WHO) estimated 100,000 people to be infected with HIV.

About 80% of those infected with HIV are intravenous drug users, most of whom are young and unemployed. The epidemic is raging in the mining and industrial cities to the east and in all the bigger ports, notably the Black Sea port of Odessa. So far there has been no effective response by the authorities, as the existence of an HIV/AIDS epidemic and

the widespread drug abuse are largely denied in Ukrainian society. MSF opened an exploratory mission in Ukraine in May 1999. The objective is to develop within three months a programme that contains both components of HIV/AIDS prevention (see the Moscow programme) as well as support to patients who live with HIV/AIDS.



UKRAINE



- National staff : 3
- International staff : 3

ENVIRONMENTAL DISASTER AFFECTS HEALTH

The Aral Sea is one of the world's largest inland seas. Over the last fifty years, the shoreline has receded some 70 miles and the sea has been half its former size. This environmental disaster is the result of the diversion of river water for large-scale irrigation. The overuse of pesticides has had a devastating effect on public health.

MSF's medical programme is based in Muynak, which once used to be located on the shore of the Aral Sea, but which now lies on a salt line encrusted with the residue of pesticides. At the end of 1997, MSF established itself in the area and is now carrying out six projects involving medical aid (tuberculosis (TB) control, improvements in the prevention and control of acute respiratory infections (ARI) and diarrheal diseases, epidemiological support to the

Ministry of Health), operational research into possible effect of this environmental disaster on public health, health education through local television, training and activities in the area of drinking water, sanitation and hygiene. To draw attention to the problems in the area, the team regularly gives lectures for international organisations. MSF is the only international medical aid organisation on the scene of what some have called the "worst environmental disaster in the world".

UZBEKISTAN



- National staff : 34
- International staff : 14

VIETNAM

AIDS/HIV PATIENTS SUFFER SOCIAL REJECTION



Since the beginning of the HIV epidemic in Vietnam in 1992, 12,500 cases have been diagnosed in the country. Under Vietnamese law, it is mandatory that all cases be officially reported. Such is the taboo associated with AIDS, that people diagnosed as being HIV positive are often refused access to health care and are rejected by their families and society at large.

In the coastal city of Nha-Trang in south-eastern Vietnam, MSF carries out an assistance programme which aims at preventing the spread of HIV/AIDS and STDs as well as improving patient care for those who have contracted these illnesses. The team runs this pilot project out of a reproductive health care clinic. MSF has been working in Can Tho province since March 1997. The programme focuses on improving patient care, and women's health care in particular, in three health care centres and a referral hospital. Access to health care remains a problem for both financial and cultural reasons, for some groups in Vietnamese society. MSF's project in Can Tho targets the HIV positive and those suffering from sexually transmitted diseases (STDs). In the southern province of Cau-Mau, MSF runs a project to improve sanitary and environmental conditions. This pilot project was initiated with a view to preventing a new outbreak of dengue fever, the acute viral disease trans-

mitted by mosquitoes, characterised by headache, fever, pains in the joints and skin rash. The project covers four communes inhabited by 75,000 people in the Cai Nuoc district. In order to implement vector control, MSF team provides water and sanitation assistance throughout the communes. MSF is training health care staff to better diagnose water-borne diseases. MSF is carrying out an evaluation on the health care situation in Cau-Mau with a view to launching a long-term project in a province only just beginning to recover from Typhoon Linda (November 1997). MSF provides humanitarian assistance to the victims of floods which destroyed much of the infrastructure in the central province of Quang Nam at the end of 1998. An MSF team assists the inhabitants of rural communities, focusing on the provision of water and sanitation assistance, the rehabilitation of health care structures as well as the distribution of medical and non-medical supplies to health structures.

- National staff : 93
- International staff : 15

YEMEN

MSF REACHES ISOLATED COMMUNITIES



The Yemeni health care system is largely under-equipped and under-staffed. Working in both the North and the South, MSF teams run programmes in the mountainous and isolated Al Hazm district in the north west of the country and in two districts of Aden in the south west.

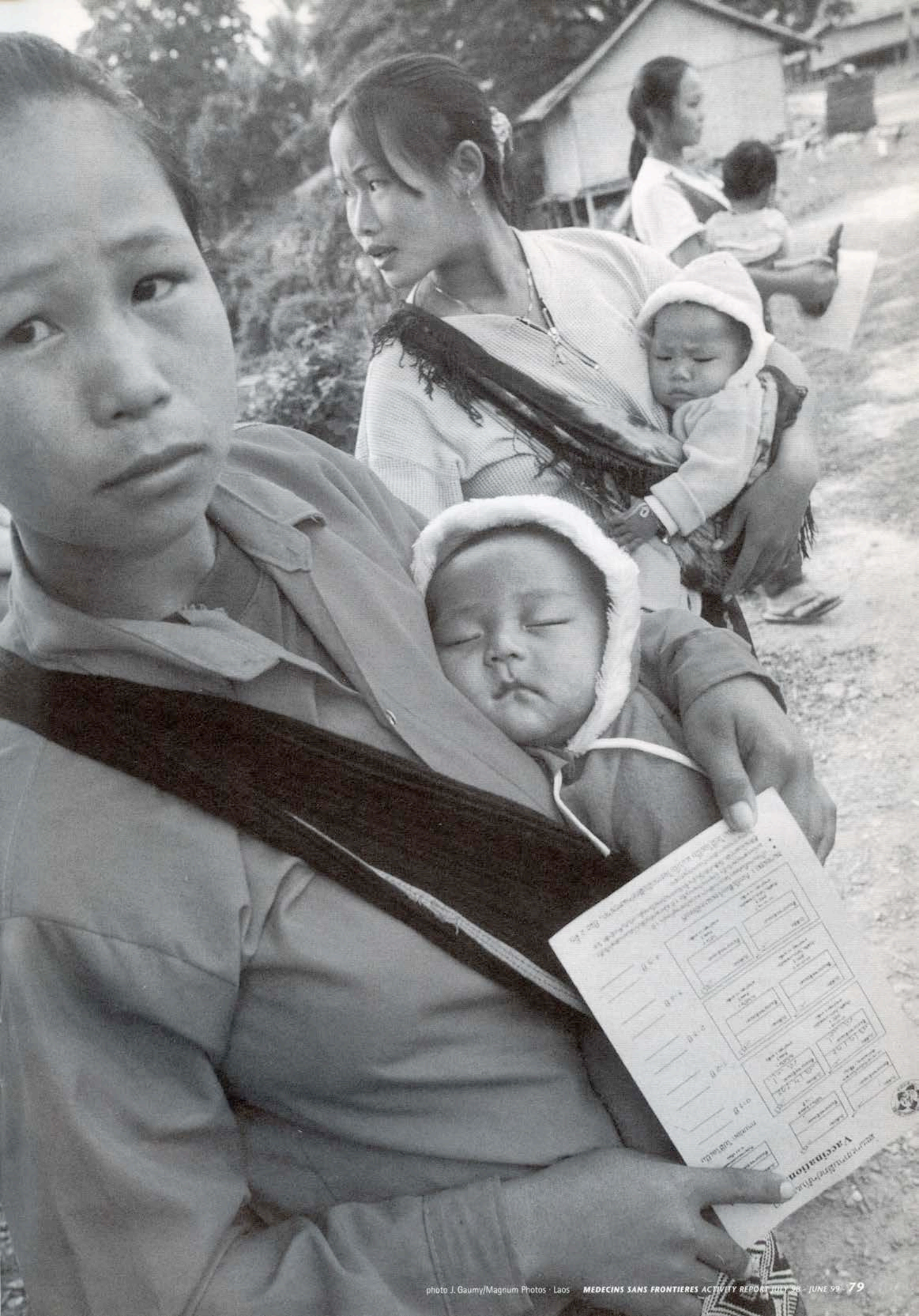
In the district of Al Hazm, 73,000 people have access to limited health care. The team participated in the relaunch of activities in the medical referral centre, medical supply and the setting up of a cost recovery system. The district's inhabitants can come to the referral

centre for medical consultations, nursing care, vaccinations and mother and child health care assistance. Support is also given to setting up health centres in surrounding villages. Although MSF no longer has a team in nearby Dhi Sufal where it provided support to health structures until 1997, the Al Hazm team continues to monitor the development of this project. In Aden, MSF works in 12 health care structures including polyclinics, health centres and other clinics. The project aims at improving nursing techniques and overall medical care through training programmes. MSF supplies medicine to the different structures and is rehabilitating buildings. The team is also in the throes of introducing a cost recovery system.

photo R. Job



- National staff : 20
- International staff : 11



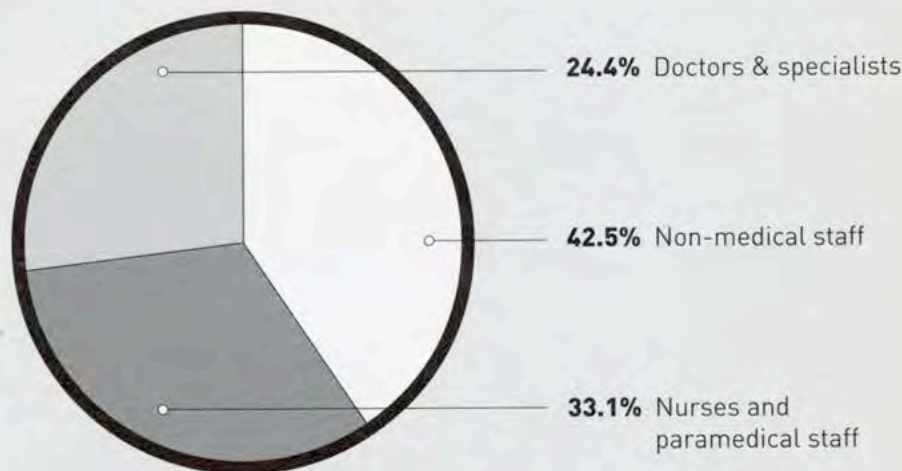


MSF FACTS

Médecins Sans Frontières (MSF) is a private and non-profit international organisation. It is currently represented by eighteen national sections in Australia, Austria, Belgium, Canada, Denmark, France, Germany, Holland, Hong Kong, Italy, Japan, Luxembourg, Norway, Spain, Sweden, Switzerland, the UK and the USA.

AID WORKERS IN THE FIELD

- **National staff :**
10,000
- **International staff :**
2,529 departures
- **Fieldposts in 1998 :**
1,278

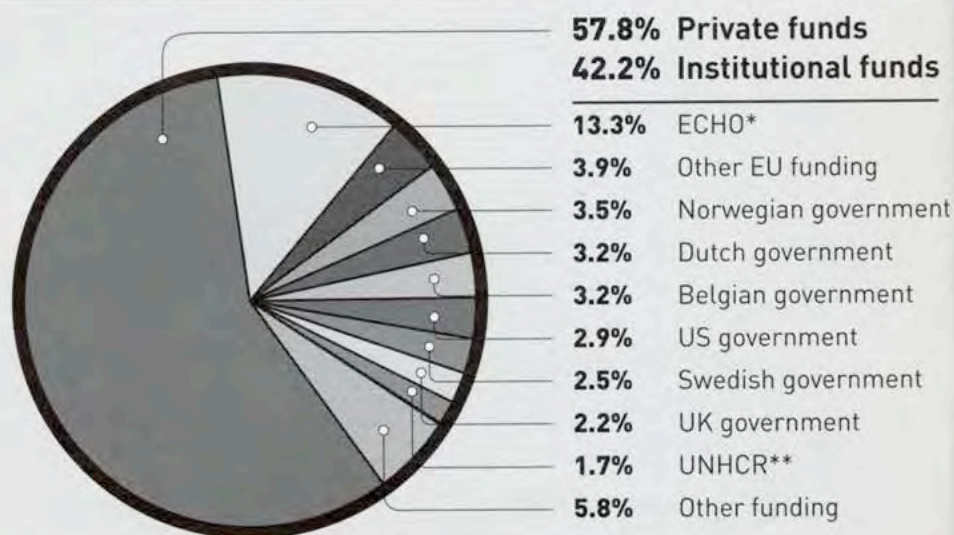


MSF'S INCOME

- **Total income :**
237 million Euros

In 1998, 57.8% of MSF's total income was provided by private donors (individuals, corporations, foundations...) - as opposed to 54% in 1997.

Grants from institutional donors (international organisations/agencies, governments etc.) represented 42.2% of MSF's resources (46% in 1997).



* ECHO is the European Commission Humanitarian Office.

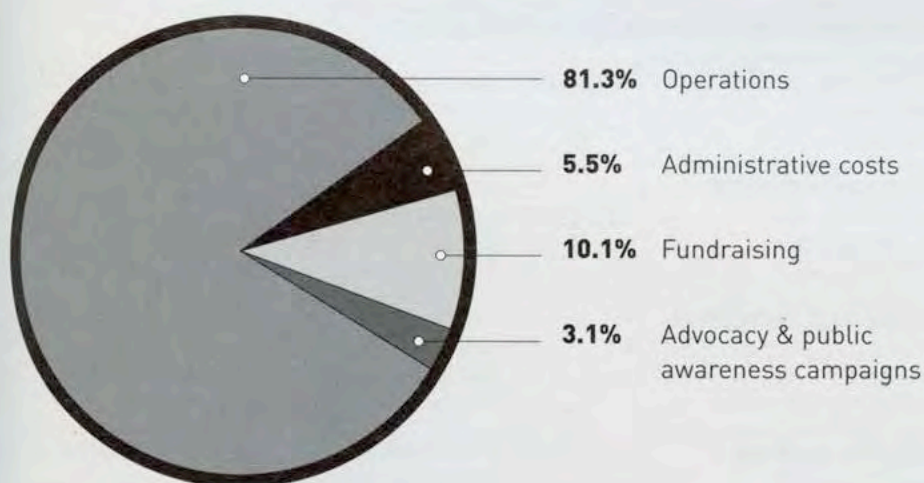
** UNHCR is the United Nations High Commissioner for Refugees.

Other institutional donors include some UN agencies and the governments of Australia, Austria, Brazil, Canada, Denmark, France, Germany, Hong Kong, Ireland, Italy, Japan, Luxembourg, Spain, Switzerland, Thailand...

NB: 23 million Euros (earmarked mostly for South Sudan and Hurricane Mitch) were collected in 1998. Most of these funds were spent in 1999 and will appear in the 1999 international accounts.

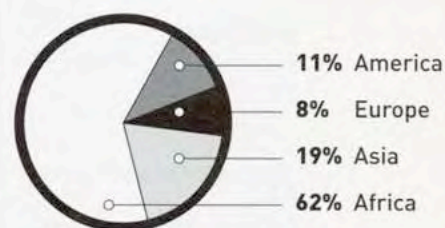
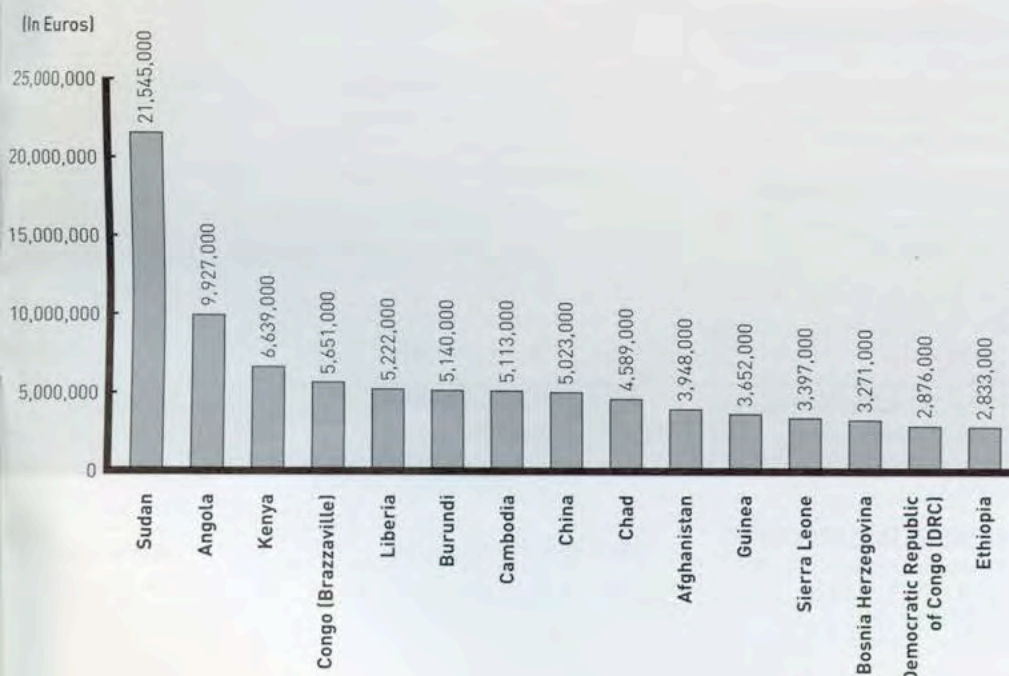
& FIGURES

HOW WAS THE MONEY SPENT?



► **Total expenditure :**
222 million Euros

WHERE WAS THE MONEY SPENT?



NOTE: these figures are based on the financial statements of all the sections currently in Médecins Sans Frontières. They have been audited nationally. MSF's accounting covers the 1998 calendar year. However our Activity Report covers the period July 1998 - June 1999.



AUSTRALIA

Fiona Terry
Michel Clerc

MEDECINS SANS FRONTIERES

Suite C, Level 2 /GPO Box 847
263 Broadway / Broadway
GLEBE2037 / 2007
New South Wales
AUSTRALIA

Tel: +61 (2) 9552.4933
Fax: +61 (2) 9552.6539
E-mail: office@sydney.msf.org

AUSTRIA

Dr Clemens Vlasich
Bé Meijer

ÄRZTE OHNE GRENZEN

Josefstaedter Strasse, 19/Postfach 53
1082 VIENNA
AUSTRIA

Tel: +43 (1) 409.72.76
Fax: +43 (1) 409.72.76.40
E-mail: office@arzteohnegrenzen.at

BELGIUM

Dr Pascal Meeus
Alex Parisel

MEDECINS SANS FRONTIERES/ARTSEN ZONDER GRENZEN

Rue Dupré, 94/Dupréstraat, 94
1090 BRUSSELS
BELGIUM

Tel: +32 (2) 474.74.74
Fax: +32 (2) 474.75.75
After hours: +32 (2) 474.74.70
E-mail: zoom@msf.be
zoom@azg.be

CANADA

Dr Michael Schull
David Morley

MEDECINS SANS FRONTIERES/DOCTORS WITHOUT BORDERS

720 Spadina Avenue - Suite 402
TORONTO, ON
M5S 1T2
CANADA

Tel: +1 (416) 964.06.19
Fax: +1 (416) 963.87.07
E-mail: msfcan@msf.ca

DENMARK

Dr Jens Hillingsø
Phil Clarke

LÆGER UDEN GRAENSER

Bernstorffsvej, 20
2900 HELLERUP
DENMARK

Tel: +45 (39) 62.63.01
Fax: +45 (39) 62.61.04
E-mail: msf-dk_mail@copenhagen.msf.org

FRANCE

Dr Philippe Biberson
Dr Karim Laouabdia

MEDECINS SANS FRONTIERES

8, Rue Saint Sabin
75544 PARIS Cedex 11
FRANCE

Tel: +33 (1) 40.21.29.29
Fax: +33 (1) 48.06.68.68
E-mail: office@paris.msf.org

GERMANY

Dr. Gundula Graack
Dr Ulrike von Pilar

ÄRZTE OHNE GRENZEN

Lievelingsweg, 102
53119 BONN
GERMANY

Tel: +49 (228) 55.950-0
Fax: +49 (228) 55.950-11
E-mail: office@bonn.msf.org

HOLLAND

Dr Bart Meijman
Austin Davis

ARTSEN ZONDER GRENZEN

Max Euweplein, 40 P.O. Box 10014
1001 EA AMSTERDAM
THE NETHERLANDS

Tel: +31 (20) 520.87.00
Fax: +31 (20) 620.51.70
E-mail: office@amsterdam.msf.org

HONG KONG

Joe Pianpiano
Olivier Bonnet

MEDECINS SANS FRONTIERES

Shop 5B
Laichikok Bay Garden
272 Lai King Hill Road
KOWLOON, HONG KONG

Tel: +8522.338.8277
Fax: +8522.304.6081
E-mail: msf_hk@pacific.net.hk

ITALY

Dr. Carlo Urbani
Nicoletta Denticio

MEDICI SENZA FRONTIERE

Via Ostiense 6/E until 01/2000
00154 ROME -
ITALY

Via Voltorno 58 since 01/2000
00185 Rome

Tel: +39 (06) 57.300.900/901
Fax: +39 (06) 57.300.902 until 01/2000
E-mail: msf@msf.it

JAPAN

Saeko Terada
Dominique Leguillier

MEDECINS SANS FRONTIERES

3-28-1Takadanobaba
Shinjuku-ku, TOKYO 169-0075
JAPAN

Tel: +81 (3) 3366-8571
Fax: +81 (3) 3366-8573
E-mail: msf@japan.msf.org

LUXEMBOURG

Dr Romain Poos
Dr Pierre Humblet

MEDECINS SANS FRONTIERES

Route du Luxembourg, 70
7240 BERELDANGE
LUXEMBOURG

Tel: + 352.33.25.15
Fax: +352.33.51.33
E-mail: office-lux@luxembourg.msf.org

NORWAY

Dr Morten Rostrup
Kurt Peleman

LEGER UTEN GRENSE

Rådhusgate, 30 A
0151 OSLO
NORWAY

Tel: +47 (22) 33.45.55
Fax: +47 (22) 33.45.51
E-mail: office-osl@oslo.msf.org

SPAIN

Dr Miguel Angel Pérez
Eric Stobbaerts

MEDICOS SIN FRONTERAS

Nou de la Rambla, 26
08001 BARCELONA
SPAIN

Tel: +34 (93) 304.61.00
Fax: +34 (93) 304.61.02
E-mail: oficina@barcelona.msf.org

SWEDEN

Johan Von Schreeb
Anna Bertmar

LÄKARE UTAN GRÄNSER

Gotlandsgaten 84
116 38 STOCKHOLM
SWEDEN

Tel: +46 (8) 55. 60.98.00
Fax: +46 (8) 55.60.98.01
E-mail: office-sth@ stockholm.msf.org

SWITZERLAND

Dr Olivier Dechevrens
Vincent Faber

MEDECINS SANS FRONTIERES/ ÄRZTE OHNE GRENZEN

12, rue du Lac
Case Postale 6090
1211 GENEVA 6
SWITZERLAND

Tel: +41 (22) 849.84.84
Fax: +41 (22) 849.84.88
E-mail: office-gva@geneva.msf.org

UK

Dr. Eric Vreede
Anne-Marie Huby

MEDECINS SANS FRONTIERES

124-132 Clerkenwell Road
LONDON EC1R 5DJ
UK

Tel: +44 (207) 713.56.00
Fax: +44 (207) 713.50.04
E-mail: office@london.msf.org

USA

Dr. John McGill
Joëlle Tanguy

DOCTORS WITHOUT BORDERS

6 East 39th Street 8th floor
NEW YORK, NY 10016
USA

Tel: +1 (212) 679.6800
Fax: +1 (212) 679.7016
E-mail: doctors@newyork.msf.org

OTHER OFFICES

INTERNATIONAL OFFICE

Dr Jean-Marie
Kindermans

MEDECINS SANS FRONTIERES

Rue de la Tourelle, 39
1040 BRUSSELS
BELGIUM

Tel: +32 (2) 280.18.81
Fax: +32 (2) 280.01.73
E-mail: office-intnl@brussels.msf.org

UN LIAISON OFFICER

New York

CATHERINE DUMAIT-HARPER

East 39th Street 8th floor
NEW YORK, NY 10016
USA

Tel: +1 (212) 655.3777
or: +1 (212) 679.6800
Fax: +1 (212) 679.7016
E-mail: catherine_harper@newyork.msf.org

UN LIAISON OFFICER

Geneva

ROBERT MULLER

Rue du Lac, 12
Case Postale 6090
1211 GENEVA 6
SWITZERLAND

Tel: +41 (22) 849.84.00
Fax: +41 (22) 849.84.04
E-mail: msf-international-gva@geneva.msf.org

INTERNATIONAL PRESIDENT

Brussels

DR JAMES ORBINSKI

rue de la Tourelle, 39
1040 Brussels
Belgium

Tel: +32 (2) 280.18.81
Fax: +32 (2) 280.01.73

UNITED ARAB EMIRATES

Tarek Daher

MÉDECINS SANS FRONTIÈRES

PO Box 47226
Abu Dhabi
United Arab Emirates

Tel: +971 (2) 317.645
Fax: +971 (2) 215.059
E-mail: msfuae@emirates.net.ae

SINGAPORE

Patricia K. Miller

MÉDECINS SANS FRONTIÈRES

15, McCallum Street
#14_03 Natwest Centre
069045 Singapore

Tel: +65/323.80.26
Fax: +65/323.80.89
E-mail: patty@pacific.net.sg



THE CHARTER OF MEDECINS SANS FRONTIERES

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

- ▶ Médecins Sans Frontières offers assistance to populations in distress, to victims of natural or man-made disasters and to victims of armed conflict without discrimination and irrespective of race, religion, creed or political affiliation.
- ▶ Médecins Sans Frontières observes 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.

