5. Long term strategy

Rwanda has been an aid dependent country for years now. The Rwandan economy has to contend with some fundamental and structural problems. Moreover, landlocked countries such as Rwanda require a regional perspective for their developmental plans. While this is recognised by most of the international and regional actors involved in Rwanda's aid programmes, not much progress has been made due to civil strife and political instability in the region. Nevertheless, some concrete regional actions have already been taken place and should be enforced[20].

A long-term strategy for the Rwandan economy is the subject of on-going discussions. However, some directions are already clear for further development.

5.1. Agricultural Sector

National income is almost exclusively based on the agricultural sector. Unemployment in this sector is very high due to overpopulation and scarcity of land. Almost 400 000 farmers (more than two million people) have less than 0,5 hectare land and live on mini-farms which is too small to generate enough harvest to feed an average family[21].

A new strategy for the agricultural sector is developed within an overall macro-economic strategy plan. Some fundamental changes are foreseen, but will be very hard to implement. Following measures are planned - though subject to major discussions - to achieve a higher production levels:

- Improved land use by more appropriate division of land for cultivation or for other activities, including " villagisation " or regroupement of people into new villages.
- Increased use of fertilisers and the construction of terraces in order to

[20] The World Bank will finance the reconstruction of the central corridor which connects Rwanda to the Indian Ocean from Isaka (Tanzania) to Dar es Salaam. WFP will continue to fund the northern corridor to Mombassa. Further, Rwanda will in the future probably become part of the East African Economic Union. This means tariff barriers for regional trade will be standardised. As regional trade is not enough to assure absorption markets, non regional trade will be an important issue to discuss as well within the WTO as for example with Europe within the framework of the Lomé Conventions.

[21] Formulation de la stratégie de dévelopement agricole, Résumé, Minagri, 1997

intensify the production.

- Land ownership should be privatised, suspending the traditional heritage system (*droit coutumière*) and all land should be for sale on the market.

The main idea of the agricultural reform is to evolve from an individual and dispersed production to more collective and regrouped farming in order to increase the agricultural production. This is an ambitious plan, not only due to cultural barriers but also given the high rate of natural increase of the population where by 2010 this sector will have to absorb 9 million people.

Another problem regarding the new policy is the lack of information towards the population. There is for example a huge resistance towards the politics of *villagisation*. Much of the villagisation depends on new constructions of homes which are often unsatisfactory. Many houses are too small for the average Rwandan family. There are no facilities for a kitchen, nor sanitation or water supply in the villages. Frequently, the housing is constructed in rigid, unnatural formations and at a distance from commercial centres, schools or water sources. Moreover, people are afraid to live isolated as a group since they are more vulnerable to be attacked. As a result, many housing blocks, built at high costs, remain unoccupied.

5.2 Private Sector

Since employment facility in the agricultural sector is limited, by 2010 some 1,2 million people (200 000 households) will have to quit farming[22]. Since, at this time, the private sector is negligible, the only way to escape unemployment, is getting a job in the public sector. Labour absorption in this sector is limited, since government revenues are irregular and uncertain. As a consequence of these combined factors, a majority of the urban population works in the informal sector.

Because of these problems, expansion of the private sector is urgently required. The development of micro-enterprises, based on the agriculture seems to attract government and aid agency interest. UNDP has already started a program to develop micro-enterprises in urban and rural areas. The industrial

[22]Ibid pg.5

sector on the other hand does not present a realistic option due to lack of skilled labour, technology and the landlocked character of Rwanda.

6. Health and humanitarian aid in Rwanda.

6.1. The health system in Rwanda

Since the war and the genocide, the Ministry of Health (Minisanté) has undertaken some fundamental reorientation in the delivery and organisation of health care. The main changes involve decentralisation and community participation for the management and financing of health care. In line with overall government policy, the Minisante will prioritise the participation of women in health development.

As mentioned earlier, ***the main constraints*** to a functioning health service sector are:

- Severe shortage of qualified and skilled personnel
- Deterioration of the health infrastructures and equipment
- Low purchasing power of citizens compromising the ability to purchase drugs or essential preventive care such as vaccinations. In some regions, where the indigent population is estimated to be around 30 per cent, this can be crippling.
- Low budget for health, having fallen from 6 - 7 per cent in pre-war period to about 2 per cent of GDP.
- A high rate of population growth (2.6 per cent per year) alongside negative economic growth (-1.2 per cent per year)[23].
- New post-conflict diseases such as physical traumatism, sexually transmitted diseases (STD), mental disorders.

At present, the Ministry of Health (Minisanté) is widely acknowledged to be efficient and capable with a health vision for the country. The Minisanté has made major inroads in rebuilding the health infrastructure including in the Red Zone (western provinces) since 1994. However, recently, due to the

[23] PNUD, Country Human Development Indicators, 1996

aforementioned deterioration in security, it is doubtful how many of the health institutions are fully functioning. Table 2 presents an overview of existing and functioning institutions in the Red Zone provinces (see section 2.1) as of November 1997.

Table 2: Health infrastructure in the Red Zone Health Regions

Health Infrastructure	Cyangugu	Gisenyi	Kibuye	Ruhengeri	Others
Operational / existing hospitals	3/4	3/4	4/4	2/2	16/18
Operational / existing health centres	2/24	24/25	18/21	27/31	173/193

Source: MSP, WHO 1997, Medresa Gisenyi Nov. 1997
NB. Informal sources indicate that the situation is actually worse than these figures show.

The health system is organised into central, intermediate and peripheral levels. The central system consists of the Minisante and three referral hospitals. There are 11 health regions managed by a medical officer at the intermediate level and 34 health districts where preventive care is provided. According to the MOH, 91 per cent of pre-war health centres in 1996 were providing basic health care services to communities.

Human resources for the health sector has seen major changes since the genocide. The number of medical doctors has been halved and of the 40 trained pharmacists early 1994 only seven remain in 1996 (see Table 3 below). The picture is equally bleak for other categories of health personnel. Of particular concern is the near absence of midwives. In general, there are regions where communities have little or no access to health services due in most cases to insecure conditions but also to distances and hilly terrain.

Table 3: Human resources of 1990-1996

Year	***Medical doctors***	***Dentists***	***Pharmacists***	***Nurse***	***Laboratory assistant***
1990	261	2	23	1226	33
1996	113	0	7	841	43

Source: MSP, WHO, April 1997

6.2 Drug supply

Drugs and medical supplies are mainly imported to Rwanda by the international community (see Table 4). Currently, they are distributed through 4 channels: OPHAR (Office Pharmaceutique du Rwanda); BUFMAR (Bureau des formation Médical Agrées[24] au Rwanda); Private Commercial Sector; International Aid Agencies (UN and ICRC) and NGOs.

Table 4 : Distribution of drugs import in the first semester 1997

Channel	Prive+Agrée	UN	NGO	Bilateral	Minisante
Per cent	17	24	52	1	6

Source : MINISANTE

The major part of the drugs and medical supplies are currently managed by OPHAR, the official supplier of drugs for the public health service. Allocations are made for each region and are provided free of charge. Minimal resources are received from Minisanté and the majority of the drug inputs are from donors and NGOs. No cash donations are made. Most donors follow an essential drug list as a guide for their supplies, although donations of inappropriate drugs are received as well[25].

The Ministry of Health was one of the first that restarted activities after the war with the development of a new plan for the health sector. Despite this quick resumption of activities, drug supply today remains a critical issue in the health sector. Typically, in a transition period, structures such as the OPHAR would have been reinforced in order to become independent of external aid. As it stands now, OPHAR does not have the capacity to manage the distribution and stockage of supplies. As a result, distribution of drugs remain uncoordinated and inequitable, both geographically and socially. At the end of 1997, drugs continued to be directly supplied to the population through

[24] "Le secteur agréés est formé par un ensemble de formations médicales directement sous la responsabilite de leurs promoteurs (souvent de l'église) pour toutes les aspects gestionnaires.": MINISANTE, Politique Nationale en matière de Santé, 1995, p2.

[25] In times of food shortages even dietetic medication has been given.

humanitarian aid agencies.

The government of Rwanda has decided to reform the drugs policy by the replacement of OPHAR by a national privatised system called CAMERWA to improve drug procurement and budgetary autonomy[26]. The basic idea of the CAMERWA is to establish an independent, non-profit purchase centre[27]. In various poor African countries[28], a distribution system such as this is already operational.

The CAMERWA will be supported by the World Bank and the European Union and will take over the stock of OPHAR. CAMERWA will purchase drugs through international tender and sell at market price to the hospitals and districts. In the medium term, financial participation of the population will be low but in the end it should cover all costs. At the beginning, the districts are expected to finance the gap between the market price and the user price. Initially, some of the districts will face difficulties in generating revenue and managing the new system. Many of the donors who are currently supporting several districts have taken into account these impending problems.

Finally, the new CAMERWA system allows for the government of Rwanda, in an emergency, to purchase drugs and supplies from the existing stocks. So, in principle, emergency donations in the future would only involve cash instead of drugs. While this reform is an encouraging initiative towards autonomy and co-ordination, it remains to be seen whether it functions effectively both from a management perspective and equity of access and distribution.

6.3 Epidemiological profile

The health profile of the Rwandan population reveals a high disease burden on the population and excessive mortalitiy due to preventable and treatable illnesses. The epidemiological profile of the country shows **a worsening of certain diseases with an elevated risk of epidemic outbreaks**.

[26] GOR-MINISANTE, Termes de référence pour l'assistance technique à la Centrale d'Achat des Médicaments Essentiels au Rwanda (CAMERWA).
[27] conforme à l'édit du 25 avril 1962 relatif aux associations sans but lucratif
[28] e.g. Tanzania and some West-African countries.

Reporting from provinces has been patchy and incomplete, particularly from the Red Zone region and it is likely that this reflects an underestimation in most cases. The following analyses is based on recent data from Minisanté and surveys of medical NGOs.

The principle cause of morbidity is malaria, accounting for more than a third of the cases seen at health centres and hospitals. Mortality from malaria accounts for nearly half of all deaths in the country followed by acute respiratory infection. Further, watery and bloody diarrhoea is an important cause of death claiming nearly 15 per cent of all deaths. Nearly 3 per cent of the morbidity load was due to trauma and a similar proportion as cause of mortality. Further examination of the type and source would be important for policy development.

HIV/AIDS is identified by the Ministry of Health as a growing epidemic and priority health and development problem in Rwanda. Since the first cases of AIDS were diagnosed in Rwanda in 1983, the epidemic has spread throughout the country at a rapid rate. At the end of 1993, 1 per cent of rural people and around a third of the urban population were infected with HIV or had full - blown AIDS. During the 1994 civil war, countless women were raped, often intentionally, by HIV-infected men, massive population movements uprooted entire communities and the world's largest refugee camps sprung up in neighbouring countries. In these conditions, it is more than probable that the HIV prevalence increased in a substantial manner. Indeed, preliminary data from the HIV Sentinel Surveillance System for 1996 indicate high HIV prevalence. While infection rates in urban Kigali are 32.6 per cent, similar to pre-war prevalence studies, those from rural areas have increased from the pre-war period, and now range from 3 to 10 per cent.

Incidence rates of major diseases based on data from the first six months of 1997 for the conflict - affected regions are presented in table 5. The main groups at high risk of disease and epidemics are returnees, who have neither land not housing; prisoners in communal cells; child head of households; refugees and unaccompanied children.

Table 5: Incidence rates for diseases by province (new cases per 1000 people per year)

	Population distribution (per cent of total)	Malaria	Diarrhoea*	Respiratory Diseases	Sexually Transmitted Diseases
Butare	*8*	215	22	49	6
Byumba	*10*	59	7	23	2
Cyangugu	*9*	55	6	13	2
Gikongoro	*7*	60	10	23	3
Gisenyi	*11*	20	7	13	2
Gitarama	*13*	90	4	19	2
Kibungo	*5*	233	8	15	2
Kibuye	*5*	92	20	44	4
Kigali	*16*	79	10	19	3
Ruhengeri	*13*	46	13	31	2
Umutare	*3*	368	30	62	6

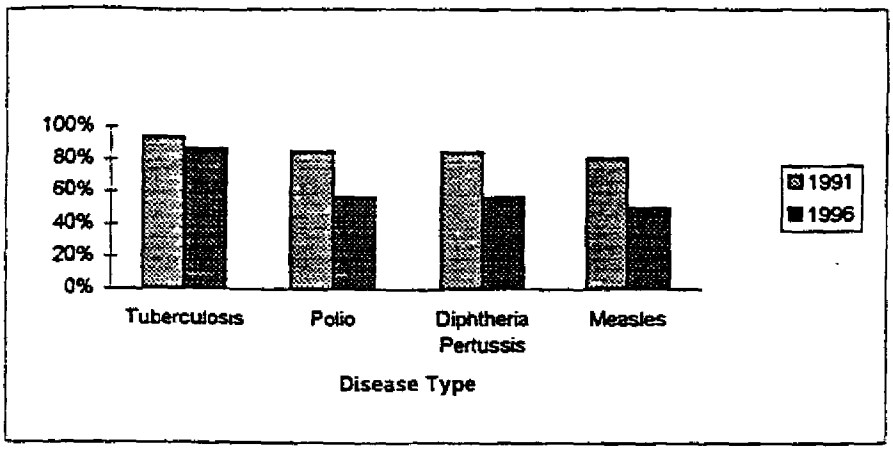
Source: Minisanté 1997

* includes cholera, bloody and non- bloody diarrhoea

With regard to disease surveillance systems, the provinces in the Red Zone virtually have non-functioning systems. Because of lack of medical personnel and indeed of available care in most health centres, cases are not even diagnosed or treated and so much less reported. For example in Gisenyi, the normal weekly epidemiological report had not been prepared for at least two months.

With regard to vaccination programmes, Rwanda had managed to attain a high vaccination coverage for children under the age of five by 1992, one of the highest coverage rates on the African continent. As displayed in Figure 3, the officially reported coverage rates fell for all of the Expanded Programme for Immunisation diseases, with the biggest decline in measles (81 per cent in 1991 to 50 per cent in 1996). These figures can only be an overestimation. The reality, taking into account failures in the cold chain or delivery system, is almost inevitably worse. Not only will a major cohort of the population remain susceptible to these diseases, but given current rates of malnutrition, expose the country to major epidemic outbreaks.

Figure 3: Comparative percentages of Vaccination Coverage for children under five years (1991 and 1996)



Source: UNICEF, Rwanda Emergency Programme, 1996

Taking into overall consideration the high levels of endemic disease, breakdown of some surveillance and control mechanisms, low vaccination coverage, together with a large reservoir of susceptible persons, the epidemic potential of this country and the region is alarming.

6.4. Population and fertility

Before the civil war, the population growth in Rwanda had begun showing signs of slowing down. Some studies showed that the total fertility rate, which had peaked at 6.4, had reached a plateau. The total population in Rwanda, after the losses incurred during the civil war was estimated to be around 6.2 million, compared to 7.2 million before the war, a decrease of 13 per cent. This figure of 6.2 million has increased in the last couple of years due to massive returns of Rwandan refugees from the neighbouring countries. The returnees are estimated to be around one million. In 1996, nearly 50 per cent of the population was between 0–14 years of age and the average Rwandan was 21 years old. Economically productive age groups accounted for 47 per cent, although the sex distribution was skewed in favour of females following the civil war and displacements outside the country[29].

The demand for family planning, which was typically low in Rwanda, had started to grow and the interest in birth spacing in families had became

[29] Socio-Demographic survey 1996, Revised Preliminary Report, FNUAP Kigali

more apparent in the period just preceding the war. Unfortunately, the mass killings and the other casualties of war proved to be a major setback to the progress made in birth spacing and family planning programmes among the population. The losses in the war reinforced the desire for large family size and high fertility behaviour among the population and the rate of contraception which had reached 10 per cent of all sexually active married couples, is estimated to have decreased to 5 per cent. The population is reported to express a need to replace the deceased members and therefore have an actively negative attitude towards any form of contraception (see Table 6).

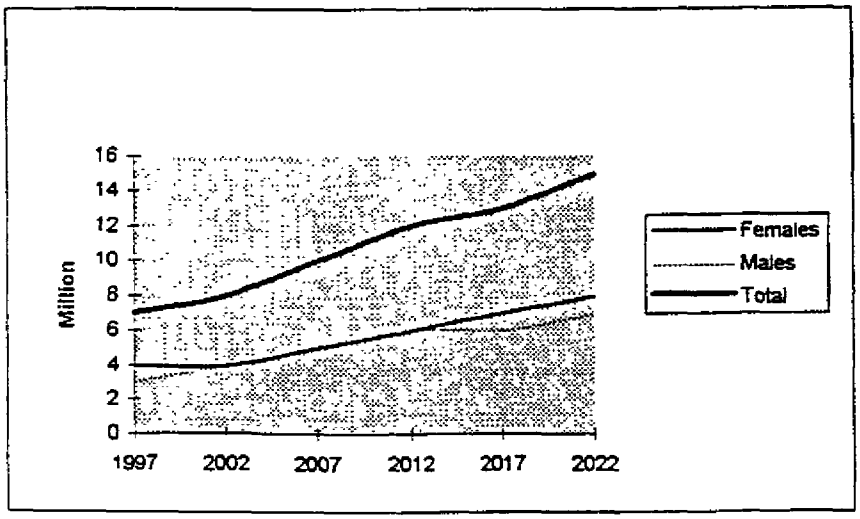
Table 6: Time trends in fertility indicators before and after the civil war in Rwanda.

Rate	1978[a]/1983[b]	1991	1996
Crude birth	54.1[a]	45.7	54.0
Total fertility	8.5[b]	6.9	8.3

Source: Socio-Demographic Survey, FNUAP Kigali, 1996

In view of the severe socio-economic condition of the country, uncontrolled population growth remains an issue with serious consequences in terms of the health of the mother and with regard to economic factors for child development. Population projections made by the FNUAP, presented in Figure 4 below, reveal substantial increases in the population in the next two decades.

Figure 4: Population projection for Rwanda by age and sex, 1997-2022



Source: Socio-Demographic Survey, FNUAP, Kigali, 1996

6.5 Mental health care

While there are many health problems that are compelling in Rwanda, mental health issues deserve special attention. They are a tragic legacy to the genocide and war that characterised Rwanda during the last decade. Mental health, typically a post-conflict issue, is often neglected at the cost of the community's capacity to recover and reconciliate. In the specific context of Rwanda, it is a critical issue, both from medical and social perspective.

Massacres, repatriation, militarisation, sudden displacements have, directly and brutally, affected a large part of the Rwandan population. Of these, children and women are the most affected as participants in and victims of the above events. The estimates in numbers of affected are alarming. In recent UNICEF study (1996), nearly all (96 per cent) of the children surveyed witnessed explicit violence and more than half have witnessed killings by machetes. About 90 per cent have lost members of their family and a little less than half of these children have lost either a father or mother. A recent estimate places over half a million children in Rwanda mostly abandoned, child soldiers, in prison or as heads of families. To these one has to add high numbers of raped and brutalised women and chronic psychiatric patients.

The government of Rwanda recognised the need for mental health care rapidly after the genocide and war. Prior to the war, the mental health programme extended only to a 250 bed psychiatric hospital Ndera in Kigali operated by a missionary group. Two psychiatric centres with inpatient facilities were created in Butare and Niamata in the early 1980s and the Ndera hospital organised a mobile team to provide decentralised ambulatory care. After the genocide, the Minisante established a stronger national policy on mental health but a disjunction between psychiatric and psycho-social care remained. Today there is a clear desire to integrate mental trauma and psychiatric care in a global approach.

Certain initiatives are already launched by the international community such as Médecins du Monde (MDM), Action Nord Sud and Swiss Development Co-operation. Local initiatives such as Association de Veuves du Genocide (AVEGA) and Association des Femmes Rwandaises (ASOFERWA) provide psychological and legal support to its members. The government, recognising the need for an active mental health programme, has a national co-

ordinator and created the National Trauma Centre (NTC). In 1994, the United Nations Children Fund (UNICEF) together with the Ministry of Rehabilitation, established the National Centre for Trauma (NTC). Nearly 15 000 social agents such as school teachers, community health workers, nurses followed a two - day training on mental health issues in social settings. The University of Rwanda, the source for trained personnel, has an active and developed programme in psychiatry and psychology but remains isolated from the line Ministry.

Despite these encouraging developments, the aforementioned initiatives are not co-ordinated in a sufficient way, which suggests the likelihood of future tensions. Further, there is still a lack of sufficient and trained personnel. More specifically, the following recommendations should be considered[30]:

- The mental health and psycho-social needs of the affected population to create the social environment necessary for peace and co-habitation should be urgently addressed. These actions have to be undertaken together with Rwandan collaborators to ensure cultural and social relevance.
- Better co-ordination of the existing and future initiatives in mental health should be achieved as soon as possible. Technical assistance in this matter would be useful.
- Expansion and improvement of training of social workers based on training of trainers model, (e.g. teachers, community workers, nurses, polices and the military, with focus on primary school teachers).
- Finally, an evaluation (never undertaken so far) of the impact of current initiatives on the affected population is essential to assess effectiveness.

[30] See further, Rapport spécial sur la santé mentale au Rwanda, Dr. Vincent Dubois, UCL, 1998.

7. Recommendations for humanitarian action and preparedness.

The time for humanitarian aid for Rwanda is clearly at an end and the country should be on the road to development. This being said, unpredictable security conditions, especially in the Red Zone, make it difficult to foresee a complete withdrawal of humanitarian emergency aid at the present time. These areas need essential health and nutrition services. In addition, the fragility of the system requires, without question, preparedness activities in case of an unexpected degradation of conditions in the country or the region.

7.1 Action in the Red Zone

Humanitarian action should continue in certain parts of the country. The activities should be concentrated in the Red Zone (Gisenyi, Kibuye, Ruhengeri and Cyangugu) where development programmes cannot function as yet. In view of the insecurity and the need to work with military escorts (that some NGOs refuse), working in partnership with local organisations could possibly be the most constructive option. This will also have a longer- term effect on strengthening local organisations for the future.

7.2 Humanitarian monitoring system

In order to determine better the humanitarian needs, a monitoring system should be an useful tool. It would facilitate the selection of projects and decision making would be less dependent on the demands/reports of the NGOs. The system would follow up a set of leading indicators that would provide a rapid overview of the regions in the country where humanitarian operations are on-going and early warning of impending crises. It would, also provide a lightweight operational policy framework for the co-ordinators in the field. This monitoring exercise could be done every 3-6 months and include re-orientations of project activities as appropriate.

7.3 Emergency food distribution

Severe shortages of food are expected in the near future. In the first instance, existing emergency feeding programmes should be expanded.

Provinces which will require emergency feeding and food distribution are the Red Zone and south western provinces (Gikongoro, Butare, Buyumba) where new feeding programmes should be initiated. For this purpose specialised agencies should be contacted urgently for proposals of action. Secondly, immediate preparations for tools, seeds and fertiliser distribution amongst the most vulnerable families could avert or minimise a severe food shortage. Based on recent experience, closer attention should be paid to the efficiency and effectiveness of distribution mechanisms, mainly better targeting of beneficiaries and improved storage, handling and supervision of food stocks.

The fact that Rwanda will be facing major food shortages in the future is mainly because of structural problems. Therefore free food distribution should be minimised and the focus should be led on development measures to increase the production.

7.4 Humanitarian targeting of vulnerable groups

Special Humanitarian projects should focus more on specific groups like ***families with children or women as heads*** of households. Rapid assessments of the profile and location of these families could increase the efficiency of the aid programmes. ***Child tracing efforts should be continued*** and receive increased support. The longer the time period between the loss and reunification, the more difficult it is to have success in reuniting families. ***Mental health of traumatised persons,*** in particular children, needs to be addressed but should be adequately evaluated and prepared before implementing programmes.

7.5 Continuity of access to drugs

Emergency contributions of drugs due to shortfalls caused by the change in the system should be foreseen. The regions most affected by conflict will probably not be able to adapt to the privatised system in the near future and will require assistance. However, the emergence of such a need will depend on how well the reform process is reforming. Preparedness measures through monitoring the situation in the field and stockpiling could be initiated immediately.

7.6 Preparedness for disease outbreaks

Epidemic preparedness (mainly in the Red Zone) focusing on ***emergency control and prevention mechanisms for communicable diseases and sentinel surveillance systems*** is recommended. As mentioned earlier, the breakdowns in surveillance systems and vaccination programmes is likely to have significantly increased the size of population susceptible to infectious disease. Diarrhoeal disease (including cholera) and malaria, both presenting resistant strains, are a constant threat for the country and the region. Preparedness for rarer diseases, such as typhus and other fevers should also be foreseen. The current situation is potentially explosive, for the country as well as for the region, should an important infectious agent manifest itself. The issue should also be examined from a regional perspective in collaboration with specialised agencies and the WHO[31].

7.7 Improved management of human resources

The quality of schools and training institutions should be urgently enhanced in order to address the shortage of qualified manpower. Furthermore, coherence between national and international systems of remuneration would reduce significantly distortions that are common in the current situation.

7.8 Approaches to transition

In the best of scenarios, transition is not an easy phase. In Rwanda, it is all the more difficult due the patchwork of different projects, ranging from humanitarian, developmental or mixed actions. Both donors and the GOR should give stronger priority to a review and reform of their activities within the perspective of the development of the country and its autonomy. The main barrier at this point, in most of the institutions, is the structural rigidity which prevents flexible programming between urgent humanitarian action and longer term programmes.

[31] A joint mission with OFDA could be planned within the TransAtlantic Initiative.

8. Conclusions and lessons learnt

At the end of 1997, Rwanda presents a complex picture where humanitarian and development assistance are implemented in different parts of the country. This is also reflected in the health sector, which is one of the major components of international assistance.

Overall, humanitarian response should only be approved in parts of the country where development programmes cannot operate. However, humanitarian aid should participate in the planning of post-crises transition projects, which are essential preconditions for development. These actions include amongst others, reconstruction of critical infrastructure, resettlement of refugees, stabilisation of the government, mental health services, essential drug programme and demobilisation of ex-combatants. Some initiatives have already been undertaken in the country and should be continued. Along with these initiatives, preparedness activities frequently overlooked once a crisis is past, is required to reinforce the community's capacity to face new crises.

Overall, development and humanitarian agencies should establish joint operating principles and ensure institutional links. Today, the problem of transition from relief to development is a priority not only in Rwanda but in many other countries in the African continent.

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Annex 1

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Prof. Debarati Guha-Sapir (Belgium)	CRED/UCL Department of Epidemiology	Epidemiology (Team leader)
Dedeurwaerdere Ann (Belgium)	CRED/UCL Department of Epidemiology	Economist (Co-ordinator)
Dr Anne Golaz (Switzerland)	Center for Disease Control and Prevention, Atlanta	Epidemiology
Dr. Vincent Dubois (Belgium)	UCL -Cliniques St. Luc Service de Psychopathologie	Psychiatrist
Van Bauwel Annelies (Belgium)	Rijksuniversiteit Gent	Development Economist

Annex 2

List of people met in Rwanda

The Government of Rwanda

Médiresa	Dr Jérôme Kayinare	Médecin Directeur de la région sanitaire de Gisenyi
Ministry of Health	Dr. V. Biruta	Minister
		Secretary General
	Dr Martine Catapano	Technical Assistant
	Dr Sylvain Aldigheri	Technical Assistant
	Mr. Logan Ndahiro	National Mental Health Coordinator
OPHAR	Mr. L. Ruvugabigwi	Pharmacist OPHAR
	Mr. Leon K	Management OPHAR
NGO co-ordination	Mr. Andi Timbon	NGO co-ordinator

United Nations Agencies

DHA	Mr. Gregory Alex	Humanitarian Policy Advisor
FAO	Mr. Laurent Gashugi	Programme Officer
UNDP	Mr Omar Bakhet	Humanitarian Co-ordinator for the Great Lakes
	Mr. Joe Comerford	Programme Manager
	Mr Xuan Luong Nguyen	Economics Advisor
UNHCR	Mr Hussain Mursal	Medical Co-ordinator
UNICEF	Mr. Lenin Guzman	Health Project Officer
UNICEF	Mrs. Lori Calvo	Chief, Children in difficult circumstances
WB	Mr. R. Venkateswarah	Resident Representative
	Mr. Chiel Lijdsman	Technical Assistant Camerwa
	Mr. J. Kagubare	Health coordinator
WHO	Dr Amidou Baba Moussa	WHO Representative
	M'Hamed Kissiyar	Consultant(Carte Sanitaire)

International organisations

CICR	Dr Jens G. Amlie	Medical Co-ordinator
	Mr. Bernard Barrett	Information Delegate

Non Governmental Organisations

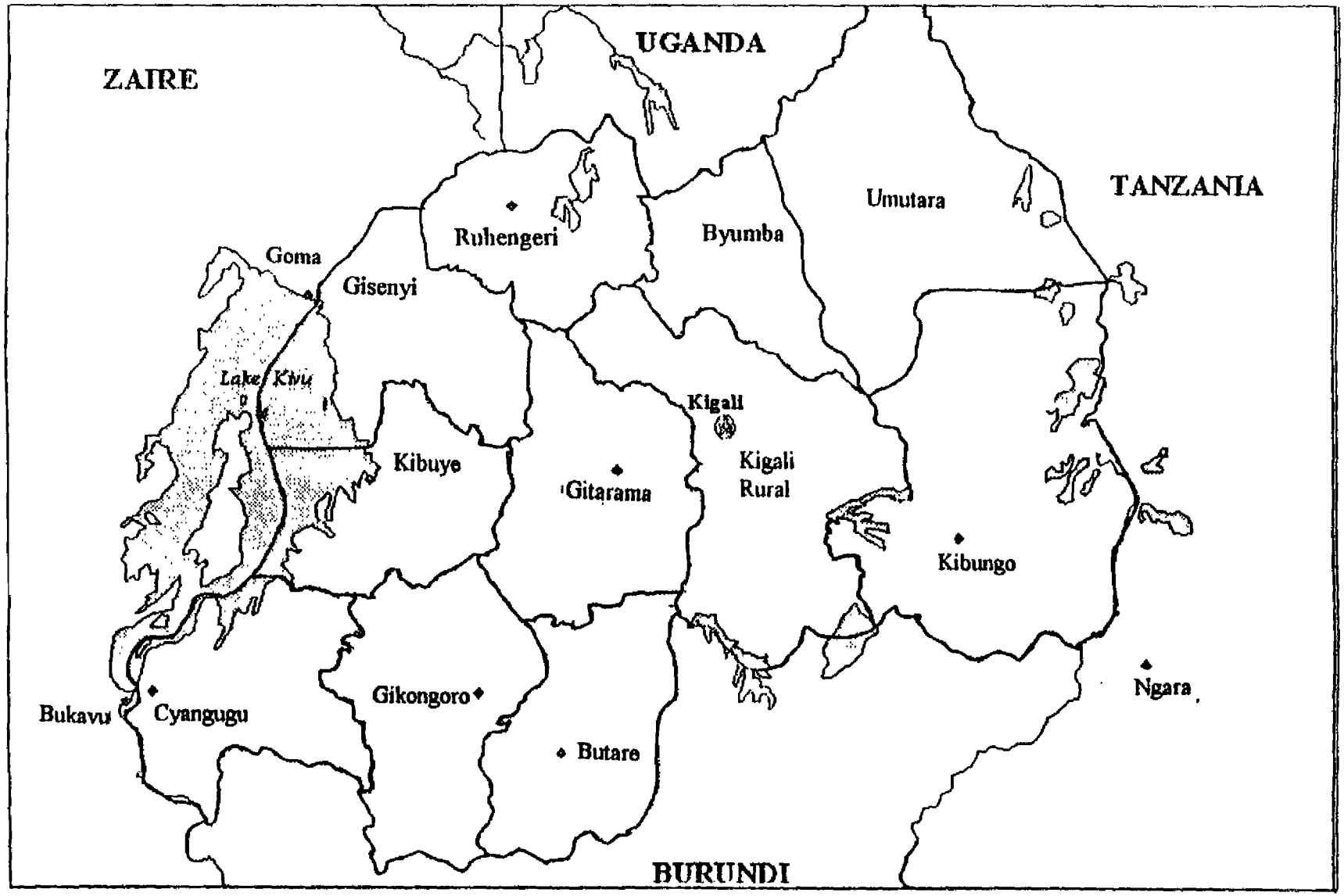
Action Nord-Sud	Mr Jean Libby	Head of mission
AVEGA	Mrs. Ester Mujawayo	Head of mission
COOPI	Mr Edzard Nebe	Head of mission

	Dr Pascal Litterio	
	Dr Achille Gavarelli	
MDM	Mr. M. Affortit	Head of mission
MSF-Belgique	Dr. Fazil Tezera	Head of mission
	Dr. Sandra Simons	Medical Co-ordinator
	Mr. Alain Brasseur	
Norwegian People's Aid	Dr. Giampiero Baldassari	Medical Co-ordinator
Save the Children Fund	Mr. Alain Pillet	Field Co-ordinator

Others

Belgian Embassy	Mr. Schriewer	Head of Mission
	Mr.Luc Verbeek	Education/Health
Butare University	Dr. Simon Gasibirege	Professor of psychology
Dutch Embassy	Mr. Michiel A. van der Ven	Head of Mission
Ndera Psychiatric Hospital	Pere Victor Quets	Administratif Director
	Mr. Raymond Bizimana	Head of Nurses
Swiss Embassy	Mr. Thomas Frey	Head of Mission
USAID/OFDA	Mrs. A. Lewis	Head of mission OFDA

RWANDAN PREFECTURES



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