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Subject

INTELLIGENCE  
HEALTH  
GENERAL

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## Archival Action



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**CORRESPONDENCE DISTRIBUTION**  
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File No: 449-16-1 ← PLS FILE

To: FMO	Remarks/Action: <u>X 11/8</u>
Med Ops	<u>11/8</u>
Med Log	
FHO	<u>11/8</u>
<u>SO Med</u>	<u>CAP</u>

Please initial and date when action complete then pass quickly

TO: CHAO  
FROM: TEAM 2  
DATE : 09 AUGUST 1995  
SUBJECT : REPORT ON RECCE PATROL CONDUCTED

#### INTRODUCTION

1. On 8 August 1995, HAC special patrol team visited SAVE and NYANZA secondary schools, all in BUTARE Prefecture. The team was composed of :

- a. MAJ MHONE ALICK leader team
- b. CAPT BEN KHELIFA member

The team left Kigali at about 0630 hrs and arrived in Butare at 0930hrs. The team was joined by UNICEF specialist MR Valere Nzeimana and the Humanitarian officer in sector 3A Maj Mostafiz.

#### AIM.

2. The aim of this paper is to present a report as observed by the team .

#### GENERAL OVERVIEW

3. The campus visited were Save and Nyanza.

(a) SAVE CAMPUS. There are three Secondary and three Primary Schools with about 3000 students as reported by Mr Jean Brada (person in charge of water supply). The water problem at the campus can be tabulated as mentioned below.

(1) The campus rely on 2 water pumps. Currently there is only one pump functioning. There is water rationing because one pump cannot supply the entire campus, however the problem is not very serious.

(2) The other pump is not functioning and very old. Repairs were carried out on the pump but to no success.

b. Nyanza Campus. Nyanza Campus is supplied with water from Electrogaz. The problem of Nyanza Secondary School is because of problems affecting Electrogaz. The problems of Electrogaz are as follows:

(1) Currently Electrogaz is using three(3) pumps, three (3) motors and standby generator which are not functioning well.



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AUSTRALIAN MEDICAL SUPPORT FORCE



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7/10

HQ UNAMIR - FMO

RECON SECTOR 2 - SUSPECTED CHOLERA AND MENINGITIS OUTBREAK

1. Following report of a cholera/meningitis outbreak in Sector 2, AUSMED was tasked to provide a recon to verify validity of the report. Elements deployed consisted of FLTLT Dohnalek MO, WO Attard HLTH INSP, and 5 members for security element.
2. Recon group were flown to Kibungu on 3 Aug 95 by helo and met by CAPT Ampiah GHANBATT MO and security element. Proceeded to meet MILOBS element at Rusumo Prefecture. En-route diverted to GHANBATT Delta Force to pickup area guide.
3. On arrival at Rusumo Prefecture, met by Majors Guindo and Ben Zine from MILOBS, who arranged meeting with the Burghameister, Mr Janvier Gasasira. Mr Gasasira indicated he had received a report from a medical assistant based at Rushonga Village, of six deaths in that area, from a constellation of symptoms he defined as Meningitis and Cholera. These deaths were reported to have occurred over the preceeding 2 weeks and all victims were recently arrived refugees from Zaire. Subsequent to these reports spreading through this region, migration out of the area by groups of local Rwandans had ensued. No further clinical or epidemiological facts could be ascertained, and decision was made to speak with the originator of the report.
4. The recon group then proceeded to the Centre de Sante at Rushonga Village in Rusumo Nyamugali, where the medical assistant Mr Philemon Sebagabo had apparently treated these suspected cases. Discussion revealed no such cases were evident. The death however had occurred several days prior, of a pregnant female transferred from Nashoi commune, due to cerebral malaria and dysentery. Review of the case history indicated no suspicion of meningitis or cholera. It was noted however, that several successfully treated cases of cerebral malaria and dysentery had been treated by this medic recently. All such cases had originated from Nashoi commune and involved refugees recently transferred from Goma, Zaire.
5. Explanation for the large number of cases was placed in part due to withdrawal of services by Africare. This NGO organisation who normally provided weekly medical services to the commune had encountered difficulties with transportation to the area. As no pharmaceuticals were thus available to this region, this neccessitated patients to attend Centre de Sante, for definitive treatment.

**UNCLASSIFIED**  
**Medical-In-Confidence**

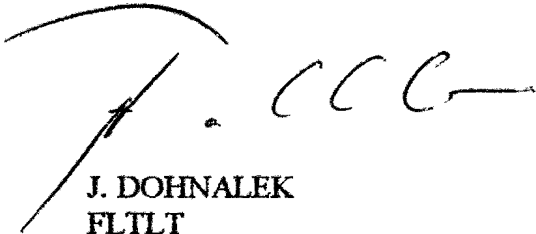
6. In order to completely exclude the possibility of an epidemic of meningitis or cholera, the recon group proceeded to Nashoi commune. En-route several communes were visited to establish whether any positive cases were documented. Although rumours were prominent, no cases of such deaths were reported.

7. At Nashoi, visitation to any unwell inhabitants, revealed no evidence of symptoms indicative of meningitis or cholera. It was reported by the Nashoi inhabitants however, that several cases of illnesses suggesting malaria had occurred recently. Morbidity and mortality figures could not be ascertained.

8. Conclusion of the investigation was that no proven cases of meningitis or cholera had occurred. The cases reported which initiated this investigation appear to be misinformed cases of dysentery and cerebral malaria.

9. Opportunity to correct this misinformation and settle commune concerns was made through liason by Mr. Gasasira and residents of Nashoi and other communes enroute back to Kibungo.

10. On completion, recon group returned to Kigali by helo from Kibungo.



J. DOHNALEK  
FLTLT  
MO AUSMED  
ASC II UNAMIR II

3 Aug 95

**Medical-In-Confidence**  
**UNCLASSIFIED**

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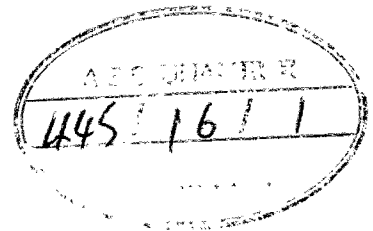
Med Ops      9/7

Med Log      10/7 GOOD REPORT - EFFICIENT REPORTS

FHO      10/7

SO Log      C 11/7

Please initial and date when action complete then pass quickly



TO : CHAO  
FROM : HAC SPECIAL PATROL TEAM  
DATE : 01 JULY 1995  
SUBJECT : REPORT ON HAC SPECIAL PATROL CARRIED OUT IN  
THE AREA OF NSHILI COMMUNE (GR 3996) GIKONGORO  
PREFECTURE ON 29/30 JUNE 1995

#### INTRODUCTION

1. On 29 June 1995, a HAC Special Patrol Team visited Nshili Commune in Gikongoro Prefecture to investigate the reported outbreak of cholera in the commune. The team left Kigali at 0800 hrs on 29 June 1995 and married up with the MILOBS Sector 4A Hum Offr and the ZAMBATT Clinical officer in Gikongoro at 1100 hrs.

2. The patrol which consisted of the under-mentioned personnel left Gikongoro at 1130 hrs on 29 June 1995 for Nshili Commune and came back to Gikongoro same day at 1830 hrs. The team came back to Kigali on 30 June 1995.

- |    |                      |   |                           |
|----|----------------------|---|---------------------------|
| a. | Capt SC Agbanusi     | - | Team Leader.              |
| b. | Capt LL Attachie     | - | Milob Sec 4A Hum Offr.    |
| c. | Lt Mushota           | - | Zambatt Clinical Officer. |
| d. | SSgt IA Okai         | - | HAC HQ                    |
| e. | Mr. Gerald Twanvgize | - | IOC Rep.                  |

#### AIM

3. The aim of this paper is to report on the outcome of the patrol.

#### CONDUCT OF THE PATROL

4. The team left Gikongoro and was met by Milobs Sec 4A team that was based in Runyombyi at Kibeho. The team led the patrol team to Nshili Commune. The Bourgmestre gave the team audience after which the team visited the Rehera Health Centre where one Mr. J.M.V. Rwaswa who works in the clinic was interviewed. The Responsible of the clinic was not available. The team was able to make some observations/findings from those that gave her audience.

## FINDINGS/OBSERVATIONS

5. The following findings/observations were made:
- a. No IDPs/Réfugees in the commune.
  - b. The commune has eighty-eight(88) orphans who are currently living with their relatives.
  - c. NGO "Save the Children" has made the necessary registration.
  - d. Other NGOs that operate in the commune are MSF - medical and TROCARE - seeds and farming implements.
  - e. Cattle rustling which was rampant in the commune has reduced considerably.
  - f. There was a minor cholera epidemic in the commune in March 1995 which was quickly handled by NGO MSF.
  - g. Most patients were those that crossed from Burundi and on the whole, about ten (10) persons were involved.
  - h. Eleven families came back from Burundi within the past two weeks to the commune.
  - i. Electricity - Nil in existence.
  - j. Transport - No organised system, people depend on trekking for their movements.
  - k. Cholera - Nil in existence now.
  - l. Dysentery/Diarrhoea - Nil.
  - m. Malaria - very minor.
  - n. NGO MSF, perfectly in charge of the dispensary.
  - o. General situation - Very normal.

## RECOMMENDATIONS

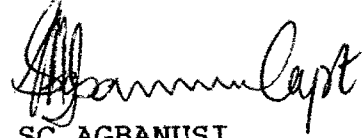
6. The following recommendations are made:
- a. There is the need for a more reliable source of information to the HAC HQ as unsure information can only lead special patrols on unnecessary wild goose chase.
  - b. Since September is the normal planting season here, more

NGOs with interest in agriculture be encouraged to provide the residents of Nshili commune with more farming implements and seeds for the coming planting season.

c. NGOs with interest in provision of portable water be encouraged to operate in the commune.

#### CONCLUSION

7. The patrol's success couldn't have been possible without the cooperation of the Sector 4A team based in Runyombyi, Sector 4A Hum Offr, the Zambatt Regimental Medical Officer who provided his clinical officer, the patrol team itself and all those interviewed. To all of them, I say many thanks.

  
SC AGBANUSI  
Capt  
Team Leader

Information:

Internal:

FC  
CMO  
DCMO  
COS  
DCOS(OPS)  
DCOS(LOG)  
FMO

External:

IOG  
UNREO

Cover Sheet Classification  
**UNCLASSIFIED**

UNITED NATIONS  
ASSISTANT REGION FOR RWANDA

Enclosure Classification  
**UNCLASSIFIED**

NATIONS UNIES  
MISSION D'ASSISTANCE AU RWANDA



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STAMP MIN 145

Page 1 of 3

18 JUL 95

TO: <b>MALAWICOY (KIBUYE AND CYANGUGU LOCATIONS)</b>	FROM <b>FMO MEDICAL BRANCH UNAMIR, KIGALI, RWANDA</b>
ATTN <b>CAPT CHINAMALE Medical Officer</b>	DATE <b>18 JUL 95</b>
FAX NO	PHONE INT + 250 84270 Ext 11116
INFO	FAX NO INT + 250 66877
Internal dist	DRAFTED BY <b>MAJ R.P. WILTSHIRE G4 MED LOG</b>
Subject: <b>NGO MEDICAL SUPPORT TO UNAMIR AVAILABLE IN SECTOR 4 - CYANGUGU</b>	
REFERENCE	

1. REQUEST MALAWICOY MEDICAL OFFICER VISIT HOSPITALS IN NEW SECTOR INCLUDING NORWEGIAN PEOPLES AID (NPA) HOSPITAL TO DETERMINE CURRENT SURGICAL SUPPORT AVAILABLE TO MALAWICOY IN THE EVENT OF AN NIGHT BAD WEATHER EMERGENCY WHERE HELICOPTER EVACUATION TO AUSMED WAS NOT AVAILABLE.
2. HOW LONG DOES NPA INTEND CONTINUING PROVISION OF SUPPORT?
3. WHAT IS THE SUPPORT AVAILABLE IN KAMEMBE OR GIHUNDWE?
4. REQUEST MEDICAL OFFICER COMPLETE THE ATTACHED FORM ON HOSPITAL AND INCLUDE HIS ASSESSMENT OF THE CAPABILITY OF THE FACILITY TO CARE FOR MALAWICOY SOLDIERS OVERNIGHT IN AN EMERGENCY. REGRET THAT A REPORT WAS NOT RECEIVED FROM ETHIOBATT ON NPA HOSPITAL.
5. REQUEST REPLY BE FAXED TO MED BR HQ UNAMIR BY 24 JUL 95.

Releasing Officer's Name	Signature	Rank Appointment	Date
WILTSHIRE		MAJ	18 JUL 95

6 part request made at 812/95 693-6-1  
29 JUL 95 RO

→ file. 445-16-1

GR 393964

38

5

TO : HQ MILOB SEC 4A

File: 5000.1(HAC)/A/1

FROM : HAC

Date: 21 June 1995

SUBJECT : OUTBREAK OF PNEUMONIA AND CHOLERA IN NSHILI

Reference: Your Weekly Hum Report 9 - 16 June 1995.

1. You reported an outbreak of pneumonia and cholera in Nshili in your last report.
2. Since your Weekly Report the week before has not been received by HAC we are requesting you to send a copy by fax.
3. We have informed IOC to organise immediate medical action.
4. To speed up the necessary health operations some further information is request from you, ie number of people affected, breakdown, comments and recommendations etc.
5. Your quick response is anticipated.

NB:

HAC TM investigated the report and confirmed that there was no epidemic in the area. Less than 10 suspected cases had been reported since MAR 95.

J. H. Lt Col 2/7

*[Signature]*

RM MANZL  
Lt Col  
DCHO

FROM: HAC

MSG PASSED TO ADJT ZAMBART FOR RMO/RAT  
RMB TO LIAISE WITH MILOB PARA AND VISIT  
NSHILI

*[Signature]*

R.V. WILSHIRE 291045200/95



UNITED NATIONS

ASSISTANCE MISSION FOR RWANDA



NATIONS UNIES

MISSION POUR L'ASSISTANCE AU RWANDA

UNAMIR - MINUAR

HQ UNAMIR MED BR

FILE: 445-16-1

MED 530/95

**To: AUS MED**

**From: FMO**

**Date: 17 May 95**

**Subject: HEALTH INTELLIGENCE - RWANDA**

1. It is requested that AUS MED conduct Health Intelligence gathering on Rwanda.
2. Attached is the minute detailing the original request for information from HQ ADF via LHQ.
3. A requirement would exist for a Hlth Asst to accompany any information gathering team.
4. Notification as to the requirement either 35m slide, digital photo or 35m photo will be provided by G4 MED.
5. Areas targeted for collection are outlined in the attached minute.
6. This task is not a force essential task but would be advantageous for future operations not only in Rwanda but Africa. Provision of this information would also assist in the hand over to the organisation which replaces us in Rwanda.
7. Point of contact at UNAMIR HQ MED BR is Major Richard Wiltshire on ext 11115.

J.E. NERNEY  
CAPT  
For FMO

INT BR

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**IMMEDIATE**

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~~00449/75~~  
File RWA 931.540  
#23

Headquarters Australian Defence Force

⑤

**MINUTE**

SG93-26180 Pt2 (41) <sup>63814</sup>

SGADF 3025/95 <sup>26 63936</sup>

~~1.000-00000-001-INT OPS~~

For Information:

LHQ (Attn: A/COL HLTH)

ASC UNAMIR II (Attn: COMASC)

Passer & ASC UNAMIR 20 Jan

**HEALTH INTELLIGENCE - RWANDA**

Reference:

A. 6097/94 dated 4 Nov 94 (NOTAL)

NOT SEEN! See below  
SO1. HLTH OPS

B. Telecon SO1 HI/SO1 INT OPS of 12 Jan 95

1. Reference A was a request for health intelligence (HI) through the health chain which has to date attracted no response. Your assistance is therefore sought in this matter.

2. SGADF HI section requires imagery covering aspects of health intelligence in Rwanda. Depictions would foreseeably include (but not be limited to) the following:

- a. environmental hazards (eg climatic extremes, pollution, road traffic incidents etc);
- b. inadequate civil infrastructure (sanitation, hygiene, accommodation, water etc);
- c. disease, conditions conducive to the outbreak of disease, disease vectors;
- d. dangerous animals and plants, results of human contact with these, endemic animal diseases which may affect humans or quarantine requirements for RTA;
- e. depictions of medical countermeasures or preventive medicine procedures being employed against any of the hazards listed above; and
- f. good or bad aspects of civilian or military health support (infrastructure, personnel, equipment, CASEVAC etc).

**RESTRICTED**  
**IMMEDIATE**

- 2 -

3. As discussed at Reference B, 35mm colour slides (about two rolls if possible, with one copy of each slide) would be preferred. The imagery is requested by ~~15 Feb 95~~.

4. Your assistance in this matter is <sup>Mid-May</sup> greatly appreciated.



J. SMITH  
WGCDR  
SO1 HI  
OSGADF

12 Jan 95

UN - REGISTRY	Action	F M O 26A
	MEDICAL BRANCH	
24 JUN 1995		
FC 0101		

FROM : R M O MALAWI COMPANY

TO : F M O MEDICAL BRANCH, HQ UNAMIR  
KIGALI RWANDA.

DATE : 23/6/95

SUBJECT: MEDICAL SUPPORT TO UNAMIR AVAILABLE FROM SWISS  
DISASTER RELIEF (SDR) KIBUYE HOSPITAL.

1. I paid a visit to Kibuye Hospital on 23/6/95 to determine current surgical support available to Malawi Coy in an event of emergency and the following was my assesment:-

- (a) There is a good surgical team available with the help of a surgion from SDR. ✓
- (b) The theatre is very good. ✓
- (c) The car theft has not affected SDR capability or intention to continue support to the Sector. ✓
- (d) Swiss Disaster Relief doesn't know how long for it is going to be in Kibuye but their contract is being renewed. ✓



Signature: G P CHINAMALE, LIEUT - R M O

23/06 '95 17:22

11234

22/06 '95 13:13

11278

FRAPBATT 4B  
UN HQ ORDERLY RM

002  
002

UN RESTRICTED

APPENDIX III TO  
ANNEX A

LOCATION, LEVEL, CAPABILITIES - level 2 and 3 only  
(Report is requested on the first of every month)

Date of report: 23-6-95

Name of Mission/medical unit KIBUYE HOSPITAL

Change in location, level, capabilities:  
NO - see former report  
YES - see report below

1. Organization:

Name, rank, title of header AR THOMAS MASIALA

Location: KIBUYE

Point of contact: \_\_\_\_\_

Phone number: /

Other communication system (numbers, radio frequencies, call sign etc): \_\_\_\_\_

Next airfield or helicopter/distance: 1 1/2 km

2. Personnel:

physicians/specialists: ONE SURGEON (SAR)

nurses: FOUR (A)

medics: ONE OTHER DOCTOR NGDS

other: ONE PHARMACY ASSISTANT, 1 LAB ASSISTANT, AUXILIARY &

total: \_\_\_\_\_

3. Beds and/or cots: total: ABOUT 120 BEDS

surgical: 15 BEDS

maximum number in case of mass casualty: 15

A-III-1/2

UN RESTRICTED

23/08 '95 17:23  
22/08 '95 13:14

11234  
11278

FRAFBATT 4B  
UN HQ ORDERLY RM

003  
003

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APPENDIX III TO  
ANNEX A

4. Medical capability: specialities PAEDIATRICIAN ONE  
isolation ward: AVAILABLE
5. Intensive care unit: ICU beds: NONE  
equipment: NONE
6. Surgical capability: specialities: ONE SURGEON (SUR)  
operating rooms: ONE  
operating teams: SURGEON, ANAESTHETIST & NURSE
7. Laboratory capabilities: microbiology: AVAILABLE  
virology: AVAILABLE  
parasitology: AVAILABLE
8. X-RAY: skeleton: AVAILABLE  
abdominal: AVAILABLE  
ultrasound: NONE  
others: /
9. Blood bank: screening methods: NONE
10. Dental Capability: NONE
11. Other special capabilities: /
12. Preventative medicine assets: VACCINES, REFRIGERATORS
13. Veterinarian service: NONE
14. Medevac capability:  
ground: (number of ambulances): ONE  
air: (number of aircraft (Capacity and location)) NONE  
request procedures incl. phone number or frequencies:

NON

SO LIBUSE HOSPITAL HAS A CAPABILITY OF CARING FOR  
MALAWI COY. SOLDIERS - 2-11-2/2  
OVERNIGHT IN AN EMERGENCY.

UN RESTRICTED

**SENBATT MEDICAL STAFF ACTIVITIES IN RWANDA**  
**FOR PERIOD 24 FEBRUARY 1995 - 11 JUNE 1995.**

**I- SENBATT SECTOR 4B PRESENTATION**

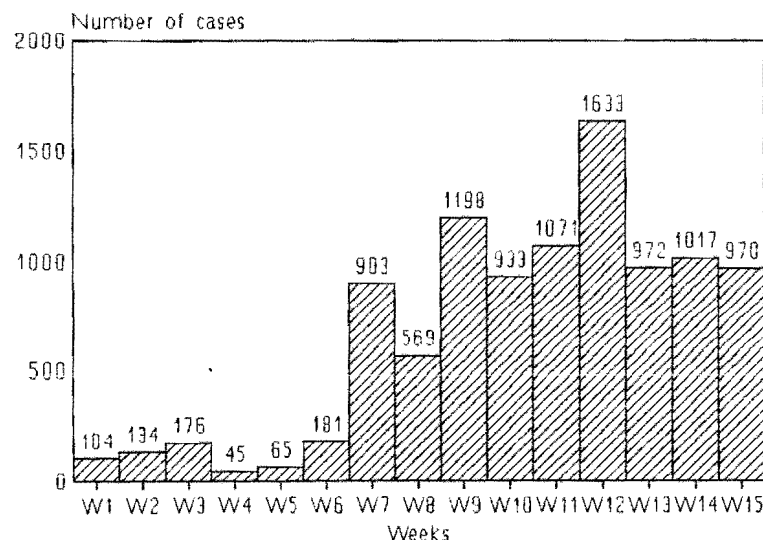
- \* Location : BUTARE ( Southern Rwanda - boundary with Burundi).
- \* call sign : C 7111
- \* superficies : about 1580 sq Km.
- \* covered population : not known.
- \* administrative division :
  - one prefecture
  - three sub-prefectures
  - twenty communes.
- \* medical facilities :
  - University Hospital
  - Kabutare Hospital (MSF)
  - Psychiatric Hospital.
- \* three orphanages
- \* twenty NGOs
- \* distance Butare - Kigali : 136 Km (about 2 hours by road).

**Senbatt positions :** in communes of Huye, Ngoma (HQ), Kigembe and Runyinya.

**II- GLOBAL ACTIVITIES**

**1- Consultation :** Number of patients treated : 9971

**a) Weekly distribution of cases :**



**Fig.1: Weekly distribution of patients attending Senbatt Clinics.**

## b) Serials-based distribution of cases :

SERIALS	DENOTATION	Abs Num	Percent
A	UN Military Pers	741	7.4
B	UN Civilian Pers	17	0.2
C	UN local hired Pers	3	0.03
D	UN Mil Observers	15	0.15
E	UN Civilian Police	0	0.
F	UN Family Members of Serials A to E	0	0.
G	Civilians/Displaced Pers	9195	92.22
TOTAL		9971	100

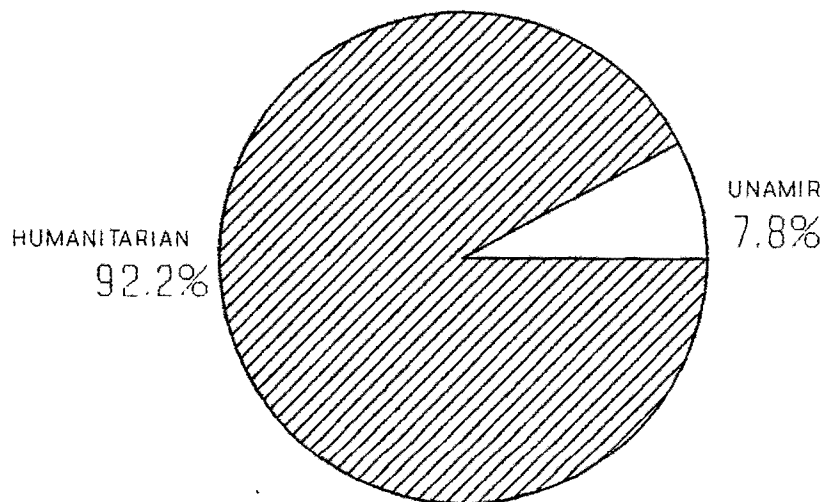


Fig.2: Serials-based distribution of patients attending Senbatt Clinics.



## c) Accumulative diagnosis stats.

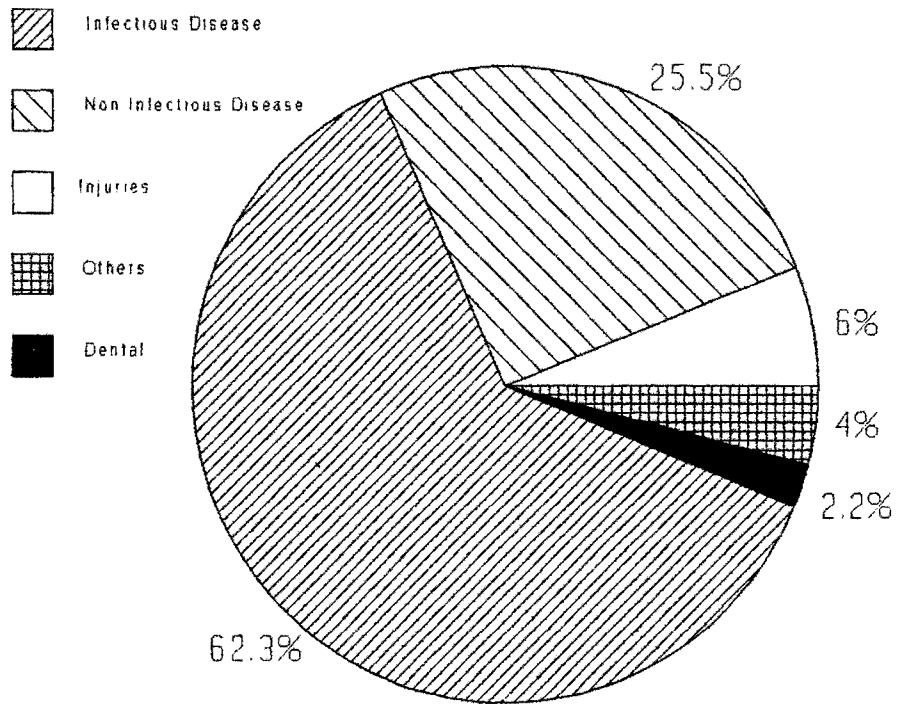


Fig.3: Diagnosis-based distribution of cases.

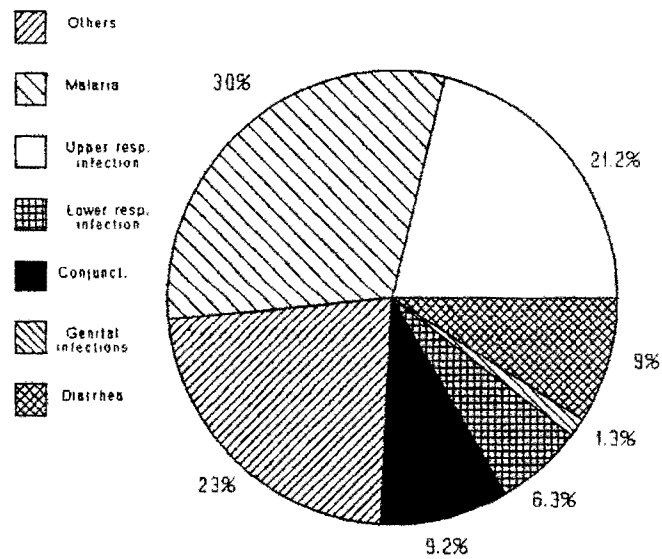


Fig.4: Distribution of infectious cases.

## 2- Evacuations :

- \* 11 CASEVAC for UN Mil Pers to Ausmed (Kigali)
- \* 10 Civ/Displaced persons to the University Hospital of Butare
- \* 01 MEDEVAC to Nairobi (Heart attack sent to Val de Grâce-Paris to undergo surgery).

## 3- Repatriations : (Senegal)

- \* 01 broken leg (repatriated on April 21 1995)
- \* 01 deceased from road traffic accident (repatriated on April 18 1995).

## III- HUMANITARIAN ACTIVITIES

### 1- General features of the treated population :

- \* Number of patients : 9195 (serial G)

#### a) Sex distribution

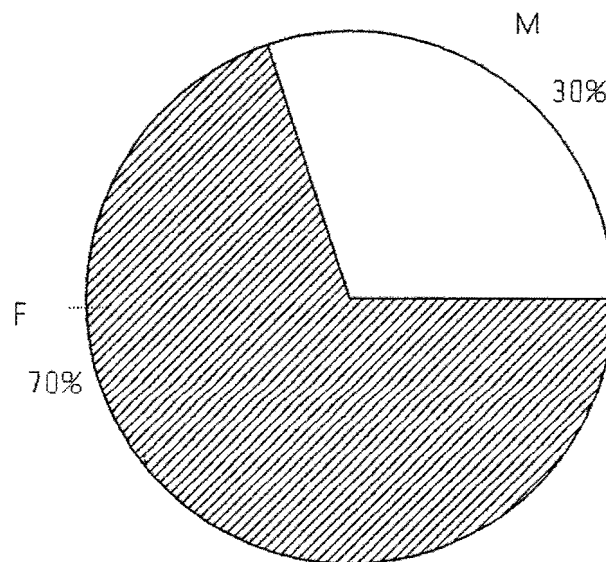


Fig.5: Sex distribution of patients attending Senbatt Clinics.

- \* sex ratio = 2.3

## b) Age-group distribution

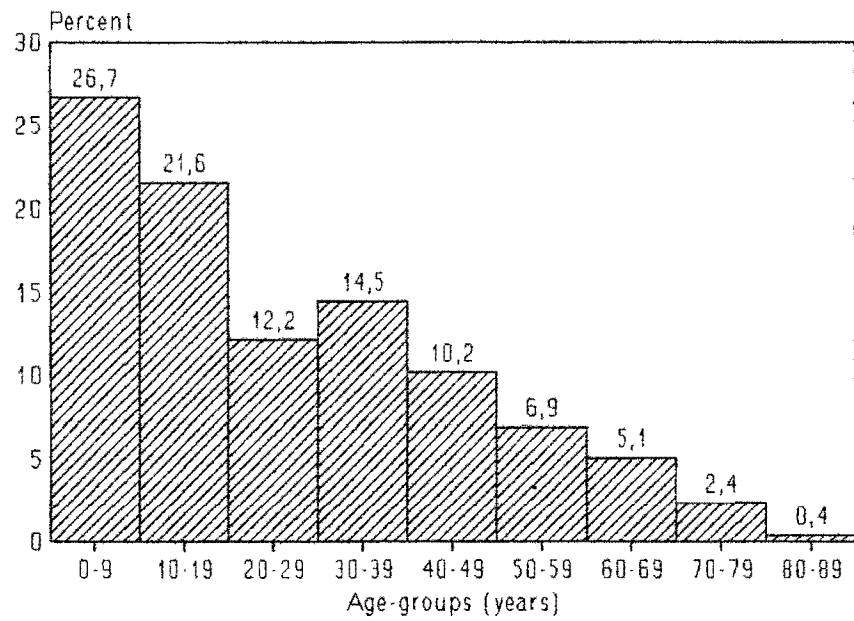


Fig.6: Age-group distribution of patients attending Senbatt Clinics.

## 2- Humanitarian diagnosis stats

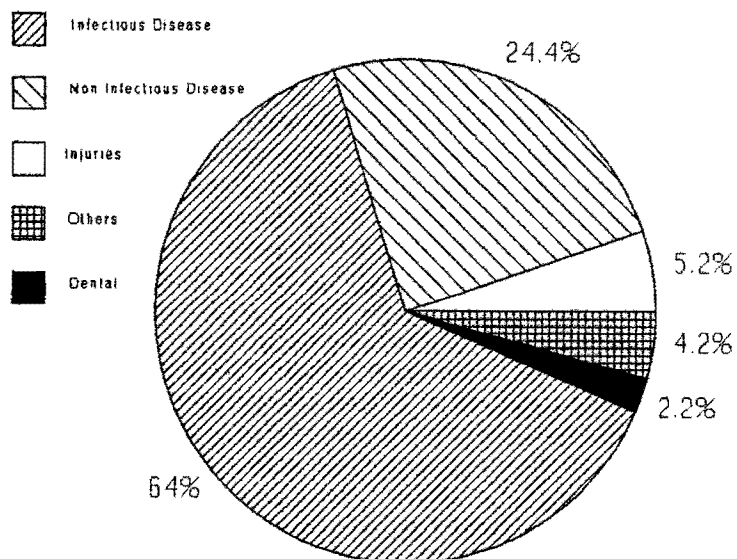


Fig.7: Humanitarian diagnosis stats.

3- Evacuations = 10 Patients.

4- Medical assistance to the orphanage of SOVU during Kibeho incident.

5- Food assistance :

\* 889 Kg of bread distributed to patients attending our clinics ( for period 03/05/95 to 19/05/95 ).

6- Water and soap supply : occasionally

7- Health education : occasionally

#### IV- UNAMIR DIAGNOSIS STATS ( = serials A,B,C,D)

\* number of UN persons treated = 776

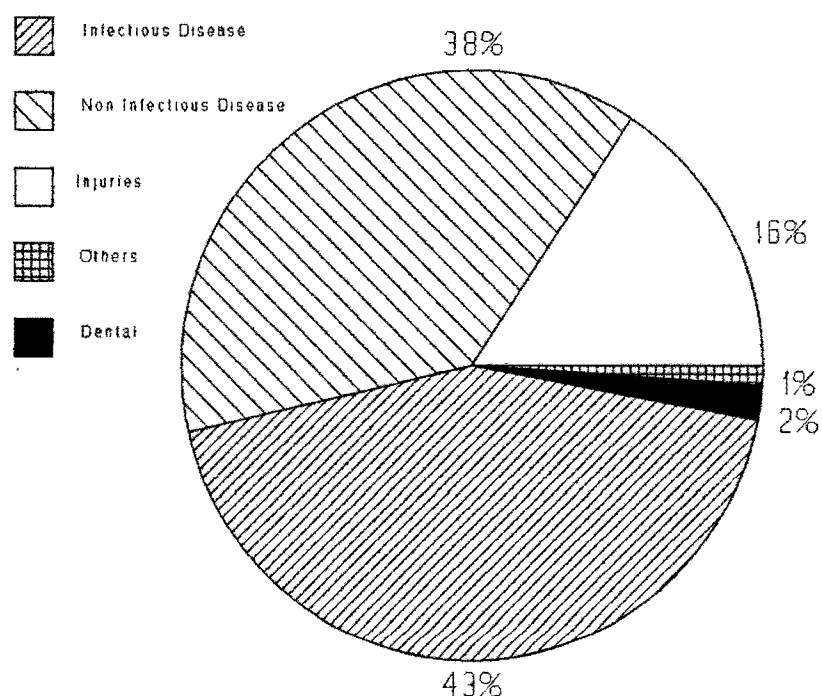


Fig.8: UNAMIR diagnosis stats.

Butare, 11 June 1995  
 Captain Masserigne SOUMARE  
 RMO SENBATT - BUTARE



NAME - MINUT

Out Going FaxNo. 663-95

Page 1 of 1

File 445-16-1

TO <b>MALAWICOY</b>	FROM <b>FMO MEDICAL BRANCH UNAMIR, KIGALI, RWANDA</b>
ATTN <b>LT CHINAMALE Medical Officer</b>	DATE <b>24 JUN 95</b>
FAX NO	PHONE - INT - 250 84270 Ext 11116
INFO	FAX NO. INT + 250 86877
Internal dist	DRAFTED BY <b>MAJ R.P. Wiltshire G4 Med Log</b>
Subject: <b>REPORT ON KIBUYE HOSPITAL</b>	
REFERENCE - <b>MALAWICOY FAX OF 23 JUN 95</b>	

COMMENTS/INSTRUCTIONS

1. THANK YOU FOR THE PROMPT AND COMPREHENSIVE REPORT ON KIBUYE HOSPITAL PROVIDED AT THE REFERENCE.
2. I AM REASSURED BY YOUR ASSESSMENT THAT APPROPRIATE SUPPORT IS AVAILABLE TO MALAWICOY IN THE SITUATION THAT AME TO KIGALI IS NOT AVAILABLE.
3. I RECEIVED THE NEWS TODAY THAT THE SDR VEHICLE HAS BEEN RETURNED.
4. REGARDS.

Releasing Officer's Name

**WILTSHIRE**

Signature

Rank/Appointment

**MAJ G4 MED**

Date

**24 JUN 95**

Cover Sheet Classification  
**UNCLASSIFIED**

Enclosure Classification  
**UNCLASSIFIED**

UN RESTRICTED

APPENDIX III TO  
ANNEX A

LOCATION, LEVEL, CAPABILITIES -- level 2 and 3 only  
(Report is requested on the first of every month)

Date of report: 31 - 5 - 1995

Name of Mission/medical unit AMREF CLINIC BYUMBA

Change in location, level, capabilities:  
NO - see former report  
YES - see report below

1. Organization:

Name, rank, title of header Dr. LISANGOLAY NOLI, MPH

Location: BYUMBA

Point of contact: BYUMBA CATHOLIC PARISH

Phone number: 64172

Other communication system (numbers, radio frequencies, call sign etc): RADIO - frequency not known

Next airfield or helicopter/distance: 200 m

2. Personnel:

physicians/specialists: ONE MPH, OB-Gyn and Surgeon

nurses: 4 Professional nurses

medics: 12

other: 12 Workers

total: 17

3. Beds and/or cots: total: 50

surgical: 1 Theatre with one operating Table

maximum number in case of mass casualty: 5

A-III-1/2

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APPENDIX III TO  
ANNEX A

4. Medical capability: specialities General medicine  
isolation ward: 1
5. Intensive care unit: ICU beds: NONE  
equipment: NONE
6. Surgical capability: specialities: General surgery  
OB-GYN  
operating rooms: 1  
operating teams: 2 DOCTORS, 4 nurses
7. Laboratory capabilities: microbiology: NONE  
virology: NONE  
parasitology: NONE
8. X-RAY: skeleton: NONE  
abdominal: "  
ultrasound: "  
others: "
9. Blood bank: screening methods: NONE
10. Dental Capability: NONE
11. Other special capabilities: NONE
12. Preventative medicine assets: IMMUNIZATION
13. Veterinarian service: NONE
14. Medevac capability:  
ground: (number of ambulances): NONE  
air: (number of aircraft (Capacity and location)  
request procedures incl. phone number or frequencies:

A-III-2/2

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UNAMIR ARCHIVES

27 JUN 95

Cover Sheet Classification  
UNCLASSIFIED  
UNITED NATIONS



Enclosure Classification  
UNCLASSIFIED  
NATIONS UNIES

FC 010-1

Out Going FaxNo. 669 95

Page 1 of 1

File 693-6-1

TO: TUNBATT 11267	FROM: FAO MEDICAL BRANCH UNAMIR, KIGALI, RWANDA
ATTN: MED CAPT BOURGHIDA SAMI Medical Officer	DATE 26 JUN 95
FAX NO	PHONE INT - 250 84270 EXT 11116
INFO:	FAX NO INT + 250 86877
Internal dist	DRAFTED BY MAJ R.P. Wiltshire G4 Med Log
Subject: HUMANITARIAN SUPPORT AND PSF MEDICAL STORES	
REFERENCE: YOUR FAX 2754	

## COMMENTS INSTRUCTIONS

1. I WILL OBTAIN ADVICE FROM PSF ABOUT HOW THE HUMANITARIAN MEDICAL STORES ARE TO BE REDISTRIBUTED NOW THAT RWANDESE CITIZEN CONSULTATIONS HAVE STOPPED AS PER YOUR REFERENCE.
2. PLEASE ADVISE MED BR IF ANY ORGANISATIONS ARE AVAILABLE IN YOUR LOCAL AREA TO UNDERTAKE MEDICAL TASK NOW THAT YOU HAVE STOPPED CONSULTATIONS.
3. REGARDS.

Releasing Officer's Name

Signature

Rank Appointment

Date

WILTSHIRE

MAJ G4 MED

26/6

Cover Sheet Classification  
UNCLASSIFIED

Enclosure Classification  
UNCLASSIFIED



**CORRESPONDENCE DISTRIBUTION**  
**COVER SHEET**

File No. 693-6-1

Correspondence No. \_\_\_\_\_

To: FMO

Remarks/Action: Δ 24/6.

Med Ops

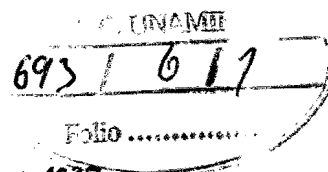
Med Log

FHO

*copy to ops/HAC 10/21/6*  
*see 665 FS*

Please initial and date when action complete then pass quickly.

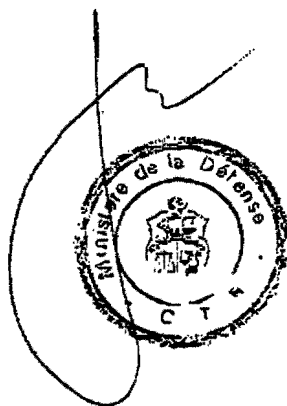
**FROM: TUNBATT H.Q**  
**TO: H.Q UNAMIR (MEDICAL BRANCH)**



**N: 2754 / TUNBATT H.Q / MEDICAL STAFF AT ..... 19 JUN 1995**

**BE INFORMED THAT THE RWANDESE CITIZEN  
CONSULTATIONS ARE STOPPED FROM JUNE 25<sup>th</sup> 1995  
BECAUSE OF THE CONTINGENT WITHDRAWAL**

**BEST REGARDS.**





NAME: MINISTRE

Out Going FaxNo. 663 95

Page 1 of 1

File 445-16-1

TO <b>MALAWICOY</b>	FROM <b>FMO MEDICAL BRANCH UNAMIR, KIGALI, RWANDA</b>
ATTN <b>LT CHINAMALE Medical Officer</b>	DATE <b>24 JUN 95</b>
FAX NO	PHONE INT + 250 84270 Ext 11116
INFO	FAX NO INT + 250 86877
Internal dist.	DRAFTED BY <b>MAJ R.P. Wiltshire G4 Med Log</b>
Subject: <b>REPORT ON KIBUYE HOSPITAL</b>	
REFERENCE: <b>MALAWICOY FAX OF 23 JUN 95</b>	

COMMENTS/INSTRUCTIONS

1. THANK YOU FOR THE PROMPT AND COMPREHENSIVE REPORT ON KIBUYE HOSPITAL PROVIDED AT THE REFERENCE.
2. I AM REASSURED BY YOUR ASSESSMENT THAT APPROPRIATE SUPPORT IS AVAILABLE TO MALAWICOY IN THE SITUATION THAT AME TO KIGALI IS NOT AVAILABLE.
3. I RECEIVED THE NEWS TODAY THAT THE SDR VEHICLE HAS BEEN RETURNED.
4. REGARDS.

Releasing Officer's Name

**WILTSHIRE**

Signature

Rank/Appointment

**MAJ G4 MED**

Date

**24 JUN 95**

Cover Sheet Classification  
UNCLASSIFIED

Enclosure Classification  
UNCLASSIFIED



Out Going FaxNo. 656-95

Page 1 of 3

File 445-16-1

TO MALAWICOY	FROM FMO MEDICAL BRANCH UNAMIR, KIGALI, RWANDA
ATTN CAPT TEMBO Medical Officer	DATE 2 JUN 95
FAX NO	PHONE INT - 250 84270 Ext 11116
INFO	FAX NO INT + 250 86877
Internal dist	DRAFTED BY MAJ R.P. WILTSHIRE G4 MED LOG
Subject: MEDICAL SUPPORT TO UNAMIR AVAILABLE FROM SWISS DISASTER RELIEF (SDR) - KIBUYE HOSPITAL	
REFERENCE	

COMMENTS/INSTRUCTIONS

1. REQUEST MALAWICOY MEDICAL OFFICER VISIT KIBUYE HOSPITAL TO DETERMINE CURRENT SURGICAL SUPPORT AVAILABLE TO MALAWICOY IN THE EVENT OF AN NIGHT BAD WEATHER EMERGENCY WHERE HELICOPTER EVACUATION TO AUSMED WAS NOT AVAILABLE.
2. IT WAS REPORTED THAT A SDR VEHICLE WAS STOLEN ON 18 JUN. HAS THIS AFFECTED SDR CAPABILITY OR INTENTION TO CONTINUE SUPPORT TO THE SECTOR? HOW LONG DOES SDR INTEND PROVIDING SUPPORT AT KIBUYE?
3. REQUEST REPLY BE FAXED TO MED BR HQ UNAMIR BY 24 JUN 95.
4. REQUEST MEDICAL OFFICER COMPLETE THE ATTACHED FORM ON THE KIBUYE HOSPITAL AND INCLUDE HIS ASSESSMENT OF THE CAPABILITY OF THE FACILITY TO CARE FOR MALAWICOY SOLDIERS OVERNIGHT IN AN EMERGENCY.

Releasing Officer's Name	Signature	Rank Appointment	Date
WILTSHIRE		MAJ G4 MED	21 JUN 95

4. Medical capability: specialities \_\_\_\_\_  
\_\_\_\_\_
- isolation ward: \_\_\_\_\_
5. Intensive care unit: ICU beds: \_\_\_\_\_
- equipment: \_\_\_\_\_
6. Surgical capability: specialities: \_\_\_\_\_  
\_\_\_\_\_
- operating rooms: \_\_\_\_\_
- operating teams: \_\_\_\_\_
7. Laboratory capabilities: microbiology: \_\_\_\_\_
- virology: \_\_\_\_\_
- parasitology: \_\_\_\_\_
8. X-RAY: skeleton: \_\_\_\_\_
- abdominal: \_\_\_\_\_
- ultrasound: \_\_\_\_\_
- others: \_\_\_\_\_
9. Blood bank: screening methods: \_\_\_\_\_  
\_\_\_\_\_
10. Dental Capability: \_\_\_\_\_
11. Other special capabilities: \_\_\_\_\_
12. Preventative medicine assets: \_\_\_\_\_
13. Veterinarian service: \_\_\_\_\_
14. Medevac capability:  
ground: (number of ambulances): \_\_\_\_\_  
air: (number of aircraft (Capacity and location) \_\_\_\_\_  
\_\_\_\_\_
- request procedures incl. phone number or frequencies:  
\_\_\_\_\_  
\_\_\_\_\_

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APPENDIX III TO  
ANNEX A

LOCATION, LEVEL, CAPABILITIES - level 2 and 3 only  
(Report is requested on the first of every month)

Date of report: \_\_\_\_\_

Name of Mission/medical  
unit \_\_\_\_\_

Change in location, level, capabilities:  
NO - see former report  
YES - see report below

1. Organization

Name, rank, title of header \_\_\_\_\_

Location: \_\_\_\_\_

Point of contact: \_\_\_\_\_

Phone number: \_\_\_\_\_

Other communication system (numbers, radio frequencies, call  
sign etc): \_\_\_\_\_

Next airfield or helicopter/distance: \_\_\_\_\_

2. Personnel:

physicians/specialists: \_\_\_\_\_

nurses: \_\_\_\_\_

medics: \_\_\_\_\_

other: \_\_\_\_\_

total: \_\_\_\_\_

3. Beds and/or cots: total: \_\_\_\_\_

surgical: \_\_\_\_\_

maximum number in case of mass casualty: \_\_\_\_\_

A-III-1/2

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Office of the Humanitarian Coordinator

Photo: UNICEF/Maggie Murray-Lee



*Humanitarian Situation Report*  
*15 April 1995*

# **RWANDA**

NATIONS UNIES



UNITED NATIONS

UNITED NATIONS



NATIONS UNIES

# ***RWANDA***

*Humanitarian Situation Report*  
*15 April 1995*

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Office of the Humanitarian Coordinator



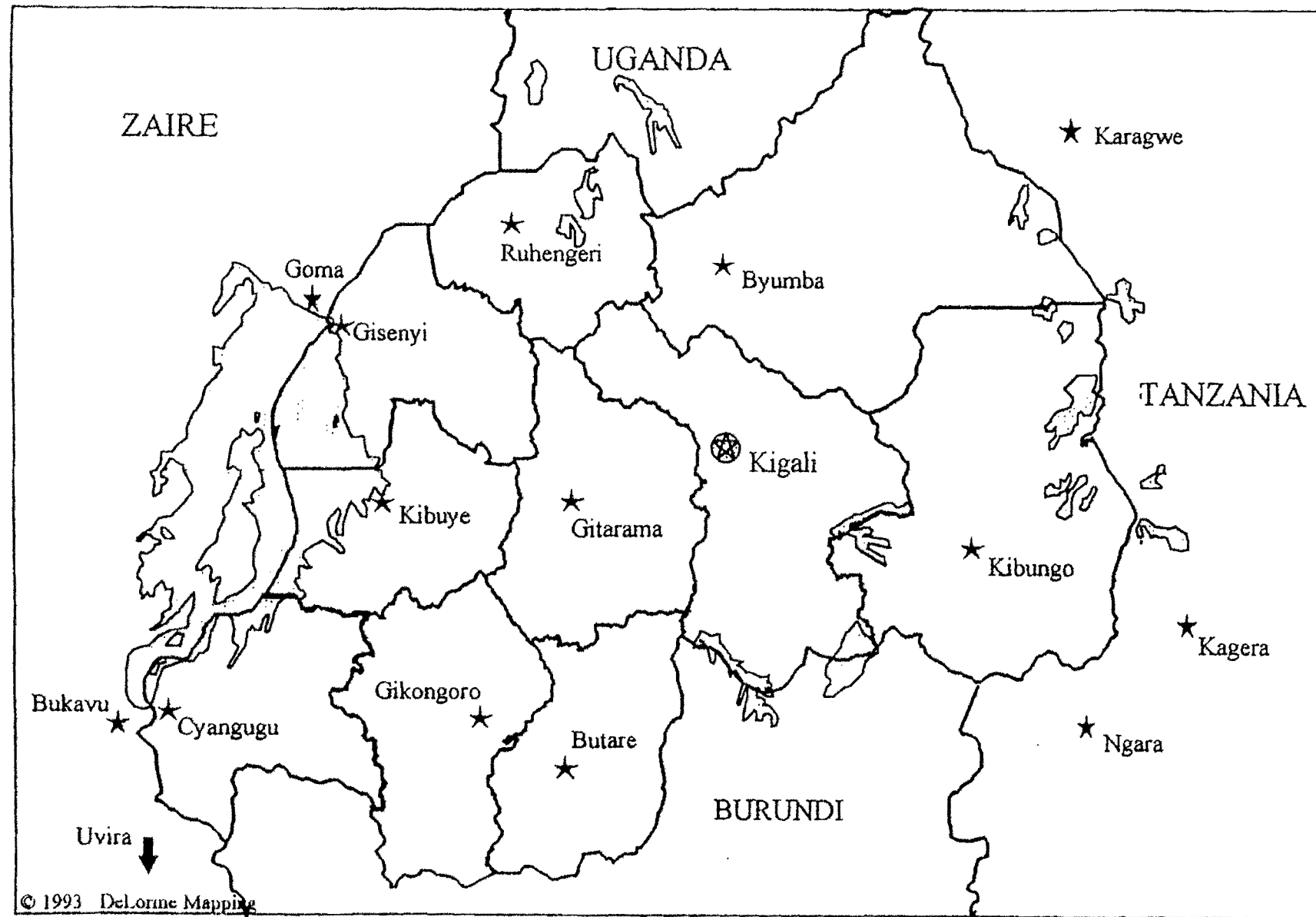
This Humanitarian Situation Report has been compiled from information gathered from the Government, UN Agencies, UNAMIR, ICRC, IOM, NGOs and Donors. It will be produced once a month and will seek to give an up-to-date picture of the progress or constraints in key areas of humanitarian interventions in Rwanda. The report will also highlight and analyse political and socio-economic trends in the country to the extent that they may have implications for on-going humanitarian activities. The Office of the Humanitarian Coordinator welcomes contributions from its humanitarian partners.

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# MAP OF RWANDA



## Overview

A week of national mourning was observed in Rwanda from 6 to 13 April in memory of those killed in last year's genocide and massacres. While new graves are still being found, it is believed that as many as one million Rwandese may have died. Rumours of ethnic reprisals for the genocide were rife during the period, leading to some displacement of populations.

In the period following the week of mourning, ten people were reported killed and an unknown number injured during a cordon and search operation launched by the RPA in Kibeho and Ndago camps for internally displaced people (IDPs) in south-west Rwanda. The two camps were the largest IDP camps, with an approximate population of 160,000. The operation preceded the launch of increased efforts by the humanitarian community to assist IDPs to return voluntarily to their home communes. Although estimated numbers of people remaining in the two camps vary, it is believed that as many as 60% of the former populations have scattered into the surrounding countryside.

The Government has announced that all seven camps for displaced persons are officially closed, but have agreed to allow aid agencies and the UN to provide emergency relief assistance, including food, water, and medical attention for populations remaining in Kibeho and Ndago. The Government has repeatedly stressed that they see the camps as a threat to national security.

In neighbouring Zaire, armed gun-men in military uniform crossed Lake Kivu, on 11 April, and attacked Birava camp for Rwandese refugees. The attack on the camp, which has a population of around 10,000, left 31 people dead, including two Zaire nationals. Over 50 people were injured. The attack has led to increased tensions between the Governments of Rwanda and Zaire. Major concerns over reports of armament and training of former government military and militia in the camps in Zaire have already been expressed by the Government of Rwanda and the international community. The Government of Zaire has denied these reports in a written statement to the UN Security Council.

Upheavals have continued in neighbouring Burundi, leading to mass population movements within the country and across the border into Tanzania. Reports of ethnic cleansing in the northern parts of the country are being investigated.

In north-east Rwanda, the resettlement of the old 1959 caseload of Rwandese refugees, mainly from Uganda and Tanzania, continues to be a major cause of concern due to the large number of livestock which have returned with the people. Overgrazing and lack of water threaten to develop into a major humanitarian emergency unless urgent actions are taken. A number of options to alleviate the problems are being explored with the Government.

Concerns over severe food aid shortages in-country have been alleviated by major improvements in the food pipeline, mainly as a result of diversions from other parts of the region. Food rations in refugee camps in neighbouring countries however, continue to be cut by as much as half due to difficulties in transporting

food into Zaire. The Government has closed the border with Zaire blocking the passage for food supplies as well for other humanitarian assistance destined for Zaire.

Although some steps have been taken to help decongest Rwanda's overcrowded prisons and detention centres, currently some 30,000 people are incarcerated, most on charges of genocide. Twenty-four prisoners died in one night due to asphyxiation in a detention centre near Kigali. The Government is now reviewing plans, with the assistance of the humanitarian community and UNAMIR, to improve conditions in the prisons and increase their capacity. National trials for genocide, meanwhile, scheduled to start on 6 April, were postponed.

General security in Kigali and other areas of the country has continued to deteriorate. Human Rights Field Officers have reported an increasing number of people killed in attacks during incursions into Rwanda from neighbouring Zaire. Armed robberies targeting offices and residences of international personnel have also increased and a number of UN vehicles have been stolen.

On a positive note, further strides have been taken during the month in the economic sector, including the revival of the private sector. Agricultural activities continue to be intensified and there is evidence of a partial recovery of a cash crop market. The resumption of academic programmes in schools and at the University are also positive steps towards the return to normalcy.

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## I. Main Developments

### *Political*

Ceremonies to commemorate the first anniversary of last year's genocide were held country-wide beginning on 7 April. The day was designated for the reburial of, amongst other people, the late Prime Minister, Madame Agathe Uwilingiyimana, and a number of Cabinet Ministers killed in the genocide. Flags, including that of the UN, were flown at half mast throughout a week-long mourning period.

The international community in Rwanda expressed its solidarity with the Government and the people of Rwanda through messages delivered on behalf of the UN Secretary General by his Special Representative during the official commemorative ceremonies, and through a signifi-

cant presence at the ceremonies. Similar messages of solidarity had earlier been expressed by the OAU Secretary General, Salim Ahmed Salim, and by the UN High Commissioner for Human Rights, Jose Ayala-Lasso, who both visited Rwanda prior to the national ceremonies.

Against the solemn background of the ceremonies was the call, amongst others, for "reconciliation between the international community and the people of Rwanda" over the former's abandonment of the Rwandese people in their greatest hour of need. Speeches at the ceremony underscored the urgent need to bring to justice perpetrators of the genocide. On national security, concern was raised over the issue of the arms

build-up in refugee camps in neighbouring countries, the continued arms embargo on Rwanda and the resultant threat to national security.

The period leading to 7 April was characterised by tension in the country due to widespread rumours of retaliatory killings to occur around the time of the anniversary of last year's genocide. In areas around Gitarama and Gikongoro, there were reports of people fleeing their home communes. The Government responded firmly by dispelling the rumours and by tightening security. Some rumour-mongers were arrested.

The recent negative shift in government attitude towards the international community has been the subject of informal debate at the UN Security Council. As part of activities organised to mark the first anniversary of the genocide, some 1,000 people demonstrated outside UNAMIR Headquarters on 11 April accusing the UN force and the international community of "complicity" in the genocide. Of deep concern to the UN in Kigali and in New York, was the involvement of some government officials who, during the anti-UNAMIR demonstrations, made inflammatory speeches. The SRSG has complained to the Government about the content of the speeches.

Criticism against the Human Rights Field Operation in Rwanda (HRFOR) by the Government and the local press has also continued, with accusations to the effect that the human rights mission in Rwanda "has strayed from its original mandate". However, following the visit of the High Commissioner for Human Rights and protests from HRFOR, the recent strident tone of criticism on the national radio has lessened.

Meanwhile, as part of efforts towards national reconciliation, recent public meetings have been held by local and national authorities at which national reconciliation continues to be advocated. Recent appointments of several returnees as bourgmestres are seen as a positive sign not only for national reconciliation, but also for building the confidence of potential returnees.

### **Security**

In addition to concerns surrounding the build-up to the anniversary of the genocide, serious concerns have been expressed over the recent reports of arms build-up and military training in Rwandan refugee camps in neighbouring countries, possibly, in preparation for an armed invasion of Rwanda. Of great concern to the Rwanda Government is the continued arms embargo imposed on Rwanda by the UN Security Council.

There are reports of increased incursions into the country by armed "bandits" in large well-organised groups with growing military characteristics. Increased mine explosions have also been reported. While many of these mines are said to have been dislodged by recent heavy storms, some are believed to have been freshly laid. The US Government and the Government of Rwanda are holding bi-lateral talks on an effective demining programme. A seven-member demining site survey team will be in Kigali between 20 - 26 April to look at possible training programmes.

Robberies targeting the international community have further added to security concerns. The offices of the International Organisation for Migration (IOM) in Kigali were robbed on 31 March during which

time valuable property and staff salaries were taken at gun-point. As a result, the organisation suspended its operations for nearly ten days. The offices of the Belgian Red Cross and the residence of the UNICEF Resident Representative have also been robbed in the last few days.

### ***Economy***

There have been positive indicators of progress towards recovery in the economic sector characterised by higher than expected agricultural production and enhanced state revenue-earning capacity. Opportunities for cash income have improved through

- i) public sector employment, although not totally dynamic;
- ii) increased trading activities and farm labour;
- iii) heavy international presence which has stimulated economic activity by offering employment in relief and rehabilitation programmes.

There has been a partial recovery of the cash crop market, for example, rehabilitation of coffee production and marketing of tea, and even small scale banana export. 37 factories, 12 of them state-owned, have resumed operation, further opening up the employment sector.

### ***Follow-up on Round Table***

On 25 March, the Permanent Technical Secretariat for Round Table Follow-up (PTS), established within the Ministry of Planning, held its first meeting with donor country representatives. The meeting was designed to enable participants to take stock of progress made in following up on the pledges made at the Round Table Conference, held in Geneva in January 1995, and to discuss ways of

improving co-ordination and co-operation between donor countries and the Rwandese Government. This meeting was followed by an expanded meeting of the Steering Committee on 30 March under the chairmanship of the Prime Minister.

The Round-Table Mid-term Review has been tentatively scheduled for 6 and 7 July 1995 in Kigali following a meeting between the Minister of Planning and UNDP representatives.

A total of US\$ 630.3 million has now been pledged by donor countries for the Programme for National Reconciliation and Socio-Economic Rehabilitation and Recovery, presented by the Government in January. This represents an increase of US\$43.5 million over the total amount pledged in Geneva. Donor countries have concluded specific agreements with the Government for the disbursements of US\$ 195.2 million worth of assistance (funds committed), while US\$ 53.3 million has now been disbursed.

***See Annexes 1, 2 and 3 for pledges and commitments to the Geneva Round Table as at 17 April 1995.***

### ***Secretary-General's Trust Fund***

The UN Trust Fund for Rwanda recently received US\$ 4.3 m from the Netherlands as a second instalment of funds pledged by the Dutch Government to the Trust Fund. The United Kingdom has also recently contributed US\$ 2 million to the Trust Fund. The Trust Fund programme of activities include Emergency Assistance for the Rehabilitation of Kigali and other urban centres as well the rehabilitation of the Judicial system.

The Minister of Planning will soon present to UNDP a list of projects the Ministry

proposes to fund from the Trust Fund. A reserve of US\$ 2 million will be set aside for urgent, but presently unascertained needs.

### Justice

The first national trials in Rwanda of people accused of having participated in last year's genocide were scheduled for 6 April 1995. However, the trials were postponed *sine die* for reasons including incomplete investigations. The announcement that the national courts would start trials on the 6 April had been received with great enthusiasm.

Many human rights groups criticised the Government's decision to start national trials, given the absence of a fully operational judicial system. Many feared that precipitated trials would banalise the judicial procedures and by extension, the genocide itself.

Within the national judicial system, nine out of eleven courts of the First Instance have a functioning prosecutor's office. Courts of the First Instance require a legal quorum of 3 judges in order to try cases. A large majority of prefectures with the exception of Butare do not meet this requirement.

UNDP is now finalising the second phase of a US\$ 3.45 million framework project for the rehabilitation of the judicial system. Intended as follow-up to the rehabilitation of prisons and the judicial system project, it comprises three main components:

- (1) the training of Rwandese judicial personnel
- (2) the recruitment of 50 expatriate judicial personnel
- (3) the establishment within the

Ministry of Justice of a structure for the coordination of external assistance and the management of project implementation.

UNHCHR and UNDP have concluded an agreement, in principle, for the joint implementation of Phase II, the programme for the rehabilitation of the Justice System.

UNHCHR will be responsible for the recruitment and fielding of 50 foreign magistrates, prosecutors, investigators, and defence lawyers and for the provision of the necessary logistical support and other infrastructure that will ensure the efficient deployment of personnel.

The Ministry of Justice, with the assistance of UNDP, has drawn up terms of reference for the expatriate personnel. The *Agence de Cooperation Culturelle et Technique* (ACCT) has said it is prepared to send 20 foreign magistrates to Rwanda once an operational plan is in place and necessary amendments to Rwandese law have been made.

The International Tribunal for Rwanda has reported that it has identified 400 suspects for possible prosecution by the Tribunal. These suspects are currently located in countries within Africa, including Rwanda, and in Europe. The Tribunal has appealed to countries harbouring the suspects to assist in bringing them before the Tribunal when called upon.

The OAU Secretary-General, during his visit to Rwanda, stated that a similar appeal will be made at the OAU summit later this year. He expressed confidence



that member states currently giving refuge to these suspects, will comply with the UN Resolution 978 urging states to arrest those persons within their territory for whom there is sufficient evidence that they were implicated in the genocide.

#### Prisons

Concerns regarding the situation in prisons have been heightened following the continued high rate of arrests and the recent death of 24 prisoners from asphyxiation due to overcrowding in a detention facility near Kigali. As part of efforts to alleviate this problem, UNAMIR, in conjunction with the Government of Rwanda, has commenced work on a project to move prisoners to less crowded facilities and to improve existing prison facilities. In this respect, 120 prisoners were moved on 10 April from Gitarama prison to Gisenyi. It is expected that 2,400 prisoners will have been relocated from the Gitarama prison by the end of the project.

Phase I of the UNDP Framework Programme in support of the rehabilitation of the Rwandese justice system, currently being implemented, includes a component for the rehabilitation of prisons and the construction of new detention centres. Four sites for new detention centres have been identified. The site at Nsinda is now being prepared with the assistance of UNAMIR and ICRC. Work undertaken at the Nyanza prison to create space for an additional 1,500 prisoners is nearly complete.

The expansion of prisons and the improvement of conditions in these facilities are seen as an immediate temporary solution. The long-term goal, however, remains that of expediting the national and international judicial process. It is

believed that at least 20% of the prisoners held nationwide may be innocent.

There are currently 30,000 prisoners in Rwandan jails and detention centres. It is estimated that 1,500 people are arrested per week. It is, however, worth noting that a small percentage of those arrested are released for lack of sufficient evidence.

#### Human Rights

The Human Rights Field Operation for Rwanda (HRFOR) may have to close down by May 1995 due to lack of funds. The mission currently has 115 field monitors. In an urgent appeal to the international community the High Commissioner for Human Rights called on Governments around the world to urgently make funds available in order enable the Operation to implement its programmes of assisting in the re-establishment of the system of justice in Rwanda.

The UNHCHR Technical Cooperation programme proposes the formation of a Governmental Commission on Accountability which will study the alternatives available to the Government in the elaboration of a judicial policy. It also proposes a systematic information gathering effort that will not only bring together various government bodies but will also provide sufficient facts to facilitate policy-making.

The HRFOR's Special Investigation Unit has recently turned over all the evidence it collected over a six-month period to the International Tribunal. From this point on, all criminal investigations related to the genocide will be conducted by the International Tribunal.

The Human Rights Education compo-

nent of the Technical Cooperation continues to gain momentum. At present, a lawyer or a teacher is carrying out programmes for Human Rights education in every prefecture in the country. At the same time, various projects for human rights education are being finalised with

8 Government ministries. In the meantime, HRFOR will hold a seminar on human rights for ministry officials at the end of April. Another seminar for senior officers in the Ministry of Defence is also scheduled for the same period.

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## **II. Humanitarian Assistance**

### ***Food***

The decision to allocate food on a regional basis, under the Burundi Regional Project, has significantly alleviated the food shortages that affected Rwanda last month. Food has been diverted from other countries in the region to Rwanda and recent donor contributions have also served to strengthen the Rwanda food pipeline. WFP currently has enough stock in-country to continue its programmes at the current level of 6,000 MT per month for the next two months. The pledging situation appears secure enough to continue this level of distribution until September 1995.

According to the recently concluded FAO/WFP Crop and Food Supply Assessment, the total number of food aid beneficiaries in Rwanda for the first semester of 1995 stands at 1.4 million. The total emergency food aid requirement is estimated at 112,000 MT cereals and 35,000 MT of pulses. Some 8,000 MT of cereals will be used to meet needs in pulses due to lower availability of the latter.

For WFP, the priority area of intervention continues to be the provision of food aid to returnees: the "new" caseload who have missed the planting season, and

the "old" caseload who have recently been allocated land as well as those still awaiting land allocation.

Food aid in Rwanda is principally provided by WFP, ICRC, Caritas and CRS. In the first semester of 1995, WFP intends to provide some 40,000 MT of food assistance. In the same period, CRS intends to distribute some 18,000 MT while ICRC will distribute a total of 38,000 MT.

Overall, the food security situation in Rwanda is currently considered to be satisfactory. However, certain areas such as Gisenyi, Kibuye, Cyangugu and Kibungo still require attention and close monitoring. The nutritional status of populations in areas such as Kibungo and Cyangugu has been the subject of concern. Assessments are being carried out to identify the most vulnerable in the community so that distribution can be prioritised to those groups who will suffer the most during the "hunger gap" that precedes the June-July harvest.

In conjunction with FAO and the European Union, WFP is currently discussing the possibility of setting up a Joint As-

assessment Unit which will work on establishing data bases for food aid as well as for the distribution of agricultural implements. The Unit will also formulate proposals to implement distributions to vulnerable groups.

In the meantime, WFP trucks destined for Zaire have for the past two weeks been prevented from crossing the border from Cyangugu into Zaire. The trucks carrying a total of 2,000 MT of food for more than 300,000 Rwandan refugees in Bukavu, Zaire, have been off-loaded in different stores within Rwanda.

Following the Government's decision to close the border, all supplies to Bukavu and Goma will be delivered via southern Uganda, by-passing Rwandan territory. However, road conditions have to be improved for regular and more consistent traffic.

### **Agriculture**

UN agencies, Government and NGOs have intensified their efforts to rehabilitate the agricultural sector with a view to restoring self-sufficiency in staple food production. An extensive seed multiplication programme has been undertaken by FAO in close collaboration with the Ministry of Agriculture (MINAGRI) and international research institutes. Together with NGOs, FAO is coordinating seeds and tools distribution for the current season (February-July 1995). This distribution comprises 2,286 MT of beans, 3.5 MT of vegetable seeds, 486 MT of sorghum, 300 MT of wheat, 232 MT of fertilizers and 514,000 hoes, benefitting almost 3 million people.

The Joint FAO/WFP crop assessment carried out in February 1995 points out some promising signs in prospects for the 1995 Season B yield. These signs

can be discerned in the increase in the settled farming population comprising mostly returning populations.

Cultivation of abandoned holdings by returnees has been permitted officially on condition that settlers give back the land upon the return of the *bona fide* landowner. In some prefectures, the policy is to allow the settlers to harvest their crops even after ceding occupied land to the rightful owners. This policy will allow the resumption of food production, especially that of cereals and pulses in Season B, thus, promoting food self-sufficiency.

The cash crop market also shows signs of a partial recovery. Tending of coffee has recommenced in parts of Gitarama while production and marketing of tea has resumed with the re-opening of several tea factories. Logging, a traditional cash income-earner has also resumed in Cyangugu.

The livestock population concentrated in the north-eastern part of the country estimated at 750,000 head of cattle poses a major humanitarian concern and threatens the 1995 Season B. There is a strong possibility of the cattle moving southwards towards the crop growing zones as grazing land becomes scarce around the National Park and especially in the Mutara region.

As efforts to address the livestock problem continue, livestock disease control is being rendered ineffective by the daily arrival of new herds. Proposed options to remedy the livestock situation in the area include the rehabilitation of abattoirs, the redistribution of selected cattle to farms in other parts of the country and the promotion of meat-processing and marketing initiatives by private entrepreneurs. The coming dry season (July-August)

will pose an ominous catastrophe with virtually no forage and water for the cattle.

### **Health**

WHO, UNICEF and UNFPA have continued to support the rehabilitation of priority health programmes in the country and to strengthen the capacity of the Ministry of Health in health management and coordination. The Health Policy document elaborated by the Ministry of Health (MINISANTE) with WHO support, is expected to be adopted by the government by the end of May. WHO, with the support of World Bank, is assisting MINISANTE in the procurement of essential drugs and in the reorganisation and reactivation of a drugs distribution system in the country. WHO is also assisting in the revision of pharmaceutical procedures.

Through a sophisticated database system, WHO is enhancing its capacity for epidemiological surveillance in particular in health screening and follow-up of populations moving from IDP camps to home communes. The WHO database is now linked to that of the Integrated Operations Centre (IOC).

The Ministry of Health, UNICEF and WHO are currently focusing on the re-establishment of EPI services at the grassroots level. So far, a total of 211 EPI facilities out of a pre-war total of 307 have been reopened. In addition, UNFPA, in collaboration with UNICEF and WHO, continues to support the National Maternal and Child Health/Family Planning Programme.

The first phase of "Operation Clean Hands", launched in January as part of the health promotion programme, is now complete with a total of 450 health

animators trained countrywide in the prevention and control of diarrhoeal diseases. The aim is to establish a countrywide network of some 3,000 health animators by June 1995.

### **Nutrition**

With the decrease in food production, coupled with an increase in the number of families returning with limited or no food supplies, large numbers of families continue to face difficulties in providing for basic nutritional needs. Aggravating this situation, is the increase in family size per household due to families taking in those rendered destitute by the war, in particular, unaccompanied children and orphans. WFP, in conjunction with CRS, continues to supply food assistance to all supplementary feeding centres and inpatient hospital programmes countrywide.

UNICEF in collaboration with the Ministry of Family and Women Affairs is intensifying efforts to "empower", in particular, female-headed households, with a view to making these households self-reliant in ensuring nutrition and household food security.

Efforts aimed at empowering the female-headed households include the relaunching of a programme that offers credit facilities to women's groups, as well as some support by UNICEF for income-generating projects, an example of which is the 2-year seed multiplication programme in Gitarama involving some 185 women in 10 groups.

UNICEF has appealed for US\$ 730,000 in 1995 for the rehabilitation of rural-based economic activities and infrastructures, including women projects and co-operatives.

### **Population**

In order to assist the Ministry of Planning (Department of Statistics) to meet urgent population data needs pending the organisation of the 1997/98 Population and Housing Census, UNFPA has been working with the Ministry of Planning in finalising a project document for a Socio-Demographic Survey and in elaborating the survey questionnaire. The principal objective of the project, which should be underway in May 1995, is to contribute to the development of a reliable population database, necessary for the implementation of emergency/rehabilitation programmes, as well as socio-economic development planning.

### **Water and Sanitation**

On the occasion of the World Water Day on 22 March, UNICEF, the lead agency in this sector, launched a country-wide awareness campaign on water conservation. According to UNICEF's estimation, 50% of the treated potable water in urban systems is wasted due to broken distribution pipes and wasteful habits in homes. This, and a high influx of returnees, has caused a shortfall in water supplies. With the opening of schools, UNICEF has focused on the provision of water and sanitation facilities to schools and children's centres country-wide. UNICEF will also provide a 45-cubic metre water reservoir for the Kigali Central Hospital and a 10,000 litre bladder tank to the Kanombe Hospital in Kigali which will allow the hospitals greater independence from the city water supply.

The Agency is now finalizing agreements with the relevant ministries and several NGOs for the capping of some 450 springs in the prefectures of Gitarama and Kigali Rural, and for the relocation of a water plant from Kigali Rural to Kaboroyota Commune in Byumba Pre-

fecture. Repairs to the generator at Karege Water Treatment Plant which provides water for five communes in Kigali Rural, an area that has received significant numbers of IDP returnees, is also complete.

Exhumation of bodies from the mass burial site at the Kigali Central Hospital has been completed. UNICEF is now negotiating with a contractor for the repair of the hospital's sewage line which was damaged when the site was used for mass burial. UNICEF has worked closely with WHO, the Ministry of Social Affairs and the Ministry of Health for both the re-burial of corpses and the repair of the sewage system.

Procedures for the procurement of materials worth US\$ 500,000 for the rehabilitation of the national electric grid line have been finalised. This a joint endeavour involving Electrogaz, the Canadian International Development Agency (CIDA), ECHO and UNICEF.

### **Education**

Educational programmes have been expanded with the re-opening of some private secondary schools and the National University of Rwanda. National Examinations for Primary schools were held on 20 March for 65,000 sixth grade pupils with logistical support in printing and transportation of the exams given primarily by the German Embassy, UNICEF, UNESCO and UNAMIR.

For the first time in Rwanda's educational history, the primary school examination was sat in four languages namely, Kinyarwanda, French, English and Kiswahili thus acknowledging the newly-emerged language diversity. It is esti-

mated that 10% of those who sat the examination will qualify to proceed to state-supported secondary schools, while another 10% will enter private secondary schools. UNICEF/UNESCO, in conjunction with the relevant government ministries, will seek ways of providing a range of non-formal educational programmes to those children and youth who do not qualify to attend secondary schools.

The Ministry of Education hopes to reopen state-supported secondary schools on 18 April. However, only a small percentage of the schools is expected to reopen as many facilities still need rehabilitation work. WFP has agreed on a three-month programme to provide food aid to boarding schools. The programme will benefit 12,900 students.

A number of faculties at the National University have opened, among them those of medicine and law. The Ministry of Higher Education has, however, not yet outlined a plan that would ensure a sequential opening of the universities faculties given the scarcity of resources and has, instead, accepted support on an *ad hoc* basis.

Makerere University, Uganda, will provide lecturers to teach English at the University while WHO is to give assistance to the School of Medicine and the School of Nursing. In a meeting with donors and international organisations, the Ministry made a request for support in the areas of repayable student loans and the rehabilitation of university equipment and buildings.

The Ministry has stated its commitment to assuring greater access to university education by removing all non-meritocratic criteria of admission such as

ethnic/regional quotas. The Ministry intends to confine its programmes to University of Butare thus shutting down its programmes in Ruhengeri to allow for savings on rehabilitation, operational and administrative costs. In the meantime, the Ministry has agreed to make available an inventory of the expertise and skills possessed by the teaching staff of the University.

### ***Children in Especially Difficult Circumstances***

Recognising the trauma suffered particularly by children and women during the war, UNICEF, in close collaboration with the Ministries of Rehabilitation and Social Integration, and Family and Women Affairs, held a two-day National Seminar on Trauma and Grief. The seminar was aimed at sensitising government, local community leaders and NGOs on the impact of war on children and their families.

The Trauma Recovery Programme is currently recruiting and training eleven regional trauma advisors and plans to open a National Trauma Recovery Centre in Kigali. The Centre, which is to have an outpatient clinic for severely traumatised children and their families, is to benefit from UNICEF's financial and technical support and is expected to become a focal point for training, documentation and research in the field of trauma.

### **Unaccompanied Children**

Due to the slow flow of pledged donor funds, UNICEF may be forced to cut back its programmes for unaccompanied children in Zaire and in Rwanda. In a recent report, UNICEF expressed an urgent need for US\$ 2 million for unaccompanied children inside Rwanda and for US\$ 1.5 for unaccompanied children in refu-

gee camps. As of 10 April, a total of 8,500 children inside and outside Rwanda had been reunited with their families through the joint efforts of international agencies. In addition, spontaneous family reunifications are taking place.

#### Children in Prison

UNICEF is spearheading the advocacy efforts for children and women. At the request of the Ministry of Justice, the Agency has supported the creation of a new special Division for Women and Children in Prison. This division has employed at least 3 lawyers to investigate cases of children accused of infraction of common law.

The number of children in prison has increased. According to the latest information from the Ministry of Justice, a total of 1,019 minors are detained in the 13 major prisons and over 145 detention centres in Rwanda. Of these children, some 200 are in prison with their detained parents. Most of the rest are accused of genocide. The first trial of a juvenile accused of genocide was opened on 6 April and adjourned along with all current cases.

The Ministry of Justice has now agreed to the transfer of 200 imprisoned children under the age of 14 from prisons throughout the country to a youth detention centre in Gitagata, some 40 kilometres south of Kigali. The children will be moved before the end of April. The rehabilitation of the Gitagata centre will be undertaken by Medecins Sans Frontieres (MSF)-Belgium and is scheduled to begin on 12 April. UNAMIR is also supporting the rehabilitation of the centre by fencing the premises and by providing manpower to speed up the transfer of the children.

With a view to providing basic education

to children in prison, one TEP kit has been provided to the Gitarama Prison where UNHCHR is seeking to support the basic education programmes which adult inmates have already begun for children and minors.

#### Child soldiers

The Ministry of Defence has identified a site in Butare, previously used as Ecole des Sous-Officiers, as a rehabilitation centre for child soldiers. UNICEF will provide some financial and material assistance for the reconstruction of the centre in Butare as well as educational materials and projects in family tracing and trauma alleviation. Particular attention will be paid to the adolescent group of 500 youths, providing them with apprenticeship training.

In Goma, Caritas has developed an education-oriented approach to support reintegration of at least 65 children who were attached to military groups in Goma. These children were primarily involved in support tasks rather than in actual combat. Furthermore, UNICEF and a partner NGO, Jeunesse Action et Environnement has completed an assessment of the situation of the child soldiers in the camps and will endeavour to resettle them in a "regular" refugee living arrangement. In Bukavu, a demobilisation project for child soldiers living in three centres is also being supported.

Table 1: Children Affiliated with Military Forces  
(Source: Ministry of Defence/UNICEF)

<i>Location</i>	<i>Number/age</i>
<i>Rwanda</i>	1,650 (10 - 14 yrs) 500 (13 - 17 yrs)
<i>Bukavu</i>	190 (5 - 10 yrs) 250 (10 - 15 yrs) 260 (16 - 18 yrs)
<i>Goma</i>	500 - 800 (10 - 17 yrs)

### ***Internally Displaced Persons***

On 18 April, RPA soldiers encircled the camps of Kibeho and Ndago in south-west Rwanda as part of a search for weapons and criminal elements. During the operations, shots were fired and populations fled in panic to UNAMIR bases in the camps. Ten people are reported killed in Kibeho and an number of people were injured. It is believed that most were crushed by the crowds or trampled on. Although the camp population calmed down the same day, large numbers of people have fled. The military operations preceded the start of the revised humanitarian strategy to improve conditions in home communes in the hope of encouraging people in the camps to return home voluntarily.

The Government has announced that all seven camps in the southwest are now officially closed and that people should leave for their home communes within the next few days. Emergency relief assistance, however, is being provided to populations who remain in Kibeho and Ndago camps, as an interim measure, but lack of shelter, particularly in Ndago camp, remains a major concern. The situation in the other five camps is not yet clear, but it is believed that at least one

of these camps has been burned. Humanitarian efforts are now focused on assisting those who can return to their home communes as quickly as possible.

Arrangements are being made with the RPA and UNAMIR to provide foot escorts for those living near enough to walk home. Transport for those living longer distances from the camps is being provided by UNHCR, IOM and UNAMIR. Poor road conditions in the vicinity of the camps, however, are hampering transport and the RPA and UNAMIR are undertaking road repairs so that the trucking operation can be accelerated.

Since February, "Operation Retour", commune committees, comprising representatives of local authorities and Human Rights Field Officers are being formed to address issues such as security, including arrest procedures, in home communes. The Government has repeatedly said that the camps, which are known to contain large numbers of people involved in last year's genocide and massacres, are a threat to national security. Earlier in the month, RPA troops closed another displaced persons camp, Kivugisa, and ordered the 4,000 population to leave.

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## **III. REGIONAL ISSUES**

Burundi has continued to teeter on the brink of an all-out ethnic war that could be similar to the one that left nearly one million people dead in Rwanda. Efforts towards conflict prevention and resolution, and peace-keeping in Burundi met with frustration when UN Member states failed to respond to the Secretary-General's request to send troops to that coun-

try in order to avert fresh ethnic strife. The disinterest of member states has been seen to reflect the international community's lack of political will.

Sharp criticism has been levelled at the international community for being ready to allocate billions of dollars to clean up after the event, mainly through post-



strife humanitarian intervention and not through preventive intervention. While many "preventive diplomacy missions" have been sent to Burundi, reports of increased tensions underline the still potentially-explosive nature of the crisis.

As a result of attacks in refugee camps in northern Burundi, panic ensued within the Rwandese refugee population and many of them chose to cross into the United Republic of Tanzania. An estimated 50,000 refugees were reported to be on the move. To encourage the refugees to go back to the camps, Tanzanian authorities closed the border between Burundi and Tanzania. On 6 April, the Government of Rwanda issued a written statement urging all Rwandese refugees at the Burundi/Tanzania border to return home to Rwanda rather than choose a second exile in another country.

### ***Refugees and Returnees***

During the month of March, some 30,400 refugees returned to Rwanda bringing the total number to 91,245 for the first three months of the year. Of these, approximately 60,000 were refugees who fled Rwanda in the early sixties and returned mainly from Uganda. The rest comprises refugees who left in April 1994.

#### i. The "old caseload" refugees

A vast majority of "old caseload" refugees is coming from Uganda and settling in the areas in the north-east of the country. They are arriving with hundreds of heads of cattle which are causing serious problems to the environment. The World Bank, UNHCR and USAID have just completed a mission whose objective was to review the Government of Rwanda's programme on the reintegration of returnees. An *aide memoire* has been submitted to the Gov-

ernment. Among other issues, the Mission recommended urgent actions which include support for the following:

- a. resettlement of the old caseload(cattle keepers) in Mutara region and in urban centres such as Kigali and Butare;
- b. information campaigns inside and outside Rwanda which are likely to enhance voluntary repatriation;
- c. assistance to vulnerable groups and women;
- d. strengthening of the judicial system.

#### ii. Burundi

The registration by commune of origin of the estimated 243,000 Rwandese refugees in Burundi has been completed. However, the prospects for their voluntary return are bleak in light of the recent attacks on refugee camps. In March, 700 refugees returned, mainly to Kibungo and South Kigali.

#### iii. Zaire

Unconfirmed reports of arms shipment to Goma destined for soldiers of the former Government who are said to be training in camps in North Kivu for a possible invasion of Rwanda render the atmosphere in camps tense. In the mean time, militia and "refugee leaders" continue to exert pressure on the camp population not to return to Rwanda. The presence of the UNHCR-assisted Zairian Camp Security Contingent (ZCSC), now standing at 762 troops and operational in Kibumba, Katale/Kahindo and Mugunga/Lac Vert, has improved the security situation in the camps making the choice to return less

dangerous. Acute food shortages are still a major concern.

Repatriation from camps in Goma and Bukavu has decreased during the reporting period. The number of people boarding UNHCR/IOM trucks has stabilised at 50 persons per day, compared to a peak 500 per day in late January and early February.

#### iv. Tanzania

In refugee camps in western Tanzania, there are reports of refugees engaging in acts of violence, including armed robberies, against the neighbouring local communities. In response, the Government of Tanzania has declared that the army could intervene and make arrests. Those found to be guilty of any offence will be tried according to the Tanzanian law. A Tripartite Agreement was signed on 12

April among United Republic of Tanzania, the Republic of Rwanda and UNHCR for the voluntary return of Rwandan refugees in Tanzania.

In March, a total of 433 refugees returned from Ngara camps in western Tanzania. Cross border consultations between UNHCR Ngara, the authorities in Kibungo and UNHCR Kibungo are taking place regularly. There are unconfirmed reports from UNHCR Karagwe that indicate that some Rwandese are now crossing the border to seek asylum in Tanzania.

#### v. Other countries of asylum.

There is a growing demand for voluntary repatriation from various countries, including Zimbabwe, Senegal and Russia. A set of guidelines has been issued to facilitate their return to Rwanda.

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## **IV. Rwanda Consolidated Inter-Agency Appeal**

Although the food pipeline for the region has improved, pledges and receipts for the Consolidated Inter-Agency Appeal for Rwanda remains disappointing. Out of the US\$ 219,490,162 requested for Rwanda in February 1995, less than US\$ 149 million has been funded. This represents under 30% of the total food aid and cash contributions requested.

For the sub-region, under half of the total US\$ 586 778,007 required for programmes for refugees in neighbouring countries and conflict-affected persons, has so far been received.

The slow rate of contribution has reduced Agencies' ability to start some planned programmes. UNICEF warns that without urgent funds, the Agency will be forced to cut back services for unaccompanied children in Zaire and Rwanda, as well as essential health, water and educational programmes.

See Annex 4, 5 and 6 for an updated financial summary of contributions. The breakdown is given by Appealing Agency and by Donor Country.

## *Annexes*

## PROGRAMME OF NATIONAL RECONCILIATION AND REHABILITATION

## FUNDS PLEDGED BY THE DONORS

(million of US dollars)

UPDATED ON 17 APRIL 1995

DONORS	SUB- PROGR. 1	SUB- PROGR. 2	SUB- PROGR. 3	OUTSIDE ROUND TABLE DOCUMENT	TOTAL
<b>BILATERAL</b>					
Austria			2.0		2.0
Belgium	13.0		21.8	1.2	36.0
Canada	7.5	1.9	15.2	0.6	25.2
France					to be determined
Germany	20.4	10.6	54.4	29.8	115.3
Ireland	0.6	N.A.	N.A.		1.6
Italy		0.3			0.3
Japan		19.3	1.3	1.4	22.0
Netherlands	16.5	1.5	14.9		32.9
New Zealand					to be announced
Russia					to be announced
Spain	N.A.		4.5		9.5
Sweden	N.A.	N.A.	N.A.		3.0
Switzerland	0.8		12.0		12.8
United Kingdom	2.8	1.0	4.1	0.2	8.1
USA	6.5		32.0	17.0	55.5
<b>SUB-TOTAL</b>	<b>68.1</b>	<b>34.6</b>	<b>162.2</b>	<b>50.2</b>	<b>324.2</b>
<b>MULTILATERAL</b>					
African Development Bank	20.0		30.0		50.0
European Union Commission	28.0		49.3	48.9	126.2
Intern. Fund Agricultural Dev			15.0		15.0
International Monetary Fund	13.0				13.0
Org. Petroleum Exp. Countries				12.9	12.9
United Nations Agencies			14.0		14.0
World Bank	45.0		30.0		75.0
<b>SUB-TOTAL</b>	<b>106.0</b>		<b>138.3</b>	<b>61.8</b>	<b>306.1</b>
<b>TOTAL FUNDS PLEDGED</b>	<b>174.1</b>	<b>34.6</b>	<b>300.5</b>	<b>112.0</b>	<b>630.3</b>
<b>FUNDS REQUESTED</b>	<b>189.6</b>	<b>273.7</b>	<b>300.9</b>		<b>764.1</b>

## Notes:

Figures in italics represent the changes occurred since the last update.

Sub-Programme 1: Financial Support (including Balance of Payments)

Sub-Programme 2: Reintegration of Refugees and Displaced

Sub-Programme 3: Rehabilitation / Development

N.A.: not allocated

Pledges by Austria, Ireland, Spain and Sweden remain to be allocated into specific sub-programmes.

Thus the sum of funds allocated to sub-programmes does not add up to the total.

## PROGRAMME OF NATIONAL RECONCILIATION AND REHABILITATION

## FUNDS DISBURSED BY THE DONORS

(million of US dollars)

UPDATED ON 17 APRIL 1995

DONORS	SUB- PROGR. 1	SUB- PROGR. 2	SUB- PROGR. 3	OUTSIDE ROUND TABLE DOCUMENT	TOTAL
<b>BILATERAL</b>					
Austria			0,3		0,3
Belgium	2,0		1,4	0,2	3,6
Canada	5,5		1,8	0,2	7,5
France					
Germany			4,1		4,1
Ireland					
Italy		0,3			0,3
Japan		1,0	1,3	1,4	3,7
Netherlands	3,5		0,5		4,0
New Zealand					
Russia					
Spain					
Sweden					
Switzerland	0,8		0,1		0,9
United Kingdom		1,0	0,6	0,2	1,8
USA	6,5			13,1	19,6
<b>SUB-TOTAL</b>	<b>18,3</b>	<b>2,3</b>	<b>10,1</b>	<b>15,1</b>	<b>45,8</b>
<b>MULTILATERAL</b>					
African Development Bank					
European Union Commission	5,0				5,0
Intern. Fund Agricultural Dev.					
International Monetary Fund					
Org. Petroleum Exp. Countries					
United Nations Agencies			2,5		2,5
World Bank					
<b>SUB-TOTAL</b>	<b>5,0</b>		<b>2,5</b>		<b>7,5</b>
<b>TOTAL FUNDS DISBURSED</b>	<b>23,3</b>	<b>2,3</b>	<b>12,6</b>	<b>15,1</b>	<b>53,3</b>
<b>FUNDS PLEDGED</b>	<b>174,1</b>	<b>34,6</b>	<b>300,5</b>	<b>112,0</b>	<b>520,3</b>

## Notes:

- Figures in italics represent the changes occurred since the last update  
 Sub-Programme 1: Financial Support (including Balance of Payments)  
 Sub-Programme 2: Reintegration of Refugees and Displaced  
 Sub-Programme 3: Rehabilitation / Development  
 N.A.: not allocated

## PROGRAMME OF NATIONAL RECONCILIATION AND REHABILITATION

## FUNDS COMMITTED BY THE DONORS

(million of US dollars)

UPDATED ON 17 APRIL 1995

DONORS	SUB- PROGR. 1	SUB- PROGR. 2	SUB- PROGR. 3	OUTSIDE ROUND TABLE DOCUMENT	TOTAL
<b>BILATERAL</b>					
Austria			0,5		0,5
Belgium	5,2		4,1	0,2	9,5
Canada	7,2	1,9	9,2	0,2	18,5
France					
Germany	6,3		20,1	3,6	30,0
Ireland					
Italy		0,3			0,3
Japan		1,0	1,3	1,4	3,7
Netherlands	5,5	0,5	1,4		7,4
New Zealand					
Russia					
Spain					
Sweden					
Switzerland	0,8		1,3		2,1
United Kingdom	0,8	1,0	0,6	0,2	2,6
USA	6,5			13,1	19,6
<b>SUB-TOTAL</b>	<b>32,3</b>	<b>4,7</b>	<b>38,5</b>	<b>18,7</b>	<b>94,2</b>
<b>MULTILATERAL</b>					
African Development Bank					
European Union Commission	28,0		13,1	6,5	47,6
Intern. Fund Agricultural Dev.					
International Monetary Fund					
Org. Petroleum Exp. Countries					
United Nations Agencies			3,5		3,5
World Bank	45,0		5,0		50,0
<b>SUB-TOTAL</b>	<b>73,0</b>		<b>21,6</b>	<b>6,5</b>	<b>101,1</b>
<b>TOTAL FUNDS COMMITTED</b>	<b>105,3</b>	<b>4,7</b>	<b>60,1</b>	<b>25,2</b>	<b>195,2</b>
<b>FUNDS PLEDGED</b>	<b>174,1</b>	<b>34,6</b>	<b>300,5</b>	<b>112,0</b>	<b>630,3</b>

## Notes:

- Figures in italics represent the changes occurred since the last update  
 Sub-Programme 1: Financial Support (including Balance of Payments)  
 Sub-Programme 2: Reintegration of Refugees and Displaced  
 Sub-Programme 3: Rehabilitation / Development  
 N.A.: not allocated

## Annex 4

Table I: 1995 UN Consolidated Inter-Agency Appeal for Persons Affected by the Crisis in Rwanda  
Updated Financial Summary - By Appealing Agency  
as of 12 April 1995

Compiled by DHA (FTS/CBSU) on the basis of information provided by the respective appealing organizations

Appealing Agency	Total Requirements (January - December 1995)		Adjusted Requirements (US\$)		Income (Pledges, Contributions, Carryover) (US\$)		Shortfall (Surplus) (US\$)		% of Needs Covered %
A. THE RWANDA PERSPECTIVE									
UNHCR *	44,275,500		44,275,500		3,332,403		40,943,097		7.5%
UNICEF **	55,650,000		55,650,000		*** 21,021,026		34,628,974		37.8%
WHO	7,482,833		7,482,833		1,185,556		6,297,279		15.8%
PAO	18,531,700		18,531,700		908,893		17,622,807		4.9%
UNESCO **	6,629,540		6,629,540		0		6,629,540		0.0%
UNHCR	10,153,050		10,153,050		3,818,935		6,334,115		37.6%
UNFEM	1,350,000		1,350,000		0		1,350,000		0.0%
UNV	1,327,064		1,327,064		119,048		1,208,016		9.0%
ICM	10,539,800		10,539,800		369,048		10,170,752		3.5%
NGOs	4,124,913		4,124,913		0		4,124,913		0.0%
UNREO/DHA	2,003,900		2,003,900		900,209		1,103,691		44.9%
WFP FOOD SUMMARY ****	MTs	US\$	MTs	US\$	MTs	US\$	MTs	US\$	%
CEREALS	86,892	33,974,772	71,361	27,902,151	33,642	13,154,022	29,742	11,629,122	58.3%
PULSES	24,825	17,799,325	23,611	16,929,087	12,566	9,009,822	7,550	5,413,350	68.0%
OIL	4,137	4,827,879	2,806	3,274,602	1,779	2,076,093	740	863,580	73.6%
SALT	0	0	0	0	60	28,020	0	0	0
CORN SOYA BEAN	0	0	0	0	223	130,901	0	0	0
SUGAR	252	165,564	168	110,376	0	0	168	110,376	0.0%
DRIED SKIM MILK	360	634,120	240	436,080	0	0	240	436,080	0.0%
HIGH PROTEIN BISCUITS	0	0	(150)	(286,050)	(150)	(286,050)	0	0	0
Subtotal for WFP	116,466	57,421,860	98,036	48,366,246	48,120	24,112,808	38,440	18,452,508	60.8%
TOTAL - RWANDA PERSPECTIVE	116,466	219,490,162	98,036	210,434,548	48,120	55,767,926	38,440	148,865,692	29.3%

\* Note that UNHCR is appealing for resources to fund activities to meet the needs of Rwandese/Burundese refugees on a regional level. Contributions/pledges not specifically earmarked to the Rwanda Programme and made in response to the Consolidated Appeal will be recorded against the UNHCR Sub-Regional budget with a percentage of these funds has been obligated to the Rwandan returnees and IDPs programme within Rwanda.

\*\* For Primary and non-formal education, requested funds will be channeled through UNICEF for subsequent reallocation to UNICEF/UNESCO activities.

\*\*\* UNICEF has determined an estimated carryover of US\$ 23.5 million of which 40% of this amount is set aside for programmes in the Sub-Region pending specific contributions.

\*\*\*\* Note the following for WFP:

- 1) Revised Requirements: A standardisation of ration rates and rationalisation of WFP Programmes within Rwanda, which took place after the finalisation of the Appeal document, led to a revision of the total food aid requirements to 116,466 MTs (US\$ 57.4 million). Note also that for WFP, food requirements are adjusted constantly depending on the monthly food availability and distribution rate in the region.
- 2) Contributions: Most of the commodities represent contributions announced in 1994, scheduled for delivery to the final destination in 1995. Note also that due to regional borrowings, loans and regional reallocations of food reflected in this table, in order to provide the most accurate picture of requirements/shortfalls, totals will not match with the donor breakdown indicated in Table II.
- 3) Shortfalls may not equal adjusted req. minus contributions, as they reflect the accurate outstanding needs (depending on borrowings, loans, etc. of food) determined by WFP for commodities in the region until the end of the year.

**Table II - Donor Breakdown of Contributions/Pledges in response (Continued)**  
to the 1995 UN Consolidated Appeal for Persons Affected by the Crisis in Rwanda  
(As of 12 April 1995)

WFP Food Contributions *	Food (MTs)		Amount US\$		Grand Total	
	1995	1994	1995	1994	Food (MTs)	Amount (US\$)
<b>Burundi Conflict Victims</b> (SRP-95-1/N02 - Emergency Food Aid)						
Austria	1,000	—	367,000	—	1,000	367,000
Germany	11,242	3,545	4,125,314	1,301,025	14,787	5,426,329
Japan	—	13,394	—	5,099,093	13,394	5,099,093
Netherlands	4,106	6,353	1,351,182	2,756,525	10,464	4,607,508
Switzerland	—	500	—	260,500	500	260,500
United Kingdom	500	—	183,500	—	500	183,500
USA	11,758	20,196	7,202,913	10,925,333	33,954	18,128,256
EU	—	736	—	631,332	736	631,332
Sub-Total for Burundi	32,506	45,229	13,750,414	20,974,169	75,535	34,704,583
<b>Rwanda Conflict Victims</b> (RWA-95-1/N01 - Emergency Food Aid)						
Canada	3,250	—	1,174,000	—	3,250	1,174,000
Canadian Food Grain Bank	—	165	—	113,305	165	113,305
Denmark	—	1,300	—	705,600	1,300	705,600
Germany	12,000	222	3,920,000	159,174	10,222	4,079,174
Japan	—	3,533	—	1,334,956	3,533	1,334,956
Sweden	—	950	—	681,150	950	681,150
United Kingdom	500	—	235,200	—	600	235,200
USA	15,480	3,742	9,015,335	4,535,773	24,222	13,551,308
EU	—	(54)	—	(40,123)	(54)	(40,123)
Sub-Total for Rwanda	29,230	15,338	14,445,035	7,544,510	44,688	21,989,845
<b>Tanzania - Refugees</b> (SRP-95-1/N02 - Emergency Food Aid)						
Austria	2,000	—	658,000	—	2,000	658,000
Denmark	4,500	—	1,430,500	—	4,500	1,430,500
Germany	1,200	6,201	394,300	2,512,004	7,401	3,206,304
Italy	—	1,400	—	763,300	1,400	763,300
United Kingdom	10,753	—	4,464,962	—	10,753	4,464,962
USA	15,234	3,285	17,596,309	2,138,947	38,569	19,735,256
EU	—	5,119	—	2,905,631	5,119	2,905,631
Sub-Total for Tanzania	33,437	16,005	24,595,071	3,620,382	69,742	28,215,453
<b>Zaire - Refugees</b> (SRP-95-1/N02 - Emergency Food Aid)						
Canada	—	13,907	—	2,329,436	13,907	2,329,436
Canadian Food Grain Bank	—	3,292	—	3,134,036	3,292	3,134,036
Denmark	—	1,701	—	335,338	1,701	335,338
Germany	13,533	4,466	6,614,340	2,179,404	18,021	8,794,244
Netherlands	1,259	1,903	1,199,997	1,695,512	3,262	2,895,509
Switzerland	—	626	—	440,078	626	440,078
United Kingdom	1,500	791	578,400	1,508,394	2,991	2,487,294
USA	50,257	4,450	39,334,471	3,929,250	64,487	43,263,721
EU	—	17,134	—	11,635,332	17,134	11,635,332
Sub-Total for Zaire	76,751	32,270	48,027,708	23,857,284	125,021	71,884,992
<b>Subtotal - Food Contributions</b>	<b>190,424</b>	<b>124,362</b>	<b>100,798,223</b>	<b>70,996,645</b>	<b>315,286</b>	<b>171,794,873</b>
<b>Grand-Total</b>	<b>190,424</b>	<b>124,362</b>	<b>100,798,223</b>	<b>70,996,645</b>	<b>315,286</b>	<b>\$293,714,565</b>

**\* NOTE:**

Due to regional borrowings, loans and regional reallocations of food reflected by WFP in Table I, in order to provide an accurate picture of the food requirements shortfalls, a difference of US\$ +920,827 exists between Table I and Table II.



**Table III: Pledges/contributions for Persons Affected by the Crisis in Rwanda**  
(Outside of the UN Consolidated Inter-Agency Appeal Framework)

*As of 12 April 1996*

This report is comprehensive to the extent that decisions have been reported to Department of Humanitarian Affairs by Donors

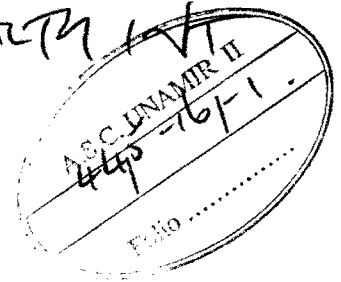
Date Reported	Donor	Channel	Description	Value US\$
16-Feb-95	Belgium	UNHCR	Cash for costs of regional OAU/UNHCR Conference on assist. to refugees/returnees/IDPs in Great Lakes Region	75,000
22-Feb-95	Canada	MSF/Canada	Cash to support the hospital in Butare, the health centres and hospital in Gicanyi and Kigali	248,227
21-Feb-95	Canada	World Vision/Canada	Cash to improve health status of unaccompanied children, returning refugees/IDPs and to improve living conditions through the provision of shelter supplies	354,610
03-Jan-95	Germany	HRLP	Cash for medical assistance for displaced persons	140,256
19-Jan-95	Italy	DHA (Pisa Warehouse)	Airlift for in-kind contributions through Pisa Warehouse in favour of the Rwandese population	232,357
16-Feb-95	Netherlands	UNHCR	Cash for costs of regional OAU/UNHCR Conference on assist. to refugees/returnees/IDPs in Great Lakes Region	30,882
18-Mar-95	Netherlands	Netherlands Field Office, Kigali	Cash for a "Relief and Rehabilitation Fund" in Rwanda - small scale projects in the field of rehab. activities	274,390
18-Mar-95	Netherlands	Netherlands Field Office, Kigali	Cash for a "Special Health Support Fund" (aiming to increase quality of health sector by purch. of medical equip.)	182,927
15-Feb-95	Netherlands	SCP/United Kingdom	Cash for secondment of a Health Advisor to work within the MOB in Kigali and the provision of support for training, workshops and study/visits	395,845
15-Feb-95	Sweden	UNHCR	Cash for costs of regional OAU/UNHCR Conference on assist. to refugees/returnees/IDPs in Great Lakes Region	67,295
15-Feb-95	Switzerland	UNHCR	Cash for costs of regional OAU/UNHCR Conference on assist. to refugees/returnees/IDPs in Great Lakes Region	21,260
28-Feb-95	United Kingdom	Action Nord-Sud/Belgium	Cash for provision of seeds and tools in Kigali prefecture to allow approx. 22,000 households (mainly farmers) to start agricultural activities for planting season	172,971
17-Feb-95	United Kingdom	Christian Aid	Cash to provide 19,929 families (mainly farmers) with one hoe per family plus beans, potato and vegetable seeds for planting after the rainy season	168,349
15-Feb-95	United Kingdom	UNHCR	Cash for costs of regional OAU/UNHCR Conference on assist. to refugees/returnees/IDPs in Great Lakes Region	47,619
28-Feb-95	United Kingdom	Morlin	Cash for rehabilitation of health centres in Gicanyi region and to assist MOE in Rwanda	362,043
28-Mar-95	United Kingdom	ICRC	Cash for the ICRC's 1995 Rwanda Emergency Appeal	357,143
27-Mar-95	United Kingdom	IFRC	Cash for the IFRC's 1995 Emorg. Appeal for Rwanda/Burundi refugees in Burundi, Tanzania, Uganda and Zaire	357,143
27-Mar-95	United Kingdom	UNDP	Cash to help strengthen the Rwandan Gov. capacity in financial, economic and human resource management	3,174,603
01-Jan-95	USA	UNDP/UNV	Cash grant to assist with human rights in Rwanda (OTI Assistance)	750,000
03-Feb-95	USA	ADRA	Cash for food-for-work, road and well programmes in the North-West (OPDA Assistance)	499,609
03-Feb-95	USA	Direct	Cash for DART operations	400,000
27-Jan-95	USA	American Refugee Comm Hse	Cash for health and water rehabilitation in North-East (OPDA Assistance)	755,174
01-Feb-95	USA	International Rescue Committee	Cash for relief and rehabilitation project in Cyangugu and Kibungo (OPDA Assistance)	999,594
01-Feb-95	USA	UNHCR	Cash for costs of regional OAU/UNHCR Conference on assist. to refugees/returnees/IDPs in Great Lakes Region	50,000
03-Feb-95	USA	World Relief	Cash for primary health care in Kibagori (OPDA Assistance)	230,036
01-Jan-95	USA	National Peace Corps	Cash to recruit and train human rights monitors (OTI Assistance)	110,000
01-Jan-95	USA	International Rescue Committee	Cash for refugees in Tanzania (State/PRM Assistance)	1,208,557
10-Jan-95	RC/Denmark	IFRC	Cash (IFRC Emergency Appeal No. 01.04/95)	75,758
12-Jan-95	RC/Monaco	IFRC	Cash (IFRC Emergency Appeal No. 01.04/95)	2,784
27-Dec-94	RC/Netherlands	IFRC	Cash for food for refugees in Goma (IFRC Emergency Appeal No. 01.04/95)	418,500
20-Dec-94	RC/United Kingdom	IFRC	Cash (IFRC Emergency Appeal No. 01.04/95)	765,152

**TOTAL**

**12,958,084**

Department of Defence  
Base Administrative Support Centre Liverpool

**MINUTE**



436-1-29

See Distribution List

**DESTRUCTION AND TESTING FOR PATHOGENS IN WATER SUPPLIES USED FOR HUMAN CONSUMPTION**

References:

- A.           Telecon SME Basic Fd Eng Wing/Hlth Sect BASC Liverpool 28 Jul 94
- B.           Discussion 1 Fd Sqn Personnel/Hlth Sect BASC Liverpool 28 Jul 94
- C.           Control of Communicable Disease in Man 15th Edition 1990
- D.           Mansons Tropical Diseases 19th Edition
- E.           MLW Part 2 Med & Dent Trg Vol 2 Pam 1 - Preventive Medicine 1986

**Introduction**

1.           The information contained in this minute and associated annexes has been generated in response to requests for the provision of information in regard to the destruction and description of the causative organism of Cholera. Additionally, a request for literature on the procedures and field kits involved with the testing of water was also made (Ref A and B refers).

2.           All in-service water purification units will destroy the organism of Cholera and other pathogens (including viruses) provided there is sufficient contact period with the organism and the sterilising agent (minimum of 30 minutes). The identification, distribution, description and methods of destruction of the cholera organisms and other pathogens, as well as the procedures for conducting bacteriological and chemical testing of water are described in the following text.

**Identification**

3.           Cholera is described as an acute bacterial enteric disease with sudden onset, profuse painless watery stools, occasional vomiting, rapid dehydration, acidosis and circulatory collapse. In severe untreated cases, death may occur within a few hours and the case fatality rate may exceed 50%. With proper treatment, the rate is below 1% (Reference C refers).

### Geographical Distribution

4. Cholera occurs endemically in India, Pakistan, Bangladesh, Afghanistan and many parts of the Far East. Epidemics occur periodically in the Middle East and in Africa and major pandemics spreading to almost all the world have occurred in the past. Classical cholera caused by *Vibrio cholerae* is limited to the Indian Pakistan subcontinent while the El Tor vibrio is responsible elsewhere. Isolated countries, such as the Andaman Islands and Australia and New Zealand, have escaped (Reference C refers)..

### Description/Destruction of the Cholera Vibrio

5. The cholera vibrio is a very minute organism, 1.5 - 2  $\mu\text{m}$  in length by 0.5 - 0.6  $\mu\text{m}$  in breadth. It is generally curved like a comma, hence its name. Growth is arrested below 15°C or above 42°C; a temperature over 50°C kills the vibrio. It multiplies rapidly without curdling in milk; it dies rapidly in distilled water; it survives longer if salt is added to the water and survives for up to 285 days in sea water.

### Disinfection of Water Supplies

6. This procedure involves the destruction of all harmful micro-organisms. All drinking water must be sterilised whether or not it is filtered. Chlorine is effective in small quantities and its action is rapid and reliable. However chlorine is absorbed by organic matter and a sufficient quantity must be added to oxidise the organic matter and other impurities. This must then leave a balance of 'free chlorine' (2 parts per million) in the water to kill the bacteria. Sunlight and time will reduce the amount of free chlorine remaining. Whilst chlorine is the most common large scale sterilising agent there are other methods.

**Note:** Potassium per-manganate (Condy's Crystals) at a dilution of 1:500 000 (faint pink colour) kills Cholera vibrios in a short time, ie. 2 ml per 1000 litres of water.

### Disinfecting Agent

7. Sodium hypochlorite solution is the most common product used to chlorinate water - calcium hypochlorite powder is occasionally used but it is more hazardous to handle and may cause an explosion if it comes in contact with organic material (e.g. petrol, oils, etc.).

8. Extreme care must be taken when using sodium hypochlorite solution or calcium hypochlorite. They are corrosive and give off fumes which are irritant to the skin, eyes and nasal passage and can quickly overcome a person in a confined area. Inhalation must therefore be avoided and the use of gloves is recommended. Prolonged storage (greater than 4 months) of sodium hypochlorite is not recommended and the capacity of the solution to maintain its strength depends on its

storage temperature, exposure to light, the initial strength of the solution and contamination by iron or other metal. Strength is lost quickly with an increase in temperature and strong light decomposes the solution. Weaker solutions lose their strength at a slower rate to that of strong solutions so if the solution must be stored for a period of time it could be diluted with clean water and the weaker solution then stored. Storage of calcium hypochlorite for longer than 1 year is not recommended - it should be stored in a cool, dark place away from organic materials.

### **Concentration of Disinfecting Agent (Dose) Recommended for Use**

9. Fresh sodium hypochlorite solution has 10-13% available free chlorine. Calcium hypochlorite powder has 70% available free chlorine and therefore this product is more concentrated and less is required to be added to water.

10. It is a usual practice to add 3-5 mg/L of chlorine to clear waters and 5-10 mg/L to dirty waters. If the tank is uncovered then the higher dose rates will be required as sunlight rapidly destroys the added chlorine. Using 5 mg/L as the common dose rate, a table showing volume and dose requirements and example calculations for proper water sterilisation is at Annex A to this minute.

### **Application of Disinfecting Agent in Tank Water**

11. It is important that the small amount of sodium or calcium hypochlorite be added to the entire volume of the water requiring treatment, i.e. it is important that the chlorine is distributed throughout the tank. Add the chlorine while the tank is filling - the full tank will then contain 3-5 mg/L of chlorine. It is essential that free chlorine is available to kill bacteria for at least one hour after being added. A smell and taste of chlorine will be present but will probably disappear in a few days, if not overnight. It is important to remember that the nationals of some overseas countries will not consume water that smell or taste of chemicals. Care must therefore be taken to provide these societies with water that has between .05 and 1 part per million free chlorine. Tank water, if treated correctly and protected from contamination, should be safe to drink one hour after treatment.

12. If the tank is already full of water it is advisable not to add concentrated hypochlorite solution or powder directly to the tank (inadequate mixing will occur) but it is better to add the hypochlorite to 5-10 buckets (40-80 litres) of water and pour this more diluted solution into the tank so as to ensure mixing. Then stir with a wooden paddle (not metal) to mix the contents.

### **Diseases Endemic to Africa**

13. Diseases endemic to Africa are shown at Annex B.

**Individual Water Treatment**

14. Instructions for individual water treatment are at Annex C.

**Puritabs/ Potable Aqua Tablets**

15. Instructions for the use of Puritabs and Potable Aqua tablets are at Annex D.

**Field Water Test Kit**

16. Instructions for the use of the Millepore Bacteriological Test Kit are at Annex E.

**Field Water Chemical Test Kit (HACH DREL 5)**

17. Instructions for the use of the HACH DREL 5 are at Annex F.

**Conclusion**

18. The information/guidelines contained in this paper and associated Annexes can be passed to personnel being deployed overseas, it is compatible with NATO members ie. USA, Canada and the UK Defence Forces. For any further information regarding this matter contact SGT P. Magnussen on 600 4668.

K.E. EVANS  
CAPT  
Area Health Officer  
6004566

Jul 94

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**Annexes:**

- A. Water Chemical Dose/Example Calculations
- B. Diseases Endemic to Africa
- C. Instructions for Individual Water Treatment
- D. Bacteriological Water Test Kit (Millepore)
- E. Chemical Water Test Kit (HACH DREL 5)

**Distribution:**

SME for Basic Field Engineer Wing  
1 CER for 1Fd Sqn  
1 Fd Hosp for Hlth Sect

**For Information:**

SMO 1 Bde  
CO BASC Liverpool

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**ANNEX A TO**  
**BASC LIVERPOOL 436-1-29**  
**DATED 29 JUL 94**

**CONCENTRATION OF DISINFECTING AGENT (DOSE) RECOMMENDED FOR USE**

Volume of water to be treated		Volume of sodium hypochlorite * solution required for 5 mg/L dose		Amount of calcium hypochlorite powder required for 5 mg/L dose	
Gallons	Litres	Pints	Litres	Pounds	Kilograms
1,000	4,600	0.4	0.2	0.07	0.03
10,000	46,000	4	2.3	0.7	0.3
22,000	100,000	9	5.1	1.5	0.7
100,000	460,000	40	23	7	3.2
220,000	1,000,000	90	51	15	7

\*assuming 10% available chlorine.

**Example Calculation**

1. To achieve 5 mg/L free chlorine in a volume of water:
  - a. Sodium hypochlorite - assuming only 10% available free chlorine, use the formula:

$$\frac{\text{Tank Volume (L)}}{20,000} = \text{Volume (L) of sodium hypochlorite}$$

e.g. for a 10,000 L tank, volume of sodium hypochlorite

$$= \frac{10,000}{20,000} = 0.5 \text{ Litres of}$$

- b. Calcium hypochlorite - assuming 70% available free chlorine, use the formula:

$$\frac{\text{Tank Volume (L)}}{140,000} = \text{Amount (kg) of calcium hypochlorite}$$

e.g. for a 10,000 L tank, amount of calcium hypochlorite

$$\frac{10,000}{140,000} = 0.07 \text{ kg i.e. 70 g}$$



**ANNEX B TO**  
**BASC LIVERPOOL 436-1-29**  
**DATED**

**WATERBORNE DISEASE ENDEMIC TO AFRICA**

1. Described in the table below are typical waterborne diseases endemic to Africa:

Pathogen	Type of Micro-organism	Disease Symptoms Produced
Vibrio cholerae	Bacterium	Cholera
Salmonella typhi	Bacterium	Typhoid
Shigella	Bacterium	Gastroenteritis
Campylobacter	Bacterium	Gastroenteritis
Hepatitis	Virus	Hepatitis
Norwalk agent	Virus	Gastroenteritis
Giardia lamblia	Protozoan	Gastroenteritis
Entamoeba histolytica	Protozoan	Amoebic dysentery
Schistosoma Mansoni	Helminth (Blood Fluke)	Schistosomiasis

2. Remember, proper clarification and sterilisation of water will destroy all pathogens.

**ANNEX C TO**  
**BASC LIVERPOOL 436-1-29**  
**DATED 29 JUL 94**

**INDIVIDUAL WATER TREATMENT**

**General**

1. There are times when the source of water hasn't been, or is not able to be, tested prior to its being used for consumption. In such instances individuals must undertake its treatment using:

- a. Water Bottles,
- b. Millbank Filters, and
- c. Water Sterilising Tablets, to carry out the two stages of purification - **CLARIFICATION and STERILISATION.**

**Millbank Filter**

2. This is a green, chain woven bag of stout cotton treated to render it rot and mould proof. It measures 140 x 140 x 20 mm, weights 20 grams, and is carried in the pocket on the water bottle cover. The weave of the bag filters out suspended matter **(including Amoebic Cysts)** while allowing the water to pass through and discharge into a water bottle from the bottom corner of the bag which runs to a point. The procedure to follow is:

- a. **THOROUGHLY WET THE BAG.** As the material is nearly water proof it is necessary for it to be thoroughly wet before use. This is done by turning the bag inside out and soaking the lower part - up to the black line - in water.
  - b. **REVERSE THE BAG.** Turn the bag back to its correct side out.
  - c. **FILL THE BAG TO THE TOP.** Use a cups canteen.
  - d. **SUSPEND THE BAG BY ITS EYELETS.** Attach it to a stake or tree branch.
  - e. **ALLOW THE FIRST HALF LITRE TO RUN TO WASTE.** Do not attempt to collect the water until the level is down to the black-line mark on the bag. In other words allow the first half litre to run to waste in order that the external of the bag is rid of any solid matter which might contaminate the water you are going to collect.
-

- f. **FILL THE WATER BOTTLE.** When the water level reaches the black-line place a water bottle below the lowest point. The filtered water will run down the outside of the bag to the pointed end and drip into the bottle. Providing the bag is thoroughly wet a bottle will fill within 5-8 minutes.

**REMEMBER:** Don't squeeze the bag or enlarge the hole size at the pointed end because all you are doing is defeating its purpose and leaving yourself open to consumption of un-potable, diseased water.

### **Sterilisation**

3. Sterilisation is best done chemically by the use of PURITABS or POTABLE AQUA TABLETS. The procedure is as follows:

- a. **RINSE AND FILL THE WATER BOTTLE.** As previously described;
- b. **ADD ONE PURITAB TABLET OR TWO POTABLE AQUA TABS.**
- c. **RECAP THE BOTTLE AND WAIT 5 MINUTES.** This ensures that the tablet is thoroughly dissolved and its chemical properties are thoroughly mixed throughout the water in the container;
- d. **WAIT A FURTHER 20 MINUTES.** This is the time required to allow the tablet(s) to take full effect. If the water is consumed prior to this time, the chemical action will not have taken effect and it will have a bitter, iodine taste.

### **Dosage Action**

4. One puritab tablet (17mg Sodium dichlorisocyanurate) dissolved in one litre of water, produces a concentration of 10 ppm of available chlorine, and a pH of 6. (Hypochlorite = 9.0).

5. Sterilisation tablets **ARE NOT INTENDED FOR ORAL ADMINISTRATION OTHER THAN IN WATER.**

6. **USE.** The recommended user doses for individuals are:

- a. One Puritab sterilises one litre (1.75 pints) of water if allowed to stand for 10 minutes or 2 litres if left for 30 minutes;
- b. **For water suspected or known to be heavily contaminated, use 2 Puritabs per litre; and**

l.

- c. For washing fruit or vegetables, add one Puritab to one litre of water and soak for at least 10 minutes, then rinse in a litre of water containing two Puritabs.

### **Puritabs Maxi**

7. One Puritab Maxi will sterilise 25 litres (approx 5.5 gallons) or a **JERRY CAN** of water in ten minutes or 50 litres if allowed to stand for half an hour. They are available in packs of 30 tablets (3 strips of 10) each of which contains 425 mg of Sodium Dichlorisocyanurate.

**NOTE 1:** Puritabs/Puritabs Maxi are effective for up to four days after which the water should be replenished and retreated.

**NOTE 2:** 6850-66-135-2321 Water Purification Tablet Iodine (**POTABLE AQUA**) may be the sterilisation agent of choice for use in Rwanda. If this is the case follow the same directions as for Puritab sterilisation incorporating two sterilisation tablets as per instructions below:

### **Directions for use (Potable Aqua Tabs):**

- a. Add two tablets to a canteen (one litre) of clear water;
- b. Replace canteen cap loosely;
- c. Wait five minutes and then shake well, allowing leakage;
- d. Tighten cap. Wait an additional thirty minutes before using for any purpose. **DO NOT** add anything to the water during this thirty minutes disinfection period ie. cordial etc.

### **Dosage Action**

8. Water purification tablets, Iodine, contains Sodium Acid Pyrophosphate, Aniltdrous 83.3 PCT, Tetraglycine Hydroperdide 16.5 PCT, Titratable Iodine 6.68 PCT and yields 8 mg of iodine, 12,s.

**ANNEX D TO**  
**BASC LIVERPOOL 436-1-29**  
**DATED 29 JUL 94**

**MILLEPORE BACTERIOLOGICAL TEST KIT**

**Reference:** A. Biological Analysis of Water & Waste Water Millepore Application Manual AM 302

**General**

0. The Millepore Bacteriological test kit is a light field incubator and test kit. The kit tests for total coliform and coliform colonies and has a capacity to test for yeast and mould bacteria.

**The Kit**

2. The test kit is housed in a blue fibreglass case with aluminium fittings. As with all water analysis and test kits the equipment is susceptible to damage if handled carelessly.

**Capabilities**

3. The capabilities of the Millepore are as follows:
- a. The incubator unit operates off several power sources - 6, 12 and 24 volt DC as well as 115 and 230 volt AC and DC.
  - b. Power cord adaptors are supplied to connect to battery terminals on vehicles.
  - c. The stainless steel rack has a capacity for 30 millepore field monitors. The racks are rust proof.

**Controls**

4. The apparatus has a temperature control and an input voltage selector switch.
-

**Operation**

5. Operation instructions are listed below:

- a. **Before connecting to a Power Source turn the voltage regular to the correct voltage.** Failure to ensure this will result in damage to the equipment and will blow the safety fuse and pilot lamp.

**Note:** Ensure spare fuses are carried.

- b. When the correct voltage is selected plug the female connection of the power cord into its respective male counterpart on the right hand side of the casing.
- c. After connecting the other end into your power source the incubator will commence heating. No on/off switch is provided or needed.
- d. The thermometer on the stainless steel rack will indicate the inside temperature of the incubator. Temperature can be controlled at this stage by adjusting the control knob.
- e. The pilot light which works in conjunction with a thermostat will control the temperature. **FOR WATER TESTING THE DESIRED TEMPERATURE IS 35°C FOR TOTAL COLIFORM PLATE COUNTS AND 43°C FOR FAECAL COLIFORM CULTURES.**

**Formula for Determining Colonies**

$$\frac{\text{No of Sheen Colonies}}{\text{ml of Sample}} \times 100 = \text{Bacteria Per 100ml of sample}$$

**ANNEX E TO**  
**BASC LIVERPOOL 436-1-29**  
**DATED 29 JUL 94**

**FIELD CHEMICAL WATER TEST KIT (HACH DREL 5)**

**The Kit (General)**

1. The Hach DREL is a lightweight portable chemical analysis kit. Capable of testing for forty eight specific chemical compositions. It has a AC/DC power capability and is completely self contained.

**What is it Used for?**

2. The kit is a field chemical analysis kit used to give an accurate chemical picture of a water source.

**The Kit**

3. The hach DREL has several important features which must be understood and these are dealt with in the following sub-paragraphs:

- a. **Light Control.** The light control operates a shutter which controls the amount of light reaching the Photocell. This control is adjusted with each procedure to produce a zero setting prior to the test being carried out.
  - b. **Light Shield.** A light shield covers the light photocell and **MUST BE CLOSED** when tests are being carried out.
  - c. **Colour Filters.** A total of nine colour filters are supplied with each kit (later kits may have a disc) the colour filters corresponding with meter scales must be used to obtain the correct result.
  - d. **Meter Scales.** The kit has meter scales which are thin cards with clearly printed scales on their faces. Damaged or bent cards should not be used.
  - e. **Meter Unit.** A meter scale is positioned centrally on the kit. At the left and side of the meter scale is a slot. Where meter scales are inserted care must be taken when inserting and removing the meter scales as rough handling could damage the meter needle and or meter scale.
-

- f. **Colimeter bottles.** Two clean square bottles are supplied with the kit. Both bottles are matched for light intensity and damages or scratched bottles should not be used. The exterior of these bottles should be clean and free from water or chemical re-agents.
  - g. **Filtrate Stand (Furette Stand).** This is a small stand which when used in conjunction with the bottle droppers dispenses a measured amount of re-agent.
  - h. **Volumetric Cylinder.** This is a glass or clear plastic tube graduated in 1ml marks and is used for specific amounts of re-agent or water.
  - i. **Demineralised Water.** This is used to clean colimeter bottles and measuring flasks to ensure accurate test results.
  - j. **Reagents.** These come in solution or powder form and are the chemicals required to give test results.
  - k. **Pipette Tube.** Used to measure parts of a ml and graduated in tenths for easy reading.
  - l. **Methods Manual.** A complete instruction booklet setting out step by step procedures for tests and fault finding diagrams - **Ensure that this is included in your kit without it unfamiliar and even experienced personnel cannot use the kit.**
-





OFFICE OF THE SURGEON GENERAL  
AUSTRALIAN DEFENCE FORCE

HEADQUARTERS AUSTRALIAN DEFENCE FORCE  
DEPARTMENT OF DEFENCE  
CANBERRA ACT 2600

008/24

## FACSIMILE MESSAGE / COVER

Classification UNCLAS	Message No	
Precedence R	Operator's Initials	Date
Facsimile Addressee COL WARPE ASC UNAMIRI	Facsimile Originator CP4-6-45 CAMPBELL PARK OFFICES CANBERRA	
Facsimile No	Facsimile No (06) 266 3933	
Telephone No	Telephone No (06) 266 3340	

Subject / Title EBOLA UPDATE		
Facsimile Reference SG 95/13703	Date 24. 5. 95	No of Pages (Including Cover) 2
Releasing Officer's Signature J. Thomas	Printed Name J. THOMAS	Rank/Appointment LEVT 80244

**WARNING:** Facsimiles on thermal paper can be highly unstable.  
If the accompanying documents contain authorisations or other important  
information they should be copied to good quality paper before filing.

## Instructions / Comments

- There are 2 suspected cases  
Kinshasa.
- A woman who had been working  
in Zaïre near Kikwit travelled home

\*LOPM SENT TO  
COMASC, MED LOY  
AND ON FILE.  
MB. 24/5.

## Ebola Chronology: 23/5/95

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### **Kinshasa: Doctors watch for the next wave**

Doctors in Zaire are closely monitoring the size of the next wave of infections. This is important because the number of infections that appear during the next week or so will show how well the education efforts are working. Medical supplies are in short supply. Also, a Swiss woman who just returned from Zaire has been put in the hospital on suspicion of having Ebola.

Ref: The Nando Times

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## Ebola Chronology: 22/5/95

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### **Rio de Janiero: Heart attack on African plane causes panic in Rio**

A brief panic is caused at the airport in Rio de Janiero by the death of a passenger on a plane arriving from Africa. The panic ends it becomes clear that the man has died of a heart attack. The plane, a South African Airlines flight from Johannesburg, is diverted away from the main terminal to a waiting ambulance.

Ref: The Nando Times

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### **Kinshasa: Doctors trap animals in search for Ebola reservoir**

In an attempt to track down the natural reservoir of the Ebola virus, researchers trap forest animals for testing. Special attention is placed on the area where the presumed first victim worked in the forest preparing charcoal.

Ref: The Nando Times

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## Ebola Chronology: 21/5/95

There was no chronology page for 5/20/95, so 5/20 and 5/21 are combined here.

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### **Geneva: WHO reports more deaths and infections. Outbreak began in December**

The WHO reports a change (over the last two days) of 137 infections with 101 of those having died. They also report that they have confirmed a case of hemmorrhagic fever at the hospital in Kikwit in December, 1994. This case is being investigated to determine if the cause was Ebola.

Ref: WHO

### **Kinshasa: New field lab available**

A new field laboratory capable of detecting Ebola in blood samples is established in Kikwit. Previously, blood samples had to be flown to the CDC in Atlanta.

Ref: The Nando Times

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**CORRESPONDENCE DISTRIBUTION**  
**COVER SHEET**

File No. 445-16-1

Correspondence No. \_\_\_\_\_

To: FMO

Remarks/Action: \_\_\_\_\_

Med Ops

Med Log

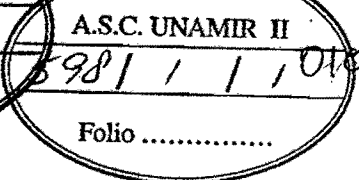
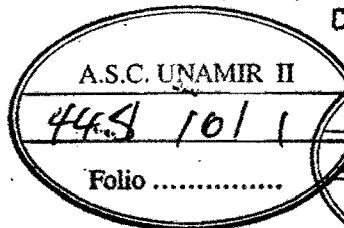
FHO

Please initial and date when action complete then pass quickly.



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AUSTRALIAN DEFENCE FORCE

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DEPARTMENT OF DEFENCE  
CANBERRA ACT 2600



FACSIMILE MESSAGE / COVER

Classification	UNCLAS
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Message No	
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Precedence	R
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Operator's Initials	Date
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Facsimile Addressee
MAJOR HOLMES
HEALTH OPS
LHQ

Facsimile Originator
CP4-6-45
CAMPBELL PARK OFFICES
CANBERRA

Facsimile No	02 399 3556
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Facsimile No	(06) 266 3933
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Telephone No	8 22 3569
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Telephone No	(06) 266
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Subject / Title	WHO REPORT AND NEWS REPORTS - RWANDA
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Facsimile Reference	95/13703	Date	22 May 95	No of Pages (Including Cover)	6
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Releasing Officer's Signature	Printed Name	Rank/Appointment
J. Thomas	LTJ S. THOMAS	SO2 H

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information they should be copied to good quality paper before filing.

Instructions / Comments

Please can this be transmitted to Asc  
UNAMIR in Kigali.

Encl 1st  
1-0870

Am.  
Pkt.

Jan Thomas.

ZCZC ENGL

WHO EPIDEMIOLOGICAL BULLETIN; SUMMARY FOR PERIOD 15 TO 19  
MAY 1995 STOP

EBOLA HAEMORRHAGIC FEVER:

ZAIRE:

INTERNATIONAL TRAVEL:

WHO RECOMMENDS THAT NO SPECIAL MEASURES BE INSTITUTED WITH  
RESPECT TO AIRCRAFT PASSENGERS OR CREW ARRIVING FROM ZAIRE STOP  
PERSONS WITH EBOLA BECOME INFECTIOUS FOR OTHERS ONLY WHEN  
THEY ARE EXTREMELY ILL AND ARE ALREADY HAEMORRHAGING (BLEEDING)  
STOP IT IS HIGHLY UNLIKELY THAT SUCH PERSONS WOULD TRY TO  
TRAVEL ON AN INTERNATIONAL FLIGHT; AND UNLIKELY THEY WOULD BE  
PERMITTED TO BOARD IF THEY DID TRY STOP IF ON BOARD, THEY WOULD  
REPRESENT A HAZARD TO MEMBERS OF THE CREW AND ANY PASSENGERS  
WHO HAD DIRECT CONTACT WITH THE PATIENT'S BLOOD STOP SUCH  
PASSENGERS SHOULD BE PLACED AS FAR AS IS PRACTICAL FROM OTHER  
PASSENGERS AND CREW STOP AIRCREWS, AS A ROUTINE, SHOULD ADVISE  
GROUND STAFF AT DESTINATION IF THEY HAVE SEVERELY ILL PASSENGERS  
ON BOARD STOP HEALTH/QUARANTINE AUTHORITIES SHOULD ARRANGE FOR  
THE ISOLATION OF THESE PASSENGERS FOR INITIAL CLINICAL SCREENING  
FOR EBOLA STOP PASSENGERS AND CREW WHO HAD CLOSE PROLONGED  
CONTACT WITH THE PATIENT (E.G. PASSENGERS SITTING IN AN  
ADJOINING SEAT BUT NOT ACROSS THE AISLE OR IN FRONT OR BEHIND  
UNLESS SPECIFIC CONTACT OCCURRED, OR CREW PROVIDING CARE)  
SHOULD BE ADVISED OF THE HAZARD AND, ON ARRIVAL, BE PLACED  
UNDER SURVEILLANCE (E.G. ACTIVE CONTACT MAINTAINED BY PHONE  
OR VISIT) STOP OTHERS IN THE AIRCRAFT SHOULD BE ADVISED OF THE  
HAZARD AND TOLD TO CONTACT A PHYSICIAN IF THEY BECOME ILL STOP  
A VERY SMALL NUMBER OF INDIVIDUALS (PRINCIPALLY HEALTH CARE  
WORKERS AND JOURNALISTS) WILL BE RETURNING TO THEIR HOME  
COUNTRIES AFTER HAVING BEEN IN KNOWN CONTACT WITH EBOLA PATIENTS  
STOP UNLESS THESE PASSENGERS ARE OBVIOUSLY ILL, NO TRAVEL  
RESTRICTIONS SHOULD BE IMPOSED, BUT SUCH PERSONS ARE ADVISED  
TO INFORM HEALTH/QUARANTINE OFFICIALS AT THEIR DESTINATION OF  
THEIR EXPOSURE HISTORY AND OF WHERE THEY MAY BE CONTACTED DURING  
THE INCUBATION PERIOD OF THE DISEASE STOP IF THEY FALL ILL DURING  
THIS PERIOD, THEY SHOULD SEEK IMMEDIATE CARE AND NOTIFY THE  
HEALTH/QUARANTINE AUTHORITIES OF THIS FACT STOP OTHER PASSENGERS  
LEAVING ZAIRE ARE ADVISED TO NOTIFY A DOCTOR IMMEDIATELY IF AN  
ILLNESS DEVELOPS DURING A PERIOD OF THREE WEEKS FROM THE  
DEPARTURE DATE STOP IN PARTICULAR, ANY FEVER SHOULD BE REPORTED  
AT ONCE AND THE PHYSICIAN INFORMED THAT THE PATIENT HAS TRAVELLED  
FROM ZAIRE STOP THE INCUBATION PERIOD FOR EBOLA HAEMORRHAGIC  
FEVER IS UP TO TWENTY-ONE DAYS STOP

NOTE TO HEALTH/QUARANTINE ADMINISTRATIONS

WHO WOULD APPRECIATE BEING INFORMED IMMEDIATELY OF ANY SUSPECT  
CASES OF EBOLA HAEMORRHAGIC FEVER ARRIVING ON THEIR TERRITORY  
AND OF THE MEASURES WHICH HAVE BEEN TAKEN REGARDING THESE CASES  
STOP

COMMUNICATIONS SHOULD BE ADDRESSED TO DIVISION OF COMMUNICABLE DISEASES (CDS); AT FAX NO. 41 22 791 41 98; OR E-MAIL TORRIGIANI GA WHO.CH OR TELEX NO. 415416 ATTENTION CDS STOP UPDATE (18 MAY 1995)

THE HEAD OF THE INTERNATIONAL COMMITTEE ON SCIENTIFIC AND TECHNICAL COORDINATION OF THE FIGHT AGAINST THE EPIDEMIC, PROFESSOR TAMFUN MUYEMBE, REPORTS THAT RETROSPECTIVE EVALUATION, HOSPITAL REGISTRATION RECORDS, ACTIVE CASE FINDING AND CONTACT TRACING BEGUN IN KIKWIT ON 13 MAY HAS SHOWN A TOTAL OF 114 CASES (79 DEATHS) OF EBOLA HAEMORRHAGIC FEVER IN KIKWIT AND SURROUNDING VILLAGES WHICH CORRESPONDS TO A CASE FATALITY RATE OF 69 PERCENT STOP THE MAJOR MEANS OF TRANSMISSION APPEARS TO BE CLOSE AND UNPROTECTED PATIENT CONTACT OR PREPARATION OF DEAD FOR BURIAL STOP PREVIOUSLY, ALL CASES REPORTED BY WHO HAD BEEN HOSPITAL PATIENTS STOP ALL KNOWN PATIENTS WHO LEFT HOSPITAL HAVE BEEN TRACED AND THEIR HOUSEHOLDS PLACED UNDER MEDICAL AND EPIDEMIOLOGICAL SURVEILLANCE STOP THE TEAM IS NOW LOOKING FOR CASES OF INFECTION AMONG PEOPLE AT HEALTH CENTRES IN AND AROUND KIKWIT STOP SURVEILLANCE HAS ALSO BEEN SET UP AT 6 LOCATIONS WITHIN A RADIUS OF 150 TO 200 KM OF KIKWIT TO TRACE INDIVIDUALS WITH THE DISEASE WHO ARE BELIEVED TO HAVE GONE TO THEIR HOMES THERE FROM THE CITY STOP THE VILLAGES ARE: KINDINGA, KINSONI, NSI-MOLOONGO, BEYASALA, YASSA/BONGA, AND VANGA STOP DESPITE INTENSIVE AND EFFECTIVE SENSITIZATION OF THE POPULATION BY THE ZAIRIAN GOVERNMENT AND NON-GOVERNMENTAL ORGANIZATIONS IN KIKWIT WHICH HAVE BEEN QUICK TO RESPOND TO THE EMERGENCY, IT IS FEARED THAT THE NUMBER OF CASES WILL INCREASE DURING THE COMING 3 WEEKS AMONG THOSE WHO HAVE ALREADY BEEN INFECTED STOP

EPIDEMIOLOGICAL

19/05/95 0938 GMT  
415768 OMS CH

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AA62054

MONDAY 22 MAY TOTALS

101 DEAD

137 CASES.

NEWS REPORT

36 1.00 19 May 95 20:16 a2186

AFR: MORE COUNTRIES TAKE ANTI-EBOLA ME

Title: AFR: MORE COUNTRIES TAKE ANTI-EBOLA MEASURES

Source:AAP Date:19 May 95 20:16:2

Source = AAPSequence No. = a2186Received : 19 May 95 20:16:20

r i bc-ZAIRE-VIRUS-REACT 19-05-95 0387

AFR: MORE COUNTRIES TAKE ANTI-EBOLA MEASURES  
ZAIRE VIRUS REACT

ADDIS ABABA, May 19 AFP - Ethiopia today joined the growing list of countries to announce the screening of airline passengers for the deadly Ebola fever raging in Zaire, while Germany prepared to ban the import of monkeys.

British officials placed three Zaireans in quarantine and South Korea asked nationals in Zaire and neighbouring African countries to be ready to evacuate if the virus spreads from the countryside to the cities.

The Ethiopian health ministry said that a group of experts was at the Addis Ababa international airport to carry out medical checks on passengers coming from Zaire, where Ebola fever has claimed at least 79 lives.

Travellers would be asked to produce a medical certificate if necessary, the ministry told the ENA news agency.

The German agriculture ministry in Bonn announced in a statement that it will ban the import from Zaire of monkeys, which are possible carriers of the virus for which there is no medical cure.

The decision came a day after the European Parliament called on all European Union countries to enforce strict health measures at ports and airports to prevent Ebola fever gaining a foothold on the continent.

In London, medical sources said a Zairean woman and her two children were sent to a hospital in the north of the capital after they arrived this week from Moscow, carrying forged passports.

The three had left Zaire a few days earlier and were taken ill when they were being questioned by immigration officials, but a health ministry spokesman said it was "unlikely" they were carrying the virus.

In South Korea, a government spokesman told AFP that the authorities had asked their nationals living in and around Zaire "to form a task force to draw up contingency plans, and they have done that".

"But so far there is no indication the virus has spread to (the Zairean capital) Kinshasa," he added. "We are making sure we are prepared for the worst."

Four embassy officials and some 66 South Koreans are reportedly living in Zaire, most of them in Kinshasa, and another 235 are known to be in neighbouring Zambia, Cameroun and Gabon.

Zairean and UN World Health Organisation officials are reportedly struggling to contain the outbreak of the virus, to Kikwit, 530 km east of Kinshasa by road, and the surrounding region.

AFP mk

19-05 2016

Title: AFR: BLOCKADE END RELIEVES ZAIRE CAPITAL, REVIVES FEAR

Source: AAP Date: 22 May 95 03:33:3

Source = AAP Sequence No. = a4128 Received : 22 May 95 03:33:37

u i bc-ZAIRE-VIRUS 22-05-95 0575

AFR: BLOCKADE END RELIEVES ZAIRE CAPITAL, REVIVES FEAR  
ZAIRE VIRUS DAYLEAD

By Matthew Tostevin of Reuters

KINSHASA, May 21 Reuter - Travellers and trucks from Zaire's virus-stricken Bandundu province poured into the capital Kinshasa today after the lifting of a blockade aimed at containing the Ebola outbreak.

But as the death toll in the south-western province passed the 100 mark, residents wondered just how safe the capital now was from the epidemic.

At the dusty Ngaba truck park, some of the 250 trucks bringing food from Bandundu province at last unloaded the goods they set off with more than a week ago.

But relief over food deliveries was tempered by concern that the trucks may have brought the virus in their cargo.

Some people at the truck park asked whether the travellers or the food they brought to sell were safe, but the arrivals were keen to point out that they had been examined by medics.

"The doctor looked in my eyes and checked my stomach. They examined about 1,500 people and only found one case of fever, and that was malaria," said student Godhe Kombo.

The World Health Organisation (WHO) in Geneva, spearheading the fight to contain the virus, said the epidemic had killed 101 of the 137 people known to have been infected -- up from 97 dead yesterday.

"We were expecting this situation. There were several people incubating the virus. We saw the same thing in 1976 in Yambuku. It will increase for a while and eventually stabilise," said Bompanda Bonkumo, president of the national commission monitoring the disease.

Authorities confirmed that the road would stay open, and traffic could move freely between Bandundu and the capital. Traders said they were preparing to go back to the south-western province, and even Kikwit itself.

"There is no barrier on the road now, only a team of health workers near Mongata to examine travellers," Kinshasa Governor Bernadin Mungul Diaka told Reuters.

"Travellers will also be examined at Kikwit. If ever there is anyone sick they can keep them there."

Mungul said he did not think opening the road would increase the chance of the virus spreading to the capital. "We follow the advice of the World Health Organisation, and the WHO says the virus can only be caught through close contact," he said.

The arrival of hundreds of tonnes of food has brought relief to Kinshasa, where food costs were already soaring.

Young men sweated to unload tonnes of manioc, bananas, peanuts and maize for the market.

"Everyone is happy the price has gone down now the blockade is



C lifted. Manioc was 120,000 new zaires (\$A34.98) a sack before, now it is down to 80,000 new zaires (\$A23.36)," said trader Mbole Zoelou.

The government and city officials imposed the blockade some 10 days ago at Mongata, about 150 kms from Kinshasa, to prevent the spread to the capital and its five million people of one of the worst diseases known to man.

The virus, spread by contact with blood or bodily fluids, causes uncontrollable bleeding. It first surfaced in the town of Kikwit, 500 kms east of the capital.

The WHO in Geneva said investigations had found the first fatal cases of Ebola fever in the Kikwit area dated back to last December, and not to March as earlier believed. Eight cases discovered from December are not included in the latest toll.

A spokesman said the WHO was setting up a field laboratory in Kikwit to test for the virus, to try to find out where it lived between outbreaks in humans.

REUTER ao

22-05 0334

**CORRESPONDENCE DISTRIBUTION**  
**COVER SHEET**

File No: \_\_\_\_\_

To: FMO	Remarks/Action: _____
Med Ops	_____
Med Log	_____
FHO	_____
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Please initial and date when action complete then pass quickly

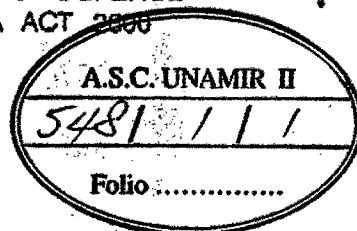
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DEPARTMENT OF DEFENCE  
CANBERRA ACT 2600

445-16-1



FACSIMILE MESSAGE / COVER

Classification	Message No 006/F/02	
Precedence a	Operator's Initials	Date
Facsimile Addressee CO ASC UNAMIR	Facsimile Originator LTC Thomas CP4-6-45 CAMPBELL PARK OFFICES CANBERRA 6/6 Med off Shes 006 2/6	
Facsimile No	Facsimile No (06) 266 3933	
Telephone No	Telephone No (06) 266 3340	

Subject / Title EBOLA VIRUS OUTBREAK.		
Facsimile Reference SG 95/13703	Date 2 JUN 95	No of Pages (Including Cover) 3
Releasing Officer's Signature J. Thomas	Printed Name J. THOMAS	Rank/Appointment LTC - 502 H1

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information they should be copied to good quality paper before filing.

Instructions / Comments

Col Warfe

A male who had visited Zaire is reported to  
be in Wilkins Hosp. Harare with suspected Ebola.  
His blood is being tested in RSA and Atlanta. The  
likelihood of infection is small because he had  
been in Zaire quite some time ago but he  
demonstrated bloody diarrhoea and fever so the  
staff isolated him.

Jan Thomas

WHO Press Release 40,

26 May 1995

**THE EBOLA EPIDEMIC IN ZAIRE: THE ACUTE PHASE IS OVER**

The International Committee on Scientific and Technical Coordination, supported by the team of the World Health Organization (WHO) in Zaire, reports today that the epidemic of Ebola haemorrhagic fever is coming under control. The number of cases detected since the beginning of the epidemic remains unchanged, except for cases occurring between January and March 1995 which have been identified in retrospect.

The latest figures indicate a total of 160 confirmed or suspected cases, distributed geographically as follows: 138 in Kikwit, 14 in Mosango, 3 in Bulungu, 2 in Imbongo and 1 each in Mukala and Dua. There have been 121 deaths in all, which gives a case fatality rate of 76%. All cases were in the Province of Bandundu. The average age of patients was 37, the youngest being 3 months old and the oldest 71 years of age. Only five patients were under 16.

It should be noted that only six new cases have been reported since 18 May 1995, which allows the specialists to affirm that the acute phase of the epidemic is over and that transmission now has been greatly reduced, if not completely halted. The new cases were expected because of the length of the incubation period, which still covers a number of persons who became infected before the arrival of the WHO team.

The specialists on the ground will have two main tasks over the next few days: to strengthen health facilities and to commence research activities to understand better the disease.

For Further Information, please contact Thomson Prentice (41 22) 7913221, Philippe Stroot (41 22) 791 2535 or Valery Abramov (41 22) 791 2543, Health Communications and Public Relations. WHO, Geneva. Fax (41 22) 791 4858.

EBOLA - ZAIRE: UPDATE

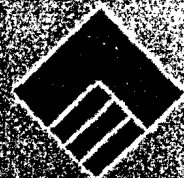
Courtesy of Jim Randle, VOA (Voice of America)

Dr David Heymann of WHO speaking today, Tues. 30 May, after returning to Geneva from Zaire, said the latest case count is 205 with 153 deaths. The increase is due to retrospectively identified cases, not to new ones.

- Moderator



GPO Box 9848  
Canberra ACT 2601  
Telephone: (06) 289 7390  
Telex: 61209 Fax: (06) 289 6963



COMMONWEALTH  
DEPARTMENT OF  
HUMAN SERVICES  
AND HEALTH

TO ALL COMOS

EBOLA UPDATE

Enclosed is some of the more recently received information on the Ebola outbreak in Zaire.

It appears that the peak of the epidemic has passed.

We have had very few reports of people coming into Australia from Zaire and no-one who has had any Ebola symptoms. Anyone who has been in Zaire in the preceding 21 days is receiving a copy of the Health Alert Notice.

At this stage, we do not propose to alter any of the arrangements currently in place at Australian ports of entry as we will need to maintain them until 21 days after the date of the last case identified by WHO. The travel advisory to Zaire in general (security grounds) and the Bandundu area in particular (Ebola) still stands.

I will let you know when we receive info on the final case from WHO.

Dr Bronwen Harvey  
Quarantine Medical Officer

31 May 1995

26/5

# COORDINATION INTERPAYS DE LA SURVEILLANCE EPIDEMIOLOGIQUE

## Bulletin Epidémiologique Bimensuel

N° 9

15 Avril 1995

Publié par

L'ORGANISATION MONDIALE DE LA SANTE

### Table des Matières

□ Introduction.....	1-1
□ Conditions de santé.....	1-2
□ Surveillance épidémiologique.....	2-3
□ Commentaires.....	3-4
□ Conclusion.....	4-4

### Bulletin Epidémiologique Bimensuel

#### 1. Introduction

Les deux premières semaines du mois d'Avril 1995 ont été marquées par de nombreux incidents de violence au sein de la population au Burundi et dans les camps de réfugiés rwandais dans ce pays. Plusieurs milliers de réfugiés ont abandonné le camp de Magara pour se diriger vers la frontière tanzanienne. Ils ont été temporairement placés (25 000 personnes) dans le camp de transit de Kabanga dans des conditions de salubrité très précaires, favorisant ainsi la recrudescence des nouveaux cas de diarrhée sanglante.

En même temps, plusieurs cas de varicelle ont été observés chez les enfants. Un autre groupe de près de 15 000 personnes venant du même camp de Magara se sont repliés sur le camp de Mugano (Muyinga).

La coordination des Agences des NU en préparation à cette situation a mis en place un plan de contingence à Ngara (Tanzanie) pour contenir l'afflux des nouveaux réfugiés venant du Burundi. Une extension du camp de Kitali Hill a été prévue pour les recevoir et des ONGs ont été identifiées (MSF-Suisse, NPA, IFRC) pour les prendre en charge.

Gx Med

1. This info is v. limited

— out of date

— not rate adjusted

2. Comparisons relative to immigration, coord

of NGOs & agencies +

Re protocols.

3/6

Au Rwanda, l'opération de rapatriement des personnes déplacées internes vers leurs communes d'origine se poursuit avec la participation du gouvernement et des Agences Humanitaires.

#### 2. Conditions de santé

Malgré la saison des pluies, l'accessibilité à l'eau potable reste limité dans plusieurs camps de réfugiés. A Ngara la quantité d'eau distribuée atteint seulement 5-8 litres/personne/jour.

A Goma la capacité de desserte est de l'ordre de 10,6 litres/jour à l'exception du camp de Tshondo où elle ne dépasse pas 5,4 litres.

La vulgarisation des latrines familiales connaît beaucoup de succès. Cette campagne permettra d'améliorer rapidement la couverture en latrines dans les camps. Les efforts de renforcement des conditions d'hygiène et d'assainissement pourraient alors être concentrés sur la gestion des déchets solides et liquides produits par les ménages.

Les rations alimentaires fournies par le PAM au cours de ce mois ne dépasseront pas 1500 Kcal/personne/jour. Comme il avait été annoncé dans les numéros précédents du bulletin, cette limitation est liée à l'insuffisance des stocks du PAM. Le HCR a entrepris une enquête nutritionnelle dans tous les camps.

Un programme de santé de la reproduction est en cours de réalisation dans les camps de Goma et de Bukavu.



Le programme de prise en charge des cas de tuberculose BK(+) a été lancé dans tous les camps. Une formation des infirmiers et des agents de santé communautaire, a été aussi envisagée par la coordination médicale HCR/OMS/ONG, pour appuyer le programme de lutte contre la tuberculose.

### 3. Surveillance Epidémiologique

La mortalité globale dans tous les camps de réfugiés reste inférieure 1/10000/jour.

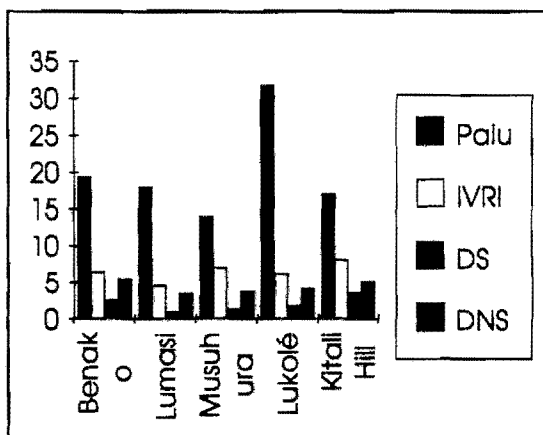
Le tableau épidémiologique au Rwanda et dans les camps est dominé par la fièvre d'origine indéterminée, le paludisme, les infections des voies respiratoires basses et hautes, la diarrhée sanglante et le groupe de maladies qualifiées "autres".

#### F.O.I./Paludisme

Ils constituent la première cause de morbidité. Plusieurs initiatives ont été entreprises pour mieux cerner le diagnostic des fièvres et plus particulièrement celui du paludisme. D'autres causes des F.O.I. comme la fièvre typhoïde, le typhus, la fièvre récurrente sont de plus en plus évoquées au cours des discussions des coordinations médicales. Des protocoles d'enquête ont été élaborés de manière isolée en fonction des capacités d'investigation locales dans les camps.

Morbidité dans les camps de Ngara I/1000/Semaine

Maladies spécifiques	Camps				
	Benak	O	Lumasi	Musuh	Ura
Paludisme	19,39	17,91	13,97	31,69	16,97
Inf.v.resp.basses	6,39	4,52	6,91	6,10	8,12
Diarrhée sanglante	2,53	0,97	1,41	1,87	3,58
Diarrhée n.sangl.	5,41	3,48	3,70	4,07	5,09
Rougeole	0,00	0,00	0,00	0,00	0,08
Méningite	0,00	0,01	0,02	0,00	0,00
Choléra	0,01	0,00	0,00	0,00	0,00

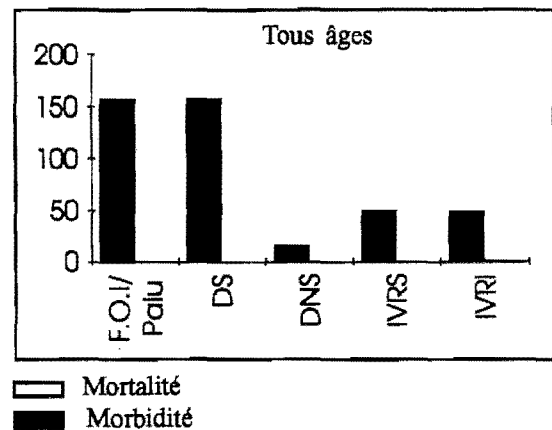


#### Diarrhée sanglante

Dans le camp de transit de Kabanga (Muyinga) au Burundi, 12 à 15 nouveaux cas sont enregistrés par jour. Ce rebond de la situation de la dysenterie est certainement liées aux conditions austères marquées par le manque d'eau et de latrines.

Morbidité et mortalité dans les camps du Burundi  
I/10 000/semaine

Maladies spécifiques	Tous âges		Moins de 5 ans	
	Morbidité	Mortalité	Morbidité	Mortalité
F.O.I./paludisme	157	0,44	260	1,1
Diarrhée sanglante	157,4	0	25,3	0
Diarrhée non sangl.	16,5	0	58,5	0
Choléra	0	0	0	0
IVRS	50,3	0	85,6	0
IVRI	49,4	0,46	113,4	0,75
Méningite	0	0	0	0
Rougeole	3,1	0	6,9	0
Affec.Dermato	15,9	0	17,2	0
MST	2,1	0,1	0	1,8
Tuberculose	0	0	0	0
Malnutrition	0,6	0,3	0,5	0



La létalité élevée liée à la diarrhée sanglante à Bukavu nécessite une revue de la prise en charge des cas ou une enquête sur les conditions des malades en dehors des structures de santé.

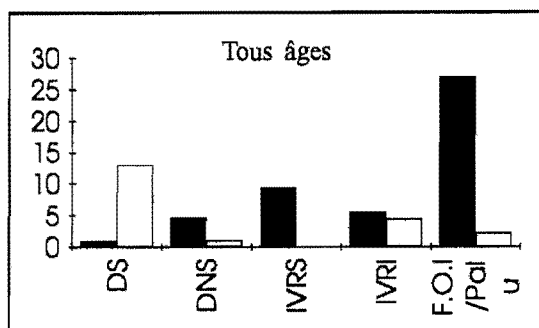
A Ngara, une augmentation des cas de diarrhée non sanglante a été constatée depuis le début de la saison des pluies. La situation est bien maîtrisée.

#### Rougeole

La rougeole chez les adultes a été notifiée dans le camp de Majuri au Burundi, dans les camps de Goma et chez certaines personnes déplacées internes au Rwanda, sans pour autant entraîner des décès.

## Morbidity et létalité dans les camps de Bukavu

Maladies spécifiques	Morbidity		Létalité	
	Tous âges	< 5 ans	Tous âges	< 5 ans
Rougeole	0,06	0,03	0,0	0,0
Méningite	0,00	0,00		
Diarrhée sanglante	0,93	2,04	13,0	16,5
Diarrhée non sangl.	4,60	11,12	1,1	0,0
Choléra	0,00	0,00		
Infec.v.resp.hautes	9,32	14,35	0,0	0,0
Infec.v.resp.basses	5,44	17,60	4,4	5,4
Conjonctivite	2,67	2,77	0,0	0,0
F.O.I./Paludisme	26,88	32,16	2,2	4,0
Traumatisme	3,32	1,38	43,6	45,5
SMT/SIDA	0,58	0,06	16,7	0,0
Malnutrition <70% P/T	0,11	0,05	0,0	0,0
Affec. Dermato.	3,33	5,68	0,0	0,0
Tuberculose	0,02	0,00	0,0	
Divers	3,78	6,35	0,0	0,0
Autres	25,18	20,27	1,9	4,7



□ Létalité  
■ Morbidity

## Méningite

Des cas sporadiques de méningite ont été notifiés dans le camp de Ntamba au Burundi sans tendance d'évolution vers une épidémie. La campagne de vaccination qui avait été prévue n'a pas pu être réalisée à cause de l'insécurité dans la zone.

## Schistosomiase

Une étude a été menée au Burundi sur 200 cas de diarrhée sanglante pour déterminer le taux de participation de la schistosomiase à cette pathologie. Les résultats seront publiés très prochainement.

## Varicelle

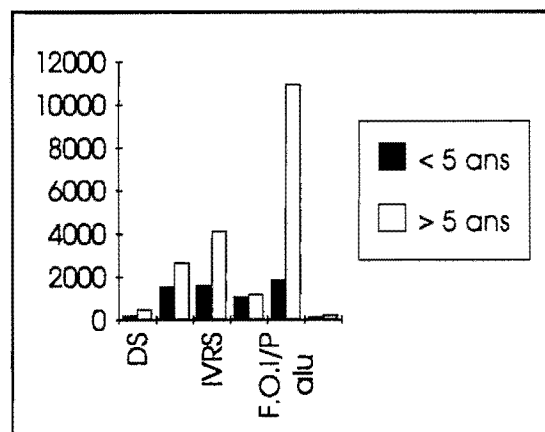
Des cas de varicelle ont été observés dans le camp de transit de Kabanga, le camp de Ruvumu lors des derniers événements du Burundi.

## MST/SIDA

Un accent particulier a été placé sur la prévention de la transmission du SIDA par voie sexuelle. Une approche active de distribution des condoms a été adoptée en même temps que l'approche passive qui consiste à la mise à la disposition des préservatifs dans les camps en vue d'en étudier l'acceptation.

Morbidity dans les camps de Goma  
I/10 000/semaine

Maladies citées	< 5 ans	> 5 ans	Population totale
Diarrhée sanglante	176	479	655
Diarrhée non sanglante	1546	2650	4996
Infec.v.resp. hautes	1605	4111	5716
Infec.v.resp. basses	1062	1189	2251
F.O.I./Paludisme	1848	10945	12793
Rougeole	129	208	337



## 4. Commentaires

Les incidents du Burundi et leur répercussion sur les camps de réfugiés rwandais ont influencé le mouvement de rapatriement volontaire vers le Rwanda. Par exemple à Goma au cours du mois de mars seulement 2 303 personnes ont volontairement regagné le Rwanda par convoi organisé et 17 558 de manière spontanée.

La réduction de l'approvisionnement alimentaire du PAM aura très certainement des effets sur l'état nutritionnel des réfugiés qui ne peuvent bénéficier de plus de 1500 Kcal/jour. Des enquêtes à intervalles régulières seraient recommandées pour suivre de près le développement de la malnutrition dans les camps et appliquer des mesures correctives tout au moins en faveur des plus vulnérables que sont les enfants, les femmes enceintes et les malades.



Les enquêtes isolées sur les causes de la fièvre d'origine indéterminée dans les camps devraient bénéficier d'un renforcement des capacités de diagnostic de laboratoire. Même si les laboratoires dans certains camps fonctionnent bien, le manque de milieux de transport des échantillons de selles, des prélèvements urétraux et vaginaux, des LCR, des crachats et leur acheminement prompt vers le laboratoire de référence jouent sur les résultats des analyses.

La notification des cas de rougeole chez les adultes devra inciter la coordination médicale à étendre les campagnes de vaccination à la population de 6 mois à 15 ans.

## 5. Conclusions

Le développement d'un même protocole pour l'enquête sur la F.O.I. est recommandée dans tous les camps de réfugiés et au Rwanda.

La même attitude adoptée pour l'harmonisation de la prise en charge des cas de tuberculose devra être poursuivie par la coordination médicale HCR/OMS/UNICEF/ONG pour aborder en commun le sujet de la F.O.I.

Le thème devra être inclus sur la liste des problèmes à discuter lors de la prochaine rencontre au mois de Mai 1995.

La recrudescence des cas de rougeole et parmi les adultes devra inciter la coordination médicale à revoir les stratégies de vaccination recommandées et leur efficacité.

**Le comité de rédaction remercie toutes les ONGs qui ont participé à la récolte des données présentées dans ce numéro.**

Ce Rapport de Synthèse a été préparé avec la collaboration des Equipes OMS.

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OFFICE OF THE SURGEON GENERAL  
AUSTRALIAN DEFENCE FORCE

HEADQUARTERS AUSTRALIAN DEFENCE FORCE  
DEPARTMENT OF DEFENCE  
CANBERRA ACT 2600

A.S.C. UNAMIR II

548 / 1 / 1

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J. THOMAS

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## Ebola Chronology: 21/5/95

**There was no chronology page for 20/5/95, so 20/5 and 21/5 are combined here.**

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### **Geneva: WHO reports more deaths and infections. Outbreak began in December**

The WHO reports a change (over the last two days) of 137 infections with 101 of those having died. They also report that they have confirmed a case of haemorrhagic fever at the hospital in Kikwit in December, 1994. This case is being investigated to determine if the cause was Ebola.

Ref: WHO

### **Kinshasa: New field lab available**

A new field laboratory capable of detecting Ebola in blood samples is established in Kikwit. Previously, blood samples had to be flown to the CDC in Atlanta.

Ref: The Nando Times

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## Ebola Chronology: 19/5/95

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### **Geneva: WHO reports more deaths and infections**

The WHO reports 124 infections and 89 of those have died. They indicate that many of the cases now being reported are not new, but only newly-discovered by the unfolding epidemiological investigation. The also report on having encouraged the Government of Zaire to change its quarantine policy to include only "hospitals, health centres and places where someone has died from Ebola or there have been suspected cases."

Ref: WHO

### **Kikwit: Many more cases expected in next wave**

Based on epidemiological studies, health workers in Zaire expect a large increase in the number of cases in the next wave of the outbreak. Hundreds are thought to be infected and in the incubation period.

Ref: NPR (RealAudio)

### **Mbankana, Zaire (16:30): Zaire eases quarantine**

Following advice from international health workers, Zaire eased its region-wide quarantine policy today and has narrowed the quarantine to cover only Kikwit itself. Experts had pointed out that the quarantine was, in fact, making the problem worse by scaring people into running from impacted areas.

Ref: The Nando Times

### **Kinshasa: Bribes get past quarantine**

People are bribing their way past roadblocks setup to quarantine possibly infected people from Kikwit and the surrounding region. According to a car rental agency in Kinshasa, \$550 is enough. Experts fear a new wave of infections among those stranded at the roadblock.

Ref: AP

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## Ebola Chronology: 18/5/95

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### **Mongata, Zaire: Quarantine strands thousands**

Thousands are stranded at a roadblock in Mongata, on the road to Kinshasa. They can't go on to Kinshasa and are too scared to return to Kikwit.

Ref: The Nando Times

### **Atlanta: CDC asks U.S immigration to watch for virus**

U.S. immigration officials are asked to watch for signs of infection in anyone arriving from Zaire. They are also asked to handout information cards that explain that an outbreak of the deadly virus is underway in Zaire.

Ref: The Nando Times

### **Kinshasa (19:42): Leading virologist criticizes government response**

Dr. Jean-Jacques Muyembe Tamfum, who helped identify the Ebola 19 virus years ago, criticizes the government in Zaire saying that the effort put into roadblocks is a waste of time and that the resources should be put into other programs.

Ref: The Nando Times

### **Geneva: WHO reports increase in cases and deaths**

WHO reports 114 infections and 79 deaths. Their reported numbers are now including suspected as well as confirmed cases. Deaths have occurred in the following areas surrounding Kikwit: Kindinga, Kinsoni, Nsi-Moloongo, Beyasala, Yassa Bonga and Vanga.

Ref: The WHO

### **Washington: Fourth Ebola strain confirmed in Ivory Coast infection**

Scientists at France's Pasteur Institute report in the May 20 issue of Lancet that a fourth strain of Ebola has been identified in the infection of a Swiss scientist who had been working in Ivory Coast. The woman has since recovered.

Ref: Voice of America

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22 May 1995

## RESEARCHERS SEEK SOURCE OF EBOLA EPIDEMIC

The International Committee on Scientific and Technical Coordination, supported by the team of experts of the World Health Organization (WHO) in Zaire, said today that there were no new cases of Ebola haemorrhagic fever and no increase in deaths since the previous update issued on 21 May 1995. One duplicated case has been discounted, giving a revised total of 136 cases and 101 deaths.

The epidemic remains stable. As the team in Kikwit is attempting to get a better idea about the severity of the expected fourth generation of cases in the epidemic, research activities are beginning which will provide answers to questions such as the clinical spectrum of disease caused by infection by the Ebola virus, the factors which cause its transmission, and who is at most risk of becoming infected.

Active surveillance continues to provide information that may lead to a possible source of the epidemic. A previous chain of deaths within one household, which appears to have begun in late December 1994, is now being linked with other cases of haemorrhagic disease and death similar to Ebola haemorrhagic fever, which passed in generations with two to three week intervals throughout January, February and March 1995.

The active surveillance team is meeting twice daily to piece together all the information, which at present seems to lead back to a middle-aged male forest worker who was an early, or possibly the first, case in this epidemic. Three Zairean veterinarians along with members of the International Commission will go to the forest site where this possible first case worked preparing charcoal. They will trap animals, insects and rodents, including bats, in search of a possible reservoir for the Ebola virus in nature.

Associated with the present epidemic, which appears to have been amplified in both Kikwit 2 Hospital and Kikwit General Hospital, there seem to be at least four offshoot parallel chains of disease and death, probably transmitted from person to person, by close contact with bodily secretions of the sick or the dead. These offshoot chains may be more close to the natural history of the disease in nature; that is, the virus enters man from some vector in nature, and causes a small outbreak of disease which, if not amplified by non-sterile techniques in health facilities, ends spontaneously after several generations of disease.

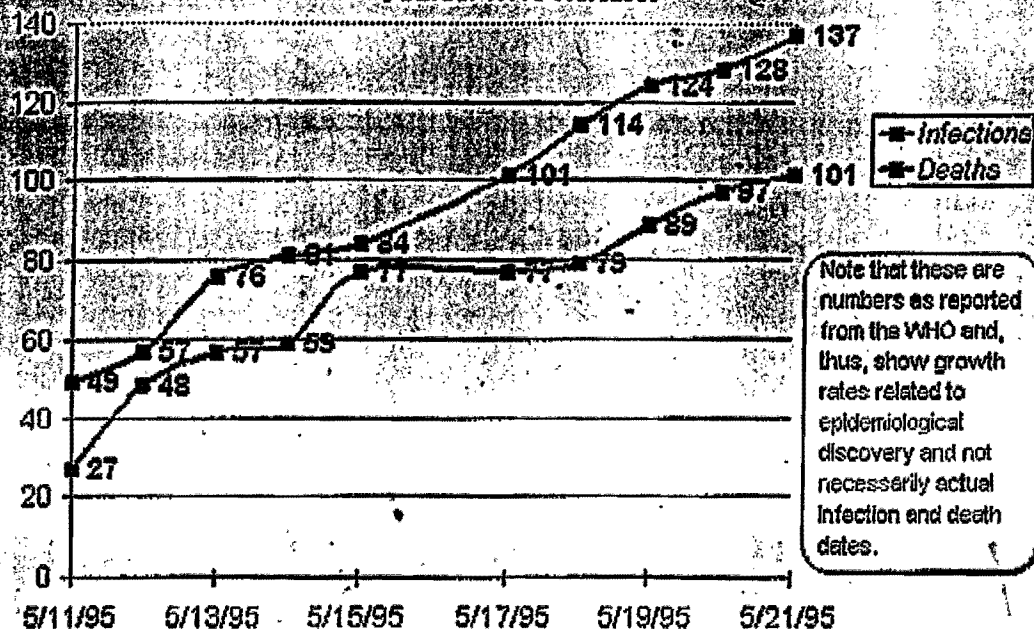
Hypotheses such as this and others will be studied by the International Commission as research activities intensify in an attempt to obtain information necessary to prevent future epidemics.

For further information please contact Thomson Prentice, telephone (41 22) 791 3221, or Philippe Stroot, telephone (41 22) 791 2535, or Valery

Abramov, telephone 791 2543, Health Communications and Public Relations,  
WHO Geneva. Fax (41 22) 791 4858.

# Deaths and Infections from 1995 Ebola Outbreak

Source: WHO Releases



NAMIR Medical Unit		Date of Report	Name of Medical Facility	Name, Rank, Title of Head
GHANBATT		15/05/95	KIBUNGO	DR MASUDI NGENDAHAYO

Location (incl GR)	Distance to airfield or LZ (Km)	Point of Contact
	1.5	

Medical Officers	Specialists	Nurses	Medical Assistants	Other
0	1	14	3	0

Beds and/or Cots (Total)	Cots (Ph No, Freq, Call Sign)
270	

Surgical Beds	Operating Rooms	Operating Teams	Surgical Specialties
42	3	1	ABDOMINAL

ICU/MICU Beds	ICU/MICU Equipment
0	0

Max expansion (for Mass Ca)
270

Medical Capability: Specialties

Isolation Ward
TB AND MEASLES

Laboratory Capabilities
PARASITOLOGY

Blood Bank (screening methods)

X-Ray
SKELETAL (BUT NOT FUNCT)

Dental

Port Med Assets
CHILD WELFARE, VACCINAT

Other Special Capabilities

Veterinarian Service	Request Procedures
0	

RW Act (Capacity and Loc)
0

Rd And (No.)
0



✓ NAMIR Medical Unit      Date of Report      Name of Medical Facility      Name, Rank, Title of Head  
GITARMA      26/04/95      KABGAYI      EVECHE KABGAYI

Location (incl GR)      Distance to airfield or LZ (Km)      Point of Contact  
           BP 66 GITARA

Medical Officers      Specialists      Nurses      Medical Assistants      Other  
4      2      29      9      29

Beds and/or Cots (Total)      Coms (Ph No, Freq, Call Sign)  
360      Ph 62009

Surgical Beds      Operating Rooms      Operating Teams      Surgical Specialties  
69      2      2      GENERAL

ICU/HDC Beds      ICU/HDC Equipment  
0      0

Max expansion (for Mass Ca)  
382

Medical Capability: Specialties  
GYNECOLOGY, SURGERY, P

Isolation Ward  
0

Laboratory Capabilities  
MICROBIOLOGY, PARASITOL

Blood Bank (screening methods)  
YES

X-Ray  
SKELETON, ABDOMINAL & C

Dental  
0

Publ Med Assets  
VACCINATION

Other Special Capabilities  
0

Veterinarian Service  
0

Request Procedures

RW Act (Capacity and Loc)  
0

Rd And (No.)

UNAMIR Medical Unit

Date of Report

Name of Medical Facility

Name, Rank, Title of Head

VENBATT

26/04/95

BUTARE

SOPHIE MAES

Location (incl GR)

Distance to airfield or LZ (Km)

Point of Contact

1

SOPHIE MAES

Medical Officers

Specialists

Nurses

Medical Assistants

Other

0

8

15

0

0

Beds and/or Cots (Total)

Coms (Ph No, Freq, Call Sign)

120

Ph 30511

Surgical Beds

Operating Rooms

Operating Teams

Surgical Specialties

ICU/MHC Beds

ICU/MHC Equipment

10

ALMOST NIL

Max expansion (for Mass Ca)

Medical Capability: Specialties

Isolation Ward

Laboratory Capabilities

PARASITOLOGY

Blood Bank (screening methods)

NIL

X-Ray

NIL

Dental

NIL

Port Med Assets

VACCINATIONS

Other Special Capabilities

NIL

Veterinarian Service

NIL

Request Procedures

RW Act (Capacity and Loc)

0

Rd Amd (No.)

2

UNAMIR Medical Unit

Date of Report

Name of Medical Facility

Name, Rank, Title of Head

RUHENGRI

12/05/95

RUHENGRI

DR MARY SKINNIDER

Location (incl GR)

Distance to airfield or LZ (Km)

Point of Contact

Medical Officers

1

Specialists

2

Nurses

76

Medical Assistants

0

Other

0

Beds and/or Cots (Total)

170

Cable (Ph No, Freq, Call Sign)

Surgical Beds

67

Operating Rooms

3

Operating Teams

1

Surgical Specialties

GENERAL SURGERY

ICU/HDC Beds

10

ICU/HDC Equipment

ASPIRATOR, OXYGEN

Max expansion (for Mass Ca)

230

Medical Capability: Specialties

SURGERY, ANAESTHETICS, G

Isolation Ward

0

Laboratory Capabilities

MICROBIOLOGY, PARASITOL

Blood Bank (screening methods)

HIV RAPID TEST, NO TREMO

X-Ray

SKELETON, ABDO, ULTRAS

Dental

1 DENTIST

Port Med Assets

0

Other Special Capabilities

OPHTHALMOLOGY

Veterinarian Service

0

Request Procedures

RW Act (Capacity and Loc)

Rd And (No.)

3

UN RESTRICTED

LOCATION, LEVEL, CAPABILITIES - level 2 and 3 only

(Report is requested on the first of every month)

saved docs, medical- gitarma

Date of report: 26.4.95

Name of Mission/Medical unit: HOPITAL KABGAYI (MSF - CARITAB)

Change in location, level, capabilities: NO - see former reports

YES - see report below

1. Organisation:

Name, rank, title of header: EVECHE KABGAYI

Location: KABGAYI

Point of contact: B.P. 66 GITARAMA

Phone number: 62009

Other communication system (number, radio frequencies, call sign etc):

Next airfield or helicopter/distance:

2. Personnel: physicians/specialists: 4 AND 2 SPECIALIST - GYNECOLOGUE, CLINISURGEIN

nurses: 29

medics: 9

other: 29 AUXILIAIRES DE SANTE

total: 71

3. Beds and/or cots: Total: 360

surgical: 69

maximum number in case of mass casualty: 382



## UN RESTRICTED

4. Medical capability: specialities: Gynecologie, chirurgie geuerale, pediatric, medicu  
isolation ward: yes
5. Intensive care unit: ICU beds:  
equipment:
6. Surgical capability: specialities: chirsugie generale  
operating rooms: 2  
operating teams: 2
7. Laboratory capabilities: microbiology: yes  
virology: no  
parasitology: yes
8. X-Ray: skeleton: yes  
abdominal: yes  
ultrasound:  
others: chest
9. Blood bank: Screening methods: yes
10. Dental Capability:
11. Other special capabilities:
12. Preventative medicine assests: vaccination
13. Veterinarian service:
14. Medevac capability: ground (number of ambulances):  
air (number of aircraft - capacity and location):  
request procedures incl. phone number or freq:

**UN RESTRICTED**

**LOCATION, LEVEL , CAPABILITIES** - level 2 and 3 only  
(Report is requested on the first of every month)

Date of report: 26 Apr 95

Name of Mission/Medical unit: Senbatt - Butare, Secot 4B

Change in location, level, capabilities: NO - see former reports  
YES - see report below

1. Organisation: Hopital De Kabutare

Name, rank, title of header: Sophie Maes - Coordinatrice Du Programme - MSF

Location: Butare

Point of contact: Sophie Maes or Caroline De Coster (MSF)

Phone number: 30511

Other communication system (number, radio frequencies, call sign etc):

MSF KABUTARE

Next airfield or helicopter/distance: 1 KM

2. Personnel: physicians/specialists: 8 (from MSF, MDM, IRT)

nurses: 15 (MSF,MDM)

medics:

other:

total: 23

3. Beds and/or cots: Total: 120

surgical:

maximum number in case of mass casualty:

**UN RESTRICTED**

senbatt

2000

5500  
5500

KABOITAS

*Journal of Management Education* 30(6)

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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that have resulted in a number of well-known cases of child abuse.

1. 1990年12月25日

• *Verfahren zur Ermittlung des zu bewertenden Vermögens* (Bewertungsverfahren)

$\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

(see page 10 for a complete list of publications with authors cited)

1992-1993

1961 - 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 26

Figure 1. The effect of the concentration of the *Agrobacterium* suspension on the transformation efficiency of *Agrobacterium* strains.

1997 年 10 月 10 日

• 2022

2000

1. *Chlorophyll a* and *Chlorophyll b* were determined by the method of Arar and Collins (1971) using a Shimadzu 1601 UV-Visible Spectrophotometer.

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[illegible]

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Y. 2021



4. Medical capability: specialities:  
isolation ward:
5. Intensive care unit: ICU beds: 10  
equipment: Presque nul (Ambu ...)
6. Surgical capability: specialities: Chirurgien, anesthésiste  
operating rooms: 2  
operating teams: 3 (1 Chirurgien and 1 Anesthésiste par équipe)
7. Laboratory capabilities: microbiology: non  
virology: non  
parasitology: GE NFS
8. X-Ray: skeleton:  
abdominal: NONE  
ultrasound:  
others:
9. Blood bank: Screening methods: Pas de banque de sang
10. Dental Capability: Nul
11. Other special capabilities: non
12. Preventative medicine assests: vaccinations - consultations prenatales
13. Veterinarian service: non
14. Medevac capability: ground (number of ambulances): 2  
air (number of aircraft - capacity and location):  
request procedures incl. phone number or freq:

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APPENDIX 3 TO  
ANNEX ALOCATION, LEVEL, CAPABILITIES - level 2 and 3 only  
(Report is requested on the first of every month)

Date of report: 12/05/1995

Name of Mission/medical unit: White Hopital Giseny.

Change in location, level, capabilities: NO - see former reports  
YES - see report below

## 1 Organization:

Name, rank, title of header:

Location:

Point of contact: D<sup>r</sup> SARAMBUYE

Phone number:

Other communication system (numbers, radio frequencies, call sign  
etc): Local avec ONG

Next airfield or helicopter/distance: nan

2. Personnel: physicians/specialists: 3 Labo - 1 X Ray - 1 nutritioniste

nurses: 38

medics: 4 Gynecologue - 3 Generalistes

other: 40

total:

3. Beds and/or cots: total: 325

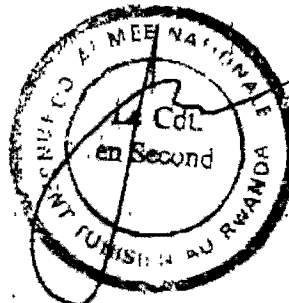
surgical:

maximum number in case of mass casualty: 3000/mois.

4. Medical capability: specialties

isolation ward: isolement de Tuberculeux (28 lits).

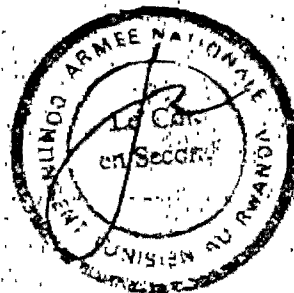
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## UN RESTRICTED

5. Intensive care unit; ICU beds: non  
equipment: non
6. Surgical capability, specialties: 40 lits  
  
operating rooms: 2 Salles + 01 non operationnelle  
operating teams: \_\_\_\_\_
7. Laboratory capabilities microbiology non operationnel  
virology // //  
parasitology // //
8. X RAY. skeleton: oui  
abdominal: oui (sans produit de contraste)  
ultrasound: non  
others: non
9. Blood bank: screening methods: qui n'est pas autonome, le sang est  
fourni par la Croix rouge de Belgique
10. Dental Capability: \_\_\_\_\_
11. Other special capabilities: non
12. Preventative medicine assets: consultation pediatrie et planning familial
13. Veterinarian service: non
14. Medevac capability: ground (number of ambulances): non  
air (number of aircraft - Capacity and Location: non  
request procedures incl. phone number or frequencies: non

UN RESTRICTED



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APPENDIX 3 TO  
ANNEX A

LOCATION, LEVEL, CAPABILITIES - level 2 and 3 only  
(Report is requested on the first of every month)

Date of report: 11 May 95.

Name of Mission/medical unit \_\_\_\_\_

Change in location, level, capabilities: NO - see former reports  
YES - see report below

1 Organization

Name, rank, title of header: Médecin Directeur de l'hôpital de Lourenço

Location: Ruhengezi Interim Directrice de Mary Skinner

Point of contact: Ruhengezi

Phone number: \_\_\_\_\_

Other communication system (numbers, radio frequencies, call sign etc): Codan Radio

Next airfield or helicopter/distance: Dans la parcelle de l'hôpital

2. Personnel: physicians/specialists Chirurgien 1 Anesthésiste 1 Médecin Généraliste 3

nurses: A1 - 5 A2 - 20 A3 - 21, Auxiliaires: 30

medics: \_\_\_\_\_

other: \_\_\_\_\_

total: \_\_\_\_\_

3. Beds and/or cots: total: 170 lits

surgical: 67

maximum number in case of mass casualty: 230

4. Medical capability: specialties ~~1~~ Surgeon 1

Anesthésiste 1, Généraliste 3

isolation ward: \_\_\_\_\_

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5. Intensive care unit: ICU beds: 10  
equipment: aspirators, oxygen
6. Surgical capability: specialities: generalist surgeon  
operating rooms: 3  
operating teams: 1
7. Laboratory capabilities microbiology: Gram stain  
virology: Ø  
parasitology: Malaria, borboli & stool
8. X-RAY skeleton: ✓  
abdominal: ✓  
ultrasound: one echo machine, non functioning well  
others:
9. Blood bank: screening methods: HIV rapid test  
No laser transfusion service - get blood from Belg Red Cross in Kigali
10. Dental Capability: 1 dentist
11. Other special capabilities: Ophthalmologie infirmier AA
12. Preventative medicine assets:
13. Veterinarian service:
14. Medevac capability: ground (number of ambulances): 1 ambulance + 3 clinics  
air (number of aircraft - Capacity and Location:   
request procedures incl. phone number or frequencies:

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# VISIT REPORT

## GENERAL

- PURPOSE OF VISIT
- DATES
- TM
- LOC VISITED.

## AUHENGERI Hosp. HOLLAND.

- MSF STAFF - LENGTH OF ASSIGNMENT - MINISTRY FOR HLTH.
- DISCUSSIONS/COOPERATIVE.
- LIKE TO VISIT TUNBATT / WELCOME VISIT BY FMO  
VISIT WITH FMO TO TUNBATT.
- Hosp FACILITIES
  - GEN DESCRIPTION
  - BEDS
  - SURGICAL CAPABILITY.
  - GD MO'S - STAFF. RADIOLOGY 2 ROOMS
  - LX
  - ANEUSH, SCANNIC LABS.
  - POE - THROUGH MSF.

## GISENYI Hosp.

- GED - NONE AVAILABLE.
- TOUR CONDUCTED IN COMPANY WITH TUNBATT MO. - WRITTEN CAPABILITY DATA TO FOLLOW.
- Hosp FAC.
  - GEN DESCRIPTION
  - BEDS
  - SURGICAL CAPABILITY - RADIOLOGY. 2 ROOMS - MANUAL PROCESSING
  - GD MO'S / STAFF.
  - LX - NONE SCANNING LABS
  - AMBU/SH - UNKNOWN.
  - POE SUGGEST MOTUNBATT LIAISE, IN ABSENCE OF RESIDENT MGO.

## TUNBATT.

- CAP'S VISITED - GISENYI - Coy 2 (Not Buzogo) MUTURA.
- RAP / HOLDING BAY
- STAFF MET MO, NURSE / LAB TECH / PHYSIC / DENTIST.
- ACCN
- FOOD STORAGE / PREPARATION AREA.
- PROBLEMS
  - LATRINES / SHOWERS
  - ACCN FOR SOLDIERS - (AT MUTURA - NO FLOOR TENTS PITCHED ON DIRT / GRAVEL.
  - (FROM ROOM)

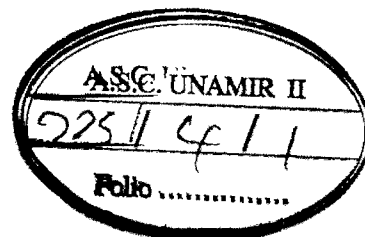
## GISENYI JAIL

## CONCLUSION

## RECOMMENDATIONS

- VISIT BY FMO - (CCP) MAT TO GISENYI HOSP.
- GISENYI JAIL - LIAISON BETWEEN MGO'S & TUNBATT.
- VISIT BY ROAD - MOBILITY
- FLEXIBILITY
- TAKE ALL DAY
- SUITABILITY OF HOPS - ROOM FOR EXPANSION
- IMPORTANCE OF FACE TO FACE DISCUSSIONS - CONTACTS FORMED
- SEEING FACILITIES FIRST HAND
- VISIT BY FMO IN NEAR FUTURE.

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UNAMIR

INTER-OFFICE-MEMORANDUM

TO : UNAMIR HQ MEDICAL BRANCH  
FMO

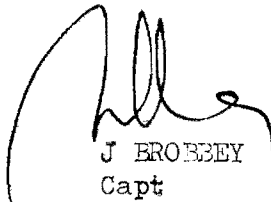
FROM : GHANBATT (RAP)

GH2/RAP/02/A

DATE : 15 MAY 95

SUBJECT : MEDICAL REPORT

1. Attached, please find APPENDIX III TO ANNEX 'A' duly completed for your necessary action.
2. Please accept for action.

  
J BROBBEEY  
Capt  
SMO-GHANBATT

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APPENDIX III TO  
ANNEX A

LOCATION, LEVEL, CAPABILITIES - level 2 and 3 only  
(Report is requested on the first of every month)

Date of report: 15 - 5 - 95

Name of Mission/medical unit UNAMIR GHANBATT 2 RAP

Change in location, level, capabilities:  
NO - see former report  
YES - see report below

1. Organization:

Name, rank, title of header DR MASUDI NGENDAHAYO

Location: KIBUNGO

Point of contact: KIBUNGO HOSPITAL

Phone number: NO

Other communication system (numbers, radio frequencies, call sign etc):

NIL

Next airfield or helicopter/distance: 1.5 KM

2. Personnel:

physicians/specialists: SURGICAL SPECIALIST (1)

nurses: 14

medics: 3

other: NO

total: 18

3. Beds and/or cots: total: 270 BEDS

surgical: 42 BEDS

maximum number in case of mass casualty: 270 BEDS

A-III-1/2

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APPENDIX III TO  
ANNEX A

4. Medical capability: specialities \_\_\_\_\_  
isolation ward: FOR TB AND MEASLES \_\_\_\_\_
5. Intensive care unit: ICU beds: NO \_\_\_\_\_  
equipment: NO \_\_\_\_\_
6. Surgical capability: specialities: ABDOMINAL \_\_\_\_\_  
operating rooms: 3 ROOMS \_\_\_\_\_  
operating teams: 1 TEAM \_\_\_\_\_
7. Laboratory capabilities: microbiology: \_\_\_\_\_  
virology: NO \_\_\_\_\_  
parasitology: YES \_\_\_\_\_
8. X-RAY: skeleton: YES BUT NOT FUNCTIONAL \_\_\_\_\_  
abdominal: \_\_\_\_\_  
ultrasound: NO \_\_\_\_\_  
others: NO \_\_\_\_\_
9. Blood bank: screening methods: NO \_\_\_\_\_
10. Dental Capability: NO \_\_\_\_\_
11. Other special capabilities: NO \_\_\_\_\_
12. Preventative medicine assets: CHILD WELFARE, VACCINATIONS \_\_\_\_\_
13. Veterinarian service: NO \_\_\_\_\_
14. Medevac capability:  
ground: (number of ambulances): NO \_\_\_\_\_  
air: (number of aircraft (Capacity and location) \_\_\_\_\_  
request procedures incl. phone number or frequencies: \_\_\_\_\_  
NO \_\_\_\_\_

A-III-2/2

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+6123601524

LHQ JOINT OPS ROOM

F-281 T-251 P-001

MAY 19 '95 16:28



SURGEON GENERAL  
AUSTRALIAN DEFENCE FORCE

Headquarters Australian Defence Force  
Department of Defence  
CANBERRA AOT 2800

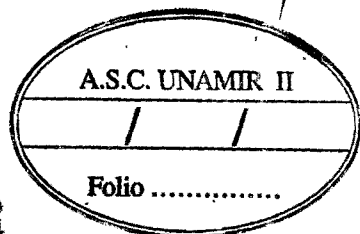
21606/9

195-005

#16

007/19

19/5  
G3 Med  
G4



## FACSIMILE MESSAGE / COVER

Classification: UNCLASSIFIED		Message Number: DHPI 3513/95	
Precedence PRIORITY			
Facsimile Addressee:  MAJOR HOLMES LHQ For TRANSMISSION TO COLWARFE ASO UNAMIR II		Facsimile Originator:  GPCAPT W.K. HARREX Director Health Planning and Intelligence CP4-6-19 CAMPBELL PARK OFFICES CANBERRA ACT	
Facsimile Number (02) 399 3556		Facsimile Number 06-2663933	
Telephone Number		Telephone Number 06-2663814	
Subject Title: HEALTH INFORMATION - EBOLA VIRUS			
Facsimile Reference 95/13703	Date 19 May 95	Number of Pages 10	
Releasing Officer Sign J Thomas	Printed Name: J.L. THOMAS	Rank/Appointment LEUT A/SOI HI	

Instructions/ Comments

Sir,

Further to our message of 17May95, enclosed is some additional information on the current Ebola virus epidemic. Most of this information has been gained from the Internet and AAP.

Best wishes

Jan

Forwarded for your information  
UPDATES at [unclear]

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- The strain is the same as the '76 outbreak. *go 12/5*
- At this stage there are no changes to Australian Quarantine procedures. *go 14/5*

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**EBOLA - ZAIRE: UPDATE**

As of 19:45 hours EST the latest update on the WHO Website was dated 15 May, but newswires quote WHO as saying today, 16 March (Presumably this should read 16 May - BH), that the total is now 93 cases with 86 deaths; 4 patients including a doctor are recovering; 5 towns infected (Kikwit, Misango, Vanga, Yassa Bonga & Kenge) but most cases are in Kikwit; no confirmed cases in Kinshasa; the riverboat captain who had sailed from Kikwit & been treated for bloody diarrhea in Kinshasa, then mistakenly discharged, has been found and tests negative; the nurse who fled to Kinshasa from Kikwit hospital has been found and quarantined pending tests.

WHO is also quoted as saying that the number of cases has quadrupled every 10-12 days over the past 3 weeks, and the number of cases can be expected to continue to rise as people incubating the disease fall ill.

Newswires report that Angola, Central African Republic and Sudan have started border checks on people coming from Zaire (Uganda, Rwanda, Burundi, Tanzania, & Zambia also share borders with Zaire, and only the Congo River separates it from the Congo, capital Brazzaville, a short ferry-ride away - Moderator), and that Belgium, France, Egypt, Philippines, South Africa, South Korea, Turkey, United Arab Republic and Yemen are screening travellers from Zaire and in some cases from other African countries.

.....  
Jack Woodall, PROMED Moderator, woodall@wadsworth.org  
.....

Re: EBOLA - WEBSITES: MORE

In the meantime try:

<http://ichiban.objarts.com/ebola/ebola.html>

David J. Sencer  
djud@mindspring

1097 Mason Woods Dr.  
Atlanta, GA 303290

Teams of health workers are fanning out to villages and towns within 150 km radius of Kikwit investigating reports that people in outlying areas have also died from Ebola virus.

NB:

19 May:

WHO figures = 114 cases  
79 deaths

J. Thomas

WHO acknowledged that authorities it had not been notified of

*unsubstantiated report*

1.00 19 May 95 00:03 a0135

AFR: THOUSANDS STRANDED IN ZAIRE BY EB

Title: AFR: THOUSANDS STRANDED IN ZAIRE BY EBOLA QUARANTINE

Source: AAP Date: 19 May 95 00:03:2

Source = AAPSequence No. = a0135Received : 19 May 95 00:03:29  
r 1. bc-ZAIRE-VIRUS-ECONOMY 19-05-95 0591

AFR: THOUSANDS STRANDED IN ZAIRE BY EBOLA QUARANTINE  
ZAIRE VIRUS ECONOMY

By Matthew Tostevin of Reuters

MONGATA, Zaire, May 18 Reuter - Hundreds of trucks and thousands of people were trapped at a roadblock on Zaire's main highway today because of quarantine measures to keep the Ebola virus away from the capital Kinshasa.

Most of the people stranded in Mongata, about 150 km from Kinshasa are fugitives from the epidemic, which is centred on Kikwit, in western Bundundu province. Many are also traders taking foodstuffs to Kinshasa.

They are terrified of returning to Bundundu where Ebola has killed at least 79 people and is spreading further into the population. The authorities won't let them into Kinshasa either.

Regional governor Payanzo Nsoso told Reuters the quarantine was disrupting the region's economy, including diamond mining.

"The effects are very bad. Local airlines serving the area told me they were going to close because they are not allowed to fly passengers between Kinshasa and Bundundu province," he said.

"I have been telling them to be patient. The biggest problem is the mines where workers depend on private aircraft for their supplies. These have been grounded by the order," he said.

"Everything is transported to the mines by plane, including spare parts and food for survival. Some foreign workers have asked to be evacuated," Payanzo said.

Mongata, which has become the focus of the measures, is a small stopping point for trucks ferrying agricultural produce out of Zaire's bread basket, which supplies the capital with up to 50 per cent of food needs. More than 2,000 people are stranded there without water or food.

"We have to revise the quarantine. We are ready to enforce the quarantine (where necessary) but the epidemic is not everywhere," Payanzo said. "Now we can have other people dying. We shouldn't let those who are alive die."

The quarantine first announced by Kinshasa governor Bernadin Mungul Diaka initially applied to travel to and from the area around Kikwit, which is 500 km from Kinshasa.

Central authorities, stepping up measures as the disease spread to towns on the highway down to the teeming capital of five million people, extended it to the whole of Bundundu.

That theoretically cut off a swath of territory stretching to the Angolan border where diamond mines are concentrated around the towns of Tembo and Kahamba, which received up to 10 flights daily before the quarantine.

The virus is passed on through contact with blood or bodily fluids and kills by causing uncontrollable bleeding.

The World Health Organisation (WHO), at the centre of efforts to contain the lethal virus, has joined in growing criticism of the

quarantine as a means of shielding Kinshasa.

"It is ridiculous. Where are the facilities to put 3,000 people in quarantine?" asked WHO regional director Dao Barakamfitiye. "There is nowhere the quarantine has worked and we at WHO don't recommend that," he told Reuters in Kikwit.

"It's the same thing when we have epidemics of cholera or meningitis. Some countries have tried to take such measures but it is always useless. The best measure is to inform the population on what to do when there is an epidemic."

There have been widespread reports confirmed by authorities that soldiers supposed to enforce the blockade are taking bribes to let people slip through the restriction zone.

Kinshasa's Mungul confirmed the quarantine was causing problems and said he was convening an inter-ministerial meeting to decide what to do. Payanzo is due to visit Mongata tomorrow.

REUTER jnb/de

19-05 0004



Press Release WHO/32 17 May 1995

## EBOLA HAEMORRHAGIC FEVER: ADVICE TO TRAVELLERS

In the wake of the universal media coverage, the current outbreak of the Ebola haemorrhagic fever in south-western Zaïre is raising questions of travellers' safety. Given the unlikelihood of any patient with Ebola haemorrhagic fever travelling from the country, the World Health Organization (WHO) does not recommend that any special measures be instituted with respect to aircraft or the general travelling public arriving from Zaïre.

A very small number of individuals (principally health care workers and journalists) will be returning to their home countries after having been in known contact with Ebola patients in Zaïre. Unless these passengers are obviously ill, no travel restrictions are required, but such persons are advised to inform health/quarantine officials at their destination of their exposure history and where they may be contacted during the incubation period of the disease. If they fall ill during this period, they should seek immediate care and notify the health/quarantine authorities of this fact.

Other passengers leaving Zaïre are advised to notify a doctor immediately if an illness develops during a period of three weeks from the departure date. In particular, any fever should be reported at once and the physician informed that the patient has travelled from Zaïre. The incubation period for Ebola haemorrhagic fever is up to 21 days. Persons with Ebola become infectious for others only when they are extremely ill and are already haemorrhaging (bleeding). It is highly unlikely that such persons would try to travel on an international flight, and unlikely that they would be permitted to board if they did try. If on board, they would represent a hazard to members of the crew and any passengers who had direct contact with the patient's blood. Such passengers should be placed as far as is practical from other passengers and crew. Aircrews, as a routine, should advise ground staff at their destination if they have severely ill passengers on board. Health and/or quarantine authorities should arrange for the isolation of these passengers for initial clinical screening for Ebola. Passengers and crew who had close prolonged contact with the patient (e.g. passengers sitting in an adjoining seat but not across the aisle or in front or behind unless specific contact occurred, or crew providing care) should be advised of the hazard and, on arrival, be placed under surveillance (e.g. active contact maintained by telephone or visit). Others in the aircraft should be advised of the hazard and told to contact a physician if they become ill.

## History of Ebola Outbreaks

This table shows information about previous outbreaks of Ebola.

Year	Strain	Cases (% Fatalities)	Comments
1976	Zaire	85 (100%) injection 149 (89%) contact 43 (91%) injection/contact	Index case apparently introduced disease into Yambuku Hospital in Zaire. Secondary transmission occurred by injection from unsterilized equipment and contact with sick people.
1976	Sudan	280 (53%)	An independent epidemic from that in Zaire arose in Nzara, Sudan, with a distinct Ebola strain. Earliest cases were traced to cotton factory in Nzara. Transmission was both nosocomial and by contact in homes. Spread to adjacent towns, including Maridi, Sudan
1977	Zaire	1 (100%)	Child in Tandala, Zaire, died with hemorrhagic fever
1979	Sudan	34 (65%)	Recurrent disease in Nzara, Sudan; the index case worked in the same room in textile factory identified in 1976 epidemic
1989	Reston	4 (0%)	Reston, Virginia: infected cynomolgus macaques imported from Philippines. Subsequent studies established Asian origin of virus. All 4 documented infections of man were subclinical

Ebola Information excerpted from C.J. Peters, et al (1993). *Emerging Viruses*, p. 161, edited by Stephen S. Morse. Oxford Univ. Press

## Nurse from Zaire virus zone found, death toll up

(c) Copyright the News & Observer Publishing Co.

### Reuters

KINSHASA, Zaire - A nurse from Zaire's Ebola virus zone who slipped out of quarantine in Kinshasa and disappeared among the capital's five million people, raising fears of a further spread of the deadly disease, has been found.

Health officials said Tuesday said they would check if she had the disease.

The officials told a daily news briefing that 86 of the 93 people reported with the deadly and incurable disease had now died. No cases have been reported in the capital Kinshasa.

Outside the sprawling central African country, more governments started screening or monitoring passengers arriving from Zaire or elsewhere in Africa to ensure they were not carrying what is one of the most lethal diseases known to man.

"We have just found where she is," Bompanda Bonkumo, head of a national committee tracking the progress of the disease, said of the nurse. Officials had the necessary equipment to find out whether she had the disease, he said. "We will be able to advise on her state of health tomorrow."

A riverboat captain, also placed in isolation in Kinshasa after arriving from Kikwit, had been given a clean bill of health, health officials said.

A statement from the committee said that 93 cases had been registered by Tuesday, of whom 72 had died in hospitals and 14 outside of hospitals. Most cases were in the town of Kikwit, 310 miles from Kinshasa.

Diplomats said the ambassadors of Belgium and the United States were due to visit Kikwit Wednesday with the Zairean health minister.

Kinshasa Gov. Bernadin Mungul Diaka said earlier the nurse had absconded from the university health center.

The virus, for which there is no vaccine or cure, is spread through contact with blood or bodily fluids and kills by causing uncontrollable bleeding.

Authorities in Kinshasa have tightened roadblocks on highways from the outbreak zone and issued leaflets and graphic posters telling members of the public not to touch corpses or open wounds.

The committee tracking the epidemic -- which broke out in Kikwit in April and has spread to at least four neighboring towns -- had asked for quarantine for 25 foreign journalists who visited Kikwit Sunday but no action has so far been taken.

Countries as far away as the Philippines, Turkey, the United Arab Emirates and Yemen started monitoring certain plane passengers, following steps taken by Egypt and Zaire's former colonial ruler Belgium.

Angola partly closed the border with its northern oil-rich Cabinda enclave. Other neighbors, Sudan and the Central African Republic tightened border checks and South Africa began monitoring travelers from Zaire.

An expatriate family working for a mining firm close to the Angolan border was evacuated to Kinshasa and sent straight into quarantine in a city clinic.

In a sign of hope, the World Health Organization said four victims in Kikwit were convalescing and one, a doctor, had recovered and left the hospital.

# Ebola FAQ: Frequently Asked Questions

Compiled by David Ornstein and Kai Matthews

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Please send your favorite *Frequently Asked Question* to us. Send the answer, too, if you can. Don't forget the references when possible.

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This page is an ongoing attempt to fill in the blanks for those who may be coming across this Ebola site with little or no previous general knowledge of Ebola. This page is specifically not designed to be a complete collection of information about Ebola; it serves as an introduction to the subject.

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## A Note about Scientific Precision

There are some places in this FAQ which give only the basic answer to the question. This is not an attempt to exclude information, but an attempt to give a concise answer. The difference between 99% and 100% accuracy is often somewhere between multiple paragraphs and an advanced degree in virology (which I don't have, by the way). If you want the complete answer, study the subject in depth.

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- What exactly is Ebola?
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- 

### What exactly is Ebola?

Ebola (ee-BOH-luh) is a virus named after a river in Zaire, its first site of discovery. A usually fatal filovirus which affects monkeys and humans, it's a kind of *hemorrhagic fever* — there are others. Filoviruses are string-shaped, often with a little hook or loop at one end. Another, *somewhat* less deadly filovirus is the Marburg virus.

### What varieties are known to exist?

Ebola Sudan (EBOS), Ebola Zaire (EBOZ), and Ebola Reston (EBOR).

It is somewhat unclear to researchers to what extent EBOS, EBOZ and EBOR are really three different viruses. See C.J. Peters, et al (1993). *Emerging Viruses*, p. 163, edited by Stephen S. Morse. Oxford Univ. Press.

### How do these varieties differ?

Clinically, they all produce similar effects. Ebola Sudan and Ebola Zaire affect humans as well as monkeys; Ebola Reston harms monkeys, but not humans. (The Ebola Reston incident is the main subject of Richard Preston's book *The Hot Zone*.) We are all very lucky that humans seem to be asymptomatic in response to Reston, since there were indications at the time of the incident that it was airborne, unlike (apparently) the other two.

How long is the incubation period/onset of symptoms?  
Anywhere from 4 days to a couple of weeks.

What are the symptoms?

Quoting the CDC:

All forms of viral hemorrhagic fever begin with fever and muscle aches. Depending on the particular virus, the disease can progress until the patient becomes very ill with respiratory problems, severe bleeding, kidney problems, and shock. The severity of viral hemorrhagic fever can range from a relatively mild illness to death.

EBFZ seems to be fatal in about 90% of the cases. EBOZ is fatal in about 60%. EBOR is not fatal to humans.

Is there any cure or vaccine?

No.

How does it damage (and usually kill) its victims?

By slowly dissolving their organs, blood cells and connective tissue, causing massive and usually fatal internal hemorrhaging.

How is it transmitted?

Ebola virus is spread through close personal contact with a person who is very ill with the disease. In previous outbreaks, person-to-person spread frequently occurred among hospital care workers or family members who were caring for an ill person infected with Ebola virus. Transmission of the virus has also occurred as a result of hypodermic needles being reused in the treatment of patients. Reusing needles is a common practice in developing countries, such as Zaire and Sudan, where the health care system is underfinanced. Medical facilities in the United States do not reuse needles. Ebola virus can also be spread from person to person through sexual contact. Close personal contact with persons who are infected but show no signs of active disease is very unlikely to result in infection. Patients who have recovered from an illness caused by Ebola virus do not pose a serious risk for spreading the infection. However, the virus may be present in the genital secretions of such persons for a brief period after their recovery, and therefore it is possible they can spread the virus through sexual contact.

Ref: CDC

Is Ebola airborne?

The Zaire and Sudan strains are not airborne. The Reston strain appears to have been transmittable by airborne means, but that strain is not harmful to humans.

Geographically, where does Ebola come from?

The Sudan and Zaire strains may come from the rainforests of northeastern Zaire and/or somewhere nearby in the bordering nations of Sudan, Uganda, and Kenya. The Marburg filovirus was circumstantially linked to the Mt. Elgon region near the Kenya-Uganda border. The Reston variety occurred in monkeys imported from the Philippines, so there may be reservoirs in Asia as well. Preston speculates that an Ebola strain may have been introduced into the Philippines from Africa by the rumored illegal importing of African game animals to remote areas of the Philippines by rich Filipino "sportsmen".

What is the natural reservoir for Ebola?

Attempts to find the source of the Ebola virus have been unsuccessful despite collection and analysis of ecologic samples from bats, monkeys, spiders and ticks. This question is currently the subject of ongoing speculation. See, for example, discussions going on in the [bionet.virology](#) USENET news group.

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Brought to you by David Ornstein - [davido@apocalypse.org](mailto:davido@apocalypse.org)

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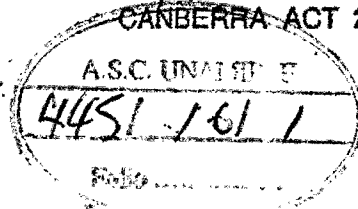
Please initial and date when action complete then pass quickly.

MR. DESSARDE  
Chief of Police (SASG office)  
Now attending parade  
1300 20/5



SURGEON GENERAL  
AUSTRALIAN DEFENCE FORCE

Headquarters Australian Defence Force  
Department of Defence  
CANBERRA ACT 2600



Classification:  
**UNCLASSIFIED**

Message Number: 3509/95

Precedence  
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Facsimile Addressee:

COL P.G. WARFE  
COMASC UNAMIR II

Facsimile Number

Telephone Number

Facsimile Originator:

GPCAPT W.K. HARREX  
Director Health Planning and  
Intelligence  
CP4-6-19  
CAMPBELL PARK OFFICES  
CANBERRA ACT

Facsimile Number 06-2663933

Telephone Number 06-2663814

Subject Title:

HEALTH INFORMATION - EBOLA VIRUS

Facsimile Reference

Date 17/5/95

Number of Pages 17

Releasing Officer Sign

Printed Name:  
W.K. HARREX

Rank/Appointment  
GPCAPT DHPI

Instructions/ Comments

Peter,

Further to our message of 15May95, enclosed is some additional information on the current Ebola virus epidemic. Most of this information has been gained from the Internet.

We are most appreciative of your collective efforts to keep us informed.

Best wishes

Warren

com sent to  
COMASC  
JP  
17/5

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# Ebola Chronology

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*Here's a chronology of events related to the new outbreak of Ebola in Zaire. The most recent events are listed first.*

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Kikwit (5/16): First case was in March

The WHO corrects previous reports that Kimfumu, a 36-year-old laboratory assistant, was the first patient in the current outbreak. The WHO now says that another, unnamed man was admitted to a hospital in Kikwit where he infected Kimfumu, a second laboratory assistant and one nurse. Ref: The Electronic Telegraph (free, but requires registration)

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Kikwit (5/15): Authorities search for two who may have brought Ebola to Kinshasa  
A manhunt begins for two people, a riverboat captain and a nurse, who may have brought Ebola to Kinshasa. The boat captain was treated in Kinshasa for Ebola-like symptoms and released before doctors realized that the symptoms might be a sign of Ebola. The nurse, who may have been in contact with infected people in Kikwit, is somewhere in Kinshasa. Neither has been tested for Ebola. Additionally: "WHO experts expect a significant increase in cases during the next two to three weeks among people who are incubating the disease having been exposed to it in the care of relatives or neighbors," said WHO spokesman Richard Leclair. Ref: The Nando Times (this is a questionable link)

---

Geneva (5/15 1:47pm): WHO is cautious

WHO reports that they won't consider the outbreak over until six weeks after the last case is found. Also, it's reported that "According to local custom, family members evacuate the bowels of the dead by hand before burial, a practice that almost guarantees transmission of the virus." Ref: The Nando Times

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Kinshasa (5/15 1:55pm): Zaire wants journalists quarantined

Zaire's Health Ministry orders journalists who visited Kikwit to report for quarantine. The secretary-general at the ministry says: "I want to point out this is not an arrest. They have to go to the clinic for the next 28 days." Ref: The Nando Times

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Kinshasa (5/15): AP reports roads open, quarantine not holding

AP reports that "Despite government statements to the contrary, roads between Kikwit and the capital remained open Saturday..." The story also says that France will require all passengers arriving from Zaire to have medical checkups. Ref: AP

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Geneva (5/14): WHO issues update (press release claims 5/13/95)

WHO issues a press release on a few more deaths and the status of new cases. Ref: WHO

---

Kinshasa (5/14): Bodies being abandoned

Because of fear, families abandon bodies of their dead instead of burying them. Reports of 30 unburied victims have been received. According to Zaire's top virologist, "It's not culturally possible to burn the bodies." Ref: The Nando Times

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Kinshasa (5/14): Kinshasa medical facilities unprepared for Ebola arrival

A hospital in Kinshasa is described. It's very unprepared if Ebola does arrive in Kinshasa: patients treating themselves, overflowing garbage in front of the hospital, three patients per bed, etc. Ref: The Nando Times

---

**Kinshasa (5/14): Patient zero contracted Ebola in Angola**

The first victim of the current outbreak is reported to have become ill during a diamond mining trip across the border into Angola. Reports suggest that he may have contracted the disease from someone who ate smoked monkey. Ref: [The Electronic Telegraph](#) (free, but requires registration)

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**Kinshasa (5/14): Kinshasa strengthens its defenses**

Roadblocks are reinforced and hospitals are put on alert as Ebola moves closer to the capital. [Image Not Loaded] Soldiers have been taking bribes to allow people to violate roadblocks. Ref: [The Nando Times](#)

---

**Khartoum, Sudan (5/14): Sudan tightens borders to avoid Ebola spread**

The Sudanese government institutes a mandatory quarantine for all visitors coming into the country from Zaire. Ref: [The Nando Times](#)

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**Geneva (5/14 2:25pm): WHO reports that Ebola strain is unchanged**

The WHO reports that the strain of Ebola in the current outbreak is the same strain that was involved in two previous outbreaks in Zaire in the 1970s. Ref: [The Nando Times](#)

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**Kinshasa (5/14): Journalists held and then released**

Troops block departure of foreign journalists after their visit to Kikwit. Intervention by the capital's governor enables them to leave. Ref: [The Nando Times](#)

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**Rome (5/14, 12:20pm): Two more nuns die**

Ebola kills two more nuns in Kikwit. Ref: [The Nando Times](#)

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**Kikwit (5/14): Experts claim that virus is starting to come under control**

Zaire's top virologist claims that things are coming under control in Kikwit. He also says that 70% of the deaths have been among health workers. A fifth Italian nun dies of Ebola. Ref: [The Nando Times](#) (this is a questionable link)

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**Kinshasa (5/13 2:13 p.m.): Ebola death in Kenge, 105 miles (170km) from Kinshasa**

Three cases of Ebola are confirmed in Kenge, a town located halfway between the initial outbreak site in Kikwit and the capital of Zaire, Kinshasa. One victim dead. Ref: [The Nando Times](#)

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**Nairobi (5/13 7 a.m.): Kenya and Tanzania on alert against Ebola virus**

Kenya and Tanzania are on the alert for Ebola-infected travellers arriving from Zaire. Ref: [The Nando Times](#)

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**Cairo (5/13 7:40 a.m.): Egypt tightens measures for fear of killer virus**

Egypt increases precautions at its airport in an effort to keep the virus out. Ref: [The Nando Times](#)

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**Kikwit, Zaire (5/12 3:37 EDT): Sneaking into the hospital. A third site?**

AP reporter *KARIN DAVIES* provides a description of the struggle on the ground in Kikwit. People reported sneaking into the unguarded hospital in Kikwit. Authorities attempt to determine if the disease has spread to a third village, Kenge, halfway to Kinshasa (the capital). Ref: [AP](#) - This link has expired

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Kinshasa, Zaire (5/12 12:21): Officials in Zaire take steps to prevent further spread  
AP reports that officials in "the city stricken by the virus" (is this Kikwit or Kinshasa or somewhere else? - ed) have "closed schools and clinics" and "canceled airline flights and ordered people to stay off the streets." Ref: AP - This link has expired

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Kikwit (5/12/95): Fear is everywhere in Kikwit  
Reporters start to arrive in Kikwit. People there are very, very scared. Reports of elbow-shaking (!) Ref: The Nando Times

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Altanta (5/12/95): CDC Issues Advisory Memo  
The CDC issues a general advisory memo about the outbreak in Zaire. Ref: CDC

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Geneva (5/12/95): WHO reports that Swiss researcher survived Ebola infection  
A Swiss researcher who became infected with Ebola in Ivory Coast at the end of last year apparently recovered. The exact reason for her survival is not known, but it may be related to a discovery of Ebola antibodies in her blood stream. Ref: The Nando Times

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New York (5/12/95): Leading experts expect Ebola to stay away from U.S.  
An expert on Ebola and U.S. government officials said that they don't expect the disease to travel to the U.S. Ref: The Nando Times

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Geneva (5/12/95): WHO recommends *against* quarantine  
The WHO issues a daily report that recommends against severe quarantine measures. The statement says that because close contact is required to transmit the disease, they don't believe that screening of, for example, airline flights arriving from the region is needed. They recommend this only for situations where a passenger is clearly sick. Ref: WHO

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Kinshasa (5/12/95): Virus spreads to third town in Zaire  
Ebola surfaces in a third town in Zaire - Yassa Bonga, 250 km (160 miles) from Kikwit. Ref: Reuters

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Belgium (5/11/95): Belgium careful about plane travelers  
Belgium is taking steps to ensure that passengers arriving by plane from Zaire (a former Belgium colony) don't bring Ebola with them. Ref: The Nando Times

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Washington (5/11/95): U.S. sends body bags and medical supplies  
The U.S. military sends a cargo plane (C-141) from Andrews Air Force Base carrying medical supplies to Zaire. According to the defense department, the shipment included: approximately 2,000 caps, 4,000 examination gloves, 2,100 disposable boots, 200 units of plasma and 2,000 disposable gowns. Ref: The Nando Times

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Bergeamo, Italy (5/11/95): Sisters of suspected Ebola victim in isolation in Italy  
Two sisters of suspected Ebola victim Flora Rondi are in isolation at Maggiore Hospital in Bergeamo, Italy on Thursday. Ref: CNN Newssource

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Holland (5/11/95): Dutch TV reports quarantine in Belgium  
*Transcript from RTL-4 Dutch TV station:* In the Masengo hospital an Italian nun died of Ebola, after possibly being infected in Kikwit. *Follow up from Dutch TV:* The nun who has died was apparently buried by relatives or friends from Belgium. These people travelled back to Belgium shortly thereafter and were placed in quarantine there.

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**Musango (5/11/95): Second city infections reported**

The relief organization Doctors Without Borders said yesterday that a team of their physicians had identified a second Ebola-like outbreak in the town of Musango, located between Zaire's capital, Kinshasa, and Kikwit, where the initial cases were reported. One of the ill nuns was transferred to Musango. According to Doctors Without Borders, at least 10 more people have contracted the disease in the hospital that received the ailing nun. The full story is [here](#).

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**ATLANTA (5/11/95 10:05 a.m.): Ebola confirmed**

The CDC has confirmed that the outbreak is, in fact, the Ebola virus. "Of the 22 samples we received from 16 people who either became ill or died, samples from 14 people tested positive for the presence of Ebola," said Bob Howard, a CDC spokesman. *Ref: The Nando Times*

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**New York/Zaire (5/10/95): Infected nuns went to another city**

According to an article by Lawrence K. Altman in the *New York Times* 5/10/95: "Dr James W. LeDuc, an expert in hemorrhagic fevers at the World Health Organization, said in an interview that his agency had received word on Sunday from its regional office in Brazzaville, Congo, that at least 72 people were infected and 56 had died.....There was an unconfirmed report that the outbreak may involve two sites. One of the Italian nuns apparently went to another, unidentified city for medical care, where she died. Her doctor is now reported to be ill with a similar disease, Dr Le Duc said."

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**Zaire (05-10-95, 4:46 PM): First case appeared March 27**

Reuters reports that the top civil servant in Zaire's health ministry told state television today that the first cases of the virus appeared on March 27.

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**Geneva (5/10/95 9:36 a.m.): WHO says world safe from Zaire deadly fever-virus**

WHO officials sought to play down fears that the fever -- compared in reports with a panic virus scenario in a current U.S. thriller film "Outbreak" -- might spread outside the central African state. [Here](#) is the full story.

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**Altanta (5/9/95): Blood samples arrive at CDC for analysis**

According to an article by Lawrence K. Altman in the *New York Times* 5/10/95: "More than a dozen blood samples from victims in Zaire arrived yesterday at the Centers for Disease Control [& Prevention], where scientists began testing for a wide variety of infectious agents."

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**Kitwit (5/9/95): Kitwit quarantined**

The army places the city of Kikwit Zaire (pop. 600,000) under quarantine

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**Washington (5/8/95): Travel Advisory Issued**

U.S. State Department issues [travel advisory](#)

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**[Image Not Loaded] Geneva/Zaire (5/7/95): Zaire tells WHO of outbreak**

As of Sunday, Zaire told the World Health Organization that it had 172 cases of the disease in Kikwit, a city of 600,000 that is about 250 miles from the Zairian capital of Kinshasa. Among the ailing are 24 health care workers, including four Italian nurse-nuns. Reports from Kinshasa to the World Health Organization suggest that two of the nuns may have died. Officials at Zaire's health ministry say the outbreak in Kikwit began April 10 when a surgical patient at Kikwit's hospital contaminated medical personnel.

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Ivory Coast (04-08-95, 7:06 PM): Ebola reported in Ivory Coast

Reuters reports that a Swiss scientist in Africa's Ivory Coast is infected with an unspecified variant of the Ebola virus as she performs a necropsy on a chimpanzee. The scientist is evacuated to Switzerland and, at the time of the report, is still alive.

## EBOLA EPIDEMIC IN ZAIRE: CASES CONTINUE TO RISE

*(Extracted from WHO Press Release WHO/31, 15 May 1995)*

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The World Health Organization's (WHO) team of experts in Zaire reported today new figures in the Ebola virus epidemic and expects the number to increase even more during the coming weeks. The team has recorded 4 new cases and 17 more deaths caused by the virus bringing to 84 the total number of cases and to 77 the number of deaths.

Based on hospital data, the number of cases has quadrupled every 10 to 12 days for the last three weeks. Having begun to actively trace new cases and contacts of people infected by the virus in the community the team is now investigating rumours of 34 additional cases and 15 deaths notified to the Zairean health authorities.

WHO experts expect a significant increase in cases during the next two or three weeks among people who are incubating the disease, after having been exposed to it during the care of relatives or neighbours with haemorrhagic fever. The team is also concerned by the fact that people do not want to go to hospital, knowing that the epidemic started there.

Professor Tamfum Muyembe, the Head of the International Committee on Scientific and Technical Coordination of the fight against the epidemic, has noted however, that an important and encouraging sign is that the population is better informed, thanks to a health education campaign and knows how to protect itself against the infection, by avoiding any close contact with patients or the bodies of those who have died. This allows the hope that transmission will soon be interrupted even if, in the meantime, the number of cases continues to rise. The campaign was launched by the Ministry of Health throughout Kikwit and surrounding villages.

Based on the findings to date in the environs of Kikwit, members of the International Committee established by WHO experts, will begin tracing possible new cases in the area of Masongo, where five deaths were reported last week and where there are probably a certain number of people incubating the infection. The Committee has had the collaboration of 22 medical students trained by the Ministry of Health in active case finding.

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Further information, Health Communications and Public Relations, WHO, Geneva, Fax No. (41 22) 791 48 68.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control and Prevention (CDC)

Atlanta, Georgia 30333

In reply, address CDC

May 12, 1995

Refer to: NCID:DQ

ADVISORY MEMORANDUM No. 111

SUBJECT: Ebola Virus Hemorrhagic Fever - Zaire

The Government of Zaire and the World Health Organization have reported an unusual outbreak of Ebola virus hemorrhagic fever in Kikwit, (approximately 250 miles southeast of Kinshasa) and the surrounding areas within Bandundu Province, Zaire. The incubation period (time before symptoms appear) for Ebola virus hemorrhagic fever may range from 2-21 days. The average is approximately 1 week. The illness is characterized by an abrupt onset of fever and headache. Continued fever, headache, general malaise, muscle aches, joint pain, and sore throat are commonly followed by vomiting, diarrhea and abdominal pain. A transient, measles-like skin rash, that subsequently becomes scaly, often appears at the end of the first week of illness. Persons infected with the virus may suffer internal hemorrhaging, severe organ failure and death.

The disease is primarily transmitted by contaminated injections and close personal contact with severely ill patients. Transmission usually occurs by direct contact with infected blood, secretions, organs or semen. Otherwise, the risk of infection is believed to be very low. Persons in the incubation period are not considered to be a significant risk to those around them.

Travelers to Zaire are at low risk of acquiring the disease under normal circumstances. To eliminate the risks, travelers should avoid the Ebola virus areas described above. Travelers in Zaire should contact the U.S. Embassy for further information after arrival in Kinshasa.

For future updates of this advisory, you may call CDC International Travelers' Voice Information Service at (404)332-4559 press 1, then press 4, and listen for the outbreak menu for Zaire or you may call the CDC Fax Information Service at (404) 332-4565 and request document #221009.

All recipient health departments, travel agencies, airlines, and shipping companies should notify prospective travelers of the recommendations in this advisory.

Brian Mahy, Ph.D.

Director

Division of Viral and  
Rickettsial Diseases

National Center for  
Infectious Diseases

Charles R. McCance

Director

Division of Quarantine

National Center for  
Infectious Diseases

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Date: 20:38:48 UT on Fri 12 May 95.



## UPDATE--ZAIRE EBOLA OUTBREAK

Contact: CDC Office of Public Affairs (404) 639-3286

May 11, 1995

### UPDATE--ZAIRE EBOLA OUTBREAK

CDC has received reports from the Government of Zaire and the World Health Organization (WHO) of illness consistent with viral hemorrhagic fever in Kikwit, Zaire. Laboratory tests performed at CDC confirms the presence of Ebola infection in specimens from some of the ill persons in Kikwit. The strain isolated is closely related to the strain that caused Ebola disease in Zaire in 1976. The number of cases and fatalities are unknown. There have been reports of possible viral hemorrhagic fever in other locations outside Kikwit, however, these reports have not been substantiated. Three CDC investigators are in route to Zaire to participate as members of the WHO and government of Zaire team investigating the outbreak.

At present, CDC believes the potential for introduction of Ebola outside of Zaire is low. The impacted area is remote and infrequently visited, and there is no direct air service between the United States and Zaire. However, public health officials and clinicians should be aware of the signs and symptoms of viral hemorrhagic fever, should question persons with suspected viral hemorrhagic fever about recent travel to Africa and should assure proper isolation if Ebola infection is suspected and contact local/state health officials.

Ebola disease is usually characterized by the sudden onset of fever, malaise, myalgia, and headache followed by vomiting and diarrhea. Persons infected with the virus may suffer massive internal hemorrhaging which may lead to severe organ failure. Transmission usually occurs by direct contact with infected blood or other bodily secretions. Transmission in hospitals and other health care settings due to contaminated needles and syringes has also been documented.

Ebola disease was first recognized in Sudan and Zaire in 1976. In those outbreaks over 600 people became ill and over 400 people died. A second outbreak also occurred in Sudan in 1979. In 1989, an episode involving the importation of non-human primates with a strain of Ebola, not thought to produce illness in humans, occurred in suburban Washington, D.C. In 1995, a case of Ebola disease was documented in a primate researcher working in Cote D'Ivoire.

For updated information on the outbreak contact: Thomas Prentiss, 9-011-41-22-791-3221, or Christopher Powell, 9-011-41-22-791-2888 at the World Health Organization, Geneva, Switzerland

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[<== Return to CDC Home Page](#)

## **Ebola Virus Hemorrhagic Fever: General Information**

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### **What are viral hemorrhagic fevers?**

Viral hemorrhagic fevers are a group of diseases caused by viruses from four distinct families of viruses: filoviruses, arenaviruses, flaviviruses, and bunyaviruses. The usual hosts for most of these viruses are rodents or arthropods (such as ticks and mosquitoes). In some cases, such as Ebola virus, the natural host for the virus is unknown. All forms of viral hemorrhagic fever begin with fever and muscle aches. Depending on the particular virus, the disease can progress until the patient becomes very ill with respiratory problems, severe bleeding, kidney problems, and shock. The severity of viral hemorrhagic fever can range from a relatively mild illness to death.

### **What is Ebola virus?**

The Ebola virus is a member of a family of RNA viruses known as filoviruses. When magnified several thousand times by an electron microscope, these viruses have the appearance of long filaments or threads. Ebola virus was discovered in 1976 and was named for a river in Zaire, Africa, where it was first detected.

### **Ebola virus hemorrhagic fever: How common is it?**

Until recently, only three outbreaks of Ebola hemorrhagic fever among people had been reported. The first two outbreaks were in 1976: one in Zaire and one in western Sudan. These were large outbreaks, resulting in more than 550 cases and 340 deaths. The third outbreak, in 1979 in Sudan, was smaller, with 34 cases and 22 fatalities. During each of these outbreaks, a majority of cases occurred in hospital settings under the challenging conditions of the developing world. These conditions, including a lack of adequate medical supplies and the frequent reusing of needles and syringes, played a major role in the spread of disease. The outbreaks were quickly controlled when appropriate medical supplies and equipment were made available and quarantine procedures were used.

The source of the Ebola virus in nature remains unknown. In an attempt to identify the source, investigators tested thousands of specimens from animals captured near the outbreak areas, but their efforts were unsuccessful. Monkeys, like humans, appear to be susceptible to infection and may serve as a source of virus if infected.

### **What do we know about the recent outbreak of Ebola virus infection?**

The recent Ebola virus outbreak is centered in Kikwit, Zaire. (Kikwit is a city of 400,000 located 400 kilometers east of Kinshasa, the capital of Zaire.) The outbreak appears to have started with a patient who had surgery in Kikwit on April 10, 1995. Members of the surgical team then developed symptoms similar to those of a viral hemorrhagic fever disease. Ebola hemorrhagic fever was suspected by a Belgium physician who reported the disease to the Zairian government. At the request of Zairian health officials, medical teams from CDC, the World Health Organization, and from Belgium, France, and South Africa are collaborating to investigate and control the outbreak in Zaire.

### **What are the symptoms of Ebola hemorrhagic fever?**

Symptoms of Ebola hemorrhagic fever begin 4 to 16 days after infection. Persons develop fever, chills, headaches, muscle aches, and loss of appetite. As the disease progresses, vomiting, diarrhea, abdominal pain, sore throat, and chest pain can occur. The blood fails to clot and patients may bleed from injection sites as well as into the gastrointestinal tract, skin, and internal organs.

### **How is the Ebola virus spread from person to person?**

Ebola virus is spread through close personal contact with a person who is very ill with the disease. In previous outbreaks, person-to-person spread frequently occurred among hospital care workers or family members who were caring for an ill person infected with Ebola virus. Transmission of the virus has also occurred as a result of hypodermic needles being reused in the treatment of patients. Reusing needles is a common practice in developing countries, such as Zaire and Sudan, where the health care system is underfinanced. Medical facilities in the United States do not reuse needles.

Ebola virus can also be spread from person to person through sexual contact. Close personal contact with persons who are infected but show no signs of active disease is very unlikely to result in infection. Patients who have recovered from an illness caused by Ebola virus do not

pose a serious risk for spreading the infection. However, the virus may be present in the genital secretions of such persons for a brief period after their recovery, and therefore it is possible they can spread the virus through sexual contact.

**How is Ebola hemorrhagic fever diagnosed?**

A diagnosis is made by detection of Ebola antigens, antibody, or genetic material, or by culture of the virus from these sources. Diagnostic tests are usually performed on clinical specimens that have been treated to inactivate (kill) the virus. Research on Ebola virus must be done in a special high-containment laboratory to protect scientists working with infected tissues.

**How will health officials control the outbreak?**

Previous outbreaks of Ebola hemorrhagic fever have been limited. These outbreaks were successfully controlled through the isolation of sick persons in a place requiring the wearing of mask, gown, and gloves; careful sterilization of needles and syringes; and proper disposal of waste and corpses.

**How do hospital personnel isolate an ill person?**

Hospital personnel isolate ill persons through a method called "barrier technique." Barrier technique includes the following actions: 1) doctors and nurses wear gowns, mask, gloves, and goggles when caring for patients; 2) the patient's visitors are restricted; 3) disposable materials are removed from the room and burned after use; 4) all reusable materials are sterilized before reuse; and 5) since the virus is easily destroyed by disinfectants, all hard surfaces are cleaned with a sanitizing solution.

**Are persons in the United States at risk?**

Persons in the United States are at risk only if they have had close personal contact with patients in Zaire who are infected with Ebola virus. There are no reports that infected persons have left the country of Zaire. The Zairian government has quarantined all persons in the affected areas and restricted movement of persons in and out of these areas. Any persons who wish to travel to Zaire are encouraged to contact the U.S. State Department (202-647-5225) for travel advisories.

**What is CDC's role in the outbreak investigation?**

CDC has sent three medical scientists to Zaire to assist with the investigation. They will provide advice and assistance in helping to control the outbreak and prevent additional cases, collect specimens for diagnostic testing, study the clinical course of the disease in the ill persons, and look for others who may have been in contact with the infected individuals. They will also be instruct the hospital staff in Zaire about how to limit the spread of the disease. Efforts will also made to find the source of the infection.

CDC also has a role in educating the U.S. public about this outbreak and about the potential threat of emerging infectious diseases. For the next several days, CDC will issue press releases and will inform the state health departments about any updates on the disease outbreak in Zaire.

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[\[Image Not Loaded\]Return to NCID Home Page](#)

## Dr. Frederick A. Murphy Talks about the Ebola Virus

*An Interview by Sean Henahan, Access Excellence*

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The book "The Hot Zone" and the film "Outbreak" have seized the public's imagination and brought into focus many issues regarding the very real threats posed by new and emerging diseases. In this interview we talk with Frederick A. Murphy, D.V.M., Ph.D., Dean of School of Veterinary Medicine, UC Davis.

At the time of the 'Reston incident', Dr. Murphy was the director of the National Center for Infectious Diseases at the CDC in Atlanta. Dr. Murphy is considered one of the world authorities on viruses. He was the first one to look at Ebola virus 'face-to-face' in the electron microscope. Dr. Murphy appears in "The Hot Zone" and his now famous photo of the Ebola virus appears in the film "Outbreak".

**Note:** Dr. Murphy has also provided an extensive bibliography and three excellent electron micrographs to accompany this interview.

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**Q:** The book "The Hot Zone" and more recently the film "Outbreak" have brought public attention to the reality of emerging viruses and potentially disastrous epidemics. It can be difficult to tell fact from fiction with these kind of sources. I'd like to ask some questions gathered from high school science teachers and students all over the country to clarify some of the issues raised by this book and this movie.

**A:** The public response to the book and the film has been phenomenal. Half of the posts for a virology conference on the Internet I look at are about the Ebola virus. I myself have had innumerable calls from the press and other media people. By the way, I want to say hello to the Access Excellence people and say I had a great time down at Genentech last summer when I spoke on the subject of new and emerging diseases.

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**Q:** Please explain how Ebola and the other filoviruses are classified and how they are related to other known viruses?

**A:** The viruses are classified in the family 'Filoviridae', with one genus, 'Filovirus'. There are four known viruses. We have Marburg virus and three Ebola viruses: Zaire, Sudan and Reston. Marburg and Ebola are distinguished by their length when purified. In the unpurified state you get all different lengths of these worm-like virions. When they are purified, the infectivity is associated with a particular particle length, which is slightly different between the Marburg and Ebola, but all of the Ebola viruses are the same length.

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**Q:** Considering how similar the Ebola viruses are, how are they differentiated?

**A:** They are very close. First of all, there is a very small serologic difference among the Ebola viruses which can help distinguish them. Second, there are sequence differences which can be determined using the tools of molecular biology.

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**Q:** What have we learned about the Ebola genome, and what remains to be learned?

**A:** Ebola Zaire has been completely sequenced and Ebola Reston is nearly completed. The gene order of these viruses reaffirms their independence as a family. Also, some ancient conserved sequences along with the gene order, i.e. the layout of the genes along the RNA molecule, put the family 'Filoviridae' into an order, the only order in virology, 'Mononegavirales'. This emphasizes the ancient phylogenetic connection between three families- 'Filoviridae', 'Paramyxoviridae' (measles, mumps) and 'Rhabdoviridae' (rabies). There is no connection with HIV.

---

**Q:** Let's talk about the pathogenicity of Ebola. How does Ebola virus infect humans?

**A:** In Zaire and Sudan, Ebola virus was spread by close contact and dirty needles. The center of the epidemic in Zaire involved a missionary hospital where needles and syringes were re-used without sterilization. Most of the staff of that hospital got sick and died. There were secondary cases involving people taking care of sick people or preparing bodies for burial, but the virus essentially shut down after that epidemic peaked.

There is something of a misconception that Ebola virus can infect just about any cell. In fact, the virus has a very specific tropism for liver cells and cells of the reticuloendothelial system,

e.g. macrophages. Massive destruction of the liver is a hallmark feature of Ebola Zaire, Ebola Sudan, and Ebola Reston (the latter in monkeys only).

---

**Q:** Ebola Zaire is said to kill nine of ten people infected. What about the surviving one person? Is anything known about natural resistance to this virus?

**A:** Starting with Marburg in 1967, there was one fellow who tested positive for the virus 30 days post-infection. In fact the virus was detected in his semen, and there was a case of sexual transmission in that circumstance. Another patient had virus in the vitreous of his eye for more than 30 days. But eventually the virus died out within these people without killing them. Ebola too is not persistently carried in the blood and appears to be self limiting in the surviving patient.

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**Q:** Given that there are some signs of natural immunity to Marburg and Ebola Zaire, and that the monkey workers were not killed after exposure to Ebola Reston, does this give us any possible approaches to vaccine development? Both the measles and rubella vaccines were based on attenuated viruses.

**A:** No, I don't think so. I don't think we would know how to select a stable, safe attenuated virus. The kind of research needed to develop a modified live virus vaccine simply could not be done given the scope of the problem. That is, you only have a few people working in labs who would need to be vaccinated, and you might want a vaccine stockpile in the event of an epidemic, but these are not the scale of circumstances where we could afford to develop a vaccine. A killed vaccine is much simpler to develop, but so far this has not worked with Ebola virus.

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**Q:** On Oct 13, 1976 you prepared a specimen from an African patient with hemorrhagic fever and suddenly realized it might be deadly serious. Can you tell us what you were thinking at that time?

**A:** When I put the specimen in the electron microscope, I was sure it was Marburg. I had worked on Marburg in 1967 and 1968 and had done a project on experimental Marburg infection in monkeys. The specimen had come back from Zaire to the CDC in Atlanta in less than optimal condition, with the tubes in the box broken. Anyone else would have taken a look and put the whole box in the autoclave, but Dr. Patricia Webb, wearing gloves, gown and mask, squeezed a few drops of fluid out of the cotton surrounding the broken tubes. That was the material the virus was isolated from. It was placed in tissue culture (monkey kidney cells) for a couple of days then I got a drop of the tissue culture fluid and prepared a specimen for the electron microscope. When I saw what I was sure was Marburg, I shut the electron microscope down and went back to the room in which I had prepared the specimen. This was in the days when hoods were a lot more primitive. I "chloroxed the hell" out of the place where I had done the preparation and carried my discard pan with gown and gloves etc. to the autoclave and ran it. Then I went back to the microscope and called Karl Johnson and Patricia Webb to take a look. I shot a cassette of pictures and with wet negatives, not good for the enlarger and I made prints which were available within minutes. I carried these dripping prints to the office of the Director of the CDC. It was very dramatic.

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**Q:** Then later when Fort Detrick called and said they thought they had found Ebola in Virginia, what was your reaction?

**A:** The way it is stated in "The Hot Zone", General Russell suggested I didn't believe him. In fact, I took it very seriously. General Russell himself had enough experience to recognize Ebola when he saw it. With Marburg 67, it was monkeys that brought the virus to Europe. In 1976 we had no idea where the virus came from, so when he said he had Ebola in monkeys I sure believed him. We went to Fort Detrick the next day.

---

**Q:** There are a number of issues concerning the response to an epidemic raised by both "The Hot Zone" and "Outbreak". How well did these describe the interaction of the various agencies?

**A:** The movie Outbreak created some false impressions. The law in our country gives the responsibility for epidemic management to state health departments, with these agencies calling the CDC when they need help. CDC has no authority to go into a state except by invitation. The Army could be called in by a state health department, but to my knowledge this never has happened.

In the Reston incident, the Virginia Health department and the CDC took over the human health side of the episode and the Army, at the request of the monkey import company, took over the animal side. It turned out after lots of surveillance of animal caretakers and their families that there was no human disease, but there was plenty of monkey disease. The Army's role involved depopulating the monkey colony. So the movie Outbreak, where the Army takes over, is rather fictional.

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**Q:** Has the Reston incident changed the way monkeys are imported and housed?

**A:** There were a series of CDC investigations after the Reston episode. There was also a complete embargo on the importation of monkeys for about a year. The CDC then relicensed importers, denying licenses to those that did not have proper facilities and staff training. So I would say there has been significant improvement in this area. Countries that used to export monkeys are also getting out of that business, primarily for species preservation reasons. The use of captive bred monkeys is absolutely the trend. The goal is for complete reliance on domestic breeding. We have to stretch the definition a bit, since there is a huge captive breeding colony on a small Caribbean island.

---

**Q:** Did anyone every figure out how an African Ebola virus ended up in a monkey from the Philippines?

**A:** No. That's a very good question. We still have no idea where Ebola lives in nature. It was not possible to do field studies in the Philippines because of a civil war going on in the area the monkeys came from. Some studies in Africa tried to trace Marburg and Ebola, but nothing has ever been found.

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**Q:** Are budget cuts affecting the ability of the CDC and other agencies to respond to epidemic outbreaks?

**A:** Yes. The Army program at USAMRIID has been cut quite a bit. Over the past few years the CDC's programs for dealing with infectious diseases have been nibbled to death by inflation. The budgets are the same in today's dollars as they were 12 years ago. In effect these programs have lost half of their purchasing power, while at the same we've seen an explosion in AIDS and other infectious diseases.

---

**Q:** Such as Hantavirus?

**A:** Yes, hantavirus is a good example. The same people from CDC and the Army who worked on the new Hantavirus outbreak previously worked on Ebola. It is a small, wonderful group of dedicated people. They really have had their budgets whacked. And then with the emergence of one disease problem after another, this has really stretched them beyond the breaking point.

---

**Q:** Can you give us an update on the Hantavirus situation?

**A:** It is amazing how quickly the virus was characterized after the first outbreak in the Four Corners area. The virus is transmitted by breathing dried dust that contains the virus (from the dried feces, urine and saliva of the mouse vector, 'Peromyscus maniculatus'). The virus could not be grown, so everything was done by molecular biological means. The first clue came with the observation of some cross serology with known hantaviruses. Everything else was done by PCR and partial sequencing. Six months later they were able to make an isolate. Since then four different variants of the virus have been isolated from more than 100 people. It still has a mortality rate above 50% and has been seen from California to the East Coast and Florida. It is incredible that this set of variant viruses was present all along and no one knew it. Although we know the vector, we also know that controlling this vector, mice, is virtually impossible.

We have a similar problem now in California, with all the rains. The mosquitoes that carry Western equine encephalitis and St. Louis encephalitis are resistant to virtually every licensed insecticide. We could have a re-emergence of these virus diseases this summer.

The most important mosquito-borne disease in the world today is dengue. This disease is emerging now in all the big cities of the Caribbean and tropical and sub-tropical America. If you get lots of dengue and multiple serotypes in an area, you get dengue hemorrhagic fever. Uncomplicated dengue infection, called breakbone fever, is like influenza, with all people recovering. But dengue hemorrhagic fever, usually seen in children, is deadly. Symptoms

include fever, shock, hemorrhaging from the nose and mouth, respiratory distress and, in some cases, death.

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**Q:** Back to the CDC. What do public health agencies need in order to fight epidemics?

**A:** The things they need are hard to come by. The National Academy of Sciences, the Institute of Medicine and the CDC have published plans on what is needed to control new and emerging diseases better. The plans focuses on better surveillance, better laboratory diagnostics, better communication and better education. The plans are very good, but the timing is terrible, since budgets are so tight, and from what I read in the papers, budgets will get much worse.

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**Q:** There have been complaints at the vast inaccuracies and dubious details in the film Outbreak. What did you think of this film?

**A:** I did see the movie. In fact, in return for the use of the electron micrographs of the virus, Warner Bros. gave us tickets to the premiere in Sacramento. I thought the early scenes in the biosafety level 1,2,3, and 4 labs looked pretty accurate. After that it became fictional, and I enjoyed it as fiction. We know a virus can't kill someone in an hour. The making of the antisera in a day was ludicrous. I think all bug movies have a problem, since once they unleash the bug, there is the problem of resolving the crisis. Like in the film, 'The Andromeda Strain', the only way to resolve the story was to have the bug mutate to become harmless. The real world is not so simple. Fourteen years into the AIDS epidemic and we still don't have a vaccine or decent drugs.

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**Q:** The CDC is one of two places in the world with remaining specimens of smallpox virus. Both the CDC specimens and the Russian specimens were scheduled for destruction, but have gained a reprieve. Should they be saved?

**A:** The collections of smallpox specimens at these places are fairly large. CDC has about 500 strains of the virus. It is highly contained in a freezer that is never opened. The WHO also visited the Russian facility and certified its safety.

I was originally in favor of the destruction of these specimens. This was for political reasons, rather than scientific ones. I thought the publicity surrounding its destruction would remind people that we had done something very good. However, within the last two years several different strains of the smallpox virus have been completely sequenced. Some really interesting genes have been found, which may contribute to the understanding of the pathogenicity and natural history of other viruses. So the current consensus is that these kinds of genes must be preserved and studied.

---

**Q:** Last question. Any advice for some one considering a career in virology?

**A:** There are several kinds of virologists. One kind of virologist is a molecular biologist who studies the nature of the virus and how it works. That is the world of molecular biology and cell biology. Virology is also an infectious disease science in the hands of physicians and veterinarians who take specialty training. Virology also interfaces with other areas of biology that have to do with how viruses are transmitted, such as entomology and mammology. The field of virology also includes the whole world of public health and preventive medicine. The starting point for anyone interested in virology is the undergraduate biology major. Then there is a fork in the road at which the person chooses to seek a degree from a medical school or veterinary school or to enter a Ph.D program in virology per se. Either way you go, I can say "it's a wonderful life".

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More information about emerging diseases and viruses can be found in  
Access Excellence...

[Science Update: Ebola Infection Reported](#)

[Current Science Seminar on Emerging Diseases](#)

and at the following Web sites:

[The National Center for Infectious Diseases](#)

[An Introduction to Molecular Virology, Univ. of Cape Town, South Africa](#)

[Brown University's Tuberculosis and HIV Research Lab <<Unknown HTML Tag>>](#)

Cover Sheet Classification <b>UNCLASSIFIED</b>	Enclosure Classification <b>UNCLASSIFIED</b>
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**UNITED NATIONS**  
ASSISTANCE MISSION FOR RWANDA



**NATIONS UNIES**  
MISSION POUR L'ASSISTANCE AU RWANDA

Out Going Fax No <sup>423</sup> 423/95

UNAMIR - MINUAR

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File <sup>445-161A</sup> 445-161A

TO: <b>CAPT JOHN NERNEY</b> <b>FORCE HEALTH OFFICER</b> <b>HQ MALAWICOY</b>	FROM: <b>FMO</b> <b>UNAMIR, KIGALI</b> <b>RWANDA</b>
ATTN:	DATE: <sup>21 APR</sup> 21 APR 95
FAX NO: <b>Fax No:</b>	PHONE: INT + 250 84270 Ext 11116
INFO:	FAX NO: INT + 250 86877
Internal dist:	DRAFTED BY: MAJ R.P. Wiltshire G4 Med Log
Subject: <b>HEALTH INFORMATION UPDATE - SECTOR 3A</b>	
REFERENCE:	

COMMENTS/INSTRUCTIONS

## PRIORITY

1. PLEASE PASS TO CAPT JOHN NERNEY WHO IS VISITING KIBUYE THIS MORNING TO ASSESS HEALTH ISSUES IN NEW MALAWICOY HQ LOCATION.
2. HE WILL BE ARRIVING BY HELICOPTER THIS MORNING.

Releasing Officer's Name	Signature	Rank/Appointment	Date
Cover Sheet Classification <b>UNCLASSIFIED</b>	Enclosure Classification <b>UNCLASSIFIED</b>		





UNAMIR - MINUAR

HEALTH INTELLIGENCE REPORTKIBUYEGeneral Information

1 This report of Kibuye was compiled from information gathered by Environmental Health Section ASC 1 on the 26-27 Nov 94 and by the FMO on 29 Mar 95

Geographical/Geophysical Factors

2 Kibuye is west of Kigali located on the Eastern shore of Lake Kivu. Kibuye is surrounded by hills and mountains. Kibuye is 1554 ft above sea-level which is in the range of the Anopheline mosquito

3 All roads to Kibuye are dirt, the roads become slippery in the wet season and mud slides are common. There was no phone communication available except for the UNAMIR satellite system.

4 Local water is from underground wells which is pumped to a water treatment facility within the town. This facility uses sedimentation tanks and rock filters with chlorine added after the filtration. Water taken from taps (26 Nov 94) in the previous UN compound showed no traces of chlorine. It is therefore recommended the town water in Kibuye be used for non-potable use only and that the MALAWICOY Health Representative maintain daily surveillance of township water.

5 Soil around the Kibuye area is rich and fertile. This was evident by the amount of crops growing in the area.

Demographic Factors

6 Approximately 10,000 people live in and around Kibuye. However 10% of those are displaced persons. Very few of the transients are returning home.

7 70% of the population is catholic with the rest being a mixture of Methodists, Adventist and Muslims.

8 At present there are three types of people living in Kibuye.

- a. Hutu,
- b. Tutsi, and
- c. Other (UN and NGO's)

9 The Rwandan Patriotic Army have acquired several buildings in the Kibuye area. They are of approximately battalion strength with a recruit training battalion also present

10. Civilians occupy mud/brick constructed houses as per most of Rwanda. Pre war the level of education was year seven as the norm with only 1% of students finishing Secondary school. The missionary secondary school is scheduled to re-open on the 15 Apr 95.

11. Typical daily-food intake is two meals consisting of beans, sweet potatoes and bananas. As with most towns seen the men drink banana beer in the evenings.

12. The people of Kibuye are frightened of arrest by the RPA. No problems were encountered when gathering information.

13. The Prefecture was generally seen to be unco-operative by the general community and the MILOPS.

14. There seems to be little activity in the area from RGF/Interhamwe. However, there has been bandits reported.

15. As with the rest of Rwanda there are RPA checkpoints on the road to Kibuye

16. The Prefect had no immediate plans for any Health Program for the area.

### **Economic Factors**

17. The major source of income for the area prior to the war was tourism. Several resorts/hotels can be seen along the shore of Lake Kivu. Post war farming has become the major resource for the area. However, UN soldiers/pers and NGO's are now contributed to the cash flow within the community.

18. Kibuye had a daily bus service to Gittarama (26 Nov 94). The buses sit 42 however, standing room only is the normal. No civilian cars were seen. The vehicles seen were owned by RPA, UN or NGO's. There were a few bikes and pushbikes but most people still get around on foot.

19. There is a Tea Industry 42 km away at Gisovu however, there is problems of obtaining transport. The plantations were not destroyed during the war

20. The area has no capability to produce medical stores of equipment.

21. The local area is still depressed from the war. The requirement to move products and medical stores in and out of Kibuye by road is hampered during the wet seasons. The UN and NGO's are supporting the community with food and medical assistance.

22. The local hospital (29 Mar 95) is currently run by Medicine Sans Frontier (MSF) and Swiss Disaster Relief. The hospital has four wards with a total of 160 beds. Treatment costs 100 Francs however, medicine is free. Money received from patients pays for local staff. The hospital statistics indicate 40 people per day for the following:

- a. Malaria 65% patients;
- b. Pneumonia 20% patients;
- c. Worms 25% patients;
- d. Dysentery 20% patients; and
- e. Brucellosis 5% patients.

23. The hospital has limited pathology available for malaria parasite and simple blood and urine biochemistry. The hospital is working at about one quarter of it's capacity as the local population is afraid to enter Kibuye, fearing arrest. The hospital has the following wards:

- a. Surgery/Trauma with anaesthesia;
- b. Internal medicine;
- c. paediatric;
- d. Isolation; and

e Maternity

24. There are several satellite clinics around the areas which are run by NGO's. There are no government run clinics at the moment. The only other medical facility is the MALAWICOY RAP which is not fully functional at present. At the moment the RPA has a 14 bed infirmary. They have a limited surgery capability as post operative care and lack of anaesthesia is a problem. Over 90% of the patients are civilian.

**Environmental Health Factors**

25. Insect vectors known to be present are:

- a. Mosquito - Malaria; and
- b. Filth Flies - Dysentery.

26. There are no Environmental control measures for the Kibuye area. Waste water is collected in large drains which run through the town. The drains are approximately 1m deep x 2m wide

27. Food preparation is similar to the rest of Rwanda with poor food hygiene standards being observed.

28. Solid wastes are disposed of in rubbish pits. These pits are usually depressions in the ground. These pits are not burned regularly and contribute to the dysentery problem by allowing access to them by vectors.

Cover Sheet Classification  
**UNCLASSIFIED**  
**UNITED NATIONS**  
ASSISTANCE MISSION FOR RWANDA



Enclosure Classification  
**UNCLASSIFIED**  
**NATIONS UNIES**  
MISSION D'ASSISTANCE POUR RWANDA

Out Going FaxNo. 95

UNAMIR MEMPHIS

Page 1 of 4

File

TO CAPT JOHN NERNEY FORCE HEALTH OFFICER HQ MALAWICOY	FROM FMO UNAMIR, KIGALI RWANDA
ATTN	DATE 21 APR 95
FAX NO Fax No:	PHONE INT - 250 84270 Ext 11116
INFO	FAX NO INT + 250 86877
Internal dist	DRAFTED BY MAJ R.P. Wiltshire G4 Med Log
Subject: <u>HEALTH INFORMATION UPDATE - SECTOR 3A</u>	
REFERENCE	

COMMENTS/INSTRUCTIONS

## PRIORITY

1. PLEASE PASS TO CAPT JOHN NERNEY WHO IS VISITING KIBUYE THIS MORNING TO ASSESS HEALTH ISSUES IN NEW MALAWICOY HQ LOCATION.
2. HE WILL BE ARRIVING BY HELICOPTER THIS MORNING.

Releasing Officer's Name

Signature

Rank Appointment

Date

Cover Sheet Classification  
**UNCLASSIFIED**

Enclosure Classification  
**UNCLASSIFIED**



UNAMIR - MINUAR

**HEALTH INTELLIGENCE REPORT****KIBUYE****General Information**

1. This report of Kibuye was compiled from information gathered by Environmental Health Section ASC 1 on the 26-27 Nov 94 and by the FMO on 29 Mar 95.

**Geographical/Geophysical Factors**

2. Kibuye is west of Kigali located on the Eastern shore of Lake Kivu. Kibuye is surrounded by hills and mountains. Kibuye is 1554 ft above sea-level which is in the range of the Anopheline mosquito.

3. All roads to Kibuye are dirt, the roads become slippery in the wet season and mud slides are common. There was no phone communication available except for the UNAMIR satellite system.

4. Local water is from underground wells which is pumped to a water treatment facility within the town. This facility uses sedimentation tanks and rock filters with chlorine added after the filtration. Water taken from taps (26 Nov 94) in the previous UN compound showed no traces of chlorine. It is therefore recommended the town water in Kibuye be used for non-potable use only and that the MALAWICOY Health Representative maintain daily surveillance of township water.

5. Soil around the Kibuye area is rich and fertile. This was evident by the amount of crops growing in the area.

**Demographic Factors**

6. Approximately 10,000 people live in and around Kibuye. However 10% of those are displaced persons. Very few of the transients are returning home.

7. 70% of the population is catholic with the rest being a mixture of Methodists, Adventist and Muslims.

8. At present there are three types of people living in Kibuye:

- a. Hutu;
- b. Tutsi; and
- c. Other (UN and NGO's)

9. The Rwandan Patriotic Army have acquired several buildings in the Kibuye area. They are of approximately battalion strength with a recruit training battalion also present.

10. Civilians occupy mud/brick constructed houses as per most of Rwanda. Pre war the level of education was year seven as the norm with only 1% of students finishing Secondary school. The missionary secondary school is scheduled to re-open on the 15 Apr 95.

11. Typical daily food intake is two meals consisting of beans, sweet potatoes and bananas. As with most towns seen the men drink banana beer in the evenings.

e. Maternity.

24. There are several satellite clinics around the areas which are run by NGO's. There are no government run clinics at the moment. The only other medical facility is the MALAWICOY RAP which is not fully functional at present. At the moment the RPA has a 14 bed infirmary. They have a limited surgery capability as post operative care and lack of anaesthesia is a problem. Over 90% of the patients are civilian.

**Environmental Health Factors**

25. Insect vectors known to be present are:

- a. Mosquito - Malaria; and
- b. Filth Flies - Dysentery.

26. There are no Environmental control measures for the Kibuye area. Waste water is collected in large drains which run through the town. The drains are approximately 1m deep x 2m wide.

27. Food preparation is similar to the rest of Rwanda with poor food hygiene standards being observed.

28. Solid wastes are disposed of in rubbish pits. These pits are usually depressions in the ground. These pits are not burned regularly and contribute to the dysentery problem by allowing access to them by vectors.

12. The people of Kibuye are frightened of arrest by the RPA. No problems were encountered when gathering information.
13. The Prefecture was generally seen to be unco-operative by the general community and the MILOPS.
14. There seems to be little activity in the area from RGF/Interhamwe. However, there has been bandits reported.
15. As with the rest of Rwanda there are RPA checkpoints on the road to Kibuye.
16. The Prefect had no immediate plans for any Health Program for the area.

### **Economic Factors**

17. The major source of income for the area prior to the war was tourism. Several resorts/hotels can be seen along the shore of Lake Kivu. Post war farming has become the major resource for the area. However, UN soldiers/pers and NGO's are now contributed to the cash flow within the community.
18. Kibuye had a daily bus service to Gittarama (26 Nov 94). The buses sit 42 however, standing room only is the normal. No civilian cars were seen. The vehicles seen were owned by RPA, UN or NGO's. There were a few bikes and pushbikes but most people still get around on foot.
19. There is a Tea Industry 42 km away at Gisovu however, there is problems of obtaining transport. The plantations were not destroyed during the war.
20. The area has no capability to produce medical stores of equipment.
21. The local area is still depressed from the war. The requirement to move products and medical stores in and out of Kibuye by road is hampered during the wet seasons. The UN and NGO's are supporting the community with food and medical assistance.
22. The local hospital (29 Mar 95) is currently run by Medicine Sans Frontier (MSF) and Swiss Disaster Relief. The hospital has four wards with a total of 160 beds. Treatment costs 100 Francs however, medicine is free. Money received from patients pays for local staff. The hospital statistics indicate 40 people per day for the following:
  - a. Malaria 65% patients;
  - b. Pneumonia 20% patients;
  - c. Worms 25% patients;
  - d. Dysentery 20% patients; and
  - e. Brucellosis 5% patients.
23. The hospital has limited pathology available for malaria parasite and simple blood and urine biochemistry. The hospital is working at about one quarter of it's capacity as the local population is afraid to enter Kibuye, fearing arrest. The hospital has the following wards:
  - a. Surgery/Trauma with anaesthesia;
  - b. Internal medicine;
  - c. paediatric;
  - d. Isolation; and

ACTION MEMO

File	Folio
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To (Name or Appointment)	Attention/Location	Reference(s)
CHN		
Subject KIRBYE		

FOR <input checked="" type="checkbox"/> Action	FOR <input type="checkbox"/> Approval	Please <input type="checkbox"/> Telephone/Discuss	<input type="checkbox"/> File on	Comment/Action is Requested by...../...../..... Nil Returns <input type="checkbox"/> Required are <input type="checkbox"/> Not Required
<input type="checkbox"/> Information	<input type="checkbox"/> Signature	<input type="checkbox"/> Note and Return/Retain .....	.....	
<input type="checkbox"/> Comments	<input type="checkbox"/> Circulation	<input type="checkbox"/> Prepare Draft Reply	<input type="checkbox"/> Signature of .....	

Additional Comments This is good, however we noted some typos  
AND QUESTIONS  
AM OK WITH MORE NO'S ETC. I DON'T  
EXPECT ANY FEED BACK FROM MALAWI CON TILL  
NEXT MONTH. WE MAY NEED TO SPEAK BEFORE  
NEXT.

Originator	Wickham	MAJ	G4		6
(Signature)	(Printed Name)	(Rank)	(Appointment)	(Phone)	(Date)



HEALTH INTELLIGENCE REPORTKIBUYEGeneral Information

X 1. This report of Kibuye was compiled from information gathered by Environmental Health Section ASC 1 on the 26-27 Nov 94 and undated by the FMO on 29 Mar 95.

Geographical/Geophysical Factors

2. Kibuye is west of Kigali located on the Eastern shore of Lake Kivu. Kibuye is surrounded by hills and mountains. Kibuye is 1554 ft above sea-level which is in the range of the Anopheline mosquito.

3. The roads to Kibuye are dirt that will be updated to bitumen at a latter stage. There is no date for the proposed upgrade of the roads. The roads become slippery in the wet season and mud slides are common. There was no phone communication available except for the UNAMIR satellite system. *from where to where?*

4. Local water is from underground wells which is pumped to a water treatment facility within the town. The facility uses sedimentation tanks and rock filters with chlorine added after the filtration. The operator responsible for water treatment has not been seen for four days. Water taken from taps in the UN compound showed no traces of chlorine. It is therefore recommended the town water in Kibuye be used for non-potable use only and that the MALAWICOY Health Representative maintain daily surveillance of township water. *currently?* *date of assessment?*

5. Soil around the Kibuye area is rich and fertile. This was evident by the amount of crops growing in the area.

Demographic Factors

6. Approximately 10,000 people live in and around Kibuye. However 10% of those are displaced persons. Very few of the transients are returning home.

7. 70% of the population is catholic with the rest being a mixture of Methodists, Adventist and Muslims.

8. At present there are three types of people living in Kibuye:

- a. Hutu;
- b. Tutsi; and
- c. Other (UN and NGO's)

9. The Rwandan Patriotic Army have acquired several buildings in the Kibuye area. They are of approximately battalion strength with a recruit training battalion also present.

10. Civilians occupy mud/brick constructed houses as per most of Rwanda. Pre war the level of education was year seven as the norm with only 1% of students finishing Secondary school. The secondary schools have not yet re-opened. — *still?*

11. Typical daily food intake is two meals consisting of beans, sweet potatoes and bananas. As with most towns seen the men drink banana beer in the evenings.
12. The people of Kibuye are frightened of arrest by the RPA. No problems were encountered when gathering information.
13. The Prefecture was generally seen to be unco-operative by the general community and the MILOPS.
14. There seems to be little activity in the area from RGF/Interhamwe. However, there has been bandits reported.
15. As with the rest of Rwanda there are RPA checkpoints on the road to Kibuye.
16. The Prefect had no immediate plans for any Health Program for the area.

### Economic Factors

17. The major source of income for the area prior to the war was tourism. Several resorts/hotels can be seen along the shore of Lake Kivu. Post war farming has become the major resource for the area. However, UN soldiers/pers and NGO's are now contributed to the cash flow within the community.

18. Kibuye has a daily bus service travel. The buses do one trip to Gittarama daily. The buses sit 42 however, standing room only is the normal. No civilian cars were seen. The vehicles seen were owned by RPA, UN or NGO's. There were a few bikes and pushbikes but most people still get around on foot. *still?*

19. There is a Tea Industry 42 km away at Gisovu however, there is problems of obtaining transport. The plantations were not destroyed during the war.

20. The area has no capability to produce medical stores of equipment.

21. The local area is still depressed from the war. The requirement to move products and medical stores in and out of Kibuye by road is hampered during the wet seasons. The UN and NGO's are supporting the community with food and medical assistance.

x 22. The local hospital is currently run by Medicine Sans Frontieres (MSF) and Swiss Disaster Relief. The hospital has four wards with a total of 160 beds. Treatment costs 100 Francs however, medicine is free. Money received from patients pays for local staff. The hospital statistics indicate 40 people per day for the following:

- a. Malaria 65% patients;
- b. Pneumonia 20% patients;
- c. Worms 25% patients;
- d. Dysentery 20% patients; and
- e. Brucellosis 5% patients.

23. The hospital has limited pathology available for malaria parasite and simple blood and urine biochemistry. The hospital is working at about one quarter of it's capacity as the local population is afraid to enter Kibuye, fearing arrest. The hospital has the following wards:

- a. Surgery/Trauma with anaesthesia;
- b. Internal medicine;

- c. paediatric;
- d. Isolation; and
- e. Maternity.

24. There are several satellite clinics around the areas which are run by NGO's. There are no government run clinics at the moment. The only other medical facility is the MALAWICOY RAP which is not fully functional at present. At the moment the RPA has a 14 bed infirmary. They have a limited surgery capability as post operative care and lack of anaesthesia is a problem. Over 90% of the patients are civilian.

#### **Environmental Health Factors**

25. Insect vectors known to be present are:

- a. Mosquito - Malaria; and
- b. Filth Flies - Dysentery.

26. There are no Environmental control measures for the Kibuye area. Waste water is collected in large drains which run through the town. The drains are approximately 1m deep x 2m wide.

27. Food preparation is similar to the rest of Rwanda with poor food hygiene standards being observed.

28. Solid wastes are disposed of in rubbish pits. These pits are usually depressions in the ground. These pits are not burned regularly and contribute to the dysentery problem by allowing access to them by vectors.

# ACTION MEMO

File

Folio

To (Name or Appointment)	Attention/Location	Reference(s)
JOHN		
Subject	HIL KUBUMS	

FOR <input checked="" type="checkbox"/> Action	FOR <input type="checkbox"/> Approval	Please <input type="checkbox"/> Telephone/Discuss	<input type="checkbox"/> File on	Comment/Action is Requested by...../...../.....
<input type="checkbox"/> Information	<input type="checkbox"/> Signature	<input type="checkbox"/> Note and Return/Retain	...../...../.....	Nil Returns are <input type="checkbox"/> Required
<input type="checkbox"/> Comments	<input type="checkbox"/> Circulation	<input type="checkbox"/> Prepare Draft Reply	Signature of .....	<input type="checkbox"/> Not Required
Additional Comments				
<p>PLEASE UPDATE THE ATTACHED W RESARD          TO THE RPT MED ASPECTS IE PARA 4.3, 4.4, 4.25          AM AND GET THE DIRECT CONTACT IN SD          CWO REF, MAP WITH LOC ETC          INT WILL ATTEMPT TO HAVE PHOTOS AVAL          SAT.          ID LIKS THIS AS TOE</p>				
Originator	WILSON	MAS	LY	20/3
(Signature)	(Printed Name)	(Rank)	(Appointment)	(Date)

ACTION MEMO

File	Folio
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To (Name or Appointment) <b>KMO</b>	Attention/Location	Reference(s)
Subject <b>UPDATE OF NOSP BLUF - KIBUYE</b>		

FOR <input checked="" type="checkbox"/> Action	FOR <input type="checkbox"/> Approval	Please <input type="checkbox"/> Telephone/Discuss	<input type="checkbox"/> File on	Comment/Action is Requested by...../...../..... Nil Returns are <input type="checkbox"/> Required <input type="checkbox"/> Not Required		
<input type="checkbox"/> Information	<input type="checkbox"/> Signature	<input type="checkbox"/> Note and Return/Retain	...../...../.....			
<input type="checkbox"/> Comments	<input type="checkbox"/> Circulation	<input type="checkbox"/> Prepare Draft Reply	Signature of .....			
Additional Comments <b>SIL</b> <b>30/3</b> <b>COULD YOU DO AN UPDATE ON THE</b> <b>NOSPITAL SECTION OF THE BLUF (AND OTHER AREAS</b> <b>IF YOU HAVE TIME). I WILL GET CORPS TO COVER</b> <b>THE WATER ETC SECTIONS.</b> <b>I HAVE INCLUDED A COPY OF THE</b> <b>APPROPRIATE SECTION OF THE SOP. ONCE WE HAVE</b> <b>THE BRICS DOWN I WILL GET MALAWI COM TO UPDATE</b> <b>WILSONS MAP G4 MED 30/3</b>						
Originator <b>[Signature]</b>	(Signature)	(Printed Name) <b>WILSONS</b>	(Rank) <b>MAJ</b>	(Appointment) <b>G4 MED</b>	(Phone)	(Date) <b>30/3</b>

ON A REGULAR BASIS.

HOPE PHOTOS WILL BE AVAILABLE TOMORROW.

RD

94 MB?

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## HEALTH INSPECTION REPORT

### KIBUYE

#### General Information

4.1 This report of Kibuye was compiled from information gathered by Environmental Health Section on the 26 -27 Nov 94.

#### Geographical/Geophysical Factors

4.2 Kibuye is west of Kigali located on the Eastern shore of Lake Kivu. Kibuye is surrounded by hills and mountains. Kibuye is 1554 ft above sea - level which is in the range of the Anopheline mosquito.

4.3 The roads to Kibuye are dirt that will be updated to bitumen at a latter stage. There is no date for the proposed upgrade of the roads. The roads become slippery in the wet season and mud slides are common. There was no phone communication available.

4.4 Local water is from underground wells which water is pumped to a water treatment facility within the town. This facility uses sedimentation tanks and rock filters with chlorine added after the filtration. The operator responsible for water treatment has not been seen for four days. Water taken from taps in the UN compound showed no traces of chlorine. It is there for recommended the town water in Kibuye be used for non potable use only and that the Fraibbat Health Representative maintain daily surveillance of township water.

4.5 Soil around the Kibuye area is rich and fertile. This was evident by the amount of crops growing in the area.

#### Demographic Factors

4.6 Approximately 10,000 people live in and around Kibuye. However 75%-80% of those are displaced persons. Most of these people are transients who are moving to and from the camps around Cyangugu and Gikongoro are closed. Very few of the transients are returning home.

4.7 70% of the population is Catholic with the rest being a mixture of Methodists, Adventist and Muslims.

4.8 At present there are three types of people living in Kibuye;

- a. Hutu,
- b. Tutsi, and
- c. Other (UN and NGO's)

4.9 The Rwandan Patriotic Army have acquired several buildings in the Kibuye area. They are of approximately battalion strength with a recruit battalion also present.

4.10 Civilians occupy mud/brick constructed houses as per most of Rwanda. Pre war the level of education was year seven as the norm with only 1% of students finishing Secondary school. The <sup>training</sup> secondary schools have not yet re-opened.

4.11 Typical daily food intake is two meals consisting of beans, sweet potatoes and bananas. As with most towns seen the men drink banana beer in the evenings.

4.12 The people of Kibuye <sup>are frightened of arrest by the RPA.</sup> have a friendly disposition toward ASC personnel. No problems were encountered when gathering information.

4.13 The prefecture was generally seen to be <sup>uncooperative</sup> ~~co-operative~~ by the general community <sup>and the</sup> MILIGAS.

4.14 There seems little activity in the area from RGF/Interhamwe. However, there has been bandits reported.

4.15 As with the rest of Rwanda there are RPA checkpoints on the road to Kibuye. The RPA were not obstructive but merely lethargic in their approach to ASC pers.

4.16 <sup>prefet</sup> The prefecter had no immediate plans for any Health Program for the area.

#### Economic Factors

4.17 The major source of income for the area prior to the war was tourism. Several resorts/hotels can be seen along the shore of Lake Kivu. Post war farming has become the major resource for the area. However, UN soldiers/pers and NGO's are now contributing to the cashflow within the community.

4.18 Kibuye has a daily bus service travel. The buses do one trip to Gittarama daily. The buses sit 42 however, standing room only is the normal. No civilian cars were seen. The vehicles seen were owned by RPA, UN or NGO's. There were a few bikes and pushbikes but most people still get around on foot.

4.19 There is a Tea Industry 42 KM away at Gisovu however, there is problems of obtaining transport. The plantations were not destroyed during the war.

4.20 the area has no capability to produce medical stores of equipment.

4.21 The local area is still depressed from the war. The requirement to move products and medical stores in and out of Kibuye by road <sup>is hampered during the wet seasons.</sup> The UN and NGO's are supporting the community with food and medical assistance.



## MSF & Swiss Disaster Relief

-3-

The local hospital is currently run by ADRA. The hospital has four wards with a total of 160 beds. Treatment costs 100 Francs however, medicine is free. Money received from patients pays for local staff. The hospital statistics indicate that 90-100 people per day for the following:

40

- a. Malaria 65% patients,
- b. Pneumonia 20% patients,
- c. Worms 25% patients,
- d. Dysentery 20% patients, and
- e. Brucellosis 5% patients.

simple blood & urine biochemistry  
for basic malaria parasite, and a

4.23 The hospital has ~~no~~ <sup>limited</sup> pathology available and specific diagnosis of disease type is impossible. The hospital has the following wards:

- a. Surgery/Trauma with anaesthesia,
- b. Internal medicine,
- c. Paediatric, and
- d. Isolation.

e. <sup>maternity</sup>

4.24 There are several satellite clinics around the areas which are run by NGO's. There are no government run clinics at the moment. The only other medical facility is the Frattatt RAP. The RAP treats approximately 80 patients a day. At the moment the RPA has a 14 bed infirmary. They have a limit surgery capability as post operative care and lack of anaesthesia is a problem. Over 90% of the patients are civilian.

MALAWICOY RAP  
Shed, not fully  
functional

### Environmental Health Factors.

4.25 Insect vectors known to be present are:

Mosquito Malaria

Filth Flies Dysentery

26 There are no Environmental control measures for the Kibuye area. Waste water is collected large drains which run through town. The drains are approximately 1m depth X 2m wide.

The hospital is working at about one quarter of its capacity as the local population is afraid to enter Kibuye, fearing dwarf.

4.27 Food preparation is similar to the rest of Rwanda with poor food hygiene standards being observed.

4.28 solid wastes are disposed of in rubbish pits. These pits are usually depressions in the ground. These pits are not burned regularly and contribute to the dysentery problem by allowing access to them by vectors.

## UN RESTRICTED

APPENDIX 3 TO  
ANNEX A

**LOCATION, LEVEL, CAPABILITIES - level 2 and 3 only**  
(Report is requested on the first of every month)

Date of report \_\_\_\_\_

Name of Mission/medical unit \_\_\_\_\_

Change in location, level, capabilities. NO - see former reports  
YES - see report below

## 1 Organization

Name, rank, title of header

Location: \_\_\_\_\_

Point of contact: \_\_\_\_\_

Phone number \_\_\_\_\_

Other communication system (numbers, radio frequencies, call sign etc): \_\_\_\_\_

Next airfield or helicopter/distance.

2. Personnel: physicians/specialists \_\_\_\_\_

nurses.

medics

other

total: \_\_\_\_\_

3. Beds and/or cots total: \_\_\_\_\_

surgical \_\_\_\_\_

maximum number in case of mass casualty.

4. Medical capability specialities \_\_\_\_\_

isolation ward \_\_\_\_\_

UN RESTRICTED

UN RESTRICTED

- 5 Intensive care unit ICU beds \_\_\_\_\_  
equipment \_\_\_\_\_
- 6 Surgical capability specialities \_\_\_\_\_  
\_\_\_\_\_  
operating rooms \_\_\_\_\_  
operating teams \_\_\_\_\_
- 7 Laboratory capabilities microbiology \_\_\_\_\_  
virology \_\_\_\_\_  
parasitology \_\_\_\_\_
- 8 X-RAY skeleton \_\_\_\_\_  
abdominal \_\_\_\_\_  
ultrasound \_\_\_\_\_  
others \_\_\_\_\_
- 9 Blood bank: screening methods \_\_\_\_\_  
\_\_\_\_\_
- 10 Dental Capability \_\_\_\_\_
- 11 Other special capabilities: \_\_\_\_\_
- 12 Preventative medicine assets: \_\_\_\_\_
- 13 Veterinarian service \_\_\_\_\_
- 14 Medevac capability ground (number of ambulances): \_\_\_\_\_  
air (number of aircraft - Capacity and Location: \_\_\_\_\_  
request procedures incl. phone number or frequencies: \_\_\_\_\_  
\_\_\_\_\_

UN RESTRICTED

<div>Dose</div> <div>Vaccin/Vaccine</div>	1re dose <i>1st dose</i>	2me dose <i>2nd dose</i>	3me dose <i>3rd dose</i>	Rappel <i>Booster</i>
BCG				
DT COQ / <i>DPT</i>				
POLIO				
ROUGEOLE / <i>MEASLES</i> <i>après 9 mois / after 9 months</i>		<div>Richard, the records were delivered to COL WARFE ? Do you know anything about it ? Brian</div>		
Autre Vaccin / <i>Other vaccine</i> .....				
ROUGEOLE / <i>MEASLES</i> <i>6-8 mois / 6 - 8 months</i>				

PAYS/COUNTRY:.....

**CARTE DE VACCINATION**  
**IMMUNIZATION CARD**

N°

Nom / *Name* : .....

Nom du père : .....  
*Father's name*

Nom de la mère : .....  
*Mother's name*

Date de naissance : .....  
*Birth date*

Sexe / *Sex* : .....

Adresse / *Adress* : .....  
.....  
.....

25/0109

MRS. W. K. S. M. R.  
SITREPS OTHERS

**FROM : WHO SPECIAL COORDINATOR  
TO : UNREO  
ATTENTION : IN COUNTRY REPORT**

RU  
PB  
Lup  
IOC  
MF  
NGO

## **EPIDEMIOLOGICAL SURVEILLANCE**

The most important events this week in the field of the epidemiological surveillance are as follow :

- Meeting with national programme managers of Tuberculosis and Lepa, AIDS, Malaria, EPI, and CDD/ARI to discuss about their contribution for to health data collection system put in place. The proposed forms have been improved to integrate special needs of these priority programs.
- An update training of the personnel of the epidemiological department at the MOH in Data base Mapping. This training session is an activity of the WHO support project for the reestablishment of nationwide epidemiological surveillance system.

WHO is cooperating with UNREO in setting up a common data base to monitor the returnees flow. The joint data base will provide information on returnees resettlement and on district population.

## **AIDS**

WHO support to the national AIDS Programme is still going on. The weekly agenda is focused primarily on planing aspects.

## **REFUGEES**

A mission has been conducted to visit Reception Centres of 1959 Refugees case load. Health conditions in these centres were very poor because of the lack of proper resources. UNHCR and WHO in conjunction with local NGOs such MSF, Caritas, Merlin and German Emergency have decided to elaborate a contingency plan to relieve the situation. A plan of action to prevent epidemics and to provide basic health care has been elaborated and will be implemented.

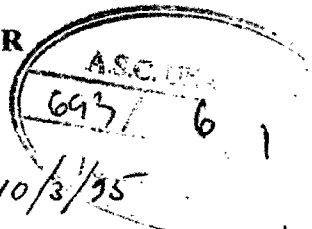
## **OTHER ACTIVITIES**

After the WHO Seminar on the Adolescent health which took place in Dakar Senegal (2/27 - 3/10/1995) and in which Rwanda was represented, WHO will finance a Government project which has to improve the adolescent accessibility to the health services.

**FROM : WHO SPECIAL COORDINATOR**

**TO : UNREO**

**ATTN : IN COUNTRY REPORT , 6-10/3/95**



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## **Health Policy**

Following the national health policy based on the District Health Approach, as adopted in January 1995, the Ministry of Health has decided to test the system in 4 pilote districts during 1995. WHO will support that experience with emphasis on the epidemiological surveillance, the drug policy, the training of district health teams and other vital programmes such as MCH, mental health and AIDS. Necessary human resources will be provided by the MOH.

## **Diseases control**

### **AIDS/STD**

WHO supported the organization of a national workshop on Sexually Transmitted Diseases (STD). A consensus on STD management policy was reached after the work shop.

A training session has been organized with the aim of reestablish the national capabilities in HIV laboratory testing. A total of 12 laboratory technicians from Kigali, Butare and Ruhengeri completed the training. It must be noted that these technicians were recruited from National AIDS Program Laboratory, University Teaching Hospital Laboratory and Transfusion Centres

Leaders from a network of 50 women's groups/associations are being trained in AIDS prevention strategies with support from WHO. Those women's associations are identified from all the 10 prefectures of the country with the collaboration of the Ministry of the Family and the Promotion of women and the Ministry of Youth.

## **Operation Retour**

WHO in collaboration with the other members of the Health Cell with regard to the Operation Retour (Internally Displaced Persons) continued to hold the weekly meetings where relevant issues were shared according to the plan of action. In this context, a trip was made to the Kibeho (Gikongoro) camp with the objective of assesment of the health situation in the camp and monitor the health screening process of the returnees from camps to the home communes. The health situation was noted to be satisfactory due to the work of NGOs field workers.

As mentioned in the previous reports, a good number of health facilities in the home communes remain non-functional because of lack of qualified personnel.



## **Epidemiological Surveillance**

WHO is assisting the Ministry of Health in up-grading the Epidemiological Information System set up in November 1994. The system will be improved so that it will include tools to monitor the health aspects of Returnees and Internal Displaced Persons.

WHO has continued with the national program on diarrhoeal diseases the study on the chemoresistance of Shigella to antibiotics in 8 prefectures of Rwanda. The results will be used to improve the national policy of Diarrhoeal Disease Control.

## **Refugees**

Around 300 to 1000 refugees are repatriated to Rwanda every week. Despite the slow return movement, agencies including WHO have judged the trend very positive.

UNHCR and WHO are working together on the health coverage and the epidemiological surveillance during repatriation. A particular attention has been paid to the Tuberculosis programme in the camps and the follow up of patient after they return to Rwanda.

## **Other activities**

WHO is having discussions with UNICEF to identify uncovered needs in assistance to the women and children victim of the rwandan tragedy. This consultation will help WHO to set up priorities of action in a project under preparation.

To: UNREG GIKONGORO, BUTARE, SECTOR 3 GITARAMA  
From: IOC  
Date: 31 Mar 95

The following transmission had problems at the first attempt, and failed at the second attempt. Here goes for the third try.

INTEGRATED OPERATIONS CENTRE  
(IOC)  
OPERATION RETOUR WEEKLY REPORT 20 - 26 MARCH 1995

Kigali, 27 March 1995

SUMMARY

The government reiterated its desire to see IDPs return home as soon as possible, through a revitalised Operation Retour.

The Integrated Task Force focused on immediate action to rehabilitate basic commune infrastructure, alongside the plan to empty the camps.

Numbers of IDPs transported under Operation Retour remained low.

SECURITY

Restricted access

Restriction of movement was reported in Mugesera commune. The Prefet of Kibungo is tackling the problem.

Possible insurgency

A routine check by RPA soldiers resulted in two people being arrested on 17 Mar in Ngarama. According to military observers, those arrested were found to be carrying grenades, and are believed to be members of the former government forces.

Rwamiko security incident

UNAMIR reported a man in Rwamiko commune, which houses Rwamiko IDP camp, robbed on 21 Mar and killed on 22 Mar, apparently by bandits.

NUMBERS

Low numbers continue

Very few people chose to leave the camps and go home. 490 people were transported from the camps, mainly Kibeho, during the reporting period. A number of these take no belongings, and are therefore not thought to be returning home but taking advantage of the transport for other reasons. Daily numbers transported were as follows:

20 Mar - 190	23 Mar - 86
21 Mar - 64	24 Mar - 85
22 Mar - 65	

This brings the total number transported by vehicle since Operation Retour began on 29 Dec 94 to 41,050.

CAMPS

New arrivals in camps

Buhoro camp was reported to have received new arrivals from

Australian Contingent  
- gent

COMASC

fly

- G3 Med

- G4 MED

Nyabisindu, Maraba, Ngoma, Muyira and Ngenda communes. Gisunzu camp was reported to have recently received 48 new arrivals, mainly from Huye, Maraba and Runyinya communes.

#### Calm in camps

All camps were reported to be calm during the reporting period.

#### New Kibeho camp figure

Kibeho camp is now reported to have a population of around 84,000, considerably lower than previously thought. Previous figures were largely drawn from food registration lists, which are routinely inflated.

#### Government visit to Kibeho

The Minister of the Interior, the Minister of Information and the Chief of Staff of the Gendarmerie visited Kibeho camp on 24 Mar. They held discussions with the inhabitants of the camp on the prospects of returning home, and current moves towards peace and national reconciliation.

#### Government urgency for camp closure

The Prefet of Gikongoro, a senior local government official, insisted on 23 Mar that a revitalised operation to close the camps be operational within two weeks. He wished Kamana camp - the southernmost - to be emptied first, and then for the operation to work north. He announced new curfew arrangements, and the forcible closure of markets - two measures which he intends to impose in Ndag0 and Rwamiko camps.

#### Liaison between Kigali and local government

Meetings in the field between central and local government are planned to ensure good consultation and coordination over Operation Retour.

#### Operation "Topaz"

A further 315 people were transferred from Groupe Scolaire (Butare educational establishment) to newly built facilities in Runyinya under "Operation Topaz". The operation has been arranged by local officials with the help of international agencies, in order to enable Groupe Scolaire to reopen. Those moving are people originating from Gikongoro communes but who are unable or unwilling to return home until the IDP camps there diminish. Groupe Scolaire has until recently been occupied by about 10,000 IDPs. A lack of water in Runyinya is being tackled by Unicef, who will provide water pending a longer-term solution.

#### COMMUNES

##### Communes in south-west Butare

The communes of Runyinya, Gishamvu and Nyakizu in the south-west of Butare prefecture are reported to be ready to absorb large numbers of returning IDPs, with few security problems. As many as 90,000 people currently in the Gikongoro camps are thought to come from these three camps, which are within 20 km of Kibeho camp. At the moment almost none of these IDPs take the opportunity to go home.

##### Commune rehabilitation

A detailed plan for commune rehabilitation is nearing finalisation. The aim is to mobilise funds for institutional support at commune level. Basic infrastructure assistance (office equipment, transport for officials, etc) is needed very quickly in communes due to receive most returning IDPs.

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## INFORMATION CAMPAIGN

## Target communes

It will be for the information campaign to target communes that will receive most people from the camps and are most ready to receive new arrivals. As other communes are judged by the Task Force/IOC to be ready for large inflows, the information campaign can also include those communes.

## Sake

The bourgmestre of Sake has been addressing the sectors of his commune in an attempt to calm those who because of rumours may be thinking of leaving Rwanda for Burundi.

## DATABASE

CARE International and WHO are contributing to the integrated humanitarian database. The British Overseas Development Agency also expressed interest in participating alongside the other organisations already involved.

## VISITS

Ambassador Khan, the SRSG, visited the IOC on 24 Mar.

## COORDINATION

The Integrated Task Force was attended by a Ministry of Justice official for the first time for many weeks - a very welcome addition. The Commune Rehabilitation Committee was tasked to produce a detailed written plan by the next Task Force meeting.

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R I.. BC-RWANDA-PRISONERS 03-31 0237

BC-RWANDA-PRISONERS

ICRC COMPLAINS ABOUT RWANDAN PRISONS

GENEVA, MARCH 31 (REUTER) - THE INTERNATIONAL COMMITTEE OF THE RED CROSS COMPLAINED ON FRIDAY ABOUT OVERCROWDING IN RWANDAN PRISONS, WHERE TENS OF THOUSANDS OF DETAINEES ARE AWAITING TRIAL ACCUSED OF TAKING PART IN LAST YEAR'S MASS KILLINGS.

THE ICRC SAID ITS PRESIDENT, CORNELIO SOMMARUGA, MET WESTERN DIPLOMATIC REPRESENTATIVES EARLIER ON FRIDAY AND APPEALED FOR NEW PLACES OF DETENTION TO BE BUILT.

IN A STATEMENT, THE ICRC SAID ITS DELEGATES WERE REGULARLY VISITING 30,000 DETAINEES IN 135 DETENTION CENTRES.

SOMMARUGA TOLD THE DIPLOMATS THAT THE PRISON POPULATION WAS GROWING BY 1,500 EVERY MONTH AND "IN A NUMBER OF INSTITUTIONS THERE WERE NOW UP TO FOUR INMATES PER SQUARE METRE OF FLOOR SPACE THROUGHOUT THE COMPOUND AND UP TO SIX PERSONS PER SQUARE METRE IN THE DORMITORIES."

THE ICRC'S CAMPAIGN TO HAVE BETTER PRISON CONDITIONS IN RWANDA -- IT FIRST APPEALED LAST YEAR -- WAS GIVEN WEIGHT BY THE DEATHS BY SUFFOCATION TWO WEEKS AGO OF 22 PRISONERS IN A JAIL NEAR KIGALI.

"SUCH INHUMAN OVERCROWDING HAS MANY CONSEQUENCES, WHICH INCLUDE DISASTROUS HYGIENE CONDITIONS -- AND THEREFORE THE RAPID SPREAD OF DISEASES, SUPPLY DIFFICULTIES AND EXACERBATED TENSION BETWEEN THE DETAINEES," THE ICRC SAID.

"INDEED, IN ADDITION TO THE HIGH DEATH RATE DUE TO THE CONDITIONS THEMSELVES, THE SITUATION HAS ALREADY GIVEN RISE TO INCIDENTS WHICH HAVE CLAIMED THE LIVES OF A NUMBER OF DETAINEES."

REUTER REUT11:41 03-31

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R I.. BC-RWANDA-BRITAIN-REFUGE 03-31 0139

BC-RWANDA-BRITAIN-REFUGEES

THOUSANDS OF RWANDAN REFUGEES FACE DEATH

LONDON, MARCH 31 (REUTER) - THOUSANDS OF RWANDAN REFUGEES FACE DEATH IN ZAIRE FROM HUNGER AND CHOLERA, THE INTERNATIONAL SOCIETY FOR HUMAN RIGHTS (ISHR) SAID IN A STATEMENT ON FRIDAY.

THE NUMBER OF REFUGEES IN THE GOMA CAMP HAS SWELLED TO 900,000 AND MASS DISTURBANCES HAVE ERUPTED BECAUSE FOOD RATIONS HAD TO BE CUT TO A THIRD OF THE 600 CALORIES NEEDED BY EACH INDIVIDUAL, THE ISHR SAID.

"LATEST REPORTS FROM ISHR'S FIELD WORKERS IN GOMA, A ZAIREAN TOWN ON THE BORDER OF RWANDA, STATE THAT THE CONDITION OF RWANDAN REFUGEES IN ZAIRE HAS ONCE AGAIN DETERIORATED."

THE ISHR SAID EXISTING MEDICAL SUPPLIES CANNOT COPE WITH THE NEW OUTBREAK OF CHOLERA.

THE CENTRAL AFRICAN COUNTRY OF RWANDA WAS PLUNGED INTO CIVIL WAR LAST YEAR WITH MORE THAN A MILLION PEOPLE KILLED AND ANOTHER TWO MILLION FLEEING THE COUNTRY.

REUTER REUT11:03 03-31

UNITED NATIONS

ASSISTANCE MISSION FOR RWANDA



NATIONS UNIES

MISSION POUR L'ASSISTANCE AU RWANDA

UNAMIR - MINUAR

File No : 445-16-1

Minute No : Med/Log 344/95

LHQ (Attn: SO1 Health Ops. Health Svcs Br)

For Info:

SGADF (Attn: SO1 HL DHPI)

#### HEALTH INFORMATION RWANDA

1. Enclosed please find some further basic information on the humanitarian support commitments and organisations working in Rwanda. All information was obtained from the Integrated Operations Centre (IOC), a NGO/Government/UN coordination organisation.
2. Please advise if this information is to be redirected to LHQ Int Br/DIO or if you wish it to be sent directly to Health Svcs Br/SGADF HL. I would appreciate Int Br/DIO being made aware of the existence of this information.
3. As stated previously, please do not hesitate to make specific requests for information.

A handwritten signature in black ink, appearing to be 'R.P. Wiltshire', written over the number '3'.

R.P. WILTSHIRE

MAJ

G4 MED

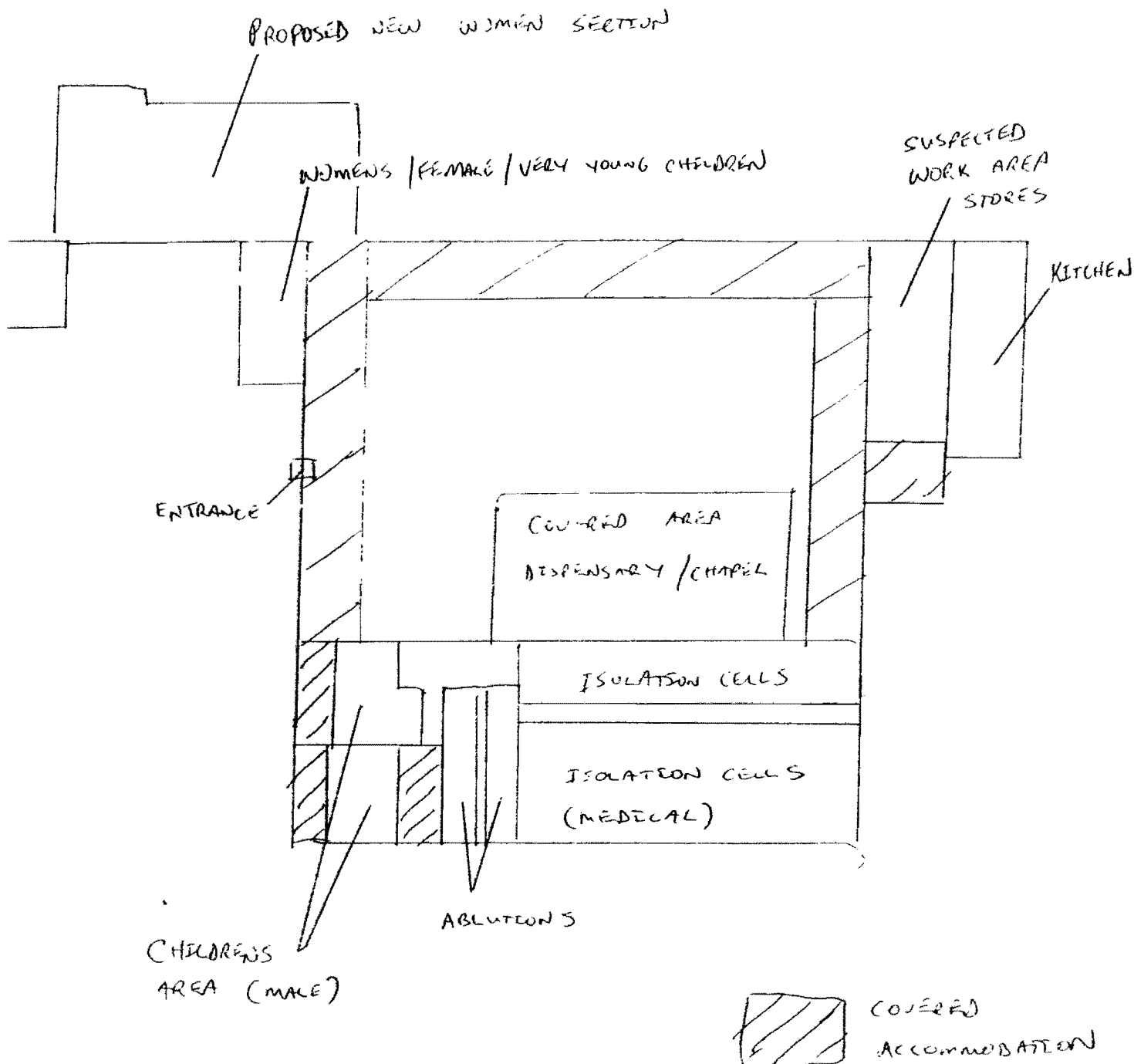
HQ UNAMIR

5 Apr 95

Enclosures (Copies to SGADF also):

1. IDP Bulletin: 20 - 26 Mar 95
2. IOC Information
3. WHO Assistance to Rwanda
4. Contact details on Organisations working in Rwanda dated 1 Apr 95
5. Structure and manning of the IOC
6. NGO Activity by Sector and Prefecture dated 29 Mar 95

KIGALI JAIL

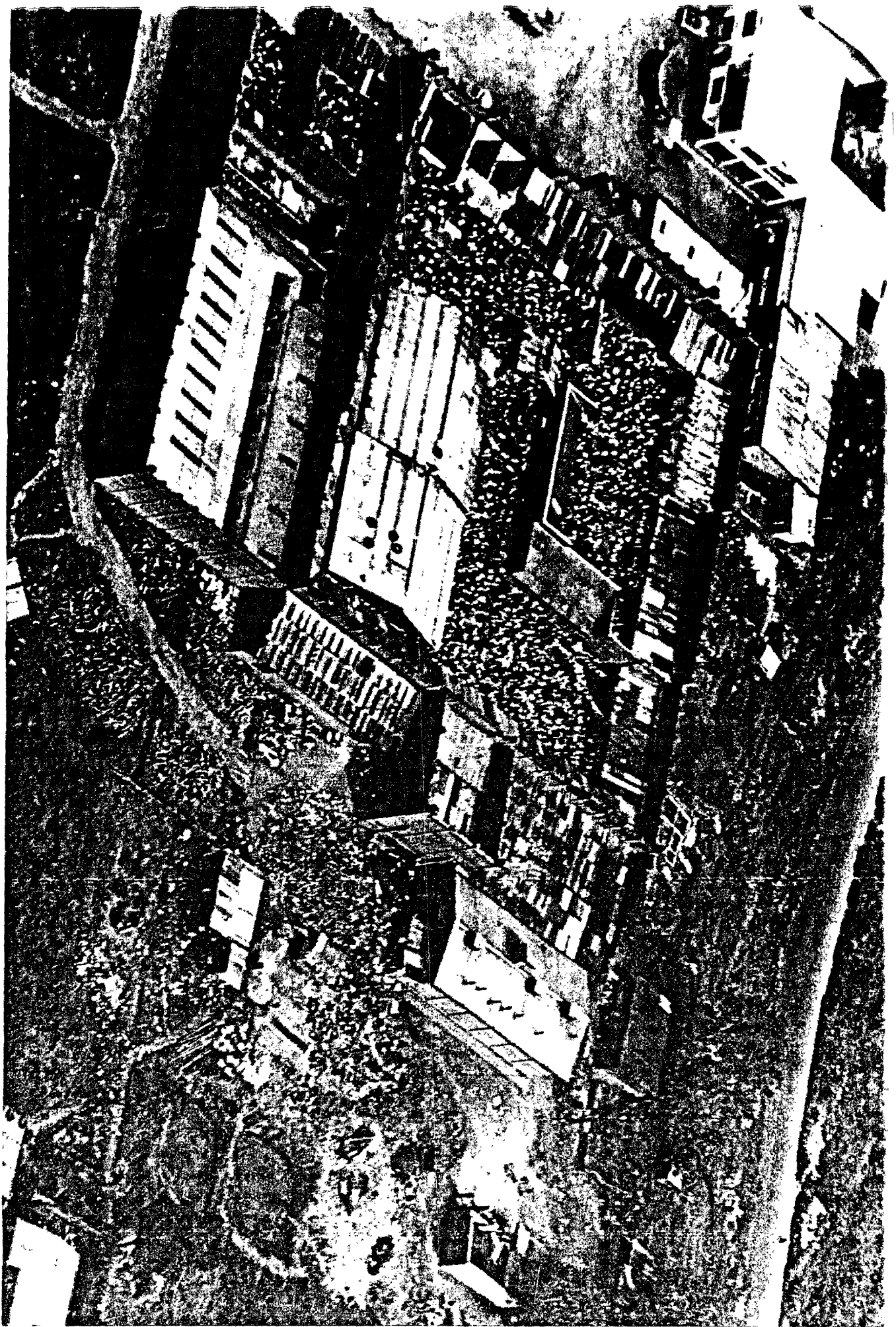


NOT TO SCALE

PERSONAL FOR CAPT NERNEY  
WO2 SMITH

KIGALI TOURISM X





# ORGANIZATIONS WORKING IN RWANDA

Produced by UNREO NGO Liaison Unit

23-Mar-95

ORGANIZATION	SHORT_NAME	CONTACT	PHONE	FAX	ADDRESS	VHF_CALL
ACORD	ACORD		74619	73614	Rue du Mont Huye	
ACTION INTL CONTRE LA FAIM (FRANCE)	AICFFR	Philippe Pallot	77682	77682	14B, rue de Progres	
ACTION INTL CONTRE LA FAIM (USA)	AICFUS	Louise Griep			BP 2349, Kigali	
ACTION NORD-SUD/HANDICAP INTL	ACTION	Alain Furlan	83689	83689	Kimihurura	
ADEPR/PMU INTERLIFE	ADEPR	Alfred Tobler, Jean Sibomana	72155		Rue de Recolte, Nyarugenge	76
ADRA	ADRA	Carl Wilkens, Ranjan Kulaserere	72570	72571	BP2	
AEF INTL	AEF	Dr Wesongah	76390		Justice Street, Nyarugenge	
AFRICA HUMANITARIAN ACTION (AHA)	AHA	Askale Binaga	72239		Rue dep Kayuku #37	
AFRICA JAPAN FORUM	AJF	Yukika Shlawel				
AFRICA MUSLIMS AGENCY	AMA	Bisher Ismail Ibrahim	72849	77690	Nyamirambo	
AFRICAN MEDICAL & RESEARCH FUND (KENYA)	AMREF	Jean Marc Michel			Byumba	
AFRICAN REVIVAL MINISTRIES	ARM	Stany Bizyaremya				
AFRICARE	AFRICARE	Cary Alan Johnson	83731	83731	former Restaurant Hellenique, Kimihurura	
AIDE ET ACTION	AIDACT	Phillippe Langillotte	73129	72364	2 Rue de L'Akagera	ALPHA
AMERICAN JEWISH JOINT DIST. COMM.	AJJDC	Manlio Dell Artocle, Charles M G			c/- IRC	
AMNESTY INTERNATIONAL	AI	Matthew Ganda	82952		Plot No. 56, Kimihurura, near Pentecost	
AMURT (SWITZERLAND)	AMURT	Ravindra K Prabhakar	72271		C/- WPF Warehouse, Industrial area	
ARMEE DU SALUT	ADS	Samuel and Liselotte Holland	83276		Kicukiro	SAVLO-KIL
ARTC	ARTC					
ASSN FINISTERIENNE DE SOLIDARITE AVEC LE	AFSR				Remera	
ASSN FRANCAISE DES VOLONTAIRES DU PROGR	AFVP	Manasse Rwibogora			Rue de L'amitie	
ASSN OF MEDICAL DOCTORS OF ASIA	AMDA	Navin Takur	72992	72992	10 Rue de Deputy Kajangwe	

ORGANIZATION	SHORT_NAME	CONTACT	PHONE	FAX	ADDRESS	VHF_CALL
ASSN POUR L'ACTION HUMANITAIRE	AAH	Sophie Romana	75186	75186	5 Rue du la Mpanga, Nyarengenge	
ATLAS LOGISTIQUE	ATLAS	Francoise Gillet	75333	75333		
AUSTRIAN RELIEF PROGRAM	ARP	Jean Mutamba	76141	76141	Boulevard de la Revolution 16	
AVIATION SANS FRONTIERES	ASF	P. De Hennin	82023	82023		
AVSI ITALY	AVSI	Albino Dacco	72326		1 Rue du Mont Juru	
BAMBINI DEL RUANDA	BAMBINI	Gianpiro Baldassarri			Canini Hospital	
BAPTIST RELIEF SERVICES	BRS	Larry Randolph	76877		12 Rue du Lac, Burera	
BORNEFONDEN	BORNE	Hans H. Krarup	84413	84413		
BRITISH DIRECT AID	BDA	John Attlee	82062 85691		Workshop "Dany" BP 1072, Indust estate	KB1
BUFMA/ MEMISA	BUFMAR	Hennie Zonderland	86176		Rue de Ministeres opp Chambre Commerce	
CANADIAN PHYSICIANS FOR AID AND RELIEF	CPAR	Gizaw Shilbru	268064			
CARE INTL	CAREINTL	Christy Gavitt	72402			
CARITAS SWITZERLAND	CARISUI	Ewald Zimmer	256486 23420		P O B 956, KABALE	
CATHOLIC RELIEF SERVICES	CRS	Chris Hännemeyer	82109, 82112	82127	Kyoliro nr Meridian Hotel	
CECI	CECI	Valmore Cole	82171	82171	Kacukiro, Kigali	
CESAL SPAIN	CESAL	Christophe Hakza	72326		1 Rue Mont du Juru	
CHILDREN'S RELIEF (GERMANY)	CRA	Christa Lehrer, Thomas Franke				
CHRISTIAN REFORMED WORLD RELIEF COMMITTEE	CRWRC	Patsy Orkar and Keith Skyler	73654, 85711		C/- FFTH, 30 Ave Depute Kamazirizi	
CHURCH WORLD ACTION/ACIST (WCC)	CWA/ACIS	Ben Holtrop	74182, 74547	77102	33 Rue Depute Kayuku, Kiyovu	
CHURCH WORLD ACTION/LUTHERAN WORLD FED	CWA/LWF	Jaap Aantjes	74182, 74547	77102	33 Rue Depute Kayuku, Kiyovu, BP968	
CHURCH WORLD SERVICE	CWS	Ruth Brown			c/- AFRICARE	ROMEO BR
CITIZENS' NETWORK	CITIZEN	Caroline Petiaux	84684	84684	Kacyiru	
COMMUNAUTE EMMAUS	EMMAUS	Abbe Marinu, M van der veen	73955		Gatsata BP 2058	
COMPASSION INTL	COMPASS	Vivian	73256		Ave de la Justice (1st floor INdR build)	
CONCERN WORLDWIDE	CONCERN	Dominic MacSorley	72208		10 Rue Mont de Juru	CHARLIEKI

ORGANIZATION	SHORT_NAME	CONTACT	PHONE	FAX	ADDRESS	VHF_CALL
COOPERAZIONE INTERNAZIONALE	COOPI	Raffaello Muraro			Magasin de l'imprimerie Scolaire, Gisenyi	
COOPIBO RWANDA	COOPIBO	Marie Goretti Nyirarukunio	72680		Avenue de la Justice BP 454	
CROIX ROUGE BELGIQUE	CRB	Willem Dewinet	72954, 73640	72955	Ave de L'Akagera	BUREAU 5
QUAMM	CUAMM	Dal Lago Tito	75722		41 Rue Depute Kayunu	
DIAN ROSSEY GORILLA FUND	DFGF	Dieter Steikls	847611		BP 105 Ruhengeri, Plot 593 Kimihurura	
DISASTER RELIEF AGENCY	DRA	Sjaak de Boer	75619, 72386	74671	5 Rue Depute Kajangwe	
ECOTERRA INTL	ECOTERRA	Louis Isabagana			c/- OXFAM Quebec	
ENFANTS DU MONDE	EDM	Laurent Tatford	77768		7 rue Bugarama, Kiyovu,	
EURONAIID	EURONAIID	Chris Brice			c/- TRANSINTRA	
FEED THE CHILDREN (EUROPE)	FTCEUR	Ulfur Bjornsson	73359	73011	Bld. de la Paix	KIGALI FTC
FONDATION TERRE DES HOMMES	FTDH		77768			
FONDATION TERRE DES HOMMES - RWANDA	HOMMES	Laurent Tatford			7 Rue du Bugarama, Kiyovu	
FOOD FOR THE HUNGRY INTL	FFTHINTL	J. Kila Reimer, S Michelle Leffler	73654		30 Ave Depute Kamazinzi	KILO ZULU
FRATERNITE NOTRE DAME INC	FRAT	Aere Marie Joseph, Marie Jeann				
FRIENDS OF THE WEST INTL (USA)	FWI	Kathryn Snyder, Tara Rice			Past IVECO towards airport	
GERMAN AGRO ACTION	GAA	Jurgen Feldmann	76348		P.O. Box 186, 11 Ave. Kiyovu	
GERMAN EMERGENCY DOCTORS	GED	Michael Smeeck, Serge Gasana			Kabuga 20 km. east of Kigali	
GESELLSCHAFT FUR TECHNISCHE ZUSAMMENARB	GTZ	M Strahler			11 Ave Kiyovu	
GLOBAL OPERATION AND DEVELOPMENT	GOD	Jacqueline Hodgkins	72570		c/- ADRA PB2 Kigali	
GOAL (IRELAND)	GOAL	John Gling			Kacyiru 880	KILO OSCA
HEALTH AID UK	HEALTH	Carrie O'Mahony, Robert Powles	72572			
HEIN NEBELING ISENSEE, ALLEMAGNE	HNI	Daniel Meier	75222	77267	PO Box 1211 Kigali or c/- German Embassy	
HELP (GERMANY)	HELP	Ulrike Kirchgaesser	75388		C/- GTZ	HOTEL KIL
HELPAE INTERNATIONAL	HAI	Helen Atkinson	83383	73684	Kimihurura	
HOPITAL SANS FRONTIERE	HSF	Carol Tricoche				



ORGANIZATION	SHORT_NAME	CONTACT	PHONE	FAX	ADDRESS	VHF_CALL
NORWEGIAN PEOPLES AID	NPA	Jens Erik Sundby	72616	72616	BP 2966, Rue du Progress, Kiyovu	KILO PAPA
NUTRIPA	NUTRIPA	Nadine Donnet	76511	76511	Ecole Francaise de Butare, Butare	
ORA INTL	ORA	Heinrich Floreck	77207			
ORPHELINS DU RWANDA	ORPHEL	Vienot Jacques-Henry			c/- ACTION Nord/Sud	
OXFAM QUEBEC	OXFAM/QB	Michel LeFevre	86957	86957	Kimihurura	
OXFAM UK I	OXFAM/UK	Jane Mathieson	82912	82912	BP 1298 Kimihurura (near Kigali Nights)	OSCAR KIL
PHARMACIENS SANS FRONTIERES	PSF	Richard Houot	75186, 7703		5 du Lac Mpanga, Nyarugenge	
PREMIERE URGENCE	PREMIERE	Pierre Verdoja			French Cultural Centre	FROG 1-10
PRODEVA/AVIONS SANS FRONTIERES	PRODEVA	G Larocque	86957	86957	Kimihurura (at OXFAM Quebec house)	
PROG. DU SECURITE ALIMENTAIRE UE RWANDA	PSAEU	Alain Houyoux	75586, 75583	74313	Rue Depute Kamusinyi	Not Provided
PROMOTIONS INITIATIVES LOCALES DEVELOPPE	PILD	Tommy-Tanbwe Nzeyimana	75145		BP 171, Kacyiru, across from Meridien	
RADIO AGATABHYA (RSF-SUISSE)	RADIOAG	Philippe Dahinden	76901	74723	Village Suisse, 32 Ave Depute Kayuko	
RED BARNET (SCF DENMARK)	RBARNET	Lars Heyn	77451		c/- SCF (US) 10 rue de Masaka	
REFUGEE TRUST IRELAND	RTI	Anne Malone	72905		next to Ethiopian Restauent, Kourvu	
SAMARITAN'S PURSE INTL RELIEF	SAMAR	Jack Norman	84780		CHK Hospital, Remera	SPK
SAVE THE CHILDREN FEDERATION (US)	SCFUS	Jay Zimmerman	76078		10 Rue Masaka	
SAVE THE CHILDREN FUND (UK)	SCFUK	Steve Rifkin	73381		Avenue de la Justice Manumetal Compound	
SENTINELLES	SENT	Dominic Vulchard	75738	72461	Swiss Embassy	
SERVICE ALLEMAND DE DEVELOPPEMENT	SAD	Ancilla Mukangira	76348		Face a L'ecole Belge	
SOLIDARITES, FRANCE	SOLID	Sylvie Robert	76619	76619	BP 1297, Kigali 20 Ave de L'armee	SOLIDARIT
SOS CHILDRENS VILLAGES	SOS	Klaus Keller	83870		Kakiru	
SUSTAINABLE AGRICULTURE SUPPORT FOR ORPH	SASO	John Hunwick			Gasetse, Kibungo	
TEAR FUND	TEAR	Marius Jodsten	76741		Muhima, Kigali	
TERRE DES HOMMES NETHERLANDS	TDHN	Marguerite Miedema	75619		Rue depute Kayangwe 5	
TRIANGLE GENERATION HUMANAIRE	TRIANGLE	Lionel Thvert, Frederic Poupard	82959		BP 372, Kimihurura across from parlimen	

ORGANIZATION	SHORT_NAME	CONTACT	PHONE	FAX	ADDRESS	VHF_CALL
TROCAIRE	TROCAIRE	Olga Mc Donogh	72937	72190	41 Rue Depute Kayuku	
VISA SANTE + ASSOC FRATERNIERE	VISA	Jean Marc Dueymes			Hopital de Rwamagana , 54 km frm Kigali	
VOLCANO VET CTR/MORRIS ANIMAL FOUND	VOLCANO	John E. Cooper	75601	76541	c/o US Embassy or Mille Colline, Kigali	
WORLD CONCERN INTL	WCONCERN	Al York	82608		Kacyiru Nord	
WORLD RELIEF INTL	WRELIEF	Jean Gakwandi, David van Vuur	77668/72613		11 Rue Kallimbi	
WORLD SOC. FOR THE PROTECTION OF ANIMALS	WSPA	Mike Pugh			Muhlira Road	
WORLD VISION INTL	WVISION	Norbert Clement	75762	76229	3 Rue Depute Kamuzinzi	VISION 1 to
ZOA REFUGEE CARE	ZOA	Gerrit Noordam			bp 3026 Nyamate	
ACTION TECHNIQUE DIUN DEVELOPPMENT COMM	ATEDEC	Jonathan Gasuzuguro			BP 2642, Remera	
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ADRI	ADRI					
APIDERBU	APIDERBU	Athanase Gakwaya	86625			
ARAMET	ARAMET					
ARBEF	ARBEF	Dr Mungwakuzwe Canisius	76127		BP 1580, Kigali	
ARDI	ARDI	Habyarimana Mwpanda	73961	73961	BP 1295, Kigali	
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ASBL DIALOGUE	ASBL	Charles Karemano				
ASSN POUR LE DEFENSE DES DROITES D	HAGARUKA	Zaina Nyiramatama Karemera	73961			
ASSN VOLONTAIRES POUR DEVELOP INTEGRE	AVODI	Michel R. Makebo			Rutongo	
BARAKABAHO FOUNDATION	BARAK	N. Lexis Birindahagabo	84102		Kayiru	
CARITAS RWANDA	CARIRWA	Michel Andre	76331		next to La Rwandaise, Rue du Lac, Rivero	
CCOAIB	CCOAIB	Landrado Mukayiranga	72217			
CFRC (IWACU)	CFRC					
COMPNGNS FONTAINIERS RWANDAIS	COFORWA	Sylvain Bourguet-Kanyamigezi			BP 53 Giterama BP 3152 Kigali	
CONSEIL NATIONAL DE CONCERTATION DES ORG	COSYLI	Mungwakuzwe Canisius, Habyar			Ave Nyabugogo, Muhola	

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KORA ASBL	KORA	Francois Lefftnema				
LA DOLOEVITA MILOT	DOLCE	Jean de dieu Hakizimana	7414077031		Remera, Kigali, BP 830	
PREFED	PREFED	Mulami Mutombo	77728	74292	BP 1897 Kigali	
RESEAU DE FEMMES POUR LE DEVELOPPMENT	RFD	Immaculee Mukankubito	73268		Nyamirambo	
RWANDA RURAL REHABILITATION INITIATIVE	RRRI	John Bonda Bideri			BP 133, Kacyiru	
RWANDAN FAIR CHILD FOUNDATION	RWAFAIR	Elijah Nduwayesu	73188			
SOC DE ST VINCENT DE PAUL	SSVP	Mathias Byusa	74495		BP 267	
SYNESER	SYN	Jean Baptiste Munderere				
HIGH COMMISSION FOR REFUGEES	UNHCR					
WORLD FOOD PROGRAMME	WFP					
CANADIAN EMBASSY	CAN	Claude Latulippe	73210	72719	BP 1177, Rue De L'Akagera	
INTERNATIONAL ORGANIZATION FOR MIGRATION	IOM	Paul Howard				KILO INDIA
INTL COMM OF THE RED CROSS	ICRC	Jean Francois Sangsue				
INTL FED OF THE RED CROSS (GENEVA)	IFRC	Adrian van Drongelen	76530	76541	Mille Collines Rm 324	
PROG DU SECURITE ALIMENTAIRE AU RWANDA	PSA	Alain Houyoux, Jacqueline Uwu	75588 75589	74313	Rue Depute Kamuzinzi (Deleg du la CEE)	
SWISS DISASTER RELIEF	SDR	Swiss Embassy	75738	72481	Swiss Embassy	

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