messages

→ N° 130 / May 2004 / Médecins Sans Frontières internal newsletter

→ Southern Sudan, next to Akuem Hospital. Florence Galy - December 2003

DOSSIER

Healthcare for women

MSF/April 2004/Jean-Hervé Bradol/Interviewed by Aurélie Grémaud.

The forthcoming AGM will provide an opportunity to address – among other issues –Healthcare for women. The president of the association, Jean-Hervé Bradol, looks at the reasons for this choice, explains the issues at stake and calls for a debate to clarify our medical goals.

→ Why has "Healthcare for women" been chosen as one of the main topics on the AGM agenda?

The debate on women's health has been generated by an observation: we fall short of our medical responsibility towards an entire category of patients, women. Concretely, certain preventive and curative healthcare procedures specific to women are rarely available on our missions, despite the high demand: the relative lack of care for rape victims is a good example, which is not without discriminatory undertones. We have to define the scope of our action if we are to improve this situation.

The aim of the discussions at the AGM and mini AGMs is to find the means to step up care for women. This is not about putting the world to rights, calling for justice and calling for an end to impunity for rapists. It is simply a question of increasing the supply of care for women, from contraception to the treatment of sexually transmitted diseases and from specialised surgery (such as fistulae) to caesareans in total safety for the patient. It is not hard to define our scope of

▶ page 4 ●●●

Number 130

We do not provide women's healthcare as such, nor men's healthcare for that matter. Nevertheless there are certain situations that are exclusive to women that may justify recourse to a doctor and that we provide a specific response to: the request for contraception, abortion, ante-natal care, deliveries and care for rape victims (medical, biological, psychiatric, surgical and legal). This justifies setting up certain tools, as well as specific drugs and materials. We do not provide women's healthcare, but we treat women: perhaps 'healthcare for women' is therefore the more appropriate term.

Emmanuel Baron
Medical Director,
November 2003

11 APRIL 2004

Arjan Is Finally Free!

MSF/April 2004/Anne Fouchard.

Twenty months, 400,000 signatures and 18 kilos less later, Arjan Erkel was finally released.

At 5 a.m. on the morning of Sunday, April 11, the MSF team received a call from the Russian organization 'Veterans of Foreign Intelligence' announcing that Arjan was free. Early that morning, the Dagestani press reported official announcements that Erkel had been rescued by a special operation by Dagestani forces.

Steve Cornish, based in the Russian Federation, had been following the affair since Arjan was kidnapped on August 12, 2002. He flew immediately to Makhachkala, Dagestan, with a physician from the Moscow team and the Dutch embassy's second secretary. They quickly came back to Moscow with Arjan and after a brief meeting with the press, Arjan returned home to Holland, arriving Sunday night. Arjan was very thin and exhausted after his 20 months of detention. Still, he wore a well-deserved smile of relief on his release. MSF, and particularly the members of the Swiss section who lived through 20 anxious months, were also immensely relieved.

The last confirmation that Arjan was still alive was in October 2003 and since then, MSF had received worrying news about his health (see Messages, No. 128). Intermediaries reported to us that he was suffering from a lung infection. Extremely concerned about Arjan's fate, MSF had in recent weeks condemned the impasse and amateur handling of the official inquiry and underlined the inaction of the Federal and Dagestani authorities leading the investigation. MSF also accused certain members of the administration and the Dagestani and Federal parliaments of being involved in the kidnapping, "as part of an intimidation campaign intended to silence those who still talk about Chechnya" (ibid).

MSF had (...) accused certain members of the administration and the Dagestani and Federal parliaments of being involved in the kidnapping.

MSF extends its deepest gratitude today to all those who offered support during this long and painful matter; in particular, the 400,000 people around the world who signed the petition, the journalists who continued to relay our calls and concerns about Arjan and the diplomats who raised Arjan's case in all their contacts with Russian Federation officials.■

RELEASE

Questions on Arjan's Release

MSF/April 2004/Jean-Hervé Bradol/Interviewed by A.F.

Was there a ransom, were officials involved or was it simply a criminal matter? Many gray areas remain surrounding Arjan's kidnapping, detention and freedom. The president of MSF France, Jean-Hervé Bradol, was closely involved in this dossier, along with the Swiss section and the crisis unit in Geneva.

→ Who are these former intelligence officers involved in freeing Arjan and how did MSF come into contact with their group?

In the summer of 2003, we really began pressuring Russian authorities. We condemned the investigators' inaction and the flimsiness of the official inquiry, which was interrupted without MSF being notified. Following those denunciations, we were advised to work through an intermediary, a private organization of former FSB officers– with the strong impression that they are a kind of 'unofficial agency of the FSB' (Russia's Federal Security Service, a successor to the KGB).

→ Why was Arjan released at this particular time, nine months after MSF contacted this group?

It is difficult to ignore the coincidence between our public accusations against certain members of the Federal and Dagestani parliaments (who we believed were involved in Arjan's kidnapping and detention) and his release. Several weeks later, in the wake of these accusations, things started to move and the FSB suddenly found a way to solve this matter.

→ In your opinion, what do the circumstances of Arjan's release reveal about this affair, which lasted 20 months?

This kidnapping was certainly politically based even if--as has been the case for several years in this region of the Caucasus--such kidnappings are accompanied by demands for money. When the situation became too embarrassing for the authorities in their dealings with regular diplomatic contacts, they quickly found a solution.

→ Since it's a question of money, did MSF pay a ransom?

We know that hundreds of thousands of euros were transferred to win Arjan's release: MSF paid a quarter and the rest was paid by the Dutch authorities. During Arjan's detention, we had commented that Western governments are in the habit of making payments to buy back their nationals, without shocking anyone. The facts confirm this.

→ Dagestani authorities announced that they undertook a special operation to free Arjan. Is that true?

Those are their words. As far as we are concerned, we have no information confirming these statements. ■

PRESS RELEASE

MSF Expresses Relief At Release of Kidnapped Aid Worker Arjan Erkel

MSF/April 2004/Press release.

Erkel's prolonged detention and conditions of release highlight continued intimidation and violence against humanitarian aid workers in the Caucasus.

Geneva/Moscow, April 14, 2004 -- The international medical humanitarian organization Médecins Sans Frontières (MSF) expressed great relief at the release of MSF aid worker Arjan Erkel on Sunday, April 11, 2004, after 20 months as a hostage in the Northern Caucasus. At the same time, MSF emphasized the heavy toll that Arjan's prolonged detention exacted on the ability to provide aid to war-affected civilians in the region.

Erkel, Head of Mission of in Daghestan, was abducted there on August 12, 2002, in the Republic of Dagestan (Russian Federation) while managing one of MSF's medical relief programs aimed at alleviating the suffering of civilian Chechens and Dagestanis affected by the conflict in Chechnya.

"MSF is extremely happy that Arjan is finally back home," said Dr. Rowan Gillies, President of MSF's International Council, "But it must be remembered that a huge price was paid not only by Arjan but countless others as well. Arjan's kidnapping led to drastic reductions of aid programs to displaced and war affected people throughout the region. It reinforced the climate of intimidation against humanitarian actors that has existed in the region for years"

The fact that Erkel was kept in prolonged detention for 20 months, and the need for MSF to hire a private Russian security company to arrange for his release, highlight the continued acceptance, by the government of the Russia Federation as well as its allies and partners, of a climate of violence in the region.

Acts of violence and threats directed against humanitarian organisations have been an ongoing phenomenon in the region over the past decade. Since 1995, more than 50 international humanitarian aid workers have been abducted. Today, the violence continues and humanitarian assistance remains crippled. "This cannot drag on any longer. It is the responsibility of the host country to redress this situation now", said Dr. Gillies.

Dr. Gillies expressed MSF's appreciation for the mobilization around Arjan's case. "MSF is extremely grateful to everyone who has shown solidarity with Arjan, from the hundreds of thousands of people in Russia, Dagestan and around the world who signed our petition, to the many representatives of national and international organizations and government officials who have shown their support." ■

DOSSIER

HEALTHCARE FOR WOMEN

page 1

action in the field of women's health: pelvic pathologies (poor post-partum care), quality caesareans, AIDS, sexually transmitted diseases and the treatment of physical violence against women.

The issue of women's health is not a technical one. Granted, there are precise medical acts that you need to know and that might call for training, but the real issue is not about the technical aspects. The issue is the collective realisation that there has not been the sufficient will to provide our female patients the general medical care they need. The first step towards this is therefore to debate, in the form of this AGM debate. Then, once the medical parameters are clear, or clearer, we can think about the specific medical training required.

We have statistics, presented in this dossier, on the number of orders for condoms and aspirating syringes for induced abortions. The figures speak for themselves. For example, not one country ordered the morning-after pill in 2001 or 2002, and 30% ordered it in 2003. The real question would be to find out in how many of the countries in which we work we should provide specific care and don't. When the question is addressed from this angle the situation becomes clearer.

I hope that these AGM debates will result in things changing for our female patients, but also for the doctors who should be more satisfied with the care provided to women.

Our delay on this issue has given rise to a shortage of care in MSF's health activities, which could have been avoided. In our rich countries, after decades of mobilisation, such care comes under general medicine. For example, the treatment of sexually transmitted diseases (STDs). In many cases, in the countries in which we work, STDs in women could be treated. But we rarely do so. The situation of the female patients is not conducive to such treatment: absence of information and even availability of treatment, few or no female health staff, and sometimes protocols are not correctly mastered. Yet this is a real medical need in a situation where no care is available. I remember this woman who was treated by a young MSF doctor after she had been suffering from an STD for over two years. Once she had recovered, she walked more than four hours just to thank the doctor who treated her.

I hope that these AGM debates will result in things changing for our female patients, but also for the doctors who should be more satisfied with the care provided to women.

The aim of these debates is to put together a catalogue of care dealing with problems specific to women, just as we have for the other patient categories. When we realised that our treatment of AIDS and tuberculosis patients was far from being up to standard, we altered our treatment protocols. And now we have to do exactly the same thing.

When female patients enter our health centres and clinics, they need to know that they can get the care they need, and quality care at that. They need to know, by whatever means deemed suitable in the circumstances, that they can ask questions about abortion, contraception, etc. There are so many places where this is possible, i.e. where there is no particular resistance by the various powers that be (family, social pressure, state).

The only aspect of women's health we are interested in is reproductive health: and then, only in ante-natal care.

Holding a debate on this subject at the AGM already represents a huge step forward, since some of us have been raising the question of women's health for over ten years now. Today, there are pitfalls that MSF

> *"At Médecins Sans Frontières, we're comfortable doing what we usually do. When it come to caring for women, we don't usually do anything special. That's really where the probem lies."*
>
> **Jean-Hervé Bradol** in M. Le Pape - P. Salignon, Civilians under fire, MSF, October 2001

WHAT ARE WE DOING FOR WOMEN?

In 2002, 26% of our projects included maternity activities (caesarean deliveries, all performed by our teams) versus 11 % in 2001.

MCH activity (pregnancy and newborn follow-up, with or without deliveries) is expanding: from 22% to 30% of our projects.
The number of women in our care needing referrals for further medical help[1] has increased from 26% in 2001 to 54% in 2002.

Supplies requested from MSF Logistique
Vacuum-aspiration syringes for manual aspirations were requested in 2003 by 30% of the countries we work in and none in 2001.
Oral contraceptives were requested by 30% in 2001 and 2003.
There were no requests for morning-after pills in 2001 and 2002, but 30% of our projects ordered them in 2003.
Male condoms were requested by all of our countries in 2003; only one country ordered female condoms.
No supplies for inducing abortions were ordered in 2001 and 2002, but three countries requested them in 2003.

Human resources
In 2001 and 2003, an average of 35 obstetricians and midwives per year were sent to 80 projects, with 10 and 15 midwives in the field. Three-quarters of these departures were on posts that matched their specialties.
It is important to point out the preponderance of national staff in the follow–up and care of pregnancies.

A womens' health "Working Group"
This group is composed of individuals from operational sections, members of the operations depts. and medical depts., specialists of the psychosocial response and others with legal expertise. The group is tasked with working on specific documents and tools and completing them.

1- Referred to a centre where we know the patient will receive the appropriate follow –up care.

needs to avoid when considering the issue of women's health. We need to restrict ourselves to what has to do directly with our responsibility as a medical association and not get involved in battles that have nothing to do with us: women's political struggles and legal battles by human rights organisations. We also have to take responsibility for our choices. For example, we cannot shy away in public from the subject of abortion.

→ There is a great disparity of access to abortion across the projects. Unlike excision, the abortion question is more unclear. Is abortion part of the range of care that MSF should be able to provide women?

Abortion is a recognised medical intervention. We can understand that individual doctors may refuse to perform it. This is the reason for the possibility of personal conscientious objection in our profession. However, as President of MSF and member of the medical profession, I believe we should acknowledge that this is a legitimate medical intervention.
It is our duty as doctors to make it

The only aspect of women's health we are interested in is reproductive health: and then, only in ante-natal care.

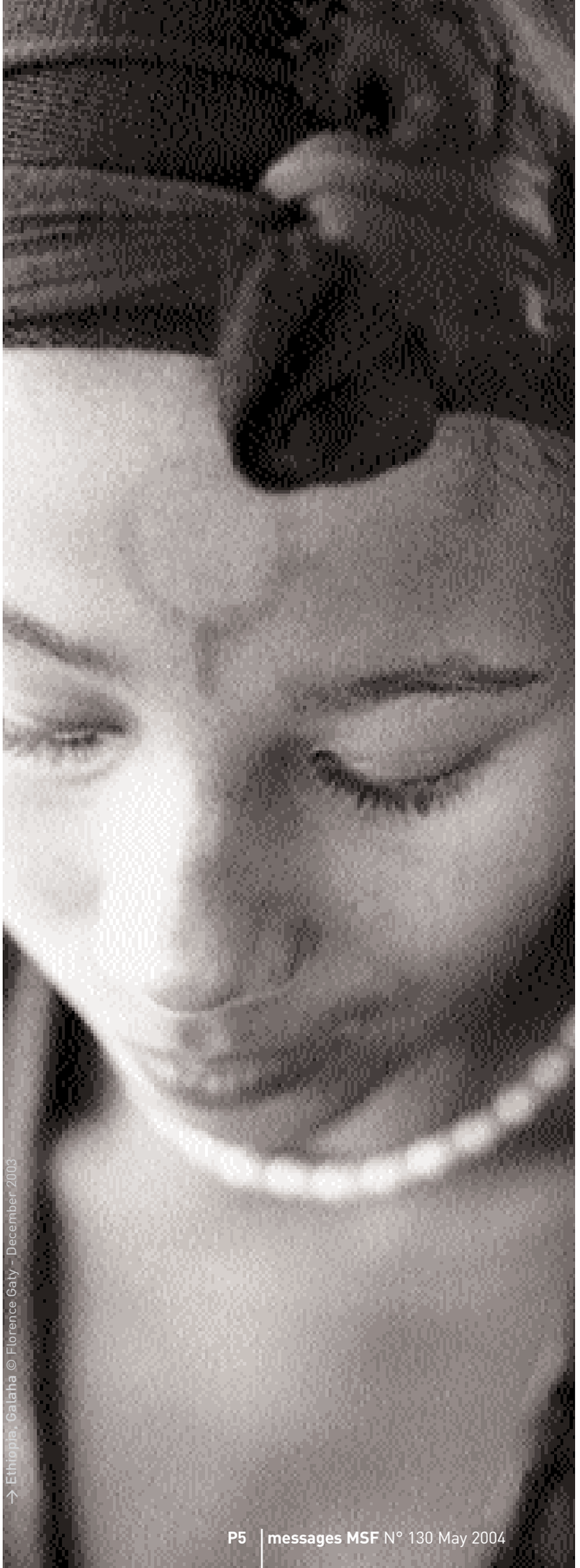
available to our patients when the possibility in the local environment exists. The medical profession's spontaneous attitude should be to make abortion available to women.
Abortion: for ... against ...? As a doctor, the answer is a resounding 'for'. Let's not forget that the medical profession demanded the monopoly of this practice, at a time when it was excluded from it, due to its disastrous effects on the health of female patients: fatal haemorrhaging and septicaemia. It was a medical victory that abortion should be practised by doctors in correct conditions, thus preserving the patient's life.

→ To conclude, what about care for victims of sexual violence?

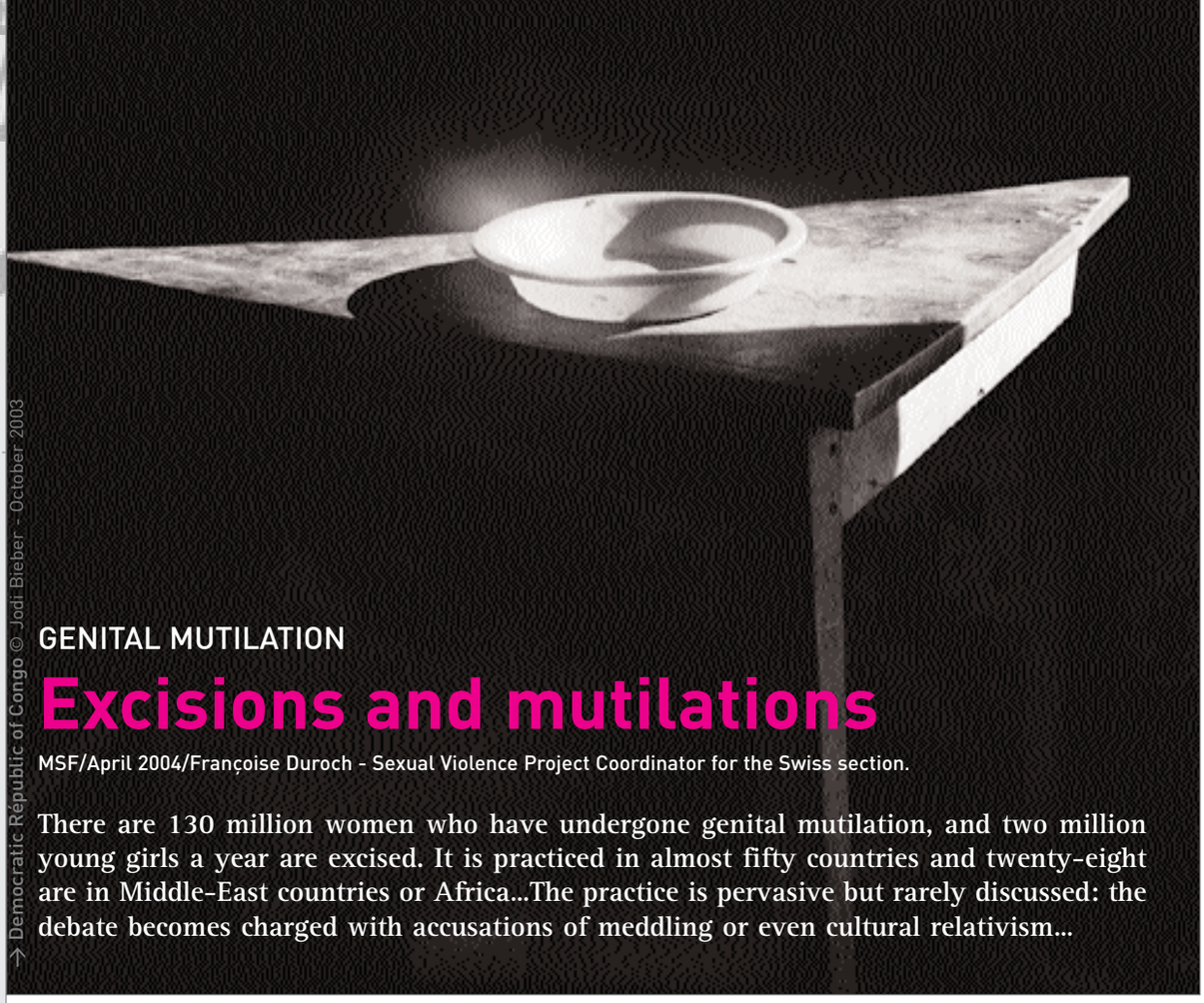
Abortion: for ... against ...? As a doctor, the answer is a resounding 'for'.

In the great lakes area, for example, although people have sporadically looked into this issue, we cannot say that this activity has developed in proportion to the needs. Whereas we have been present and working in conflict zones in the DRC for over ten years, it is as if we suddenly discovered in 2003 that huge numbers of women are raped. This is not about supporting a mishmash of political correctness. When I hear someone at MSF, talking about 'rape as a weapon of war' in the DRC and inanely using the term "rape survivor", I cannot help but think of the contradiciton. A survivor is someone who has narrowly escaped certain death. Whereas in many places where we work and where rape is rife, the rapists, to blazon their power, often want the women to survive and even get pregnant. Rape is part of a policy of terror. 'Survival' is therefore not the happy ending that the term suggests.
At a time when we have barely started to work on the issues surrounding care to rape victims, it is inappropriate and arrogant, if not downright indecent, for MSF to launch into pompous liturgies that demand an end to impunity and generalised access to healthcare in devastated countries where the State is struggling to get its activities going again. At the same time, as one of our colleagues testified to American Congress, we are not clear about one explicit medical responsibility: what to do when a woman asks for an abortion after having been raped.■

Jean-Hervé Bradol, President



→ Ethiopia, Galaha © Florence Gaty - December 2003



Democratic République of Congo © Jodi Bieber - October 2003

GENITAL MUTILATION

Excisions and mutilations

MSF/April 2004/Françoise Duroch - Sexual Violence Project Coordinator for the Swiss section.

There are 130 million women who have undergone genital mutilation, and two million young girls a year are excised. It is practiced in almost fifty countries and twenty-eight are in Middle-East countries or Africa...The practice is pervasive but rarely discussed: the debate becomes charged with accusations of meddling or even cultural relativism...

→ Midwives in some of our field missions have been faced with the dilemma of whether "to treat or not to treat". In other words, they ask" should I wait until a woman arrives at the hospital after being badly botched up? or, "do I perform the excision myself to en sure that it is done safely?" The question really meant "should we provide sterile instruments to perform genital mutilation?" The position is quite clear. There will be no participation whatsoever in this type of mutilation. MSF personnel will not take part in these procedures.

Excerpt from the minutes of the meeting of the Board of Directors and Executive (Nov. 2003)

Circumcision dates back to early Egypt, but some authors believe the practice of genital mutilation began in Neolithic times[1]. A pagan and esoteric practice, its goal is primarily to reveal initiation secrets through a symbolic resurrection. Girls and boys are sexually branded to take on the role of adulthood and reproduce[2]. Pierrette Herzberger-Fofana also emphasizes the mythical roots of the practice of infibulation in the Horn of Africa. During Arab razzias, infibulation was intended to protect women against rape[3].

When it is an intrinsic part of societies in which it is practiced, excision becomes a norm which serves to delineate the social roles. Since it is part of culture as a whole, the practice is a complex one.

For Abraham, male circumcision was a sign of allegiance God. But the obligatory nature of excision in the Islamic Sunnah is up for debate. In fact, many Islamic theologians agree today that FGM is not condoned by the Koran[4]. With the exception of Oman, excisions are not performed in most Gulf region countries. The Catholic Church has not yet taken an official position against FGM, but some African religious dignitaries have spoken out clearly against the practice: "If God created man and woman as absolute good, how can we destroy the marvel of the creator with a blade, knife or broken glass[5]?"

→ SIGNIFICANT CULTURAL PRACTICE?

Some groups claim the clitoris has magic powers: the Bambaras of Mali practice excisions to avoid injuring the penis during intercourse. The Mossis of Burkina Faso and the Ibos of Nigeria believe that the clitoris could be harmful during childbirth...

Excisions serve to differentiate the roles of men and women in society. The "advantages" of excision cited by its proponents are numerous, these include preventing a woman from having sex outside marriage, preventing the clitoris from harming the man's penis or the baby during childbirth, and enhanced fertility.

When it is an intrinsic part of societies in which it is practiced, excision becomes a norm which serves to delineate the social roles. Since it is part of culture as a whole, the practice is a complex one. There is controversy over the question of culturalism versus cultural relativism. Tobie Nathan explains the psychological problems of non-mutilated women this way, "If a custom is not tossed out of the window, then it must be done step by step[6]". Reactions from feminist groups opposing FGM were swift. A spokesperson for GAMS replied to Tobie Nathan by saying "Return to your former role of a man who does not know what goes on inside the body and soul of a woman, especially an African one, and let women describe their own condi-

tion and control their destiny".
As Georges Devereux, the founder of ethnopsychiatry explains, cultural relativism is dangerous as it can give rise to a type of neo-racism which reduces man and his behavior to the culture to which he belongs.

→ FEMINISM AND UNIVERSALISM

Opposition to the practice of mutilation has often been the launching pad of feminist movements around the ideological issue of the control of women's sexuality. That's because these practices are considered

As Georges Devereux, the founder of ethnopsychiatry explains, cultural relativism is dangerous as it can give rise to a type of neo-racism which reduces man and his behavior to the culture to which he belongs.

significant, as social practices like these reduce female infidelity and the risk of illegitimate children. Monique Ilboudo[7] describes the diversity of such practices: e.g. keeping a woman isolated in the harems in the East; preventing sexual relations by physical means such as the chastity belt in the West; and decreasing female sexual desires and relegating female libido only to the act of reproducing. Some feminists believe that excision is a way of keeping women alienated, thereby leaving human reproduction within the domain of patriarchal systems.
Isabelle Gilette, a militant feminist with GAMS, an organization opposing sexual mutilations, explains in the September 1998 issue of Le Monde Diplomatique that "traditionally, it was a rite of passage, involving an initiation ritual outside of the village. You were taught how to bear the pain of childbirth and other pain which may come your way." With the current trend of performing excisions on increasingly younger children, the rite is losing its symbolic significance.

Because FGM affects a woman's very core, that is, her sexual and cultural identity, it can be addressed only in the context of the culture in which it is practiced. Some African feminists are very sensitive to this issue because "Black-African women have suffered enough from colonial and neo-colonial attitudes[8]" and they see the battle against FGMs as an excuse to stigmatize their culture. A group of radical Western feminists attending the 1980 Copenhagen Womens' Conference inappropriately decided to show photographs of genitals of mutilated women, without discussing it with the women concerned beforehand. The Association of African Women for Research and Development (AAWORD) recommended that African culture should not always be discussed in terms of oppression, and one of its representatives pointed out that "solidarity cannot exist when until we affirm our own identity and respect one another". ■

1 - 1 Severine Auffret, Des couteaux contres des femmes, (Knives against Women) Des femmes, Paris, 1983.
2 - 2 Gerard Zwang. La circonsion demystifiee (Circumcision Demystified)
3 - 3 Pierrette Herzberger-Fofana. Les Mutilations Genitales Feminines (Female Genital Mutilations) University of Erlangen-Nuremberg.
4 - 4 Sheik Tantawi, High Imam of Al-Azhar in Egypt states that « the custom of excision has nothing to do with religion ».
5 - 5 Reverend Lopy, Kolda Seminary, Senegal, November 29 to December 1, 1993.
6 - 6 Interview with Tobie Nathan in Sciences et Nature, Number 52, February 1995, page 79. The author later denied this interview claiming his views were misinterpreted and taken out of context. Shortly thereafter, he took an official position against FGMs.
7 - 7 In "L'excision, une violence sexiste sur fond culturel" (« Excisions, sexist violence under the veil of culture »). Monique Ilboudo, University of Ouagoudougou, Boletin Antropologico Number 49, Mayo-Agosto 2000, page 8.
8 - 8 Awa Thiam, La parole aux Negresses, (Addressing Black Women) Denoel, Paris, 1978.

"The use of the term "mutilation" presents a double problem. Firstly, a medical one, as it covers a variety of different practices, and the very word "mutilation " is not a medical term. Furthermore, since these practices affect a large number of women, it would seem a bit hasty and abusive to think of them all as mutilated women. Is it wise to label these women as "mutilated", when we know the term in our society is not an innocuous one, but one that stirs up heated debates? We can argue over whether we should use a word that can be used against women or stigmatizes them, but the fact remains that it is a criminal act."

Jean-Hervé Bradol -
Excerpt from the minutes of the meeting of the Board of Directors and Executive (Nov. 2003)

THE CONSEQUENCES ON WOMEN'S HEALTH

All excisions are irreversible, affect the quality of life and endanger the health status of women.

All FGMs carry immediate risks -pain, hemorrhage- which can lead to shock and even death. There is also a risk of anemia, especially if the child has a vulnerable nutritional status. There are also risks of other infections such as abscesses, tetanus and gangrene.

There are other long term complications, notably for Type II and Type III mutilations. These range from pelvic infections, lithiasis, urinary tract infections such as pyelonephritis, recurring abscesses and dermoid cysts, to chronic pain, tearing of scar tissue, dyspareunia, dysmenorrhea and recurring vaginitis. (39)

Obstetrical complications are also numerous and frequent, leading to the death of the mother and baby during childbirth. Complications include dystocia, perineal tearing, recto-vaginal and vesico-vaginal fistulae which can cause urinary incontinence, a socially debilitating condition for a woman. FGMs also affect sexuality, leading to emotional problems and low self esteem that are difficult to measure. Stephane Hugonnet, a physician, points out that some women also have difficulty achieving orgasm, but there are others who report that some women still experience sexual pleasure.

SEXUAL VIOLENCE

Historical and anthropological aspects

MSF/April 2004/Françoise Duroch.

Inextricably linked to the way women are considered by society and representations of violence, rape is imperceptibly tolerated, even considered legitimate as long as it is not (as in times of war), a serious disruption to social order.

"If we look at the events from a critical, abstract perspective, we may find it hard to understand how an organization like MSF - with all its experience of conflict, civil war, the brutality of armed militias, and refugee camps - had not already considered, in both general and medical terms, what should be done to adress the apparent acceptance ans widespread use of mass rape in modern warfare. Given the burgeoning AIDS apidemic, how can we explain this failure to prepare? What is the underlying reason?"

Marc Le Pape in
M. Le Pape - P. Salignon,
Civilians under fire, MSF,
October 2001

Rape was long considered as hardly any different from other forms of social brutality that were tolerated in Europe, and is also closely linked to the way women are considered by society.

Rape is inextricably associated with a society's notion of violence, as well as with the status of women in general and sexuality in particular. Sexuality and violence are governed by forms of ideology that associate sexuality with a morally acceptable violence and denigrate the notion of pleasure.

→ WHO IS GUILTY: THE RAPIST OR THE WOMAN WHO IS RAPED?

James W. Prescott[1] points to the historical and Biblical acceptance of rape: Genesis 19 affirms that whereas raping a women is an acceptable act, raping a man is perversion. Under Islamic law, although adultery and fornication are strictly forbidden, rape raises a problem of interpretation and in some countries the enforcement of the law is still problematical. For example, the law of 1979 in Pakistan makes very little distinction between outright fornication, adultery and rape, regarding all three simply as crimes. In the event that the victim's innocence cannot be established, the victim may later be charged with the crime of fornication, which has the effect of strongly inhibiting women from reporting rape. On the basis of these different legislative treatments, L.M. Larocque identifies two different perceptions of rape: either it is considered without regard to sexuality, as a "violent crime" having little to do with sexual relations, in which case it is this violence that defines rape as a crime; or it is "the illegitimate sexual act that is the source of the crime[2]".

La loi pakistanaise de 1979 établit très peu de distinction entre la fornication pure, l'adultère et le viol, tous considérés comme des crimes.

→ **République démocratique du Congo** © Jodi Bieber - octobre 2003

→ WHEN MARRIAGE WIPES OUT DISHONOUR

The main problem is that rape is rarely reported, because rape constitutes a stain on the family honour. Even where it is explicitly punishable by law, as in Egypt, victims prefer to remain silent about an act that would heap opprobrium on an entire community. Both the crime and the victim vanish while society remains mute, and both recognition of the crime and redress for the victim are impossible. In such a social order, it is not the rapist but the victim who is considered to be at fault, and to "extinguish" her fault, the latter must marry her assailant. In Tunisia, a law enacted in 1969 stipulates that the rapist shall not be incriminated if he agrees to marry the victim. In many Latin American countries (Peru, Costa Rica, Uruguay etc.), marriage simply effaces the crime. In Lebanon, if a rape judgement has already been handed down, the execution of the judgement is suspended in the event of a legal union between a rapist and his victim.

→ RAPE AS AN AFFRONT TO THE SOCIAL ORDER

Rape is regarded as an affront to social order, an "impurity" that must be purified through ritual. In Bangladesh, where it is alleged that, following the conflict with Pakistan, nearly 200,000 Bengali women were raped, the government undertook a media campaign: the women who had been raped were hailed as heroines of the war of independence. This campaign – or rather, this attempt at a ritual social purification of these women – did not have the hoped-for results, as the victims were nevertheless rejected by society.

The existence of widespread rape in a country can be used for political ends. It is therefore necessary to be especially vigilant concerning the possibility that MSF might be manipulated when implementing a project aimed at providing care for the victims of sexual abuse.

We need to examine the ideological and anthropological bases of rape, a complex subject surrounded by many taboos, before we can understand how they were integrated in some societies in such a way as to lead to a kind of legitimation of sexual violence – a form of violence that stems from male dominance.

→ MALE DOMINANCE: THEORETICAL ASPECTS

THE ANXIETY OF PATERNITY

Female sexuality is of fundamental importance to the survival of humanity as a species. Whereas the mother's identity is always known, the father's role in parentage can prove doubtful. Hence there are a number of social structures whose purpose is to oversee women's sexuality in order to reduce the uncertainty of the biological relationship of paternity. For example, Christian marriage and its accompanying vows of marital fidelity not only serve to assuage this male anxiety but also make it possible to ensure "constant exposure to coition, and hence constant exposure to the risk of pregnancy[3]", which is optimal for human reproduction, as women's period of fertility is rather short, relatively speaking.

Paola Talbet has identified three distinct ways in which men have assumed ownership over women's bodies for reproductive purposes: "breaking" them to accept coition, with genital mutilation and rape as its initiatory forms and the aim of which is to overcome any attempts at resistance on the part of pubescent girls; conjugal duty, which may be exercised through various forms of blackmail; and tight supervision[4] of pregnancies, which are subject to taboos on contraception and abortion in some societies.

For some schools of feminism, rape is not simply a sexual act but a means of maintaining social dominance over women. "What exactly is rape? Is it or is it not a sexual act? We need to reach a common understanding of the concept of sexuality. Rape is an act of oppression inflicted by a (social) man on a (social) woman, ... it is highly sexual in the sense that it is frequently a sexual activity, but most importantly in the sense that it opposes men and women: the underlying aspect of rape is social sexual differentiation. If men rape women, it is precisely because they are women socially speaking.... Rape is sexual mainly because it is based on the highly social difference between the sexes[5]".

The existence of widespread rape in a country can be used for political ends. It is therefore necessary to be especially vigilant concerning the possibility that MSF might be manipulated when implementing a project aimed at providing care for the victims of sexual abuse.

DANGEROUS ARGUMENTS

Some explanations of rape make use of extremely dangerous arguments. Sociobiology, a discipline that systematically studies the biological foundations of all social behaviour, explains rape as follows: "the man is trying to increase his reproductive success through the use of violence; the women resists in order to test the vigour of her partner. In the end, she yields after realizing that the rapist has the vigour required to give her a sufficiently hardy child[6]". As some men have no means of ensuring parenthood other than through the use of violence, rape is thus legitimized by the natural need of all living beings to have descendants. It goes without saying that the ideological consequences of such arguments are disastrous.

→ Definition

"Rape was considered more an act of immodesty than an act of violence, it was interpreted more as illicit pleasure than illicit harm (...) the victim was therefore irreconcilably associated with the image of the act, a prisoner of its misdeed – like an animal in the act of bestiality which was judged so vile that the judiciary did not hesitate to condemn it to strangling or burning and the dispersing of its ashes in the wind."

Georges VIGARELLO,
Histoire du viol
(XVIème-XXème siècle),
Points-Seuil,
coll Histoire, 1998.

→ Overheard during the Mini-AGMs

"Concerning rape, the tendency is to make the womwn feel guilty : she shouldn't have worn those clothes, she shouldn't have been out at that hour, she shouldn't have been out with that kind of company. If it is the rape of a child, the mother is responsible as she is responsible for the education of her children. The father is only considered responsible if he has committed incest."

"We regard the child as the pure, totally innocent victim of violence. Men are the preferred target of the executioners and torturers. It's easy to see how men of fighting age can be targets. But women are seen as victims by default. I think there's a whole underlying set of arguments that is never brought into play during our operations, and that doesn't make caring for women any easier."

Jean-Hervé Bradol
in M. Le Pape - P. Salignon, Civilians under fire, MSF, October 2001

RAPE IN ARMED CONFLICTS

Rape in armed conflicts is regarded by some authors as a new form of warfare. It becomes a means of taking over the enemy ethnic group and may, for example, be aimed at inflicting a "demographic plague[7]" that attempts to annihilate the adversary by demographic means. The psychologist Françoise Sironi notes that strategies of deculturation, including rape, are widely used in contemporary conflicts: "Attacks on ritual objects and the planned organization ... of murders aiming deliberately at breaking links of transmission and parenthood are deculturation practices widely used in contemporary conflicts[8]". The systematic raping of women – in Bosnia, for example – and the children born of such rapes are, according to the author, "the means of realizing the intention of a third party, namely to crossbreed filiations in a deliberate and violent manner, within a single generation", using the uterus to attack the cultural identity of the adversary.

« the women who had been raped stated that they were dead forever, since they had been subjected to utter profanation. »

The aim is to tarnish the honour of men by possessing the bodies of women. In the case of the widespread rapes committed in Kosovo, compounded by kidnappings, sexual torture and imprisonment, the aim of the Serbs was to strike a blow at the men who had taken refuge in the mountains. The testimony of Kosovar women showed the deadly moral injury represented by rape: "the women who had been raped stated that they were dead forever, since they had been subjected to utter profanation[9]".

Rape can also be a highly effective instrument of propaganda: "the demonization of Albanians through hate-mongering was based on a recurrent theme: the rape of Serb women by Albanian men. This propaganda, widely disseminated by the media, presented the rape of Serb women by Albanians as a frequent, daily, massive occurrence, which was supposedly taking place everywhere, all the time[10]".

It is therefore important, in any context where MSF finds frequent cases of rape, to be wary of any attempt by the powers that be to exploit this phenomenon for political ends. ■

→ Democratic Republic of Congo © Jodi Bieber - October 2003

SEXUAL VIOLENCE IN DEMOCRATIC REPUBLIC OF CONGO (DRC)

Excluding purely sexual considerations, the main aim of violence on women in the DRC is to crush the moral personality of victims, to ingrain the violence permanently in their private conscience, to cut away all social, filial and family relations: social relations because it destroys the fabric of solidarity which existed in the DRC before the beginning of hostilities, and filial and family relations as it is an absolute, total war that takes away the humanity of its victims, to the point of even transgressing the ethical norms practiced during a conflict. The story of Father Jacques B is emblematic. He was forced to witness the rape of his two young daughters before being killed after refusing, in spite of being threatened, to have sexual relations with them. This refusal to the soldier was based on a normal intrinsic aspect of humanity rather than a cultural one, as no man, here or elsewhere, can have this type of relation with his mother or daughter.

1 - James W. Prescott, "Le plaisir du corps et l'origine de la violence", Bulletin of the Atomic Scientists, November 1975.
2 - Lyne Marie Larocque, "De l'inévitable écart entre la logique religieuse et la réalité sociale : le viol en Islam", Religiologiques, no. 11, Spring 1995, pp.193-208.
3 - Paola Talbet, L'arraisonnement des femmes, Paris, 1985, p. 98
4 - Paola Talbet notes that obstetrics, over the course of its development, gradually became a matter for men, with female attendants and midwives being relegated to the status of underlings.
5 - M. Plaza, "Nos hommages et leurs intérêts", Questions féministes, no. 3, 1979, Paris, p. 93.
6 - Y. Christen, L'heure de la sociobiologie, Albin Michel, Paris, 1979, p. 97.
7 - K. Guenivet, "Violences sexuelles la nouvelle arme de guerre", La nouvelle lettre de la FIDH, no. 48, June 2001. The author is speaking here of the conflict in the former Yugoslavia, where women were not only raped but also detained and confined so that they would give birth to Serb children.
8 - F. Sironi, "Les stratégies de déculturation dans les conflits contemporains, nature et traitement des attaques contre les objets culturels", Revue de psychiatrie sud/nord, no. 12, 1999.
9 - Seminar on violence against women, Des abus domestiques à l'esclavage, Sub-committee on violence against women, Report of the Council of Europe, Bari, 5 January 2000.
10 - Garapond A., Kullashi M. in Kosovo - L'imaginaire du viol (source internet)

MSF and healthcare for women who are victims of sexual violence

MSF/November 2003/Excerpt from the Board/Executive.

Responsibility towards victims of sexual violence has not always been considered part of our activities. Today, there is a concerted objective to provide assistance to these women, especially in areas of conflict. This activity is undertaken in close collaboration with other participants and we are trying to incorporate it into our existing activities. Raising awareness on this issue amongst our teams and other partners on site is essential. An international working group has been put together to draft working documents to help and improve the case management of these women.

→ RAISING AWARENESS A NECESSITY

The WHO estimates that only 10% of women who have been raped in a camp attend a medical consultation. This reflects the obvious difficulty for these women to attend a consultation as well as a distinct lack of provision of treatment, or at least basic steps towards treatment. What is more, many women come for consultation very late after the attack.

→ CARE OF VICTIMS OF SEXUAL VIOLENCE

Medical care, which varies according to the case, follows classical guidelines – compilation of information, physical examination, treatment of skin and mucous lesions, pregnancy test, prescription of emergency contraception, preventive treatments for sexually transmitted diseases, including HIV, voluntary termination of pregnancy as well as tetanus and hepatitis B vaccination. These activities are usually carried out in the maternity ward. In certain projects, psychological treatment of the trauma is provided through consultations with a psychologist.

A certificate describing the lesions can be drafted. Samples can also be taken to put together forensic proof and we must be able to direct victims wishing to take legal action. It is not up to MSF to either press charges on behalf of the victim or to give the medical certificate to anybody - but to guarantee support if they ask for it. There is no proactive action on our part before the court. Rape is defined as any act of sexual penetration by force, threat, being taken unawares or violence. However, there are several legal definitions of rape, definitions of sexual abuse etc. Thus, the International Criminal Court's definition is different from that of the French Criminal Court. The victims know exactly what rape is and MSF has no right to challenge the victim's experience and does not set up an enquiry.

When a person shows up and says that he or she has been a victim of rape or domestic abuse, MSF believes that person.

When a person shows up and says that he or she has been a victim of rape or domestic abuse, MSF believes that person.

For very young victims, it is relatively easy to have no medical doubt. For others, proof of violence is not necessarily evident but it is our principle to believe the victim. The certificate that we draft does not take into account that there has been a rape but considers what we see and what the victims say they have experienced.

Prevention starts from the physical management of a camp, an area, raising awareness among those responsible for protection, raising the authorities' awareness, and indeed the media. 'Témoignage' is also a crucial part of our activities that helps us better understand the problems.■

ON ADVOCACY

"Although merely talking about a traumatic episode can be considered as having a therapeutic effect, the problem of sexual violence goes beyond medical practice and must be integrated into advocacy activities. To understand rape in the DRC, the complexity of the political processes at work in this region of Africa need to be understood. Beyond the individual or collective violence, it is important to identify the institutional and non-institutional players who are accountable for perpetrating this violence. For solutions to be effective, appropriate community-based networks must be established and qualitative and quantitative data have to be collected. This will help us understand the problem and give us ammunition for improving our process of speaking out about traumatic experiences." .

Françoise Duroch

> *"... Rape engenders a multitude of overlapping suffering (physical and moral pain, social rejection, consequences for children, breakup of the family unit etc.). The question has not taken also this time to come to the surface at MSF because of MSF's immaturity in managing complex problems - located at the intersection of broader issues- or its inability to pursue this type of activity over the longer term."*
>
> **Françoise Duroch**

SEXUAL VIOLENCE

Responding to the obvious need for mental health

MSF/April 2004/Thierry Baubet, Psychiatrist/Interviewed by Isabelle Ferry.

Although the trauma of rape goes well beyond physical suffering, MSF only provides counselling to women under the "victims of sexual violence" programme in Brazzaville. This interview with Thierry Baubet, MSF Medical Department Psychiatrist, looks into the whys and wherefores.

→ What mental healthcare does MSF provide for female rape victims today and with what therapeutic aims?

Counselling covers a number of sessions. The first phase of the work, the "psychological debriefing", generally aims to get the victim to talk about her ordeal and then try to address the emotions felt to help the person make sense of these emotions. Obviously, you have to respect the person's manner of speaking or not speaking. You can't "force" someone to talk. There are two goals: to provide immediate solace and ease the pain, but also to try and prevent the appearance of trauma-related problems later on such as post-traumatic stress disorder and depression, which are severe chronic complications that can appear long after the rape.

In some cases, the patient – adult or child – remains "stuck" in the terror of the traumatic scene and has flashbacks and nightmares of it, resulting in intense distress, which prevents her from reacting, thinking, learning, and so on. In this case, we can offer a short course of four to five sessions of therapy with the aim of freeing the individual from this state of mental "paralysis". Every day, we see the value of these brief courses of treatment which, even if they don't always eliminate all the symptoms, at least allow the patient to regain a satisfactory level of mental functioning.

We also sometimes have to handle real psychiatric emergencies such as agitated depression, stupor, suicidal crises and delirious fits, which sometimes call for medicinal treatment.

Brazzaville remains a "pilot" programme in that we decided to take advantage of the fact that we're there for some time to gain as thorough an understanding as possible of the impact of such violence on the population and how we can respond.

→ Why did we choose Brazzaville to launch this type of programme?

The demand came from the field. The teams working in emergency situations in the field were quick to report back that just treating the body wasn't enough. It took some time to decide to launch a psychological treatment programme. We sometimes heard arguments against the idea, which mainly echoed our apprehension. Today, we have shown that this is possible and realistic with reasonable resources. Brazzaville remains a "pilot" programme in that we decided to take advantage of the fact that we're there for some time to gain as thorough an understanding as possible of the impact of such violence on the population and how we can respond.

→ Sexual violence is a problem we frequently encounter, especially in our medico-surgical programmes. So why is psychological care not a priority in this case?

It will take some time for things to fall into place, for it to become part of the MSF set-up. The work underway in Brazzaville and the conclusions we draw from it will serve to do just that. Nevertheless, it doesn't look as if an unequivocal operational answer can be found to the problem of sexual violence. In Kosovo, for example, it would have been impossible to set up such a programme. We hardly ever "saw" any female rape victims even though we knew that a lot of women had been raped … We saw them for other reasons and often they didn't talk about it. Aside from in cases of systematic mass rape, such as in Brazzaville, it would be easy to "be blind" to this problem. For many women, the physical wounds are less serious than other war wounds; shame, guilt and the risk of social exclusion are such that they don't want to talk about it. When they do, it is more often than not in the form of a physical complaint, as we've seen in many cultures. So we could come across this problem in many programmes without knowing it, relegating it to the "body pain" or "other" boxes on our work report forms!

Sexual violence harms the mind as much as the body. It calls for a crosscutting physical, psychological and social approach to prevent serious complications…

Sexual violence harms the mind as much as the body. It calls for a crosscutting physical, psychological and social approach to prevent serious complications on these three fronts. In any case, these are elements that I believe MSF agrees about.

We are currently working in two directions to be able to move forwards on this issue: what programmes should be set up in situations of "mass" sexual violence and how can the identification and treatment of these female patients be improved more across the board in the different types of places where we work? ■

→ Brazzaville, then afterwards

"Our clinical work has long-term effects that we will be analysing in more detail this year in the form of a study conducted with Epicentre. This study includes the clinical re-evaluation of female patients treated in the Brazzaville programme in 2002, analysis of the large database we have put together and the evaluation of what becomes of newborn babies conceived by rape. By the end of this work, we will be able to make recommendations that can be applied to other places, in emergency situations and in medium-term contexts."

Thierry Baubet

ABORTION

What's the problem?

MSF/November 2003/Excerpt from the Board/Executive.

Can abortions be performed in the field? Can we settle for replying that we "do not prohibit abortion"? For the doctor is this a matter of conscience, culture or law? What about the technical aspects? When this form of care is not available in the country can we hide behind a clause of conscience that essentially results in a refusal to provide care? These issues concerning abortion were discussed during the meeting of the Board of Directors and the Executive...

- The service provided is very uneven depending on the projects. If the healthcare itself does not pose any problems for MSF from an ethical point of view, there are questions concerning operations: can we perform illegal acts or not? Does MSF assume responsibility for this? Although, in theory, the "headquarters" are clear with respect to the association's responsibility, this does not apply in the field where, considering the environment, decisions are difficult to make.
- "In the case of abortion, the only limit is that of the doctor, his/her clause of conscience. However, do we consider abortion something that we should be able to offer women? We cannot reply, "We don't prohibit it."
- Today, it is not a matter of refusing but of including abortion in the range of care provided or ensured by MSF. There is still the matter of technical competence: are all of the physicians qualified to perform abortion by aspiration? If we have quality reference hospitals where the patient will be cared for, why not. Performing abortions within MSF, outside a surgical project where we have gynecologists/obstetricians remains an open question.
- If there are limits, they are not technical in nature. Abortion is not a technically complicated procedure. The limits concern the context of the intervention, namely the legality of abortion in the country concerned.
- We cannot say that there are no technical problems since, for our personnel, competence is a priority. We must consider all of the questions raised by abortion within a country before performing abortions. It is a specialized operation but one which must gradually be implemented within our missions.
- If we look at the current situation, we do not have the impression that abortions are performed frequently, and not for technical reasons. The difficulty is real. There is culture and the law, two parameters which enter into the decision. Will MSF assume responsibility in an area where abortion is prohibited by law or culturally unacceptable, for covering the physician who performs abortions within an MSF structure or outside MSF? What criteria are the directors of MSF using to deal with this issue? Our principles are fuzzy and that is the principal reason why the teams do not perform abortions more frequently.

Extract – Executive Board: "A medical NGO is responsible for proposing or at least guaranteeing abortion, with the possibility for each physician not to perform this act if it is against his/her personal convictions. Of course, the local context, namely the laws in effect in the country and the human resources available for performing abortions, must be assessed." ■

In the case of abortion, the only limit is that of the doctor, his/her clause of conscience. However, do we consider abortion something that we should be able to offer women? We cannot reply, « We don't prohibit it ».

→ **Democratic Republic of Congo** © Jodi Bieber - October 2003

→ Orders for Bordeaux : as indirect indicators.
this concerns 24 countries out of 33 as indirect indicators: no countries ordered the equipment required in 2001 and 2002 and three placed orders in 2003.
Extract – Board/Executive

> *"A medical NGO is responsible for proposing or at least guaranteeing abortion, with the possibility for each physician not to perform this act if it is against his/her personal convictions. Of course, the local context, namely the laws in effect in the country and the human resources available for performing abortions, must be assessed."*
>
> **Excerpt from the Board/Executive,** November 2003

ABORTION

Stop the reactionnaries within MSF!

MSF/March 2004/Gaëlle Fedida - Responsable de programme adjointe.

Law, technical complexities or conscientious objection... for Gaëlle, none of these arguments withstand serious examination: they leave room however for the famous knitting needles...

For certain physicians working with Médecins Sans Frontières, abortion is a Pandora's Box that must not be opened. Obviously there is room for discussion and our attitude in this respect is not as clear as with respect to the treatment of cholera.
As soon as the topic is raised, a number of issues appear – law, technical aspects, and moral aspects – so as to avoid dealing with the association's medical policy as such. Yet, concrete cases are submitted to us on a daily basis as part of our programs. And what hesistancy! How can we assume to limit ourselves to defining a simple "protocol" in response to a "problem"? Instead, there is an urgent need for us to question the "care package" we claim to make available to women and stop treating matters on an ad hoc basis. The objections are presented as rational and objective, although none can withstand a rational examination.

Instead, there is an urgent need for us to question the "care package" we claim to make available to women and stop treating matters on an ad hoc basis.

→ THE LAW

Abortions are prohibited in many countries where we work. By performing an abortion and violating the law, we would expose the mission, the MSF image, the security of the teams and the very presence of MSF in the country. Yet, it seems to me that this is exactly what we have been doing for 35 years and it's what our very name implies.
Moreover, it is often very possible to get around these laws through the subtle distinction between a therapeutic abortion and a voluntary abortion. It is always possible for a doctor to declare that there is a mental problem for a mother who does not want her child when no other medical indication exists.

→ TECHNICAL COMPLEXITY

Abortion is allegedly a particularly complicated technical act requiring specific equipment which not everyone knows how to use. This is not the opinion of most of the physicians I questioned. This medical operation is, moreover, included in most of the training provided to general practitioners. The famous "vacuum" appears quite simple to those who do not have a stubborn wish to deny the issue. Yet, as in the case of other actions, there is obviously no question of requiring someone to do something which he/she does not feel qualified to do since the first professional responsibility of the doctor is to know his/her limits and cause no harm.
If, during a mission, none of us can or wants to take charge of such cases, it is often possible to find national doctors in the city who are prepared to do so. Once again, it is a matter of referring the patient with the required material.

→ CONSCIENTIOUS OBJECTION

"Let our physicians act according to their soul and conscience." It is not a matter of ordering our doctors to do anything they do not want to do as a result of their convictions. Needless to say, all volunteers retain their personal ethics.
This question is all the more pertinent with respect to national caregivers. Of course, conscientious objection must be respected. Yet all of the teams must know that we include this operation among those which are possible, even if they are not involved. Considering the galloping papist prevalence in most of the countries where we intervene, the vigilance of the expatriates is essential for ensuring that we welcome and listen to all patients. For this, they must feel that they have the support of their headquarters.

Let us not hide behind false arguments, and remain at the anecdotal stage, without even feeling comfortable there. Let us ensure that the knitting needle is not the only recourse for a woman who wants an abortion near an MSF mission! The reactionaries No Passarán at MSF! ■

→ Sri Lanka, Hospital on Mannar Island © H

→ On abortion

"The main problem is the legislation in the countries where we work. In concrete terms, if a woman wishes to have an abortion because she has already had five or six children, the question of legality is raised. Fortunately, we take a firmer stand when the pregnancy is the result of rape. Doctors can always perform a therapeutic abortion. 95% of abortions can be induced by taking two drugs (RU 486 + prostaglandins), with no trauma for the woman. However, it is difficult to offer these medical abortions to our patients as it is extremely difficult to get hold of RU 486. In France, for example, it is only available from family planning centres. It is important to know what the risks are if prostaglandins are taken alone, which is nevertheless less effective than using the two drugs together."

Elisabeth Szumilin,
Medical Department

FAMILY PLANNING

"Post-natal Contraception"

MSF/March 2004/Philippe Le Vaillant - Head of Mission Niger.

The document on women's health as part of the texts for the mini AGMs is, I feel, missing a chapter. This matter is rarely discussed, yet I feel that it is important...

This is a form of indirect violence resulting from the suffering caused by the loss of their children, while they live in a society that pushes them to bring children into the world without giving them the means to bring them up. Here, In Nigeria, I use a term that clearly says what it means: post-natal contraception. Of course, this come under your classification of family planning or its absence, but no where is any mention made of the consequences of this lack of family planning which are dramatic although seldom mentioned.

When I arrived in Niger, during the initial study I made on abandonment, a man astonished me by summing up this high infant mortality, saying, "It's the women's fault", which he felt was logical since women are solely responsible for bringing up children. Developing this further, it could be said that the rejection of contraception, combined with an incitement to fertility, results in a form of hyperfertility that invariably leads to a high infant mortality rate. Since the responsibility for children is born solely by women, the suffering created by the failure which each death represents, belongs specifically to them. In Niger, for example, where the fertility rate is the highest in the world, as is the case of the illiteracy rate (particularly among women) more than half of all women have a child before they are 18 years old. Their lack of education, combined with the early age at which they marry, means that the first child is all too often lost, which is even more traumatizing for a woman who cannot express herself. At our nutrition center, we meet women who bring in their sick children. It is the fourth or fifth child, but the only one who has survived. And this region is not affected by famine; it is, In fact a region that is considered the breadbasket of the country. It is possible that the initial experience, with the death of the first-born, conditioned the mother's behavior with respect to the surviving children, locking her into a spiral of failure.

The suffering caused by the loss of a child and the guilt experienced through their inability to keep their child alive are the source of a violence against women that is not as obvious as rape, excision or abortion. But it exists all too often.

The refusal of the men to give their wives the best possible conditions (in a given environment) in which to raise their children reduces the role of the mother to that of a simple progenitor who brings her brood into the world, only to have destiny take its due. The resulting sense of guilt is often one of the first reasons causing women to remain silent and not demand another status. Since she cannot do the job she has been assigned well, why would she presume to take on others? This is the thinking to which man has confined her. And it is for this reason that contraception is intolerable for the men. It is also the reason why we find it difficult to understand that this infant death rate, which so angers us, is not generally perceived as a real problem by the political or sanitary authorities.

The suffering caused by the loss of a child and the guilt experienced through their inability to keep their child alive are the source of a violence against women that is not as obvious as rape, excision or abortion. But it exists all too often. ■

arrie Timmermans

"When in the field recently, I was told by (male) care workers that they would not attend the mini-AGMs as, since the subject was women's health, they did not feel that the meetings concerned them. However, on the contrary, there should be no segregation when it comes to talking about women's health issues. Women are physiologically vulnerable during pregnancy and particularly when giving birth. Women and girls are also vulnerable culturally and socially and are subject to violence. So I told these men that talking about women's health is not just talking about their wives giving birth...it is also talking about their daughters and mothers – about the mainstay of society that Women are. In Ingushetia, for example, what would happen to the children and family if the Chechen women just gave up and did nothing?"

Marie-Madeleine Leplomb,
Responsable de programme

FAMILY PLANNING

MSF: vague policies

MSF/April 2004/Myrto Shaefer - Interviewed by Laurence Hugues.

Three questions for Dr. Myrto Schaefer, ARP, about contraception and Family Planning.

→ **Thaïland, Surin hospital** © Stefan Pleger - February 2004

"Although we carry out pre-natal consultations, we do not always know where the women will be giving birth. We need to make sure that the places we refer them to for difficult births are good referral centres, that the women are looked after properly there. Even if we no longer see the patient we have referred, this does not mean that we shouldn't make sure she is given good medical care. (...) Maternal health is a very specific field of medicine and yet we do not have a full-time medical specialist at headquarters."

Marie-Madeleine Leplomb
Responsable de programme

→ What types of contraceptives are there available on MSF missions?

First of all, there are condoms for men! They are available on all MSF programs. As for other methods of contraception, it all depends. In programs where we can follow patients on a medium- and even long-term basis, such as in the Karens camps in Thailand, we can offer the pill. Otherwise, in mother-child health programs where we cannot follow the women, we propose injectable contraceptives, every three months. This enables the women to control births without the problems of having to take a daily contraceptive, although there is the inconvenience of receiving an injection with a higher dose of hormones. On certain programs, and on a case by case basis, we are able to propose tubal ligation to women who, after numerous pregnancies, do not want any more children.

WHAT ABOUT FEMALE CONDOMS?

Last year, one single mission ordered female condoms. What about this method of contraception? The March 2004 issue of Remaides* contains a charming ad from 1908 praising the "female condom with a pneumatic ring", called the "practical", and described as "a second, protective vagina which guarantees complete security, retains the illusion of naturalness, and makes sensations more intense." So, it's not like we've invented anything new. This condom has several advantages: it allows the woman to manage her contraception and not depend on the good will of her partner, it can be inserted several hours prior to sexual relations, thereby preventing "limp biscuit" type incidents after bitter discussions about the need for protection against STDs and AIDS and, finally, it allows claustrophobic men not to feel "smothered" by the latex of the male condom. Inconveniences? It can be difficult to insert the first few times, relatively noisy (the plastic squeaks...) and, above all, it's expensive.
Read the March issue of Remaides, which is a special issue devoted solely to this method of contraception. Although it is not yet widely used, it is becoming more popular.

* newsletter on HIV and AIDS treatments published by Aides

→ If a woman in a precarious situation, who has not had access to contraceptives comes to an MSF program and asks for an abortion, what would the answer be ?

Once again, it depends on the program and the country where we are intervening. For me, this is typically the type of action we must not ask the national staff to perform. Performing an abortion in a country where it is officially prohibited is the responsibility of the expatriates. Of course, we have to make sure, before they leave on mission, that the expatriate doctor working for a program where he/she may be required to do something along these lines is not opposed to abortion.
With respect to technical matters, I tend to favor the aspiration method, which is less invasive and safer. It should be noted that clandestine abortions are a major cause of death – I feel that it is important for us to address these matters.

It should be noted that clandestine abortions are a major cause of death – I feel that it is important for us to address these matters.

→ Family planning at MSF: is everything clear or is there still work to be done?

These questions always give rise to debates. No, things are not always as clear as they should be. Yet, with a minimum amount of explanations, we can rise above cultural barriers. I've seen this in the Somalian refugee camps in Dadab, for example! Within the association, there may still be cultural or other barriers which require in-depth discussion so as to provide answers to all of these questions. ■

Afghanistan: sad records...

MSF/March 2004/Excerpts from an article by Christian DELAHAYE – Le Quotidien du médecin (15.03.04).

Until March 2003, when MSF opened a maternity in Daste-Barchi, there was no facility to deal with the 150 children, on average, who are born each day in this particularly precarious neighborhood in Kabul. Today, more than 300 women give birth there each month.

Giving birth in a specialized facility is the exception in Afghanistan. Most women give birth at home, assisted by the women in their family or the traditional mid-wife, who is often not qualified.
Anne-Sophie COUTIN has just completed a six-month mission as medical coordinator in Kabul. She described her experience in "Le Quotidien du médecin"*:

Every month, we make 1,200 ante-natal consultations

(...) "What I really noticed in this consultation center, which is open to women, children and men, was the huge demand for care for women. In a single year, the demand increased three-fold. Every month, we make 1,200 ante-natal consultations, 300 contraception consultations and deliver as many children. Apart from the two large hospitals in the centre, this is the only facility for deliveries. 96% of the deliveries are normal. Occasionally, women who have given birth at home arrive in a state of shock, as a result of placenta retention." (...)
(...) "The Minister of Health, Dr. Soheila Seddick, a woman, has made women's health a priority in her reconstruction policy. Reconstruction is starting off from absolutely nothing. Efforts are being made, such as tetanus immunization and care for newborns, but the people here have significant health needs." (...) ■

→ Afghanistan, Kabul : hospital in Darste Barshi © Heidi Holzer - Nov. 2003

→ Child Birth on Maternal Maternity

The conditions of childbirth and the treatment of complications have an effect on maternal mortality. We must orient our efforts toward these aspects in order to reduce maternal mortality and properly respond to the needs underlying patient consultations. This activity must be integrated into the panel of normal activities.

There are two specific goals :
- What the MSF teams can provide: gynaecology, traditional consultation, contraception, treating rape victims, and ante-natal and post-natal monitoring.
- What we can provide or ensure: childbirth and related complications, termination of pregnancies, and C-sections or fistula surgery.

Excerpt from the Board/Executive, November 2003

ELOQUENT FIGURES...

According to an investigation conducted by Unicef and the Centers for Disease Control (CDC), in 2002, although the maternal mortality rate varies according to the region (access to resources and care varies significantly between the cities and the rural zones), Afghanistan still has one of the highest maternal mortality rates in the world (approximately 1,600 deaths for 100,000 live births*).

In fact, half of the Afghan women between the ages of 15 and 49 who die do so as a result of a pregnancy or delivery (most of the deceased women are between 20 and 29 years old). More than 40% of these deaths could have been prevented if these women had been followed or supported better. Only 7% of the women who died while giving birth were assisted by a qualified health agent.

Little progress has been made to reduce the problem of maternal mortality and a lot of Afghan women continue to die each year during the course of their pregnancy or while giving birth. The consequences are even more dramatic when you consider the fact (also according to the Unicef-CDC study) that if a mother dies while giving birth her child has only one chance in four of surviving to reach his/her first birthday.

* WHO figures

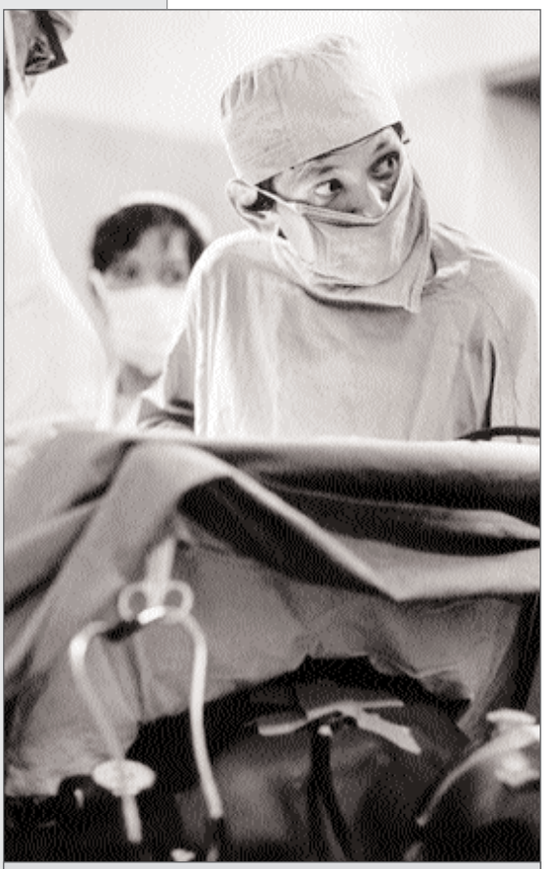
Isabelle Merny (MSF), Rémi Vallet (MSF) & Christian Delahaye (le Quotidien du médecin)

SURGERY

Defining the Priorities for Women's Health

MSF/April 2004/Sinan Khaddaj - Surgeon.

For a long time now, Médecins Sans Frontières has been working on surgical programs essentially intended to care for victims of violence. Although surgery occupies an obvious place in the treatment of people who have been injured, surgical care for women depends largely on the type of pathology and the degree of urgency...



→ Cambodia, Kompong Thom hospital
© Jan Banning - May 1997

"In certain missions, we pay for expensive referrals of elective surgical cases (e.g. cataract operations), while within the same mission, we do not even ensure a satisfactory medical environment for women in labour, even though this is a priority for us."

Marie-Madeleine Leplomb
Responsable de programme

Without exaggerating, we can say that MSF's emergency surgical care for women is satisfactory when it comes to "direct violence" and obstetrics. In fact, our surgeons operate regularly to repair vaginal and rectal tears in women who have been raped. Unfortunately, women are "preferred targets" in any violent situation.

Likewise, in the field of obstetrics, everything that does not involve a normal delivery is likely to involve emergency surgery: cesarean sections, the treatment of ectopic pregnancies, septic abortions and perineal tears are obvious examples. These procedures are, for the most part, practiced on all of our surgical missions.

"Elective" surgical activities, however, remain modest and even voluntarily limited! It rarely goes beyond hysterectomies for fibroid tumors and care of prolapsed uteruses. This "voluntary abstention" is the result not only of a certain desire to give priority to emergencies but also the fact that the general surgeon has been replaced by the specialized surgeon and diagnostic means such as ultrasounds, etc. are limited as a result of the precarious situations in which we operate.

For example, vesicovaginal and rectovaginal fistulas (pathological opening between the bladder or the rectum and the vagina) are among the surgical interventions that are neglected. A direct result of pregnancies that are not monitored properly and prolonged deliveries, these pathologies are relatively widespread. These fistulas have a profound effect on patients, on both a social level and in terms of their health. Permanently soiled, these women are repudiated by their spouses and those around them, and are subject to repeated urinary infections with all of the consequences and suffering imaginable.

Yet today, MSF does not deal with fistulas and the teams, who cannot rely on reference hospitals capable of caring for such problems, find this very frustrating. Although this matter has generated a great deal of debate within the association, everyone agrees that there are legitimate grounds for handling such cases. We just have to determine how. Several approaches have been considered, starting with the creation of specialized centers based on the experience of the "Fistula Centre" in Addis Abeba. Another idea is under discussion: ad hoc intervention on the part of a specialized team responsible for handling a certain number of patients who have been pre-selected and prepared in advance, as part of our surgical missions.

Cancers in general and particularly in women (gynecological cancer, breast cancer, etc.) should also be classified as neglected illnesses. Unfortunately our surgical treatment will continue to be limited to palliative procedures or incomplete interventions for a long time yet as a result of the complexity of the matter and the lack of diagnostic means, staging and adjuvant therapy (radiation therapy and chemotherapy).

Given the importance of surgery in women's health, I have deliberately stressed the neglected issues, hoping that they will help us to better define our future surgical priorities. Everyone is welcome to join in the discussion. ■

Yet today, MSF does not deal with fistulas and the teams, who cannot rely on reference hospitals capable of caring for such problems, find this very frustrating. Although this matter has generated a great deal of debate within the association, everyone agrees that there are legitimate grounds for handling such cases.

ASSISTANT COORDINATORS

Key posts for our mission

MSF/April 2004/Marie Kernec, Human Resources Officer, and Cécile Anjaleu, National Staff Coordinator.

Who are the 'assistant coordinators' on our various missions? What do we mean by 'assistant coordinator'; what precisely is their job profile? Does your own team have one? How much room for manoeuvre do they have? Is their role a decision-making one? Are they an integral part of the coordination team? Do they feel closely associated with the MSF project?

→ **Guinea, Boreah refugee camp** © Roger Job - November 2001

Only one mission in five currently benefits from the presence of an assistant coordinator. Generally chosen for his or her powers of analysis, representation and coordination, this assistant is often relegated in official meetings to the position of glorified translator, an enlightened interpreter for the head of mission. They may also play the part of liaison officer (renewing visas, etc.), general secretary for coordination, or internal communications officer within the mission. It is rare to find an assistant coordinator who is genuinely involved in coordination meetings and decisions, in a position to influence operational reflexion or feel fully associated with the MSF project.

This post ought, logically, to carry major responsibilities. Instead, it seems relatively ill defined, and must certainly be frustrating for the person concerned (and for the coordination team itself, which restructures its precise tasks to suit new arrivals).

To give an example, the former assistant coordinator in Afghanistan took the post of assistant administrator as soon as it became free: a job that was more clearly defined, not so random or precarious. In contrast, the present assistant coordinator in Nepal is able to fulfil his true role, assessing the local situation, making contacts and participating in decisions as to how the programmes should be run. A right-hand-man to the head of mission, he is a key figure in coordination, although he is not required to shoulder final responsibility for actions which could place him in an awkward position in his own country.

The difference in these job profiles can probably be explained by the sizes of the missions and of the heterogeneous coordination teams: it seems to be easier for the assistant coordinator to find his or her place in a smaller team, than in a team of four people.

What conclusions can we draw from our observations? Much depends on the personalities of the heads of mission seeking an assistant coordinator, and on how these assistants are recruited: whether it's by internal promotion, or by looking for someone from outside with a coordination profile, if that person doesn't exist within the organization. Some NGOs and institutions have, moreover, started to look into these posts, which support the continuity of missions.

And how do we, at MSF, really envisage the future development of this kind of post? Are we prepared to establish within each coordination team a genuine right-hand-man to the Head of Mission, who will sustain the memory of the mission, although without taking official responsibility for its actions?

Same question for the profile of assistant medical coordinator, who ensures that medical policies and project quality are monitored over the duration of the project. How exactly should tasks be apportioned? How should we deal with problems of respective roles and the frustrations felt by an assistant who has to hand over the reins at the arrival of each new head of mission or medco? What about powers of decision? How can we widen our recruitment for this type of position? What will it involve in terms of training and visits to headquarters, so as to promote a better knowledge of MSF and a greater commitment to the association?

Beyond these questions about coordination job profiles, the issue here is our readiness and ability to rethink the organization of our work and break free from the traditional pattern of 'decision-making ex-pats - local staff'. Can we identify and promote the key people in our missions, pro-actively recruiting from outside when the ideal person is not already working within our teams, truly involving these people in decisions about our projects, giving them clearly defined, long-term responsibilities...?

Although positive examples exist, they are still too rare: how many coordination meetings today - in our missions or our projects - truly involve key people from our local teams? The debate is underway. ■

REVIEW

France and the people of Rwanda

MSF/April 2004.

This article was written by Dr Jean-Hervé Bradol, President of Médecins Sans Frontières, Dr Rony Brauman, Associate Professor at the Institute of Political Sciences, Paris, and ex-President of Médecins Sans Frontières, André Guichaoua, Professor of Sociology at the University of Paris I Panthéon – Sorbonne, Claudine Vidal, Emeritus Research Director at the CNRS (Centre National de la Recherche Scientifique) signatories of an appeal for the creation of a parliamentary commission to study the role of France in Rwanda between 1990 and 1994, (an appeal that appeared in Libération on 3 March 1998) and Marc Le Pape, Member of the Board of Directors of Médecins Sans Frontières.

On the tenth anniversary of the Tutsi genocide in Rwanda, French politicians, both former and current ministers, have confirmed that they are still congratulating themselves on French policies in Rwanda between 1990 and 1994. They alone have never called into question the actions of the French government, while the Belgian and American governments, as well as the UN, have publicly admitted that they made mistakes and that those mistakes had tragic consequences. In Rwanda the authorities have, on the one hand, organized public mourning and, on the other hand, taken the opportunity as usual to settle political scores. This year, President Paul Kagamé chose to attack France, whom he accused of direct complicity with the perpetrators of the genocide.

it is shocking to witness this orgy of self-satisfaction, when an examination of the period 1990-1993 shows the extent to which France chose to ignore indications of the Rwandan regime's murderous intentions and practices.

Criticism of French government policies in Rwanda began as early as 1993. Following the genocide, there was mounting pressure on the authorities to shed light on France's role there; the signatories of this text contributed to that pressure by demanding a parliamentary investigation. The latter took place in 1998, and concluded with a severe indictment of French involvement in Rwanda, the aim of which was to prevent at all costs a military victory for the RPF (Rwandan Patriotic Front), at the expense of: 'underestimating the authoritarian, ethnic and racist nature of the Rwandan regime'; arming and organizing an army that 'certain members of the French military may have come to see as their own creation'; establishing a French military presence 'which stretched acceptable boundaries of military involvement in the field'; continuing to confer legitimacy on the interim government [set up after the assassination of President Habyarimana] and 'failing to grasp the reality of the genocide'. Although the four-volume report of this enquiry are a vital step towards establishing the truth about French official policy in Rwanda, there are still clearly many questions left unanswered, such as those concerning arms shipments after 7 April 1994.

The old and new ministers, however, take no notice whatsoever of the established facts or the conclusions of the parliamentary commission. They all defend their own areas of responsibility and praise the merits of their ministerial departments. The day after the Rwandan president had made his accusations, Hubert Védrine, a former socialist foreign minister and general secretary to the presidency of the Republic from 1991 to 1995, defended French diplomacy by saying that, 'while other countries remained completely indifferent, France tried to curb the spiral of evil'. Dominique de Villepin recently stated that, in launching Operation Turquoise, 'France chose the path of humanitarian intervention'. Michèle Alliot-Marie claims to be 'scandalized' that anyone might criticize 'the action' of French troops. Jack Lang, has also defended French policy in Rwanda. These attitudes have not changed since 1994. They were reaffirmed by everyone (except Michel Rocard) at the parliamentary enquiry in 1998. So what caused the failure, i.e. the genocide? The Rwandans themselves, or the international community. As for the consequences of France's long political, military, diplomatic and economic involvement there, these are apparently either positive or non-existent. In the speeches we've heard, French involvement stops with the signing of the Arusha Peace Accords in August 1993 (providing for the withdrawal of French troops) and takes up again in June 1994 with Operation Turquoise, described as strictly humanitarian.

This clamour of ministerial indignation coincides with the ten-year anniversary, which might instead be seen as the ideal moment for a look back over the facts and some soul-searching. In the light of everything that is known and documented about the relationship between France and the regime that perpetrated the genocide, it is shocking. Indeed, it is shocking to witness this orgy of self-satisfaction, when an examination of the period 1990-1993 shows the extent to which France chose to ignore indications of the Rwandan regime's mur-

> *"Crying over the deaths is not enough. Especially by those who did not witness their families disappear. Remembering, for me, is first of all recalling the actions and responsibilities specific to each player."*
>
> **Jean-Hervé Bradol**
> (In 1994 Jean-Hervé was RP for MSF France in Rwanda and spent several weeks in Kigali to help the surgical team that had stayed during the genocide).

derous intentions and practices. The French authorities at that time knew what the regime was like: diplomatic telegrams emphasized its capacity for criminal behaviour and pointed out the various elements of its genocidal policy. Yet instead of weakening a government that had no other support in the international community, to use Hubert Védrine's own expression, France assisted it right to the end, even after 7 April 1994 during the extermination of the Rwandan Tutsis. Ministers may, in their present defence of French involvement in Rwanda, pass quickly over the period 1990-1993, but they are particularly proud of Operation Turquoise, which they see as a symbol of France's moral commitment and sense of responsibility. It has been established, however, that one of this military operation's objectives was to prevent the total victory of the RPF in a Rwanda whose army had disintegrated, leaving only the genocidal forces organized and active.

It is in the nature of French political culture never to admit to mistakes, unless forced to do so by legal intervention or the routine release of documents from the archives (generally decades after the event!). All our ministers conform rigidly to this pattern, maintaining an attitude of infallibility to the point of denying all the evidence. These political leaders give the impression that they are enclosed in a circle and would like to keep us there too, in the name of a patriotic assent that is particularly inappropriate in these circumstances. Their attitude of infallibility seems to us to belong to a different era, and we find it unacceptable. The genocide of the Rwandan Tutsis did indeed take place; France has considerable responsibility for what happened, and the constant denial of this responsibility reflects on the whole French body politic. The first step in resolving this would be to make a gesture of humility and regret towards the Rwandan people, by acknowledging the simple truth: that although 'everyone knew that there was huge potential for a massacre', to use Hubert Védrine's own words, French political leaders did not use all the means at their disposal – and at that time, it was they who had the most – to paralyse the Rwandan political and military authorities who were preparing the genocide of the Tutsis. ■

A politically correct Commemoration

MSF/April 2003/Jean-Hervé Bradol/Interviewed by Rémi Vallet.

Jean-Hervé Bradol, President of Médecins Sans Frontières, looks back on the Rwandan genocide and its implications for humanitarian organizations.

→ What did the genocide in Rwanda represent for humanitarian action, and for MSF in particular?

The genocide disintegrated the famous neutrality of humanitarian actors. Emergency aid, even though it saves lives, can in no way justify neutrality when faced with a political movement's programme to exterminate an entire group of people. The only way to demonstrate opposition is to request armed intervention against the executioners, which MSF did in June 1994 with its appeal "doctors cannot stop genocide". Genocide is the unique situation when, contrary to its policy of not participating in hostilities, humanitarian organizations express their favour for military intervention.

Unfortunately, international military intervention against the perpetrators of the genocide never took place and the military victory of the FPR (Rwandan's Patriotic Front) occurred following the massacre of most to the victims. The United Nations, which had forces stationed there at the time, bears the huge responsibility of not attempting to protect the Rwandan Tutsis. France, however, is guilty of supporting a genocidal regime for too long. Moreover, when France finally did intervene, it led "neutral" military action (Operation Turquoise), which contributed to providing sanctuary to the perpetrators of the genocide in the refugee camps in Zaire.

→ Did MSF misevaluate the situation prior to the start of the massacres?

In spite of the alarming information that circulated from 1993, no one had predicted the extermination of 800,000 people in less than three months. However, the question which should be put to humanitarian organizations is not "was your political prognostic of the development of the Rwandan situation correct, did you see the genocide coming?" but rather "did you do what was necessary, before the beginning of the genocide, to ensure that your aid did not feed the extremist militia already involved in massacres?". In fact, it is in the complaisance towards the government and its militia, by allowing them to carry out the massive diversion of relief, that lays the cruellest question for aid organizations with regards their direct responsibility.

Before April 1994 the extremists in Rwanda infiltrated the relief system to reroute symbolic and material aid (vehicles, food, etc.). For example, the diversion of food aid reached such a point as to starve the 300,000 Burundian refugees that arrived in October 1993 and a portion of the 800,000 Rwandan IDPs gathered in camps prior to the genocide. This contributed to maintaining the death rate in the camps at frightening levels. Consequently, between October 1993 and March 1994, 9,000 Burundian refugees died.

→ The Kivu camps, in Zaire, were sanctuaries for a number of genocidal perpetrators. Faced with this fact, MSF France decided to withdraw as of 1994, contrary to other sections. 10 years later, have these differences been reconciled?

History decided. Neutrality loses its meaning in the context of genocide. To remain in camps controlled by perpetrators of a genocide, beyond the emergency period of the installation, is a form of complicity. Even more so as it was obvious to everyone that these criminals fuelled themselves by looting the aid organizations. MSF France did well to leave in 1994. The other sections did well to leave in 1995, but they should have done so earlier.

→ What is your opinion on the way in which the Rwandan genocide is remembered on the occasion of its anniversary?

In my opinion, it is intolerable to see a new discussion surface that blames the genocide on unavoidable ethnic opposition and that trivializes political extremism as if it were a spontaneous popular predilection shared by every Hutu in Rwanda. However this is but contempt for the social and political life of Rwandans, which sadly tarnishes many outside views of politics in African countries.

It's also the occasion for a politically correct commemoration marked with incantations in the "never again" vein. Need we remind everyone that in 1994, on a visit to Auschwitz, Prime Minister Edouard Balladur already tried to voice this type of definitive statement, at a time when 800,000 people were exterminated in Rwanda? Unfortunately, some organizations, Médecins du Monde or MSF Belgium for example, participate in this type of commemoration.

Moreover, commemorating the genocide has become one of the core themes of the current Rwandan government's propaganda, a government guilty of major crimes. Should we associate ourselves with such a campaign?

→ MSF France has not been present in Rwanda since 1996. Have any attempts been made since to start new programmes there?

In 1995, MSF France was expelled for confronting fairly early the new Rwandan regime. We denounced the violence carried out by the new regime, such as the massacre of at least 4,000 people in the Kibeho camp in April 1995, right in front of the MSF team and the UN's Zambian soldiers. Government ministers, as well as Paul Kagame, asked us to keep quiet, which we refused to do.

For 10 years, the regime in place has quashed any form of opposition by violence, often with recourse to political assassinations. The regime is responsible for the slaughter of thousands of people in Rwanda as in Congo. It is not that we do not want to work in Rwanda, but rather we have been forced out by a regime that hides its own crimes by remembering the genocide of Rwandan Tutsis, and using force to keep any conflicting voice quiet inside the country, international organizations included. ■

Sudan, Darfur, Jijira Adi Abbe village, destroyed by government forces.
© Marcus Bleasdale – Febrary 2004

SUDAN/DARFUR

Loneliness and distress in Darfur

MSF/April 2004/Interviewed by Anne Fouchard.

Coralie and Jean-Sébastien are the team of 2 who, after the forced and sudden closure of Nyala camp, went to Mornay where they nearly spent two months. Mornay has been under attack for a while and they had to take care of 80 wounded, as any medical reference was impossible for security reasons. In Darfur, MSF has seen about 115,000 displaced among an estimated population of 600,000. People in really bad and poor conditions, in a context of extreme violence?

"We arrived in Nyala in early december, when there still were about 10,000 to 15,000 displaced in spontaneous settlement around the town. At this time, Nyala was the only spot in which MSF was working in Darfur, to assist the displaced population estimated at 600,000. For now, more than 115,000 inhabitants have been seen by several MSF exploratory missions and we still have no idea on the others' whereabouts.

Since the very beginning, we could understand that there was a clear will from the authorities to have the displaced moved to 15 km away from Nyala. As we just finished our clinic, the last fence being held, the camp closed : the people fled away to escape forced relocalization in Belel, this camp which not at all ready to welcome displaced. For now, there are no more than 500

persons in this site which still doesn't have any proper installation. We didn't get support from the UN agencies from the beginning, even though

It is the first time I faced such a dilemma, says Coralie : as a nurse, I was not skilled to cure people, but was it ethical not to do anything ? So, we did all we could: we settled a ward with 15 beds for the wounded, provided with some water the displaced, gave some basic essential items and started nutritional assistance.

they changed their mind later on. The Nyala story created a tense relationship with local authorities, as they were not happy with our public statement. We had to deal with this for a while, had problems to reach new places of settlement identified in exploratory missions earlier, like Zalinge. But as we could reach Mornay, the referral authorities changed (then we depend on western Darfur authorities and no longer on Southern Darfur administration), and made things easier.

The most striking element is the incredible change which occurred in this specific region in two months: when we were on our way to Mornay, we could see villages burning along the road ; on our way back, there was not a single house anymore ; one can hardly see a living soul between Zalinge and El Genina. In the meantime, the area had been cleaned. On our way to Mornay, we could see people along the road with their belongings, fleeing away. Some elders or youngest, those who couldn't walk were left behind. We drove some elderly to Mornay. Mornay is a small town of about 3,000 inhabitants. It has now turned to a big town : when we arrived in Mornay, there were about 20,000 displaced. It's at least 60,000 displaced now, coming from villages located from 50 to 60 kilometers around, all attacked.

We received 80 wounded that we had to take in charge: many bullets in their bodies, children shot? Civilians were not spared. In the first days of the attack, we received a woman with her three months years old baby, both wounded by bullets. We tried to transfer her to El Genina hospital. The car in which she left was attacked by Jinjiwets, everyone except her and her kid were killed. This woman has been incredibly lucky : she could manage to reach the hospital and she and the baby are doing well. There are very few men among the displaced population and, among the women, 17 notified rapes. People are raped, beaten or killed. From what we could see, there are heavy massacres and violence in the region. All along the attacks on Mornay, we couldn't move around, helicopters and bombings were preventing from any movement. We were just the 2 of us, one logistician and one nurse, to provide heavy health care to wounded? It is the first time I faced such a dilemma, says Coralie : as a nurse, I was not skilled to cure people, but was it ethical not to do anything? So, we did all we could: we settled a ward with 15 beds for the wounded, provided with some water the displaced, gave some basic essential items and started nutritional assistance. The nutritional situation is worsening and worrying: we can see cattle dying in the streets of Mornay. People have to go farer and farer to get fodder ; as it's very risky, they go in groups of 50. When we arrived, we evaluated that about one third of the families were having stocks of sorgho still. For how long? During the nutritional screening, we evaluated that 4,000 children. Now it's more than 12,000. We have 300 severely malnourished children and 1,200 in supplementary. We are trying to reach the villages in which people say there are displaced still with no assistance. Names of villages that people mentioned in which there should be about 40,000 displaced : Kerenik, Abila, Sisse, Soulou? The villages we couldn't reach so far where people say the situation is terrible.

More assistance is urgently needed, not only in Mornay. Lack of water, lack of food, lack of basic items? It is a huge crisis and an emergency reaction is needed. But the mobilization of aid agencies is still expected?

More assistance is urgently needed, not only in Mornay. Lack of water, lack of food, lack of basic items? It is a huge crisis and an emergency reaction is needed. But the mobilization of aid agencies is still expected?" ■

→ **Soudan, Darfour,** the camp of Nyala empted of its inhabitants by the Sudanese army - January 2004

POINT INFO

→ May 3, 2004, Darfur: deep concern

A logical consequence of delayed nutritional aid (despite promises to the contrary) : the number of cases of malnutrition in children tripled in three weeks in Mornay, Zalinge, and Niertit. We currently have 380 children in the TFC in Mornay and have instituted a blanket feeding for 15,000 children. After the confirmation of several cases, we vaccinated against measles.

All sections put together, we have located 400 000 of the 800 000 displaced persons. The ICRC has announced a large aid operation, as WFP. However, this vital aid has still not arrived, which is of great concern particularly as the imminent rainy season could seriously complicate transportation.

MISSION

CÔTE D'IVOIRE

CÔTE D'IVOIRE/MACA

Behind the bars of the Maca

MSF/avril 2004/Laurence Hugues.

Médecins Sans Frontières has been working in the Maison d'Arrêt Centrale d'Abidjan (the Central Detention Center of Abidjan, the MACA) since 1997. With a supposed capacity of 1500 detainees, the prison is permanently overcrowded, with numbers averaging over 5400 persons. Conditions are ripe for epidemics...

→ © MSF - September 2003

In fact it was a cholera outbreak that first bought Médecins Sans Frontières to work in the MACA. "At the time, it was very probably the place with the highest mortality rate in Côte d'Ivoire [Republic of Ivory Coast]," recalls Graziella Godain, Responsable de Programme. "In 1997, mortality was 8 per 10,000 during epidemics, and 1.5 the rest of the time."

After a drastic reduction in the mortality rate, the organization began to think of withdrawing. General Gueï's coup d'état in December 1999 threw everything up in the air again. Political instability set in. Then came the coup d'état of September 2002, which split Côte d'Ivoire in two and disrupted everything, including the prison where MSF is still working...

"How's it going, boss?" Samia says in greeting to a tall, strapping fellow, naked to the waist, with a determined look about him. As a general practitioner, she cares for six hospital wards and the isolation ward of the infirmary at the MACA. "I had never worked in a prison setting. I had seen "Midnight Express! That's all!" recounts Samia with a smile. "For the first time I was a bit apprehensive before leaving on a mission," joins in Genevieve, field coordinator for the MACA, who nonetheless has eighteen years of MSF work behind her, including ten years in the field. "Still, it's going all right!"

« At the time, it was very probably the place with the highest mortality rate in Côte d'Ivoire [Republic of Ivory Coast], recalls Graziella Godain, Responsable de Programme. In 1997, mortality was 8 per 10,000 during epidemics, and 1.5 the rest of the time. »

"On top of the medical activities, the legal and social interventions helped in particular to reduce assaults on suspects in certain police stations."

Geneviève,
Field coordinator at the Maca

MEDICAL ACTIVITY

- In 2003 there were more than 19,000 medical consultations held at the MACA. Since August 2003, the implementation of a new system of directly observed treatment [DOT] has allowed the number of consultations to fall by a third or a quarter. This system of administering medication in the presence of medical staff has without doubt lessened the chances of prescription drug dealing.
- In the spring of 2004, after renovating the lab, MSF has opened new tuberculosis activities, which prior to this were limited to caring for patients with multi-drug-resistant forms [MDR] of the disease.
- The supplemental nutritional program serves about 220 detainees at present.

→ HERE, EVERYTHING HAS A PRICE

In the courtyard at the MACA, one might almost forget the muffled sounds of banging doors, the darkness, the men crammed in the cells. Every day the


detainees of buildings A and B can spend the day outdoors—except for those being punished, who are confined to the "armored division", the solitary confinement cells in building C, where the long-termers live. Under the trees, in the corners of the buildings, men talk endlessly, wait around, get bored...Some do garden work—little patches of green and yams. Others stand guard in front of the women's building—90 women at present, three of them with children. Dope you get in the Colombia section, cigarettes from the market, with sauce to go with your rice. In short, for those who have the means, everything here can be got through dealing, everything has its price, including health care access. Every day, men in torn t-shirts, with haunted looks on their faces, come to gulp down the high-protein porridge prepared by the MSF teams. Malnutrition can set in very quickly in the most fragile, the most destitute, those who don't have relatives in Abidjan or whose relatives have disowned them.

→ SHARKS AND LITTLE FISH

In December, repeated water cutoffs and the expectation of end-of-the year pardons heightened the tension in a prison always on the edge of imploding. "Even the sharks were starting to eat each other," relates Samia. The "Sharks" are the 'big shots" in charge of keeping order in the buildings, because here it's the detainees who are "keyholders", responsible for opening and closing the cell doors during the day. During the daytime in this "self-managing" prison, attacks and fights are also handled by the prisoners. In a small dressings room, the nurse and health worker see to someone with a cut above the eye. Outside, on the bench, two young men wait their turn. The plaintiffs caught them and beat them up before turning them over to the police—a typical way to deal with someone caught in the act. Acts of violence are, of course, part of the daily routine in the prison, and they come in all varieties. Last month, a young man was hospitalized after being raped. Prostitution, abuse, or simply sexual activity between consenting adults: another of the realities of prison life that the penal administration sometimes has trouble recognizing. AIDS, however, is spreading here, as elsewhere. Tuberculosis also: this is the main cause of death during non-epidemic periods. MSF has just decided to become more involved in this activity [see inset]. "The political and administrative situation is still far from returning to normal. It is only within that context that we can foresee a transfer of our activities to the penal administration," concludes Graziel-la. "So that's where we are for the time being, whether we're acting as substitutes, or whether we're in a period of transition, which will take a minimum of two years. We take on the job and we accept it."■

In December, repeated water cutoffs and the expectation of end-of-the year pardons heightened the tension in a prison always on the edge of imploding.

MARCOUSSIS RICE

So named by the detainees because it was introduced at about the same time that the peace accords were signed by the loyalists and the rebels, Marcoussis rice is distributed twice a week. Its special characteristic: an addition of QB-mix, a mixture with a high content of vitamins and micro-nutrients, which is intended to fill in for the severe nutritional gaps in prison food. As it was, in the winter of 2002, an outbreak of beriberi, caused by the lack of vitamin B1 in the food, affected 721 detainees and led to 7 deaths.

A DAILY FIGHT AGAINST CHOLERA

In the unhealthy and overcrowded prison environment, the cholera bacterium can spread with frightening speed. A large logistics project was therefore launched in 1997 to upgrade the whole drainage network and to improve general hygiene in the cells and buildings. Despite this herculean effort, cholera broke out again right after September 19, 2002, with over 600 cases registered. This most recent epidemic to date underscores the extreme weakness of this environment, where a couple days without water and access to health care can lead to a worst-case scenario.

POINT INFO

→ May 3, 2004, Madagascar: consequences of the cyclone Gafilo

In the northeastern Antalaha region we have distributed medicines, helped to reconstruct roofs, and supplied other material to the affected population. The region's "prosperity" (due in particular to vanilla cultivation) and the purchasing power in the zone lead us to believe that there are no serious nutritional problems in the area. However, the situation is more critical in the areas surrounding Monodave, in the southwest of the island, which are poorly accessible due to flooding. The evaluation being conducted in the area (200, 000 inhabitants) has not yet allowed us to estimate the nutritional needs of the affected population. Some people are able to meet their needs through fishing and subsistence farming, although the situations vary enormously. There is no nutritional crisis at the moment, but our current evaluation of food security in the area has not yet led to definitive conclusions.
In the meantime, we have opened a TFC in Monodave.

MISSION

SIERRA LEONE

SIERRA LEONE/MALARIA

Protocol: change of

MSF/April 2004/L.H.

In March the government of Sierra Leone agreed to modify its national malaria treatment protocol to include artemisinin-based combination therapies (ACT). A review of the months of pressure and debate.

→ Sierra Leone, Kailahun hospital ©

→ Context

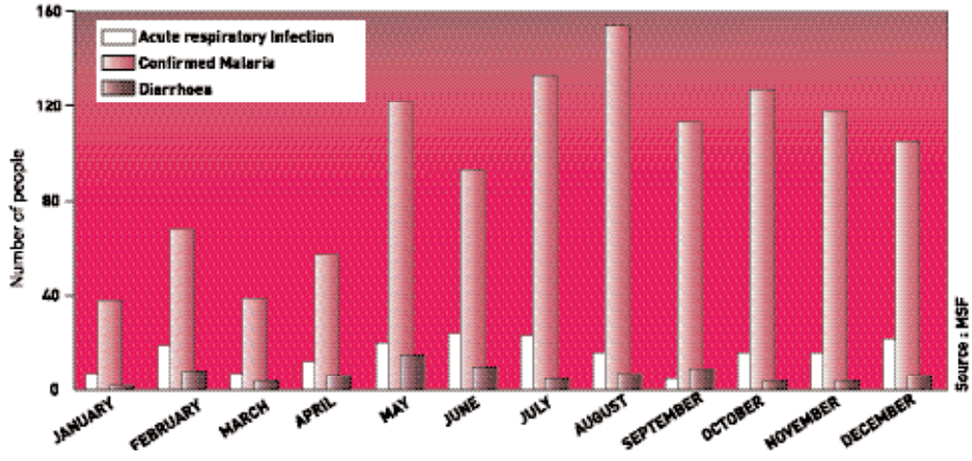
Sierra Leone is slowly recovering from a decade of armed conflict that killed tens of thousands and displaced nearly two million people. Despite the peace, living conditions are still very harsh, with per capita income under 150 euros and an average life expectancy of 40 years. Malaria, a major cause of mortality, claims victims all year round. A Ministry of Health study revealed that in Freetown, the capital, malaria was responsible for 42% of pediatric deaths. Other researchers found that in the southern part of the country, it was responsible for 27% of all deaths.

"Sierra Leone probably has the highest per capita malaria rate in the world," stresses Francesco Checchi, the Epicentre epidemiologist following the situation there. "Transmission is steady throughout the year." A textbook case, Sierra Leone has been the subject of numerous studies on the disease. There has, however, been very little documentation on resistance to treatment. A drug resistance study initiated by MSF and conducted between October 2002 and May 2003 characterized the efficacy—or lack thereof—of standard antimalarials (see map and legend). Chloroquine failed in 40% to 79% of cases, depending on the region.

The study wasn't all that easy to do. Organized at the national level, it involved three MSF sections and two other NGOs, MERLIN and Concern. Once approved by the ethics committee, the project took several months to complete, against a backdrop of inter-section bickering, skirmishes with members of the Health Ministry, and irritation at the WHO. Just the usual, you say? "I really think it was the worst experience I've had since being at MSF," Francesco smiles. "I can give you some examples: while one study was in progress, the door was nailed shut by the district medical chief; PCR samples disappeared in Freetown (by some miracle they showed up in Paris, and were then mistakenly sent back to...Freetown!); several boxes of blades were destroyed by an incompetent driver, etc. Then, MERLIN's results had to be thrown out for lack of rigor. Not to mention the turnover: at Kailahun, five different doctors supervised the study...." More than fifty people were directly or indirectly involved in conducting the study. While this gave rise to much confusion, such a large a group also had its advantages. According to Stephane Doyon, MSF-France's head of mission in Sierra Leone, "Involving as many actors as possible—NGOs, ministries, the WHO, etc.—lent the outcome legitimacy. Naturally, when the initial results came in, the Ministry wasn't thrilled to see that chloroquine and Fansidar got burned...."

Because as soon as the work was finished and officials at the Health Ministry accepted the report, a whole new round of consensus meetings was needed to present

Principal Pathologies - Paediatric ward in Kailahun, Sierra Leone, 2003.



labels

educom@mac.com - January 2003

Map of the study sites with observed chloroquine (CQ), sulfadoxine-pyrimethamine (SP) and amodiaquine (AQ) failure proportions. Sierra Leone multi-centric antimalarial efficacy study, 2002-2003 (map source : US Geological Survey, modifications by Epicentre 13 octobre 2003).

Excerpt from the Resistance Study Report « Efficacy of Antimalarials in Sierra Leone : results form Six in vivo Studies of Chloroquine, Sulfadoxine Pyrimethamine and Amodiaquine" octobre 2003. « Antimalarial resistance has reached crisis proportions in Sierra Leone. The efficacy of the current first-line treatment, CQ, is dramatically low, with obvious consequences for morbidity and mortality ».

This treatment should be abandoned as soon as possible, and combination therapy introduced. SP resistance, in steep ascent throughout Africa, is concerning in Sierra Leone, and precludes its effective use. A combination of artesunate and AQ should be prioritised for deployment ; however, its efficacy should be verified in key sites. Artemether-lumefantrine (Coartem®) is an alternative option.

the results and draw the obvious conclusion: the national protocol had to be changed. The process was held up for weeks on end. "Once the WHO decided to get moving, we started to see some change," Stephane says. "It still took until the end of November." A meeting schedule involving all the health actors was then set up. Discussions seemed to be moving along on the right track when MSF received a letter from the Pharmacy Board notifying them that the importation and use of ACT were prohibited, even though the drugs were available at private pharmacies. This ministerial table-thumping had no effect, however. One month later, at a consensus meeting, the government announced that it was going to change the national malaria treatment protocol to include artemisinin-based combination therapies. The NGOs have been invited to participate right away in the introduction of ACTs, a process that's expected to last until the end of 2006. The government of Sierra Leone recently requested financial support for the new protocol from the Global Fund, and their request is likely to be granted. Once the money starts flowing they'll need to organize training in diagnosis and treatment, then the introduction of ACTs in practice. This could turn out to be a long, slow and laborious process. To be continued... ■

LIBERIA: A PIONEER, IN SPITE OF THE WAR

An Epicentre study conducted in 2000 at Harper hospital, near the border with Côte D'Ivoire, showed very high levels of resistance to standard antimalarials. There was 74% resistance to chloroquine, and over 50% resistance to Fansidar. On the basis of this study, MSF began discussions with the Ministry of Health to change the national malaria treatment protocol to include artemisinin-based combination therapies (ACTs). The government ratified the protocol change barely a month before LURD rebels launched
their offensive against the capital. This was probably one of the last major decisions made by Charles Taylor's regime, which was overthrown a few weeks later. Later, the request for funds needed to introduce ACT was approved. With twelve million dollars expected to be released soon by the Global Fund, this example should encourage other countries to follow Liberia's example.

MISSION

SIERRA LEONE

SIERRA LEONE/MALARIA

Agreement and Disagreements

MSF/April 2004/Questions to Stéphane Doyon/Interviewed by L.H.

Three questions for Stephane Doyon, head of mission in Sierra Leone, who describes the various stages towards the change in protocol.

→ Sierra Leone, Kailahun hospital © educom@mac.com - January 2003

→ It took months of negotiation to convince the government of Sierra Leone of the need to change the national protocol. Was this a tough battle?

"Our primary goal was to provide appropriate treatment for our patients. That this led to a change in the national protocol was a huge bonus! There was strong disagreement between sections on these issues, anyway—between those that had already started using ACTs and those that were waiting to lobby for use at the national level. Later, some decided to make their participation conditional—no malaria program without ACTs—while others were more flexible and continued to follow the national protocol. Finally, we agreed to adopt a uniform strategy—to make our participation conditional. That is, we took a rather hard line, at the risk of placing ourselves in frank opposition to the government. There were several small crises that led to direct confrontation."

→ What, in your opinion, helped the most?

"Martin de Smet, with the Malaria Working Group, and Epicentre's Francesco Checchi did a huge amount of work. They were meticulous in laying the groundwork for the consensus meeting that finally convinced the government. The Health Minister really appreciated their help, because she had just been appointed. Sierra Leone needed to prepare an anti-malaria action plan and funding proposal for the Global Fund, and our two experts gave them a lot of assistance. Before the meeting they also prepared an entire series of technical documents that helped in the decision-making process. In particular, they estimated the cost of the protocol change, which turned out to be much lower than the Ministry people expected. As it happens, these officials use, and give their children, ACTs that they have to buy at private pharmacies for high prices (between 5 and 8 USD per treatment). Well, with WHO-negotiated prices the treatment costs about 4 times less (1.5 to 2 USD, depending on whether or not Paracheck is used). The demonstration was pretty convincing!"

→ What happens next?

"The political decision has been made. Now it's time to act, and implement the new protocol. It's an enormous undertaking, and I hope Sierra Leonean authorities and the WHO will be able to get everyone going. MSF will continue to keep a careful eye on the speed and the methods of implementation. We'll be the watchdogs—as always!" ■

POINT INFO

→ May 3, 2004, Niger: measles vaccination campaign has been concluded

We have concluded our vaccination campaign in three regions. With the support of the WHO, more than 109.000 vaccinations were carried out in the villages Niamey, Tahoua, Konni, and Tillaberi, with an estimated coverage of 51 to 97 %.

The epidemic appears to have reached its climax. We are continuing with our curative activities by handing out kits and supervising their distribution.

Despite free treatment, patients are still charged for hospitalization, because the government has not declared an epidemic.

A team from Epicentre is currently conducting an evaluation of the percentage of the population vaccinated as well as documenting the number of cases; the team is beginning a retrospective study in order to demonstrate that the mortality rate linked to measles in Niger is highly underestimated.

BURUNDI: A THREE-YEAR BATTLE TO CHANGE THE TREATMENT PROTOCOL

Between the end of 2000 and July 2001, Burundi suffered a malaria epidemic of unprecedented proportions. Nearly three and a half million cases were reported throughout this country of 6.5 million people. While in eight months MSF diagnosed and treated about 1.2 million people in the northern provinces of Kayanza, Ngozi, and Karuzi, more lives would certainly have been saved by the use of treatments more effective than that recommended by the national protocol. MSF fought to use artemisinin-based combinations, but to no avail. This tug-of-war with Burundian authorities culminated in the expulsion, in 2001, of our head of mission.

Finally, in 2002, the WHO published a clear and detailed recommendation on the need to use ACTs in countries with resistance to standard antimalarials. After a month of lobbying, the decision to change the national protocol was ratified at a July 2002 consensus meeting organized by Burundi's Health Ministry. In November 2003 the new protocol was put in place. It uses artemisinin derivatives (artesunate) in combination with amodiaquine, another antimalarial that has retained its efficacy. Burundi thus became one of the first African countries, along with Zambia and Tanzania, to use artemisinin derivatives.

MALARIA CAMPAIGN

"It's time to take ACTion"

MSF/April 2004/Florence Ratajczak interviews Ann Avril, head of fundraising.

MSF has launched a national anti-malaria campaign around this year's Africa Malaria Day, April 25th. Ann Avril, head of fundraising, discusses the campaign's goals, message, issues and methods.

→ Can you describe for us the goals of this anti-malaria campaign?

The goal of this campaign is to recruit new donors—that is, to find a new audience through this issue. Malaria was not chosen at random; it's the number one disease treated by MSF in Africa. Fighting malaria is a goal and priority shared by Operations, the Medical department, our field teams, the Essential Medicines campaign...and Communications as well. But it's a fairly complex problem. In addition to the challenge of treating large numbers of people, there's another major obstacle: providing them with effective drugs. Such complex issues are hard to explain—especially in fundraising, which depends primarily on ads that allow little space or time.

Also, deciding to base a campaign on a disease is new. We usually launch our donation drives when there's an emergency affecting a very specific population, as in Afghanistan in late 2001 and Angola in 2002. This, however, is a multidimensional issue and common to several countries—primarily in Africa—where epidemics rage and where teams run into multiple obstacles trying to provide appropriate treatment for patients, as in Burundi in 2001, or more recently in Ethiopia.

So we're asking for our donors' help to respond to upcoming epidemics and to fund malaria diagnosis and treatment. The ideas is then to perhaps invite them to support our activities in a broader sense, or to become regular contributors through the "1 ¤ a week" program.

→ Which messages are you hoping will rally donors?

It was hard to find a catchy anti-malaria ad, since the French public are with the disease. With about 7000 cases, its effects in France are minimal. So we had to find a new concept that would raise public awareness to the fact that this is a serious, deadly disease that takes a huge number of lives each year. An agency helped us with the timing of the campaign, and offered to design it—all free of charge, of course. Though it might seem extremely opportunistic, we immediately went for the concept they suggested! With two million deaths a year, we do not have a problem with the reference to a weapon of mass destruction. We also needed to use the disease vector, the mosquito—despite the fact that we don't do prevention—because it's the only common denominator between the French and malaria.

→ How do you introduce the issue of ineffective drugs to the general public?

We tried to talk about artemisinin-based combinations, but the stretch between an unfamiliar disease and the inefficacy of some treatments hampers donations. Also, what can contributors do about the fact that many countries resist changing their protocols? All they can do is support us, secure in the knowledge that we'll use our energy to give patients appropriate drugs while trying to effect change. Anyway, haven't they been the ones paying for these significantly more expensive treatments up until now?

While the artemisinin-based combination therapy (ACT) issue might be too technical for the general public, it will nevertheless be the main argument we present to journalists. Hence the title of our press kit: "It's time to take ACTion."

→ What types of ads will the campaign use?

With such a strong concept, posters would certainly be one of the most appropriate vehicles, specifically 4x3 and bus shelter posters in big cities and airports, primarily. But this won't be enough, because passersby seeing a poster rarely have anything on them to write down the address or phone number. We'll also use TV and radio spots, and a newspaper ad. We'll have dedicated space on the website and we'll send out 550,000 mailings in May to households in Paris. Since the advertising space is being donated, we only have to pay production costs.

Though we're launching the campaign on April 25th in connection with Africa Malaria Day, the publicity drive will mainly take place in May and June, and last until summer. We can comfortably continue the drive at least through the end of 2004, and into 2005 as well, even if other urgent situations come up between now and then that demand our attention. ■

To support the campaign : BP 2004 – 75011 Paris, par téléphone 3260 dites « Médecins Sans Frontières », www.msf.fr

31 COUNTRIES - 33 COORDINATION TEAMS

PORTRAITS
OF THE HEADS OF MISSION

MSF/Updated 15 May 2004

01 
Christelle Mizerat
RDC Beni
(2/01/04 → 15/07/04)

02 
Gregory Elder
Nord soudan
(26/04/04 → 25/04/05)

02bis 
François Delfoss
Nord soudan
(15/03/03 → 15/05/04)

03 
Frederic Sanchez
Congo Brazza
(20/04/04 → 19/04/05)

04 
Catherine Quillet
Cambodge
(9/01/01 → 8/01/05)

05 
Sylvie Pouit
Guatemala
(3/03/02 → 1/03/05)

06 
Yves Marchandy
Chine
(9/11/02 → 14/10/04)

07 
Philippe Cachet
Madagascar
(1/02/03 → 27/05/04)

08 
Philippe Le Vaillant
Niger
(7/04/03 → 15/10/04)

09 
Yann Libessart
Burundi
(26/05/03 → 26/05/04)

10 
Jean-François Corty
Iran
(13/06/03 → 30/09/04)

11 
Isabelle Voiret
Ouganda
(6/07/03 → 5/07/04)

12 
Christine Genevier
Kenya
(14/08/03 → 13/08/04)

13 
Sylvaine Lonlas
RDC Gbadolite
(14/08/03 → 28/02/05)

14 
Laura Brav
Sud Soudan
(25/08/03 → 25/05/04)

15 
Eric Ouannes
Corée
(26/08/03 → 25/08/04)

16 
Jean-Luc Anglade
Ethiopie
(1/09/03 → 31/08/04)

17 
Filipe Ribeiro
Georgie
(4/09/03 → 15/09/04)

18 
Stephane Doyon
Sierra Leone
(25/10/03 → 24/10/04)

19 
Peter Orr
Côte d'Ivoire
(15/11/03 → 15/05/04)

20 
Fabrice Weissman
Guinée
(27/11/03 → 26/05/04)

21 
Hubb Verhagen
Afghanistan
(1/12/03 → 15/06/04)

22 
Jean Rigal
Thaïlande
(28/12/03 → 27/12/04)

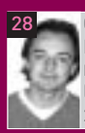
23 
Gabriel Trujillo-escudero
RDC Katanga
(5/01/04 → 4/01/04)

24 
Thierry Vanvert
Colombie
(5/01/04 → 4/01/05)

25 
Philippe Clerc
Nepal
(5/01/04 → 5/01/05)

26 
Thierry Arnoult
Indonesie
(1/02/04 → 30/06/04)

27 
Xavier Trompette
Liberia
(26/02/04 → 25/08/04)

28 
Olivier Maizoue
Palestine
(23/03/04 → 22/05/04)

29 
Manuel Lannaud
Russie
(12/04/04 → 30/03/05)

30 
Asis Das
Myanmar
(14/04/04 → 15/04/05)

31 
Christian Ferrier
Armenie
(26/01/04 → 25/07/04)

32 
Annette Esprit
France
(01/09/03 → ???)

33 
Geneviève Jezequel
Tchad
(23/03/04 → 22/05/04)

34 
Arnaud Jeannin
Malawi
(01/01/04 → ???)

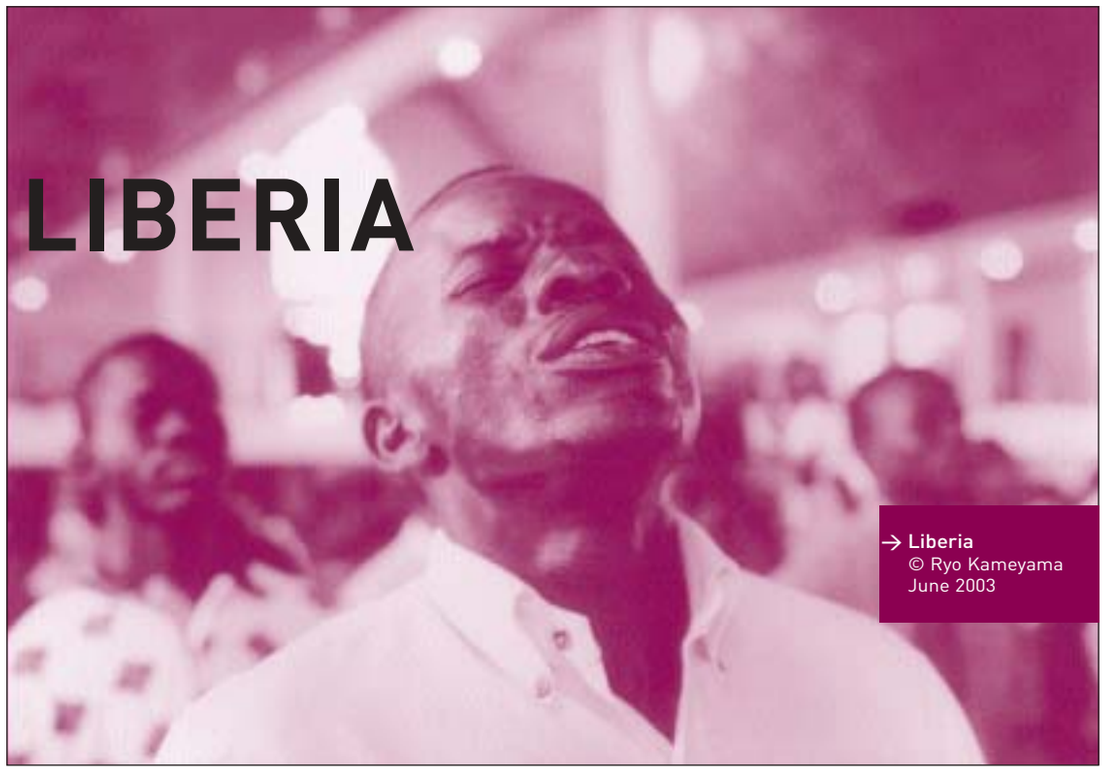
FROM
THE FIELD

MONROVIA

KARMA LIBERIA

MSF/Febrary 2004/Romain Gitenet.

It is a new experience, one far removed from video games and big Hollywood productions. It is the exhortation of all your senses, the stimulation of a heart thought to have atrophied. When we attempt the experience, we accept the dictate of our bodies, and the inescapability of our five senses.



→ Liberia
© Ryo Kameyama
June 2003

First, it is your sense of sight that will impose unforgettable images that will haunt even your dreams. The distinctive scent of conflict that brings to your sense of smell an indescribable odor: the stagnation of waste waters in the open ditches, the precarious conditions of the displaced relieving themselves on city's roadsides, the sweat of the dehydrating laborer. Next, your sense of hearing is assaulted. The gruesome war stories pollute the soft African melody that usually charms your ear, and the gunfire of scattered attacks by fighters who refuse to disarm are heard in certain faraway neighborhoods of the city. The combination of images, odors and sounds leaves a bitter taste in your mouth, sometimes spicy, at times very disagreeable. Only your sense of touch is free from torment. The man is pleasant, he taps you on the shoulder, and shakes your hand while snapping his thumb on yours, in a gesture of consideration. Adversity has not disrupted his dignity.

Your senses are on alert, and your emotions tightly controlled, however do you think you are ready for the experience?

You doze off in the airplane only to awaken a few hours later in the body of a spectator attempting to be an actor. But life here is not a stage. Distress is not so deeply felt if it is merely observed. It simply is lived, with the force of gangrene that will ravage the inside of your body. It's a little of all that, Liberia Karma.

Be warned, welcome to this very real world!

You are 30 years old and live in Bong County, 20 kms from the only cross-country road, which is guarded by UN peacekeepers. Twenty unfrotunate kilometers that could have changed your life. You have been walking all day carrying your 2 year old daughter in your arms. The MSF doctor immediately admits her to the TFC for intensive treatment. The poor child breathes death. The countdown has already begun, and even those who are not doctors feel the absence of life in her mass of bones. A cellophane film could not have covered her skeleton any better than the thin skin that would serve as her shroud. She comes from one of the many villages still being terrorized by fighter raids, where only the deprived are left to fight. They loot like they always have and starve those struggling to feed their families. Your only fault, poor 30 year old woman, is that you did not live on the main road. In a few hours, your baby will be in the other world. You believe in heaven and hope fervently that there will be amnesia once she attempts to cross the pearly gates, where she will never have to think of the past week, when the gnawing of her stomach ripped through her little spirit. This is your Karma: you win 4 points for adversity.

You are 19 years old and were studying at Monrovia high-school when the LURD bombarded the city with rocket bombs. It was the summer of 2003, but you will not remember the top musical hits of the season that is ideal for going on outings with friends. The only outing that haunts your mind now is the memory of your three friends bolted away like lightning. The classroom was packed. The rocket bomb smashed the main wall, sending bodies that were closest to the impact flying to the middle of the room. You felt a pain in your arm; you were also affected by the impact. However, the blood on your face was not yours. You dashed outside, following the panicked crowd. You tripped over bodies while covering your ears. How naive! You thought that by silencing the sound of the bombs, you could keep them from falling. Looking back, you still do not know how you got out alive. You won a second chance at the game of life. The wound on your arm healed but there will always be a scar, as a kind of tribute to your friends. This is your Karma, you lose your friends, and you win 6 points for nervousness.

You're quietly making your way to the airport to pick up an administrator arriving in Liberia. You're happy, it's someone you know and haven't seen in nearly a year. You're driving the new MSF Lima 1 Land Cruiser; it's a welcome change from the old rustbucket usually assigned to you. Suddenly, armed men block the road and force you to stop. You obey, but you're still beaten black and blue. Lying on the tarmac, you don't feel the pain shooting through you for very long because you sink into unconsciousness. It's only upon

waking that you feel the ravages, the results of this blind violence that has paralysed your country for years. You're in the MSF car, the one that came to get you, not the one that was just stolen from you. Your clothes have been taken, your money and your glasses too, leaving you only with large bruises to cover your skin. Your left leg, paralysed by the pain, will not let you forget for weeks that peace is still a long way off. The UN roadblock a few metres from where you were attacked didn't prevent anything. Other vehicles were stolen or torched. And then the pain pierces your soul. You relive an earlier humiliation. It was in March 2003, in Harper, during the evacuation of the mission. There, along with two other colleagues, you were also violently beaten. You don't understand, you're scared. Scared of humankind, scared that you might one day not escape, scared that MSF might not be able to protect you. Maybe that's your biggest fear: not being safe behind that MSF logo. Since the incident, you're a little confused, losing yourself in your thoughts, trying to escape this reality. That's your Karma, you win 5 points for anxiety.

You're 30 years old, maybe 35. It doesn't matter, you've been marked in so many ways that you look 40. Shots ring out from everywhere, you're forced to slalom in between rocket bombs. You're carrying your gravely ill mother in your arms. You finally make it to the MSF house, converted into a makeshift hospital. The medical teams are overwhelmed treating war wounds, and patients are rigorously sorted out as they come in. They can't take your mother for lack of space. You have braved the most formidable dangers to fail at the very doorstep of those who are supposed to save her. She dies before your eyes. Her last breath puts out the little flame that had been burning in your heart. Since then, your spirit has been consumed. Desperate, you accept work as a stretcher-bearer for MSF, partly to feed yourself, but also to keep your deteriorating mind occupied. And so you carry that stretcher through the bombed out neighbourhoods. The unbearable images of bodies, some lacerated, others cut into pieces, keep accumulating. After a few weeks, law and order is restored and a ceasefire is enforced. You are no longer needed. You are thanked for what you have done, but not for what else you could have done. As a parting gift you're left with bloody memories and the last smile on your mother's face. It's a heavy burden to carry. And it's one you won't carry for long. A few months later, hatred has invaded your mind. You show up at the MSF offices, screaming your misery, asking for money without really caring whether you get it. You don't care what you say, you just want to rid yourself of this hatred that you can't contain anymore. You start rambling, you swear. Everybody has to die, you are not afraid of dying, and you'll be back to kill every single last MSF employee. They'll understand your pain, you're already killing them with your screams and motions. You've already burst into the hospital, forcing your way inside the operating room, disrupting a surgery that ended badly. Did the patient die because of you? Would he have died despite all the commotion you caused? Doesn't matter; you've seen so many dead. Who cared about your mother? You're giving way to madness, looking for someone to blame for all this pain that is dragging you down. It's a bad Karma, and a heavy one to bear. You lose 10 points for mental health and are hovering closer and closer to madness.

→ Liberia
© Ryo Kameyama
June 2003

You don't know your own age. Perhaps you are nine months old, if pregnancy can be considered as the beginning of existence. You might be a boy or a girl, but you really don't care about gender. You only want to understand the pain that's spreading throughout your body. You were so comfortable in your pouch, but your life has been unbearable since it tore open. You do not have a conscience; that's what's preventing you from panicking. A pain that you cannot identify emanates from your neck and lungs. It is your mother who is screaming while you are suffering; she is trying to give birth to you. Rest assured, the only beautiful story that starts with pain is the one that begins life. Later on, life can mould with joy and prolong happiness indefinitely. Pain is not inevitable, but most probable. However, let's not precipitate events. For the time

→ **Liberia**
© Ryo Kameyama
June 2003

being, a midwife is helping your mother free you from this belly, which after having been a basket of nourishment feels more and more like a prison. Your initial outing into the world is done poorly; your feet are out first. You are in breach position, as if seated on the threshold of a life that is being offered to you from the outside. Your lower body is pulled out of your mother. You feel sucked up, kidnapped and assaulted. Poor, fragile little being _ you cannot resist for long against this treatment. Just why is your head so big, and why can it not go out through the same channel as your body managed to do? Perhaps you are frailer than the other babies. And you are, because you will never see the promises this world has to offer. The midwife's final movement, which should have brought you into this world, releases you brusquely from your pain. Your body is almost released, almost out. But your life is no longer there. Your head is stuck inside, a prisoner of the stranglehold that had been your secure cradle for nine months. It suffocates you in the end. You will never hear the tears, or the noise of the forceps in charge of crushing your corpse so as to extract your remains and free your mother from your dead body. Your Karma lasted only a few minutes. You lost 10 points for your life. You do not even know whether you actually had 10 points; you will never know.

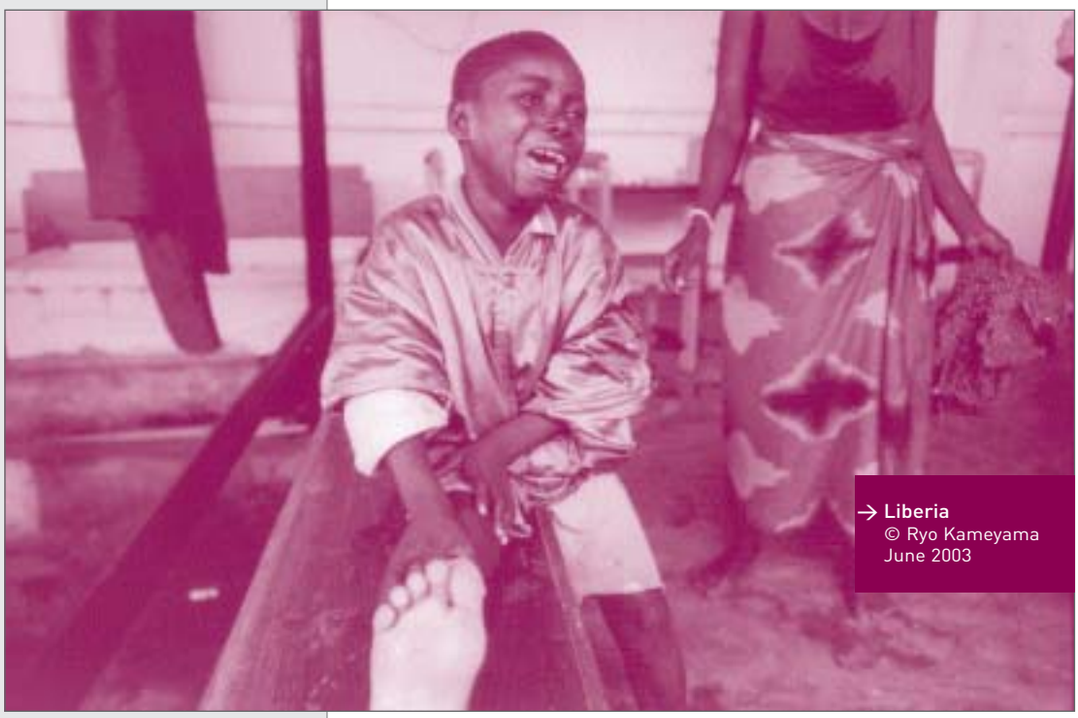
You are 35 years old and a tube connected to your stomach is sticking out of your nose while your body is stretched out on a MSF hospital bed. You need surgery, but your case seems to warrant medical intervention rather than an incision; however, your condition is getting worse day by day. Luck has abandoned you; your arrival at the hospital coincides with the departure of the expatriate surgeon. You are feeling the full brunt of MSF's HR crisis, but you don't care. You don't even know what it means. You feel a sharp pain in your stomach. The new surgeon arrives in only six days. What will become of you during that period? The hospital's director wants to have you transferred to the surgical unit of the ICRC, but it is overflowing. He refuses to admit you because your case does not seem to require surgery. Internal haemorrhaging hits you in the stomach two days later. You are admitted to the ICRC's emergency ward, but it is already too late. You should have been a surgical rather than a clinical case. And whatever were you thinking, coming to the hospital like that at a time when there was no surgeon? Your Karma is filled with bad luck. Good fortune has run out, and you are left with no lucky star and no life either.

You are almost 40 years old. You are leaving an MSF office where hundreds have piled in to flee the bullets and rocket bombs that are falling on civilians. What a rotten summer, a real waste! Your colleagues and neighboring residents have found refuge in the office. They have brought their families. Nearly 500 people are heaped into a building, bringing on every imaginable difficulty that could arise from water and food shortages, as well as human waste disposal. You finally reach your neighbourhood. You climb onto the balcony to gather your family and to bring them back to the office. A whistling sound is heard, and in the time it takes to be identified, the rocket bomb crashes into the wall of the house. The explosions carry off your suddenly amputated arm while shrapnel penetrates your skin. You fall into emptiness. You are soon lying on the ground and have lost control of your life, which is draining away in every direction. Somebody picks you up and carries you to the hospital. You prolong your final breath _ a reflex rather than a gesture of hope. What can you think about? What is there to think about in such moments? Your wife and children? No, this is not a film? How can one think when pain is ripping through your body? You are leaving this world and all of your worries

“Liberia Karma is not a PlayStation with animated characters that can be brought down with the single move of a joystick, nor is it a board game. Instead, it is a society suffering from the games played by a few and from the stakes of a handful of individuals.”

behind. Don't worry about your family because MSF will hire your wife in a few weeks so that she can provide for your children's needs. You can die peacefully, but what does peace have to do with the pain engulfing a body that is just barely alive? It is your Karma to die in this war and to leave this world suffering. You score 15 points for trauma, but wherever you are going, the game is now over.

You are a 28-year-old woman and you can no longer stand being locked up in this container. The prisoners beside you are your family members or comrades on a common journey. It's your father who wanted to come back home. He made the decision for all of you to flee your refugee camp in Guinea to return to Nimba county. Northern Liberia is at peace: at least this is what he believed. Yet, as soon as you crossed the border, a group of gunmen attacked you. They helped themselves as they have always done. What else can they do! For 14 years they have considered theirs whatever they have "found". They want money, they seize it. They want food, they steal it. They want a woman, they rape her. You no longer count the number of rapists who have taken turns to gratify themselves over your body these past 48 hours. You are prostrate in the container, huddled up in a corner, fearful of the slightest noise coming from the door opening mechanism. You know that every time that door opens, the armed men take some women out from among the confined group. They must find you to their liking, since you are often called outside. How long will this last? You have no idea. No need to worry: a UN convoy is on its way to free you and your kin. But that container will stay imprinted in your memory for many years. You have lost the little trust you had left in men. Perhaps when your future husband will make love to you, you will only experience pain, despite him only wanting to make you happy. This is your Karma! You have lost 5 points for self-esteem and earned 10 points for humiliation. Welcome home.



→ **Liberia**
© Ryo Kameyama
June 2003

You are 33 years old and you only live in bliss. You didn't believe that a heart could be so overwhelmed by repeated assaults of pleasure. If that heart was able to endure all the hatred and distress following weeks of war, it can store up all the love that it receives without risk of being satiated. But you no longer have control over events. Your life resembles a tightrope act, where you must move forward even though the spirit is clouded and the will is subjected to the beloved. The force of your will makes you lie alongside the road that you travel, and embrace your loved one with a kiss you wish would last an eternity. Your heart is relaxed, it is opening up to the world. It is regaining trust in humanity, rapidly healing from the scars of the past. Formerly a nonbeliever, you are born again. The little flame that once lit up your eyes has rekindled. Cracks are running along the enclosure wall that you had erected around your heart. There are many breaches. Yesterday, you shed a tear when watching a love film. This evening, you are lying on the beach, eyes to the stars, with a serene heart, since the future can only be glorious. You are thinking about her and you smile. You have forgotten that you are lying on sand that covers anonymous bodies and unidentified war victims who were buried hastily. Life goes on and it promises a Karma filled with future bliss. You are radiant, you are alive and you have earned 6 points for serenity.

Liberia Karma is not a PlayStation with animated characters that can be brought down with the single move of a joystick, nor is it a board game. Instead, it is a society suffering from the games played by a few and from the stakes of a handful of individuals. The context continually evolves, but the rules are fixed. A society cannot be indefinitely humiliated without triggering profound changes to the way it functions. Let's try then to write the sequel of the story -before it gets written by a new mob of bloodthirsty criminals- so not to miss out on life, which is what every being comes to Earth for. We are not talking about the kind of life imposed on the Liberian people during the past fourteen years of existence. We are talking instead about a life based on construction, not survival. Our sequel could be titled Liberia Karma Reloaded. Your mission, if you accept it, is to fight abuses that have become democratized and which have affected the judgment of the soundest individuals in this region. Your weapons: sensitivity, kindness, respect, consideration and humanity. These are the five attitudes that you shall instill in every heart. However, drained hearts can take time to become impregnated with such values. It is up to you to inculcate them parsimoniously. Sow them when the climate is suitable. The soil is rich, so these values will grow, you can count on it. It is over cemeteries that the most beautiful cultures ■

Romain Gitenet
Administrator in Monrovia

WATCH AND READ

New books available in the documentation centre (March 2004)

MSF / Christine Pinto (01 40 21 27 13)

→ NEW BOOKS

KGB CONNEXION : LE SYSTÈME POUTINE D'HÉLÈNE BLANC / Paris : Editions Hors Commerce, 2004, 321 pages.

THE CONGO FROM LEOPOLD TO KABILA : A PEOPLE'S HISTORY DE GEORGES NZONGOLA-NTALAJA / London : Zeb Books, 2003, 304 pages.

HISTOIRE GÉNÉRALE DU CONGO: DE L'HÉRITAGE ANCIEN À LA RÉPUBLIQUE DÉMOCRATIQUE D'ISODORE NDAYWEL È NZIEM / Paris, Bruxelles: De Boeck & Larcier, Département Duculot, 1998, 954 pages.

AFRICAN-AMERICAN EXPLORATION IN WEST AFRICA : FOUR NINETEENTH-CENTURY DIARIES EDITED BY JAMES FAIRHEAD, TIM GEYSBEEK, SWEND E. HOLSOE, MELISSA LEACH / Boomington: Indiana University Press, 2003, 488 pages.

IN THE SHADOW OF "JUST WARS": VIOLENCE, POLITICS AND HUMANITARIAN ACTION DIRIGÉ PAR FABRICE WEISSMAN (ENGLISH TEXT EDITED BY FIONA TERRY) / London: Médecins sans Frontières, 2003, 371 pages (version anglaise d' « A l'ombre des guerres justes - Populations en danger »).

HETEROTROPHIC PLATE COUNTS AND DRINKING-WATER SAFETY: THE SIGNIFICANCE OF HPCS FOR WATER QUALITY AND HUMAN HEALTH DE L'OMS / London: IWA Publishing, 2003, 255 pages.

→ NEW VIDEOS

MONDIALISATION DE LA SANTÉ : LA FUITE DES SOIGNANTS / PATIENTS DU NORD, COBAYES DU SUD
G.Capelle (Fr,2003), 2 épisodes, France 5, 2 X 55mn

MSF
DOCTORS WITHOUT BORDERS: LIFE IN THE FIELD
National Geographic Channel, 13 épisodes, VA

IRAQ
IRAK, UN AN APRÈS : UNE LIBERTÉ SANS PAIX
A.Rados (France/Allemagne, 2004) / J.Armbruster (France/Allemagne, 2004) / R.Mugnerot (2003), Thema, Arte, 140 mn

DRC
L'AFRIQUE EN MORCEAUX: LA TRAGÉDIE DES GRANDS LACS (2 ÉPISODES)
J.El-Tahri / P.Chappell (France, 2000), Les Mercredis de l'Histoire, Arte, 105 mn

RUSSIA
COURAGEUSES ET BATTANTES : LES FEMMES RUSSES

PHOTOS:

MSF/Andrea Bussotti - Christine Dufour

PALESTINE
GAZA, HEBRON, JENINE, 03 / 2004,
© Philippe Conti.

AFGHANISTAN
KABUL: HÔPITAL DE DASHTE BARCHI ; MAZAR-I-SHARIF , DAWLATABAD, CHIMTAL, CHARKENT), 11 / 2003,
© Heidi Holzer.

VARIOUS COUNTRY
CHINE, INDE, PAKISTAN, BENIN, VIETNAM : « SOURIRES »,
© Flore Lamoureux

→ NEWS FROM EUP AND AUDIO-VISUAL UPDATE

MSF/FRANÇOIS DUMAINE, SARA MC LEOD
The French and English version of our annual production 'A Year in Focus'will be ready for the Annual General Meeting in mid-May. Copies will be available for the field.
The short, 52-minute version of the third part of our series on AIDS,"ARVs, and then ...", will also be ready for the AGM. We plan to put all three films on a single DVD - 'Overcoming our Fears', 'ARVs: work in progress' and "ARVs, and then ...". It will also include the long version of the third film which you'll be able to watch in full or chapter by chapter (the film is presented in three chapters, each one showing different problems our teams are confronted with: Guatemala, where MSF has opened an HIV clinic, a country where there is no political will to provide care for people living with HIV/AIDS; Thailand, where MSF works in a district hospital providing care for people living with HIV/AIDS, a country where there is the political will and where generic antiretroviral drugs are available, and Malawi, where MSF is currently treating nearly 2,000 people living with HIV/AIDS, a country with limited means, both financially and in terms of medical personnel.

PRESS REVUE

MSF / Johanna Rankin

→ Arjan

Sunday, April 11, Arjan is finally liberated after 20 months of captivity. This dramatic liberation gave rise to numerous articles in the press as well as radio and television announcements. It was an opportunity to revisit the circumstances surrounding his abduction and the role of the FSB. Le Monde also denoted that "the UN representative for humanitarian affairs, Jan Egeland, had considered that Erkel's liberation was a positive sign for the return of humanitarian organizations to Chechnya".

→ Malaria Campaign

Launched April 15 with a press conference held at MSF, the malaria campaign is beginning to find its place in the media. Radio and television are the first to discuss the campaign, but the press is also taking up the message, following l'Humanité's example: "MSF, which treats an average of 3000 patients per day world-wide, is sounding the alarm in connection with the fourth Africa Malaria Day, the 25th of April, 2004. And [they] intend to put pressure toward a widespread accessibility of ACT treatment, recommended as a priority by the WHO since 2002."

HEALING DESPITE EVERYTHING...
ANASTHESIA AND SURGERY : A PHOTO EXHIBITION

In association with the 33rd **General Assembly**, to thank the volunteers* for their contribution to our programs, Médecins sans Frontières presents a photographic exhibition :
Anasthesia and surgery **"healing despite everything..."**
Preview accompanied by the inaugural address of
Jean-Hervé Bradol, president of MSF, in the "grande salle" (main room) on **the 15th of May, at 19:30.**
*in particular Madeleine Boyer, Isabelle Lemasson and Enrico Marchis.

TO MSF READERS

Here is the third issue of the new Messages. There are, of course, improvements to be made and we are gradually integrating your remarks. Many thanks to all those who have participated in this project by contributing, making remarks and/or helping to improve it.

Reminder about you internal newsletter:
Messages is your newsletter. It is therefore up to you to provide material. There is no censor, as long as certain rules are respected. We refuse to publish any articles that contain personal attacks (however it must be said, there have been very few of these) and we do not accept anonymous texts. If these basic rules are respected, an editorial committee meets to determine the contents of the next issue. Various criteria are considered: the latest news, pertinence, speaking out at MSF, priorities concerning the agenda, challenges and problems of the association, dossiers to work on etc. Not all articles are therefore published as soon as we receive them: however we do try to publish them as soon as possible.
You can send your texts via your Head of Mission, your RP, your communications officer etc.
Thanking you in advance,

The Comm dept.

RESOURCES

MSF is recruiting

URGENT NEEDS FOR OUR SURGICAL MISSIONS

We have surgical missions in :

- Macenta , Guinea.
- Monrovia, Liberia.
- Bouaké, Côté d'ivoire.
- Adré, Tchad (border with Sudan).
- Makamba et Kinama (Bujumbura), Burundi.
- Bétou, Congo Brazzaville.
- El Jenina opening (Northern Sudan, Darfur) and in Ankoro (DRC, Katanga).

Are you a surgeon, anesthetist or OT nurse and available to leave mission?
Contact Ingrid (Ford), HRO for surgical mission.
at 01 40 27 81 or : ingrid.ford@paris.msf.org.

Do not hesitate to contact us to give us your dates of availability in the coming months...

UN(E) CHARGÉ(E) DE RESSOURCES HUMAINES
(as fluent french is essential for the position, this vacancy notice has not been translated)

MISSION

La mission du CRH est d'identifier et de proposer la personne la mieux adaptée aux programmes sur le terrain en prenant en compte l'individu, ses compétences et son engagement. En outre, il assure le lien spécifique et constant entre le siège de l'association et les équipes sur le terrain.

PRINCIPALES ACTIVITES

- Conseiller et venir en appui aux missions suivies par son desk, en matière de Ressources Humaines.
- Rechercher les profils adaptés aux postes à pourvoir sur le terrain (soit dans les fichiers de Paris, soit dans les fichiers des sections partenaires).
- Assurer le briefing du candidat au départ.
- Suivre l'intégration de la personne dans sa mission et le déroulement de celle-ci.
- Assurer le débriefing de la personne à son retour et évaluer la mission effectuée en lien avec les autres membres du desk.
- Il est en charge du suivi d'un pool particulier de personnel international (médecins, paramédicaux, logisticiens, administrateurs...).
- Il doit connaître le personnel national occupant les postes à responsabilité ou ayant un potentiel à le devenir, et le personnel national aux postes « clés » dans la mission.
- Il doit veiller à l'intégration du personnel national dans les équipes et au projet MSF.
- Veiller au développement des compétences des personnes par leur formation continue.
- Préparer les statistiques RH terrain mensuelles.
- Contribuer à la réflexion sur les dossiers de fond RH terrain.

PROFIL RECHERCHÉ

- Expérience MSF à un poste à responsabilités indispensable.
- Langue : français et anglais lus et écrits obligatoires.
- Grande capacité d'attention et d'écoute et sens du relationnel.
- Capacité à mener un entretien, à évaluer, mémoriser et synthétiser.
- Intérêt pour la gestion des ressources humaines et le travail en équipe

OUVERTURE DU POSTE

Poste en CDD de 5 mois

Salaire brut mensuel : 2365.55 euros + prime de 13ème mois

Candidatures à adresser avant le 28/05/04 à :

MSF – Esther MOUKORI – 8, rue Saint Sabin – 75011 PARIS

(ou par email : emoukori@paris.msf.org)

PRESS REVUE (CONT.)

→ Rwanda

The commemoration of the Rwandan genocide was heavily covered in the press this past month. France's role especially is subject to debate. In an interview published on the site msf.fr, Jean-Hervé Bradol emphasizes that "This is also an occasion for a morally correct commemoration tinged with magic incantations of "never again". Do we need to be reminded that in 1994, while visiting Auschwitz, Prime Minister Edouard Balladur already used these sorts of words, at the very moment that 800,000 people were being exterminated in Rwanda?"

→ Darfur

Covered amply during the first week of April, the conflict in Darfur is mentioned less in the French press since the announcement of the cease-fire on April 11. On the other hand, following UN declarations, the American media are paying more attention to this subject, taking up the term "ethnic cleansing", which MSF refuses to use: "Mr. Egeland [UN emergency relief coordinator] said the UN was getting daily reports of atrocities from Darfur. He said it appeared to be an organised campaign of ethnic cleansing, with villages looted and burnt down and food and seed supplies destroyed in a 'scorched earth' policy" (BBC).

→ Debate on humanitarian organizations

The accounts of humanitarian associations are being dissected. The magazine Que Choisir (April 2004) presents and analyzes the numbers. Jean-Hervé Bradol comments: "We attempt to evaluate our programs better internally, to publish precise data. But it's true that there is a lack of exterior control over the totality of the associations. A legitimate and effective structure that could take on this task remains to be created."

TURN OVER HEADQUARTERS

COMMUNICATION

→ Nicolas BEAUDOUIN is working on the realisation of the Face to Face exhibition from 01/03/04 until 19/06/04.

→ Mvouama MASSAMBA is working on the data management of new donors recruited through the Face to Face campaign from 15/03/04 until 26/11/04.

→ Axelle MOTTE Embauchée en CDD du 29/03/04 au 29/06/04. Axelle aura en charge la supervision des équipes de médiateurs dans le cadre de l'opération Face to Face.

OPERATIONS

→ Myrto SCHAEFER is supervising the mediators of the Face to Face campaign from 29/03/04 until 29/06/04.

MEDICAL DEPTARTMENT

→ Françoise PUECH-WEISS Has joined the dept part time. Axelle is a pharmacist.

GENERAL MANAGEMENT

→ Mathieu BUTRUILLE Has joined the dept as general services assistant from 29/03/04 until 30/06/04.

VACANCIES AT HEADQUARTERS

COMMUNICATIONS AND FUNDRAISING

The department is recruiting mediators (one month contracts) for its Face to Face campaign which will run from 1/04/04 until 31/10/04.

POSITIONS TO FILL

→ FIELD VACANCIES

→ ASAP

- medical coordinator, Liberia, Monrovia
- Medical coordinator/Head of mission, Angola, Luanda, 1 year
- Head of mission, Palestine, Jerusalem, 1 year
- Head of mission (nurse), DRC, Beni, 6 months
- Head of mission, Uganda, Kampala, 1 year
- medical coordinator (medical), DRC, Kin/Lubumbashi, 1 year
- Nurse field co, DRC, Kitenge, 6 months
- Nurse field co, Iran, Zahedan, 9 months
- Log/adm field co, Thailand, Sanghklaburi, 9 months
- Nurse field co, DRC, Mukumbu, 6 months

- Experienced medical, Indonesia, Djakarta, 6-12 months
- Medical, Uganda, Soroti, 1 year
- Medical, Georgia, Abkasia HAP, 9 months
- Medical, Thailand, Sanghklaburi, 9 months
- Hospital medical, Liberia, Monrovia, 9 months
- TB medical , Armenia, Erevan, 6 months
- HIV medical, China, Nanning, 1 year
- Medical, Burundi, Makamba, 6 months

- Vacci nurse, Northern Sudan, Mornay, 6 months

- Logistician, Madagascar, for the hurricane, 1-3 months
- Builder logistician, Angola, Kwanza Norte, 6 months
- Builder logistician, Armenia, Erevan, 1 month a half
- Food distribution logistician, Northern Sudan, Al Jamena, 3 months
- Logistician field co, Guinea, Conakry, 6 months
- Logistician, Ethiopia, Galaha, 6 months
- Logistician, Malawi, Blantyre, 3 months
- Builder logistician, Southern Sudan, Akuem, 2 months
- Logistician, Niger, 3 months
- logistician, Liberia, Monrovia, 3-6 months
- Field administrator, Ethiopia, Galaha, 6 months

→ May

- Head of mission (nurse), DRC, Beni, interim period
- Head of mission, Ivory Coast, Adbidjan, 1 year
- Medical coordinator (nurse), DRC, Kin/Lubumbashi, 1 year

- Nurse field co, Burma, Kayinstate, 6 months
- Nurse field co, Ivory Coast, Bouake, 6-9 months
- Nurse field co, Afghanistan, Kabul, 6 months
- Nurse field co, Burundi, Kinama, 6-9 months

- Paediatrician medical, Northern Sudan, Maïgoma, 6 months
- Medical, Nepal, Rukum, 6 months
- Malaria medical, Sierra Leone, Kailahun, 4 months
- Medical, Ivory Coast, Bouake, 6 months
- Medical, DRC, Loko (trypano), 6 months
- Medical, Angola, Caala, 6 months
- Supervision nurse, Northern Sudan, Maïgoma, 6 months
- Psychologist, Guatemala, Lomas, 6 months
- Psychologist, Northern Sudan, Maïgoma, 6-9 months
- Nurse, Southern Sudan, Kotobi, 6 months
- Nurse, Liberia, Bong, 6 months
- Nurse, Liberia, Lofa, 6 months
- Mid-wife, Southern Sudan, Akuem, 6 months
- Mid-wife, Uganda, Arua, 1 year
- Capital logistician, DRC, Lubumbashi, 6 months
- Logistician, Guinea, Macenta, 6-12 months
- Logistician, Burma, Kayinstate, 6 months
- Logistician field co, Liberia, Monrovia, 6 months
- Logistician field co, DRC, Lubumbashi, 1 year

- Administrator, Madagascar, Tananarive, 1 year
- Field administrator, Congo Betou, 6 months
- Administrator, for emergencies, 1 year
- Administrator, Niger, Niamey, 1 year
- Administrator, Sierra Leone, Freetown, I year

Médecins Sans Frontières - 8, rue Saint Sabin - 75544 Paris Cedex 11 - Tel. : +33 (0) 1 40 21 29 29Fax : +33 (0) 1 48 06 68 68 - www.msf.fr
Editor in chief: Anne Fouchard - Editing: Olivier Falhun - Dossier « Healthcare for women »: Aurélie Grémaud - Photo librarian: Andrea Bussotti - Translation and editing: Caroline Serraf - TSF - Layout: Sébastien Chappoton / TC Graphite - Design: Exces communication - Printing: Artecom.