messages

→ N°134 / March 2005 / Médecins Sans Frontières' newsletter www.msf.fr

DOSSIER

FOLLOWING THE WAVE

MISSIONS

DEBATES

DAZIBAO

INFOS

RESOURCES

→Indonesia, Banda Aceh © Martin Chaffiotte - Janvier 2005

ASIA

Following the wave

MSF / February 2005 / Aurélie Grémaud / Translated by Frank Elliot

On the 26th December last year, a powerful earthquake off the coast of Sumatra created a tsunami that brought destruction to the countries on the shores the Indian Ocean. Almost 300.000 people died or were reported missing. Indonesia was the most affected country with 100.000 dead, 120.000 missing and several thousands injured. In Sri Lanka more than 30.000 people died and 500.000 have been displaced.

Aceh was first hit by an extremely violent earthquake — 9 on the Richter scale — that caused most of the destruction. The towns and villages that were destroyed were then ravaged by the tidal wave. Hundreds of kilometres of coastline were destroyed: houses, infrastructure and boats were washed away and the local economy destroyed.

On December 27th, MSF, working alongside national rescue efforts, starting dispatching equipment and volunteers to respond to the emergency needs. The huge resources deployed have not always been channelled into appropriate assistance, and in Indonesia especially the population remains still today in a precarious situation. After the first few days of the emergency during which medical and logistical assistance were necessary, MSF volunteers found themselves in a difficult situation. There was no medical emergency, but all around them there was destruction. National teams were generally able to deal with the

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Translated by Amanda MacGurn

The wave killed and carried everything away. In its wake reason gave way to frenzy in all directions: declarations of intention, money, humanitarian aid, volunteers, exaggerations... Despite this turmoil and media pressure, MSF decided to go against the flow and suspend its request for donations, forcing certain operators back to a very harsh reality. As wise as it was necessary, this decision consolidated the relationship of trust that unites us with our donors. From Ethiopia in 1985 to Darfur this year, our interventions have been proof of this trust. As our main source of independence, the support of these donors has helped us, sometimes single-handedly, to take on emergency missions and to lucidly resist those that carry us away.

DOSSIER

Following the wave

→ Unprecedent generosity

International solidarity demonstrated an unprecedented avalanche of donations sent to all aid organisations. The MSF international movement received more than 90 million euros — including 8 million in France — and the Red Cross Federation nearly 900 million euros. In addition to the repeated scenes of catastrophe aired by the media, there has been a frenzy of statements of intent by States : in total nearly ten billion dollars have been promised.

immediate crisis and abundant numbers of aid teams had promised to set up activities after carrying out their assessments. All this took place against a backdrop of pressure to act - pressure from the media in addition to pressure from other quarters.

→ INITIALLY A LOCAL RESPONSE

The tsunami has not affected countries lacking in health or social facilities. Efficient local authorities, with qualified staff, and the national armies were more or less able to respond to the immediate emergency. Yet this capacity to respond appears to have been largely underestimated by the international humanitarian aid effort that arrived on the scene as though prepared for an emergency. In Sri Lanka, the survivors of the tsunami were quickly re-housed in public buildings or among the local population. Right from the first night hundreds of Sri Lankan doctors and nurses made their way to the areas that had suffered damage. The hospital in Batticaloa experienced a dramatic increase in activity in the four days following the tsunami. : 700 patients were treated, including 375 hospitalisations and 190 surgical operations. Compared to some places in Indonesia where medical staff perished when healthcare buildings were destroyed, the Sri Lankan medical teams were able to respond to the emergency situation and also organised some fifteen mobile consultations in the area. MSF donated a surgical kit for these teams.

In this context the needs are based on the shortcomings of the immediate local response: exhausted medical teams, depleted emergency stocks, inability of local food back up to carry on indefinitely. In this situation the need is « to reinforce the net ».

→ STAGGERING AMOUNTS OF AID

On top of the effective local response came floods of international aid organisations and foreign militaries. Promises of aid worth thousands of euros do not guarantee that aid will be delivered in an appropriate or equitable way. The many offers of assistance, of varying quality, can lead to aberrations. For example, a Sri Lankan doctor working in a camp of 2000 people witnessed, in one day, 21 medical teams each carrying out their own assessment. These aberrations can sometimes lead to therapeutic dangers: vaccination of the same people by different medical teams or, even more serious, repeated administration of vitamin A that becomes toxic when excessive doses are administered.

The case of Meulaboh hospital (Indonesia) clearly illustrates the emergency assistance bottleneck: even though 14 international surgeons were working in the operating theatre to operate on some fifteen or so seriously injured people, the remainder of the hospital was running with only six nurses instead of the 203 who were working there before the tsunami.

Although it is important to adapt programmes to the changing situation, the abundance of resources deployed created, in the immediate term, a kind of smoke screen: each organisation carried out

MSF ACTIVITIES IN INDONESIA AND SRI LANKA

ACEH, INDONESIA

- **Emergency freight** : 1,213 tons
- **MSF presence** : Banda Aceh, Blandpidiie, Lamno, Lhokseumaze, Medan, Meulaboh, Peribu, Sigli, Simulue Island, Tapakktuan

MAIN ACTIVITIES :

- Assistance to main hospitals in Meulaboh and Sigli.
- Measles vaccination campaign.
- Treatment of tetanus cases and vaccinations : 91 cases have been recorded in Aceh since the tsunami
- Psychological support programs together with medical consultations in certain places.
- Epidemiological surveillance
- Distribution of tents, non-food items, and tools to 6.000 families.
- Mobile consultations : 16.000 consultations in January (wounds, respiratory infections, diarrhoea, skin diseases)
- Water and Sanitation activities : bladder tanks and water supply systems set up, water trucking, cleaning out and renovation of wells.

SRI LANKA

- Emergency material received: 513 tons
- MSF teams currently based in: Kiliniochi, Mullaitivu, Batticaloa, Ampara, Matara, Hambantota, and Tangalla
- Medical assistance via mobile consultations and existing medical facilities, setting up temporary hospitals in the region of Ampara.
- Mental Health via a local NGO in the North
- Donations of medical material and medication to medical facilities
- Distribution of tents, blankets, non-food items, and hygiene kits for several thousand people
- Water and Sanitation activities (same activities as Aceh)
- Construction of semi-permanent shelters in the country's southern zones

their own assessment and promised specific assistance... but assistance that is to come in the future. It is therefore difficult to know which of these promises will be kept. For example, in the Batticaloa region various organisations have promised to distribute tents, but only MSF has actually distributed a sizeable number (2.000 tents). After the immediate life-threatening emergency phase, the needs are psychological support, correct and more permanent shelter, free medical care, the distribution of tools and equipment.....

→ AN EXCEPTIONAL SITUATION

In the wake of the medical teams many cargo planes loaded with drugs and equipment landed. With no knowledge of the medical situation in the area, this kind of response was essential. In some places, immediate staff and equipment backup were required. As Marie-Noëlle Rodrigue of the emergency desk explains: « When emergency medical services are called out, they don't know whether it's for a heart attack or an inflamed finger nail, but they go out with their equipment ».

In contrast to operations such as those in Darfur or even the Democratic Republic of Congo, where the immediate survival of people was at stake, the overall population was never in a life-threatening emergency. In this particular case, the dead are dead, the injured have been taken into care and the others are mourning the loss of their relatives, suffering the effects of the destruction of their belongings and

IIn this particular case, the dead are dead, the injured have been taken into care and the others are mourning the loss of their relatives, suffering the effects of the destruction of their belongings and their source of livelihood, and troubled by a future that seems hopeless.

→ Trincomalee : 1 doctor for 400 people.

In the district of Trincomalee, Sri Lanka, there was in mid-January one doctor for 400 people. In Mornay, Darfur, in a population of 80.000 there is one MSF international doctor assisted by Sudanese healthcare professionals. In the Democratic Republic of the Congo, in the Northern Ubangui region, 3 doctors including 1 MSF doctor treat a population of 300.000 people.

→ **Sri Lanka, Batticaloa** © John Stanmeyer-VII - December 2004

DOSSIER

Following the wave

→ In the region of Trincomalee on the eastern coast of Sri Lanka, measles vaccination coverage is now 85%. 80% coverage is considered as excluding any risks of an epidemic.

their source of livelihood, and troubled by a future that seems hopeless. To-day, the priority for those who have survived the tsunami is to find the means to rebuild their lives. How do you motivate people to live their lives once again? This is one of the main challenges with which the aid programme is now faced.

For an exceptional situation, an exceptional response that requires MSF to go further than the measures "usually" takes to deal with crises. The reality of the situation conflicts with the desire to act : in this situation we should not act just for the sake of acting. There is a period where we can help - this period lies after the first few days of life-threatening emergency and before the reconstruction phase, which is the responsibility of the States and government development aid. By choosing MSF as a vector of their generosity, donors are providing the opportunity to act differently and to explore new avenues that lead to real added value for the devastated population. For all that, if according to the assessment of needs, the teams do not identify any added value in their intervention, the donors will then be contacted in order to reallocate their donations or to be reimbursed. Nevertheless, experience shows that aid does not reach everyone in the same way. People marginalized because of economic, political or even religious reasons risk being marginalized even within the aid system. Also, where there is a massive distribution of aid, this aid can quickly become a means of controlling people. Taking these factors into account, the exact form of this aid has yet to be defined and depends on the needs identified once the veil of promises has been lifted. ■

For an exceptional situation, an exceptional response that requires MSF to go further than the « usual » measures it adopts to deal with crises.

→ **Indonesia, Banda Aceh** © Martin Chaffiotte - January 2005

→ Indonesia, Sigli © Martin Chaffiotte - January 2005

DONATIONS

Why we have stopped collecting donations for the emergency in Asia

MSF / January 2005 / Interview by Ann Avril and Bénédicte Jeannerod / Translated by Gareth Wilson

One week after the tsunami, MSF's General Director Pierre Salignon announced the decision to suspend the collection of donations for the emergency in Asia. Here is Pierre's explanation published on January 4th on the MSF website.

→ Médecins sans frontières has received an extraordinary number of donations. What do you think of this outpouring of generosity?

The outpouring of generosity we are currently experiencing is quite exceptional, as is the extent of the disaster and the surge of emotion it has aroused around the world. We are extremely grateful to our donors, whose contributions make our emergency relief operations. In France, as in all MSF offices worldwide, we have been witnessing unprecedented levels of public support. Eight days after the disaster, we had already collected over 40 million euros worldwide for the emergency, with the French office alone receiving some 5 million euros. To put things in perspective: at the same time last year, following the Iranian earthquake in Bam, MSF France received 600,000 euros in donations in a fortnight. This summer, for the Darfur emergency, we were able to collect just over 650,000 euros in a period of 2 months. So what we are really dealing with here today are donations, the size of which has never been collected in such a short space of time.

→ Concretely, how do you intend to use these funds in the field?

After conducting several exploratory trips and providing some ad hoc support in the field, particularly in Thailand, we have decided to focus our main efforts along the eastern and southern coasts of Sri Lanka and in the Banda Aceh region in northern Indonesia, two zones in which the populations have been particularly hard-hit (for more information about our operations, click here).

The exceptional nature of the situation requires an exceptional response. Given the extent of the disaster and the extent of the task we are faced with, we may also be required to go beyond our strictly medical role, as was the case in Kosovo in 1999 when we set up the "1,000 roofs for Kosovo" programme. Indeed, in addition to immediate emergency requirements (healthcare, water, shelter, food, etc.), significant medium- and long-term needs will also need to be catered to in the affected countries. Even though we have already started thinking along these lines, it must be remembered that we are a medical NGO and not specialists in reconstruction, an area in which we possess neither the competence nor the capacity. Moreover, catering to such needs is more a matter of bilateral aid at the state level.

I stress the point again: our decision stems from our desire to be totally transparent with our donors.

This is why we are suspending the collection of donations for our relief programmes in those areas affected by the tidal wave. The money we have already received will enable us to conduct large-scale operations in the countries in question.

→ Given the wave of emotion aroused by the disaster, isn't it a bit shocking to ask that no more donations be sent for asia?

Don't get me wrong. We have absolutely no intention of stifling the surge of solidarity for Asia. Our decision applies to our association alone. We have taken this decision because the 40 million euros that we have already collected for South Asia are sufficient for us to implement a massive, wide-ranging operation.

We have very strict commitments vis-à-vis our donors - each euro received for South Asia will be spent on programmes in the region. This is true for those donations that we have already received, as well as for those that are still coming in by post with requests that they be allocated to this particular disaster. If we receive more than is required, we've undertaken individual asking each donor individually if they are willing to have their donations allocated to another disaster area, or, if necessary, to refund them.

This is the first time that we have had to make the decision to suspend a call on the generosity of our donors. We realize that this may be perceived as totally contrary to the prevailing atmosphere of generosity and support but it is merely a question of being open and honest with our donors. We see no reason to continue to appeal to the public for donations for operations that are already funded.

On the other hand, we are constantly in need of public support and funding for all of our other programmes. We continue to work, in particular, with the victims of pandemic diseases, such as AIDS and tuberculosis, and with populations who are the victims of forgotten conflicts, such as the war in the Democratic Republic of Congo, or of conflicts which no longer make the headlines, such as in Darfur (Sudan). For all of these programmes, which receive less media attention, we have an ongoing need for public support. ■

LE MONDE

"It's time to get our feet back on the ground"

Le Monde / 6th January 2005 / Interview by Cécile Chambraud / Translated by Laura Ball

Cécile Chambraud, of France's daily newspaper Le Monde, asks Doctor Jean-Hervé Bradol, the president of Médecins Sans Frontières, why MSF has suspended its appeal for donations.

→ Why has MSF suspended the collection of donations for the emergency in Asia?

In itself, this is a very positive phenomenon: it is the unprecedented surge of generosity that has led to this situation. But there is the time for emotion, for media coverage of the catastrophe, for broadcasting scenes of the wave and the line up of bodies; and there is the time to organize and provide assistance. They are different.

We have people stationed in Sri Lanka and Sumatra, people who know these countries well and who have reacted very quickly to the disaster. They project setting up sizeable assistance operations, but MSF has already collected 40 million euros worldwide since last weekend. To put this in perspective, China for example has pledged 60 million euros. When raising funds for the tsunami victims we do not add any small print indicating that, if necessary, the money collected may be re-directed to other causes. We promise our donors that we will use their donation as they intended. We also have a second responsibility which is to carry out these relief operations ourselves. We do our best to ensure that the funds are used wisely. It is a matter of integrity.

But there is the time for emotion, for media coverage of the catastrophe, for broadcasting scenes of the wave and the line up of bodies; and there is the time to organize and provide assistance. They are different.

→ So you believe that 40 million Euros will be enough?

Yes - given MSF's operational capacity and the situation on the ground where there are huge numbers of aid agencies. In Darfur we were the only agency present for several months. This is not the case in Asia. Here, there has been a massive influx of resources, both military and civilian. In Aceh, there are already American and Australian troops, Dutch helicopters and French civilian security is on its way. The deployment of international aid is unprecedented.

I have never witnessed such a deluge of donations in my twenty years of emergency medicine. We assessed the cost of our operations and decided we should inform our donors of our conclusion that over and above the sum already raised, we would probably not be able to honour our promise to use the funds as originally intended. Our colleagues in Hong Kong and the USA have done the same. The MSF-USA website received donations of 4.5 million dollars in a single day! They probably could have collected more funds, but it was my duty to say that MSF was not capable of doing any more.

> *"An emergency relief group (MSF) was saying (...) that such programmes were not infinitely expandable the more money was made available. But what MSF revealed was that this last assumption is the one on which so many relief and development agencies have based their appeals. The more money you give us, they imply, the more we will be able to do. That, of course, is no more true in relief and development than it is in any other sphere of human endeavour. At best, such a claim is sometimes true; certainly, it is often false."*

David Rieff, - « MSF's tough succour » in Prospect – Février 2005

→ Indonesia, Banda Aceh, pause pour une brigade de pompiers venus d'une autre province afin d'aider à la recherche des corps, dans le quartier de Lam Jam.
© Martin Chaffiotte - janvier 2005

→ Is this a way of drawing attention to the way in which donations are used?
Yes - we did not wish to criticise anyone. The controversy was sparked by Jean-Christophe Rufin - president of Action Contre La Faim. I would like to emphasise one point though: at the moment there are requests for money to carry out emergency aid with images of the injured and the homeless who need immediate help yet at the same time there is talk of reconstruction. These are not the same thing! Reconstruction of a region, or of a country, is 'public development aid' and this is the responsibility of governments, the World Bank and the G8. If we are to ask individuals (who already finance this work by paying taxes) to further support this through their donations, we must be very clear that this is what we are asking. We must not benefit from the extreme emotion to switch money from one area, or one project, to another. Other organisations are pointing out that they carry out reconstruction work as well as emergency assistance...

Then people should be told! If the money is to be used to re-build administrative buildings, for example, I don't think that makes sense. I don't believe that, in the current climate, donors would consciously choose that.

→ Do you see any risk in this situation?
85% of our funding in France and 80% internationally comes from individual private donors, making MSF an exception in our field. This is because we have strict policies. We do not wish to compromise this. We would prefer to expose ourselves to criticism than to have to explain to our donors in several months that we were unable to honour our commit-

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Claire Rieux is a doctor working in Indonesia with MSF. She regularly sends us her diary entries, here we publish a few excerpts

CLAIRE RIEUX'S DIARY- Day 21 Post-Tsunami - Sigli Hospital

Idawati, 22, is leaving the intensive care unit, where she spent more than a week in critical condition. She arrived at the hospital with a deep groin wound and a pulmonary infection from inhaling seawater. She underwent emergency surgery but the infection had already spread and she developed septicemia. Virginie, a nurse specializing in intensive care, and I stayed with Idawati well into the night to care for her and monitor her condition. With our eyes glued to the equipment that allowed us to keep close track of her blood pressure, pulse, and breathing patterns, we adjusted our treatments. Little by little, her condition improved and thanks to those efforts, combined with the work of the Indonesian team, she is out of danger.

01.16.05

She is now smiling and doing much better, so today I finally asked her what had happened. When the tsunami struck, the future teacher was in Banda Aceh, in the house she shared with some other students. She was doing the laundry. All of a sudden, she heard people yelling. She managed to run about 150 feet before the wave caught her. The next thing she remembers is that some friends came for her and brought her to Sigli, two hours away, because the Banda Aceh hospitals still standing were overflowing with people. Her school was destroyed and she does not know what happened to some of her friends there. Fortunately, her family members are safe and she has somewhere to go when she leaves the hospital. That is not the case for many others, like Zafrizal, one of 30 survivors from his village of 900 inhabitants. After receiving emergency medical care, the next issue will be to help survivors rebuild psychologically and materially, in terms of housing and tools, so that life can go on.

PRESS REVUE

(TSUNAMI)

MSF/ February 2005/ Aurélie Grémaud and Olivier Falhun
Transleted by Amanda MacGurn

→ A matter of performance

"On Tuesday MSF's invigorating and worthy clarification led to the deflation of compassionate charity, end of episode, back brutal to reality," wrote Pierre Marcelle, on fine form as always, in a Libération article titled, Un plan cul. The same week, in its column En forme, en panne, the newspaper *Le Point* compared Pierre Salignon's weak performace (accused of having created a shock in the NGO community) to Douste-Blazy's vigourous, much admired, performance that persuaded the head of Sanofi to help Sri Lanka.

CLAIRE RIEUX'S DIARY - Day 24 Post-Tsunami - Sigli Hospital

01.19.05

People are starting to return to the areas that were destroyed. In these places at the end of the world, rubble and debris are strewn next to a book, a mattress, or a chunk of wall with a mirror still hanging from it. We meet a father who clutches a small piece of green fabric. He tells us that it is from his son's pants. The waves carried off his 5-year-old. Some people are sitting in front of what remains of their house or boat, a cigarette dangling from their lips. Their gaze is a bit empty. But many have come looking for anything they might be able to use to rebuild: planks of wood, bricks, or rebar. Bare-handed and wearing flip-flops, they rummage through the piles, risking injury and tetanus. There are several tetanus cases in Aceh province right now. We currently have six tetanus patients at the Sigli hospital and have developed a specific treatment plan for them. Several of them are in a semi-coma and require intensive care, often for more than two weeks. They were injured during the tsunami and could not be treated properly or quickly enough, particularly with respect to vaccinations and injections of anti-tetanus immunoglobulin. We don't want any more new cases. That's why we have begun systematic prevention efforts for all patients who come in with injuries. We also have to consider the possibility of an information campaign in cooperation with local authorities in an effort to halt this pathology.

> *"We must be very wary of all the alarming predictions of catastrophes that are circulating. Collective hysteria is associating tidal waves with major epidemics, famines... For the moment we haven't even identified a lack of food."*
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> **Graziella Godain. Deputy director of Operations quoted in Le Panorama du médecin 10 January 2005**

ments. Obviously, this sparks some debate: it seems honesty poses a problem. My fear is that, if we start abusing emotions in these situations, our support base will be eroded.
Furthermore, there are a lot of misconceptions surrounding natural disasters: the affected population is not completely bewildered or incapable of a reaction; it is not overseas aid that saves people in immediate danger - 80% of people rescued from natural disasters are saved by friends, family, and neighbours. And dead bodies do not spread epidemic diseases in these situations.

→ What should now take priority in terms of international aid?
In the aftermath of the disaster, it is very important to help people find shelter and a source of income. But it will not be foreign aid that saves people trapped in a landslide or from drowning. Some large-scale disasters cause a collective state of psychological agitation, which makes people lose their view of reality. It was a bit like that last week. Now it's time to get our feet back on the ground, carry out the necessary work with care and put some reality back into the situation. ■

→ **Indonesia, Aceh** © Dominique Plasson - January 2005

EPIDEMIOLOGY

"Natural disasters do not necessarily lead to epidemics"

MSF / 30 December 2004 / Interview by Remi Vallet

Aside the ideas broadcasted by the media, what risk is there of epidemics? Dr Philip Guerin, epidemiologist at Epicentre, explains a certain number of misconceptions and insists on the necessity of setting up a specific surveillance system.

→ In medical terms, what are the consequences of a natural disaster, such as the tidal wave in South Asia last Sunday?

You need to distinguish the direct and indirect consequences. The immediate impact is the huge number of victims from the disaster: the dead, of course, but also the injured, who have to be treated as quickly as possible. People are suffering from cuts and fractures and, if there is no treatment, their wounds quickly become infected in the difficult conditions.

And then, the tidal wave has destroyed houses and infrastructures, in particular drinking water supply systems (wells, pipes etc.). The destruction of homes often means that populations are being displaced and forced to regroup themselves in very makeshift conditions. This is the biggest risk in health terms: forced overcrowding, insufficient access to drinking water and medical treatment and, sometimes, food.

These circumstances can result in diseases and encourage the spread of disease. Sleeping outdoors and in makeshift shelters, people can contract respiratory infections, especially children. After Cyclone Mitch in Central America in 1998, 70% of our consultations involved respiratory infections, because the homeless caught cold during the night. There is also a risk of diarrhoea-related diseases as a result of consumption of contaminated water.

→ We have heard talk of a major risk of epidemics. What sort of epidemics and should we be worried?

From the current doom-mongering, you would think that the event itself (the tsunami) would lead to a wave of epidemics. That's quite untrue. Our experience of natural disasters proves that they do not lead to epidemics. I repeat that it is the displacement of populations that encourages epidemics.

The media is focusing on the problem of bodies that have not yet been buried or burnt. But, here again, experience proves that this is far from being the greatest threat. For the survivors, the priority in public health terms is access to drinking water and medical treatment. Of course, bodies have to be collected, but that is more for psychological reasons in these kinds of circumstances. In medical terms, some corpses may harbour bacteria that cause diarrhoea, but have not with an epidemic potential.

The destruction of homes often means that populations are being displaced and forced to regroup themselves in very makeshift conditions. This the biggest risk in health terms.

On the other hand, in the case of certain specific pathologies (cholera,

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PRESS REVUE (TSUNAMI)

→ Lyrical outburst

Sylvie Brunel's forum in Le Monde also thanked MSF for having the boldness to suspend their requests for donations. In a text titled Thank you MSF, the former president of ACF denounces other aid organizations without naming them by saying "that [they] take advantage of the window of opportunity opened to them (...) to collect funds," and she uses this as a reminder of "the need for transparency as well as the evaluation of humanitarian aid." She seems almost lyrical in her conclusion, where she applauds MSF's courage for having also denounced that international aid was being embezzled by Ethiopian authorities.

01.20.05

CLAIRE RIEUX'DIARY

Day 25 Post-Tsunami
Sigli Hospital

Today we went out to conduct an anti-measles vaccination campaign. We don't have any reported cases right now, but the displaced persons are living in close conditions that can promote the spread of the disease. After an hour's drive through rice fields, we stopped at the first camp. About 100 families are living in tents placed around the mosque. We set up our equipment while one of the camp managers used a megaphone to alert people that we had arrived. Children lined up to follow the whole circuit: registration, confirmation of their nutrition status, vitamin A, vaccination, and vaccination card. Some were very calm about the process but others screamed when they saw us approach, which made everyone else laugh. These people have lost everything and they're still laughing. What a lesson. In some camps, living conditions remain precarious. More than 50 people are sharing a single tent. They are sleeping on mats on the ground, which is often muddy because of the daily rains. Access to water and availability of latrines remains a problem. However, it is not easy to plan for sanitation in these camps because they are temporary and constantly shifting. One of the options is to distribute water daily, along with family tents, plastic sheeting, water containers, mosquito nets, and soap. At least that will make it possible for people to hold on for a while under better conditions, hoping that this situation will be resolved as soon as possible and that people will be able to rebuild their houses quickly and go back to work.

PRESS REVUE (TSUNAMI)

→ **Spoiled Rich**
While the media was in full swing and the forecast of catastrophes increased by the day particularly regarding the risk of epidemics, the controversy on donations started. In an article titled MSF, un pavé dans la marre de générosité, (a dampener in the flow of generosity) which appeared in the January 5th edition of the newspaper Libération, a representative of ACF commented: "MSF is struggling with having too much, whereas we're struggling with too little."

→ **Sri Lanka, East Coast** © Aurelie Gremaud / **MSF** - January 2005

dengue, malaria etc.), they already have to exist in the countries concerned for there to be a risk of an epidemic. For example, in the case of cholera, the cholera vibrio (the bacterium responsible for the disease), must be present in order to spread. The risk of cholera is very small in Thailand, Malaysia and the Maldives and moderate in Sri Lanka, Burma (Myanmar), Indonesia and India.

The risk is thus limited, but once the risk exists, even if it is limited, we need to be vigilant. In order to detect the start of epidemics, we rapidly need to put in place a system of surveillance specific to this disaster.

The risk is thus limited, but once the risk exists, even if it is limited, we need to be vigilant. In order to detect the start of epidemics, we rapidly need to put in place a system of surveillance specific to this disaster. And, where necessary, we need to be ready to react so that we can treat the sick and endeavour to stop the disease from spreading. The biggest problem in this case is to set up a system of surveillance in the most isolated areas.

→ What is the role of a humanitarian medical organisation such as MSF in a catastrophe such as this one?

First of all, assessing the needs on a case-by-case basis. The situations vary significantly from country to country. In Sri Lanka and Indonesia, the health systems are already fragile and have been submerged by the influx of injured because these countries have been affected so violently. Thailand and Malaysia are less affected and more developed and are, therefore, better equipped to respond. Furthermore, within any country, there are always segments of the population that are neglected by the aid agencies and these are the ones on whom we try to focus our efforts.

We may be asked to intervene in various ways. Sometimes we can help to take care of the injured, where there is a need for this. But caring for the injured is an emergency in the first few days and NGOs often arrive too late for that. So the main part of our action will be to ensure access to treatment, emergency distributions of equipment (plastic tarpaulins for the shelters, blankets etc.) and water supplies for the populations affected by the disaster. In the short term, this should lead to an improvement in their living conditions and limit the mortality rate in the event of the appearance and spread of diseases. Finally, we can participate in the epidemiological surveillance effort. A team from Epicentre (the MSF epidemiological unit) is going to the region to support the health authorities and MSF teams. ■

Humanitarianism: "centrefold charity"

MSF / January 2005 / Collected by OF / Translated by Christopher Scala

In a number of newspaper interviews at the beginning of the year, Rony Brauman, former president and currently member of the MSF Foundation, analysed the origins and limits of the current media fervour.

The extraordinary reaction to the tsunami can be at least partially attributed to the sheer scale of the earthquake, the number of countries affected, the eruption from the depths of the ocean, and the incredible violence of the tidal wave. The human toll is but one factor; let's not forget that at least ten natural disasters over the past century, some only recently, led to the loss of a similar number of human lives. Man-made disasters, which span a longer period of time, are infinitely more deadly but less visible. The thousands of western tourists killed by the tsunami brought us closer to the distant suffering and enhanced the purity of these victims - as opposed to victims of conflicts or epidemics such as AIDS. With the exception of children, victims of man-made disasters cannot really be perceived as being totally innocent of their misfortune.

→ POLITICIANS CARRIED ALONG BY THE MEDIA CURRENT

In view of the above, it is easy to understand governments' reactions and the subsequent compassion contest. However, a parallel must be drawn between this protocol of pity and other international decisions, including those that undermine any serious attempt at battling the most deadly epidemics: "When we talk about the globalisation of awareness and solidarity, there is something insulting for all those who have been forgotten by this particular globalisation[1]".

The obviously sincere emotion felt by the network executives - and shared by the rest of us does not prevent the merging of marketing, image strategy and compassion.

The television rituals and the transformation of television stations into tools of solidarity, i.e. fundraisers, clouded the perspective necessary to determine priorities and to look at this disaster in relation to others taking place at the same time in the world. The obviously sincere emotion felt by the network executives - and shared by the rest of us does not prevent the merging of marketing, image strategy and compassion. "[The television stations] foster the perception that they wield widespread power and are able to engage in social actions (...) When PPDA[2] ends a special "solidarity" broadcast by looking French viewers straight in the eye saying: "you are wonderful", who is he to say that? My father, my guardian?[3]

→ AID IN A DISTORTED MIRROR

By buying into the marketing of compassion, we end up reinventing reality so that it conforms to the image that we give it. Between potential epidemics and the extensive actions to prevent them there is ample room for negative exaggeration [see page 9, interview with epidemiologist Philippe Guérin], as if it were absolutely necessary to convince ourselves of the need to intervene. At the risk of rendering help ineffective, misrepresenting reality, and "obliterating reason[3]": "international assistance alone seems to matter, as if local assistance indicates a shortcoming at the international level. A Sri Lankan doctor doesn't really count as a doctor, although hundreds of them stepped in immediately to help their colleagues in the disaster areas ". The excessive photodocumentation of mangled corpses and decomposing bodies calls to mind in stark contrast the ban on showing any dead body after 11 September in the name of decency and respect for the victims.[4]"This is no longer the collective expression of a humanitarian sentiment, it's more the touting of pornography ".

→ MSF: AN UGLY DUCKLING?

There is nothing laughable about this compassion, of course, but it does need to be distinguished from the resounding and false sentimentalism that cloaks it. "The risk is that in the end all this work will be considered a deception, a fraud[6]", fed by an unhealthy blurring of roles: " I expect the newspapers that I read and look at to inform me, not mobilise me. Mobilising is the role of the totalitarian press. It's propaganda. (...) It's not the role of television stations to call for donations to NGOs[7]". Who is going to answer for the huge amounts collected for the emergency rescue operation? Heads of aid organisations intend to go beyond the phase of emergency help, of course, and make a long-term commitment. There will undoubtedly be things to do, but it is not the Red Cross, MSF or Unicef that are going to rebuild the devastated regions. It will be governments and local authorities, businesses and public financing that will fill the truly key roles. By stating that it would stop accepting donations for tsunami victims, MSF has generated a very positive debate, appealing to donors' intelligence and not just to their emotions. Supported by numerous members of other NGOs, this position has triggered a controversy due to questions that were then asked of the other organisations. Some of them lost their calm, maybe feeling personally indicted. This was the risk - not the intention - of a decision that was as difficult as it was necessary. In all likelihood it won't be too long before the same questions are asked again. ■

There will undoubtedly be things to do, but it is not the Red Cross, MSF or Unicef that are going to rebuild the devastated regions. It will be governments and local authorities, businesses and public financing that will fill the truly key roles.

→ Sri Lanka © Henk Braam - January 2005

1- In Les Inrockuptibles, No. 476 January 2005.
2- Prominent news announcer of the largest private French television station (TF1)
3- in Télérama No. 2870 - loc. cit.
4- R. Brauman in Le Figaro magazine - 15 January 2005
5- ibid.
6- ibid.
7- R. Brauman in Les Inrockuptibles, No. 476 - January 2005

PRESS REVUE (TSUNAMI)

→ **Certified Expert**
The European commissioner Louis Michel emphasized his belief that it is "remarkably daring to say that they no longer need money. Once again they've demonstrated that they deserve our praise and admiration more than the others. I completely agree with their point of view. It's not by throwing money in the face of misfortune that one is considered generous. Generosity comes with managing resources wisely." (article titled *MSF, une attitude courageuse que je soutiens,* from *La Libre Belgique,* January 6)

RELATIONS WITH DONORS

"Our commitments must be clear and respected"

MSF / January 2005 / Marc Sauvagnac, MSF Financial Director / Translated by Rachel Empringham

Following the events in Asia and the wave of solidarity that they generated, Marc Sauvagnac, Financial Director of Médecins Sans Frontieres, explains in detail MSF's commitment to its donors, and takes a look at the mechanisms aimed at improving the transparency of NGOs.

→ Can you tell us what the consequences of the wave of solidarity generated by the events in Asia are for MSF?

MSF is a medical organisation that intervenes in emergency and post emergency situations. We have established teams that are experienced in emergency situations and in a position to quickly evaluate the response that MSF can provide, taking into account the context of intervention, the nature and consequences of the events, its own operational capacity and the number of actors present.

In the case of Asia, two weeks after the Tsunami, the 18 sections that comprise the MSF international movement had collected more than 40 million euros [and today more than 90 million euros]. These donations, prompted by the effects of the disaster, must be allocated to it from a legal and professional code of ethics point of view. During that time, we evaluated the nature and scope of the operational response. In view of the respect we have for our donors, we only considered it honest to inform them that their support for these operations was sufficient with regard to the activities we envisaged setting up in the field, and to remind them of the very significant volume of our operations in the 80 countries where we intervene in the context of armed conflict, epidemics and endemic diseases.

Over and above the law, MSF has strict commitments with regards to its donors. We promise to spend the money for the events that have prompted their support and to run our operations ourselves. Furthermore, we promise not to continue our operations with the sole aim of spending the allocated funds but to continue only if we consider our action to be pertinent and of quality. This is why we appeal more generally to our donors to support us in all our activities, particularly through our "1 euro per week" collection campaign.

In the case of natural disasters, the immediacy of media coverage providing significantly more visibility than for other crises often provokes a disparity between the operational reality of MSF and the support reaction of donors.

In the case of natural disasters, the immediacy of media coverage providing significantly more visibility than for other crises often provokes a disparity between the operational reality of MSF and the support reaction of donors who are heavily appealed to by the media and organisations.

In order to respect our commitments, we chose to come forward and outline the reality of the facts to our donors. This decision was neither easy nor agreeable to take in light of the reaction that it provoked.

→ Many donors who contact us tell us that they trust us to allocate their donations where we deem it most useful. Why in this case are we so particular?

Firstly, it is required by law. The Cour des Comptes (revenue court), which has a mandate to, among other things, control the good use of funds received by organisations benefiting from public generosity, verifies that the goodwill of the donors has been properly respected. Furthermore, our

CLAIRE RIEUX'S DIARY - Day 26 Post-Tsunami - Sigli Hospital

01.21.05

The imam chanted all night long - it's the Aïd holiday. Our Indonesian team woke up early to pray and tonight we will all have a good dinner together. Internationals and Indonesians, we have all come here with the same intention - to help the tsunami victims. Yudi, a young OB-GYN, was working in Banda Aceh. His hospital, an imposing white building, still dominates the landscape at the coast but the damage is so extensive that major repairs will be necessary before it can resume functioning. Some of his colleagues, particularly the head of his department and the man's family, are dead. He wanted to help his country and came to find us. The story is the same with Usman, a surgeon and professor at the Bandung medical school on the island of Java, and Edriania, a private nurse who was caring for a single wealthy patient. She cried so much watching television that she asked her employer for leave to come here. Avi is a banker in Jakarta. He's working with us as a translator and helps us manage in all sorts of situations. Joyo, Katija, Yunis, Yusuf and Tiur are nurses. Nasar and Tina are the lead doctors on the mobile clinics (specialized consultations in the camps and villages). At the hospital, we are working with a medical-surgical team from Surabaya University. They have some experience with natural disasters. We are sharing our knowledge and the way we do things. It's good to feel that sense of solidarity in the field every day.

ability to intervene in an independent manner relies on the relationship of trust that unites us with our donors. For this reason, our commitments with regard to them must be clear and respected.

The nature of the donation appeal therefore determines its allocation. In the case of this disaster, organisations made a clear appeal for support from donors to enable them to intervene in Asia. Organisations must be able to guarantee that the donations allocated will be used for the cause that motivated them.

In France, the *Comité de la Charte*, a private initiative created in 1989 bringing together fifty or so organisations, aims to help them clarify their practices. MSF is not part of this *Comité* and I will come back to this subject. The *Comité de la Charte* has to its credit brought some clarification to laws that were sometimes badly adapted to the practical reality of the management of organisations. The organisations that are part of the *Comité* promise to respect its charter, notably concerning the nature of donation appeals that should not contain any "inaccuracy, ambiguity, exaggeration, omission...that could deceive the public". It is clear that were an organisation to make an "exaggerated" appeal for the collection of funds for Asia in relation to its intervention capacity, it would not be respecting the charter to which it adheres.

MSF did not wish to be part of the Comité de la Charte since it awards a seal of good management ("*Donnez en confiance*", 'give in confidence') to the organisations who respect the charter however the committee is financed by its member organisations; consequently this seal is basically automatically awarded.

We are of course in favour of audits by public organisations such as the *Cour des Comptes*. These audits are essential to retaining donors' trust.

→ Many critics point out that we could have forwarded the surplus of collected funds to other NGOs, or we could have directed our donors towards other NGOs. What do you reply to these criticisms?

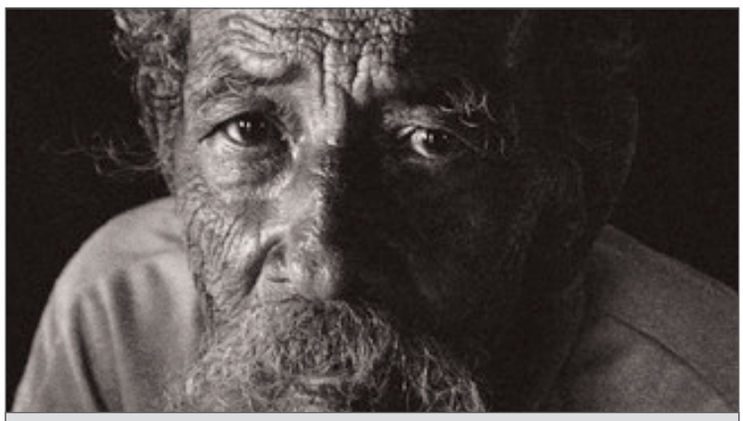
Here again our commitments are clear. We ourselves run our aid operations. Funds that have been entrusted to us are our responsibility. We independently evaluate the needs, determine the nature of our response and control the implementation of aid and the means associated with it. In certain exceptional cases we may be prompted to support other organisations with whom we work in the field. This support is in line with the continuation of operations undertaken by us, of which we control the context, the nature of the intervention and for which we are sure that our support positively benefits the vulnerable populations that we have identified.

However the committee is financed by its member organisations; consequently this seal is basically automatically awarded.

As for directing our donors towards such and such an organisation, again we would need to be in a position to have an opinion on the quality of their activities. This is not our role, this does not form part of our social objectives and we have enough to do with our own evaluations.

→ What does this notion of evaluation involve?

What does the notion of evaluation encompass? Firstly, respect for our donors, their intentions and their money. This comes back to the specifications laid down by law relating to the presentation of accounts by associations, which must give donors a clear vision of the use of their donations. This type of evaluation is implemented through the audits carried out by the Cour des Comptes.



→ **Indonesia, Banda Aceh** © Martin Chaffiotte - January 2005

CLAIRE RIEUX'S DIARY - Day 27 Post-Tsunami - Sigli Hospital

01.23.05

Very, very intense emotions today. One of our patients has contracted tetanus and is not doing well at all. He has difficulties breathing. We do not have the mechanical ventilator needed for him to breathe. Gathered at his bedside, we are debating the best options for the patient. "We" are the Sigli team: doctors, surgeons, anesthesiologists, nurses from Surabaya, the local hospital, and MSF. The day before yesterday, another MSF surgeon called to inform me that a German hospital ship, navigating along the coast of Banda Aceh, was equipped with an intensive care/ resuscitation unit. It's the only place in the region where a patient can be mechanically ventilated. I contacted them and explained the situation. They will pick up the patient using a helicopter. Francois, logistician and a great organizer, found the best place for the helicopter to land: the stadium. Meanwhile, we decided to perform a tracheostomy (an incision above the Adam's apple into the trachea to facilitate breathing). We inflated the patient's lungs with an "Ambu" bag, ventilating manually, and all of us taking turns. The patient's wife, ever-present and so caring since the beginning of her husband's ordeal, is now confused and undecided. She sees her husband lying unconscious, a hole in the trachea and we are telling her that we are going to transport him to a German ship near Banda Aceh in a helicopter. She doesn't have the courage to accompany him and it's the patient's brother who will. It's 11 a.m., the German team is expected at 2:30 p.m. The waiting begins. Silence in the intensive care unit as time seems to have stopped for everyone. All ears are tensed, attentive to the slightest sound of a helicopter's engine in the distance. Suddenly, they are here: three giant men equipped with high-tech medical gear. After a quick discussion, the patient is transferred to the hospital's ambulance, driven by a surgeon from the emergency unit. At the stadium, a curious crowd has gathered around the massive helicopter. The stretcher is carried into the helicopter, doors close, everybody steps away, and the "bird" takes off in a gale of dust.

> *"By forcing itself to be completely transparent concerning the allocation of its funds, MSF has revealed the limits of ad hoc compassion. In the end this is the most reasonable approach."*
>
> **Marc-Olivier Padis (Co-author with Thierry Pech of Multinationales du cœur- Published by Seuil) quoted in Le nouvel Economiste January 14th-20th 2005.**

Furthermore, it is the responsibility of associations to maintain clear relationships with their donors, by communicating elements which enable them to have a detailed description of the activities undertaken, their objectives and the means assigned to them. MSF communicates on a very regular basis with its donors, via its public announcements, magazines and newsletters that are sent to them regularly, its internet site which gives access to the content of operations as well as through the annual financial report which details the nature and destination of our resources. This report details the expenditure of each programme, country by country, and the sources of their financing.
Another aspect of evaluation is that of the pertinence and quality of operations. It is as necessary for organisations themselves as it is for donors to have a critical reading of operations in order to improve the quality.
The problem is not simple as humanitarian interventions do not lie in a no man's land. Understanding of the environment and political context are elements that are key to the quality of the activity. Furthermore, humanitarian action is not summarised by the simple distribution of medication or aid materials. Our patients not only have a physical and biological body but there is also a psychological, political and socioeconomical factor. It is a question of totally independently identifying the most vulnerable populations, victims of conflicts or epidemics, of ensuring that the response is pertinent and of quality and of guaranteeing that the aid reaches them directly. All this at reasonable cost, employing means in line with the objectives. Humanitarian medicine must therefore take into account elements that go above and beyond the simple therapeutic response. Any analysis or evaluation must take into account these different aspects.

Currently, initiatives concerning the evaluation of humanitarian operations are limited to the finalisation of a system of references that are very centred on the quality of bureaucratic procedures and the rigorous management of associations. This is already very good but undoubtedly insufficient.
It remains to be determined who can have the mandate to evaluate activities. Direct intervention by the States in the field of evaluation is not particularly desirable, as these are generally direct or indirect players in the conflicts or have, at the very least, their own interests in the resolution of the crisis situations. ■

PRESS REVUE (TSUNAMI)

→ **Mobilization!**
After eye-witness reports and horrific images, the press quickly turned to the mobilisation of donors. "We're expecting to see a significant effort from our regular as well as our spontaneous donors," said Ann Avril on December 29th in Le Monde. "It would be good if we could collect 600,000 euros over the next two weeks."
One month later, the French section has collected 8 million euros and the international movement 90 million euros.

FUNDRAISING

Donors particularly reactive to natural catastrophes

MSF/ January 2005/Ann Avril, head of fundraising

Ann Avril looks at funds collected during recent fundraising campaigns and analyses their efficacy.

Crises that receive a lot of media coverage have always been a cheaper way of raising awareness among new donors than direct marketing. However the sudden generosity that is dictated by emotion or indignation is usually only passing. This is confirmed by the fact that although in the media for only a brief period of time, natural catastrophes generate the best results in terms of generosity and also at minimum cost as advertising spaces are usually free. The two recent catastrophes (Iran and the tsunami) are examples of this, even more so as they occurred during periods that are particularly propitious for donations- the Christmas period. In contrast, we had to invest both time and money into our recent campaigns to draw donors' attention to the victims of conflicts or pandemics. These investments (advertising, direct marketing etc) are also possible because by nature these types of crises generally span a longer period of time.

→ NGOs collect an estimated 40% of their private funds in the last quarter of the year.
© Laurent Chamussy / Sipa-press / 2005

→ THE TOOLS

A specific P.O. box is sometimes set up for a particular crisis, but this is rare and does not usually bring in a large number of donations(except for example when mentioned on the television news). The website is of course the most reactive tool, but until the catastrophe in Asia when we collected over 2.5 million euros on-

→ RECENT FUNDRAISING CAMPAIGNS AT MSF

Year	Period	Duration	Campaign	Amount collected	Investment	Ratio
2001	Oct.-Dec.	3 months	Afghanistan (conflict)	1 160 000 €	600 000 €	1,93 €
2002	May-July	3 months	Angola (famine)	1 370 000 €	150 000 €	9,13 €
2003	December	15 days	Iran (natural catastrophe)	650 000 €	5 000 €	130,00 €
2004	April-June	3 months	Malaria (illness)	200 000 €	114 000 €	1,75 €
2004	July-August	2 months	Darfur (conflict)	705 000 €	100 000 €	7,05 €
2004	December	15 days	Asia (natural catastrophe)	7 000 000 €	15 000 €	466,67 €

Amount collected = Total earmarked donations
Investment = buying advertising space, extra mailings, Technical advertising costs

line in one week, this is still a marginal tool in terms of fundraising. The mailing of faxes to business companies is by far the most profitable tool, on condition that the crisis is widely covered in the media. And to get crises in the media there's nothing like advertising. For Afghanistan in 2001, Angola in 2002, malaria or Darfur in 2004, MSF therefore bought advertising space. This financial effort means we can generally obtain broadcasting slots that are more interesting for the public that we are targeting, as well as obtaining much more free advertising.

It is important to also highlight that MSF invested much more than usual for the conflict in Afghanistan. A large part went into mailings, a technique that is expensive but that has the advantage that we can measure the profitability of our investments very precisely. The 'competition' between NGOs was also very strong in the 'Afghan context'.

→ THE CAMPAIGN'S MESSAGE

It is interesting to note that in the two least profitable fundraising campaigns (malaria and Afghanistan), besides the complexity of the subject or context, the messages, which were exceptionally confided to external agencies, were daring (malaria: mosquito/weapon of mass destruction, Afghanistan: 'We no longer need to show images to convince you that Afghans need our help) and never showed pictures of victims. Does this mean that the authenticity of 'home-made' campaigns put together in haste on a shoestring and buckets of good while sitting around a bottle of whisky will always attract the most support from the public? ■

VOLUNTEERS

Inflation of Human Resources

MSF / January 2005 / OF / Translated by Gaelle Treffot

Compared to Darfur, there were a huge number of candidates to leave on mission after the catastrophe in Asia.

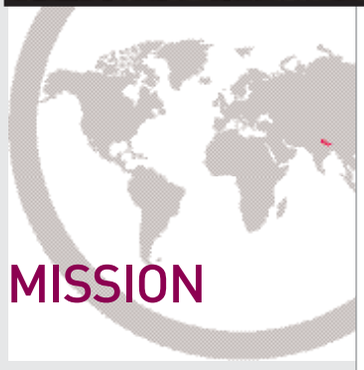
Of the last two 'major crises' the human resources department has had to recruit volunteers for (the emergency in Darfur and the tsunami), the disaster in Asia generated by far the most candidates (and reactivation of volunteers that have already been on mission with MSF). "Although the HR team worked very hard to find experienced volunteers for Darfur (using a new tool: internet), the results were far less successful than for Asia » explains Marie-Laure Le Coconnier, active recruitment officer. "Of the 595 'Darfur' applications received in 4 months via internet, 14 were given a favourable follow up and 7 people actually left on mission (of which only 1 to Chad)!" These results are similar to the classic recruitment by post, says Marie-Laure, who underlines that many applications came from abroad which often pose insurmountable problems (difficulty or even impossibility to set up an interview, complicated administrative procedures...).
"Contrary to Darfur we have not been pro-active at all for Asia as we already had people available for this emergency : volunteers who had been through the normal recruitment process. Nevertheless we received 411 written applications by post (including 189 specifically for Asia) whereas we usually receive one hundred! Of these, 161 applications are of potential interest to us for other missions. "Whether these people will concretely leave on mission it's still too early to say" concludes Marie-Laure: in reply to the recruitment campaign for Darfur. MSF identified 222 potentially interesting candidates, however only 15 decided to continue the active recruitment process. ■

Nevertheless we received 411 written applications by post (including 189 specifically for Asia) whereas we usually receive one hundred!

PRESS REVUE (TSUNAMI)

→ Epilogue ?
Le Monde dated 11 January 2005, signed by Dominique Le Guilledoux, foreign correspondent in Trincomalee:
MSF fears a vast 'humanitarian circus', a race for the limelight, agencies 'setting up major programmes to prove that we exist'».
An MSF doctor who denounces the race to become known rather than to set up efficient aid, concludes : « I hope there will be a major earthquake in the field of humanitarian reflection. It can't go on like this. »

→ Nepal, Rukum, Salle Airport © Colin Morand / MSF - May 2004



MISSION

NEPAL

MSF's difficulty to work

MSF / January 2005 / Interview by Laurence Hugues / Translated by Mary Cassidy

Programme Manager Emmanuel Drouhin talks about the operational difficulties faced by MSF teams in Nepal.

→ "WE'RE WORKING IN AN ENCLAVE"

The civil war between Maoist rebels and government forces has led to over 10,000 deaths since 1996. Without a front line or clearly-defined combat areas, this is a "dirty war" which is becoming more and more radical and the populations who live in the mountains are caught in the crossfire. We are currently working in a small hospital in the district of Rukum, in an enclave under government control. We are on the edge of the areas under Maoist control, where we are unable to work. Given the needs we should like to do more. However it is extremely difficult to obtain the possibility of providing humanitarian assistance in the remote areas under guerrilla control. No NGO is working in the Maoist areas any longer.

→ EXPLAINING WHAT MSF DOES

We have visited these areas over 20 times, and multiplied our contacts there. The local chiefs need approval from their leadership before authorising us to work in their districts. However, the Maoist leaders, who are now labelled as "terrorists" and are on Interpol's files, have cut off all links with the outside world, including journalists.

How can we find a way to provide humanitarian assistance in Nepal? It's a textbook case. Only by working there can we demonstrate what MSF is and why as an emergency relief organisation we should be present in this conflict.

How can we explain to them what MSF stands for, explain our independence and our action principles in order to persuade them to let us return to their areas and treat their people? We have already had to spend a great deal of time explaining to the government authorities how we differ from all the development NGOs working in the country; now we have to convince the guerrilla leaders. We want totally independent access to these populations, so that we can establish and respond to medical needs on the spot.

→ NEPAL, A TEXTBOOK CASE

How can we find a way to provide humanitarian assistance in Nepal? It's a textbook case. Only by working there can we demonstrate what MSF is and why as an emergency relief organisation we should be present in this conflict.

We are therefore going to send a team to the mountains for three months, on the lines of what we did in Afghanistan during the war between the Russians and the Afghan resistance fighters. The team will treat patients in need of assistance and at the same time assess the population's needs. We are also sending an exploratory mission to the Terai Valley on the Indian border to identify secondary health needs, as this region is populated by tens of thousands of displaced persons who have fled the war, forced recruitment and waves of repression. ■

NEPAL

Dilemmas in Nepal

MSF / December 2004 / Duncan Mclean / translated by Jocelyn St Denis

The civil war that has engulfed the Kingdom of Nepal since 1996 and led to more than 10,000 deaths provides a depressingly prescient case study for some of the fundamental dilemmas facing aid agencies in the 21st century. By Duncan Mclean, author of an internal report on the situation in Nepal.

With both the Maoist insurgents and the palace dictating the agenda of the country the space for compromise has become less and less apparent. Mainstream political parties in particular have been excluded from debate or, as was the case in the past, have been co-opted into the current power structures. As the conflict escalates and civilian casualties mount, regional actors have found themselves drawn into the fray. Both India and China have direct strategic interests at play while the US has brought the debate squarely into its own prerogatives regarding the 'war on terror'. Maintaining neutrality in such circumstances becomes a real challenge, as aid agencies are placed into the difficult quandary of obtaining access to areas controlled by interlocutors officially banned.

→ A PROGRESSIVE DETERIORATION

Modern Nepal is no stranger to foreign assistance. The self-imposed isolation apparent throughout most of its history contrasts dramatically with the outside influence seen in Nepal since 1951. Throughout the cold war the politics of external economic assistance made itself felt. In this regard the shifting paradigms of mainstream development discourse have been mirrored in Nepal over the past fifty years. Its early focus on growth-oriented modernization through infrastructure developments of dams, electricity, irrigations, industry and roads, was conveniently in line with the early Panchayat, or party-less politics, years. Poverty reduction in the form of basic needs and hunger came to dominate development discourse in the early seventies while, more recently,

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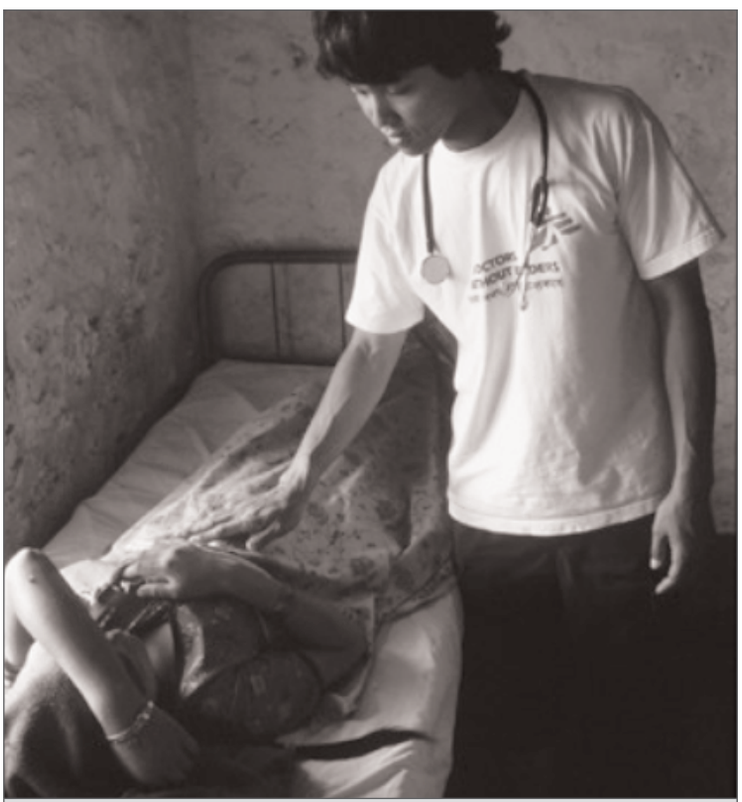

→ **Nepal, Salle hospital** © Tomas van Houtryve - July 2004

TIMELINE

MSF / january 2005 / LH
Translated by Andrew Race

→ 1990
The 'Kathmandu Spring': large public demonstrations organised by parties which were underground at the time, such as the Nepali Congress and the Communist Party of Nepal, lead to a democratic constitution. The Panchayat, a system relying on the support of landowners in order to guarantee the power of the king, is abolished.

→ 1991
The Nepali Congress wins the first democratic elections.

→ 1995
Liberalisation has above all been of benefit to the elite classes, to the great disappointment of the working class. The Nepalese Maoist movement, which originated at the same time as the Naxalite movements in the 70s in India, founds the Nepal Communist Party (Maoist) and preaches armed struggle. A wave of repression, Operation Romeo, is launched in Rukum and Rolpa against the Maoists and their supposed supporters amongst the people.

→ February 1996
The Maoists present a 40 point programme for political and social reform and then launch the '**people's war**'.

→ 1998
New extremely violent repressive operations (murders, rapes, torture, arbitrary arrests etc.), including 'Kilo Sierra 2'.

→ 1st June 2001
Massacre of the royal family. King Gyanendra ascends to the throne. This is followed by the first ceasefire.

MISSION

Nepal

TIMELINE

(CONT.)

→ November 2001
The ceasefire breaks down and a state of emergency is declared. The king launches the army against the rebels.

→ May 2002
Dissolution of Parliament. In October, the king dismisses the Prime Minister, Sher Bahadur Dueba, and assumes executive power.

→ January 2003
Second ceasefire. Lasts until August.

→ June 2004
New nomination of Deuba for the post of Prime Minister.

→ August 18-24, 2004
Blockade of Kathmandu by the Maoists.

→ November 2004
Approx. 300 killed during confrontations between police and guerillas.

→ February 2, 2005
After dismissing the prime minister and announcing a state of emergency, the king of Nepal took power and formed a new royalist government. He also called on the Maoists to commence negotiations.

the establishment of democracy and civil society has come to the fore thus justifying retrospectively the previous failures. With the latter now in tatters questions are justifiably being asked as what has been practically achieved? This situation is unlikely to be clarified with the arrival of emergency-oriented NGOs.

Even the arrival of organizations such as MSF provides an indication of the progressive deterioration of the situation within the country. Areas that previously received grants towards community-empowerment programs and the like now struggle to maintain a minimum of public services in the face of near constant threats of violence. Despite being signatory to 18 international human rights treaties, in addition to those guaranteed in the Constitution of 1990, human rights abuses by both the state and Maoists have been well documented. With 60 to 80 percent of the casualties estimated to be civilian, there have also been cases of arbitrary killings, disappearances, torture and rape.

→ CAUGHT IN A STRANGLEHOLD

With rural persons increasingly caught in the crossfire and the choice of between being forcibly enlisted by the Maoists and either harassed or killed by the security services, many have fled. Those that choose to stay have described the need to wear two faces: one for the Maoists and one for the state. Internal displacement due to the conflict is estimated at 100,000 to 150,000 although the vast majority are not registered due to a limited public assistance and fears of retaliation from either the Maoists of the security services. Although the government has no data, it is generally assumed that the expanding slums around Kathmandu and a few other urban centers are the consequence. A 'displacement allowance' of 100 Rs a day has been provided although not for victims of the security services. Distinguishing between traditional economic migrants and those fleeing the conflict is almost impossible given that, in addition to being preyed upon by both sides, basic services in rural areas have almost ceased to exist. Infrastructure in the cities has consequently been strained as roads, water supplies, sanitation and waste management, in addition to health and education, are unable to cope.

Access to basic health care has also been influenced by verbal decrees by the Ministry of Health demanding that health workers do not treat people 'involved in terrorist activities without informing the local administration or security organization.' An obvious consequence is that people within rural areas will not seek medical care for fear of being accused of being Maoist.

In the broader region, the policies of both India and China reflect their mutual and justifiable suspicions over each other's intentions. The latter's basic objective is the prevention of India emerging as the regional power over both Southeast Asia and Central Asia as they had historically. Meanwhile Delhi's policies are directed at counter-containment strategies of China. This has left successive Nepalese governments with little room to manoeuvre in addition to an entrenched paranoia of outside intervention. Given the indebtedness of the country to foreign lenders and the apparent failure of the development this is hardly surprising.

→ BETWEEN NEGOTIATIONS AND REFUSAL

At the time of writing[1], official discourse regarding the conflict is that it is simply a question of an emerging democracy versus a terrorist organization. This has presented those Nepalese living in areas outside of government control, in other words most non-urban centres, with a fundamental dilemma. To remain invites retaliation from either the security services or the Maoists. The option of fleeing, mostly to India, means a life in exile with economic conditions hardly better than those left behind. For those organizations attempting to respond to those basic needs in Maoist controlled areas, there exists the conundrum of obligatory negotiations with interlocutors officially labelled as terrorist pariahs or quite simply a refusal of access. To what degree aid agencies are prepared to collaborate in an international order that has reduced complex situations into a black and white 'war on terror' is, and is likely to remain, a fundamental concern in trying to meet the needs of vulnerable populations. Meanwhile the conflict in Nepal is heavily laden with irony as the supposed beneficiaries of those in whose name the 'people's war' has been waged are those whose suffering is greatest. ■

1- At the beginning of February King Gyanendra took over control of the country.

→ **Nepal** © Jean-Marc Rohmer

KOREA

The great disillusionment of North Korean refugees

MSF / October 2004 / Hayoung Li, clinical psychologist in Seoul, South Korea / Translated by Karen Tucker

Clinical psychologist Hayoung Li is part of the South Korean team working for MSF in Seoul. Although influenced by a family history that reflects Korean history (her uncle went to North Korea with the Red Army during the war) and raised in fear of North Koreans, she has managed to overcome her preconceptions and provide this report on the status of the most vulnerable North Korean refugees.

"Do you believe it is possible for human beings to be reduced to skin and bones? They struggle with hunger until their death, digging in the earth to find something to eat. Then their bodies swell up from top to bottom until they die". I was overwhelmed by such stories from North Korean refugees. My patients tend to put their head in their hands and imply that I could never understand. ... After all the suffering they endured throughout their lives in North Korea, they then went on to experience additional trauma during their exile in China, Mongolia, Thailand or Viet Nam, such as being constantly pursued by the Chinese police. The guilt they feel for "abandoning" their families - sometimes even children - in North Korea only aggravates their mental state. And to add insult to injury, their dreams of an easy life in South Korea have not come true; most had thought they would be welcomed as heroes.

→ PSYCHOLOGICAL DISTRESS

When they arrive in South Korea, North Korean refugees are investigated by the intelligence services to make sure they're not spies - a process that can take a few days to several months. Then they spend three months in Hanawon, a reeducation centre where they learn to adjust to South Korean life. The government promises them South Korean nationality (after two years in the country) and provides them with housing and a monthly allowance. But they use most of this money to pay off their smugglers, leaving them with little money for living expenses.

Because the refugees are unskilled, have no experience with modern technology and are unaccustomed to the South Korean system, few of them manage to enter the workforce. Only 2% of the country's 5,700 refugees are currently working; the rest are dependent on the government.

Because the refugees are unskilled, have no experience with modern technology and are unaccustomed to the South Korean system, few of them manage to enter the workforce.

They therefore have a constant feeling of fragility, sadness and timidity even though they have enough to eat, experience no direct threats to their life and do not risk forced repatriation. They are always on the alert, haunted by a sense of insecurity and fear. They have trouble eating and sleeping. I have even heard that some want to return to their country. As a result, their behaviour is unstable and a large number of them try to forget their problems through alcohol and gambling. Many also suffer from physical ailments, such as headaches and heart palpitations, largely because they have trouble expressing their feelings. These psychological problems cause many misunderstandings with South Koreans, who consider them lazy, indifferent and violent, when they are simply ill.

→ PSYCHOLOGICAL SUPPORT: BEGINNING STAGES

Despite such distress and stigmatization, the refugees have received very little psychological support. The Hanawon centre has just set up a psychological unit and MSF only recently received authorization to provide psychological counselling in social service centres. That is why I believe that the organizations helping the North Koreans here consider MSF's activities essential.

The major problem facing MSF is making contact with the refugees because, in these circumstances, very few of them request help for themselves. Once contact is established, you quickly realize the importance of treatment. All the patients I have met say the same thing: they want to forget their past. That is why they have great difficulty discussing their problems at first. Therapy gives them the opportunity to go through a depressive phase so that they can then get the help they need to get back on their feet. They gain greater stability and become more accepting of their past and present so that they can plan for the future.

Unfortunately, despite the growing influx of North Koreans, very few psychologists and psychiatrists are aware of the refugees' psychological problems. Yet understanding and helping those who feel lonely, sick and anxious is a necessary condition for their integration into South Korean society. ■

NEW BOOK AVAILABLE

→ « Je regrette d'être né là-bas » (I regret being born there)
Corée du Nord: l'enfer et l'exil

By Marine Buissonnière (international secretary of the international MSF movement) and Sophie Delaunay (ex head of mission in South Korea). Stories and witness reports of North Koreans exiled in South Korea. 200 pages. Published by Robert Laffont.

MSF ACTIVITIES IN SEOUL

Since February 2002, a Médecins Sans Frontières team has been working in South Korea to provide medical and psychological treatment to the most vulnerable North Korean refugees. This effort allows us to continue documenting the situation in North Korea and learn more about the refugees' support networks. (MSF left the country in 1998 because it was not able to operate freely.)

→ Sudan, Murnay © Michael Zumstein / L'Œil Public - September 2004

DEBATES

SUDAN

Darfur, or the Peace Disagreement

MSF / February 2005 / Interview by Caroline Livio / Translated by Diantha Guessous

Marc Lavergne, Research Director at the CNRS, a specialist on the Middle East and the Horn of Africa, and author of "Soudan contemporain" ("Contemporary Sudan")[1] went to West Darfur at the end of 2004. Here he reports on the situation today in the region.

→ Two years after the start of the Darfur conflict, how would you describe the current situation?

The Darfur crisis can now be described as a low-intensity conflict. The cease-fire signed on April 8, 2004 in N'djamena between the different parties involved is more or less respected. There are attacks in South Darfur, to the east of Jebel Marra, but it is no longer a question of all-out war as was the case in late 2003 and early 2004. The evolution of the conflict in coming months is closely linked to the fate of the displaced populations. They do not want to return home because the Khartoum government and the militias who chased them from their lands will only let them return to farm their lands to the profit of their new masters! In addition the Khartoum government is faced with a dilemma: it can neither go against the Janjawid militias that it had mobilised, nor quarrel with the international community. The major asset of the government is, however, that the West does not have strategic or oil stakes in Darfur. Thus, it is very likely that the international community will not really mobilise itself for Darfur, but instead continue to bandage its wounds through humanitarian action.

→ Can resolution of the Khartoum-SPLA conflict have an impact on Darfur?

The SPLA will start sharing power with the regime as of March 2005. They have committed themselves to stopping support of the Darfur rebels and to staying out of the war against them. This commitment is a test of their integration into government policy because the SPLA on the one hand, and the SLA and JEM [rebel groups of Darfur] on the other, share the same objective: a more equitable distribution of wealth in Sudan. Moreover, there is a risk that opponents to sharing power with the SPLA will use the situation and oblige the SPLA to accept the consequences of its position within the government, i.e. to choose between unfailing support of the ruling powers or the rebels' cause. The signature of North-South agreements therefore increases the complexity of the situation. This should be a factor for peace, but in reality, it will lead to escalation. Darfur may be a means of shattering this signed peace agreement..

→ What will become of the displaced populations?

For the displaced populations, the current situation cannot go on. In a city like Mornay for example, in West Darfur, where more than 70,000 people are regrouped around a village of 5000 residents, the situation is non-viable in the long term: there is no economic activity, the cultivable land around the city is insufficient, there is no school, etc. Guerrilla actions will probably start again once rebel groups have been re-armed, and the government may resume air strikes against the civil population. Despite all this, the international community will not intervene. Since the beginning of the conflict, international actors have violently criticised Khartoum and its militias, but their actions have been far more moderate than their words. Thus, the mandate granted to the African Union is very limited. It consists of protecting observers, who are slow to arrive, but their role is not to ensure protection of the different populations. Only humanitarian support of displaced people will continue: the populations have been able to cultivate only a minute portion of their lands and they will remain largely dependent on international aid for another year.

→ How are MSF actions perceived?

MSF was the first organisation to be present during the initial and most violent phase of the conflict, which gives the displaced a feeling of security. Thus in Mornay, the populations stayed because of the presence of MSF teams. At this camp, as at Zalingei and Nyertétei, people are very appreciative of both the presence and the activities of the association. MSF is also one of the rare organisations to approach not only officials, but also traditional leaders in its attempts to better grasp the situation... Government authorities also have a very favourable view of MSF because they know the principles of the organisation, present in the Sudan for 25 years. However, one shouldn't be fooled, because the Sudanese authorities also know how to use the MSF aura by distorting its position statements for their own benefit. For example, the position taken by MSF concerning the genocide accusation was turned into a tool by Khartoum through tireless repetition of its out-of-context abridgement of that position: " MSF says that genocide has not occurred in Darfur", thereby forgetting that MSF had also and above all denounced the extreme massacres and violence inflicted on the civilian population.. The independence of MSF remains an advantage, but in the field, that can be different. For much of the population, MSF is only one among 70 other NGOs. ■

1- ***Le soudan contemporain*** **- Marc Lavergne - 1989 - Karthala - CERMOC**

POINT INFO

→ 15/02/05,
Chad: launching of meningitis vaccination campaign

At the end of January MSF launched a meningitis vaccination campaign in eastern Chad in the Sudanese refugee camps of Bredjing and Farchana, as well as in surrounding zones and in the town of Adré. MSF is working alongside local health authorities and the International Federation of Red Cross and Red Crescent Societies.

Within a two-week period the MSF teams vaccinated nearly 70.000 people. In addition to creating fixed vaccination sites in the refugee camps and in three sites in Adré, mobile teams have covered also peripheral areas.

The epidemic that is affecting this region of Chad is due to a relatively rare strain, the mengingococcus serogroup "W135".

UGANDA

Tactics and tact

MSF / November 2004 / Isabelle Voiret, Head of Mission in Uganda and Kate Evans, MSF-USA

On July 29, 2004, more than 700 people in Arua, Uganda celebrated the two-year anniversary of access to antiretroviral (ARV) treatment through MSFF's project at Arua Regional Referral Hospital[1]. In organizing this event, MSFF urged the national government and other care providers to provide treatment for free to all of those who need it; to use generic fixed-dose combinations of ARVs; and to involve the entire community. In view of the high demands and the need to preserve a working environment, there are many issues that need to be considered before elaborating this type of message.

Today in Uganda, nearly 150,000 of the 550,000 people living with HIV/AIDS clinically require ARV treatment now. Only 23,000 people receive it, though, and nearly 80% of them must pay to some degree for their care. In Arua, Uganda, MSF provides free antiretroviral (ARV) therapy to more than 1,100 people and monitors the need for treatment for another 2.000 patients. As part of its comprehensive package of care, MSF also provides services to prevent mother to child transmission, treatment and prevention of opportunistic infections and sexually transmitted diseases, and palliative care.

Throughout the process of structuring the two-year commemoration and defining MSF's message, there was extensive internal discussion regarding MSF's positioning vis-à-vis the Ugandan government. In June, the Ministry of Health announced their plan to roll out treatment to 2,700 people through district hospitals by the end of the year. The plan's modest commitments, lack of transparency regarding eligibility criteria, and its perceived bias towards military personnel and civil

→ **Mozambic** © Martin Beaulieau - 2004

> *If it weren't for ARVs so that people could see the benefit of being open about their status, we would not have come this far. Now people form their own support groups, which is really due to free treatment because otherwise what is the benefit of being open.*
>
> **Rose, founder of women's peer support group**

servants provoked severe criticism from AIDS activists in Uganda and at the XV International AIDS Conference in Bangkok. Activists called for a more extensive and transparent treatment plan particularly in light of the resources and credit President Museveni and his administration receive internationally for their response to HIV/AIDS.

→ QUESTIONS

The experience of defining MSF's message and position in relation to the Ugandan government raised several questions that may apply to other MSF HIV/AIDS projects: how can MSF work closely with national ministries of health (MoH) in our projects when those same authorities are failing to implement treatment programs at the scope required without implicitly accepting their response? How do we balance the need to maintain relationships and engage ministries of health in our projects without being perceived as undermining the demands and criticisms of people living with HIV/AIDS and other AIDS treatment advocates? As MSF gets closer to handing over more of its AIDS treatment programs to national governments, we will have to overcome the challenge of continuing to hold these authorities accountable while also ensuring the long-term sustainability of our projects.

In Uganda, MSF did not want to commend the government's response, which would undermine local groups or people living with HIV/AIDS who were calling for their government to do better. At the same time, the relationship with local ministry of health staff and their involvement are essential to the success and sustainability of the project, so MSF did not feel comfortable criticizing the scope or policies of the national treatment plan. As a result of these competing interests, MSF did not comment on the shortcomings of the national treatment plan but did call for expanded access to treatment in general and provided space for Ugandan activists to criticize the national plan in the presence of the Minister of Health.

→ RESPONSIBILITIES

This strategy can be seen as too diplomatic or simply too weak, but it also demonstrates how strongly we believe that people living with HIV/AIDS have to take the lead in the battle to get access to treatment for all. Not only are they the groups most affected by national policies, and as such best positioned to call on their government to assume its responsibilities, but by taking the lead, they can also provide critical input into future decisions regarding allocating donor resources and implementing the national plan. However, this strategy also raises questions. How can MSF ensure that we are not co-opted by the government or perceived as such? If we want to be sure that local people living with HIV/AIDS are at the forefront of efforts to increase access and hold their governments accountable, then what role does MSF have in helping those groups take the lead?

This and other questions will be answered differently throughout the course of the HIV/AIDS projects in Arua and elsewhere, depending on the actions and capacities of national and local actors. The event on July 29, 2004 resulted in a balancing act that reflected the team's belief that MSF can provide an opportunity for people living with HIV/AIDS to confront their government, but should not speak for them. While MSF succeeded in striking a balance in Arua, we will need to continue to evaluate the effectiveness of this strategy as the context evolves. ■

1- In the presence the minister of health, Stephan Lewis, the United Nations' special envoy for HIV/AIDS in Africa, representatives of the Global Fund, Unicef, WHO, the American embassy and international HIV/AIDS patient networks.

→ **Arua** © MSF - July 2004

Fake progress

MSF / January 2005 / Presse release

On January 25 MSF issued a press release in reaction to the publication by the World Health Organisation (WHO) of its «3 by 5» progress report. For MSF, not only is the 'progress' not progress, it also tries to mask the little international response to the Aids pandemic and the increasing obstacles to access to medications – particularly generics. Here is the MSF press release.

Only 12% of the world's 6 million AIDS patients at risk of death have access to treatment. The WHO's self-satisfaction of the progress of the '3 by 5' initiative masks the fact that the target set cannot be reached.

→ **Mozambic** © Martin Beaulieu - 2004

MSF is angry at the WHO's self-satisfaction. In its '3 by 5'[1] progress report, the WHO congratulates itself on the '«spectacular increase» and the «extraordinary efforts » concerning the fight against the AIDSpandemic. However only 700.000, or 12%, of the nearly six million people urgently in need of antiretroviral (ARV) treatment have access to it today. The World Health Organisation seems to draw satisfaction from these shocking figures. Our experience of treating AIDS patients –Médecins Sans Frontières treats over 25.000 patients in 27 countries with ARVs– brings us to the opposite conclusion.

Treatment expansion is moving at a snail's pace. Only 260.000 new patients have started ARV therapy since July 2004. At this rate, how long will the 6 million patients in danger of death have to wait before receiving treatment ? The '3 by 5' target is therfore only a misleading slogan, whereas the pandemic continues to spread: 5 million people become infected by the AIDS virus every year; 8.000 people die of AIDS every day.

Future perspectives are even more alarming: the current response to the pandemic, which is far from sufficient, is being strangled by a series of obstacles and pressures on generics. Yet it was the competition among generics that forced down the price of first line ARVs from 10.000 to 300 dollars per year per patient and thus made it possible to treat patients in developing countries.

Since January 1st 2005, India must abide by WTO regulations. This country, the main producer of affordable ARV generics, can therefore no longer copy new drugs. However, the appearance of resistance to first generation drugs makes access to second generation drugs essential. This leads to a de facto medical apartheid, condemning the world's poorest patients who cannot afford the latest innovations.

Furthermore, countries and pharmaceutical countries that produce brand name ARVs are stepping up their offensives to discredit generic medicines that are already available and to stop their use and production.

Rather than congratulating itself, the World Health organisation should be sounding the alarm and pushing other actors (states, pharmaceutical industries, international institutions) to take a radically different attitude. The two priorities should be to increase the number of patients on ARV and to make innovations available to everyone so as not to abandon patients who are currently under treatment. ■

1- Which targets three million people on ARVs by the end of 2005

ASIA / DRC

MSF and reconstruction?

MSF / January 2005 / Marc Le Pape, sociologist and member of the board of directors / translated by Christopher Scala

MSF does not consider it appropriate to get involved in the reconstruction projects in Asia, yet it is carrying out a hospital rehabilitation programme in the Katanga region of the Democratic Republic of Congo. What is the difference? Marc Le Pape, a member of the board of directors, explains.

→ DRC, Ankoro hospital © MSF - 2004

The exceptional outpouring of generosity came quickly in response to the 26 December disaster in Asia. The reasons for this come quickly too: scope of the tidal wave, archaic fears (the flood, the sudden and irresistible wave, subterranean fractures, Eden laid waste), the presence and death of numerous Western tourists, the disappearance of bodies, the intense media coverage, the fragility of the victims, the lure of South Asia, and the season - Christmas, a joyful time of gift-giving.

On 3 January, as the outpouring gathered momentum, MSF announced that it would stop fundraising. This decision ran against the grain and generated reactions of shock. But the announcement didn't stop there. It described other deadly situations and causes for which MSF and other international organisations and institutions are unable to raise sufficient funds and organise the necessary help. It sought to stir the human emotions of those at the fore of the world's generosity, such as heads of state, politicians, NGO heads, media leaders and artists.

It is true that the aid objectives mentioned by MSF in the 3 January announcement are now regularly mentioned: AIDS victims in Africa and the populations of the Democratic Republic of Congo and Darfur.

Even so, the generous energy continues to be channelled toward South Asia. The unprecedented scope of this energy is sometimes presented as the sign of a new state of mind, the "globalisation of solidarity". It is clear that this does not mean that the objects of concern are globalised, however. This is the basis of MSF's reasoning in stopping donations, to which many NGOs and charity organisations respond: what about reconstruction? Schools, infrastructures, hospitals and health centres, homes, and economic equipment have been destroyed. Let's collect the required funds for the medium and long term while sensitivity to the disaster remains high and donations are coming in.

Acting for and in a hospital, as MSF does, represents a drop of water where immense public concern is necessary. A drop of water and no more, but that's a lot for those whom this assistance allows us to treat.

In response to the outpouring from fundraisers and donors, MSF states that it only raises money to accomplish services that it can render and that it would not get involved in reconstruction projects that should be financed by public development assistance with the involvement of the States, the World Bank, the European Union and other intergovernmental and financial alliances...not by an emergency medical organisation.

There is a large difference between the disaster in South Asia and other situations in which MSF gets involved for several years. MSF runs costly programmes in the Democratic Republic of Congo, including in Katanga. In the small town of Ankoro, MSF provides medical aid and is renovating the hospital needed to house this assistance which could not be properly maintained during the war years (1998-2002). The hospital was looted and destroyed several times (most recently in November 2002), but the Congolese medical team did its best to continue its work. Nobody could expect the State to restore the institution due to the many health centres and hospitals in similar need and the crucial political uncertainty. In other words, if MSF does not step in, it is unlikely that the medical working conditions will improve in this hospital deep in rural Congo. It is more realistic to assume that the reconstruction of the Congolese state takes priority.

Acting for and in a hospital, as MSF does, represents a drop of water where immense public concern is necessary. A drop of water and no more, but that's a lot for those whom this assistance allows us to treat. In the absence of globalised solidarity aimed at the DRC, the purpose of this limited local help is in part to show what can be done in Congo. It is clear that Congo, like nearly all of Africa, is the object of a global devaluation campaign, one of the themes of which is that (most) African countries are pits into which donated money disappears. In response to this negative ideology, the purpose of MSF's project in Ankoro is decidedly not to support a general reconstruction policy. Apart from its immediate medical impact, the project is meant to be a sign that ambitious concern has its place and is effective following a disaster that has lasted years - even in Congo, even during a crisis period. We cannot know the future course of history and if this initiative will have any demonstrative, follow-on effect. ■

"*The unprecedented scope of this energy is sometimes presented as the sign of a new state of mind, the "globalisation of solidarity". It is clear that this does not mean that the objects of concern are globalised, however.*"

INFOS

FROM THE BOARD

To Head of Missions and Field Coordinators

The Board's '*Commission d'examen des adhésions*'[1] would like to recall certain 'warnings' concerning the nature of applications for membership to the MSF association.

It seems there is a confusion between application for membership to the association, application to become an expatriate staff member and application for a job, which means we have been led to refuse certain membership applications.

MSF's statutes state that employees who have been recruited locally in the countries where we work may apply for membership to the association on the condition that they are members of the medical profession or that their competencies are necessary to carry out the operations of the association.

All applicants must be familiar with the Charter and statutes of the association, and all applications must be voluntary.

All persons whose applications have been validated by the Board and who have paid the yearly subscription fee (fixed by the Board) are considered members of the association. Other than voting at the Annual General Meeting and receiving Messages, membership to the association does not give any added rights that may distinguish a member from any other volunteer or MSF employee: being a member does not provide any particular privilege over other members of the team.

Membership to the association does note mean:

- expatriation
- a guarantee of employment
- participation in the coordination team

Members of the association who are present in the field or on field visits must ensure that applicants understand what membership means and what it does and does not bring. All applicants must fill out the application form.

The board « commission d'examen des adhésions »:
Cécile Serre-Combe
Jean-Paul Dixméras
Marc Le Pape

1 - The committee that approves all membership applications to the MSF association.

TRAINING COURSES (EPICENTRE)

→ RESPONSE TO EPIDEMICS

From 7th to 11th March 2005 in MSF Paris headquarters - duration : 5 jours - french speaking session

→ TARGET GROUP

- Medical or para-medical personnel with basic knowledge in epidemiology and at least one experience within an epidemic context
- Priority to capital coordinators, emergency coordinators and national deputy coordinators
- Second line of recruitment: Field coordinators with at least two missions in this position
- Committed for at least another 12 months (for the expatriate in one or several missions)

By the end of the course, the trainee will be able to:

- Carry out an outbreak investigation
- Detect an outbreak
- Define necessary strategies and organise effective management of epidemics

Pathologies involved are : meningitis, diarrhoeal diseases, haemorrhagic fevers, malaria and measles

TRAINING OF TRAINERS

From 29th March to 8th April 2005 in MSF Paris headquarters - duration : 9 days - english speaking session

→ TARGET GROUP

- Medical, para-medical or logistics officer, with prior field experience, preferably in training, likely to train personnel in the context of a medical mission in precarious situation.
- Field coordinators, medical coordinators or any other person who has to coach teams working with training activities.

→ OVERALL OBJECTIVE OF THE COURSE

This course intends to provide a methodology that allows trainees to realize adult learning activities.
This course intends to develop training competencies.

By the end of the course trainees will be able to:

- Analyse a given initial situation
- Plan and prepare a training activity (adapted to the context)
- Prepare and organise a teaching session
- Prepare and organize tutorial activities
- Define and implement a pertinent trainees' evaluation system
- Animate and manage a group

For further information and to apply: contact your desk or Epicentre - Isabelle Beauquesne (01 40 21 29 27) or Danielle Michel (01 40 21 29 48)

WATCH AND READ

New books available in the documentation centre

MSF / Alix Minvielle / December 22nd 2004

→ MEDICAL

COUNSELLING AND THERAPY WITH REFUGEES AND VICTIMS OF TRAUMA : PSYCHOLOGICAL PROBLEMS OF VICTIMS OF WAR, TORTURE AND REPRESSION / G. Van der Veer.- 2e éd.- Chichester : John Wiley & Sons, 1998.- 191 p.

GUIDELINES FOR THE INPATIENT TREATMENT OF SEVERELY MALNOURISHED CHILDREN / A. Ashworth, S. Khanum, A. Jackson, C. Schofield.- Genève : OMS.- 48 p.

L'INTERRUPTION VOLONTAIRE DE GROSSESSE ET SA PRÉVENTION / J-C Pons, F. Vendittelli, P. Lachcar.-Paris : Masson, 2004.- 335 p.- (Pratique en gynécologie-obstétrique)

MANAGING NEWBORN PROBLEMS: A GUIDE FOR DOCTORS, NURSES, AND MIDWIVES / OMS.- Genève : OMS, 2003.- (Integrated Management of Pregnancy and Childbirth)

PREGNANCY, CHILDBIRTH, POSTPARTUM AND NEWBORN CARE: A GUIDE FOR ESSENTIAL PRACTICE / OMS.- Genève : OMS, 2003

SCIENCE ET CONSCIENCE : UNE HISTOIRE DE L'ÉTHIQUE MÉDICALE / B. Halioua.- Paris : Editions Lian Levi, 2004.- 390 p.

VIH ET SIDA : PRISE EN CHARGE ET SUIVI DU PATIENT / C. Katlama, J. Ghosn.- Paris : Masson, 2004.- 178 p.

→ GEOPOLITICAL

ILS NOUS AVAIENT PROMIS LA PAIX : OPÉRATIONS DE L'ONU ET POPULATIONS LOCALES / B Pouligny.- Paris : Presses de Sciences PO, 2004.- 356 p.

INTERVENTIONS HUMANITAIRES ? / Centre Tricontinental.- Alternatives sud, vol. 11, 2004, n° 3.- Paris : Ed. Syllepse, 2004.- 179 p.

LES NOUVEAUX MONDES REBELLES : CONFLITS, TERRORISME ET CONTESTATIONS / J-M Balencie, A. de La Grange.- Paris : Ed. Michalon, 2005.- 503 p.

LE SERMENT TCHÉTCHÈNE : UN CHIRURGIEN DANS LA GUERRE / K. Baiev, R. Daniloff, N. Daniloff.- éd. Française.- Paris : JC Lattès, 2005.- 429 p.

TCHÉTCHÉNIE : UNE AFFAIRE INTÉRIEURE ? RUSSES ET TCHÉTCHÈNES DANS L'ÉTAU DE LA GUERRE / A. Le Huéron, A. Merlin, A. Regamey, S. Serrano.- Paris : Autrement, 2005.- 166 p.

VIOLENT ENTREPRENEURS : THE USE OF FORCE IN THE MAKING OF RUSSIAN CAPITALISM / V. Volkov.- New York : Cornell University Press, 2002.- 201 p.

→ AVAILABLE IN THE DOCUMENTATION - MSF / Christine Dufour

Burundi : Cibitoke, camps de réfugiés du Congo (juin à sept 2004) : C. Besnard / MSF - Iran : programmes de réfugiés afghans de Zahedan (nov 2003) et Masshad (février 2004) + tremblement de terre à Bam (janvier 2004) : JF Corty / MSF - Liberia : TFC dans le Bong (sept 2004) : G. Libeau / MSF - Nepal : Rukum (mai 2004) : C. Morand / MSF Palestine : Gaza : Rafah + Dar el Bala (mai 2004) : A. Sargos - Tchad : Réfugiés du Darfour + choléra à N'Djamena (sept 2004) : P. Poupin / EditingServer.com Thaïlande : Maela village TB (octobre 2004) : S. Marchand / MSF

RECRUITMENT

The fundraising department is recruiting 2 supervisors for its street teams and for the 2005 tour of the « Acteurs d'Urgence » exhibition (M\F)

→ CONTEXT

Médecins Sans Frontières continues to recruit private donors all over France in order to contribute towards increasing its private financial resources which guarantee its independence, efficacy and speed of intervention in the field.

→ THE POSITION

In contact with the operational manager based in Paris, the position involves managing and motivating, both in the street and during the exhibition, a team of 7 mediators whose objective is to recruit new donors.

→ QUALIFICATIONS/COMMENTS

Field experience is an advantage, good leadership and people skills are essential. The position is physically demanding and requires considerable travelling.

→ CONTRACT

The positions are open on fixed-term contracts from mid-March to mid July and from mid-August to mid November.
Closing date for applications : March 1st 2005 . Please contact Fleury GIRARD - 01 40 21 27 40 - fgirard@msf.org

Tribute to Evelyne

Evelyn did not tolerate
injustice or scorn;
She enjoyed honest
and sincere relationships.
She was earnestly committed to MSF;
She went out into the field to bring
more than just relief.
She is missed by her friends
and her patients in Uganda, Sudan,
and Zambia.
Her death leaves a big empty space
in the MSF Rhone-Alps office.

Evelyne Grange died on October 12, 2004

RESOURCES

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For further information:

- on the activities of the French section of MSF: www.msf.fr

- on the activities of the other MSF sections: www.msf.org

TURN OVER HEADQUARTERS

OPÉRATIONS	
→ **Gaëlle FEDIDA**	has replaced Chris BRASHER as RP on desk C.
→ **Nadia AÏD**	has been recruited on a fixed term contract as secretary in the dept: 01/01/05 -31/07/05.
→ **Jean-François CORTY**	is the new ARP on desk C.
FINANCIAL	
→ **Arnaud THERY**	(assistant field financial controller) has replaced Tony VICTORINE who has left MSF.
→ **Elisabeth NGUYEN**	(accountant) has replaced Manuel COLIM.
→ **Chantal MIR**	has joined the department on a fixed term contract until 12/10/05.
LOGISTICS	
→ **Olivier LE GAC**	will be with the dept as radio IT technician until 30/09/05.
→ **François-Pierre LEMETAYER**	is the new logistics supervisor on the team.
RECEPTION AND GENERAL SERVICES	
→ **Jonathan MAHIER**	is working at reception after having worked with the mission in France.
→ **Mathieu JACQUET**	is working in general services after having worked with the mission in France.
→ **Sam LOTTIGIER**	will be working at reception until 31/07/05.
FIELD RH	
→ **Nicolas VEILLEUX**	has been appointed HRO on desk C and replaces Pascale AUGE who left MSF in November.
→ **Frédéric ULMANN**	will be helping active recruitment until 30/11/05.
→ **Alejandra DRANNIKOW**	has been recruited as human resources officer until 19/06/05.
→ **Christa LINKENHEIL**	has been recruited as roving HRO until 30/06/05.
→ **Florence PENFEUNTEUN**	has been recruited on a fixed term contract as assistant HRO in the *bureau des departs*: 03/01/05 - 31/07/05.
→ **Ayni LACHARMOISE**	is helping in the *bureau des départs* until the end of March 2005.
→ **Caroline DECOSTER**	has been recruited human resources officer until 02/05/05.
→ **Pascale PINAY**	has been recruited as HRO to temporarily replace Christophe CANEVET.

Due to the lack of space, others recent mouvements regarding headquarters will be published in the next edition.

POSITIONS TO FILL

→ FIELD VACANCIES

→ ASAP

- Head of mission, Sierra Leone, Freetown, 1 year
- Medical coordinator, Ivory Coast, Abidjan, 1 year
- Medical coordinator, Darfur, El Geneina, 6 months
- Medical coordinator, Chad, N'Jamena, 6 months
- Head of mission, Haiti, Port-au-Prince, 1 year
- Emergencies coordinator, Flying, Everywhere, 1 year
- Nurse field co, Ivory Coast, La macca, 6 months
- Medical field co, Indonesia, Sigli, 3-6 months
- Nurse field co, Darfur, Zalinguei, 6 months
- Medical field co, Poland, Warsaw, 6 months
- non-medical field co, Liberia, Lofa, 6 months
- Nurse field co, Burma, Mudon, 6-9 months
- Nurse field co, Chad, Adre, 6 months
- Nurse field co, Guatemala, Guatemala City, 1 year
- Medical, Darfur, Zalinguei, 6 months
- Medical, Georgia, Sukhumi, 9-12 months
- Medical, Darfur, El Geneina, 6 months
- Medical, DRC, Ankoro, 6-9 months
- Wide-wife, Ivory Coast, Bouake, 6 months
- Psychologist, Poland, Warsaw, 6 months
- Nurse, DRC, Kitengue, 6 months
- Nurse, Haiti, Cité Soleil, 6 months
- Wide-wife, Liberia, Monrovia, 6 months
- Wide-Wife, Burundi, Makamba, 2-3 months
- Administrator logistician, Darfur, Mornay, 6 months
- Logistician, China, Nanning, 3-4 months
- Logistician, Nigeria, Explo/opening, 3 months
- Logistician RT, Indonesia, Djakarta, 3-6 months
- Logistician relief, Sri Lanka, Batticaloa, 3-6 months
- Logistician relief, Sri Lanka, Colombo, 3-6 months
- Watsan, DRC, Katanga, 3 months
- Logistician officer based in capital, Sierra Leone, Freetown, 1 year
- Logistician, DRC, Ankoro, 6 months
- Logistician blanket feeding, Northern Sudan, Darfur/Flying, 6 months
- Financial administrator, Darfur, El Geneina, 3 months
- RRH, Liberia, Monrovia, 1 year
- Field administrator, DRC, Ankoro, 6-9 months
- administrator, China, Nanning, 1 year

→ Mars

- Head of mission, Cambodia, Phnom Penh,1 year
- Medical coordinator, Russia, Moscow, 12-24 months
- Medical coordinator, Southern Sudan, Loki, 1 year
- Head of mission, Southern Sudan, Loki, 1 year
- Medical coordinator (medical), DRC, Kinshasa, 1 year
- Nurse field co, Ivory Coast, Bouake, 6 months
- Nurse field co, Angola, Camabatella, 6 months
- Medical, Liberia, Lofa, 6 months
- TB medical, Thailand, Maesot, 6 months
- Medical, Nepal, Rukum, 6 months
- Psychologist, China, Baoji, 9-12 months
- Psychologist, Occuped Palestian Territories, Gaza, 6 months
- Nurse, Southern Sudan, Kotobi, 6 months
- Technical Lab, Kenya, Mathare, 6-9 months
- Wide-wife/nurse, Uganda, Arua, 6-12 months
- IPD nurse, Darfur, Mornay, 6 months
- Nut nurse, Southern Sudan, Akuem, 6 months
- TB technical lab, Armenia, Erevan, 6 months
- Logistician, Niger, Maradi, 6 months
- RTL, Burma, Rangoon, 1 year
- Logistician, Indonesia, Meulaboh, 3-6 months
- Logistician, Thailand, Maesot, 6 months
- Administrator/Log, Angola, Kaala, 3 months
- Administrator, Uganda, Kampala, 1 year
- RHH, Uganda, Kampala, 1 year
- Administrator, Guinea, Conakry, 1 year
- Administrator, Chad, N'Jamena

A reminder : we also have vacancies for surgeons, anaesthetists and OT nurses in the following missions

Surgeons

Burundi, Makamba, Ivory Coast, Bouake, Guinea, Macenta, Liberia, Monrovia, Chad, Adré, DRC, Ankoro, Haiti, Port-au-Prince

Anaesthetists

Ivory Coast, Bouaké, Guinea, Macenta, Liberia, Monrovia, Chad, Adré, DRC, Ankoro, Haiti, Port-au-Prince

OT Nurses

Ivory Coast, Bouake, Liberia, Monrovia, DRC, Ankoro, Sudan, El Geneina, Haiti, Port-au-Prince

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