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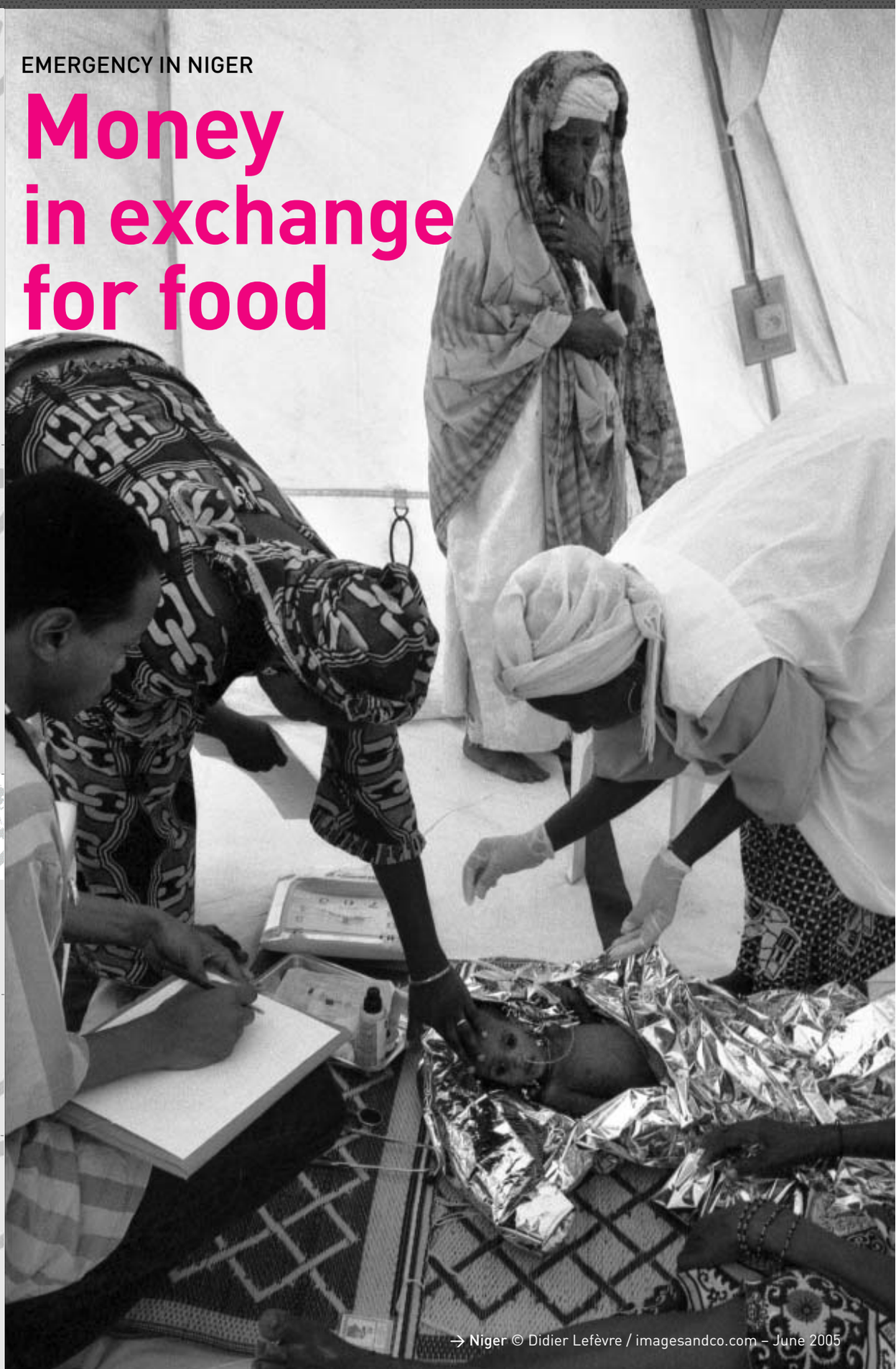
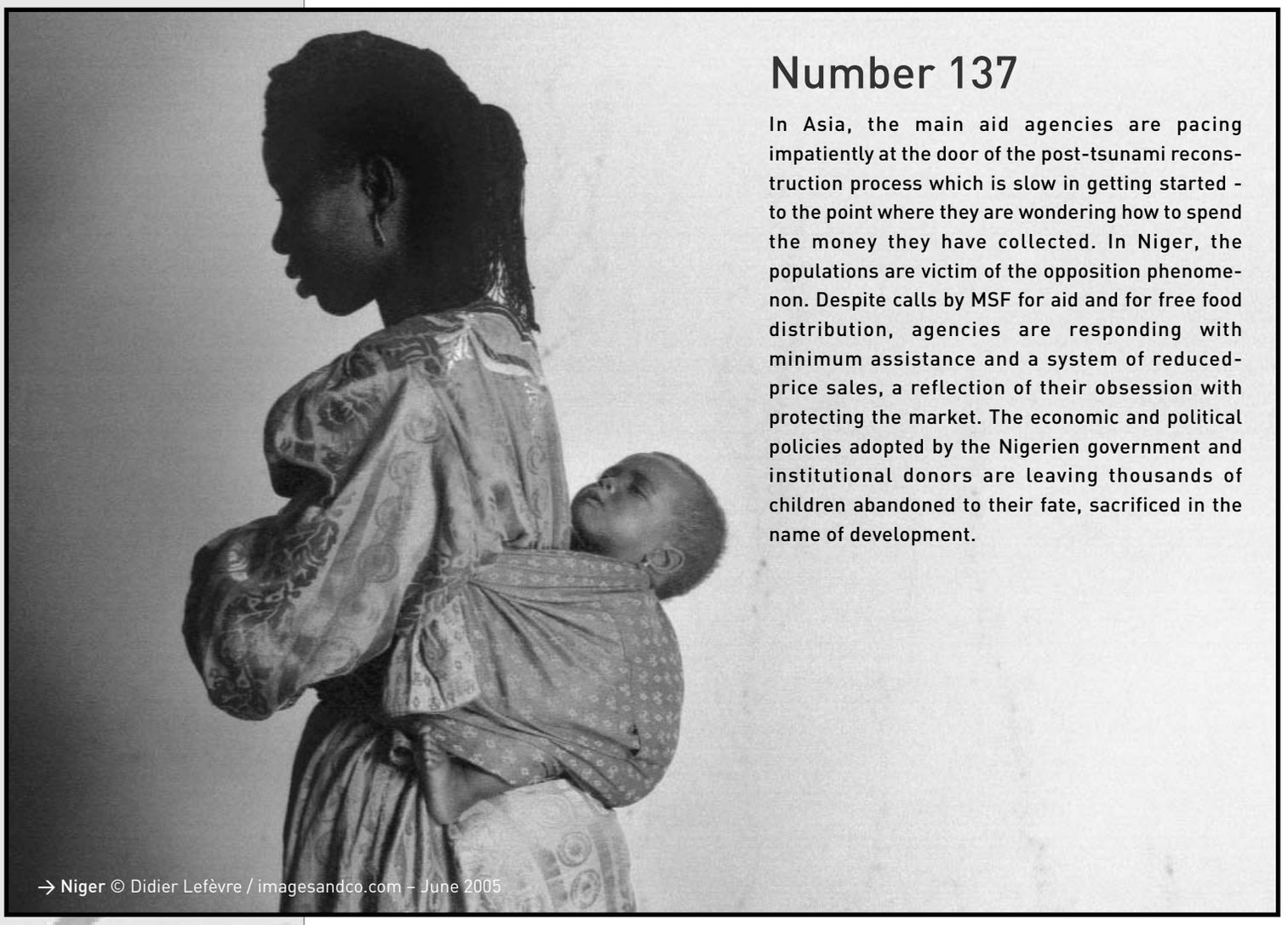


→ Niger © Didier Lefèvre / imagesandco.com – June 2005



→ **Niger** © Didier Lefèvre / imagesandco.com – June 2005

Number 137

In Asia, the main aid agencies are pacing impatiently at the door of the post-tsunami reconstruction process which is slow in getting started - to the point where they are wondering how to spend the money they have collected. In Niger, the populations are victim of the opposition phenomenon. Despite calls by MSF for aid and for free food distribution, agencies are responding with minimum assistance and a system of reduced-price sales, a reflection of their obsession with protecting the market. The economic and political policies adopted by the Nigerien government and institutional donors are leaving thousands of children abandoned to their fate, sacrificed in the name of development.

DOSSIER

EMERGENCY IN NIGER

Money in exchange for food

MSF / June 2005 / Isabelle Defourny, Deputy Programme Manager / Translated by Alison Quayle

An early warning was sounded in October 2004 about the food situation in Niger. Yet in late June 2005, the aid system is still not able to provide appropriate help for the most vulnerable. In effect this amounts to condemning children from Niger's poorest families to death by starvation.

October 2004. A mission[1] revealed an expected shortfall of 223,000 metric tonnes of grain in Niger for the year 2004-2005, representing 7.5 % of the country's needs. While this shortfall is not enormous on a national scale, the mission explained that this must not mask the extreme nutritional vulnerability of more than 3 million people in over 3,000 villages. The mission recommended that the public authorities and organisations involved in development programmes should intervene to make up the grain shortfall.

Following this assessment, the government of Niger made a request to the World Food Programme (WFP) for 78,000 metric tonnes of grain at the end of November. Niger received only 6,562 metric tonnes, in other words less than 10 % of what they had asked for.

During January, February and March, there was a significant increase in the number of children suffering from severe malnutrition in the centres run by Médecins Sans Frontières. In April, various nutritional surveys confirmed how serious the situation was. Niger's National Assembly launched its own emergency food aid appeal to the international community.

On May 19th, the UN asked for 16 million dollars to contain the crisis. A

> *"The food crisis has been officially acknowledged, yet effectively denied, as evidenced by the lack of emergency free food distributions. The government and institutional donors are leaving NGOs to set up this "appropriate method of free, targeted food distributions", while their main preoccupation is to protect the market."*
>
> **Excerpt from the MSF briefing document, June 28, 2005**

few days later, Niger's Prime Minister reiterated his government's appeal.

→ THOSE MOST AT RISK HAVE TO PAY FOR FOOD...

How is it that, despite these repeated warnings, there has still been no response? Faced with this crisis, the only reaction of the Niger authorities - with the support of the international agencies and development organizations - has been to set up a system to sell millet at a "reduced price".
Between September 2004 and June 2005, 42,000 metric tonnes of millet were sold at below-market prices. These quantities, for 3.4 million people at risk, are nowhere near enough. They work out at less than 12 kg of millet per person for 9 months, but on average one person eats 20 kg per month!

Most importantly, at the beginning of June, Niger's Prime Minister himself recognised that this initiative was ineffective, when he stated that of the 3.6 million people threatened by food shortages, hundreds of thousands are so poor that they cannot afford to buy grain, even at low prices. Those hardest hit by the food crisis are of course those who are poorest: not only farmers who have suffered bad harvests, but also stockbreeders and artisans. Many have come to the end of their resources, having sold their possessions and their animals in order to buy food.

In practice, these measures come down to making those who have the greatest need and the least money pay for the aid they receive.

The government then suggested another "solution": grain loans, to be repaid after the harvest. This measure may have the advantage of making food immediately available to those who need it most, but it puts a serious strain on the family's reserves for the following year, and perpetuates the vicious circle of poverty.

In practice, these measures come down to making those who have the greatest need and the least money pay for the aid they receive.

→ ... AND HEALTH CARE IS BEYOND REACH FOR THE POOR

The situation regarding medical care for severely malnourished children (those at immediate risk of dying) is straightforward: health care in Niger has to be paid for, and the poor cannot afford it. For the moment, MSF is one of the few humanitarian agencies to have set up a treatment programme for the malnourished.
Retrospective mortality surveys among children under 5, carried out by Epicentre and MSF in April in the Keita, Dakoro and Mayayi areas, showed mortality rates already above emergency levels, at a time of year when there is little disease. Once the rainy season arrives in June, diarrhoea and malaria will appear and will make the situation of children already weakened by lack of food even more precarious. Although it would stop the situation getting worse and would prevent a great many deaths, free food distribution in the areas worst affected by food shortages always raises strong reservations among institutional donors, UN agencies and the government, and it is still not on the agenda. The various parties involved always cite the risk of destabilizing the market to justify their refusal, and it takes precedence over the need to deploy vital aid

Once the rainy season arrives in June, diarrhoea and malaria will appear and will make the situation of children already weakened by lack of food even more precarious.

to prevent the weakest from sinking into malnutrition and dying very quickly. Free medical care for children under five in the hardest-hit regions has also not been set up yet, despite the promises of Niger's Health Minister.
This refusal to recognize the urgency of the situation and to consider exceptional measures amounts to condemning children from tens of thousands of Niger's poorest families to death by starvation. ■

1- Joint mission run by two UN agencies (Food and Agriculture Organisation, World Food Programme) and the CILSS (Permanent Interstate Committee for Drought Control in the Sahel).

EMERGENCY IN NIGER

Niger: the sacrificial victims of development

MSF / June 2005 / Interview by Anne Yzebe/ Translated by Marcy St John

The food security system in Niger has undergone serious changes over the past thirty years. Once based on state control of prices, it is now jointly managed by the state and by institutional donors with the purpose of developing trade. Jean-Hervé Jezequel, social sciences researcher, spent two weeks in Niger studying the food security 'action plan' that has been set up.

→ What is the policy on prevention and management of food crises in Niger?
Without embellishing the past, before the 1980s there was a strict system of price restraints on food products. The OPVN, the office of food products in Niger, imposed price controls on merchants, sometimes with backup from security forces. During the 1980s, structural adjustment policies led the Nigerien government to dismantle this system which was hindering free market forces. To replace it, the main institutional donors (France, the European Union), the U.N. agencies (WFP, FAO...), and the state joined together to develop in 1998 a new food security mechanism called "the action plan". It was endowed with national security reserves and an intervention fund. In 2000, the Operational Strategy for Food Security [SOSA] detailed the philosophy of the "action plan". It set forth the two main objectives: one is the ongoing improvement of food security and crisis prevention, and the other is the management of food crises. SOSA points out that there must not be any prioritization of these two goals; long-range policy, concerning development, and short-term assistance, in the case of crisis, are considered complementary. It also insists that "food security is a public service". This is what the texts say in writing. The reality on the ground is quite different.

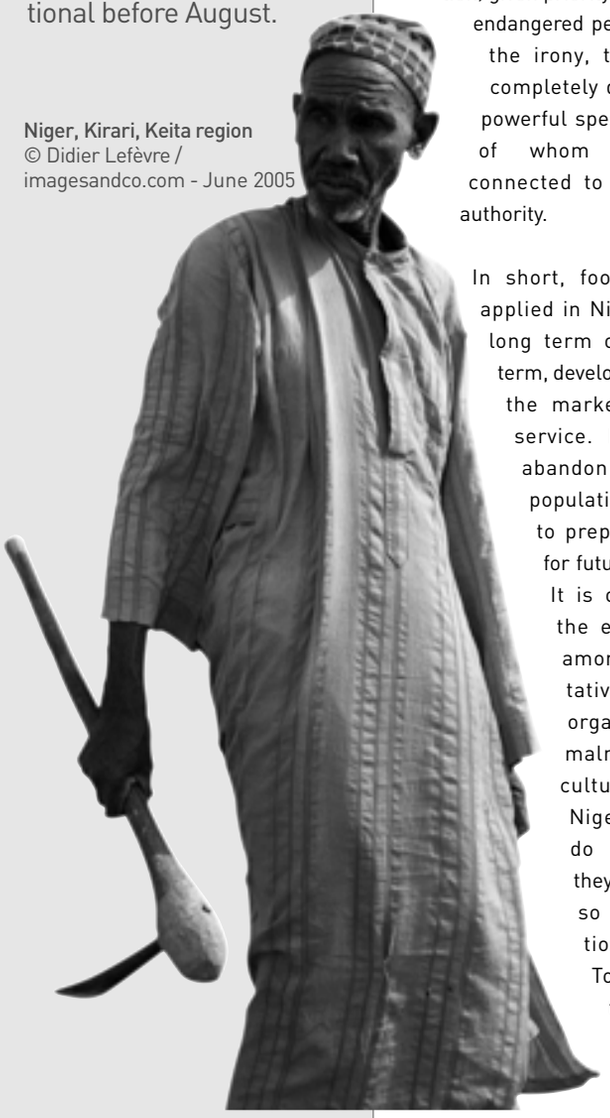
→ What is the response to the current food crisis?
It is barely an exaggeration to say that they are responding to a crisis situation by building dikes for irrigated agriculture! The tools being used are those of development, often inappropriate for the current crisis situation. For example, the grain banks that were created in haste are rapidly running out of funds; the capital lent out at the start cannot be repaid. The action plan also uses sales at reduced prices, but the volume is clearly not enough to really have an impact on the market and has therefore been ineffective in lowering the price of millet. Furthermore, these sales do not provide the people most at risk with access to food. What does selling at reduced price mean? In practice, it obliges a farmer to buy a sack of millet at twice his production cost, at 10,000 CFAfr at the subsidized price versus 4000 to 6000 CFAfr when bought in October. But they continue with this tool, because emergency aid, meaning free distributions, is considered as a last-resort solution that they are reluctant to use.
Thus, in early June, at a meeting of the Joint Commission for

DOSSIER

NIGER : MONEY IN EXCHANGE FOR FOOD

POINT INFO

→ 08/07/05
Niger : waiting
Despite our appeals for help, aid agencies are taking a long time to set up operations : apart from World Vision and ACF, there has been almost no concrete assistance provided. The WFP has still not declared an emergency, and SCF and OXFAM will not be operational before August.



Niger, Kirari, Keita region
© Didier Lefèvre / imagesandco.com - June 2005

Consultation, the decision-making body of the "action plan" which includes representatives of the state and of institutional donors, the government of Niger declared that despite the seriousness of the food crisis, it would not set up any free distribution operations. The only political reaction from the institutional donors came from the ambassador of France, who was glad that there was a "policy that will not destabilize the markets". The ambience was almost surreal: ignoring the emergency food situation, economic considerations were, without hesitation, given priority over the fate of endangered people. To top off the irony, this market is completely destabilized by powerful speculators, many of whom are closely connected to the people in authority.

The only political reaction from the institutional donors came from the ambassador of France, who was glad that there was a "policy that will not destabilize the markets".

In short, food security as applied in Niger favors the long term over the short term, development over aid, the market over public service. It chooses to abandon the present population by claiming to prepare protection for future generations. It is often heard in the embassies and among representatives of U.N. organizations that malnutrition has a cultural cause: in Niger, children do not count, they are neglected, so malnutrition is prevalent. To see proof of the opposite, one has only to visit the CRENI [Intensive therapeutic Feeding Center] at Maradi and observe the relationships between mothers and their children. In view of how the food security situation is approached by international agencies and by the government, one wonders today who it is that is really neglecting the fate of Nigerien children.

→ Isn't the early warning system supposed to monitor the health situation of the population?
But it is not the health situation that is closely watched, it's the grain deficit! Why are there figures to the exact ton on the amount of the grain deficit, and meanwhile no figures on how many children are suffering from malnutrition and where? Health information has been practically nonexistent since USAID [U.S. Agency for International Development] dropped its support of the National Health Information System in 1997! To what extent does this lack of data reflect a lack of interest by the international community and by the Nigerien government in its population? All that can be said is that the resources are focused on the measurement of grain production and on the condition of the market, not on the condition of the population's health. Moreover, one is not necessarily representative of the other. First, because malnutrition depends in part on access to healthcare, not solely access to food. Secondly, our basic precept is that the food crisis is linked to bad harvests, but the reality is much more complex. Third, we must remember that determining vulnerability has political ramifications, since food aid is going to depend on it. Each village wants to make sure it is not overlooked. Thus the zones of vulnerability, as well as the dates for intervention, are defined via criteria that are not all strictly relevant...This year, sales at reduced prices began in November, one month before the presidential elections. It is undoubtedly not by chance that the rural populations call these sales "the special presidential operation".

→ If the crisis is not due solely to the grain deficit, what happened?
This is very complicated, and any answer is, of necessity, a partial one. It is not automatically the villages with the worst harvests that have the fewest resources. For example, in the northern part of the agro-pastoral area, migration to urban areas is a significant source of income which adds to and sometimes exceeds agricultural production. It's this income from urban migration that allows people to get through lean periods. The interruption of migration towards Côte d'Ivoire or Togo can have direct consequences on the food situation in these villages...This crisis did not begin in 2004 with bad harvests! Throughout the southern zone, the farming zone, especially Maradi, the farmers sell a portion of their production at the end of the harvest, around October. It's the main source of income, to have some money for weddings, clothing, for social life in general. But if they find themselves short on reserves during the lean period, between June and September, they often have to buy back millet at much higher prices, prices that are exploding this year. In the month of October, a 100 kilo bag sold at 4000 to 6000 CFAfr: this year, in June, it has gone up to 23,000 CFAfr in the markets. Purchasing power has gone down, but since millet is an indispensable staple food, farmers have no choice other than to go into debt. So they fall back on bartering: a 100 kilo bag received now in exchange for four or five delivered at harvest time-an interest rate of 400%-500%! The failure of the policy of development combined with the speculative operations of the grain market translates into the indebtedness of a whole segment of the population. Malnutrition does not depend solely on resources, which themselves do not depend solely on agricultural production. Perhaps the plan of action does not refuse, in so many words, to bring help to populations suffering from the food crisis, but in point of fact, priority is given to the policy of development, not to short-term assistance. For fear that aid to the victims of the food crisis might upset the establishment of an effective market system, the plan of action is reluctant to use emergency measures such as free distribution of food. ■

Health information has been practically nonexistent since USAID [U.S. Agency for International Development] dropped its support of the National Health Information System in 1997!

→ Niger © Didier Lefèvre / imagesandco.com - June 2005

EMERGENCY IN NIGER

"Free food distributions must be organised"

MSF / June 2005 / Interview by A.Y. / Translated by Alison Keroack

At the beginning of June, MSF teams opened a fourth therapeutic feeding centre in Tahoua. A Nigerien nurse working for MSF since 2001, Issiaka Abdou is the mission's field coordinator. He does not hide his concern about the deterioration of the nutritional situation here, and the inadequacy of national and international mobilization.

→ It's been two months now since MSF sounded the alarm about the malnutrition situation in Niger. What has changed since then?

You would expect an immediate reaction when faced with such an emergency. However, nothing, or almost nothing, has changed on the ground.

Besides the feeding centre in Maradi, opened in 2001, Médecins Sans Frontières has opened three new centres in Dakoro, Keita, and Tahoua. 27 ambulatory feeding centres now complete this activity. Admissions continue to increase, with close to 1,000 children suffering from severe malnutrition admitted each week in the month of June! However children suffering from moderate malnutrition also need medical care.

Although there is talk of various projects, they are taking a long time to materialize. The crisis has now been acknowledged. The government has asked for aid, and organizations have launched funding appeals. But apart from this change of position, nothing in fact is happening! Food aid on the ground is not arriving - or very little- to the families who need it most, and access to care is still very limited. What are we waiting for? The worst will happen soon if nothing is done. Food needs to be distributed as quickly as possible and children under five need free access to healthcare.

→ Why has the urgency moved up a notch?

A nutrition survey in April showed that one child in five was suffering from malnutrition in the villages in the north of Maradi and Tahoua provinces. Out of 1,500 families surveyed, 67 mothers reported having lost a child less than five years old in the last one hundred days, which indicated a mortality rate already higher than emergency threshold.

Since then, the situation has become even worse. We already see many cases of severe malnutrition: children who weigh between three and five kilos at the age of one or even two years old... Not all of them survive. Each week there are between ten and twenty deaths. Besides these, how many die in the villages without anyone knowing?

The beginning of the rainy season in June increases the risk for weakened children of deteriorating into severe malnutrition and dying: malaria, diarrhoea, or respiratory infections are becoming increasingly common. Weakened children do not have the strength to fight disease. Inversely, sick children do not have the strength to swallow what little food they have.

It is already too late for some. But for the rest who still have a chance, we must act quickly.

→ Don't health centres in Niger take care of sick and malnourished children?

Theoretically, in Niger all patients have to pay the consultation fees, but all medications are free. In reality, the consultation fee costs between 300 and 600 CFAfr (0.5-1 euros) for children, and medications are not free. For instance, at the hospital in Tahoua during the month of May, we calculated that on average, the prescription for a child suffering from malnutrition costs around 15,000 CFAfr (23 euros). Those who cannot pay do not receive any medications. As a result, very few children have access to care.

In 26 health centres children are provided free healthcare on the day that

> *"To allow affected populations to devote themselves exclusively to farm work, the mission recommends the continuance, reinforcement and close monitoring of actions undertaken to alleviate the crisis: the sale of cereals and animal feed at reduced prices, food-for-work and cash-for-work programmes, cereal banks and farm credit, all of which should target the most vulnerable households"*
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> **Excerpts from a joint WFP, FEWS NET, CC/SAP report (World Food Programme - Famine Early Warning Systems - Early Warning System Coordination Unit) June 15 2005**

Niger © Didier Lefèvre / imagesandco.com
June 2005

→ The financing of our operations

Although MSF collected 106 million euros internationally after the catastrophe in Asie, the total international budget for its Tsunami programmes is estimated at 24 million euros. Respecting its promise, MSF has decided to contact its donors to ask whether they agree that their earmarked donation be used for other emergencies or forgotten crises. The emergency programme in Niger is just such a case (an estimated budget of 8 million euros until October) and explains why we have not launched a public fundraising appeal for this emergency.

an MSF ambulatory feeding centre is present in the village. The Prime Minister has recently asked that all malnourished children be provided free healthcare. It remains to be seen whether this measure will be applied. Sick children who are not yet malnourished must also be provided free healthcare before they start to lose weight.

→ In the areas worst affected by malnutrition, new sales at reduced price and "rural credits" have been announced. Why ask for free food distributions?

Those who have no money left cannot pay, even at reduced prices. The poorest are excluded from this aid system. This is why the government wants to put the rural credit into effect: families would receive three 100-kilo bags of cereals, to be repaid in October. We don't know yet how this will work- who will receive this aid and in what time frame. In particular, the question to ask is how many families will be able to repay these three bags and in what time frame? Even in years with a good harvest, there is a lean period during which malnutrition increases. In Maradi, we have observed this every year since 2001. What is a good harvest? Seven months of reserves, until May. This means that reimbursing two months' worth of food in October leaves only five months' worth of reserves. There is therefore the risk of significant malnutrition from next April onward.

This is why free food distribution are essential in the most severely affected villages. This allows families to feed themselves without selling their goods, without mortgaging future harvests, and thus avoiding a vicious circle. ■

EMERGENCY IN NIGER

Operation XXL

MSF/ June 2005/ Interview by A.Y. / Translated by Alison Keroack

With 6,000 tons of food aid expected and close to 450 people mobilized, the emergency mission in Niger is one of the largest malnutrition treatment programmes in the history of MSF. Program manager Emmanuel Drouhin describes the projects and the resources deployed.

→ What is our current treatment capacity in Niger?

We expect 20,000 admissions in our programs in Niger this year. In 2004, we treated 10,000 children - this was a third of all admissions in our feeding programs worldwide. During the first semester of 2005 we have already treated 9,000 children: admissions, however, double in the second semester. Out of five therapeutic feeding centres, four opened between April and June. And we've gone from ten to over thirty ambulatory centres. There are currently approximately 3,600 children in our programme, of which 600 are in the internal phase and 3,000 are in the external phase. The average length of hospitalisation is five days, and treatment lasts for a month.``

The programme targets children between six months and five years old, however it is mainly children under three who end up in our centres; close to half of them suffer from associated illnesses. There are four doctors per feeding centre for hospitalisations and others who work in the ambulatory centres. Nevertheless, the mortality rate among children released from our programmes is approximately 6%.

→ What measures have we set up concerning access to care?

Moderately malnourished or sick children who come to the ambulatory centres receive free consultations and medications. Some are referred to hospitals when the situation calls for it, but these cases are still rare. We want to reinforce our capacity to provide medical assistance as access to health care is a major problem. The incidence of diarrhoea and malaria is going to increase in the rainy season; we can no longer simply provide one consultation day per week, when our teams pass through. We are thinking of setting up pharmacies, treatment protocols and a way of remunerating personnel so that sick children can receive free care in existing health centres. We must also try to refer patients to a health care facility, whether it's one of our feeding centres or a hospital.

→ Access to food is also a major problem. What are we doing about it?

Right now, we are distributing food rations to children admitted to our programs. During treatment, they receive a 'protection' ration consisting of 25kg of Unimix and 5 litres of oil. When they leave the programme, we give them a family ration of 50kg of millet, 25 kg of *niebe* (beans), and 10 litres of oil. It's an enormous logistics operation, which includes two warehouses with a capacity of 500 to 1,000 tons based in Maradi and Tahoua. We have two other warehouses in Keita and Dakoro, with a capacity of around a hundred tons each. This setup is essential to ensure a daily supply to the ambulatory centres.

We are going to reinforce our food distributions even further, however, since up until now we have had to turn away moderately malnourished patients. I've seen mothers go on strike- they refuse to move, to leave with nothing! Other NGOs are finally arriving to distribute food to the malnourished, but they are going to work north of Maradi. In the south, we will distribute rations to moderately malnourished children who come to our centres: 25 kilos of Unimix and 5 litres of oil per child per month for three months, until the harvests at the end of September. ■

Indonesia, Meulaboh © Stefan Pleger – February 2005

Six months after the tsunami disaster that ravaged the coasts of Southeast Asia, a debate has started at MSF on the veritable utility of our action in a context of unprecedented mobilization. What activities are we running, and what issues does our intervention raise?

ASIA - NIGER

A two-tier aid system?

MSF / July 2005 / Thierry Allafort, head of the emergency sector, and Bénédicte Jeannerod, deputy communication director / Translated by Eurotexte

Whereas hundreds of aid organizations are still present in the regions of Sri Lanka and Indonesia that were affected by the tsunami, nobody seems interested in helping Niger and its tens of thousands of inhabitants who are facing a serious food crisis. The main concern of a number of organization leaders is to spend "down to the last cent" of the billions of dollars raised after the fatal tsunami and to avoid wasting money as much as possible. Yet the only aid that has been offered to victims of the food shortage in Niger by local authorities, international organizations, and institutional donors is completely inadequate; the aid has to be paid for, and most families cannot afford it.

In the case of the tsunami, the main consequence of the disaster was that nearly 300,000 people died, suddenly and brutally, and significant areas of the coastline were destroyed. Survivors of the flooded areas lost all they owned and were left only with the pain caused by the deaths of their loved ones. In short, their lives fell apart. Yet their survival was not threatened. The tsunamis hit relatively developed countries which, at a national level, were only slightly destabilized by the disaster: administrative authorities, health systems, distribution networks and mutual aid networks continued to function. This was evident in the days following the tragedy and even more afterwards.

Once the few weeks of emergency were over, the needs of flooded populations were and still are mainly a matter of reconstruction and the politics of land and ownership: the priority for these populations is to be able to re-establish themselves on a piece of land, to have a house, to find work, etc. Governments and relevant

DOSSIER

TSUNAMI : SIX MONTHS LATER

→ Six years ago

"One of the most common myths associated with natural disasters is that cadavers are responsible for epidemics. In many cases, the management of cadavers rests on the false belief that they represent an epidemic hazard if not immediately buried or burned. In fact, the health hazard associated with dead bodies is negligible."

Excerpt from a WHO press release dated August 20th 1999

operators (town planners, builders, public works companies, etc.) are now at the centre of the process, which will mostly be financed from the budgets of the governments concerned and with bilateral aid (indirectly, our taxes). Private humanitarian organizations will play only a marginal role through micro-projects, in some remote regions and with excluded communities that are neglected by state powers. The presence of NGOs and of their financial help is not a deciding factor: the only deciding factors will be the reality of inter-state commitments and the political determination of the Sri Lankan and Indonesian authorities to care for their citizens, to redefine land occupation and town planning projects, to make it possible for families to return to their plots of land or elsewhere, to set out specifications for building homes, to entrust markets to private companies, etc. Like in Honduras, Iran, and even France (Toulouse), this process will take years, and the public's generosity will not make much of a difference. This is because NGOs do not have decision-making power in these areas. Contrary to a rather popular belief, humanitarianism cannot solve everything...

In the case of Niger, we are faced with a life-threatening emergency. In other words, assistance could mean the difference between life and death (...)

→ NIGER: AID STILL COMES AT A PRICE

In the case of Niger, we are faced with a life-threatening emergency. In other words, assistance could mean the difference between life and death: if the tens of thousands of families who have used up their food stocks four months before the next harvest do not immediately receive free food, children will deteriorate into acute malnutrition and their survival will be endangered.

If children who are already sick do not immediately receive medical care, they will be doomed within a very short time. 1000 children suffering from acute malnutrition are admitted to our programmes every week. Despite this, the humanitarian organizations and United Nations agencies responding to this emergency situation can be counted on the fingers of one hand, and the only offer being made to people faced with this serious crisis is to make them pay for aid: to preserve the equilibrium of the local millet market in the area, the authorities in Niger and institutional donors are refusing to set up free food handouts in the most affected towns, and they are offering millet that is less expensive than before but not free; that is, it is inaccessible for the most destitute populations, the same people who are suffering the most from a lack of food. In regions of Southeast Asia however, in the minds of the same humanitarian players, the issue of destabilizing local markets with the arrival of 'rich' foreign organizations (real estate market inflation, price increases for essential goods, qualified human resources moving from local markets to international organisations that pay more, etc.) was not a reason to stop the arrival of aid.

→ "CUSTOMERS" WHO NEED TO BE SATISFIED?

Tsunami, Niger: double standards? The question is shocking and borderline demagogic. Yet it has the merit of showing the illogicality of the aid system, which is widely maintained by aid organizations themselves. The first anomaly, which would then trigger a whole series of other anomalies, was that after the tsunami, aid was deployed not in response to real needs that were evaluated on site and that fell under the responsibility of humanitarian assistance, but rather in response to an unprecedented outpouring of emotion and the desire to spend the colossal amounts of money that had been raised. Although such a phenomenon is not new and cannot be criticised in itself, it is certainly the first time in the history of humanitarian action that the use of aid has been dictated to such an extent by pressure stemming from money and emotion. This pressure was encouraged by the media, which were heavily involved in the fund-raising operation, and it introduced an approach where donors have become "customers" who need to be satisfied. In addition to all of this, there was a diagnostic error concerning the nature of needs and the spread of false information by people who the public saw as 'references': a few days after the disaster, the WHO said for example that more people would die from epidemics than from the tsunami itself. Yet reality clearly contradicted the dismal prediction: people who are used to intervening following natural disasters, including WHO specialists, are well aware that such disasters do not themselves cause epidemics to break out.

This exaggeration, which was added to the other reasons to donate, widened the gap between the surge of public solidarity provoked by the disaster and the needs of survivors, which mostly are no longer a matter for the generosity of the general public but rather for State policy. The archetype of the Western aid worker 'rushing to help victims of the apocalypse' and able to solve everything is nothing new. But it has been pushed to an extreme, perhaps unintentionally, by a large number of media groups and assistance organizations that need to justify to their donors the colossal funds collected.

(...) it is certainly the first time in the history of humanitarian action that the use of aid has been dictated to such an extent by pressure stemming from money and emotion.

Humanitarian organizations are able to provide assistance thanks to public compassion and solidarity. With the agreement of donors, MSF has been able to set up programmes in Niger using funds collected during the Tsunami crisis. If solidarity itself is one of the reasons for intervention, given the lack of solidarity towards the current crisis in Niger MSF is all the more obliged to intervene. ■

INDONESIA

From the tsunami to the consequences of conflict

MSF / June 2005 / Thierry Durand / Translated by Isabelle Andrews

Thierry Durand, MSF France's Head of Mission in Aceh province from March to the end of May 2005, reviews our actions and examines the challenges facing our current programmes.

It's quite difficult to give an appraisal of the emergency activities we set up in response to the direct effects of the tsunami. The presence of a massive number of aid organisations on the ground meant that MSF's action was not distinct, or identified as such by the Indonesians. Neither did it enable focused action in a satisfactory framework; it was a free-for-all.

The emotion provoked by the Christmas apocalypse in South East Asia, which was broadcast round the clock on every channel the world over, prompted unprecedented solidarity and financial generosity. The tumult - and the aid frenzy which immediately followed it - were also disproportionate to actual needs, and Banda Aceh turned into a convention of a multiplicity of organisations in search of land and victims to save. Alongside the usual organisations normally present in such contexts, we saw scientologists, the Mexican army, the French 4x4 federation and a surfers association turning up, to name but a few.

From a medical point of view, given the situation - more dead that injured, disrupted yet existent health services, and large numbers of 'competing' organisations intervening - our action was fairly limited, and consisted mainly of providing support inside facilities run by the ministry of health.

It was not always easy to find our role, which our teams found very frustrating, particularly since they felt that the media coverage of the crisis reflected neither the actual needs of the population nor the activities of intervening NGOs. It would possibly have been a more effective, less frustrating option to have set up an MSF facility for a short period in certain locations.

The distribution of materials (shelters, tools, etc) we organised both in Meulaboh and Sigli, generally went well. Likewise, providing 'reconstruction' materials was a good idea and had a direct impact on over 20,000 families. The small activity of getting boat building started again was a worthwhile initiative, particularly as it was then emulated elsewhere; in many villages where we weren't working, fishermen or other NGOs followed our lead.

→ **Indonesia, Meulaboh** © Stefan Pleger - February 2005

As for treating the victims of the tsunami, it is generally felt that in the end, the most valuable work is that of psychological treatment, i.e. prevention and treatment of post-traumatic disorders.

After the aid gridlock, the situation has settled a little, despite the 155 organisations of various kinds still listed in the province. Although there are still many small sites of displaced or effected people, water and food needs are generally covered and there is therefore no life-threatening situation. From now on, the problems related to the tsunami are more law and land-related: what to reconstruct, and where and how to rebuild. These are not humanitarian issues, and instead highlight the difficult political and social relationship between the population and it's representatives on the one hand, and the government and public financial donors on the other.

As we have neither the sanction nor the skills to intervene in this area, and because Aceh province is the scene of conflict between the Indonesian government and GAM (the Free Aceh Movement), we redirected our activities in April in order to focus on the consequences of the conflict on the population.

On top of our psychological assistance programme and our involvement in the hospital in Beurnoun, we are also covering part of the surgical activity in Sigli hospital (emergencies and surgery for the poorest patients) and have set up mobile clinics in the mountain areas.

At the moment, nothing about our experience in the Pidie district - be it the pathologies encountered there or the day to day life and work of our team - can qualify our activities there as related to the consequences of conflict. Instead we are dealing with roads accidents, strokes, and cases of hypertension, heart failure and diabetes, often in fairly elderly people. We're not seeing the normal repercussions of conflict on populations - injured and displaced people, and other forms of significant indirect damage like the total or partial breakup of public services, health and of the economic fabric of an area. We are in a low-intensity conflict situation, the effects of which may not be immediately perceptible, but that does not mean they do not exist.

We are in a low-intensity conflict situation, the effects of which may not be immediately perceptible, but that does not mean they do not exist.

Our intervention, which is centred in hospitals, probably doesn't enable us to see or understand the nature or scale of the current conflict, or its real consequences on the population. It is a challenge for our programmes; our mobile setups in the mountain areas - those most affected by the conflict - are just starting and should give us a better grasp of the situation. However, when, at regular intervals, we re-evaluate the relevance of our activity and what added value our programmes bring to a country where a network of both public and private healthcare exists, we should consider whether our work is actually linked to the conflict in Aceh. ■

TSUNAMI, OPERATIONAL CHOICES

Our intervention and its limits

MSF / June 2005 / Interview by Olivier Falhun / Translated by Karen Tucker

Graziella Godain, deputy director of operations for the French section of MSF, reviews the assistance we provided in response to the December 26 disaster in Southeast Asia and explains why there are limits to our activities.

"The difficulty with any activity that has the wind in its sails, is that the more wind there is the more it advances. The question is, is it heading in the right direction or it is just drifting. Is this the case with humanitarian action today?"

Excerpt for 'L'humanitaire post-moderne" by Philippe Biberson (ex-president of MSF) in Messages - May 2000

→ **Indonesia, Pasi Rawa** © Stefan Pleger - February 2005

→ Can you explain the steps we took to aid the tsunami victims?

All MSF sections immediately responded by carrying out a number of exploratory missions. We were in the various disaster areas within 24 to 48 hours. It very quickly became apparent that Sri Lanka and Indonesia were the most affected countries. That's where we focused our efforts. MSF's French section set up operations on the east coast of Sri Lanka and in Aceh province in northern Sumatra. Our efforts were divided into three stages based on the situation on the ground. The first stage, emergency medical care, was the shortest. We know that natural disasters cause more deaths than injuries and do not lead to an overall destabilization of the health care system as is the case with war. In both Sri Lanka and Indonesia, local health care workers, not international aid agencies, were the ones who played a decisive role in the survival of seriously wounded victims.

We supported the hospitals in Meulaboh and Sigli by handling post-operative care for the wounded for only about two weeks. At the same time, our teams continued to travel around the region to get a better idea of the situation of affected populations. That allowed us to measure the scope of the national and international response. Humanitarian aid, whether food, medical care or drinking water, flooded in on a massive scale. On the other hand, there weren't enough shelters for affected families. So we distributed tents to families, allowing them to live wherever they wanted - in refugee camps where aid was more available, on their own plot of land or elsewhere. We also distributed

supplies such as tools and kitchen utensils, which was the second stage of our operations in an environment in which aid was reaching a point of saturation, sometimes to the point of absurdity.

In Sri Lanka, one of our teams was the 20th to visit a village the same day, while another team in Indonesia was surprised to find several hundred people who had received no outside aid three weeks after the disaster. Psychological counselling was another need that wasn't being met locally and it's an area in which we have real legitimacy. That was part of our effort and still is today; we're treating people who went through a very traumatic event. We are now in the third stage of our efforts, a stage after the most urgent needs have been taken care of.

→ What does the third stage consist of and is it within MSF's purview now that the victims' survival is no longer at stake?

Once the emergency phase was over, we could have returned home given our areas of expertise and the number of aid agencies involved. But the feeling of solidarity and our donors' confidence in us led us to consider undertaking efforts beyond our usual scope of activity. For example, we decided to build boats to help the people in certain villages in which we had provided resources in order to help them earn a living. Our aim wasn't to rebuild affected villages' entire boat fleet but to encourage imitation, "prime the pump" and give others the desire to do the same thing. After we made sure that raw materials were available, 80 boats were built before many people followed suit and took over - and did an ever better job than us! We came up with other ideas but decided against them. I'm referring especially to the distribution of money in the form of cheques, for example. While the idea was not seriously considered in the Sri Lanka region where we were operating - because the government had distributed money to victims - I don't think it was sufficiently explored for Aceh in Indonesia. Our teams may not have felt comfortable about playing "moving safes" out of fear of creating injustices, or maybe this type of action was just too removed from our usual humanitarian efforts. If this solution had been chosen, I want to emphasize that the money would've been distributed to a limited number of people, whom we would have clearly identified right at the start, like we did for the boats.

→ There was another activity we could have got involved in - reconstruction. Why didn't MSF participate in this?

When people refer to "reconstruction" it is important to specify what they are referring to. This involves urban planning, socioeconomic development, reconfiguring the demographic map, property ownership and plans for occupying land: it is a question of politics involving government officials and bilateral aid between states. They are not talking about floors, nails and four wooden posts topped by corrugated iron! The question is who decides what, what the government wants, who owns what, where you can relocate families who lived along the coats, what decisions will be made about the land registry. And MSF obviously doesn't have the skills or the influence necessary to have a say in this type of decision. In our opinion, that is neither the role nor the place of a humanitarian organization.

We know that natural disasters cause more deaths than injuries and do not lead to an overall destabilization of the health care system as is the case with war.

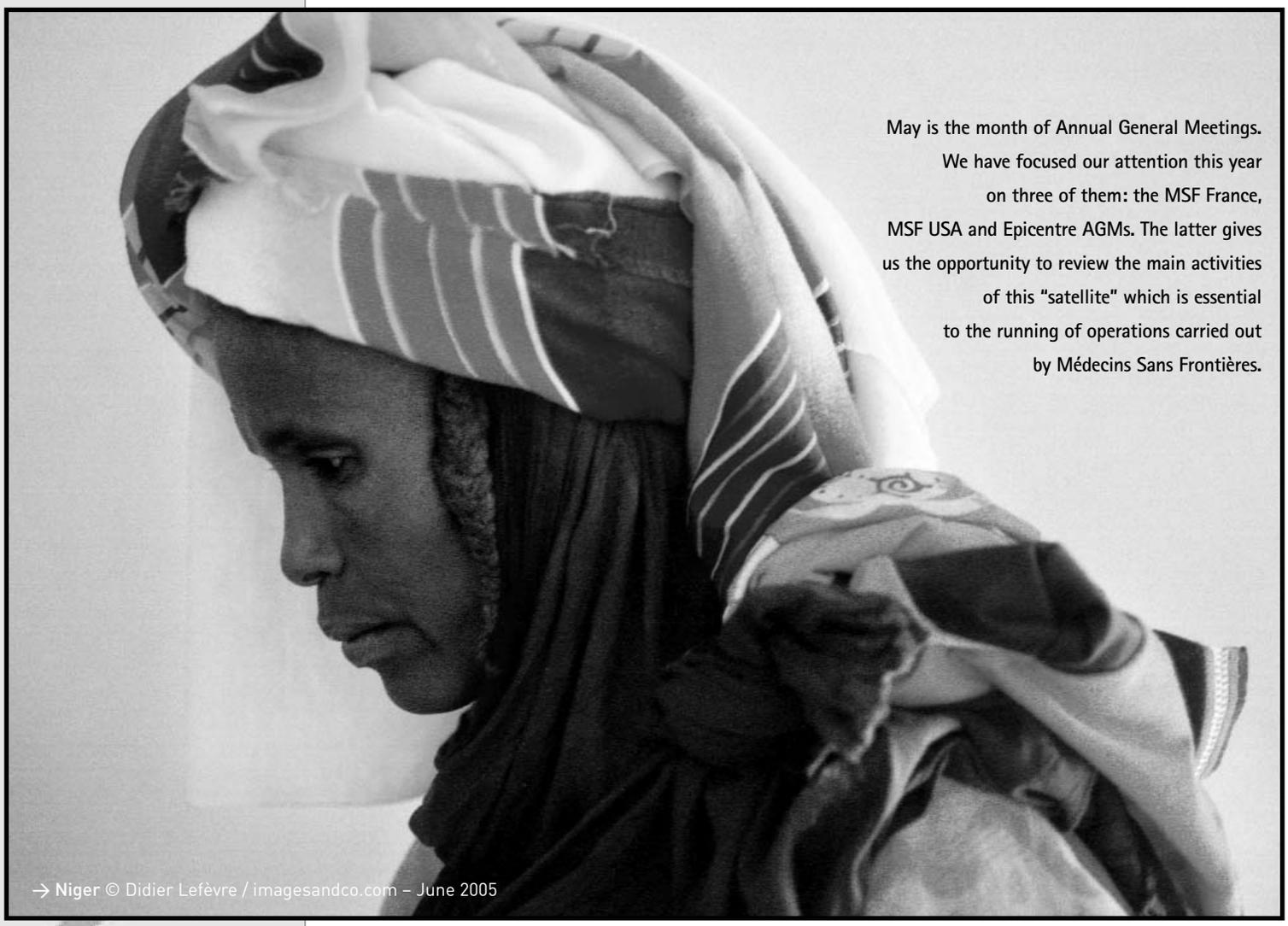
In addition, past experiences - after Hurricane Mitch and the Bam earthquake, for example - demonstrate that the participation of humanitarian organizations in reconstruction is not decisive. That is why we still find shocking situations six months after the tsunami, such as people still living in tents and even by the water. The property, financial and administrative stakes are such that they slow up the process. Our returning volunteers keep saying the same thing when they describe life in Sri Lanka or Aceh today: meetings, negotiations, but reconstruction is at a standstill aside from individuals who are rebuilding on their own. Reconstruction will therefore take a long time and when it finally gets going, it will be construction and other private companies that will win the contracts and play the most important role.

Aid agencies that raised money to invest in reconstruction will have to subcontract their programmes to these companies. Once again, that's not our idea of humanitarian work. As an emergency medical organization, we prefer to use our skills in acute crisis situations that are being ignored, completely abandoned by aid groups, like Niger, where we can save lives in regions seriously affected by food shortages. ■

POINT INFO

→ 08/07/05 ; Nigeria : worrying signs

One week after opening a feeding centre in Katsina (inpatient and ambulatory care), we already have 200 children in care - including some who are very severely malnourished. Katsina is near the border with Niger, about fifty kilometres from Maradi. We launched an assessment mission there after realising that the malnourished children treated by the MSF teams in Maradi came from this region in northern Nigeria. There had also been a measles epidemic in this zone: 27,000 cases had been recorded. With 200 children in the first week, without our teams being proactive, it is very probable that we are going to see a very high number of children. We have therefore sent extra human resources to increase our treatment capacity. A nutrition survey is currently being carried out and a food security survey will also help us to better understand the situation.



→ **Niger** © Didier Lefèvre / imagesandco.com – June 2005

May is the month of Annual General Meetings. We have focused our attention this year on three of them: the MSF France, MSF USA and Epicentre AGMs. The latter gives us the opportunity to review the main activities of this "satellite" which is essential to the running of operations carried out by Médecins Sans Frontières.

DEBATES

AGM 2005 : REVIEW AND PERSPECTIVES

Pressure on our activities

MSF / June 2005 / Interview by Rémi Vallet / Translated by Susan Pasco

On 28th and 29th May, Médecins Sans Frontières held its 34th Annual General Meeting. Dr Jean-Hervé Bradol, president of the association, took this opportunity to recall the main points of the past year. He highlighted the violence and legal pressure exercised against MSF, as well as underlining the progress achieved in terms of quality of action. He also pointed out the areas in which MSF still needs to make an effort.

→ What events in 2004 stand out in your mind?

Last June, the assassination of five of our volunteers in Afghanistan led us to stop all our activities in the country. In November, the last MSF teams still working in Iraq withdrew. These two events underline the fact that when large and powerful political and military coalitions see humanitarian deployment as an integral part of their action, independent organisations cannot find the 'space' in which to work. The confusion between the military and aid organisations that these coalitions fuel results in armed resistance groups targeting humanitarian aid workers and military personnel alike. That said, it must be emphasized that the prime responsibility belongs to these groups, who make a policy of assassinating humanitarian aid workers.

2004 confirmed what we had sensed after Kosovo, i.e. that we had to distance ourselves from the call to "just wars", in order to affirm our independent position. This does not mean we must systematically denounce all military operations, as these can have a positive impact in the short term for the survival

of populations in danger, as shown for example by the British intervention in Sierra Leone, or United Nations' peace-keeping force in Timor.

Another worrying trend is the "judiciarization" of pressure on aid organisations. To reduce embarrassing witnesses to silence, States do not hesitate to expel them from their territory. But when media attention prevents them from keeping observers at a distance, they attempt to muzzle them by taking legal action.

Since the release of our volunteer Arjan Erkel in April 2004, after 20 months of captivity in the North Caucasus, the Dutch government has been claiming a million euros (the ransom it alleges it paid) from MSF and submitted its claim to a court dealing with commercial litigation. It should be noted in passing that the Dutch government has not presented any concrete evidence to sustain the theory of a loan granted to MSF. In reality, it is demanding that we reimburse a ransom in a context of human trafficking. And last week, the Sudanese government arrested and charged two employees of the Dutch section in Sudan for publishing a report on sexual violence in Darfur. This is the first time that MSF has found itself issued with writs simultaneously by two governments who have begun proceedings against it within a few months of each other. And even though the Dutch and Sudanese governments cannot be considered in the same terms, their objectives are similar: to dissimulate crimes of State, such as those committed in Darfur, for the Sudanese government, and those committed in Chechnya by the Russian authorities, concerning the Dutch government.

→ Is your assessment of the programmes conducted by MSF in 2004 satisfactory ?

In 2004, we achieved a record volume of operations, in particular with the highest number of volunteers sent on field operations in the history of MSF. Not that we are operating in a logic of growth for its own sake, but this effort enabled us to save many lives. 4,500 children treated in our feeding centres in Darfur, and 10,000 in Niger, mean that as many deaths have been avoided. This is certainly a reason for satisfaction, and I would like to thank our donors, who make our action possible, as well as our teams.

For the past 7 years, we have prioritized quality of action. To achieve this we have doubled the expenditure dedicated to our programs in the field. We have also continued to defend and affirm our independence.

The aid system is dominated by large inter-state agencies (World Food Programme, UNICEF, WHO) and auxiliary state organizations (bilateral aid). Many NGOs are integrated into this system and depend on it both financially and for ideological reasons. The programmes of these embedded organisations are therefore influenced by political considerations, instead of being constructed on the basis of the immediate needs of populations. If we want to be different, it is not through snobbery, but to develop our aid operations independently, wherever they seem to us to be the most relevant, and as effectively as possible.

For instance, coming back to the tsunami on 26 December 2004: the facts have confirmed our initial diagnosis and are in accordance with pre-existing documentation on natural catastrophes. The earthquake and the tidal wave had an extremely violent impact, but unfortunately they left far more dead than wounded. And, contrary to common myths, natural catastrophes do not in themselves cause epidemics. The devastation of the areas affected by the tsunami was huge, particularly in Indonesia and Sri Lanka, but the resulting needs are above all in the domain of rebuilding. As a humanitarian organisation, this is neither within our purview nor within our capabilities, this is the responsibility of States.

I am therefore very satisfied that we rapidly decided to stop fundraising for this emergency, that we communicated clearly with our donors, taking into account the information that we had received from our teams in the field.

→ In practical terms, how has the quality of MSF operations improved?

In terms of "quality of service", we have just come to the end of a period of great innovation during which we have made progress in numerous areas. To treat malaria, all our teams now use ACT*, the only treatment that is really effective. In the field of food and nutrition, we have improved our treatment, thanks in particular to the use of new therapeutic foods such as Plumpy'nut©, and recourse to general food distributions where necessary. Concerning Aids, we have shown that it is possible to treat patients in poor countries with antiretroviral drugs. And we are now offering better medical treatment to women who have been raped.

ELECTED BOARD MEMBERS - MAY 2005

© Stéphane Gladieu - May 2005

Back row : Dr Pierre-Pascal VANDINI, Dr Marc GASTELLU, Dr Marie-Pierre ALLIE (vice-présidente), Dr Elise KLEMENT (secrétaire générale), **3rd row** : Marc LAVERGNE, Dr Jean-Hervé BRADOL (président), Jacques ALLIX, Anne GUIBERT, **2nd row** : Dr Jean-Paul DIXMERAS (vice-président), Dr Philippe HOUDART (trésorier), Christine NADORI (cooptée), **front row** : Marc LE PAPE (secrétaire général), Michel AGIER, absents de la photo : Marie-Christine FERIR, Sylvie LEMMET, Dr François BOURDILLON.

→ What areas need improvement?

We must be vigilant and ensure that management of our considerable resources does not take precedence over the main purpose of our action, and work on aspects of our operations that still need improvement. We are sometimes satisfied with insufficient "humanitarian standards". When we are working in refugee camps or displaced persons' camps, we are satisfied with one latrine for 100 people, or 20 litres of water per person per day in emergency situations. But after the initial emergency phase, we need to go beyond these minimum requirements. Another example: in our surgical programmes, pain relief is not always provided in a satisfactory manner.

In addition, in medical terms, our progress is sometimes slowed down by our own prejudices concerning patients and our difficulty in questioning the protocols recommended by the World Health Organization (WHO). Tuberculosis treatment is a striking example of this and in stark contrast with the approach we have developed for Aids. We have applied DOTS (Direct Observation Treatment Strategy), advocated by the WHO, to the letter. This is a police-like distribution method - the nursing personnel supply the medication each day as required, and check that patients take it properly - and is very restricting (requiring long hospitalisation of patients), giving rise to treatment being abandoned during the programme. For Aids, by trusting patients to take their treatment correctly, we have set up a remote monitoring system that works well, with a monthly medical consultation to distribute the medication and deal with the side-effects. For tuberculosis, we are just starting to introduce this system of self-administered treatment with remote monitoring.

→ What are the prospects for 2005?

At the moment, we are very worried about the food emergency in Niger. The number of children admitted to our severe malnutrition programmes has increased sharply, and a nutrition survey has revealed the true extent of this alarming situation. We have increased operations and sent additional teams and food to the area, but it is absolutely essential that other aid organisation mobilize in order to avoid a catastrophe. ■

1- ACT : Artemisinin-based combined therapy.

DEBATE AT MSF USA'S AGM

Aids and MSF's responsibility

MSF /June 2005 / Virginie Raisson, MSF-USA Board Member

175 people[1] attended MSF-USA's Annual General Meeting held on June 17-19 in New York City. Thoughtful and provocative debates took place on international governance, operations in conflict areas-in particular, the effectiveness and safety of so-called "remote control" programs--and decentralized operations. But some of the strongest debate came from the discussion on the roles and responsibilities of MSF in the fight against HIV/AIDS.

The debate was marked by strong differences in opinion over the extent of MSF's intervention in the AIDS catastrophe: from the very basic question of defining "our" patients to the limits of the organization's response.

"We should not consider having HIV treatment with antiretrovirals in every project," said Dr. Gildon Beall, an HIV/AIDS specialist who has worked with MSF-France in China and Thailand. Dr. Beall questioned whether the adherence counseling that has been crucial to the success of MSF's AIDS programs could be replicated in refugee camps. Dr. Beall warned, "You can't do [counseling] in a refugee camp or a feeding center where people are not going to come back next week."

The scope of our HIV/AIDS programs was also cause for debate. Some saw MSF as nearing the limits for inclusion of new HIV/AIDS patients.

Dr. Rowan Gillies, MSF International Council President, disagreed: "Refugee camps tend to last for a long time. We have to tell the patient that we will be around for 2 years. And ask them, 'would you like to go for treatment?' And the answer is going to be 'yes.'"

The scope of our HIV/AIDS programs was also cause for debate. Some saw MSF as nearing the limits for inclusion of new HIV/AIDS patients. Dr. Chetan Seshadri, who recently returned from Chiradzulu, Malawi, where MSF-France had to temporarily stop inclusion asked, "Who do we say 'no' to? Who do we send home?"

To which, Gorik Ooms, MSF-Belgium General Director made the case that MSF must look critically at its programs to find a way to meet the needs in the field, "What do you do when you have a cholera epidemic and your cholera treatment center is full-you make it bigger. So I think for AIDS we have to do the same and we have to realize we are so far away from any idea of coverage." He added, The only way we can do it is by relying more on the public health system and, therefore, I think we have an obligation to help make it better. But not necessarily within the whole country."

But Dr. Jean-Herve Bradol, President of MSF-France, disagreed. He challenged the idea that MSF has a responsibility for improving public health systems, and questioned the difficulty of defining 'our' patients.

"When a patient dies we go to the family and we are accountable for this," said Dr. Bradol. "If you delegate this responsibility then no one is accountable. We have 30,000 patients under our responsibility. Our first responsibility is to keep them alive, and this is going to be a fierce challenge."

And part of this responsibility to 'our' patients starts with "not just paying lip service to the idea that we need to be much more seriously involved with the communities we work with," said Rachel Cohen, US Director of the Access Campaign. "MSF needs to get much more serious both at field and international level about how to take into account the feedback we get from 'our' patients, and the communities we work with because they are the ones who have to live with the mess once we leave."

"When a patient dies we go to the family and we are accountable for this," said Dr. Bradol. "If you delegate this responsibility then no one is accountable (...)"

The debate moved on to more general questions about access to health care and whether MSF is confronting barriers to treatment beyond access to drugs and diagnostics, such as the dearth of human resources in the countries where MSF works, or the financial barriers imposed by patient user fees, or the stigma surrounding HIV/AIDS.

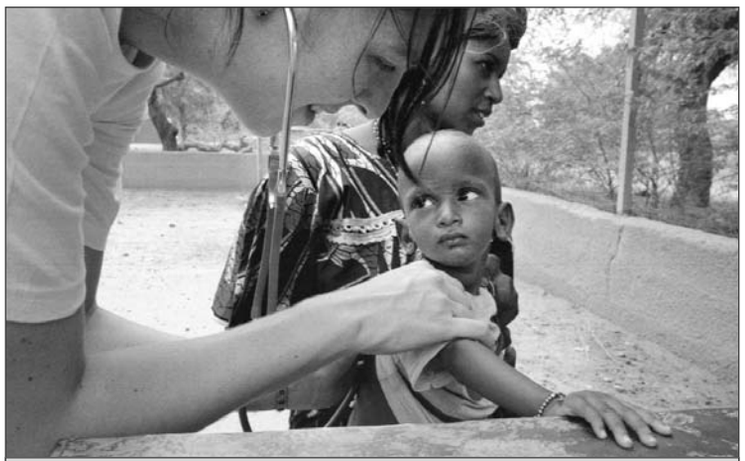
An additional highlight was the introduction of resolutions for the first time. It was a learning process, but many association members participated in the drafting and debating of resolutions. Minutes from the debates and the final resolutions will be made available on the MSF-USA association web site. No doubt the debates will continue. ■

1- This year there was one representative of each MSF section present and attendance was up 32% compared to last year.

Epicentre's current activities

MSF / juin 2005 / Interview by O.F. / Translated by Isabelle Andrews

Epicentre's Annual General Meeting was held on June17th. This important event is an opportunity to recall the main activities of Medecins Sans Frontières' partner organisation. Vincent Brown, General Director of this MSF 'satellite' which specialises in intervention epidemiology, answers our questions.



→ **Niger, Tabalak community** © Didier Lefèvre / imagesandco.com - June 2005

→ What are Epicentre's main areas of intervention?

Epicentre's activity has many facets: consultation and training have now joined the more 'traditional' research-based work of the organisation. Let's look first at the example of research: new strategies introduced into MSF programmes need to be evaluated - strategies such as the use of ACT against malaria, the medical care given to people suffering from AIDS, or the clinical trials of ceftriaxone - as opposed to oily chloramphenicol - to treat a meningitis epidemic. Another important part of our research activity is evaluating laboratory tests. This is particularly relevant in the case of Rapid Diagnosis Tests (RDTs) which are carried out to detect the presence of malaria vectors.

Another major aspect of our work is that of the consultations in the field. These consist of intervention epidemiology missions which are dictated by the urgency of a situation, and thus by definition cannot be scheduled beforehand. These missions help identify the required priority responses in terms of, for example, sanitation, vaccination, nutrition, the setting up of alert or surveillance systems to monitor disease etc.

And last but not least is training. Along with training officers, our epidemiologists and other experts such as statisticians and IT specialists need to be available to respond to the training needs not only of MSF, but also of other institutions such as universities.

Through sessions like the PSP (Populations in Precarious Situations), which we continually update, or training courses on responding to epidemics, we try to ensure that we pass on the key messages - vital of implementing MSF's work in the field - in order to maximise the impact of the programmes and to enable us to properly investigate an epidemic.

Elsewhere, a measles study is currently being conducted (...) The WHO does not recommend mass immunisation campaigns, judging their impact to be insufficient. In order to counter these arguments we need to gather considerable data (...)

→ Can you give us some examples of recent research conducted by Epicentre?

In the fight against malaria (which was the subject of a third of research projects in 2004), we carried out almost 30 efficacy studies over a period of three to four years. These enabled us to prove the inefficacy of most of the medications used up to that point (particularly that of chloroquine), and to choose the best replacement medication. This work has played an integral part in the strategy chosen by MSF i.e. use of ACT. The majority of MSF interventions now use these combination therapies, the efficacy of which is proven.

The second example is that of care for patients with AIDS. The study project in this area represented almost a quarter of our activity, and will continue its logical progression in 2005. We'll particularly keep in mind the adherence study conducted with patients in Malawi after six months of treatment, which confirms biologically the good results which were clinically observed in a cohort study of patients on antiretroviral (ARV) treatment. The need to document the long term outcome of these patients has also prompted another study, being conducted in Cambodia, the preliminary results of which are very encouraging. They show that 85% of patients that have been on ARV treatment for 24 months have survived, with 66% of deaths having occurred over the first six months. Other studies of this type are to follow, particularly in east Africa.

Elsewhere, a measles study is currently being conducted: in relation to the peak of an epidemic, up to what point can mass vaccination be carried out? The Belgian and French sections have asked Epicentre to examine this issue. The WHO does not recommend mass immunisation campaigns, judging their impact to be insufficient. In order to counter these arguments we need to gather considerable data: data gathered at consultations and followed up with proper research studies in several countries. This was started in Niger last year, and continues this year in Nigeria and Chad. These studies are long, and not always easy to implement. There are research projects of varying degrees of complexity in most areas of the work of MSF, for example, neglected diseases, mental health, nutrition, infectious diseases, mortality, emergencies, violence etc.

→ Is this research - and your activities in general - of interest to Medecins Sans Frontieres teams only?

Clearly there are certain studies that are of interest not only to MSF but also to international partners; Epicentre is now widely involved with other organisations. For example, the HIV / AIDS study carried out in Cambodia was in collaboration with the Pasteur Institute of Cambodia, the AP-HP and Inserm , and was co-funded by MSF and Sidaction. This is in fact one of the projects that is establishing Epicentre's legitimacy, and which is helping to strengthen the climate of trust with external partners and the various sections of MSF alike. The internationalisation of the MSF movement must surely contribute to this dynamic as well.

However, for the Epicentre 'tool' to remain coherent with our mandate of 'quality', it is equally important that MSF filters its requests in order to identify priorities. Our obsession with maintaining our ability to react means that we now work on a 'just-in-time' basis. What is more, the increase in our activities over the last two years is forcing us to limit our workload in order to maintain the necessary rigour in our work - which implicates above all of the ethics of our work and the survival and lives of patients, but also the credibility of MSF, and therefore of its 'satellite', Epicentre. ■

1- Artemisinine-based combination therapy

2- Paris public hospitals administration

3- French national institute for health and medical research

TRIBUNE

Humanitarian action on trial

Le Monde / June 14th 2005/ Philippe Ryfman/ Translated by Melanie Stallard

Philippe Ryfman is a lawyer and co-director of the development, international cooperation and humanitarian action DESS[1] at Paris-I university.

At first glance the affair seems trivial: it is just a trial. It is certainly less so when we learn who the protagonists are: on the one side a state, the Netherlands; on the other a non-governmental organisation (NGO), MSF-Switzerland.

The Hague is bringing legal proceedings against the Swiss branch of the international movement Médecins Sans Frontières to claim one million euros (Le *Monde* dated May 29th) - the ransom the Dutch government paid to kidnappers of one of its citizens (Arjan Erkel, kidnapped in the Russian Caucuses on August 12th 2002 and released on April 8th 2004).

The fact that Prime Minister Balkenende's government thus acknowledges having made such a payment, after having virtuously denied it, is in itself a rare occurrence. Generally, states are careful not to admit to this sort of transaction. But the fact that it is demanding its « reimbursement » by the NGO for whom the hostage was on assignment is definitely a first.

For the moment the proceedings are progressing very discreetly. The court dealing with the case is not a criminal court. The dossier has been submitted to the civil division of the county court of Geneva (the headquarters of the association in question are located). Apparently this court does not wish to give the case too much publicity, but there are many discernable signs that in fact these are political proceedings instituted against a humanitarian association.

This is another "first", at least for a democracy. The dossier presents the traditional characteristics of a political trial, i.e. the legal institution being used by the complainant state for objectives that have nothing at all to do with law and justice, but everything to do with political aims. As is usually the case, the political aims are not openly stated.

As far as we know, the legal grounds of the dossier are not at all sound. No loan contract or agreement has ever been signed or even discussed by MSF-Switzerland, any other branch of MSF or a fortiori the international movement,

(...) there are many discernable signs that in fact these are political proceedings instituted against a humanitarian association.

and the complainant government. No letters, no electronic mails and no witness statements were produced at the hearing either. The Dutch Ministry of Foreign Affairs seems to be relying on a simple telephone call made from its Embassy in Moscow to the NGO's office in the Russian capital at the beginning of April 2004.

We cannot really imagine an individual or a firm daring to go to court in similar conditions, with such an empty dossier, in order to claim the reimbursement of an alleged debt of one million euros. But that has not stopped the Dutch government.

Their attitude is even stranger given that their diplomatic resources had displayed continued, distinct apathy during the long detention of a man who is one of their own citizens. They were only roused (in March 2004) by the campaigns led by MSF to raise public awareness in Europe of the hostage's plight.

Strangely, the Dutch government is pretending to forget the obligations a democratic state has towards its citizens (this one was treated as human merchandise); and to forget the rules of international humanitarian law concerning the protection that must be given to humanitarian

workers. This collection of rules clearly applies to the case of Arjan Erkel.

Moreover, by admitting that they « bought » the freedom of the latter, they run the risk of encouraging other kidnappers to take action. And it is scandalous that a state (a law-abiding state) passed on a request that clearly came from the Russian authorities, de facto and without turning a hair. There is no serious doubt that the Russian authorities were involved in dealing with the dossier (to what extent we do not know). They themselves, or at least some of the services that answer to them, had an ambiguous role in this affair - to say the least.

It is normal to question if the Dutch state is pursuing aims other than the simple «recovery» of a sum that, though significant, remains very modest in relation in its annual budget. In other words, isn't what the humanitarian organisation is being blamed for, implicitly and insidiously, its independence and the help it is quite rightly giving to populations that are suffering, in this case the Chechen population?

With these proceedings, the Hague is showing a contrario the status that some large international NGOs have acquired, among them MSF, on the scene of our globalised world. In the various crisis areas and in the complex structure of contemporary international relations, states and inter-state organisations have not been the sole protagonists for a long time now.

What the Dutch state's action seems to be reflecting more deeply is the prolegomenon of a sophisticated attack that some Western states might want to launch on the NGOs that are hindering them politically, so as to try to reduce their weight and influence. Up until now, it was above all dictatorial, authoritarian, or even totalitarian states who displayed their hostility to NGOs, more or less openly. The fact that the attack has been launched by a democratic regime cannot be seen as insignificant.

In other words, when (as is the case in Chechnya at present) the possibility of providing humanitarian assistance is very limited and one of the parties in the conflict (here the Russian authorities) is making it very difficult to help the population, the message delivered to NGOs with this trial, if it is carried through, will be very clear: they will have the choice of being absent or withdrawing!

Such a proposal is evidently unacceptable for the whole of the non-governmental community. The Head of Mission of MSF-Netherlands and one of his deputies were arrested then released on bail by the Sudanese authorities several days ago because of a report (published two months before) on the rapes attributed to the pro-governmental militia in Darfur. This is unlikely to have been a pure coincidence. Very rapidly those hampered by the operations or advocacy role of NGOs will rush to jump at the opportunity these precedents will give them.

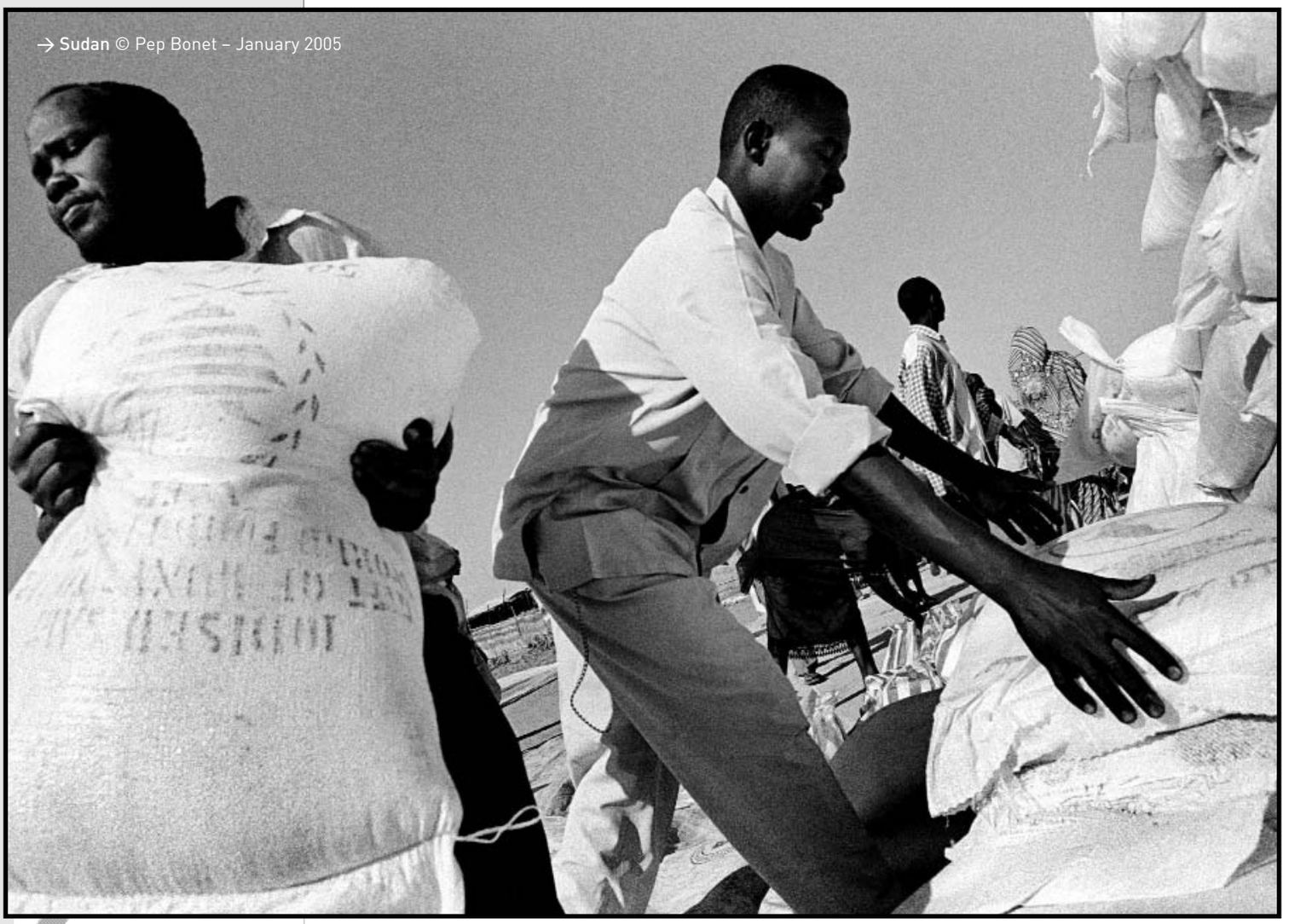
If the claim wins, we must not under-estimate the indirect consequences of such a trial on the already precarious security of the on-site teams, with the probable increase in the risk of kidnapping. And what can be said about the new responsibilities this would place on the management teams of NGOs who insist on remaining loyal to their mandates? As far as insurance is concerned, premiums that are already high for staff on this type of site would probably fly sky high, while claims for compensation by victims of kidnapping, people who have been wounded, or persons entitled under them would grow in number.

the message delivered to NGOs with this trial, if it is carried through, will be very clear: they will have the choice of being absent or withdrawing!

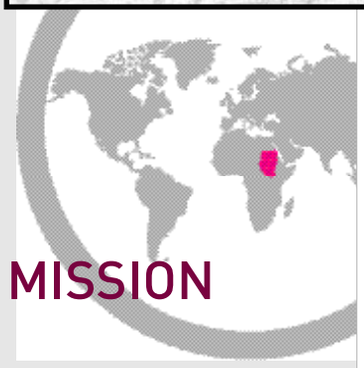
It is thus important for everyone, in the humanitarian community, the states and international organisations to be aware of the scope of such a trial. They should work at different levels to convince the Hague that a simple withdrawal of its claim and the cancellation of the legal proceedings would be the only fair and equitable solution.

Of course, the internal governance at MSF and their own specific stance mean that they have requested neither help nor support from other NGOs. But the humanitarian NGOs, and everyone involved in humanitarian work should offer their unfloundering solidarity. Not to protect or defend a particular organisation or its position, or the NGO environment as such, but because the success of the Dutch government's action would be harmful first and foremost to the very people for whom humanitarian aid is intended, above all in areas where there are so-called "forgotten" crises. ■

1- ***Diplôme d'Etudes Supérieures Spécialisées*** **(post-graduate diploma in an applied subject lasting one year)**



→ **Sudan** © Pep Bonet – January 2005



MISSION

SUDAN : MALNUTRITION

A critical situation in Akuem

MSF / June 2005 / Caroline Livio / Translated by Robert Corner

4% severe malnutrition, 26% global malnutrition, 60 to 70 new admissions per day to our supplementary feeding centre, 40 to 50 per week to the therapeutic feeding centre... The figures speak for themselves, and show the particularly critical nutritional situation reigning during the "hunger gap" in Akuem, Aweil East County, Bahr El Gazal.

→ In Akuem and elsewhere

This year, several parts of Bahr El Gazal are also affected. In the county of Tonj, for example, where MSF Switzerland are working, malnutrition rates are just as high, with 2.8% of severe malnutrition and 21% global malnutrition.

In Bahr el Ghazal the 'hunger gap' is always a period of chronic food insecurity. «In 'normal' years, the sorghum stocks, the main crop of the area, already start to wane in January/February. This leads the population to rely on wild foods, fishing, goat or cow's milk as well as any secondary crops (maize, okra, sesame) that are harvested at the end of July » explains Claire Magone, head of mission in southern Sudan. "Between the end of the sorghum stock and the nearest harvests the 'hunger gap' is therefore a period of attrition - particularly in June and July". In addition to this chronic food insecurity, there are additional factors that increase the risk of malnutrition: insufficient access to water and healthcare, inadequate hygiene conditions and ill adapted weaning practices.

→ THE LAST DROP...

It takes just one aggravating factor to turn this relative insecurity into a real emergency. Last year the low rainfall and the drought that followed resulted in poor harvests and lower food stocks than in previous years. The drought triggers a vicious spiral, as it reduces the grazing available for livestock. To make matters worse, with the signing of the peace process between the

THE CHANGES IN AKUEM AS A RESULT OF THE PEACE PROCESS

Since the signing of the peace agreements the little village of Akuem (pop. 3 000 - 4 000) has begun to change. The most obvious change is in the level of traffic, commercial traffic in particular, and - more surprisingly - coming in from the North. Much of the movement is from the town of Aweil, which, whilst not being far, has long been cut off from Akuem as it is located in the government-controlled zone. There are also lots of trucks arriving from the north, and even buses bringing the "returnees" back home. The town market is also better supplied, as is the market at Malualkon, another village more to the east, which has become the official capital of Aweil East County to which Akuem belongs. It's mostly clothes, kitchenware, and sandals on sale, however, and only basic food stuffs like groundnuts, maize, sorghum, onions, lentils, sugar and salt, and in small quantities. Food availability however in this region marked by chronic food insecurity remains as low as ever.

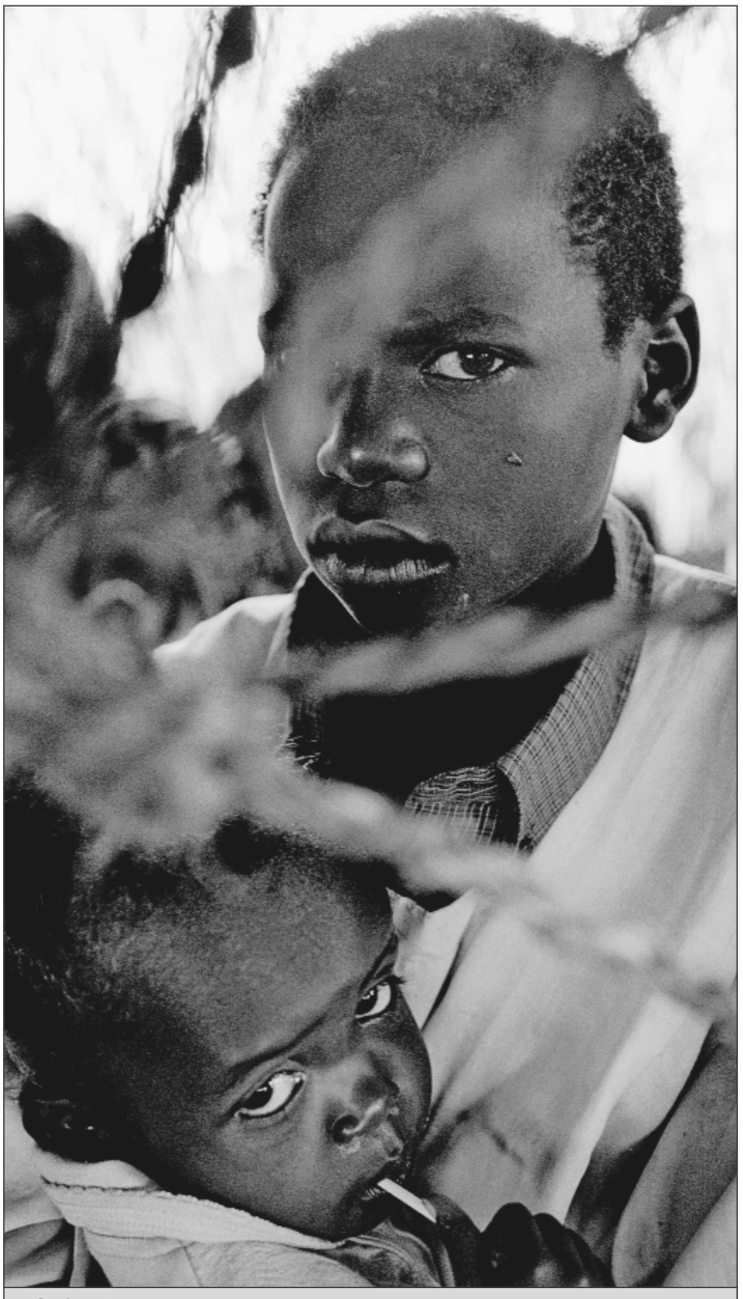
North and the South in January this year, many of those who had been displaced, fleeing the war in Bahr el Gazal to take refuge in the north, are starting to return home. These "returnees" set up home near their families. The first three months of 2005 saw the return of 87 000 people to the Bahr el Gazal area, and 25 000 to Aweil East County. So today the small amount of food that is available has to be shared with far more people than before.

→ 4% OF SEVERE MALNUTRITION

The feeding centre has therefore seen admissions rise sharply over the last weeks. At the end of June there were 232 children being treated in the therapeutic feeding centre; the large majority of them have had to be hospitalised, whilst others receive outpatient care. 600 children have already been admitted to the supplementary feeding centre. The nutrition survey carried out by Epicentre for the period 18 - 22 June has therefore revealed a very critical situation. In the four districts were the nutrition survey was carried out, the total population is estimated at over 200,000 people. The teams are expecting to have to treat up to 1000 severely malnourished children and 7000 moderately malnourished.

→ REINFORCEMENTS

A "blanket feeding" operation is now being planned i.e. the distribution of 60,000 family food rations, with the aim of preventing moderate malnutrition and thus preventing children from degenerating into severe malnutrition. "This will help us reach more children than we can with the supplementary feeding centres", says Pauline Horrill, who is programme manager. "Even though our priority is still to treat those with severe malnutrition and keep the mortality rate down". The teams are therefore going to reinforce the treatment capacity of the therapeutic feeding centre. The treatment has been designed in two phases, one for children needing hospitalisation, and one for those who, whilst severely malnourished, do not need to be kept at the centre - they will be examined once a week and receive a family food ration. ■



→ **Sudan** © Pep Bonet - January 2005

POINT INFO

→ au 08/07/05
Tchad : malnutrition following measles

Following the activities set up during the measles epidemic in N'djamena, the capital of the country (treatment and immunisation campaigns), we have now opened feeding centres - measles is a serious risk factor for malnutrition. Over 1300 children are currently being treated by the teams of MSF France and MSF Belgium. We had planned to close this programme in July, but given that it is the middle of the hunger gap period and the high number of children suffering from malnutrition, we cannot close this activity. We are therefore discussing with MSF Belgium how to find a solution.

MISSION

HAITI

HAITI/PORT-AU-PRINCE

United Nations failing

MSF / June 2005 / Pierre Salignon, General Director/ translated by Nina Freidman

Pierre Salignon has recently returned from a visit to Haiti. He describes the extreme violence reigning in Port-au-Prince's poorest neighborhoods and how the United Nations Stabilization Mission in Haiti (Minustah) —far from restoring calm— has been drawn into a war against supporters of former President Aristide.

POINT INFO

→ au 06/07/05

Haiti: Press Release

As violent attacks intensify and spread in Port-au-Prince, we called on all armed groups in the city to respect the safety of civilians and allow those wounded during clashes immediate access to emergency medical care. Since MSF opened a trauma centre in Port-au-Prince in December 2004, medical and surgical teams have treated more than 3,100 patients, including more than one-third for violence-related injuries (861 gunshot victims, 126 for machete or knife wounds, 67 for beatings, and 40 for rape). Half of those treated for such injuries are women, children, or elderly.

Wednesday, June 22, 2005. It's about ten a.m. in Port-au-Prince. A Haitian Red Cross ambulance pulls up to the emergency entrance of St. Joseph's Hospital, sirens wailing. Two Red Cross volunteers wearing white helmets jump out of the car. They lift a man with a gunshot wound out on a bloody stretcher. He was gunned down, it seems, just a few moments ago on the streets of the Haitian capital, during an exchange of gunfire between UN troops and supporters of exiled President Jean-Bertrand Aristide, the notorious Chimères. The hospital is a flurry of activity. Doctors and nurses rush about. Five emergency gunshot wounds have already been admitted this morning. One man, stretched out on a bed, is giving blood for a relative; another is undergoing surgery for a severe abdominal wound. In all, a fairly ordinary morning in Port-au-Prince.

People in Haiti are living in constant fear, caught as they are between widespread criminal violence and an armed insurrection against Prime Minister Gérard Latortue who was put in power in late 2004 after the autocratic President Aristide was pressured into exile, mainly by the US and France. More than a third of the city is considered "extremely dangerous," at the mercy of armed groups, most of them Aristide supporters. A Haitian member of the MSF team gave this grim summary of the situation: "When you walk down the street, you don't know whether you're still alive or already dead."

While the UN Security Council renewed the mandate of the UN "Stabilization" Mission in Haiti-7,400 blue helmets and international policemen, plus an additional 1,000 men for the upcoming pre-electoral period-violence against civilians in Port au Prince is a daily occurrence (the rest of the country is still calm), and the number of wounded treated by MSF continues to grow.

In response to the lack of appropriate medical care for the wounded, in late December 2004 MSF opened a 56-bed trauma center at St. Joseph's, a Port-au-Prince hospital. It's the only place that provides free, high quality emergency medical and surgical care for the many victims of violence. Since March 2005, MSF has also provided post-surgical physiotherapy at a 27-bed physical rehabilitation center.

The direct violence seen in this medical program (gunshot victims and knife wounds, beatings, burns, head trauma) simply reflects the deteriorating security situation, and its direct effect on the population.

By early July, the MSF team had treated teams have treated more than 3,100 patients - 1,112, for violence-related injuries. Almost half of victims are women, children, or elderly, most often injured during violent confronta-

→ **Haiti, Port-au-Prince** © MSF - January 2005

tions between either the Haitian National Police (HNP) or UN forces and criminal pro-Aristide groups entrenched in several of the capital's slums.

Nearly 900, or one third, of the victims have been treated for gunshot wounds-in some cases caused by exploding bullets. The vast majority of the thirty or so deaths recorded at St. Joseph's Hospital between December 2004 and May 2005 were from gunshot wounds. About forty women have also been treated for rape, with the victims receiving both medical and psychological care.

Some of the wounded are brought in by the UN or by private taxis. But most of the injured are referred to MSF by the Haitian Red Cross, who put themselves at considerable risk every day in order to do their work. In mid-June, two of their volunteers were seriously injured (and treated by MSF) in the seaside slum of Cité Soleil,

The international community bears a lot of the responsibility. Minustah cannot "reestablish peace" in Port-au-Prince.

during an exchange of gunfire between Minustah soldiers and the Chimères. One of the gang leaders had warned, "If UN soldiers show up on our streets, we'll shoot."

According to medical personnel, it's very hard for wounded men and teenaged boys to get to St. Joseph's. Suspected by the police of belonging to armed opposition groups, they fear being arrested or executed by the police before they can even receive care. One injured man, transported to St. Joseph's by a local taxi, was arrested right in front of two stretcher-bearers before they could take him out of the vehicle, and driven by the police to Port-au-Prince's general hospital, where he died an hour later, under police guard and without care.

Faced with the ever-worsening security situation in Port-au-Prince, in early July MSF made a public appeal to all armed actors to spare civilians and facilitate the transfer of the wounded to hospitals, particularly to St. Joseph's emergency unit, which is trying to take in all of the wounded, no matter who they are. It's not easy. Civilians, young "combatants" from the slums, and policemen lay side-by-side in hospital rooms, all wounded in the violence wracking the Haitian capital. News of MSF's treatment program has progressively spread through all the neighborhoods, particularly the poorest, but also to those involved in national and international politics. Let's hope that means greater security for MSF's patients and medical and surgical teams in this difficult context.

But we shouldn't delude ourselves. The situation could well deteriorate further, leading to even more violence. The international community bears a lot of the responsibility. Minustah cannot "reestablish peace" in Port-au-Prince. Because of its mandate from the UN Security Council allowing it to use force in order to accomplish its "mission", it has become an armed player in the conflict, a source of violence against civilians during police operations in the slums. No longer taken aback by "collateral damage" caused by UN soldiers, one of its representatives even sees it as the price that has to be paid in order to "stabilize" Port-au-Prince. No matter if Minustah is now seen by a significant segment of the population as an occupation force, buttressing a transitional government with limited powers. Meanwhile, Haitians continue to live in extreme poverty, faceless victims of an almost forgotten conflict whose quick and peaceful resolution appears highly unlikely. ■

POINT INFO

→ 06/07/05; Closure of programs in Guinea

Our activities in Guinea will come to a close in mid-July. Since May 2003, we have been in charge of the surgical ward in Macenta hospital; in 2004 we carried out 1000 operations, of which 40% were emergencies. We are also leaving the Liberian refugee camp in Kuankan where in started working in 2002 [29,850 consultations in 2004]. Last year we also responded to a cholera epidemic in Conakry. Today, the return of Liberian refugees to their country of origin leads us to close down our programs, while still keeping an eye on the highly unstable political situation in the country.

PORTRAIT

The travels of Abdul

MSF / March 2005 / Michaël Neuman / Translated by Ros Mendy

→ © MSF / D.R.

A project logistician in Beni, Abdul was born in 1974 in Kingezi Basi, in the eastern province of the DRC, a border post between Sudan and what was then Zaire, not far from Uganda.

Coming from a frontier zone between three countries shaken by war and violence, Abdul Ramaddhan, a project logistician in Beni, finds it difficult to identify with today's Africa and the conflicts scattered over it. Abdul was born 31 years ago. His father was a farmer, his mother a trader. His father was a Kakwa - a community decimated by the wars that have ravaged this region, and sometimes still do. His grandfather came from the Nuba Mountains in Sudan. Born a Christian, he converted to Islam. Abdul is a third-generation Muslim.

Abdul has always experienced exile and his whole life has been made up of successive migrations. In the 70s, his father joined the regime of Amin Dada - a Kakwa like himself. He joined the Ugandan army. At the end of the decade he returned to Congo and his family followed him. But faced with the acts of violence committed by Mobutu's troops sent to secure the border, in particular rapes, livestock thefts and looting, the family was forced to leave again. So in 1982, father and children moved to Sudan. At the time, the Ugandan army was embarking on cross-border raids to pursue the ADF rebels whose rear base was in Zaire. So it was in Yei and then Juba that Abdul continued his education, in English, and also learnt Arabic. *"The French schools never made it as far as where I lived."*

Abdul has always experienced exile and his whole life has been made up of successive migrations.

Because they were short of money, while John Garang was launching his rebellion, father and children left for Uganda and joined Museveni who, after taking power, was recalling the soldiers of the old regime. So Abdul divided his time between Uganda and Zaire, spending the school holidays in Ariwara, the town where his mother was living. Abdul saw his father intermittently - until 1995, when his father was killed during an army operation against the rebels of the LRA.

At 19 years old, rejecting a future that looked bleak and taking stock of a life of wandering, he decided to take himself in hand and left for Bunia to study mechanics. There he met a man who took him under his wing. When the man left for Uganda, fleeing a country in total decline, Abdul looked after his family before they too left.

Having become a driver and mechanic, Abdul was forced to put himself at the disposal of the AFDL army. This was in 1996 when the Rwandan incursions into Zaire and the rebellion led by Laurent-Désiré Kabila were inflaming the northeast of the country. Then, because the various military forces fighting in the eastern province, particularly in Ituri, were short of drivers, he served in succession, often under duress, the Rwandan army and the rebel groups. *"I had to drive them or they'd have killed me"*, says Abdul. Then he joined a mining company operating in Ituri. He "drove" the RCD-K-ML when the rebel group was defeated in 2002 by the Ugandan army, and returned to Bunia and then Ariwara where he stayed for a few months in the autumn of 2002. At the time, the region's inhabitants were protected by the Ugandan troops. He already had a wife and three children, who had stayed in Bunia.

Following the announcement of the retreat of the Ugandan troops in March 2003, confrontations between the Lendu and Hema communities seemed inevitable. Abdul returned to Bunia to look for his family, who were living with 18 members of the extended family. He and his wife, a Hema, could have fled by car or plane, but decided to stay. *"What was the point of leaving if our family would not survive the imminent massacres?"* explains Abdul. The massacres broke out in May 2003 and the family had no alternative but to flee, this time on foot. This was the 18 May. They still had to cross some Lendu zones, negotiate and buy safe-conducts. The column of 30 people took seven days to reach Eregenti, 150 km further south, seven days of march through the bush. His third child was 5 months old. The family finally reached Beni on 22 June, 33 days after setting out.

When Abdul and his family arrived in Beni, Médecins Sans Frontières was preparing for the arrival of displaced persons from Ituri and launched the construction of a camp just north of Beni. So it was in Tuha that Abdul and his family settled *"in the first block of the first village of the first camp zone"*. He built his house in five days and quickly found work as a labourer with MSF, where his mechanic's skills were soon spotted by the camp's expatriate logistician, Jérôme. Abdul maintained the motor pumps: *"similar to the ones I used to see in the mines. Water circuits - I was familiar with all that"*. Very soon he took on more complex tasks. On 3 September 2003, Abdul was awarded his first contract. Since then he has been a project logistician, working in the displaced persons camps, in the health centres and in the cholera emergency centres in Vitschumbi, Kasindi and Nyakakoma. Abdul still works in Tuha, where he is supervising in particular the rehabilitation of houses built at the start of the camp in the summer of 2003, as well as

PRESS REVIEW

MSF/June2005/Jana Peters - O.F.

→ Intimidation

MSF Holland's head of mission in Darfur, Paul Foreman, was arrested May 30, 2005 by the Sudanese authorities. He was freed on bail the same day. Vincent Hoedt, regional coordinator for MSF Holland, also was arrested, the next day. He, too, was freed on bail. MSF Holland had published a report on sexual violence in Darfur. As a result, the Sudanese authorities accuse it of having committed crimes against the state, of spying, and of having published false reports. But this report dates from March 2005: "The action of blocking our two coordinators from their work is going to affect at some point the running of MSF missions in Darfur. Is this what the Sudanese authorities are looking for? Or do they simply want to intimidate us in order to prevent us from reporting on the reality in the field?" asked Pauline Horrill in La Croix. Since then, the Sudanese authorities have backtracked and in the end filed no charges against the two volunteers from the Dutch section.

water supplies, latrine and drainage maintenance. At the moment he is replacing the original roofs of plastic sheeting with thatch. And of course, he is also responsible for maintaining the health stations in Tuha and Oicha, another camp for displaced persons from Ituri, on the Bunia road.

"What was the point of leaving if our family would not survive the imminent massacres?"

When he arrived in Beni, Abdul did not understand French. Since then, this man who speaks English, Swahili, Arabic, Lingala and a number of languages from his place of birth, has added a new working language to his repertoire. He is also good with computers and is starting to learn IT in Beni, where he is attending classes. A year ago Abdul returned to live in Beni. He now has enough money to rent a house and the pressure from the displaced persons in the camp was becoming hard to bear. *"People would wake me up at night because their roof was leaking. I had to move away from work"*.

He now has four children aged between 8 years and 5 months and also looks after two children he has taken in. *"A few years ago, when there was nothing more I could do with my life, someone rescued me. I am trying to do the same thing."* ■

IN MEMORIAM

Homage to Catherine Lepetit

Catherine Lepetit quietly left us a few weeks ago. Her path was that of a captivating woman, living life to the full, curious about everything and about other people. She became a doctor passionate about her work, involved in many areas of health in France, before going further afield to Yemen with MSF.

Early on, Catherine became enthralled by the strange discipline, little noted in France at the time-public health. For her it was a tool for both analysis and for combat, and it was the basis of her whole vision of medicine. She had a unique view of her work and of her way of carrying it out, deeply humanist and demanding, with a permanent link between the individual dimension and the collective dimension, between daily contact with the patient and a long-range vision of the healthcare system. Catherine was outraged by the injustices that exist in the world of healthcare, whether it was miners in the north suffering from silicosis or migrant worker women, issues she worked a lot on, or Seine-Saint-Denis, the department in which she practiced during several periods of her life. This outrage never kept her from having a sense of humor. Quite the contrary-it was an often caustic humor, but never really mean-spirited.

Working as a general practitioner, Catherine first crossed paths with MSF through the "spaghetti group", a small group of doctors lobbying for access to healthcare at MSF via other organizations or their own medical practices. In meeting after spaghetti meeting they wanted to remake the world, especially as regards access to healthcare. After the first meeting, around a big dish of spaghetti, the group took on a formidable lobbying effort to call for the reform of the law on free medical care. Catherine contributed her enlightened ideas, her vision of things, always original and deeply committed.

Later Catherine left her general practitioner's office and went to work for the MSF mission in France. Little by little, she who always felt that one must first get involved close to home, felt like taking the leap, to go work "elsewhere". One fine day she did it: she left for Yemen as head of the MSF mission.

In this position, she showed the same talent, the same way of getting to the bottom of the questions that she asked herself. She also brought to it an original and provoking view, not hesitating to criticize what she thought deserved criticism in humanitarian aid or in the world of associations, putting her finger on things that others did not necessarily see. She was one of the first to bring up the subject of letting national staff join the association, a subject which was the object of much dissension at the time. She did it with conviction and with talent, going through to bringing her questions before the Board of Directors.

Her return to France with Tarek, whom she had met in Yemen, was highlighted by the birth of her daughter, Lena, and the beginning of the illness which she would fight against with courage and lucidity for four years. Far from withdrawing into herself, she continued to work on the issues that she was passionate about. After another stint with the French mission, she once again practiced in Seine-Saint-Denis, first in a research program studying job-related cancer, renewing her old sense of outrage to defend those who lose their life while earning a living. She then joined the PMI service [maternal and child welfare], where she remained practically until the end, with her joie de vivre and her courage that moved and fascinated all those who shared her last months.

To Tarek, Lena, and to all her family, we send our friendship. ■

E. Luciolli et M. Vicenti

PRESS REVIEW (CONT.)

→ Hostage taking in Democratic Republic of Congo

On Thursday, June 2, 2005, a French worker with Médecins Sans Frontières and his Congolese driver were kidnapped by armed men in Ituri, a region in the northeast of the Democratic Republic of Congo [DRC] racked by conflicts. The two volunteers were taken hostage while they were driving in a clearly marked car on the way to the refugee camp of Jina [Djugu region], located 35 kilometers north of Bunia, the district capital of Ituri.
They were unconditionally released on Saturday, June 11, 2005. For several days, MSF had been in contact with the kidnappers via an intermediary in Ituri and had also begun similar measures with the Congolese authorities in Kinshasa.

→ Driving school

In an interview granted to the daily paper Libération [June 25, 2005], German Velasquez, team coordinator for the access to essential medicines department at the WHO, expressed concern about the exorbitant cost of second line medicines and criticizes "the very strong [pressures being exerted] to tighten the conditions for supplying generic medicines". Using the example of MSF for support, he emphasizes that price today is the main barrier, "contrary to what the pharmaceutical industry keeps repeating. [...] To put it another way, it's like contending that an African peasant doesn't have a Mercedes Benz because he doesn't have a driver's license [...]."

INFOS

PRESS REVIEW (CONT.)

→ Business is business

"The European Union negotiates controversial aid for Chechnya with Moscow," reads the headline in the daily Le Monde in its July 2nd issue. Nathalie Nougayrède's article describes how the European Commission is set to approve an aid program for the "rehabilitation" of the North Caucasus, a program which "for the first time would be outside a strictly humanitarian framework". This possible decision [to be debated in July among EU members] would be a victory for the Kremlin and would grant it-according to skeptics-"European backing for its policy of repression". Furthermore, the EU backed down this year from presenting a resolution on Chechnya to the U.N. Human Rights Commission, and is "negotiating its long-term Russian gas and crude oil supplies".

Review of the statutes

MSF / June 2005 / Message from the Board of Directors / translated by Robert Corner

We are now in the final phase of the review of the statutes of our Association. Responsibility for the review fell on the Board of Directors whose role it is to organise the 'association side' of the organisation. After several years of preparatory work a special committee has helped, over the last two years, identify the necessary modifications to be made to the current statutes, which date back to 1997.

→ **AG 2005** © MSF / D.R. - May 2005

The changes proposed by the Board were presented at the last AGM held on 28 and 29 May. They can be consulted on the MSF France association website that has recently been put on-line (see article below). It is now up to you to contribute to the debate before the Extraordinary General Meeting to be held in the autumn. This forum will remain open until 15 August. The Extraordinary General Meeting will bring the review to completion with all the members of the association.

The new foundations thus laid for MSF France will have a significant impact on the Association, which will find itself operating with a new social mandate.

There are a number of points underlying these changes and linked to recent developments at MSF and perspectives for the future:

- The integration into the statutes of our broadening areas of intervention social violence and lack of access to health care outside situations of armed conflict.
- The integration of research and development activities, which require political positioning and financial investment (DNDi or other)
- The reassertion of our international dynamics (partner sections in the decision-making process)
- The extension of the range of skills deployed by MSF (beyond medical)
- Improvements to the 'association side' of the organisation (access to non-voting membership for salaried staff at headquarters; a limit on the number of proxy votes, distance voting)
- Improvements to the efficacy of the Board of Directors (opening up one of the Vice-President seats to a non-medic; remuneration of the President or other elected Board member).

This revision of the statutes will also bring them fully into line with the latest regulations.

The statutes committee was formed after the renewal of the Board of Directors and is composed of Marie-Pierre ALLIE, Jacques ALLIX, Christine NADORI. ■

Our association online : www.msf.fr/asso

MSF / June 2005 / Alain Fredaigue / Translated by Alison Quayle

Sometimes it's a good idea to state the obvious. To say that MSF is an association is nothing new, but it serves as a reminder of the specific kind of commitment its members make as part of the association. First and foremost a commitment in terms of the help that volunteers give to populations at risk, but also a personal commitment to actively participate in the association that unites us.

It's not only technical medical and logistical skills that have enabled MSF to develop and create its own vision of the humanitarian world. It's also our collective capacity to reflect on our actions and our association's objectives.

For instance, with the revision of the Statutes of the Association, this is a choice to be made concerning part of MSF. To regard this revision as merely administrative adjustments would a serious mistake. The modalities for electing the president, and the integration of the research and development dimension, which require political involvement and financial investment, cannot be decided in a conclave at the end of a board meeting. Above all, there must be an internal debate, in which every member (or future member) must get involved.

The decision will be ratified at an extraordinary general meeting to be held at the end of 2005, but between now and then it is essential that every member should have the chance to read and comment on the proposed changes to the statutes of our association.

In order to facilitate this exchange of opinions amongst ourselves possible, we have set up an "association" website. A starting point for what will eventually become a veritable meeting place for all MSF's members, this mini site already offers access to forums and the chance to (re)read the written contributions you made in preparation for the AGM. You will of course also find the current Statutes of Association and the proposals put forward by the board.

The site is not and will not become a mouthpiece for the Communications department, it is a tool for everyone, and you have to make it work. We have given you the space, and it is up to you to fill it.

This forum will be built with your help, and apart from the contributions we're expecting from you don't hesitate to suggest other sections (small ads, personal announcements, apartment exchanges, arrangements for parties etc.).

To plunge into the world of the online association, add the site address to your favourites now: **www.msf.fr/asso**

The login and password are available from heads of mission and from headquarters staff.

Looking forward to seeing you on the site... ■

WATCH AND READ

Si c'était toi ?[1]

MSF / June 2005 / Laurence Hugues / Translated by Robert Corner

Romain Gitenet is an experienced MSF volunteer, joining first as an administrator then later as head of mission. He has just published a collection of stories with Éditions Silma entitled Si c'était toi. Loyal readers of Messages will have read the first of these last year: Karma Liberia relates the Lurd offensive on Monrovia through a number of different characters. Following on from this violent and disturbing account Romain now continues the series of stories "through the eyes of individual characters": a refugee whose poverty leads her to prostitution, a child turned soldier, an "aid worker" back home in France but unable to express to kith and kin the continuing fear of being caught under mortar fire... These highly disturbing stories are set in the Democratic Republic of the Congo, Sudan and elsewhere, moving from outbreaks of civil war to bouts of malaria - the collection is not necessarily the most appropriate of gifts to one's loved ones as one leaves for the field... "You promise yourself you'll never leave again. You've been, you've seen, you're back. End of the story." Well, it's not that simple, as these real-life stories prove, stories that continue to haunt us, long after we've closed the covers...

Extract (translated from the French):

"You feel strange all of a sudden. Weak, feverish. You open your eyes, and you're in the Sudan. You're a little girl, seven years old. What do you expect? There's no good age for being sick. You're feeling dizzy... It's the heat and the fever, making you feel so strange. Your mother is here, by your side. But she's like the others; she thinks you've gone mad. You've been behaving so strangely recently. You'd become aggressive, and seized by fits of madness. And then, suddenly, you'd stop and fall asleep. (...) The doctor summarizes the situation to your mother. If we wait any longer you could slide into a coma, and that's where you'll stay. There's only one option Melarsoprol, an arsenic-based drug. The injections hurt, and you're really going to suffer. The problem is.... it doesn't always work for everyone. (...) You've a one-in-three chance of not making it; that's the way it is take it, or leave it." ■

1- ***Si cétait toi*** **(If it was you), Romain Gitenet, Éditions Silma. 144 pages - 13.60 euros. In bookshops, or on the web: www.sicetaittoi.com**

Famine and forced relocations in Ethiopia 1984-1986

MSF / June 2005 / Laurence Binet

The sixth volume of the 'MSF Speaking out' case-study collection is dedicated to a key-episode in MSF's History: the first time MSF found itself in confrontation with a government on whose territory it was working and refused to serve as the instrument of oppression.

In 1983, a famine began in Ethiopia's northern provinces that would affect millions of people.

The spirit of solidarity aroused by media coverage of the catastrophe made it possible to raise an unprecedented amount of international aid from institutional donors and individuals in the West.

However, the Ethiopian regime diverted a portion of that aid, to carry out forced population transfers from rebel areas in the arid, high altitude, northern plateaus to the more fertile plains in the south of the country where the population could be more easily controlled. At least 100,000 people were estimated to have died during resettlement operations in malaria-infested regions.

The authorities pressed for transfers to the south, regularly impeding the teams' work. On several occasions, the teams were forbidden to treat certain individuals or to distribute blankets. MSF teams also witnessed round-ups carried out by the Ethiopian army among the camp populations

On several occasions, the authorities refused to authorise MSF's request to open a therapeutic feeding centre in Kelala, which could have prevented the deaths of several thousands of children. In October 1985, MSF France publicly denounced the government's refusal to open a therapeutic feeding centre, along with its misuse of international aid for forced population transfers, and the shocking conditions under which transfers were being carried out.

In December, the Ethiopian government expelled MSF France from the country.

The majority of the other aid organisations working in Ethiopia, did not take a public position on the forced resettlements. Others criticised MSF's position, which they described as 'political'.

MSF Belgium team members did not witness forced transfers, and thus did not take a public position. They continued to develop their programmes with the agreement of Ethiopian authorities.

These events occurred within the context of an unprecedented humanitarian mobilisation and media attention and confronted MSF with a series of new dilemmas:

- What should be done if it appears that aid is being used against the populations for whom it is intended?
- Could MSF's denunciation endanger international aid operations in Ethiopia?
- By taking such positions, could MSF put its own existence and, thus, its other activities at risk?

Like the previous case studies, the latest addition to the "MSF Speaking out" collection is composed of extracts from documents and interviews. This editing is aimed at reconstructing the debates and decision processes that led to resolve the dilemmas. It is available in English and in French, in the field, and at the documentation center. Additional copies can be obtained from the CRASH and the communications department . ■

Please send your comments to: lbinet@paris.msf.org

INFOS

PRESS REVUE (CONT.)

→ We are the world

From Band Aid to Live Eight, Bob Geldof has been an active militant for two decades. In an article « *L'aide n'éradique pas la pauvreté* » (aid will not eradicate poverty) published in Le Figaro on 8/07/05, Alain Destexhe (ex general sectary of MSF's international office) describes his doubts about this latest campaign « Make poverty history ». "No rallying slogan, like 'Health for everyone by 2000' has kept it's promise." "At the risk of being a killjoy, we seriously doubt the transformation virtues of a show - even a 'global' one" adds Rony Brauman in Alternatives internationals (July August 2005 issue). Recalling the episode in Ethiopia, Rony point out the amnesia of the rock star and his Band Aid friends who 'twenty years later, avoiding all embarrassing questions, congratulate themselves again (...) But there is no reason to deprive oneself of going to see an exceptional concert" he concludes.

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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

WATCH AND READ

"Congo: peace held hostage"

MSF/ June 2005/ Chloé Gelin

The new EUP documentary for MSF
Author: Marc le Pape
Director : Robert Genoud
Duration: 52 minutes
Filmed in November 2004 in Katanga, DRC

Two years after the official end of the war in 2002, the fighting continues in North Katanga. The military and militia have turned their weapons on the civilian population: sexual violence, banditry, pillaging and burning of villages are daily occurrences. However these rarely catch the attention of the international community, only when the number of victims massacred is more than the 'usual'. "Congo: peace held hostage" follows the life of several witnesses: How do people go about their lives in constant fear? How do people live with the ever present violence that has continued for years, leading to deprivations, flight and illness?

The film is to be shown in July and August 2005 to the authorities and press in Kinshasa and Lubumbashi , and to the population in Ankoro and Kitenge where the documentary was filmed. ■

WATCH AND READ

New books available in the documentation center

MSF / June 2005 / Alix Minvielle (01 40 21 27 13)

→ MEDICAL

CLASSIFICATION INTERNATIONALE DES MALADIES : ADAPTATION À L'ODONTO-STOMATOLOGIE / OMS.- 3e édition.- Genève : OMS, 1997.-183 p.

COMBAT FACE AU SIDA : SANTÉ, DROGUES, SOCIÉTÉ : RAPPORT ONUSIDA 2004 / Revue Combat, n° 38, Décembre 2004.- 44 p.

HAND DUG WELLS AND THEIR CONSTRUCTION / S.B.Watts, W.E.Wood.- 2nd edition 1979.- Rugby : ITDG Publishing, reprinted 2005.- 253 p.

PRESCRIPTION FOR HEALTHY DEVELOPMENT: INCREASING ACCESS TO MEDICINES: UN MILLENNIUM PROJECT : TASK FORCE ON HIV/AIDS, MALARIA, TB, AND ACCESS TO ESSENTIAL MEDICINES: WORKING GROUP ON ACCESS TO ESSENTIAL MEDICINES 2005 / B. Leach, J.E. Paluzzi, P. Munderi (coord.).- Londres : Earthscan, 2005.- 170 p.

→ GEOPOLITIC

COLUMBIA: A BRUTAL HISTORY / G. Simons.- Londres : Saqi, 2004.- 384 p.

ECOLOGIE POLITIQUE D'UN DÉSASTRE : LE HONDURAS APRÈS L'OURAGAN MITCH / A-M. d'Ans.- Paris : Karthala, 2005.- 275 p.- (coll. Hommes et sociétés).

MISSION EN GUINÉE : HUMANITAIRES, VERTIGE ET POUSSIÈRES / B. Sagot, J-N. Martin (collab.).- Paris : L'Harmattan, 2005.- 161 p.

→ AVAILABLE IN THE PHOTO LIBRARY (and database int.) - MSF / Christine Dufour

DBI : **Niger** : June 2005, Tahoua + Keita, CNT, Didier Lefèvre / imagesandco.com; May 2005, Maradi + Dakoro + Kaita, CNT, logistic and food distribution, MSF; May 2005, Maradi + Dakoro, CNT, Stephan Oberreit / MSF - **Haiti** : February 2005, Port-au-Prince, surgery, MSF - **China** : May 2003, Guangxi, Gongdong hospital, Chien Min Chung.

Photo Library : **Liberia** : March 2004, Lofa and Bong refugees camps, logistic, Didier Assal / MSF (not DBI)

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messages

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TURN OVER HEADQUARTERS

FIELD HR

→ **Laetitia LIEBERT**	joined desk E as human resources officer at the beginning of June
→ **Franck ELOI**	is replacing Cécile AUJALEU (on maternity leave) as national staff coordinator
→ **Anne SAUNDERS**	has been appointed Active Recruitment Officer, replacing Marie-Laure Le Coconnier who left MSF in May
→ **Amanda HARVEY**	left her position of Field Human Resources Director in May

OPERATIONS

→ **Mercedes TATAY**	was appointed Programme Manager of the emergency desk
→ **Thierry ALLAFORT**	is head of the emergency sector

COMMUNICATION & FUNDRAISING

→ **Chloé GELIN**	has joined the department as Communications officer (on a fixed term contract) replacing Aurélie GREMAUD who has left to work for MSF-CH
→ **Irène NZAKOU**	started as assistant press relations officer in June (fixed term contract)

LOGISTIC

→ **Eric BARTE**	was Technical Coordinator in March
→ **Laurent DEDIEU**	joined the New York desk in June as Logistics Supervisor

RECEPTION & GENERAL SERVICES

→ **Sylvio BORDELAIS**	started as receptionist (fixed term contract) in June, replacing Angélique BARBA who has left MSF
→ **Paulette RODDE**	our irreplaceable caretaker left at the end of May to settle in her house in Auvergne after working 17 years at headquarters.

EMIRATES DESK

→ **Frédéric VIGNEAU**	has started as director of the UAE office, replacing Ismael FOUAD

FOUNDATION

→ **Céline DERCHE**	started as support pharmacist for the Campaign in June (fixed term contract)

POSITIONS TO FILL

→ FIELD VACANCIES

→ ASAP

- medical coordinator, Russia, Moscow, 12-24 months
- medical coordinator, Ivory Coast, Abidjan, 1 year
- medical coordinator (nurse), DRC, Lubumbashi, 1 year
- medical coordinator, DRC, Beni, 1 year
- medical coordinator, Camdodia, Phnom Penh, 1 year
- medical coordinator/head of mission, Chad, Ndjamena, 1 year
- medical coordinator, Northern Sudan, Khartoum, 1 year
- medical coordinator, Uganda, Kampala, 1 year
- medical coordinator, Niger, Niamey, 6 months
- Head of mission, Ivory Coast, Abidjan, 1 year
- medical coordinator, Nigeria, Katsina, 6 months
- Nurse field co, DRC, Ankoro, 6 months
- Nurse field co, Darfur, El Geneina, 6 months
- Nurse field co, Darfur, Mornay, 6-9 months
- Nurse field co, Niger, Keita, 6 months
- Nurse field co Nut, Madagascar, Fianarantsoa, 6 months
- Nurse field co, Nigeria, Katsina, 6 months
- field co, Darfur, Zalingei, 6-9 months
- Nurse field co, Haïti, St Joseph, 6 months
- medical, Iran, Mashad, 9 months
- medical, DRC, Rutsuru, 6 months
- medical, DRC, Mukubu, 6 months
- HIV medical, Cambodia, Phnom Penh, 12 months
- medical, Palestina, Gaza, 2 months
- medical, Niger, Aguié, 6 months
- medical, Madagascar, Fianarantsoa, 6 months
- medical, Darfur, Nyertiti, 6 months
- ICU medical, Haïti, St Joseph, 6 months
- gynaecologist, Liberia, Monrovia, 6 months
- TB/chemist nurse, DRC, Ankoro, 6 months
- nurse, DRC, Mukubu, 6 months
- nurse, Chad, Adre, 6 months
- mid-wife, Kenya, Mathare, 6 months
- chemist, Liberia, Monrovia, 6 months
- psychomogist, Palestina, Nablus, 6 months
- physiotherapist, Haïti, St Joseph, 6 months
- logistician field co, Southern Sudan, Loki, 12 months
- logistician, Haït, Port au Prince, 6 months
- logistician field co, Nigeria, Abuja, 12 months
- logistician/Adm, Indonesia, Sigli, 6 months
- logistician/Adm, PM, DRC, Ankoro, 6 months
- logistician/Adm, PM, Darfur, Niertiti, 6 months
- field administrator, Nigeria, Katsina, 6 months
- administrator PM, Nepal, Katmandou, 5 months
- PM, Thailand, Bangkok, 1 year
- administrator, Southern Sudan, Maigoma, 9 months
- administrator, Ethiopia, Addis Abeba, 12 months

→ SEPTEMBER

- non medical field co, Sierra Leone, Freetown, 9 months
- medical coordinator, Malawi, Blantyre, 12 months
- medical, DRC, Kitenge, 6 months
- medical, Chad, Adre, 6 months
- TB medical, Southern Sudan, Akuem, 7 months
- DOTS nurse, Armenia, Erevan, 3-4 months
- nurse, Korea, Seoul, 9-12 months

→ OCTOBER

- medical field co, Georgia, Tbilissi, 12 months
- field co, Southern Sudan, Kotobi, 6 months
- HIV medical, Uganda, Arua, 12 months
- mid-wife, Ivory Coast, Bouaké, 6 months
- logistician field co, Ivory Coast, Abidjan, 6-12 months
- administrator, Northern Sudan, Maigoma, 9 months
- administrator, Ethiopia, Addis Abeba, 12 months

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

Surgeons : Ivory Coast, Bouake - Liberia, Monrovia - Chad, Adre - DRC, Ankoro - DRC, Kayna - Haïti, Port au Prince

Anaesthetists : Ivory Coast, Bouake - Guinea, Macenta - Liberia, Monrovia - Chad, Adre - DRC, Kayna - Haiti, Port au Prince - Indonesia, Sigli

OT Nurses : Ivory Coast, Bouake - Guinea, Macenta - Liberia, Monrovia - Sudan, El Geneina - Haiti, Port au Prince - Indonesia, Sigli