messages

→ N° 138 / November 2005 / Médecins Sans Frontières'newsletter www.msf.fr

DOSSIER

MEDICAL RESPONSABILITIES

DEBATES

MISSIONS

→ Ouzbekistan © Rip Hopkins / Agence Vu - August 2002

→ xxxxxxx © xxxxxxx

MEDICAL RESPONSABILITIES

From intentions to illusions

MSF / September 2005 / Dr. Emmanuel Baron, Director of the Medical Department / Translated by Anne Witt-Greenberg

The notion of medical responsibility directly evokes the medical act performed by the caregiver. However this act takes place in a given context and a legal framework, just as it results from certain operational or technical choices made by the association. To dicuss our medical responsibility is therefore to attempt, in a moving framework, to define its scope while resisting the tendency to encompass everything.

Each medical act comprises several levels of involvement by the caregiver. It is his duty to respond to the request of the patient, using the knowledge and means available, while respecting medical and individual ethics. A doctor is responsible for his acts and must be able to account for them, just as he has the duty to report any violation of the rules of his profession.

Beyond the duty to provide care, are the medical-legal obligations to protect the patient (e.g. confidentiality and medical certificates). The violation of these obligations entails civil or penal sanctions. However practicing medicine in precarious situations also leads us to consider our responsibility not only as caregivers, but also as humanitarian actors. As in reality we are very rarely asked to answer for these obligations, the impunity that results means that we must be doubly vigilant. The level of responsibility that the association

•••

Number 138

The notion of medical responsibility carries with it the obligation to implement the means necessary to provide quality medical care. This obligation requires that we regularly analyse the relevance and objectives of our projects, and these cannot be separated from the environment –national and international- in which they take place. Our responsibility is therefore connected to factors that are not directly related to the medical act itself, but the objective is to 'put the patient first'. The paradox is even in our name 'Médecins Sans Frontières' or the eternal equation of quality medicine and the conditions in which it is carried out. Faced with such diverse situtations, is it possible to talk about medical responsibility? Yes, but far from a new dogma, the question helps us improve and regularly debate our practices, taking into account the environment in which in which we carry out our work and the intentions of our practice.

DOSSIER

Medical responsabilities

→ To readers of Messages

We have chosen to illustrate this dossier with extracts from the 2004-2005 annual report, presented by Jean-Hervé Bradol, President of MSF, and also with excerpts from the critical review of operations in Darfur (Sudan), published by MSF on 30th August, at the request of the Board. This evaluation carried out by Dr Corinne Danet, Sophie Delaunay, Dr Evelyn de Poortere (Epicentre) and Fabrice Weissman (Crash), is part of a critical approach to operations that aims to identify possible weaknesses in an intervention (the operations carried out in Darfur between October 2003 and October 2004) and the ways to correct them.

assumes for the health situation of a population also questions MSF. A debate with multiple intricacies opens here where the notion of responsibility is implicated on several levels: the decision to intervene or not, the means to be implemented, and the results to be observed.

→ **Angola, Kuito** © Sébastien Rich - November 2004

→ THE OBLIGATION TO IMPLEMENT THE NECESSARY MEANS

It is part of our medical responsibility to continually develop the means at the disposal of the teams. This concerns, for example, the choice of medicines and materials in our lists. Our current work on the improvement of diagnostics and their integration into routine practice are also part of this. How can we feel responsible for the future of a patient, how can we carry out medical acts if they are based on a poor or non-evaluated clinical situation? But we cannot develop technological responses without questions. The obligation to implement the means necessary has its limits. These limits are linked to the definition of the MSF project (our range of care is not always relevant in our projects), to the absence of availability at an acceptable cost of a particular drug or diagnostic test (viral load of patients infected with HIV), to the complexity or specialization that certain techniques require (for example, resuscitation and intensive care involve complex and very specialized techniques), to certain internal constraints (we have our limits in patient follow up capacity). Although technical limits exist, they do not necessarily have to serve as an excuse for inertia. Thus we have reacted and, through the creation of the Campaign for Access to Essential Medicines and the Drugs for Neglected Diseased Initiative, we have shown a responsible attitude by refusing an unacceptable situation for our patients. Operational research at the service of our practices is another example.

→ THE FRAMEWORK OF OUR RESPONSIBILITY

Limits of another order are related to the "scope" of the medical act. Where does it begin and where does it end? The conditions in which a patient is examined for example, is our responsibility. We hope to improve the decency of our healthcare facilities. The temporary structures that we hope to set up in certain missions are an illustration of this intention. Around the medical act itself, the doctor, and the association upon which he depends, cannot ignore other important factors that will have an impact on the life and the welfare of the patients. We have accepted as one of our responsibilities to make drinking water and food accessible to the people that we are helping. This type of "prescription" is in the medical tradition.

The limits of medical assistance are therefore also up for debate. It extends beyond the act of care itself. Can we ignore the social, legal, or economic environment of the patients that we treat? Does our responsibility vis-à-vis a patient stop once we have left the consultation room? The doctor's responsibility undoubtedly goes beyond the identification of his patient's illness and the prescription that follows. Thus, beyond the health facility, where are the limits of our desire to protect our patients? A question that does not necessarily imply that its implementation is our responsibility.

→ A LOGIC OF RESULTS

If the obligation of implementing the necessary means is a concept inherent to medical practice, we must also analyze the results of our medical choices and recommendations. Do we have a responsibility to provide results? It would no doubt be more appropriate to say that we must be guided by a logic of results. It is with this in spirit that we analyze our medical activities. It is part of our medical responsibility to examine our interventions, and to reorient them if needs be.

Medical responsibility therefore goes beyond its strictly legal framework. It a notion that is in constant evolution and calls us to consider our actions on an individual as well as on a collective level, to weigh our choices and study uncertainties. Because this responsibility is part of an ever-changing activity, is refined through experience, calls for means that are in constant evolution and is continually confronted with new dilemmas, it forces us to repeatedly question our project. ■

→ Sierra Leone, Magbwaka © Sven Torfinn - April 2002

SURGERY AND MEDICAL RESPONSIBILITY

A Critical Assessment of Current Practice

MSF / September 2005 / Dr Sinan Khaddaj, head of surgery, Medical Department / Translated by Angela Dickson

Medical responsibility, where surgery is concerned, consists in providing the field with competent human resources, adequate equipment, necessary drugs and appropriate logistics, in order to meet the safety conditions required to perform surgery. However, taking into account the objectives and limitations fixed by MSF, these practical requirements are not always met ...

The 'general surgeon', capable of turning a hand to anything, is a dying breed. Universities now train only specialists, who are ill-equipped to meet the challenges inherent to the areas in which we work. We therefore have to be on the lookout and ensure that surgeons are not working beyond their capabilities under the pressure of emergency situations.

Briefings are essential, but they cannot replace written protocols which codify good practice.

Unfortunately, we are behind in the publication of these protocols, and our contribution in this area is therefore still limited.The surgical team also includes an anaesthetist, an operating-theatre nurse and national staff, and must function as a unit. Teamwork and exchange of skills and know-how are indispensable to providing quality care.

We still tend to blame others – particularly national staff – for failures which are the result of insufficient or non-existent co-ordination.

→ AN APPROPRIATE SURGICAL ENVIRONMENT

The safe practice of surgery requires functional infrastructure. To ensure clean theatres and adequate space and electrical circuits, significant renovation and building work is often required. Progress made by the logistics department now means that adequate water and electricity can be supplied. Emphasis is also put on waste collection and processing.

By nature this work cannot be carried out in an emergency (lack of construction workers, supply difficulties etc). We therefore often have to resort to temporary measures such as the use of inflatable tents - a possible solution during renovation and building works.

• • •

→ Medical secrecy

Medical secrecy is protected by international humanitarian law. Any limitations on doctor-patient confidentiality and privileges must be set forth in the laws of the country. This means that a simple order or regulation issued by a military or administrative authority does not authorize a doctor to breach his or her obligation of medical secrecy.

Françoise Bouchet-Saulnier in "The pratical guide to humanitarian law". Rowman and littlefield Publishers, Inc. - 2002

THE MEDICAL REPORT

MSF/ September 2005/ Françoise Saulnier, legal advisor at MSF

The individual medical report is both a 'medical obligation' and a document that patients have the right to demand both in times of peace and war. Far from being a useless document, in times of unrest the report describes facts that risk otherwise of being denied. It opens and preserves the rights of the patient (victim status, refugee status, non-refoulement, indemnisation, relocalisation etc). Certain rights are immediate, they allow the patient to benefit from aid programmes or special humanitarian assistance set up for certain categories of people, rape victims, victims of persecution, children in danger etc. As to its use in legal proceedings, victims of criminal acts have ten years to bring their case before the courts. The medical report does not have to be drawn up by a national medical examiner to be valid. It can be drawn up by any general practitioner working officially in the country. And it works! In times of unrest, it is important to ensure that the report is not signed by a doctor that is exposed to possible reprisals, which may be the case for national doctors working in their home country. It is therefore advisable that an expatriate doctor takes on this responsibility.

In situations of conflict, international law provides extra protection for doctors, in particular by reinforcing medical secrecy e.g. national law obliges doctors to declare all bullet wounds, whereas international law dispenses them of this in times of conflict so that they can continue to provide care and document any exactions committed. They are not obliged to name names when informing the authorities. Victims in possession of medicals report can choose when and how to demand their rights from the authorities.

DOSSIER

Medical responsabilities

→ The Haïti programme

This project...has another aim, which is to accompany patients further than is usual in emergency surgical programmes: in other words, until they have regained their functions as much as possible. In the past, to caricature a bit, we would operate a patient for a fracture when required, and then, if the bone had set, the wound healed, we would consider our job done. Now we are going to explore, with due humility, the possibilities of functional rehabilitation activities.

Jean-Hervé Bradol.
Excerpt from the President's 2004-2005 Annual Report

→ APPROPRIATE TECHNICAL EQUIPMENT

Medical responsibility obliges us to investigate all available diagnostic technology and treatment possibilities. We can no longer do without radiology and claim to be able to treat fractures properly. Likewise, there are significant risks associated with managing a difficult pregnancy without the aid of ultrasound. Yet for the moment only three missions have radiology facilities, and none has ultrasound equipment.
Laboratory tests available to our surgical programmes are limited to transfusion, haemoglobin and haematocrit, which is insufficient if patients are to be treated appropriately. However, portable equipment does exist; it is easy to use and enables renal function and electrolyte tests to be performed. Why resist the introduction of such devices in the field? When we fail to use modern equipment, are we not fostering the cult of 'precarious medicine'?
The introduction of resuscitation equipment such as defibrillators, syringe pumps and ventilators is currently being considered, and the medical department has already begun the debate on this subject. We welcome all input in this debate.

→ PRIMUM NON NOCERE

Our field teams are urging us – and rightly so – to set up treatment for vesico-vaginal fistulas. It is undeniable that this condition has serious consequences, and that it has a considerable effect on patients' lives. However, in view of the lack of specialists, improvised treatment would represent a professional error and a breach of our obligations.
We are aware of the limits imposed by our lack of equipment and/or skills, and cannot manage all conditions (cancers, prostates etc). Voluntarily not treating certain conditions is a demonstration of our primary responsibility: primum non nocere.

→ BEYOND TECHNIQUE

Surgery is not limited to the technical side or the operations alone. The human dimension of surgery must be considered, as well as the social context. Amputations, for example, are often difficult to accept, and must therefore never be addressed from a purely mechanical and technical approach.
Medical responsibility is not limited to the surgeon; it is the responsibility of the whole team to discuss the necessity and consequences of procedures, and they must ensure the quality of post-operative care. Unfortunately, we have noted a lack of discussion and co-ordination in this area in our missions.
Within the medical ethics framework, we are concerned about breaches in the doctor-patient relationship. Obtaining the informed consent of the patient is often forgotten. We rarely allow ourselves the time to explain to the patient the procedure that he is to undergo and its consequences, particularly the potential for pain and incapacity.
As for follow-up, we should ask; why do we ignore the medical file, and why are we content with a cursory operation note? This is an ethical as well as a legal obligation. Should practitioners need reminding to fill in the data collection forms? Our attitudes in this area must change.

→ LIMITS OF THE PROJECT

Surgical missions are usually set in violent and politically unstable situations. Surgery is seen as emergency treatment. Saving lives is our priority, but we tend to neglect the physical rehabilitation of surgical patients.
When the Trauma Centre was opened in Port au Prince, we created a rehabilitation centre caring for the physical and mental well-being of surgical patients. Clinical practice has since shown the necessity for such a programme.
Perhaps an integrated rehabilitation centre should be standard practice in our surgical missions? Such a policy would enable us to fulfil our responsibility to ensure continuity of care.
Beyond rhetoric, and beyond the law and morality – which will always be invoked in discussions of medical responsibility – the only relevant matter now is a debate on our limitations and about our objectives and the means by which these may be met. ■

PAIN MANAGEMENT

Ongoing Pain

Médecins Sans Frontières / September 2005 / Rémi Vallet / Translated by Anne Witt-Greenberg.

Sudan, beginning of the 1980's. In one of MSF's programs a man was operated on for a hernia. The anaesthetist decided a general anaesthesia was unnecessary, but the local anaesthetic was not sufficient. "The incredible thing was that the patient endured the entire operation without flinching," remembers Jean-Paul Dixmeras, surgeon on duty that day. Surgery at MSF has evolved since then. In Ankoro, Bouaké, or Port-au-Prince, operations are now performed under proper anaesthesia. But what about pain management in our programs?

For a long time, everyone ignored the question of pain. 'The fifth vital sign' as it is called in the United States has only recently become the object of attention. "During my studies to become an anaesthetist nurse almost 20 years ago, there was no teaching whatsoever on the control of post-operative pain," describes Xavier Lassalle, the pain specialist in the medical department. Later, while all French hospitals began creating pain specialist positions, MSF was slow to react. "During my year in Cambodia in

1990, I must have used a maximum of a dozen ampoules of morphine over the entire year," remembers Xavier. And when in 2000, he analysed pain management in MSF programs, the figures spoke for themselves: for 10,000 operations that year, only ten ampoules of morphine had been sent to the field. This is unbelievable when one knows that in France, after a Caesarian, a woman receives up to six ampoules per day for 2 days. It is therefore not surprising that 65% of the patients in Batticaloa (Sri Lanka) declared that they had felt intense pain, a percentage that rose to 85% among the victims of third-degree burns.

"Today, nobody is against pain management; it would not be politically correct. But it seems a half-hearted effort."

→HALF-HEARTED EFFORT

The results of this study have yet to produce a real impact in the field. Xavier Lassalle notes, "Today, nobody is against pain management; it would not be politically correct. But it seems a half-hearted effort." Even in the surgery programs, for which Xavier has developed indicators (supply of analgesics, quality of prescriptions, regular evaluations), much remains to be done. Thus, in the "trauma center" of Port-au-Prince, patients in the post-operative phase receive analgesics, but the regular evaluation of their pain is not done. Xavier equates this to, "prescribing treatment for hypertension without measuring blood pressure."

Besides surgery programs, only the mission in Abkhazia (healthcare for a vulnerable population, often elderly persons) emphasizes pain management, and with good results. "One of the patients suffering from lung cancer was bedridden because he was in such severe pain," describes Xavier. "Thanks to 300 milligrams of morphine per day, he has been able to recover a certain level of autonomy." Yet, except for this program that provides palliative care, the facts show that pain management is not always a priority.

The only person capable of evaluating the degree of pain is the patient himself. And that is where the problem lies, Xavier explains, because doctors and nurses often have difficulty accepting that the diagnosis is not in their hands.

During the briefings of medical volunteers, the subject is rarely mentioned. In the field the teams prescribe analgesics, but often do not carry out the systematic and regular evaluation of the patients' pain.

The medical coordinators in the field are, of course, supposed to ensure this is carried out, but they are often overwhelmed with other tasks. Similarly, a session is devoted to this topic during the yearly Medical Week, but only about thirty caregivers attend it each year. When the doctors from headquarters go to the field they evaluate pain management, but the sporadic nature of these visits limits their impact. Catherine Hewison, of the medical department, acknowledges that "We have not set up a system that is strict enough to guarantee correct pain management in all of our programs."

→TO OVERCOME PRECONCEPTIONS

To improve pain management in our programs, it is important to analyse and overcome common, deeply rooted preconceptions on cultural representations, humanitarian medicine and the patient-caregiver relationship (see box). But it is above all necessary to install the habit of systematically evaluating the level of pain of patients. There is no fixed standardized reference point, no objective scale of pain to guide the caregivers. The same medical gesture will provoke a different level of pain from one patient to another. The origin of the patient does not give us any indication about his pain. The only person capable of evaluating the degree of pain is the patient himself. And that is where the problem lies, Xavier explains, because "doctors and nurses often have difficulty accepting that the diagnosis is not in their hands. It is all the more delicate as in most contexts where MSF intervenes, the patients are not used to spontaneously expressing their pain, even less to asking for treatment to relieve it, contrary to what we see in France. We must therefore let the patient speak, question him about his pain. In "Pain," a film to raise awareness produced in 2001, a man is recovering from an operation in the Connaught hospital in Sierra Leone.

He seems relaxed, speaks calmly. However, when the MSF doctor asks him to evaluate his suffering on a scale of 0 to 10, he responds 10 without hesitating. "Without evaluation, there is no pain management," insists Xavier. For the patients who do not use numbers, the simple verbal scale (no pain, mild, moderate, or severe pain) has shown its effectiveness. "Evaluation is essential, for it is on the basis of that that the caregiver can refer to a protocol and make a prescription, from paracetamol up to morphine," he explains. For pain management to become an integral part of MSF programmes it would suffice, in theory, to include the evaluation of pain in the consultations. In practice however, perhaps it is necessary to also readdress the patient-caregiver relationship. ■

COMMON MISCONCEPTIONS
Comments by Xavier Lassalle

- **« The priority is to cure our patients; to treat pain is comfort »**

Except for certain specific cases, it's true that relieving pain does not in itself bring any considerable medical benefit. But too many volunteers have a tendency to consider the treatment of pain as a luxury. However, when the means are available, we have the obligation to use those means. It is a question of medical responsibility.

- **« Supplying analgesics is complicated »**

Not anymore. In all of our programs, we can have the necessary products: paracetamol and anti-inflammatory medicines for mild pain, codeine and tramadol for moderate pain, and morphine for severe pain. Even in Abkhazia where – as in all of the former Soviet republics and satellites – morphine is still perceived as the last medicine before death, we have succeeded in importing large quantities of it. However, the enormous progress MSF has made with regards to the supplying of drugs does not guarantee the good use of analgesics. In France, morphine has been available for centuries; however it only started to be used effectively about twenty years ago.

- **« Morphine is a dangerous product »**

Morphine is a powerful and interesting medicine that makes it possible to treat most pains. The more you give, the more the pain eases. There is a risk of respiratory depression, but adequate monitoring of the patient makes it possible to prevent this problem. As for the risk of addiction, it is very low when morphine is used advisedly, that is to say, to treat pain. Thus, a study carried out in the United States on 10,000 victims of third-degree burns shows that once they had recovered, none of them had developed an addiction to morphine.

- **« In countries where we intervene, patients experience less pain then Western patients »**

This is false. Studies have shown that there is little or no « ethnic variation » in pain. On the other hand, there are very strong individual variations – with, for the same operation, a consumption of morphine of 1 to 5 according to the patient. What does change, for contextual and cultural reasons, is not the level of pain, but the expression of this pain. The problem is that this leads caregivers to underprescribe. For example, studies carried out in the emergency departments of the United States have shown that black patients received less analgesics than white patients.

- **« The patients in the countries where we intervene are more sensitive to analgesics »**

« There too, it is completely false, since metabolisms are very similar from one group of individuals to the other, and this leads to a habit of under-prescription. There are, however, some genetic particularities. Thus, almost 15% of Asians are insensitive to codeine. »

“
- *Only extremely proactive actions, carried out by motivated and competent teams, can produce results;*

- *Above and beyond the legal, practical and social constraints associated with abortion, the absence of a clear MSF protocol on this topic has not made the work of teams trying to include it in the healthcare they provide any easier.*
”

Extract from the Critical Review of MSF-France operations in Darfur (Sudan) October 2003 – October 2004

MEDICAL RESPONSIBILITY AND SEXUAL VIOLENCE

Overcoming the resistance

MSF / Septembre 2005 / Françoise Duroch, consultant for victims of sexual violence programmes / MSF Switzerland

When it comes to responding to the problem of sexual violence, our medical practices sometimes come up against resistance, or are wavered to comprise with the reality of certain situations. However, our medical responsibility compels us to avoid judgements and to overcome the “reflexes” – both conscious and unconscious – which prevent us from doing as much as we can.

Although responsibility means “the obligation of a person or organisation to answer for their actions and to assume the consequences”, this concept becomes more difficult to define when attempting to carry out medical actions in precarious settings.

Although medical responsibility implies, among other things, an obligation of resources – i.e. the need for any doctor to make available to the patient every possible up-to-date medical resource - putting these imperatives into action in the field sometimes proves more complicated.

Violence involves intention and harm, an aggressor and a victim. It is often tinged with cultural initiation functions and sometimes has political, economic or religious designs. Defining our individual and collective responsibility to people and societies beset by this kind of violence is therefore a particularly delicate task.

But medical responsibility is no police work. It is not about investigating whether patients are telling the truth, nor is it an exercise in anthropology or social sciences

→ SILENCE IMPLIES CONSENT...

It is tempting to resort to cultural relativism to hide our distress when faced with phenomena where our action is (and should be) limited. For example, it is all too common to hear mentioned the libertine sexually practices attributed to beneficiary populations. When picking and choosing in the supermarket of culture, we prefer to adopt the moral freedom, which we think we see within the beneficiary population rather than analysing or appropriating the censures that go along with them.

How often to you hear the debate “Does rape really happen in Africa?” and “You know, some peoples have a violent sexuality”, a premise which would mean accepting that all values are relative depending on the cultural context to which they are bound. However the people directly concerned are always absent from the debate, deprived of the right to self-determine the values that concern them.

Snippets of conversations can be heard in the field and the headquarters: doubts about the victim-status of certain female patients (who want to conceal consensual relations with their partner behind rape); suspicion about the motives of raped patients in asking for treatment (they come to get a bit of soap and clothing); never-ending debates on whether it is possible to talk about rape or sexual exploitation in the case of pre-pubescent girls. Hours and hours are spent discussing the definition of cases, particularly surrounding the concept of consent.

→ WORKING WITH THE INVISIBLE

But medical responsibility is no police work. It is not about investigating whether patients are telling

SEXUAL VIOLENCE

Once again, the issue of violence against women was not ignored. The delay was probably due to the all too real operational difficulties and the lack of competent staff. The ideological exploitation of rape, whose prevalence is difficult to measure, may also have contributed to minimising the issue. There is also a certain conservatism, which should not be underestimated, amongst some expatriate staff that makes them less receptive to issues of rape, family planning or abortion.

To conclude, it is important to underline that all women who came for help within 72 hours of having been raped were given prophylactic treatment against HIV infection. The others received the standard protocol. Abortions were introduced in the range of healthcare provided from September onwards. This is an extremely sensitive issue given that non-therapeutic abortions are forbidden in Sudan. Although legally rape victims have the right to abortions, the procedure to follow is so complex that it is de facto of no value.

However much it has been exaggerated by propaganda, rape is a reality in Darfur and it is difficult to gauge the extent of the problem. Though MSF-F provided the specific care required to women who came forward for help, we found it difficult to draw in women who were hesitant to consult a doctor. There are significant practical obstacles. However, it is clear that there was not enough effort put into overcoming these obstacles.

Extract from the critical review of MSF-France operations in Darfur (Sudan) – October 2003 – October 2004

the truth, nor is it an exercise in anthropology or social sciences - even though the cultural aspects must of course be considered, not only in the case of rapes, but also in broader terms when dealing with concepts of health, relationship to the body, violence and sexuality.

Our medical responsibility could begin therefore with facilitating access to care for these female patients, for whom such access is often very limited compared to the general population. This can come down to working with the invisible, leaving the responsibility for setting up these activities entirely up to the will and "militancy" of one or more of our members.
In emergency situations, making this kind of care available can sometimes come into competition with other health imperatives. In such cases we are forced to carry out a kind of ranking of the victims, with the risk of creating a form of competition between them. These priorities, which are often dictated by individual or public health issues (cholera is still a diarrhoea which kills within hours), are based on an ideological basis which we sometimes forget to question.

→ THE RESPONSIBILITY TO PROVIDE CARE

On the other hand, if the 'everything is cultural' stumbling block is to be avoided, so it is with the potential "imperialist" attitude consisting in dictating populations' best interests, particularly regarding denunciation and bearing witness - especially where medical care is lacking or non-existent. Medical responsibility is primarily a matter between patient and practitioner; the obligation of resources – even in precarious settings – is above all the obligation to provide care and to ensure its quality. In this case it could be a matter of antibiotic treatment for STIs, PEP, reparatory surgery (particularly in the case of vesicovaginal fistula) and mental health issues.

These priorities, which are often dictated by individual or public health issues (cholera is still a diarrhoea which kills within hours), are based on an ideological basis which we sometimes forget to question.

It is sometimes difficult for teams to work on the consequences of violence without being able to act on the causes: nonetheless, we should not ignore the care that we must and can provide to populations, even if it may seem inadequate given the chronic, structural or political nature of these phenomena. The responsibility of practitioners and organisations in these emergency situations goes far beyond a legal concept - it is also related to political, ethical and civil responsibility.
Writing a medical certificate necessary to register an act of violence (i.e. exercising legal medicine) to some extent symbolises the singular responsibility of the doctor towards the patient: by signing the document, they are committing themselves personally, and engaging or re-engaging in inter-individual medicine within group and public health systems. This can be a salutary exercise when the suffering of patients is sometimes reduced to epidemic statistics without names or faces, and it should continue to be the ethical foundation on which our medical practices are based. ■

ABORTION AND MEDICAL RESPONSIBILITY

Abortion, in theory and in practice

MSF / September 2005 / Interview by Chloé Gelin

Dr Anne-Sophie Coutin, specialist in obstetrics and gynaecology, recalls how MSF's policy towards abortion has evolved and underlines the obstacles that still sometimes prevent women from having an abortion in our programmes.

→ What was MSF's policy on abortion a few years ago ?
Before, we did not perform abortions. We did not listen to women's requests, we did not consider is a medical priority and did not provide the means to carry out the intervention. When I was on my first mission in Afghanistan even I, an obstetrician/gynaecologist, did not give the issue any thought. Everything changed when we started to address the specific issue of women's health and medical staff where faced with cases where abortion was an integral part of the healthcare to be provided (rape, fistula...). In our programmes providing care to victims of sexual violence, women asked us to perform abortions e.g. in Congo Brazzaville. The question of abortion in general, not only in the context of sexual violence, was then addressed as a public health issue.

Who are we to judge the distress and moral suffering of a woman? Our role is to accompany patients, to offer them a solution: it is not our role to judge and analyse their motivations.

→ What is MSF's policy today?
MSF's policy is clear, in theory: abortion is considered a medical procedure. [see box: resolution of the International Council]. But there are still many obstacles:
- **Technical obstacles**: we must ensure quality healthcare. Since July 1st, the WHO has at last included the abortion pill (mifepristone and misoprostol) on their list of essential medicines. This protocol for drug-induced abortion means that it is possible to avoid surgery. Nevertheless surgery (curetage or aspiration) is necessary in 5% of cases in the event of an incomplete drug-induced abortion. It is therefore essential to have the necessary materials and qualified personnel (short training) available in the field to carry out this intervention and to provide treatment for possible complications.
- **Legal obstacles**: MSF is not competent to fight for the right to abortion. Performing abortions can put the teams at considerable

ON 21 NOVEMBER 2004, THE IC ADOPTED THE FOLLOWING RESOLUTION

1 – **The provision of comprehensive reproductive health care is essential in all MSF general medical programs.**
2 – **Despite recent improvements and efforts, such care is still poorly accessible to patients in MSF programs.**
3 – **The availability of safe abortion should be integrated as a part of reproductive health care in all contexts where it is relevant.**
4 – **MSF's role in termination of pregnancy must be based on the medical and human needs of our patients.**

risk in countries where it is forbidden. The decision is therefore taken on a case by case basis. Furthermore, the abortion pill is banned from import in several countries.

- Moral obstacles: abortion is an act requested by the patient, and it is the subject of heated debates among national and expatriate staff. Nevertheless these individual opinions must not be allowed to sway our policy. Who are we to judge the distress and moral suffering of a woman? Our role is to accompany patients, to offer them a solution: it is not our role to judge and analyse their motivations. ■

MALAWI: AIDS

An obligation to break new ground

MSF / September 2005 / Interview by Olivier Falhun / Translated by Diantha Guessous

Having for a long time focused on scaling up (increasing inclusion of new patients onto our active case file), our teams in Chiradzulu are now facing the question of the quality of care. How can we provide treatment to the largest number of patients possible while ensuring quality healthcare? Dr Jean-François Corty, deputy programs manager, answers our questions.

→ Why is MSF revising its strategy in Malawi?

Up until now, we have tried to develop a program focused on scaling up inclusions, with limited human resources. Regularly evaluated and amended, this project has proved its worth. Now, however, it is no longer in keeping with our perception of medical responsibility in a district where the HIV incidence rate exceeds 20% in adults. We have 9,000 patients in our cohort today – half of them on ARV –our quality goal therefore leads us to question the direction of our program and force us to break new ground. On their return from a recent visit to Malawi, Jean-Hervé Bradol and Gaëlle Fedida (program manager) both emphasised that our legitimacy will be reinforced when the quality care we provide is extended to a sizeable number of patients. This will show the appropriateness of our choices and approach to AIDS. While all this is complex, it is also our responsibility to describe the current situation and state publicly how few the existing tools are to confront it.

Once numbers permit, we'll resume the scaling up for patients who haven't yet been diagnosed, meanwhile the Ministry of Health continues to include 120 new patients a month at the HIV clinic at the hospital.

→ What is going to concretely change in the case management of HIV we provide?

In collaboration with the Ministry of Health – which has begun triomune treatment for 45,000 patients – we are going to re-focus our activity on hospital-based services (paediatrics, adult TB and hospitalisation) in order to improve the management of opportunistic infections, reduce secondary effects and work on second, even third, line treatment, with more resources. We will also continue regularly visiting health centres in the district and including for treatment patients from our cohort who deteriorate into the 'ARV stage', as well as children and tuberculosis sufferers (200 per month). Once numbers permit, we'll resume the scaling up for patients who haven't yet been diagnosed, meanwhile the Ministry of Health continues to include 120 new patients a month at the HIV clinic at the hospital. On another front, we've decided to provide food to all those suffering malnutrition in our treatment group. Six tonnes of food have already been distributed through health centres. And we're negotiating with the ministry to do

→ **Malawi** © Gael Turine - October 2004

"*We continue to make progress on the AIDS front. MSF France has approximately 10,000 people on antiretroviral treatments. Last year's figure was 7,000. It is clear that acceleration or « scaling up » policy as we've termed it, of inclusions is being implement in our mission. We have really accelerated the number of patients put on antiretrovirals in our treatment cohorts. This is very positive.*
But there's also the impression – and I don't know how to put this – that we're in a sense beginning to mark time. The next stages are a little hard to work out, but the matter is extremely difficult so this is not surprising. Changing to second-line treatments is somewhat slow. Less toxic molecules, even for first-line treatment, are available, but their cost needs to be urgently reduced. We do not always apply the necessary energy to these questions."

Jean-Hervé Bradol
Extract from the Rapport moral 28th May 2005

the same in the hospital. Our initial model was built on the concept of decentralisation, which we're going to try to improve this by training nurses and nurse's aides in the health centres. The goal is to make the latter more self-sufficient. Progress has already been made, especially in the management of opportunistic infections and in the follow-up of patients already on ARV who've stabilised. That leaves the question of nurses starting the treatment once the clinical examination of the patient requires it. That's the third stage. But in order to extend decentralisation further we are going to try and go beyond this framework by becoming involved in the villages and the groups of patients who live in them. Considering the prevalence and the scarcity of resources, the idea is that these patients become active in their own medical treatment, that they become 'partners' in our action in a way that's yet to be determined.

No two situations are ever the same: Malawi is not Cambodia, the political will and means are never the same, prevalence figures are always different. We must therefore proceed on a case by case basis, within national programs.

→ Can we speak then of a revolution in AIDS management at MSF?

Certainly not. We're experimenting, because the situation we face demands it, as it has always done, inspiring MSF to break new ground. In a certain way we are 'going all the way' in one district, so as to offer quality care and to be consistent with our medical policy. How far will we go with scaling up? We don't know yet. But one thing is sure: we can never have a standard answer. No two situations are ever the same: Malawi is not Cambodia, the political will and means are never the same, prevalence figures are always different. We must therefore proceed on a case by case basis, within national programs. On the other hand, by gradually abandoning vertical programs and targeting other pathologies, and by having a more transversal approach, we hope our experience might be useful to others, especially in countries where politicians are still dragging their feet.

→ Are the geographic criteria for inclusion still valid?

We decided to work in the Chiradzulu district. So these geographic criteria remain. From the point of view of both patients and their carers, this is an extremely hard decision. It regularly causes frustration and clearly great distress. But this dilemma – one of many – does show one thing at least: that we are right at the heart of the AIDS issue. As a result, and because we are answerable for our operational decisions, we're right in the thick of all the problems which others are slow to respond to. Nonetheless, in Malawi as in other places, the fact that we practise a certain exclusion is part and parcel of our action. Not to accept this idea is to have misunderstood that there are limits to our action. Our medical responsibility compels us to set limits, and to account for our actions. Suggesting that we leave too many patients by the wayside through this strategy is unrealistic, defeatist rhetoric. ■

"Let's revive our exchange of expertise and staff between missions; let's encourage discussions between sections (for example the MSF Belgium program in Malawi); let's meet with other actors on the international stage working in the same direction we are, in Brazil, in France or elsewhere, let's continue to promote the distribution of quality drugs at accessible prices."

Extract from the Management Committee - August 2005

MEDICINES AND MEDICAL RESPONSIBILITY

Medicines, an indicator of our activities?

MSF / September 2005 / Caroline Livio / Translated by Alison Keroak

Providing quality care means, among other things, "ensuring the uninterrupted availability of quality medicines in our programmes". However, supplying these medicines is complicated, whether via international or local purchasing circuits. In reality, we do not always have the medicines that we need at our disposal. And the lack of available information in our programmes still prevents us correlating consumption and medical activity.

→ **Sudan, Darfur** © Martyn Broughton / MSF - April 2005

Before discussing drug quality, it is important to backtrack a bit first. "The drug market was completely deregulated after the Marrakesh Agreement, which laid the foundations of the World Trade Organization (WTO) in 1995, leading to market liberalization and a decrease in regulation," notes Jacques Pinel. This led to the expansion of emerging countries that produce generic drugs – particularly India and China – and as a result, the arrival of affordable drugs on the market. Since no international regulatory agency exists, it is up to the buyer to check the quality of the drugs. If the buyer is a poor country, it rarely has the means to the ensure the quality control of its purchases, and the markets of developing countries have been flooded by cheap medicines of very variable quality e.g. almost half of the artesunate available in southeast Asia is counterfeit! As a buyer on the international market and as an importer in the countries where it works, MSF must approach these high-risk markets in a professional manner, and this led to the creation of a pharmacist position in each of the five operational centres [see box]. When buying or importing medicines, MSF has a duel set of responsibilities: its responsibilities to its patients as a prescriber, and its legal responsibilities towards the national authorities as an importer.

→ QUALITY IS THE OBJECTIVE

The quality of medicines depends, among other things, on the relevance of international and local purchasing procedures, as well as the correct management of transportation and stocks. "To validate supply sources, MSF has developed international validation procedures for product/producer pairs," explains Sophie-Marie Scouflaire, the pharmacist at MSF-France. It is the role of the pharmacists at the purchasing

When buying or importing medicines, MSF has a duel set of responsibilities: its responsibilities to its patients as a prescriber, and its legal responsibilities towards the national authorities as an importer.

and supplies centres* to 'evaluate' potential sources: auditing production procedures in the factories, compiling of dossiers, etc. The final evaluation is conducted by the international pharmacy coordinator and the pharmacists in the operational centres. Each office is thus responsible for each medicine assessed as "MSF qualified".

While MSF favours grouping purchases through its logistics centres in order to ensure the quality of its medicines, more than 40% of medicines for the French section are purchased locally: either because it is impossible to import them, or because local purchasing is an operational decision e.g. the latter was the case for antiretroviral (ARV) drugs when the programmes were opened: the objective was to "prime" local availability so that ARVs would also be available outside of MSF programmes.

→ OBSTACLES TO IMPORTATION

However, more and more countries are imposing limits on the importation of medicines. Some countries only allow the importation of medicines included on their national lists or registered with them. This is the case in Burundi, Ethiopia, Uganda, Kenya, and Sudan, among others. In other countries, importing medicines is almost impossible, such as in Thailand, China, or Colombia. "The pharmacists from the operational section visit in priority programmes supplied by the local market, in order to study the national regulations, visit manufacturers or the local distributors/importers, and to check the origin of products that can be purchased locally by MSF," explains Sophie-Marie. These various constraints, however, sometimes prevent us from obtaining the medicines we need. For example, in Thailand, the medicines required to treat patients with multiresistant tuberculosis are not available, or are sometimes of an unacceptable quality. "We have been trying, without success, to officially import these products for the past two years," she explains.

→ COHERENCE AND FOLLOW-UP

To have quality medicines available day-to-day, without shortages, requires a general coherence of medical programmes. "All medical staff must be made to realise the need to track consumption, and for prescribers, the importance of respecting the protocols set out by MSF. Expatriate turnover and the internationalisation of teams, with prescription habits that may differ, do not help matters. This can lead to a destabilization of all supplies, and a potential disruption in the quality of care for our patients."

Shortages can also be related to supply difficulties or delays from MSF Logistics, hence the need for buffer stocks. In southern Sudan, a delayed delivery of anti-tuberculosis drugs forced the teams to change their usual prescriptions. Fear of having to destroy expired drugs often leads to underestimating the level of buffer stocks required. And yet, experience has shown that destroying medicines because they are past their expiry date is generally very rare: a study conducted over two years in Congo-Brazzaville showed that only 1.8% of the medicine budget was destroyed due to expiry, despite the programs' instability.

Drug consumption should be able to reflect the degree of coherence in our medical activities. Paradoxically, this operational analysis is not possible right now. "We do not yet have a precise analysis of consumption in the field," notes Sophie-Marie. "We have information from our international order forms, we can compile a list of exports made by MSF Logistics, and the financial controllers can indicate the amounts spent on local purchases. But it's impossible to know, for instance, how many artesunate pills have been used since the beginning of the year." Therefore, it's equally impossible to detect errors or possible drift. "For this reason, and to help our teams in the field optimise their management, we have been working for several months on a software program that will allow headquarters to have a overall view of consumption and to correlate it with medical activities," concluded Sophie-Marie. ■

"All medical staff must be made to realise the need to track consumption, and for prescribers, the importance of respecting the protocols set out by MSF.

THE EVOLUTION OF MEDICINES AT MSF

For many years medicines were considered "consumable operational tools" simply requiring a regular supply, like …. spare parts for a Toyota. Medicines arrived from MSF Logistics, who bought the generics from producers based in the North. Very few questioned the quality issue, and national authorities allowed these importations, especially for refugee programmes which made up the majority of our programmes at the time.

Drug management in these programs was facilitated by the fact that we treated a limited number of pathologies using standard protocols that called for essential medicines that were often old, well-known, and inexpensive. In just a few years all this changed: the arrival of new diseases such as AIDS, resistance to usual medicines, markets opening, deregulation, patents, counterfeit medicines, artificially elevated prices of recent products, the stop of production of less profitable drugs and of applied research into tropical diseases. The Campaign for Access to Essential Medicines was born, and an international coordination of pharmacists was created.

1- MSF Logistics, Transfer, and the supply dept. of MSF Holland

→ The network of pharmacists, how does it work?

An international coordinator supervises the pharmacists in the five operational centres, the purchasing centres, and the Campaign for Access to Essential Medicines.
This team deals with all the problems related to medicines in the 80 countries where MSF works and ensures the quality of approximately 1000 medicines of different origins, bought at the best price possible. Little by little, "field" pharmacists are also being integrated into certain programmes – these pharmacists are in charge, if the need arises, of managing the pharmacy and medical supplies, problems regarding imports, follow-up of local purchases, and overseeing the distribution of medicines to patients.

WHAT KIND OF CASE MANAGEMENT

Freedom for patients?

MSF / September 2005 / Anne Yzebe / Translated by Jan Todd

Our patients are increasingly taking their treatment at home, on their own, with weekly or monthly medical supervision. This growth in patient autonomy was not so much an objective, as a necessity. Over the past five it has taken not only therapeutic innovations, but also time, discussions and failures to bring about this evolution in patient self-care.

→ Asia, Thailand
© StefanPleger@yahoo.com

Who was it that publicly doubted the capacity of African patients"who don't know what a watch is[1]" to take their treatment at given times? Nobody at MSF... And yet, in practice, there are many obstacles, at all levels, when it comes to ensuring less stringent medical patient monitoring. "For a doctor, making patients take more responsibility for themselves is not in itself an objective", explains Gaëlle Fedida, programme manager. "Our real duty is to make sure that the treatment causes as little inconvenience as possible, which involves giving a certain amount of the responsibility to the patient." Letting the patient take his medication at home, rather than hospitalising him, in fact places a much heavier responsibility on the care-provider. "An MSF doctor is like any other: it's not just patients in poorer countries, in France we don't trust patients either," underlines Brigitte Vasset, in charge of TB in the Medical Department. "In France the law on patient access to their medical files is only three years old. Patients are treated like children everywhere".

→ PROGRESS USING PEANUTS

A ready-to-eat food supplement was introduced four year ago. It is only now however that this therapeutic innovation is in widespread use thus avoiding the constraint of long hospital stays for thousands of children and their mothers. Plumpy'nut was tested in 1999 in nutritional centres in Brazzaville, and in 2001 came the idea of using it in outpatient care for children with no severe health problems who have an appetite. In 2002, the decision was taken to develop this system in Niger, where a third of children were leaving the programme before they are fully recovered. One year later, there were still few transfers to outpatient treatment. "Doctors find it very hard to let acutely malnourished children go home, they're afraid and just don't do it.", explains Gaëlle Fedida, then deputy programme manager of the Niger desk. "In the beginning, the only children transferred to outpatient care were those who were practically cured, who had reached 80% of their target weight." A new Head of Mission, enthusiastic about this project, went into the field. His objective was to increase the number of transfers right from the moment of admission. "On paper, the strategy seems very good, but when you're in the field, it's really difficult", recalls Philippe Le Vaillant, Head of Mission in 2003, "You can't demand that of young doctors and nurses, many of whom are on their first missions." Eventually this prompted a phone call to Paris during which the programme manager told him: "If that's how it is, we're leaving." The transfers to outpatients began with the help of three expatriate African doctors who had years of experience with MSF in Africa. Today, more than half of all severely malnourished children are treated as outpatients right from the moment of their admission. The recovery rate is 85%.

→ SUPPORTING AIDS PATIENTS

There has also been "success" in the AIDS programs. Nine years after the appearance of triple-therapies, four years after the first antiretroviral (ARV) treatment in an MSF programme, more than 30,000 patients are on ARV therapy in MSF programmes in 27 countries. Adherence is satisfactory and the patients have extended life expectancies. But we are still trying to strike the right balance between patient autonomy and medical supervision. "You can't send an ambulance, two psychiatrists and three doctors whenever a patient doesn't show up", Gaëlle Fedida exaggerates deliberately. "But a lot of things can happen in two months. We must provide support." Instead of taking total responsibility, which poses problems in terms of accommodation and provision of water and food, there is a relationship of co-responsibility which includes raising awareness and providing support.

→ THE HURDLE OF DOT[2]

"AIDS has changed everything, the change to ARV treatments has transformed the patient relationship." says Emmanuel Drouhin, programme manager. "Before, we never considered trusting the patient. For example, in Thailand, in the tuberculosis programme, just a few months ago, we had motorbike teams who went out every day with their lists of patients and their medications. They went to

PATIENT AUTONOMY

There is another determining factor in improving care: we make progress when we are more optimistic about our patients' (the beneficiaries of our actions) ability to be autonomous, to use the products themselves, and when we are less caught up in the control and almost police-like administering of medicine or therapeutic foods. Distributing this product (Plumpy Nut) in ambulatory centres to three-quarters of children suffering from severe malnutrition has been somewhat of a revolution. So has daring to distribute antiretrovirals to patients, trusting them to take them correctly. We can clearly see, by comparing with tuberculosis where the system that monitors the taking of treatment is much more rigid, that we actually had, at the beginning, the preconception that the patients were not able to take their treatment regularly and to persevere with it. It seems to me that there is a lesson to be drawn from this in order to encourage a change in practice and to become far more efficient. We must not hesitate to use 'high-tech' products, and must put aside our preconceptions by trusting patients to use them correctly. Progress has been a result of our change of attitude on these points rather than the creation of a specialised system to check that all the techniques on the ground are properly implemented.

Jean-Hervé Bradol
Extract from the Rapport moral – 28th May 2005

TUBERCULOSIS

For quite some years now we have been analysing the inadequacies of the programmes fighting against this endemic. We know them well: the absence of an effective vaccine; an obsolete diagnostic test; an overly-long and ineffective treatment for poly and multiresistant forms. We also lack many products for children, as well as ones that are easily administered. We have an almost police-like way of checking that medicine is being taken that is not adapted to the situation and that does not conceal how insufficient our means are. In comparison, the trust that we place in our AIDS patients when we prescribe them antiretrovirals and the results obtained should push us to question our case management of tuberculosis patients. We must act, now, and quickly. We hope to see programmes where we no longer practice DOTS (directly observed treatment strategy) in these cases.

Jean-Hervé Bradol
Extract from the policy report – 28 May 2005

visit each patient at their workplace so they could make sure they all swallowed their pills. They watched them swallow them and set off again, same thing every day. Now we see things differently." But most of the 2,600 TB patients monitored by MSF still take their medication under medical supervision, as advised by DOT, the strategy recommended by the World Health Organistion. "Tuberculosis is not AIDS!" protested the doctor formerly in charge of tuberculosis in Thailand, refusing, despite DOT's very high non-adherence rates, to give a patient one month's worth of drugs. In Abkhazia, the aim was clear in 2004, but in Spring 2005, there was still not one single patient on monthly follow-up. "There is a deep-rooted notion that patients are not capable", observes Gaëlle Fedida, programme manager. "It's not possible for everyone, but the vast majority of patients should be able to come once a month". It has been forgotten that in Afghanistan, at the start of the 1980s, patients were already being given a month's worth of their treatment.

There is a risk: rejecting or adopting one single strategy for all patients in all nutrition, tuberculosis or AIDS programmes. "We must watch out for pendulum swings", warns Brigitte Vasset, "We need to adapt every time. You can't expect a patient who weighs 40 kilos to walk for several hours to come and pick up his medication! The outpatient system works very well in Niger, but in Akuem, in Sudan, it's been a disaster. It's up to us to tailor strategies, which will be different for Ethiopian nomads or for displaced persons in a camp in Liberia". Even if this strategy cannot be universally applied, what it can do is inspire new practices in other programmes. ■

1- Statement by Andrew Natsios, Director of the U.S. Agency for Internation Development (USAID)
2- Directly Observed Treatment

WHAT KIND OF CASE MANAGEMENT

Patients or pathologies?

MSF / September 2005 / Interviews by O.F. / Translated by Carole Patten

Are we prisoners of our programmes' fixed objectives? Can we accept to treat a patient only for tuberculosis when he also suffers from AIDS. It is dangerous to consider programmes in a purely «vertical» manner, explains Brigitte Vasset from the medical department.

→ What are the dangers of vertical programmes that you mentioned in preparation for this interview ?

«When you plan an intervention the aim is to act at a given time to tackle a given problem, with the required means, energy and human resources. But in our excessive desire to define our intervention, we sometimes overlook other serious cases which call into question our medical responsibility. In a therapeutic feeding centre a child may end up waiting at the door because he doesn't meet the admission criteria, even though he's suffering from pneumonia! This happened in 1998 in Sudan. It was a very difficult situation for the teams to cope with. You know what to do, but you don't have the tools to do it. In our emergency programme in Niger, progress has been made. We have set up a paediatric unit for those who are not suffering from malnutrition, as elsewhere they would have to pay for treatment. This takes us to the issue of the context in which we are working, i.e. the existence or otherwise of health facilities that are capable of providing quality patient care. If people have easy access to other centres, and effective treatments, vertical treatments are not a problem. But for example, I remember in Uganda the health centres close to our Trypano programme didn't have the medicines to treat patients suffering from respiratory infections, despite being much easier to treat. And in some situations, our assistance can even result in dilemmas: in Kenya, at first we were only addressing the TB problem, without tackling AIDS. And yet, almost 80% of people with tuberculosis in Kenya are also HIV positive. We later revised the programme's objectives to focus on AIDS. But it's only now that we are starting to change our approach:

In a therapeutic feeding centre a child may end up waiting at the door because he doesn't meet the admission criteria, even though he's suffering from pneumonia!

• • •

"When we cannot treat certain patients suffering from infectious diseases, we must justify the reason why - taking into account both those peoples interests and the dangers that threaten existing MSF activities and not the other way round (in other words, considering, from the start, that these sick people cannot be treated and systematically ignoring a category of patients"

Jean-Marie Kindermans in An Operational Policy for Infectious Diseases Messages No 114, April 2001

in Kenya this year, a patient infected with AIDS and tuberculosis will have both treatments available to them.

→ What problems does referring a patient to another health facility pose?

A patient must receive correct care, while taking into account the constraints he may have. A patient seeks treatment so that he can live, he should not have to struggle to receive treatment! Patients receiving AIDS treatments in our programmes sometimes have to walk hours on end to get their TB treatment miles away. They have to go to several different places, even if it means spending time and money travelling: not to mention the effectiveness of the treatments they are offered; the quality of the diagnoses and the costs they have to pay for further examinations. Not only does all this generate very heavy, sometimes impossible, constraints for the patients and their family - what's more, it also makes it more difficult to adhere to their treatment correctly. And yet it's the patient who should be at the centre of our concerns! Signigicant progress will have been made when the day we can say to an HIV patient on our programme in Homa Bay, Kenya: «Listen, we think you have tuberculosis, so we are going to provide treatment for this too.»

But this sort of advance sometimes conflicts with the nature of MSF, making it difficult in some emergency interventions to offer long-term treatment for certain pathologies, like tuberculosis or AIDS.

→ Do you mean that in some cases, our medical responsibility comes up against the limits of our operational choices?

Yes, but you can also look at the problem the other way round. If MSF is a medical organisation, responsible and liable for its actions, MSF must define an operational policy, outlining the framework for its interventions, and setting realistic objectives. Our medical responsibility makes no sense unless it is accountable to someone. We should therefore be accountable to the patients and their families for our actions. We must ensure the quality of our activities and the continuity of the care by providing full information to the patient, setting a minimum duration when opening our programmes, and accepting the responsibility of staying longer if necessary, for want of a satisfying solution.

Just as the organisation cannot act without setting limits, it must also compromise with those imposed upon it: violent situations and war restrict our actions, as do the governments of the countries where we intervene. In Liberia, for example, the authorities will not allow us to follow our own procedure for treating tuberculosis, just as they forbade us to use artemisinin three years ago: although we used it all the same ! We had a row about malaria, and we'll have another one about TB... Sometimes our intention to treat patients comes up against the impossibility of treating certain pathologies. ■

→ **South Africa, Khayelitsha** © Francesco Zizola / Magnum Photos - November 2003

Feedback on AGM discussions

MARBURG, OR OPERATIONAL MISTAKES

MSF / September 2005 / O.F.

During the debate on medical responsibility at the annual general meeting, discussion turned to the MSF operation in Angola to counter the Marburg epidemic. The highly lethal nature of this viral hemorrhagic fever meant that the teams had to work wearing special protective clothing, similar to those worn by cosmonauts. In the town of Uige, MSF set up an isolation and treatment centre for patients, which led one volunteers to comment «We're asking them to come here and throw themselves straight into the grave». A member of the audience described that we were reduced to «health police», while another expressed regret concerning the remote, paranoiac attitude of the majority of caregivers, increasing the gap already exists between doctor and patient. Most ultimately agreed that the brutality of the operation was regrettable, and concluded that in future anthropologists and psychologists should be involved to a greater degree in such circumstances, since caregivers' actions consist here in particular of supporting the patients and their loved ones through the dying process.

Closing down programmes

MSF / September 2005 / O.F. / Translated by Marcy St John

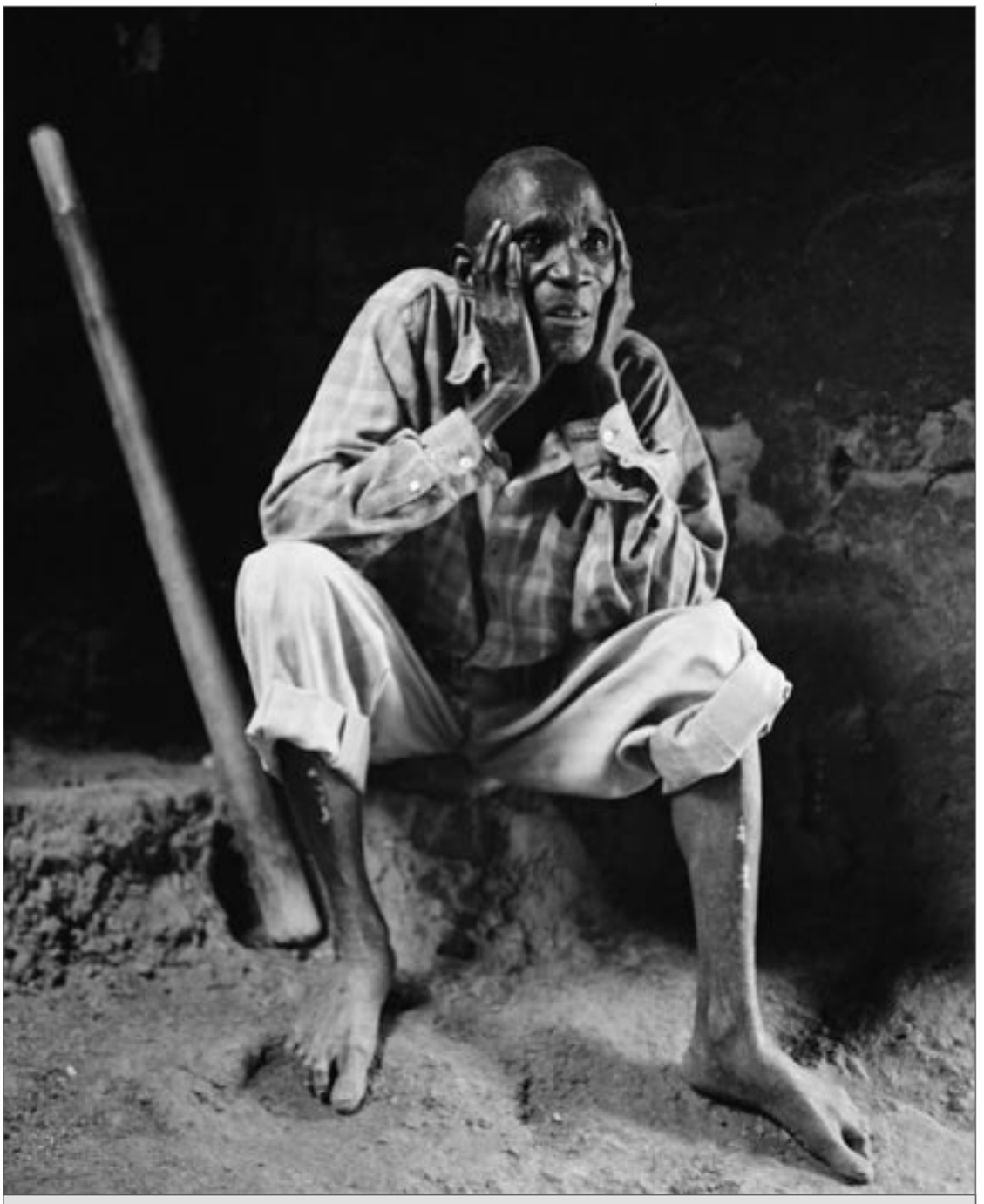
What are the consequences of closing down a program? Can we guarantee continuation of care? How far can we go? Even though contexts vary and outside events sometimes disrupt our programs, any decision to close a programme calls into questions our medical responsibility—and its limits.

First off, Dr. Mercedes Tataï, Program Manager for the emergency desk, tells us that she has never closed a programme in the field; she then emphasizes that opening a program comes first and it is part of our medical responsibility to ensure that this is pertinent. "This pertinence at the opening of a program will influence the condition of its closure." MSF's General Director Pierre Salignon also stresses pertinence and the opening/closure tandem, two terms which he does not think of as opposites and is indeed tempted to link. "The yearly activity figures detailing the opening and closure of programmes reflect, first and foremost, how dynamic our operational projects is."

To open in order to close, to close in order to open: these are the two sides of a coin that pays face value, unlike for development projects. "At MSF I sometimes hear that it's the logic of needs that prevails over everything else," Pierre continues. "I don't agree. That would be giving us an omnipotence that we don't have. Our intervention must meet an objective, and it's this objective, regularly examined and revised, that justifies our presence or not. A program takes place in a specific context, where there are specific humanitarian and medical problems to which are allocated resources, means, staff, and budgets. These are not infinitely extendable. Although for a humanitarian it is psychologically easier to open than to close a mission, it is important to adhere to closure decisions. These decisions may indeed be difficult, but they correspond to our operational policy and attest to the coherence of our action."

→ SETTING THE RIGHT GOAL

Dr. Marie-Madeleine Leplomb, program manager for China, discuses the difficulty of defining goals and the consequences of our departure from the Gongdong project, in Guangxi province. "We were looking for a way to work in China. We had to find an opening. At first, we began slowly by trying to improve the case management of patients in referral hospitals as well as access to healthcare (which is fee-based in China) for minorities without means. We worked with



→ **DRC** © Fiona Lloyd Davies - June 2005

> *The disengagement of NGOs is difficult, whether from an emotional point of view or by virtue of routines and the weight which makes all structures last – and which give members the justification for its continuation. In the same way, certain missions continue for political reasons, because it is useful to have a base in a volatile zone so that we can anticipate events and respond to them better. Lastly, humanitarian expatriates develop, in the course of their career in humanitarian work, an increasingly critical relationship with the sustainability of their actions, recognising that it is unproductive to leave at the end of the 12 months which have been particularly necessary for understanding the society we are intervening in.*
>
> **Pascal Dauvin, Johanna Siméant & C.A.H.I.E.R in Humanitarian Work, Presses de Sciences Po April 2002**

'village doctors', by giving them resources corresponding to their abilities. In short, the idea was to harmonize their knowledge and their prescription practices, while aware that medicines were their main source of income. Health economists worked with us to set up a system of payment for doctors, so that by prescribing less, but better, they could break even financially. The other area of this work involved obviously the patients. A sliding fee scale according to the patient's means was devised. Progressively, this project expanded. The Minister of Health had a favourable view of the program. But when we left, everything fell apart. The 'village doctors' went back to their old ways and the system collapsed."

(...) when we left, everything fell apart. The 'village doctors' went back to their old ways and the system collapsed.

→ THE HANDOVER IN SURIN

Some programs draw us into a complex reality, with multiple dilemmas e.g. ARV programs. Although they involve issues that very often push us to the limits of our medical responsibility [see AIDS program in Malawi, page 8], the exception in Surin, Thailand, singularly demonstrates the possibility of a handover of our activities. "The authorities came to see us and agreed to take over our activities," explains Emmanuel Drouhin, program manager. "The political will was there, and they took over the care of our 1700 patients under treatment. We prepared the handover carefully between June and December 2004. The Heath Minister had agreed to commit to a long-term effort, on a national scale, and the relationship of trust built up with him led to continued quality patient care. Today MSF carries out follow-up visits from time to time and supplies second-line medicines and paediatric formulations which are still unavailable in Thailand." The fact remains that Thailand is not Malawi, that the development of the AIDS pandemic and its treatment are still challenging MSF programs, and that the success of a handover depends on the context, which is generally unstable.

→ CHOICES TO CONSIDER

The "standards" that we set ourselves do not always facilitate the handover of our activities: "Our quality criteria are sometimes difficult for other actors to 'replicate'. We often set the bar quite high. Is it really the role of MSF to substitute in for the Ministry of Health? Isn't it rather our role to confront the authorities about their responsibilities?" asks Marie-Madeleine Leplomb.

Malika Saim and Dr. Denis Lemasson (DRC Program Manager and Deputy Program Manager respectively) drive the point home: "Although the experience and the skills of MSF may endure beyond our presence, they are above all a way of ensuring the quality of help when we intervene. It's an induced effect!" Both agree, however, that there is a need to better define medical responsibility. "It's not by restricting it that you reduce it, quite the contrary," Denis explains. "I prefer to talk about the limits. To meet our goals, our intervention must be defined in space and time. In the DRC, we are creating access to care that often did not exist before and which will not exist afterwards." Malika summarises: "Whether you like it or not, it's parenthetical!" In this health desert regularly struck by violence, they add, "If our deci-

→ **Angola, Malange** © Tom Koene - May 2002

sions to step in were based solely on epidemiological criteria, particularly in terms of emergency thresholds and death rates, we should be opening projects everywhere in the DRC. It is therefore essential to define the humanitarian problems to which we decide to respond."

→ THE GBADOLITE EXPERIENCE

Take the Gbadolite project: it was Malika who opened it in 2000, and it was Denis, working as Deputy Program Manager, who closed it in 2005. When the teams arrived five years ago to serve a population in a rebel zone, they frequently reviewed their goals as the insecurity of the setting diminished. The last project, trypanosomiasis and access to healthcare, was closed this year. Malika remembers how the population reacted when MSF arrived: "They hadn't seen anyone in over two years, and they greeted us with shouts of 'Don't bother—we're already dead!" Five years later, several groups of women demonstrated in protest against MSF's departure. "They brought up the issue of failure to assist a person in danger," Denis recounts. "It's hard to hear a mother call out to you, 'My kid, who's going to take care of my kid when you leave?' " The search for an organization to take over the project having ended in failure (except for the trypanosomiasis project), the case of Gbadolite illustrates the dilemmas posed by operational decisions and highlights that often only we are present. "We decided to position ourselves further to the east, where attacks continue," Malika confides. "But after five years in Gbadolite, we knew that such a decision would not be without conflicts. It's proof, as if it were needed, that no matter the figures, criteria for effectiveness or even efficacy, these arguments will always be hard for an especially deprived population to accept. The simple fact of going out to meet people and living side by side with them represents elements that we mention very little – but these are essential."

→ ADVANCE PLANNING AND ITS LIMITS

From the closure of the program in the Panshir valley at the start of 2003 (Denis was present) to the hurried departure from Ghazni, handled by Marie-Madeleine Leplomb, the Afghan experience highlights the issue of advance planning. "Our tuberculosis program was accepted because of its good results," explains Marie-Madeleine. "But the authorities did not have the means to take over the program, maybe it was also a way of skirting their responsibilities, against the background of a latent war. Given the context, we were aware of the threat of an evacuation at any moment. For some time the expatriates had been 'supervising' the work from Kabul, as a security measure. We had made plans for the patients to be able to get all of their treatments in the event of a hurried departure. And all this is what happened, after a UNHCR member was killed. Patient care was maintained up to the end, but we were unable to guarantee follow-up care. We were unable to carry out our search for nine 'defaulters' whom we would have tried to persuade to continue their treatment under normal

In the DRC, we are creating access to care that often did not exist before and which will not exist afterwards." Malika summarises: "Whether you like it or not, it's parenthetical!

•••

→ **Kenya, Homa Bay** © Andrew Njoroge / MSF - August 2002

"The infinite variety of medicines, as well as representations of health, forbid one, except for certain cases, to speak of a sanitary wilderness. It is a common preconception, but contradicted by reality: at the most we could speak of, in some cases, a biomedical wilderness. This is because we do not want to give ourselves the trouble of decoding these complex realities, because we are driven by extra-medical conditions, in particular a logic of pure action, disconnected from the expectations of the population. We prefer to say that there is nothing and, consequently, that everything is needed."

Phillipe Biberson in Sanitary Utopias, (chap. The Sanitary Wilderness) under the direction of Rony Brauman MSF / Editions Le Pommier September 2000

circumstances. As for the dozens of 'beneficiaries' whom we saw on a monthly basis, we knew that we were leaving nothing behind for them."

With both Malika Saim and Denis Lemasson having experienced closures, they began the interview with these words: "Once you've closed down a mission, you no longer open one the same way. A project must always be considered in its totality, like a story which has a beginning, a middle, and an end. You don't open a six-month project like you open one that will last three years." The nature of our interventions also confronts us with limits linked to the dangers facing Médecins Sans Frontières. On this issue, Pierre Salignon stresses, "It is always possible to evoke our medical responsibility, but is this argument still pertinent, in Afghanistan or in Iraq, when the lives of our teams are at stake?" He emphasizes even more forcefully that unlimited and blind medical responsibility would inevitably lead to the irresponsibility of a humanitarian actor like MSF: "would lead us into a wall and beyond our operational framework, a framework that is essential to our actions." He also takes a more positive approach: "Not only are programs meant to be closed, but these closures can also bear witness to the success of an intervention. Let us not forget that. I am equally convinced that something always remains behind. Frustrations exist; we will never be able to respond to everything and everyone. With Madagascar and Gbadolite in mind, we have to admit the difficulty we have sometimes in explaining the reasons for a closure. 'We're abandoning them,' we sometimes tell ourselves. But this harsh perception is perhaps the price we have to pay in order to not lose sight of the responsibilities which we have assigned to ourselves." ■

"They brought up the issue of failure to assist a person in danger," Denis recounts. "It's hard to hear a mother call out to you, 'My kid, who's going to take care of my kid when you leave?' "

1- Patients who have stopped taking their traitment before completing the course

→ Recommended reading: WMA Medical Ethics Manual

This manual questions the notion of universal medical ethics and highlights the ethical dilemmas that arise in questions on health, the carer/patient relationship, relations between a doctor and society, relations between a doctor and his colleagues. This book is not a set of 'guidelines', it reaffirms however the imperative 'to put the patient first'.
On the website: www.wma.net/e/

Free report on AGM discussions

LIMITS OF OUR ACTION: MISUNDERSTANDING OR DISAGREEMENT?

MSF / September 2005 / O.F. / Translated by Sue Pascoe

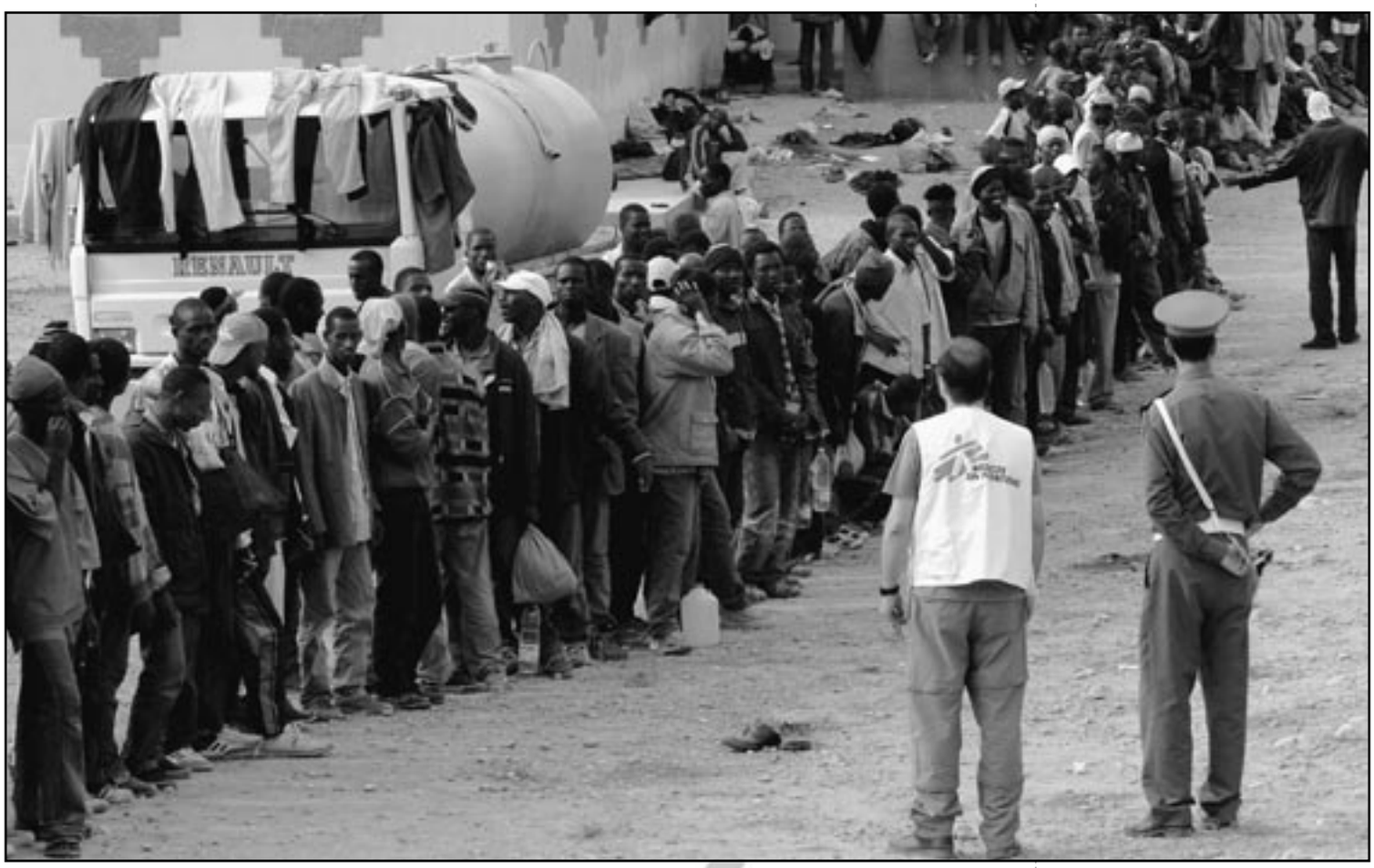
«Why doesn't MSF see any humanitarian reason to stay with us?». This question could have been asked by the inhabitants of Gbadolite (DRC), when MSF decided to close this programme. But going beyond the questions raised by this decision – in terms of analysis of the situation, operational choices or again the perception of the population – this second part of the discussion, dedicated to the limits of our medical responsibility, also provided the occasion to return to the subject of the role of humanitarian organizations.

After recalling that 97 projects had been closed and 85 opened during the past three years, Guillermo Bertoletti, operations director for the French section, emphasized that MSF's operational policy is not to make access to treatment easier for everyone, but to take action as required, in reaction to a major crisis that endangers the survival of a population. He recalled the origin of the humanitarian movement, born of the war, to underline the fact that a policy of social development only makes sense in peacetime.

However Gorik Ooms (general director of the Belgian section) qualified these remarks. According to him, while it is evident that it is not MSF's role to embark on permanent programmes, there is no choice but to accept that many of the problems affecting populations are the result of political choices, and that we should try to exercise greater influence on these choices.
Using the case of Burundi as an example, he recalled that the now-won battle to make ACT freely available has paradoxically not produced the expected effects, since the cost recovery policy implemented by the authorities is encouraging caregivers to continue to prescribe chloroquine. For him, MSF should have condemned this situation, «shown the difference between free treatment and fee-based treatment», just as MSF had previously «shown the difference between chloroquine and ACT», instead of leaving and claiming victory. Christophe Fournier, the programme manager at the time, expressed his disagreement, emphasizing that, as in Sudan, this «battle» for ACT introduction was not solely conducted by MSF but by a whole community of caregivers who had mobilized (Burundi doctors in particular).

He insisted on the fact that it was not up to MSF to «tell people what to do» or to militate for any «health model' whatsoever, also doubting that MSF members could one day «associate themselves with a particular model».

«I do not think it is our job to explain to the Ministry of Health how it should organize itself, but I do believe that it is our role to demonstrate the result of their political choice», stated Gorik.
« This political choice has not come from nowhere. Behind it are sponsors, the World Bank, an entire so-called «war on poverty» philosophy which is leading to human lives being sacrificed because it is considered that this will help economic growth, etc. And I think our role is to condemn it. (...) What really upsets me is that we say on the Campaign web site that we have succeeded in introducing ACT in Burundi, that this was a big battle and a great success, when we know that for 90% of the population this is simply not true. We have an obligation to condemn this situation, instead of simply leaving and telling ourselves that we'll do better elsewhere.»



→ Morocco, Bouarfa, detention centre
© Chema Moya - October 2005

DEBATES

How far does our responsibility go?

MSF / September 2005 / Interview by O.F. / Translated by Lyn Lemaire

For MSF's legal advisor, Françoise Bouchet-Saulnier, our medical responsibility cannot ignore humanitarian law. Between care and the call to arms, there is a gap to fill that calls into question not only the limits, but the substance of our responsibility.

« We have a double medical responsibility with regards to our patients, depending on whether they suffer from an illness or whether they are victims of misdemeanours or felonies, such as ill-treatment or violence. If patients have rights, then victims have rights superior to those of patients: the right to a medical report certifying evidence of signs of violence and ill-treatment, and – more broadly – the right to an appropriate response directed at stopping these acts.

When we diagnose malnutrition, our response – in word and in action – aims to treat the malnourished but also to act upon the causes of malnutrition by demanding or organizing food distribution. There cannot be a double standard when we are caring for victims of rape, torture, or war injuries; obviously we must provide care, but we must also ask ourselves how best to prevent the violence from recurring. In national and international law, the health care agent plays a role in the investigation and reporting of violence, as well as in the search for a solution for these victims. These obligations obviously vary depending on the context—peace or war—and on the existence of functioning institutions. Medical responsibility cannot shirk the « humanitarian » responsibility established by the law of the same name. We must thus be wary

→ **The potentially perverse effects of MSF's public statements on sexual violence**

In Mornay for MSF-F, as in Garsilla for MSF-H, our public denunciations of attacks on women were followed by a drop in rape consultations because of the intimidating measures taken by the authorities to dissuade patients from seeking medical attention.

Extract from the critical review of MSF-France operations in Darfur (Sudan) October 2003 – October 2004

of a potentially perverse effect of our desire to re-centre our activities on the medical act, one that would lead us to ignore our other responsibilities. Nor should we believe that all diagnoses of violence will lead

[...] when we are caring for victims of rape, torture, or war injuries; obviously we must provide care, but we must also ask ourselves how best to prevent the violence from recurring.

to a demand for the intervention of international forces. Between the provision of medical care and the call to arms lies a world of possibilities! We must reflect on the « positive » content of this space and set our limits, by drawing the line beyond simply healthcare. This line encompasses individual diagnosis and care, but also collective diagnosis and documentation concerning the state of the population and the causes of their suffering. It also encompasses the identification of national and international authorities and institutions that have a responsibility with regards to these populations, as well as the role of alerting these other agents.

We must identify our areas of responsibility in order to be define its limits and to defend ourselves when our actions are questioned. As such, when the Sudanese government, who accused MSF of jeopardizing the security of the State by publishing a report on the rapes committed in Darfour, MSF and other institutions maintained that the publication of such reports was part of the normal responsibility of a humanitarian and medical NGO. In the MACA prison, MSF treats prisoners who are victims of torture and ill-treatment. It was by conducting a systematic medical examination on admission to the prison that we were able to establish the origin of the violence. The evidence of facts and the identification of responsible parties allowed prison administrators to notify the Minister of the Interior, who then intervened in certain police precincts that were particularly violent. « Humanitarian » action is action that provides a practical substitute for a temporary deficiency or failure of the authorities. But if it obscures the responsibility of other agents, it risks aggravating exceptional situations, as well as of « facilitating » the tolerance and the continuation of the violence, failure and negligence that it was supposed to alleviate. » ■

EXPOSURE AND PROTECTION: THE EFFECTS

At the very beginning of the intervention, the Mornay teams wondered whether they were not in the process of drawing the population into a trap by giving them a false sense of security just by being there. Nothing allowed us to guarantee that the village would not, in turn, be a victim of destruction and massacres. This was not the case. Does foreign presence in Mornay explain why it was spared? Perhaps, but in any case this cannot be the only explication.

Though it would be dangerous to believe that two tee-shirt clad volunteers deterred the army and its back-up troops from razing the camps to the ground, the teams did, however, help the displaced to escape certain forms of violence. By providing water and eliminating the need for women and children to stray far from the camp site to fetch water from the river, where armed men would attack them, MSF-F has, in a sense, 'protected' some of the displaced people. Moreover, the media attention given to the crisis, the international pressures exerted against the regime and the subsequent deployment of observers from the African Union contributed to tempering the harsh treatment of civilians in places accessible to foreign witnesses. The steps taken by MSF-France to ask the authorities to put an end to the acts of violence committed by their men have played a significant role in this matter, as has our (late) participation in the public disclosure of these aggressions.
In short, it seems that our operations have not contributed to exposing civilians to extra violence, but that they have, in a marginal way, contributed to curbing the violent acts in the sites where MSF has set up programmes.

Extract from the critical review of MSF-France operations in Darfur (Sudan) October 2003 – October 2004

AN ISSUE DEBATED

Moral respo

MSF / September 2005 / Dr Milton Tectonidis / Translated by Ruth Winlo

The concept of medical responsibility sucks. Like the duty to intervene. The humanitarian imperative. The responsibility to protect. International law. The right to be fed. Good and Evil...

All these abstractions lead nowhere but downhill. Unfortunately, history teaches us that abstract ideas have concrete effects...and not always desirable ones.
It was their medical responsibilities which were used in self-justification by those who kept quiet when MSF got kicked out of Ethiopia in late 1985. Some even volunteered to help the government do its dirty work.
It was the humanitarian imperative which turned "destroying life to save life" into a moral gesture in Somalia in 1993.
It was in the name of their medical responsibilities that some people decided to stay in the camps in Kivu province once the emergency was over in 1994, in order to help the killers control their slaves.
It was in the name of the right to be fed that an aid worker dared to claim that the Niger operation in 2005 was " an 80% success," since the distribution of free food had been targeted at places where his agency was working, whilst areas where huge numbers of severely malnourished children were coming forward received precisely nothing.
"Two things fill my heart with ever new and ever growing admiration and respect, as my thoughts focus on and engage with them: the star-studded sky above me and the moral law within." (Kant)
Gibberish. Waffle. There is something profoundly absolutist in these appeals to conscience. The affirmation of certainties and the search for final solutions. The ends justify the means.
"It's not doubt that drives men mad, it's certainty." (Nietzsche)
Instead of dwelling on morality, let us confine ourselves to ethics. Practical ethics. Decision-making ethics.

nsibility or practical ethics?

Pragmatic ethics. Which, by definition, are never fixed. There are no ends, only means.

→ WHAT SHOULD MSF'S MEDICAL ETHICS BE?

Do everything possible for our patients. Systematically target the worst cases, using triage in its noble sense of treating first those in greatest need. Always go one step further. "…. there is only one medical situation: the patient's clinical condition … the doctor is only a doctor if he handles the situation according to this rule: he must do as much as he can, caring for this person who is asking for his help (no 'ingérence' here!) to the fullest possible extent, with all the knowledge and all the resources within his capacity, with no thought for anything else."

"It is not because things are difficult that we dare not, it is because we dare not that things are difficult." (Seneca)

It is when humanitarian aid efforts claim to do good that they become dangerous. Let us be content with the formula of doing as little harm as we can.

→ WHAT ABOUT THE ETHICS OF SPEAKING OUT?

Swim against the tide. Open our mouths when others are closing theirs - without thinking that we are necessarily always right.

Our "partners" often see us as excitable hysterics who cannot be pigeonholed. "Arrange, classify" as Foucault would say. It's the business of all governments, even those who build their careers on the misery of others. As long as it lasts.

Humanitarian aid can never be a good thing. It is when humanitarian aid efforts claim to do good that they become dangerous. Let us be content with the formula of doing as little harm as we can. ■

1- F.Jean. Ethiopie: "Du bon usage de la famine". [Ethiopia: Making good use of the famine]. MSF, 1986

2- R. Brauman. "Le Crime Humanitaire (Somalie)". [The Crime against Humanity (Somalia)]. Arléa, 1993.

3- A. Badiou. L'éthique: "Essai sur la conscience du mal". [Ethics: Essay on the awareness of evil] Nous, 2003

"The humanitarian movement has, thus, as if seized by the dizzying heights of its media success, gone from having a rarely assumed ethical responsibility to a judicial responsibility that it cannot assume. In other words, without being conscious of it, we have gone from the ambition to relieve individual distress to an aspiration to master collective destinies. At Médécins Sans Frontières, the definition of this ethical responsibility has notably evolved in the course of its 25-year history. But it has also been – and remains – the subject of impassioned controversy, whether between different national groups, or at the heart of them."

Rony Brauman, extract from Populations in Danger - 1996

→ **Pakistan, Muzaffarad** © Bruno Stevens / Cosmos - October 2005

Which idea of medicine does MSF embrace?

MSF / January 2005 / Denis Lemasson, assistant programme manager

How is the patient to make sense of the way we practice medicine? What do I represent for the patient? What images of man and his body do we promote, and what ideologies underpin them? When we talk about "MSF medical policy", what do we imagine is the healthcare environment that we create? Some of the many questions that remain to be answered...

→ **Niger, Zinder** © Henk Braam - August 2005

MSF has stimulated much-needed debate about the relationship between its action and politics and the media. But the medical act itself, which we assume our teams really do know about, is rarely questioned, apart from in its purely technical aspects. And yet because of the nature of our work, the way we look at the core issue of the contact between the carer and the patient is of critical importance. All the more so as that meeting invariably brings together two individuals from strikingly disparate environments and very different cultural backgrounds.

Failure to think hard about the nature of the medical act makes you a prisoner of that act, dependent on a single form of knowledge. Today's biomedical community shares the view that medicine is "natural" – as if medicine enjoys supra-territorial privileges, which make it independent of the psychological, social, cultural and political frameworks within which it operates. That assumption also sees the medical act as being about the application of a technique, with the patient as an organic machine. So the act can be applied everywhere in a standard fashion. But if this were the case we would be just a step away from freely available, standardized healthcare for everyone on the planet...

This way of thinking reduces medicine to the treatment of organs. And it reduces patients, viewed through the eyes of the medic, to objects. How many times have I heard well-mea-

→ To read, or re-read:

"Utopies sanitaires", edited by Rony Brauman, published by Le Pommier (2000). This collective publication reflects on the challenges and diversity of medical practices around the world.

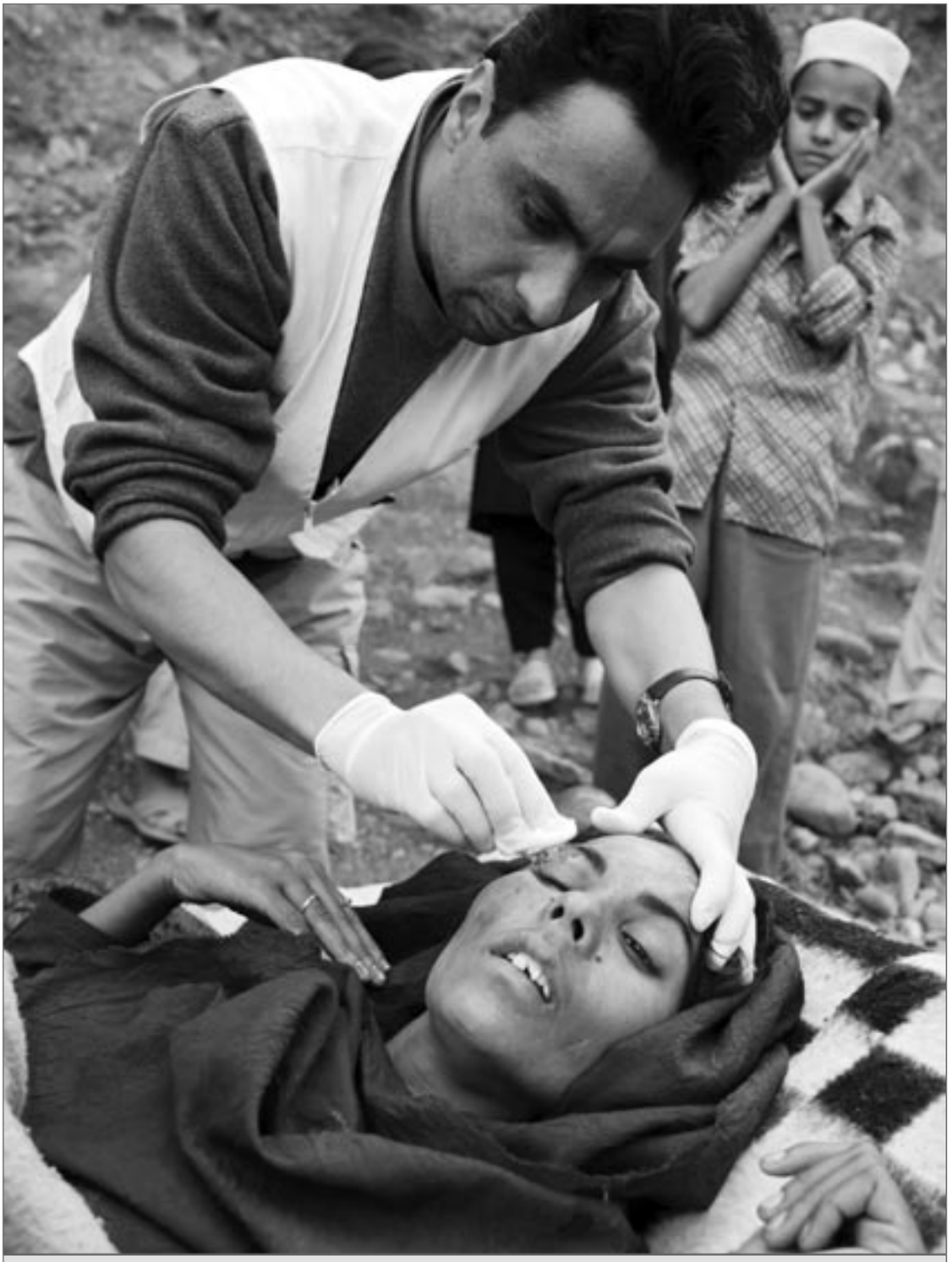
ning expatriates telling their patients "Listen, I'm the one who tells you what's good for you," "I'm the one who knows what's the matter with you," "I'm the one who tells you if you're going to live or die." Talk like this suggests an approach to medicine that dismisses the importance of the patient's own views and their knowledge of their own illness.

It also suggests a colonialist approach to medicine, where the power of the doctor (often, though not always, an expatriate) over a patient deemed to be ignorant (and therefore uncivilized?). It is the power of a science over the bodies of the sick. And so the medical act of the humanitarian worker is no longer a political act at the service of an "ethics of concern". It is an inhuman application of a mechanistic ideology. Where does this lead us? To humanitarian medicine promoting its own power? To doctors whose job is no longer to care but merely to pronounce diagnosis? To a mission which claims to bring civilization and sew 'without borders' the seeds of its own preconceptions?

These are issues that our association must keep coming back to, and our carers hold at the front of their minds, if we are not to lose sight of the meaning of our actions and start running projects which are at odds with our intentions. We have to guard against the encroachment of a veterinary type medicine whose sole justification is a reduction in mortality rates. People's lives cannot be reduced to a doctor's opinion. A healthcare relationship has to be an exchange not only "between the experience of the patient and the scientific knowledge of the doctor, but also between the patient's knowledge of his/her own illness and the doctor's experience"[1]. We cannot ignore these two aspects because we cannot care for an individual without taking into account his personal experiences or his cultural background. If they remove those, doctors are artificially cutting themselves off from the life of the sick individual. They are no longer physicians caring for people, but medical technicians treating illnesses and organs.

Life is not a part of medicine; it is medicine that is a part of life. The work of the doctor and the experience of the patient depend on the anthropological framework in which they take place. While the doctor looks for the indirect signs of the illness (signs whose significance increases the more they depart from psychological or behavioural norms), the patient lives his or her illness. Patients have no defined pathology; they suffer. Illness transforms the world of the patient and in some cases can undermine it, even destroy it altogether. This inside view of the illness is a key part of the doctor-patient interview. That does not mean to say that treatment should become the specialised job of a psychiatrist, although the fact that psychiatry is the only response to this issue does underline the shortcomings in our approach to caring.

Pain is too rarely considered important in our work. That is symptomatic of a wider failure to acknowledge the view of the patient. Evaluation of pain necessarily involves the active participation of the patient. Medicine which is excessively centred on the illness often forgets to treat the pain which the illness causes. Dealing with pain is at the heart of the caring relationship. If being a doctor means nothing more than curing illnesses, then pain is a useful signal. But if being a doctor means caring as well as curing, then the patient's pain should be at the centre of our concerns.



→ **Pakistan, Muzaffarabad** © Bruno Stevens / Cosmos - October 2005

DEBATES

Medical responsabilities

Listening to what patients have to say is about accepting their difference from us, and their integrity. It is about transcending the power relationship between doctor and patient. The biomedical approach often treats the patient's words as interference when they convey more than is strictly necessary for diagnostic purposes. Patients are expected to say, in a concise and scientific fashion, what they feel. But patients lack the knowledge to articulate their suffering, which anyway cannot be stripped of its emotional component. We also need to listen to understand better and then to care. The carer can then adapt themselves to the needs of the patient and help the patient marshal their resources in the fight against the illness. Which brings us to the question of how we are supposed to understand what the other feels. If we do not try to think about the connections between their life and their culture, we can only appreciate the experiences of the other through our own. An element of personal interpretation is inevitable and a doctor depends on their own experiences of illness to interpret those of a patient. Even so, we must try to go beyond our own assumptions to see the unique situation of the patient. Anthropological studies of illness are therefore of major interest in our approach to caring.

Biomedicine is clearly not "natural" but cultivated. It consists in "transforming human misery into suffering, and countering illness with cure[2]. In 1988, Georges Canguilhem proposed an epistemological definition of medicine as the "evolutionary sum of the applied sciences[3]." By this definition we need to draw on numerous fields of knowledge – psychoanalysis, medical history, anthropology, sociology, law, literary studies. "The irrational, clearly a strand in the ineluctable bond between the illness and human mental phenomena and culture, grows in significance the more we overlook it[4]." We cannot do without the human sciences.

The medical act has to be seen in the context of the place where it happens. We have to adapt our programmes much better to the cultural, economic and social conditions. To ignore, as we usually do, the context in which care is given – by imposing our own medical logistics – must often be seen as cultural aggression. It's dangerous not to reflect on the image we project of ourselves. At a time when so much debate is going on about how local populations see us as part of the western powers, maybe we should also reflect on what we can do to rid ourselves of the resource-rich image of humanitarian aid, where we offer the same "packaged" healthcare as the other NGOs which we so readily decry.

Which idea of medicine should MSF embrace? One answer would be to give a more important place to anthropology and sociology, which would allow carers to restore medicine to its cultural context and improve our grasp of its relationship to history. It is the responsibility of MSF to be clear on these issues and to make the new direction a living reality. Then we can move from the idea of medicine as a "science of the body" to become militants of medicine as the "science of humankind". ■

1- F. Laplantine, "Anthropologie de la maladie", "Bibliothèque scientifique Payot", 1986, p.17.
2- B. Good, "Comment faire de l'anthropologie médicale ?" Médecine, rationalité et vécu, Le Plessis- Robinson,1998, p.69.
3- G. Canguilhem, "Le statut épistémologique de la médecine", Review of the history fot he philosophy of science, issue 10 (supplement): 15-29, 1988.
4- F. Laplantine, "Anthropologie de la maladie", Payot, 1986, p.325.

→ Short bibliography

- Pierre Aïach, Daniel Delanoë, "**L'ère de la médicalisation**", "**Ecce homo sanitas**", Anthropos, 1998
- Michel Foucault, "**Naissance de la clinique**", PUF, 1979

→ **Niger, Zinder** © Henk Braam - August 2005

→ **Pakistan** © Bruno Stevens / Cosmos - October 2005

PAKISTAN / EARTHQUAKE

Disaster and distress

MSF / 20 October 2005 / Interview by Isabelle Merny / Translated by Lex Hall

Jean-Francois Corty is a doctor. On the 10th of October, two days after the earthquake that struck Kashmir, he left for the devastated region. Accompanied by Nick Lawson, the head of mission and David Lang, a logistician, Jean-Francois carried out the exploratory missions and preliminary assessments necessary before setting up assistance activities. What they found was particularly alarming.

→ TUESDAY 11 OCTOBER

We arrived in the Pakistani capital, Islamabad. On arrival we meet up with our colleagues from the Dutch and Belgian sections of MSF. We decide to split up to cover the following geographical regions: they will head to Pakistani-Kashmir, leaving us to go to the North-West Frontier Province, to Mansehra and the Kagan Valley. David stays in Islamabad to oversee the dispatch of material, a lot of it by air. Nick and I head to the hospital in Abottabad where there are a large number of patients, many of whom have been brought here by helicopter. The 1000 available beds are all occupied and there are doctors and medicine. The building was damaged during the quake and as a result the sick find themselves outside under fragile shelters. Hygiene conditions are terrible; it's pouring with rain and the number of latrines is insufficient.

→ WEDNESDAY 12 OCTOBER

Morning

We arrive in Mansehra, a region of 1 million people, 30,000 of whom are in the city itself. Here as well the hospital has suffered, the walls

> *"Disorganisation doesn't mean lack of aid or care, on the contrary the Pakistani medical organisations reacted quickly and took control of the situation. As with the Tsunami, the most efficient are the local teams who arrive first on the scene. It's not until after that international NGOs like us join the effort."*
>
> **J.-F. Corty**

MISSION

PAKISTAN

“Although the intensity of the quake in Bam was weaker than that seen in Pakistan, on a proportional basis the death toll was far higher owing to suffocation with the collapse of adobe houses. 30,000 to 80,000 inhabitants of the town perished, but few of the survivors suffered serious injury. The latest official figures on November 2nd put the death toll at 73,000 with 69,000 injured. Despite correct healthcare provision under normal circumstances, the hospitals simply cannot cope with the flood of patients. Patient follow-up, particularly post-operative or psychological care, are not the current priority. In France, if we’d been struck by a disaster on this scale, the hospital system would be just as overloaded!”

J.-F. Corty

show heavy cracks. The maternity ward, the operating theatre and an outside building are the only facilities still of any use. 400 to 500 patients are in tents opposite the hospital. The hygiene conditions the same as those in Abottabad. 8000 injured have been transferred here by army helicopters and 300 new patients arrive each day. A Pakistani civil surgery team is here and is operating round the clock. There are around 40 doctors. We do a tour of Mansehra: some schools, public buildings and private clinics still stand and are put to use as makeshift wards. More than 1000 patients wait on the campus of a university, the Post Graduate College, where Pakistani doctors carry out 150 operations a day. In total, five surgical teams, each with several surgeons, are in the town. At each centre for the wounded, however, we see the same shortfall in hygiene and post-operative follow-up.

Afternoon

Balakot is the last town accessible by road. After that, a helicopter is required to reach the Kagan Valley. Balakot is totally destroyed. The Pakistani army is on-site stabilising the sick before evacuating them by helicopter to hospitals in the large cities throughout the country. Health posts have been set up by the Ministry of Health. Facilities have also been set up by foreign organisations, in particular from China and the United Arab Emirates. Emergency rescue workers, including teams from France, are still on-site. The streets are filled with people and it’s impossible to distinguish between the thousands of victims and volunteers who have come to help.

→ 13 AND 14 OCTOBER

On Thursday we return to Mansehra for a medical assessment. This will be the departure point for the helicopters. I must also look into finding a house for the teams.
On Friday, two MSF doctors and an MSF nurse who arrived the night before join the Pakistani teams in the hospital at Mansehra. While there’s no shortage of doctors, the organisation is nevertheless chaotic. One load of material arrives by helicopter, the other by truck: we start to unload. Work starts on setting up the pharmacy.

→ 15 AND 16 OCTOBER

On Saturday, Nick conducts an exploratory mission in Batagram (30,000 inhabitants), to the north of Mansehra and accessible by road. Ukrainian and Japanese civil security teams have set up a field hospital here. After some internal discussion, it was decided we would take over the activities, particularly surgery. Teams are made up: one in Balakot and one in Mansehra (pharmacy and hospital) where a water and hygiene operation has been launched (installing latrines, showers and water outlets for all the sick accommodated in the tents).

The following day, Nick goes to Balakot accompanied by a logistician, a nurse and a doctor. From there he reports that all sorts of associations – NGOs and otherwise – are pouring in.

→ MONDAY 17 OCTOBER

Two teams (comprising a logistician, a nurse and a doctor) each carrying one ton of material, leave Mansehra by helicopter bound for the Kagan Valley.

Work will focus on two areas in the valley: Kagan and Kawai. Helicopters have spotted many villages (some of around 4000 people) which are yet to receive material or medical aid of any sort.

In Mansehra 80m_ tents are being set up to provide post-operative care to the injured in need of medical follow-up and nursing care. A surgeon, an anaesthetist, a theatre nurse, a GP and a midwife have joined Batagram to take charge of the field hospital set up by Ukrainian civil security.

→ TUESDAY 18 OCTOBER

Two "Médecins Sans Frontières" psychologists leave Islamabad for Mansehra and begin work immediately. ■

THOUSANDS OF WOUNDED

MSF / October 2005 / Dr Jean-François Corty

Every minute helicopters drop off more injured with terrible and infected wounds. The operations and surgical procedures are endless. All around amputees and people in plaster wade through mud. Everything is done in an emergency, in a rush. It reminds me of images from a war zone!

The traditional Pakistani dwelling is a permanent structure made from stone. As a result there were many fractures. Seven days after the quake we’re seeing complications such as wounds and infected fractures, gangrene, and cases of tetanus. When the quake struck (at 8am) many men were out working. Consequently I’ve seen mainly women and children injured following the collapse of houses and schools.

In an emergency of this scale, with the amount of injured patients, there is no time to carry out micro-surgery: there are many amputations.

In addition, there are people suffering from “crush syndrome”: renal impairment caused by muscles being compressed for long periods of time under the rubble. Cases of psychological trauma will also require treatment as will people suffering from chronic illness (diabetes, heart disease, etc.). Provisions also have to be made to treat those who fall sick during this period when the hospital system is overloaded. Winter is coming and we can expect to treat hypothermia and respiratory infections. The earthquake will not itself cause epidemics, but the grouping of the quake’s victims in precarious conditions means we have to be vigilant. It may be necessary to carry out a vaccination campaign against measles in future camps due to the vaccination coverage in the region being too low (61%).

The crisis is far from over

MSF / 20 September 2005 / Interview conducted by Laurence Binet

In Niger, the number of children suffering from severe malnutrition in Doctors Without Borders/Médecins Sans Frontières (MSF) therapeutic feeding centres remains critically high. Thierry Allafort-Duverger, head of MSF's emergency desk, reflects on a nutritional crisis, which is far from over.

→ Therapeutic feedin centers (red)

→ What is the latest on the nutritional crisis in Niger?

Since the start of 2005, we have treated over 30,000 children suffering from severe malnutrition in our therapeutic feeding centres, and we expect the number to rise to 50,000 by the end of this year.

The admission rate in our therapeutic feeding centres in Maradi and Zinder remains critically high. We have admitted an average of 1800 severely malnourished children a week in the Maradi region since the beginning of August.

→ MSF has been calling for free food distributions since April 2005. What is the current situation in terms of access to food for the people of Niger?

Up until July, we were continually calling into question the decision taken by the Nigerien government and other aid providers to respond to the crisis by selling food rather than distributing it for free. From mid-July, the increased media coverage–which was late but nevertheless effective–led to an international aid effort. However, the implementation of food distributions organized by the World Food Program (WFP) has been targeted according to harvest levels, without taking into account the nutritional status of the people concerned. Consequently, they have failed to reach those most in need.

As things stand, the Nigerien government, with the support of WFP, is calling for food distributions to end at the beginning of October–two weeks after the beginning of the harvest – so as not to destabilize the market. It is true that an injection of outside food aid could hamper the sale of harvests and could have a negative effect on the income of Niger's rural population farmers. But as the UN Secretary-General remarked to the Financial Times after his visit to the country on August 23: «When it is too late for prevention, because a crisis has already erupted, life-saving emergency aid cannot be subordinated to some future goal of self-reliance.»[1]

We're still faced with an emergency situation. All efforts to provide free aid to affected families in order to prevent their children from falling victim to malnutrition are as necessary as ever. That said, we insist that the distributions be redirected towards the areas in which families suffering from acute malnutrition are located.

MSF teams are going to distribute part of UNICEF's aid to the worst affected villages to the south of Zinder. This is welcome news.

• • •

POINT INFO

→ on 28/10/05

Niger :
The crisis continues

According to official statements, the food crisis in Niger is over. But the number of medical admissions for severe malnutrition remains high: 1400 during week 42, over 1200 in week 43, and this is just from Maradi and Madarounfa, since the other centers have been handed over to other aid agencies. Food distributions to those with moderate malnutrition and to those at risk have now ended, but when the teams spot cases of moderate malnutrition during screening for severe malnutrition, the child receives a ration of Unimix. We remain concerned about the future : Will 2006 look like the previous years ? No measures have been taken to improve the situation for at-risk families. We are all getting ready; we'll see if we've been heard.

→ **Niger** © Henk Braam - August 2005

MISSION

NIGER

POINT INFO

→ on 28/10/05
Guatemala : In the wake of Stan

Hurricane Stan stuck southern Guatemala in early October, especially along the Pacific coast area, which suffered flooding. The mountainous regions were hit by landslides and mudflows. The three MSF sections present in the country divided up the zones of intervention. After a preliminary exploratory mission, where we distributed medicine and emergency non-food items, we decided to concentrate our operations in the area around Chiquimulilla, located in the southeast part of the country, working with 15,000 people [3000 families] for a period of three months. Our activities include a health component, focusing on the care facilities in the area, and a major logistics component, with distribution of emergency non-items, hygiene kits, cooking sets, and building materials and tools.

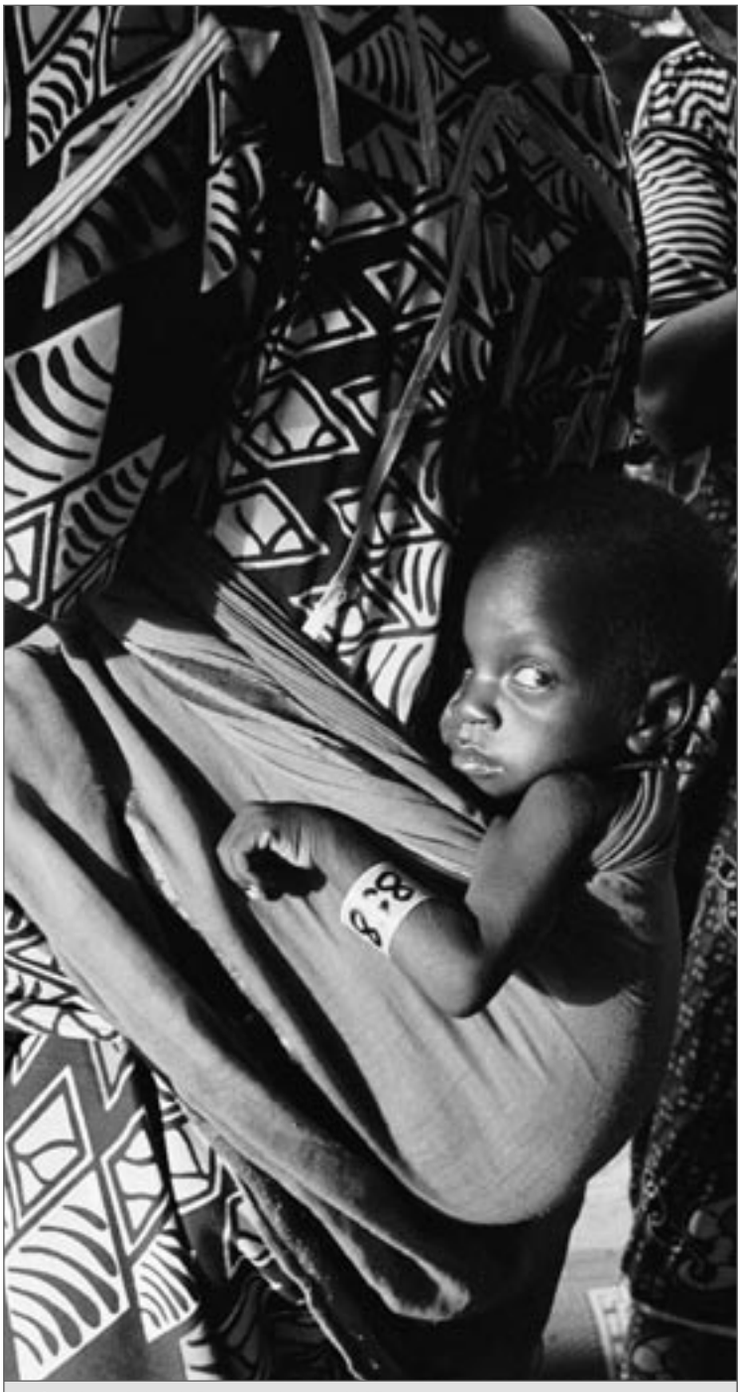
→ Is the food shortage the sole cause of malnutrition?

At the beginning of the year, MSF teams noted an abnormally high number of admissions of children suffering from severe malnutrition i.e. children in danger of dying (three times higher than for the same period during the previous year). It's when we started providing care for these children that we discovered the extent of the food shortage in Niger.

The shortage is not linked to food production, but rather to distribution of the food. We have observed that the majority of the children being admitted to our centres come from regions in the south, considered to be «the cereal belt» of Niger, and therefore less affected than other areas this year by the drop in harvests. It's in fact the poorest families who have been most affected.

They have no means of paying for food and no means of paying for care when their children need it. They're not in a position to cope with the increase in prices brought on by market deregulation and speculation.

The reality is that the problem is not due solely to production, but also to the existence of poverty in certain sections of the population. Ignoring this reality is akin to condemning the families most at-risk.



→ **Niger** © Henk Braam - August 2005

→ What can be done with a situation that is often presented as inevitable?

We have been working in Niger since 2001 and have recorded widespread endemic acute malnutrition, with yearly epidemic peaks of varying intensity. The slightest breakdown, be it a drop in harvests or a rise in prices, is enough to trigger a dramatic rise in the number of children falling victim to severe malnutrition. However nothing has been set up to combat this highly endemic situation or to provide an emergency response to epidemic peaks. As a result, thousands of children are sacrificed each year.

We have been working in Niger since 2001 and have recorded widespread endemic acute malnutrition, with yearly epidemic peaks of varying intensity.

The current crisis has provided us with an opportunity to re-mobilise international aid agencies on the problem of malnutrition. The government, UNICEF, and other organizations that have intervened in Niger during the course of the nutritional crisis are working together to set up a permanent system for the treatment of acute malnutrition. To date, MSF has treated up to 30,000 children and has shown that such a system is possible. But our action alone is not enough to tackle a problem that affects tens of thousands of children each year. And since the families concerned don't have the means to pay for medical care and specialized food for young children, these provisions must be made available free of charge in health centres within the Nigerien health system. ■

1- Africa cannot grow or be free on an empty stomach», opinion piece by Kofi Annan in the Financial Times, August 29th, 2005.

NIGERIA

Severe malnutrition following measles

MSF / August - September 2005 / Laurence Binet

In the state of Katsina, in the north of Nigeria Doctors Without Borders (MSF) has opened a therapeutic feeding centre and several outpatient feeding centres to treat children suffering from severe malnutrition. Thierry Allafort-Duverger explains some of the causes of the situation.

→ What led MSF to open a treatment program for children suffering from severe malnutrition in the state of Katsina in Nigeria?

In June, we conducted an evaluation mission in the Katsina region following a measles epidemic that affected at least 27,000 children.[1] Our nutritional survey showed the rate of severe malnutrition to be nearly 3%. Consequently, at the beginning of July, we opened an emergency therapeutic feeding centre in the city of Katsina, and then gradually set up outpatient therapeutic feeding centres in the region. We plan to maintain these facilities and even increase their capacity in coming weeks, until the end of the wet season. In fact, it is during this period that diarrhoea and malaria flare up and affect especially children weakened by malnutrition.

→ Are the causes of the crisis the same and is it as serious as in neighbouring Niger, where there a serious epidemic of acute malnutrition is ongoing?

The severe malnutrition rates that we found in Nigeria are on the same scale as those in Niger, but the global malnutrition rates (10%). are half of those in Niger. This leads us to believe that the majority of these many cases of severe malnutrition are due to the measles epidemic. 50% of the children currently admitted to our therapeutic centre have been infected with measles.

Of course, the increase of food insecurity and the upsurge of prices have contributed to this crisis. Poverty limits a family's ability to buy food and gain access to medical care, which is not free.

Even though its wealth is very unevenly distributed, Nigeria is a much richer State than its neighbours, thanks especially to its oil revenue. It has large markets well-stocked with foodstuffs and a road infrastructure that allows their transport...

In fact, it is in Nigeria, in the city of Kano, that the World Food Program has just bought 3000 tons of food for distribution in Niger!

OUR OPERATIONS ON 25 OCTOBER 2005

1 therapeutic feeding centre in the city of Katsina

12 outpatient therapeutic feeding centres around Katsina and Daura

9 000 children admitted since the start of our operation

700 admissions per week on the average

10 000 à 12000 total expected admissions

→ How can the deadly measles malnutrition cycle be prevented?

Experience has shown that it is imperative to vaccinate children during measles epidemics that affect large numbers of children, many of whom die. Our retrospective mortality survey carried out in the region of Katsina showed mortality rates of 6 per 10,000 per day among children under five[2]. www 70 % of these children died following serious complications of measles such as pulmonary disease and development of severe malnutrition.

Thus, it is vital not only to provide hospital or outpatient care for children suffering from measles, but also to ensure proper medical care for severe malnutrition.

Vaccinating during epidemics would make it possible to reduce the need for complicated, costly medical care.

→ Does that mean that vaccination is less costly than treatment?

Yes. We have calculated the comparative costs during the course of our measles epidemic operation in Chad, which began in early 2005. They are as follows:

- Inpatient treatment of a child suffering from a serious complication of measles: 178 €
- Outpatient treatment of a child suffering from severe malnutrition (post-measles): 275 €
- Inpatient treatment of a child suffering from severe malnutrition (post-measles): 600 €
- Vaccination of a child against measles: 4 €

Vaccination means less suffering for children and also means mothers do not have to leave home in order to take a sick child to hospital.■

1- Number of cases recorded by the Ministry of Health. The exact figure is undoubtedly higher.

2- generally accepted critical threshold : 2/10,000/ day

POINT INFO

→ on 28/10/05

Nigeria : Malnutrition continues in the north, care coverage problematic for the injured in the south

The teams had noticed a "admissions plateau", indicating perhaps a drop in the number of children. But the arrival of the rainy season and its associated illnesses resulted in a smaller drop than foreseen. This program is still run by 15 expatriates. The question that remains now concerns the future of this program. Malnutrition persists as a chronic phenomenon in the northern part of the country, and that being the case, we would like to remain involved long-term. But we continue to have trouble working with the authorities who still won't recognize the existence of this severe malnutrition. Our teams are readying the smooth transfer of our activities to the Ministry of Health, meaning it's time for us to prepare a new intervention project.

In the south we are trying to follow through with our activities in the medical center for the injured which opened in Port Harcourt. But we are encountering difficulties in finding and bringing in the patients: the teams have set up extremely strict security protocols, limiting movement around the city. In addition, administrative restrictions on the importation of surgical supplies are especially tight: the last order sent at the end of August has just arrived. We are going to try to improve this situation.

MISSION

SUDAN

SUDAN / DARFUR

Ongoing tension, mounting insecurity

MSF / September 2005 / Caroline Livio / Translated by Karen Tucker

Gabriel Trujillo, MSF's deputy program manager for Sudan, has just returned from Darfur where episodes of violence are again hindering our operations. In western Darfur, our area of operations, the displaced populations continue to live in great insecurity, still subject to violence and continuing conflict.

→ **Sudan** © Martyn Broughton - April 2005

→ How has the situation evolved over the past year and a half for the populations in Darfur?

When MSF first started working in Darfur, in late 2003 and early 2004, the civilian populations displaced by violence and fighting were completely destitute, which required the setting up of large-scale medical, nutritional and sanitation programs, MSF's largest operation in 10 years. More than a year and half later, the situation has changed. The number of humanitarian organizations in the field has grown and, while the displaced population is still living in great insecurity, the epidemiological indicators show that medical and nutritional needs are covered, even though there are disparities among northern, southern and western Darfur.

→ Can you describe the current context that we are working in?

Darfur is once again the scene of conflict between rival factions. This violence has had a direct impact on our activities: we have had to restrict all travel by road – as they have become more and more dangerous- and we can therefore no longer refer patients in need of surgery to other facilities. We are looking into the possibility of transferring these patients by helicopter. The situation for the population continues to be critical due to the high level of insecurity, which is not only continuing but increasing inside and outside the camps. What's more, the displaced populations face ongoing pressure to return to their homes. At the same time, you can't help but notice the absence of a political solution to the conflict. In this environment of ongoing tension and insecurity, our presence remains essential.

→ What is our operational approach in Darfur today?

We have set up the necessary means to respond to the possible needs in the event of conflict in the areas where we are working, El Geneina, Mornay, Zalingei and Niertiti. In addition to our efforts in these four zones we have begun to set up mobile medical activities in Jebel Mara to provide care to isolated populations living in two sites of 25,000 people each – Thur and Kuthrum. Thur is controlled by the government and Kuthrum by the SLA, one of Darfur's rebel movements. It is difficult to determine the level of violence committed against these populations, but their isolation in Jebel Mara has deprived them of access to medical care until now. We travel to these two sites from Niertiti every week and are trying to increase the number of our visits. It is important to evaluate the medical needs of the nomad populations in order to set up a relevant healthcare response. We also plan to provide more health care to women in Mornay, Zalingei and Niertiti because the ongoing violence that especially targets women remains one of the major problems in the IDP camps. For example, direct victims of violence (wounds, burns) are the second leading cause of admission, after respiratory infections, to the emergency services of the hospital we're running in Mornay. Three percent of admissions are the result of sexual assaults. ■

The situation for the population continues to be critical due to the high level of insecurity, which is not only continuing but increasing inside and outside the camps.

OUR ACTIVITIES IN DARFUR

We ceased our activities in El Geneina hospital at the end of September. However we are still present in Mornay, Zalingei, Niertiti and western Darfur, to 300,000 people, of whom half are displaced.
We are continuing our activities in the hospital in Mornay, which include some 6,000 medical consultations monthly; in Zalingei, in clinics set up in a displaced persons' camp and in the pediatric department of the city hospital; and in Niertiti, where we are running a health care center with hospital beds.
With respect to feeding programs, we are treating a number of severely malnourished children in Mornay, Zalingei and Niertiti. In Mornay, admissions increased in July after the World Food Program stopped distributing food for several weeks. In Zalingei, malnutrition is more commonly related to episodes of diarrhea during the rainy season. The same holds true for Niertiti, where we are receiving children from Jebel Mara.

POINT INFO

→ on 28/10/05
Sudan: Outbreak of fever in Kordofan
Nearly 200 cases of fever with hemorragic symptoms were recently registered in Kordofan, Sudan. Examinations are underway to confirm the type of disease. Our head of mission is currently doing an on-site exploratory mission.

Congo Brazzaville © Alixandra Fenton - March 2003

CONGO / BRAZZAVILLE

Once upon a time in Brazzaville

MSF / September 2005 / Anne Yzebe / Translated by Ruth Winlo

In December 1998, Brazzaville was once more at war. MSF had left the country nine months earlier, the emergency during the war of June 1997 having come to an end. But events triggered the rapid return of Médecins Sans Frontières, marking the beginning of a mission which would last for six years. MSF has just closed its programmes in Congo-Brazzaville.

The emergency period began at the end of 1998: 800,000 people fled the fighting, including 250,000 who arrived in the capital Brazzaville to find refuge. MSF set up the triage of patients and referred the most serious cases to the Makélékélé hospital and the CHU, which had supplies of medications. Four therapeutic feeding centres and two cholera treatment centres were opened.

The end of 1999 was marked by two peace agreements: one in Pointe-Noire and one in Brazzaville. MSF gradually developed medical and feeding programmes as enclaved areas opened up. 15,000 severely malnourished children were treated in Brazzaville, Kinkala, Mindouli and Sibiti.

In 2000 another war, in the Democratic Republic of the Congo (DRC), sparked a new emergency: approximately 65,000 refugees fleeing the fighting in the DRC settled along the border, in the region of Likouala. An assistance programme for the refugees was set up. In the districts of Njoundou and Bétou, MSF opened fixed and mobile clinics, rehabilitated the health centres, set up a drinking water supply system and carried out several vaccination programmes.

Between 1998 and 2000, civilians were the victims of numerous acts of violence, reported by MSF in the book "A war against civilians"[1]. MSF decided to help victims of rape. The "sexual violence" programme started in March 2000 in the Makélékélé hospital in Brazzaville, with free medical consultations (medical care, morning-after pill, preventive treatment against STDs, HIV screening and measures to reduce the risk of becoming HIV positive) and psychological support.

→ THE DISPLACED RETURN HOME

2001 seemed like the year of transition. There emergency due to armed conflict was over, but the destruction of health facilities meant that treatment could not be provided to the displaced persons who were returning to their villages. MSF focused its activities on medical care in the districts of Mindouli, and Sibiti, and in the region of Likouala (136,000 outpatient consultations were carried out in 2001). Whereas the lack of health care staff and the cost recovery system (the reintroduction by the Congolese Ministry of Health of charging payment for consultations) limited access to treatment, the centres gradually regained their autonomy, leading to the progressive closure by MSF of its programmes.

There was one exception: in Bétou, where there were still large numbers of refugees, the programme was stepped up. The only referral centre in the region was run entirely by MSF. In 2001, the bed capacity increased from 4 to 65, with medical, paediatric, obstetric-gynaecological and surgical departments. In 2002, the hospital saw a significant volume of work, with an average of almost 2000 outpatient consultations, 250 hospital admissions and 5 to 8 emergency operations per month.

→ THE VIOLENT ERA

But in 2002 fighting resumed between the Congolese armed forces and the Ninja rebels in the Pool region and in the capital, leading to population displacements, massacres, rapes, looting, and destruction. The region was inaccessible to humanitarian assistance. In Brazzaville MSF stepped in to help 80,000 displaced persons with a

• • •

→ Six years later

1200 Médecins Sans Frontières volunteers have worked on this mission. More than 400,000 outpatient consultations were carried out between January 2001 and April 2005. MSF has treated 1500 victims of sexual violence in Brazzaville and 1267 operations were carried out in Bétou. This mission represented almost 12 million euros of humanitarian aid.

To read:
Civilians under fire. Humanitarian practices in the Congo Republic 1998-2000
Edited by Marc Le Pape, Pierre Salignon
MSF, October 2001

MISSION

CONGO - BRAZZAVILLE

temporary clinic and a vaccination programme. More than 15,000 consultations and about a thousand hospital referrals were carried out between January and July 2003, the date of closure.

The rape victim programme continued in Makélékélé hospital, and in 2003 at the Talangai hospital. The 'victims of sexual violence' programme was supplemented by individual psychotherapy. Particular attention was paid to the children of the victims and to children born as a result of rape. A survey conducted by Epicentre[2] in 2004 showed that, one year on, 70% of victims were still benefiting from the psychological support they were given. Links with the network of associations providing social welfare were strengthened.

→ **Congo Brazzaville** © Alain Fredaigue / MSF - March 2003

→ THE POOL ACCESSIBLE AT LAST

MSF returned to the Pool area in June 2003, after a new peace agreement between the belligerents. A new shock: the villages had been plundered of everything they contained, the inhabitants were totally destitute and most of the health centres had been destroyed. Everything had to be re-built from scratch.

Mobile clinics and a support unit at the hospital to which they were referred gave the local population and the displaced persons access to treatment in the Mindouli district. Almost 8000 consultations on 11 sites and a polio-measles vaccination programme were carried out between July and November 2003, the date on which work was suspended for security reasons. From June to December, the hospital for its part provided nearly 2,800 outpatient consultations per month.

In 2004, progress towards peace was at a standstill, the region remained unsafe and thefts, acts of violence and pressure against the humanitarian agencies increased. In spite of these difficulties, work resumed. MSF participated in the re-opening of 14 health centres in the Mindouli district, providing medicines, medical supervision and training to the hospital and 5 outlying centres. More than 55,000 outpatient consultations and nearly 3000 hospital admissions took place at the hospital.

→ FROM A MILITARY TO A SOCIAL ISSUE

In 2004, MSF had two other programmes, one in Bétou and one in Brazzaville. The rebuilding of the health centre in Bétou turned into the construction of a hospital: 1000m2 renovated, 1000m2 newly constructed. The hospital now has many wards: outpatients and vaccinations, internal medicine, paediatrics and a feeding centre, emergencies and observation, obstetrics/gynaecology, surgery, and an isolation ward for TB patients, as well as hygiene, water supply and guard services. There are 8 hospitalisation wards, and 2 operating theatres. When the hospital was opened, in August 2004, MSF did the calculations: 242,000 consultations, 9600 admissions and 737 surgical procedures in 4 years. 59 expatriates have worked on this project and the budget for its construction and running costs has been in excess of 3 millions euros.

In Brazzaville, the profile of victims of sexual violence has changed: in 2000, half the assailants were soldiers. 3 years later, intra-family and community violence is on the increase and the large majority of victims are minors. On March 8 2003, International Women's Day, MSF launched an information campaign, "I say no to rape", to raise awareness of the scale of the problem of rape in Congo.

→ WITHDRAWAL FROM CONGO-BRAZZAVILLE

2005 has been the year of withdrawal from the Republic of the Congo, with MSF handing over its programmes to other organisations whenever possible. In the Pool, the improvement in security conditions and the handover of our work by MSF Holland, who are present in the region, ensured that conditions were right for our withdrawal. In the region of Likouala, the programme was no longer justified by the presence of refugees, a large number of whom had left. Unfortunately the handover of Bétou hospital to the Ministry of Health has been a failure. When MSF left the hospital, no staff from the Ministry of Health were there to take over. The hospital was quickly emptied of its equipment and patients as medical treatment is now charged for. But in Brazzaville, the "sexual violence" programme goes on: with the financial support of the World Bank, the state-run hospitals are taking over for the next 5 years. ■

> *"(...) In the case of the people of Brazzaville and Pool, for example, the image of starving children dominated that of rape victims. The image of the men who were summarily executed was also relegated to little more than a detail."*
>
> **Jean-Hervé Bradol in « Civilians under Fire » (Op. cit. p.31)**

1- "Une guerre contre les civils". Comments on the humanitarian practices in Congo-Brazzaville 1998-2000 General Editors : Marc Le Pape, Pierre Salignon. By Hélène Asensi, Rémy Bazenguissa, Jean-Hervé Bradol, Marc Le pape, Joanne Liu, Christian Losson, Marie Rose Moro, Pierre Salignon - Pub. Karthala, October 2001

2- A non-profit-making organisation created in 1987 by MSF. It brings together health professionals specialising in public health and epidemiology.

DRC / NORTH KIVU

Land of predation

MSF / August 2005 / Denis Lemasson, Deputy Programme Manager / Translated by Carole Patten

The North Kivu region continues to be the scene of multiple conflicts inflicting death and physical abuse on the civilian population. MSF has decided to extend its activities by opening projects in Kayna and Rutshuru, two localities particularly exposed to the violence of the conflicts.

Josephine starts to tremble. She is looking towards the bottom of the valley towards the armed men. She mumbles over and over again : «Les barbus, les barbus (the men with beards)...» Josephine recoils, a child tied onto her back. Her feet and legs are covered in brown earth. I can see the fear spreading across her face: it's terrible. She steps back and stumbles. She turns to flee, once again. And runs off.

Remnants of the violent pillaging are everywhere: scattered clothing torn to rags, broken doors... For the past month, militias have been killing, abusing and mutilating the inhabitants of the area. Josephine now sleeps in a village to the north, four hours walk away. Despite the risks, she comes here every day to tend to tiny plots of land. This morning she came with two former neighbours to plant potato tubers.

We are in Bulindi, in the province of North Kivu (eastern DRC). Only one man has stayed in the village. He has nowhere to go. He sleeps in the bush and spends his days in the village. The man shows us his injuries, with what seems an apologetic smile. Two months earlier, another militia had attacked. They tied him up, cut off his ear and struck him with a machete on his legs and chest. The militia did not kill him; he doesn't know why.

→ **DRC, North-Kivu** © Denis Lemasson / MSF - August 2005

→ CRYSTALLIZATION

Josephine and this man could be from any village in this part of North Kivu where the violence is concentrated. From Kayna to Goma, fear and suffering are part of daily life. There are rival militias, made up of soldiers from Uganda, Rwanda and Kinshasa (and actively supported by their governments) who fight, pillage, abuse and kill. There are also government armed forces (FARDC), with little or no pay, who too participate in these atrocities against civilians and factions refusing to join the government forces involved. The reasons for the violence are complex, resulting from conflicts of varying nature[1] : the continuation of the Rwandan crisis that has transferred over to the east of the DRC; the battle for power in Kinshasa that opposes and divides the Congolese elite; the militarised social and agrarian conflicts, and the control of mining resources and cross-border commerce. In this province many national issues are crystallized, stirring up the violence. There can be no peace nor elections in DRC without peace in North Kivu. June saw the renewal of the transition process. In protest demonstrations, organised notably by Etienne Tshisekedi, dozens of people were killed and several dozen injured. The preparation for the general elections in June 2006 indicates the need to accelerate the restructuring of the armed forces and the immediate disarmament of the foreign armed groups based in DRC, particularly in the east of the country. There is legitimate concern about whether this process will be carried out correctly.

In this province many national issues are crystallized, stirring up the violence. There can be no peace nor elections in DRC without peace in North Kivu.

→ DIFFICULT AID

On the ground, no one can tell combatants and civilians apart. Certain militias were created to defend the territories where their members live. They have, however, become actors in the conflict themselves and seek to assert their power over the civilians. The victims, far from being people unknown to their aggressors, sometimes belong to the same community, or the same village. Insecurity makes it difficult to deploy medical aid in the region. Further to the North, in Ituri, the Swiss MSF teams were

• • •

POINT INFO

→ DRC, North-Kivu

Since Monday, October 31, joint military operationsby MONUC and FARDC [the Congolese army] took place nearly everywhere throughout North-Kivu. In East Rutchuru they are targeting the FDLR [composed of Interhamwe and ex-FAR members], who are south of Kayna and in the Virunga park lands. Our teams have recorded no deaths, injuries, or displacements of the population. At the same time, additional similar operations took place north of Butembo, targeting the Mai-Mai, leading to 32 deaths. Once again, no injuries or displacements were noted.

MISSION

Democratic Republic of Congo

forced to withdraw from projects in the periphery of Bunia following the kidnapping of two of their members for ten days. In North Kivu, access is limited in the zones which are too dangerous to operate in e.g. south of Kanyabayonga. By increasing our contacts with all of the militias we nevertheless manage to provide healthcare to a large part of the province.

→ EXPANSION NEVERTHELESS

Since mid-June, we have extended our activities and opened a programme in Kayna hospital. Here we can provide care for all emergency cases, both medical and surgical. We are still running a therapeutic feeding centre, 5 supplementary feeding centres and a consultation for rape victims (more than 700 cases treated since September 2004).

We are also opening a new project in Rutshuru -between Virunga national park and the Ugandan border- an area particularly effected these last months by heavy fighting, that has led to pillaging, wounded civilians, rape, population displacement, malnutrition, and the heightened risk of diseases with epidemic potential e.g. cholera.

Since 1998, the war and its consequences have already caused the deaths of 3.8 million people[2] in the Democratic Republic of Congo. ■

1- See: Marchal (Roland), Anatomie des guerres en Afrique, in Questions internationales, January-February 2004

2- Estimate at the end of April 2004/ Source : IRC - Mortality in the Democratic Republic of Congo: Results from a Nationwide Survey (April - July 2004)

→ **DRC, North-Kivu** © Denis Lemasson / MSF - August 2005

→ DRC, North-Kivu
© Denis Lemasson / MSF
August 2005

FROM THE FIELD

Setting up in Kiwanja

MSF / October 2005 / Anne Vallaeys, journalist and writer / Translated by Christopher Scala

On August 5, Anne Vallaeys joined an MSF team leaving for North-Kivu to open an advanced medical post in Kiwanja. For this issue of Messages, Ms. Vallaeys, the author of Médecins Sans Frontières, la biographie (published by Fayard), describes the early days of this mission near the eastern border of the Democratic Republic of Congo, an area deep in the grip of military instability. She recounts the discoveries, confrontations and dilemmas that two 'first-missions', backed by MSF teams from Beni and Kayna, experienced on arrival in the field.

Tuesday, August 9. After four days on the road from Kampala, the capital of Uganda, the new MSF 'arrivals' reached Kiwanja in the Democratic Republic of Congo. The first view of this town in the region of Rutshuru in North-Kivu is a streak of asphalt bordered on both sides by a patchwork of dark cement buildings, where vegetation obscures the rough-hewn boards and corrugated iron. At first, there is nothing particularly different from other towns passed since entering Congo. Bars, discotheques, little "Chez Mamie" hotels, car and bike repair workshops, hairdressers, pharmacies, containers transformed into Vodacom concessions ("the Cellular Pioneer in the DRC"). An assortment of stalls spread out in the fragile shade of the acacias, under umbrellas. Pyramids of tomatoes, pineapple, bunches of green bananas, a collection of palm oil flasks, cassava bread, cartons of Ambassadeur cigarettes, Vache-Qui-Rit cheese sold by the triangle and boxes of Super fort insecticide. There is no shortage of merchandise. Activity is intense on this road, overrun with vehicles whose axles grind under the weight of their load. Pedestrians, cars, bikes, carts and oblivious goats, everything in constant motion, the radios blasting music. Life.

Among the customers, however, khaki silhouettes wearing berets stroll along in clusters, Kalashnikovs slung across their

FROM THE FIELD

shoulders. The sudden arrival of a UN pick-up loaded with armed blue helmets brings the MSF team back to reality: fifteen days earlier, on this main road, two hours north of Kiwanja, the towns of Nyamirima, Buramba and Kisharo were the scene of violent clashes between a thousand Mai Mai combatants and FARDC troops. The assault was so fierce that the "national" Congolese army retreated two days later to re-position, taking advantage of a "corridor" set up by MONUC soldiers. Rumors speak of a thousand dead. Since these clashes, seven thousand men, women and children, fleeing the fighting as well as the pillage and exactions wrought by both camps, have taken refuge in Kiwanja and the surrounding villages.

→ **RDC, Nord-Kivu** © Denis Lemasson / MSF - August 2005

"Good time to open a new program", wrote Jean-Sébastien Matte in his weekly report of August 5. He is in charge of the MSF North-Kivu coordination team. A coordination team had been based since December 2002 in Beni, on the northern edge of Beni province, eight hours by dirt road from Kiwanja.

In 2004, MSF was alerted of the situation in Rutshuru, a large forested region, bordered on the west by Virunga National Park. It stretches from north of Goma to the shores of Lake Edward, on the flank between the Rwandan and Ugandan borders. The alert came from Kayna, in the neighboring province of Lubero, northwest of Rutshuru, where an MSF mission has been running a nutrition program and the hospital since January 2004. The field teams had observed frequent comings and goings from the east, but nothing major: the "arrivals" would come in small groups, in trucks or minibus, most on foot, nearly empty-handed, as if they were going to market. In July, these fluctuating movements increased considerably in number to the point that "refugee committees" started developing as more and more "arrivals" turned up in Kayna and the surrounding area. At the end of the month, eight thousand refugees, sheltered by host families, had been registered. Most came from towns and villages located along the Rutshuru-Ishasha road. What was happening there, why were these people leaving, what was the political and health situation in the eastern border area?

On July 31, 2004, an MSF exploratory mission arrived onsite. The report they delivered fifteen days later was somber: the context was complex and tensions high. A concentration of unending conflicts have been spilling blood in eastern DRC for a good ten years, with the same factions confronting eachother: Rwandan rebels and partisans, the Interahamwe who wrought genocide upon the Tutsis in 1994, Mai Mai militias (acting on the orders, some say, of someone named Jackson, who was recruited and trained by the Ugandan army), "local defense forces" armed by this or that well-known politician or warlord, not to mention the "inciviques" – the local name for poachers and other bandits. All sides are constantly settling scores as alliances shift and splits occur, and, in the confusion, each clan fights over the smallest inch of land in search of loot and vengeance. The civilian population, caught in the middle, can't tell who is who. The general situation – from Kiwanja to Katwiguru, Kisharo to Buramba and Nyamirima to Ishasha – is one of armed gangs attacking villagers in their homes and fields, raping women and girls, and looting and torching towns. The FARDC[1], a motley group of soldiers from the Congolese army, which is supposed to keep the peace in the region, only adds to the chaos. Unpaid and poorly disciplined soldiers take part in the pillage economy, and are even accused by the population of being the main cause of "tracasseries". And then there is the MONUC[2], authorized by the international community in support of the "peace process" in the DRC. Given the size and geography of the country, how can fourth thousand blue helmets, deployed across the eastern expanse of Congo, possibly protect the population in such an explosive context?

In an evaluation of regional health facilities, the MSF exploratory team observed that the main cause of hospitalization in Rutshuru general hospital were bullet wounds: between six and nine cases every week in the first six months of 2004. However, the mission concluded: "There is no medical or nutritional emergency in the region. There are health facilities staffed by motivated personnel that are capable of providing basic services in the current situation – on condition that

1- **FARDC : Force armées de la République démocratique du Congo**

2- **MONUC : Mission d'observation des Nations unies au Congo**

PRESS REVIEW

MSF / November 2005 / O.F.

→ Update on the Arjan case

Is it MSF who can't manage to make a political statement, or is it the media who balk at passing it along?
In any case, the politic aspect of the lawsuit brought by the Dutch government against MSF has received little press coverage as of yet. In the November 1st edition of Le Figaro, the newspaper noted that "the main issue is not so much the amount laid out on the table as the political significance of the gesture". Nevertheless, the complacence of Europeans in the face of Russian authority has barely been touched upon. Trafficking in human beings, practiced with the duplicity of a government, has not come out in the papers, either. They have focused instead on the procedural aspects of the affair and on a "position of principle", that both the NGO and the Dutch government hold, "for fear of encouraging kidnappers" (also from Le Figaro). Will we be able to get past the squabbling to tackle the real issues at the heart of this lawsuit? That is the question.

these health centers are not regularly looted or ransacked by the different armed groups…" That is one way of reminding people that the main concern – improving the safety of the residents of Rutshuru – is a political responsibility rather than a situation requiring a humanitarian response. That's where things stood in Rutshuru in 2004.
Over the months that followed, MSF focused its efforts on the province of Lubero, on the western flank of Virunga Park, where the situation flared up suddenly in December. Fighting erupted between the rebel Hutus from the Democratic Liberation Forces of Rwanda (FDLR), present in Ikobo region, and the Kinyarwanda-speaking Congolese troops from the RCD-Goma, which included strange officers speaking English and Kinyarwanda, the language spoken mainly in Rwanda. The government army forces, positioned to help rebuff this "Rwandan invasion", ended up scattering instead of containing the fighting! In their retreat, they terrorized and looted people encountered on the way, provoking an exodus from villages along the road leading to the FARDC headquarters in Lubero, one hundred kilometers from Kayna, which became a ghost town. Seven days later, further to the south, the road running along Lake Kivu was the scene of clashes generated by five hundred Mai Mai who ended the truce that they had observed until then toward their old enemies from the RCD. The belligerents fought with heavy weapons for hours on end, before the Mai Mai were forced to withdraw toward the neighboring province of South-Kivu, which fully backed President Kabila. Just one example of the uncontrolled incidents that have taken place during a "peace process" that nearly sixteen thousand UN blue helmets, the largest peacekeeping operation in the world, have been unable to safeguard.

The most fragile zone appeared to lie along the Kiwanja-Nyamirima road, where half a dozen abandoned villages bore witness to the displacement of eight thousand people.

As this conflict brewed, MSF sent a second exploratory mission from April 4 to 9, 2005 to Rutshuru. "Since the last MSF visit, it cannot be said that the social climate has improved", reads the report. "An atmosphere of distrust and suspicion – even paranoia – prevails. The milieu is opaque and the people are tightlipped, which makes it very difficult to understand the context in detail." With regards to the population displacements, the mission noted: "There is no mass movement, there are sporadic movements in response to attacks from different factions." Disordered and unstable, the errant commandos are referred to by a number of names by the population: "foresters", "inciviques", "Jackson's Mai Mais", "Interahamwe", "FDLR", and "bandits". "What is clear," according to the report, "is that the people are in a precarious situation, where access to medical care is very limited. The people are on their last legs and trying, as best they can, to tend to their fields in the hope of reaping some benefit."
The most fragile zone appeared to lie along the Kiwanja-Nyamirima road, where half a dozen abandoned villages bore witness to the displacement of eight thousand people. "This is also where we have counted the largest number of victims of sexual violence, one to four cases reported per month in the various health centers visited."
In conclusion: "The context and configuration are similar to those that the people and our teams are experiencing in Lubero and in the Kayna health zone, but without the permanent presence of any international humanitarian organization on the ground in order to come to the assistance of these people living in a precarious situation."
The MSF team suggested providing a response to the medical emergencies along the Rutshuru-Nyamirima road. This response would be based in the Katwiguru health center, equidistant from the two towns. With the assistance of local medical staff paid by the association, MSF would provide free primary care and help for women victims of sexual violence. The association would also manage transport and follow-up care for medical and obstetric emergencies at Rutshuru general hospital, where the surgical unit would be supplied with appropriate equipment and medicines.

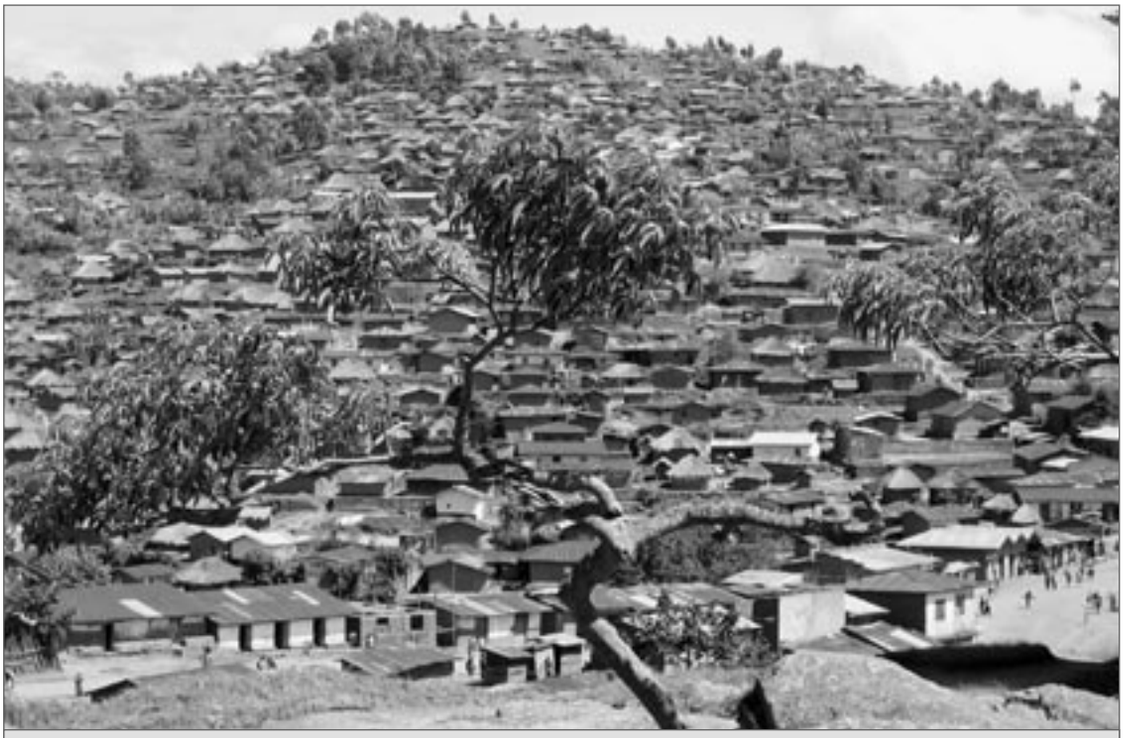
→ **DRC, North-Kivu - From left to right : Dr Teddy Ngondu (field doctor), Jean-Sébastien Matte (Coord. North-Kivu), Mao Kasareka (Assistant Log.)** © Denis Lemasson / MSF - August 2005

August 2005, Kiwanja. At the entrance to the city, MSF's presence is distinguished from the other simple buildings only by the association's sticker on the rusty zinc gate, which creaks when a 4x4 goes by. On the doorstep, Filipe Ribeiro and Marie-Jo Michelet welcome the newcomers. Benjamin Hébert and Didier Dellea are relieved to have reached the end of their long journey. Ten hours in a plane from Charles de Gaulle airport in Paris to Entebbe, via Brussels and Nairobi, then, after a night in Kampala, lodged by MSF's mission in Uganda, six hours in a 4x4 to the customs-post of the Democratic Republic of Congo, "Land of hope, country of the future" reads the peeling sign on the thatched customs house there. Three hours

PRESS REVIEW (CONT.)

→ A warm welcome

The papers have extensively covered the recent events in Ceuta and Melilla. On September 29, these two Spanish enclaves on Moroccan soil were the deadly stage where hundreds of immigrants attempted to cross into European territory.
The police used force to stop the immigrants and at least five people were killed. This repression also brought up a situation of regular violence that the Spanish section of MSF cited in a recent report. The October 1st edition of Le Monde announced, "MSF estimates that 6,300 migrants, rather than the 1,400 reported by official statistics, have died in the past ten years in the Ceuta and Melilla zone". In the same report, MSF criticizes the detention conditions of illegal immigrants once they have been arrested.
The Spanish section found itself in the news, also, when its teams discovered 500 illegal immigrants abandoned in the middle of the desert: On October 10, Libération described their journey in an article entitled, "Their clothes and shoes taken away, they were sent to die, without water".



→ **DRC, North-Kivu** © Denis Lemasson / MSF - August 2005

to the MSF base in Beni, then, the next day, six more hours to the Kayna mission, in the south. Another night of rest and then, the following day, two hours on the road eastward to Kiwanja. "You don't get to Congo without earning it!" says Benjamin.

(...) the four-day three-night trip was more valuable than any theoretical discussions held in preparatory meetings in Paris. Physical and human realities win out over briefings. Reality absorbs everything.

Benjamin, 24 years old, was recruited by the headquarters in Rue Saint-Sabin seventeen days earlier. "We are opening a mission in North-Kivu, DRC. A conflict zone. Your CV as a logistics officer matches the job profile, there will also be an experienced nurse and a field coordinator with extensive emergency experience on the team. Departure is scheduled for August 5. Mission duration: six months. What do you think?" For the sake of form, Benjamin took a night to consider the offer. "I would have gone anywhere. I had had enough of the factory and its broken men. I wanted to get away from that." Didier, 46 years old, an emergency room doctor – a 'workman' specialized in medicine, as he calls himself – would have preferred Asia, but "as emergencies go, why not Africa?" These two "first-missions" were completely ignorant of Rutshuru. Did they even know where North-Kivu was located on the map of Congo?
The long African trip tested their nerves. Wavering constantly between apprehension and impatience to get down to work, they were bedeviled always by the same questions: Would they be up to the challenge? What was really expected of them? It is clear that the four-day three-night trip was more valuable than any theoretical discussions held in preparatory meetings in Paris. Physical and human realities win out over briefings. Reality absorbs everything.
They spent an evening and a day at MSF-Beni. This opportunity to observe gave them a better grasp of the mission's dangerous environment, yet did not reassure them about the role that they would have to assume.
Fabien Carteau, the technical and logistics officer for MSF-Beni, briefed Benjamin and confirmed his fears: in Kiwanja, apart from the logistics and maintenance of the base's three vehicles, he would be responsible for administrative tasks (accounting, the salaries of the expatriates and local staff) and for managing supplies and inventory, the food stores, and fuel supplies and materials necessary for the proper functioning of the house and the "work site".

Benjamin was feeling low: "Fabien told me that there was nothing in the Kiwanja house apart from the cold chain. I would have to fit out the entire building, find stores and compare prices. Including the mobile phones that I'd have to buy. Fabien just gave me a list and said figure it out! 'Don't worry, everything depends on local contact,' he explained. Here I am left completely on my own, I'm going to have a rough time of it, I knew it, this is how it works, but what anxiety!" Didier, the doctor, is familiarizing himself with MSF's medical protocols with the help of the Congolese doctor Teddy. "He's given me some books, some a bit old... No problem for the diagnostics and basic treatment, but what do they order for serious cases, hospitalizations? In France, everything varies from one doctor to the next, depending on his personality and treatment habits. I have to adapt. This could be difficult, but I can't wait to be in the field. I hope all the same that I have some leeway..."

Jean-Sébastien Matte, the head of the Beni mission, summarized the geopolitical situation of North-Kivu for the "first-missions" before they left for Kiwanja. He also discussed the languages spoken, including some expressions in Swahili, "that you'll pick up quickly!" Finally, he talked about the security regulations specific to the region, along with instructions in the event of evacuation.

Then it was on to Kayna, where the travelers arrived the same afternoon, around 3 o'clock. The atmosphere at the base was tense: Marie, a Colombian anesthesiologist on her first MSF mission, returned from the hospital pretty shaken up after a caesarian with a ruptured uterus, the umpteenth emergency

Filipe went on to describing MSF activities in detail: "The Katwiguru health center, the focus of our intervention, is forty-five minutes from Kiwanja. In the middle of the shit, that's what we wanted, right?

in the operating theatre. "This is the first time in ten years in the business," she says, exhausted. She dropped into her chair, the places at the table had already been set for lunch. "The mother lost her uterus and her baby, but she is safe. Since six thirty this morning, I've had five people in the theatre constantly." Marie had not even tasted her lentils when Kitoko Kambale, the radio operator, burst in. "Emergency, Marie!" She disappeared immediately. Benjamin and Didier, confronted firsthand with the harshness of the missions, walked toward the hospital, pensive, on the heels of the logistics officer Jean-Claude Mutsindo. He explained to them in detail the sanitation system, waste incineration, the sterilization of medical equipment, in short, the general organization of a hospital that had been renovated one year earlier by MSF. Which heartens Benjamin: "J.C. briefed me well, he taught me lots of things. Who to trust, how to scout out fuel and gas supplies... Guys like that are good, I understand everything better now, I wanted to see it with my own eyes, I am relieved."

Didier, the emergency-room doctor from Montreuil, remained silent the next day during the final leg of the trip to Kiwanja, absorbed in reading the "Clinical Guidelines".

Kiwanja, finally. The pleasure of being welcomed, greetings and introductions. Filipe, a Portuguese volunteer, well experienced in emergencies with MSF who has worked in Burundi, Angola, Abkhazia and Ivory Coast since the mid-1990s, had been in Rutshuru for ten days. As Field Coordinator, he has spent a lot of time visiting the local authorities, the provincial governor, the regional administrator, tax officials, "refugee committees," official doctors in the two health zones, and the Rutshuru and Nyamirima hospitals. He had a meeting with the MONUC commander, officers in the government armed forces, road haulers, priests and evangelist ministers. "No animosity toward us, quite the opposite: we are welcome."

An experienced nurse, Marie-Jo Michelet is also well acquainted with emergencies. Her first mission was in Afghanistan in the early 1980s, and she has taken part in a number of interventions since then, such as Angola, Ethiopia, Niger, Guinea, Kosovo and Sudan. In early August, she joined Filipe in Goma. There were also Mao and Delmas, seasoned Congolese logistics officers "on loan" for a week from the MSF staff in Beni and Kayna. Finally, there were Juddy, the cook, Zaïna, the washerwoman, Tshombe, the driver, and two guards. The decor of the house looked more like a worksite than a residence. Two masons were putting the finishing touches on a surrounding wall raised in height by three rows of bricks for security. Under a cluster of pines bedecked with chirping nests, three carpenters saw and nail the tables, chairs and shelves that will furnish the grey cement cube, equipped for the time being with a timeless velvet sofa and four makeshift beds. Somewhat out of place, lying at the foot of a simple wood post serving as a radio antenna, a sickly dog eyed the comers and goers. Abandoned by the former tenants, he must adapt to his new masters. The team gathered around a table, under the arbor, where a goat stew was cooking. Filipe summarized recent events. "Last week, the FARDC and the Mai Mai clashed in Virunga Park, several kilometers from Ishasha. Thirty-six Mai Mai died according to rumors, around twenty according to the Congolese Red Cross which picked up seven bodies. Since the start of the month, not a day has gone by without an 'incident' being reported. Generally attacks on civilian vehicles on the Rutshuru-Ishasha road. Early in the morning, or after 6 p.m., which explains why people return from the fields around 3 or 4 p.m. We are doing the same during our movements in risky zones, between 8 a.m. and 5 p.m." Filipe went on to describing MSF activities in detail: "The Katwiguru health center, the focus of our intervention, is forty-five minutes from Kiwanja. In the middle of the shit, that's what we wanted, right? The state has withdrawn, the staff, five people, are no longer paid, and as for medical equipment and medicines, the little that I have seen is hidden in the roof of the building for fear of being stolen." The MSF team, in agreement with the Congolese nurse posted there, was going to take over the health center. Drug supply, preventive medicine, primary care, and short-term hospitalizations

→ **DRC, North-Kivu** © Denis Lemasson / MSF - August 2005

PRESS REVIEW (CONT.)

→ Excess weight

Between the "flood of donations to southeast Asia after the tsunami" and "the great indifference surrounding the famine in Niger", the press is wondering about the degree of generosity in the wake of the earthquake that hit the Cashmere region in the October 26th edition of Libération. While many humanitarian actors consider the mobilization to be too weak, others try to put things in perspective, such as Michel Brugière, general director of Médecins du Monde: "What happened in Pakistan is the average course for a normal catastrophe. (...) What was unusual was what happened after the tsunami." Nevertheless, the media's tone remains that of urgency, especially in the face of the difficulty accessing the most remote areas. It's "a logistical nightmare", according to Jan Egeland, emergency humanitarian aid coordinator for the UN. In the November 5th edition of Le Monde, he launched a call to action to both public and private donors before concluding with these words: "During the catastrophe of the tsunami, the United Nations had collected 80% of the required funds within ten days. Conversely, in Pakistan, almost a month later, only 22% of the requested funds for emergency aid have been collected."

– no more than three days. The most serious cases would be transferred to Rutshuru general hospital. "Afterwards, an ambulance will go get patients from other health centers, so we will evaluate MSF's ability to react to emergencies in the Ishasha-Nyakakoma zone. I have met with all the medical staff in the area, and they are waiting impatiently for us."

Security beckoned, there wasn't a moment to lose, we had to be back on the road at 4:15 p.m. Truth be told, the tour was fast since the spaces were small, the equipment rare, and the rooms lacked the essentials.

Filipe planned a visit to Katwiguru that same afternoon. Off they were again. Forty-five minutes on a road scarred with ruts and cracks, winding between two green "walls", dense and compact. Here and there, hamlets of square huts, all identical, made of cob and thatch. The Land Rover advanced as cautiously as a cat, maneuvered by Tshombe. There were many people on this dirt road, it was sowing season and the rains were threatening. Men armed with Kalashnikovs, in uniform or civilian clothing, lingered on the sidelines. Which side were they on? Ragged kids shouted out Padiri! – "father" in Swahili – as the 4x4 went through the villages.

Kilometer 21. Katwiguru. A town that looked like any other town, apart from a tiny brick building, freshly whitewashed, edged in periwinkle blue, on an esplanade scattered with banana trees. "Welcome!" Two well-dressed young men greeted us. The nurse posted there, Innocent, was in charge of the center, and Sylvain was the lab assistant/hygienist. Firm, interminable handshakes. The space filled with a cloud of quiet kids. Jean-Pierre, the head of the village management committee, said "We are very happy to see you among us in these difficult times of insecurity." Security beckoned, there wasn't a moment to lose, we had to be back on the road at 4:15 p.m. Truth be told, the tour was fast since the spaces were small, the equipment rare, and the rooms lacked the essentials. We visited the "maternity," the "consultation room," the "observation room," the "laboratory" and the "treatment room." Notebook in hand, Marie-Jo notes: here, a sink without a faucet, "we must check the drainage"; there, a microscope, "just for stool samples," noted Sylvain. The gynecology couch is holding up, but "the leg rests need to be repaired"; "no autoclave for sterilization, Sylvain?" – "No, we boil things." The bedframes were alright, but the mattresses were rotten. "If you agree, Innocent, the big room should be reorganized. The sick will be registered outside, under the shelter that we will build. This will give us space for four more beds for short-term hospitalizations. What do you think, Innocent?" – "Okay, that's good". "Waste management, did you see, Mao?" – "Yes, it's zero, the placenta hole, everything must be burned. Things seem okay with the latrines, there is water and pressure, the only thing is that it's not clean..."

→ **RDC, North-Kivu** © Denis Lemasson / MSF - August 2005

The MSF team brought a young woman and her sick child back with them in the 4x4. A fever of 40°, anemic, malaria maybe. Marie-Jo comforted the mother. Seeing that she hadn't taken anything with her, no bowl or food, Marie-Jo murmured: "We will have to give her some money for the three days of hospitalization in Rutshuru."

In front of the MSF gate in Kiwanja, men offered their services. It had been like that every day all week. Tireless, Filipe explained to them: "We are not opening a clinic. The Katwiguru health centre is fully staffed, we are only looking for A1 and A2 nurses. No, not a hairdresser..." One job-seeker, smiling, said: "No work here, we are waging a psychological war against you!"

That evening in Kiwanja, under the small light of the arbor, the discussion continues for another two hours around a few Primus beers. "In terms of prevention, things are OK," says Marie-Jo, "but in terms of treatment, there're major problems...no furniture, a broken sterilizer, waste management is a calamity. The obstetrician has not finished his training, he needs to be backed up by an A1 nurse, but what will the local staff think? Will we find an applicant willing to stay overnight there?" "We can't go in like bulldozers," Filipe said, "we need to work with the spirit of the health center and its team. Act simple, as lightly as possible." Mao and Benjamin suggested erecting a bamboo wall around the plot of land to keep out kids curious about the "muzungus" – the whites. "The center's management committee must decide that," said Filipe, "we are only the hired help. Be careful not to cause a land dispute with the neighbors." "When does work begin, Mao?" asked Marie-Jo. "Tomorrow. The workers will arrive at 9 a.m. with paint and bamboo. Everything will be ready in a week." "Great. But that doesn't stop us from getting down to work, does it? What do you think, Didier?" "Whenever you want, I'm ready."

They agree to start in two days time, as the following morning was reserved for a meeting with Dr. Vinckler, head doctor of the health zone, and Dr. Martin, head of Rutshuru hospital.

That night, the light was on until late in Didier's room. Engrossed in the "Clinical Guidelines," the doctor absorbed MSF's protocols under his mosquito netting. It's not easy to change the habits of a Parisian emergency-room doctor! That same night, in the pharmacy room with shelves lined with drugs and health equipment, Marie-Jo used a checklist to verify the contents of the trunk that would go to Rutshuru hospital, the famous donation that had been agreed during MSF's exploratory mission several months earlier. In the next room, in front of the computer, Filipe was finalizing a memorandum of understanding to be submitted to Dr. Vinckler, while Benjamin sorted through a mountain of job applications from Kiwanja locals. Fabien, from the Beni mission, transmitted the news from Radio-Okapi by VHF: according to MONUC, a series of clashes had taken place between the FARDC and the Mai Mai near Katwiguru. There were reportedly four dead and twelve prisoners among the FARDC soldiers. During the withdrawal, these soldiers allegedly looted houses.

Wednesday, August 10. At first sight, the Rutshuru hospital looked to be in good shape. Built by the Belgians in the 1950s, the well-designed building is well ventilated. There are a series of square pavilions, connected by long, shaded paths around a wooded open-air patio. Under a mango tree, women in multicolored dress were beating cassava and grilling bananas, while others laid out the laundry on the thick grass. A gentle scene. Behind the walls it was another story.

Martin, the Congolese doctor, was not there. So Marie-Jo and Didier's visit to the hospital was conducted by Ghislain, the head nurse. Pediatrics, lab, radiology, internal medicine, maternity ward, surgery, pharmacy – everywhere the same poor state of repair, deterioration, and ruin. With the cycle of violence and the looting, explained Ghislain, "a vicious circle has ensued." Too poor to pay their health expenses, the patients deserted the hospital. Without any patients, the hospital no longer had the financial reserves to provide minimum care: "And without drugs, why even use these buildings?" Almost apologizing for the sorry state of the premises, Ghislain spoke softly, but then he perked up: "It's good that people are interested in us. It's encouraging!" He summed up with the following sentence, heard over and over throughout the region: "There is too much suffering!"

The traumatology ward was particularly bad. It was housed in a dark dormitory, twenty beds with grey mosquito nets. Not a sound was heard. Empty gazes followed the whites approaching the lab-coated nurse at the end of the row. Even before the MSF team could introduce themselves, the young man warned, in a biting tone: "I have no intention of playing the tour guide. My place is here, with my patients." Abruptly, he walks around the room, stopping randomly. "Here is a bullet wound! Another bullet wound! Another bullet wound!" he ticked off, angrily, pointing to seven bandaged bodies, immobile. Here a bullet in the leg

FROM THE FIELD

PRESS REVIEW (CONT.)

→ Better death than prevention

Interest in Niger is dropping off. However, in an October 13 headline, a short article on the nutrition crisis and food distributions published in Politis notes that "The emergency goes on". "While the Nigerien government, backed by the WPF, would like to halt the distributions already, MSF insists that the neediest families still get access to free food," the reporter details. For its part, the magazine Telerama focuses attention on "the famine that nobody cared about", making this its cover story for the week of September 28. The reporter sums it up: "Nine months of apathy, one month of enthusiasm." He continues, noting that " 'What time do the children die?' is the kind of question the reporters asked the doctors in July." The weekly points out that "it took dying children for the television networks to get involved." The article also quotes comments from the communications officer at the site: "They were going right through the area for the children already saved and they made straight for the intensive care area. We had become a supermarket for photo ops. [...] What the reporters wanted to get on film was dying babies." Finally, Niger, the trash on special offer, is worth money, just like food.

took off the kneecap, there it was an abdomen, "If I opened it, you would be shocked". This woman? "Stabbed by an incivique, three days ago". This man? "Four bullets in the foot, it's all mangled." And this other man, the shoulder and the neck covered in blood? "A soldier, growled the nurse. We don't ask them to pay. Out of fear." "What do you give for pain?" asked Marie-Jo. "Acetaminophen," responded the nurse. He stopped at the head of a bed where a man was curled up, face and skull buried under a thick bandage. "This guy's a catastrophe. The bullet entered from behind and blew off the front. Everything is gone, even the jaw is ruined. Do you think we can do anything?" Marie-Jo hesitated: "We'd have to open... Do you have morphine?" "No, no morphine." You make do with what you have. The wounded man let's himself be examined, without a moan or even a sigh. Necrosis. Marie-Jo suggested transferring him to Goma, MSF would pay for the transport.

In the 4x4, on the road to Kiwanja, Didier and Marie-Jo exchanged their impressions. Not great. No proper sterilization, two nurses for the whole hospital after 5 p.m., the only two doctors frequently do not show up for days at a time. In such a situation, can they really refer patients from Katwiguru to the general hospital? They could take over the hospital and put in a surgeon and anesthesiologist, but concretely for what activity? More dilemmas. "Smoothly running missions just don't exist," said Marie-Jo.

Later, at the house, having retreated to the pharmacy-store, she again took inventory of the medical equipment to be donated to Rutshuru hospital. She wondered about the choices of certain medicines. Such as the one for cesareans, "despite the fact that there's no surgeon at the hospital." "Potassium, okay. But this product can kill. Is it appropriate for the doctor's skill level? First do no harm!"

In his room, Didier mumbled: "Panda: climb up; lala: lie down; ikala: sit down; tosha nguo: get undressed; poumua sana: breathe deeply; aksanti: thank you..." A few words of Swahili that Innocent scribbled on a page.

Thursday, October 11, 9:30 a.m. There was a crowd when the MSF 4x4 arrived at the Katwiguru health center. The patients, women mainly, babies in their arms or tied onto their backs, were waiting. Timid greetings and smiles welcomed the "muzungu" doctor. Didier began the day of consultations along with Innocent and Sylvain. Marie-Jo and Filipe went to Nyamirima hospital, farther north. They had an appointment with head doctor Garry.

Didier and Innocent set themselves up in the only available room, since the others were occupied by the painters already at work. The first day of consultations, and what havoc! "Everyone out!" yelled Sylvain to the mass of patients, "the painters can't work!" Two very old men, leaning on long sticks, stood undaunted in front of the doctor's office. Respect for the elderly. Seated near the door, Sylvain registered patients in a spiral notebook, "Consultations. 2005-2006," one after the other. Anastasia Kawira Wetewabo, an old lady, climbed on the scales: 36 kilograms. Sylvain took her temperature, 36.9°.

"A bench, we need a bench!" shouted Innocent. A very old man, shoulders covered by a red woolen shawl, entered the consultation room with the help of two old men.Behind the building, surrounded by a swarm of curious children, a dozen men trimmed bamboo sticks with machetes for the future wall. Benjamin and Mao had negotiated the price: 160 dollars for the sticks. "You hammer in a nail, 30 pairs of eyes stare at you, I don't like this superstar thing," mumbled Benjamin, the young logistics officer. "I feel like I'm doing nothing but supervising, I don't do anything myself, I'm like a boss. I hate that..."

That day, around fifty consultations were registered, and eighteen were planned for the following day.

"Cases of malaria, gastritis, parasitosis, otitis, not to mention 'fakers,' curious people pretending to have a back problem to have a look at the white doctor."

In the evening in Kiwanja, Didier described his day to the rest of the team who had all gathered for the daily briefing. Who, that morning, would have imagined that MSF's scope of action would be subject to such harsh constraints and dilemmas during that first day of consultations? Didier mentioned two "serious cases" which he decided to take in the 4x4 to refer them to Rutshuru hospital. "A molar pregnancy in a woman and a man with a colon tumor." "You shouldn't have transferred the cancer patient," says Marie-Jo. "Do you think they are capable of operating in the hospital? I don't. So what's the point? Our action is limited to emergency interventions: peritonitis, appendicitis, yes; cancer, no! That falls under chronic... What are they going to do with the patient? Keep him hospitalized for four or six months, cut off from family and friends? Why? For nothing... He would be better off at home, in Katwiguru, taking pain medication." Didier resisted: "Removing a tumor is no more complicated than peritonitis. If you doubt the skills of the staff at Rutshuru hospital, why send them medical equipment? We need to be logical. I am a doctor, not the head of mission or the coordinator. That is not my responsibility. If you want to do emergencies, you shouldn't be in a health center, where we will deal only with primary care."

"Removing a tumor is no more complicated than peritonitis. If you doubt the skills of the staff at Rutshuru hospital, why send them medical equipment? We need to be logical. I am a doctor, not the head of mission or the coordinator.

The reality of field work dispels the illusions of traditional medical practice. Didier was still learning.

Six o'clock was approaching, when night falls abruptly. The VHF post crackled to life for the daily radio contact. Jean-Sébastien, from Beni, asked for an update: "Is everything OK?" "Everything OK," answered Filipe. Nothing to report." "Roger. Talk to you tomorrow."

That night the first rains fell on Kiwanja in a heavy downpour. The sky filled with thunderous roars and flashes of lightning. What would be the condition of the road to Katwiguru the next day? ■

Anne Vallaeys

→**DRC** © Gabriel Trujillo / MSF - 2004

INFOS

DRC / NORTH KATANGA

"Congo, la paix en otage" (Congo, Peace Held Hostage)

MSF / August 2005 / Chloé Gelin / Translated by Anne Witt-Greenberg

To show the violence endured by the people in North Katanga and to break the silence that surrounds them, MSF showed the film «Congo, la paix en otage» to officials and to the public in the Democratic Republic of Congo (DRC). The screenings were followed by animated discussions, and the Congolese media covered the issue extensively.

The documentary «Congo, la paix en otage», by Marc Le Pape[1] and Robert Genoud[2] , was filmed in November 2004 in Katanga. The film was the idea of Loïck Barriquand, then programme manager. "We decided to make this film because the violence committed against the civilians in North Katanga was deliberately stifled. Some officials had even denied the existence of this violence when we published a press release in March 2004. The aim of the film was to stimulate debate in the DRC about this situation."

The film was shown to Congolese officials on July 22nd in Kinshasa and July 25th in Lubumbashi, the provincial capital of Katanga. Over 400 people attended the two screenings, including ministers, deputies, senators, governors, ambassadors, generals, the media, representatives of civil society and religious communities.

Between July 27th and August 10th, "Congo, la paix en otage" was shown to the population and to officials in Ankoro and Kitenge, the locations where the documentary was filmed. In these two towns, the small video-clubs organized free screenings of the film.

Following its broadcast on four Congolese television channels, some tens of newspapers and radio stations relayed the discussions. Loïck Barriquand was present at

the screening in Kinshasa, "Our objective was reached on all levels: the number of people present at the screenings, the presence or the representation of most officials, the content and force of the debates, the stands and criticisms voiced, and the extensive media coverage. Through these screenings, the authorities went from denial to recognition of the problem. We have sparked the debate, the rest is no longer our responsibility."

→ THE AUDIENCE'S REACTION

The audience was struck by the film. "After seeing these images, we were all deeply moved... Harrowing images... I was brought to tears... This film goes beyond all understanding." Many seemed to ignore the level of violence suffered by the population in North Katanga. Thus a woman senator, a native of North Katanga, claimed to be astonished to see what is going on at home. "I cannot afford to go there. You have revealed the truth that is being concealed from us."

At no screening did the participants question the authenticity of the film. Marc Le Pape, who was present at all the screenings, describes his impressions. "At no moment did I feel any aggressiveness directed towards MSF during the discussions." The participants perceived the film as "questioning, an acknowledgement of the suffering, an attention to their plight, to raise awareness."

The only criticisms of the film originated from the field. Thus an ICRC[3] employee in Ankoro asked "Why was the film not made sooner, when things were really heated in Ankoro? It could have saved human lives and avoided material destruction." The representatives from the presidential party in Ankoro[4] expressed regrets that "The film politically accuses government authorities... Is this a medical or a political film?... Everything that is being exposed calls into question those who rule us..."

→ IN KINSHASA AND LUBUMBASHI: INDICTMENT OF POLITICAL RESPONSIBILITIES

At the start of the discussions, the finger was pointed at those responsible for this situation of violence.

All the participants highlighted the responsibility of the government, which had armed civilians during the war. "We did not calculate the consequences of distributing weapons to the population."

The authorities in Kinshasa were denounced more harshly than the provincial authorities. The governor from Kinshasa started the debate with a virulent attack. "It's always the Kinshasa authorities that pull the strings in the east and in the other provinces of the Democratic Republic of Congo. I would have liked to see in this room all the people who have assassinated the population in the eastern DRC and who today are sprawling in Kinshasa..." Similarly, in Lubumbashi, a lawyer made clear that "[T]he province governor does not possess the means to implement his policies: all the money from the provincial is intended for Kinshasa. The governor can therefore play no role whatsoever in certain parts of his Province."

According to other participants, "the true source of the problem does not originate in the DRC, it originates elsewhere, in the international community." The governor of Kinshasa wonders, "To what extent is the United Nations' mission in the DRC not responsible for this situation?" For the Minister of the Female Condition and the Family, it is about "a responsibility shared by the DRC, through its political leaders, and the international community as well." According to a lawyer from Lubumbashi, "In

"(...) Through these screenings, the authorities went from denial to recognition of the problem. We have sparked the debate, the rest is no longer our responsibility."

FOUNDATION: RAPES AT THE HEART OF WAR PRACTICES IN THE XXTH CENTURY

Conference and Debate with Stephane Audoin-Rouzeau, historian, Thursday, December 1st, at 5:00pm.

The civil war in Congo Brazzaville from 1998 to 2000 compelled MSF to address the issue of **sexual violences in conflict situations**. Despite the development of a specific protocol to treat victims of this type of violence, the implementation of such programs, in Darfur or the DRC, continues to face important obstacles, very often linked with our lack of understanding of this phenomenon.

The MSF Foundation's «Crash» has invited Stephane Audoin-Rouzeau, scholar at EHESS in Paris, to present us with a historical perspective on this issue. He is the author of **«The Ennemy's Child, 1914-1918. Rape, abortion and infanticide during the Great War»** and has been working for several years on an approach to the collective experience of the XXth century's conflicts using cultural history and anthropology. Françoise Duroch, in charge of **«sexual violence» programs** at MSF-CH, will take part in the following discussion.

Mitwaba, the Maï-Maï have new weapons. We know who supplies them, the Monuc[5] also knows it, but nothing is done." In Lubumbashi, several participants regretted the few charges brought against the military officials behind the violence in Ankoro in November 2002. "Only the lowest-ranking soldiers were sentenced, not the military officials." "It is all too easy to say that the violence is only committed by the Maï-Maï. But we know that the military, too, have committed violent acts... The Maï-Maï were exploited." "We must take the big warlords to trial and punish them. As long as this is not done, there will be no solution."

→ THE POPULATION MUST MOBILIZE ITS EFFORTS

In Kitenge, the assistant administrator of the Territory opened the debate by encouraging the population to mobilize its efforts. "You've seen villages destroyed: the roads, schools, churches have gone. Are you going to wait for Kinshasa and Lubumbashi to replace what has been destroyed? What should we be doing in the aftermath? That's what I am asking the population around me." Several participants tried to play things down. "This government is not incompetent. It brought us peace... Weapons are already counted. There is no problem." This to which the head doctor of the Kitenge area retorted, "Even a single weapon, a single life that perishes, we must not minimize it. All of us must denounce it. We must not wait for Kinshasa to intervene." The major, commander of military forces in Ankoro contended, "In my jurisdiction, such acts will not be able to recur as long as I am there. I am going to control my men." ■

1- Researcher at CNRS and member of the MSF Board of Directors
2- Documentary maker
3- International Committee of the Red Cross
4- Ankoro is the city of origin of the family of former President Laurent Désiré Kabila, father of the current president
5- United Nations Mission in DR Congo

MSF INTERNATIONAL

Lost in la Mancha?

MSF / October 2005 / Questions addressed to Anne Guibert, member of the Board of Administrators / Translated by Diantha Guessous

Ten years after Chantilly, the La Mancha meetings will bring together the 19 sections in Luxemburg to lay out and redefine the guiding principles of MSF's action. More than just a date, it is a process that will go on until March 2006, and that calls for the constructive participation of the majority. Anne Guibert sheds light on the stakes involved, pitfalls to avoid and reasons to participate.

→ In your view, what are the major stakes for La Mancha?
What is at stake is to overcome the obstacles that handicap the action of MSF. From one section to another we perceive MSF's role differently, we don't always agree on the implications of the independence that we all claim and demand, and we don't raise funds in the same way, etc. Managing the repeated crises arising from these differences eventually becomes costly in both time and energy. Will a common effort to work on our guiding principles and their implications allow us to avoid new periods of defiance and the consequent reductions in efficacy? Over the past year there seems to have been a strong desire among sections to put all these contentious issues on the table. Now is the time to put this willingness to the test. If we manage to agree on our action principles, the other challenge will be to adapt our operations to the current structure of MSF. What are the mechanisms that will allow us to improve section-wide implementation of decisions, the respect of minority positions and 'associative' participation? We shall have to be imaginative.

→ What are the prerequisites for MSF to gain from this process?
Good will and some preliminary clarification. The willingness of the different sections to reconsider and if necessary, adapt our action principles seems to exist. It remains to be seen how that will be expressed when we have to agree, for example, on new mechanisms for the control and distribution of funds raised. As for "preliminary clarification", I have the impression when I read the various written contributions to la Mancha, that the questions raised are very broad, very open. In a first stage, that makes it possible to identify the areas of malfunction, but it now seems necessary to narrow the debates so as to avoid their becoming too dispersed: la Mancha will not be a cure-all. Let's identify what exactly can be dealt with at this level and encourage preparatory work so that concrete proposals will emerge before the actual meeting...

→ Why should we participate?
One may be distrustful of the scale of la Mancha and fear the "high mass" effect – we do need to be vigilant about the scale of the process – but as a matter of fact, we have a direct operational interest in ensuring that this process will produce adapted and acceptable decisions. If we fail to make our views known upstream, internally and between sections, if we fail to make an effort to convince during the preparatory stage, it is unlikely that the debates will produce conclusions that satisfy us. And we won't be re-doing La Mancha every year. ■

WATCH AND READ

New books available in the documentation center (September & October 2005)

MSF / Christine Pinto (01 40 21 27 13)

New photos available at the "photothèques" (and soon available on the Data Base):

→ Thailand
Hmongs juillet 2005, Christian Blanc / MSF

→ Uganda
Aire de gestion des déchets de l'hôpital MSF d'Arua, mai 2005, Etienne Quetin / MSF

→ Niger
- Madarounfa, centre nutritionnel ambulatoire août 2005, Chloe gelin / MSF
- Zinder, CRENIs et centres ambulatoires septembre 2005, Chloe gelin / MSF
- Zinder, CRENIs et centres ambulatoires septembre 2005, Christophe Calais / MSF

→ Pakistan
Séisme, Mansehra et village de Dadar octobre 2005, Claire Reynaud / MSF

→ MEDICAL

BASIC EPIDEMIOLOGY / R. Beaglehole, R. Bonita, T. Kjellström.- Genève : OMS, 2003.- 174 p.

GESTION CLINIQUE DES VICTIMES DE VIOL : DÉVELOPPEMENT DE PROTOCOLES À ADOPTER AVEC LES RÉFUGIÉS ET LES PERSONNES DÉPLACÉES DANS LEUR PROPRE PAYS / OMS.- édition révisée.- Genève : OMS, 2005.- 66 p.

GUIDELINES FOR MEDICO-LEGAL CARE FOR VICTIMS OF SEXUAL VIOLENCE / OMS.- Genève : OMS, 2003.- 144 p.

GUIDELINES FOR THE INPATIENT TREATMENT OF SEVERELY MALNOURISHED CHILDREN / OMS.- Genève : OMS, 2005.- 48 p.

INFECTION VIH, MÉMENTO THÉRAPEUTIQUE 2005 / Jean-Michel Dariosecq, Anne-Marie Taburet, Pierre-Marie Girard. – Rueil-Malmaison : Doin, 2005. – 423 p.

MANAGING NEWBORN PROBLEMS: A GUIDE FOR DOCTORS, NURSES AND MIDWIVES / OMS.- Genève : OMS, 2003.

TB/HIV : MANUEL CLINIQUE / OMS.- seconde édition.- Genève : OMS, 2005.- 227 p.

→ GEOPOLITIC

DES NOUVELLES DE TCHÉTCHÉNIE / Textes réunis par le Comité Tchétchénie. – Paris : Paris Méditerranée, 2005. – 173 p.

LA COORDINATION DES SECTIONS DE MÉDECINS SANS FRONTIÈRES FACE À LA CATASTROPHE DU TSUNAMI SUR L'ÎLE DE SUMATRA / Philippe Galland.- Aix Marseille : université de droit, d'économie et des sciences d'Aix Marseille, 2005.- 83 p.

L'ONU DANS LA CRISE EN SIERRA LEONE : LES MÉANDRES D'UNE NÉGOCIATION / Jean-Marc Châtaigner.- Paris : Karthala, 2005.- 197 p.- (coll. Etudes et recherches du CEAN)

ROGUE REGIME: KIM JONG IL AND THE LOOMING THREAT OF NORTH KOREA / Jasper Becker. – New York: Oxford University Press, 2005. – 300 p.

RWANDA 1994 : LES POLITIQUES DU GÉNOCIDE À BUTARE / André Guichaoua. – Paris : Karthala, 2005. – 497 p.

TRAINING (EPICENTRE)

→ RESPONSE TO EPIDEMICS

dates: from 5th to 9th of décember 2005 in MSF-paris headquarters - english speaking session

→ TARGET GROUP: Medical or para-medical personnel with basic knowledge in epidemiology and at least one experience within an epidemic context . Priority to capital coordinators, emergency coordinators and national deputy coordinators

→ OVERALL OBJECTIVE: To improve the quality of field interventions for outbreak control by informing participants about recent data and future perspectives and giving them operational tools to be alert and reactive towards potentially epidemic diseases.

→ OBJECTIVES: Pathologies involved are : meningitis, diarrhoeal diseases, haemorrhagic fevers, influenza, malaria and measles. By the end of the course, the trainees will be able to:
- Carry out an outbreak investigation
- Detect an outbreak
- Define necessary strategies and organise effective management of epidemics

→ IMMUNIZATION

dates : from 16th to 23th of november 2005 in MSF-spain / barcelona headquarters english speaking session - duration : 6 days

→ TARGET GROUPS: Medical or para-medical personnel who will run a feeding centre (intensive and/or supplementary) and/or take part in the setting up of vaccine activities.

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

→ Epidemiology
Define, calculate and use epidemiological indicators

→ Nutrition
- Set MSF actions in the general context of food crisis
- Diagnose acute malnutrition among children
- Discuss the different types of nutritional programmes
- Ensure management of children with acute malnutrition
- Ensure functioning of the feeding centre (intensive and/or supplementary)

→ Immunization
- Describe the basic principles of vaccination
- Supervise the validity of the cold chain
- Plan and implement vaccination activities in an emergency situation
- Monitor the activities within a vaccination campaign, analyse the results and define the actions to implement

For further information and to apply, contact your desk or Epicentre : Isabelle Beauquesne (+33 (0)1 40 21 29 27) or Danielle Michel (+33 (0)1 40 21 29 48)

TURN OVER AT HEADQUARTERS

F.H. RESOURCES	
→ **Corine WAGNER**	was appointed human resources officer in August.
→ **Loïck BARRIQUAND**	started as Director of Field Human Resources in September.
→ **Charlotte MOTTEZ**	was appointed human resources officer in October.
→ **Alejandra DRANNIKOW**	left her position as human resources officer at the end of September.
→ **Christa LINKENHEIL**	left her position as human resources officer in September.
HEADQUARTERS H.R.	
→ **Jeanne GAUTIER**	returned to her position as "Gestionnaire" RH in September.
→ **Jacques LOTTIGIER**	left his position as "Gestionnaire" RH at the end of August .
→ **Chrystèle DE TOMASO**	started as assistant human resources officer in September.
→ **Corine PUECH**	started as assistant human resources officer in October.
→ **Ayni LACHARMOISE**	left her position as assistant human resources officer in October.
→ **Florence PENFEUNTEUN**	returned to her position as assistant human resources officer in November.
OPERATIONS DEPT.	
→ **Malika SAIM**	left her position as assistant human resources officer in October.
→ **Coralie LECHELLE**	was appointed RP of Desk B in September.
→ **Noelle RODRIGUE**	was appointed ARP of the emergency desk replacing Marie Noelle RODRIGUE who has been appointed RP of the desk in New York .
MEDICAL DEPT.	
→ **Claude LAURO MARTY**	started working on drug management in September.
→ **Magali BOYCE**	returned to the department in September.
COMMUNICATIONS AND FUNDRAISING D.	
→ **Christine PINTO**	returned to her position as Documentaliste in September.
→ **Alix MINVIELLE**	started as data base manager in September.
→ **Kate De RIVERO**	was appointed communications officer in October replacing Chloé GELIN who has returned to the field.
→ **Laurence HUGUES**	has left MSF France to become Director of Communications of MSF Canada.
→ **Irène NZAKOU**	replaced Elisabeth CASTAING (who is on a study course) as secretary of the communication dept in September.
→ **Cléo ALBERT**	started as marketing assistant in October.
LOGISTICS	
→ **Stéphane FOULON**	started as Superlog in October.
RECEPTION AND GENERAL SERVICES	
→ **Anne DARRAS**	started as receptionist in October.
FINANCE DEPT.	
→ **Alexis SMIGIELSKI**	started as assistant financial controller at the end of August, replacing Carine LE ROUX who has left for the field.
→ **Guillaume OULD AOUDIA**	was appointed financial controller on the USA desk in September.
→ **Estelle TEILLET**	was appointed financial-evaluation controller in October.
IT	
→ **Saïda ATALLAH**	started as field IT officer in September.
CAMPAIGN OF ACCESS TO ESSENTIAL MEDICINES	
→ **Martine USDIN**	started as biologist in September.
→ **Corine NABOULET**	started as pharmacist in November.
EPICENTRE	
→ **Christophe ANDRE**	(ex-financial controller at MSF) replaced Françoise STOREY as new Adminsitrative and Financial Director in September

PRESS CONTACT:
anne.yzebe@msf.org
kate.rivero@msf.org

Reactions and contributions:
olivier.falhun@msf.org

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**

messages

Médecins Sans Frontières
8, rue Saint Sabin
75544 Paris Cedex 11
Tel.: +33 (0) 1 40 21 29 29
Fax: +33 (0) 1 48 06 68 68
www.msf.fr
Editor in Chief:
Laurence Binet, Bénédicte Jeannerod, Stéphane Oberreit
Editing: Olivier Falhun
Translation: Caroline Serraf / TSF
Photo librarian: Alix Minvielle -
Layout: Sébastien Chappoton / tcgraphite
Design: Exces communication
Print: Artecom.