messages

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

NATURAL DISASTERS

Lessons learned in Pakistan

MSF/ December 2005 / Interview by Olivier Falhun / Translated by Marcy St John

What difficulties has MSF encountered during its response to the victims of the earthquake that struck Pakistan on October 8? What lessons can we draw from this? One year after the tsunami that ravaged South-East Asia, what are the questions on natural disasters being discussed at MSF? General Director Pierre Salignon, back from Pakistan, replies:

→ **What do you think of our response in Pakistan?**

The sheer magnitude of earthquake was unbelievable. It destroyed towns and villages over a widespread area that, for the most part, is very difficult to access. In this mountainous region of Kashmir and northwest Pakistan, official tolls have recorded 80,000 dead and over 70,000 injured. An estimated three million people have been affected by the disaster. More than a month after the earthquake, the inhabitants are still injured, homeless and in shock. This has been one of the largest emergencies MSF has had to face this year[1], and has presented numerous operational difficulties. We have had to set up assistance in remote areas that are accessible essentially only by helicopter, provide care to a large number of seriously injured persons, and see to the material needs of those affected. As in South-East Asia, it is the local aid agencies that have once again been the most reactive. During the first few days, despite the chaos, Pakistani doctors and rescue workers, followed by specialized teams from throughout the world, deployed as best they could. 8000 injured converged very quickly on Mansehra, in the northwest border province. Assembly-line surgery took place under deplorable hygiene

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The myth of triumphant humanitarianism has taken a knocking. Although the tsunami catastrophe unleashed an unprecedented wave of solidarity, it also revealed the difficulty aid agencies have justifying the scale of their interventions - particularly when the dead were dead and the wounded were already receiving treatment. Along the same lines but without the same wave of solidarity, the earthquake in Pakistan resulted in less deaths but in over 70 000 wounded, in a region that is particularly difficult to reach and where the climate is extremely harsh. The tsunami exception was followed by the Kashmir exception, the consequences of the latter showing all the complexities of setting up emergency assistance, of responding with discernment to the many needs of the affected population - which we did not succeed in doing at the beginning. On the one hand humanitarianism can provoke errors, on the other it can commit errors. Maybe this is the lesson to be learnt from these two exceptions. ■

DOSSIER

Natural disasters Lessons learned in Pakistan

→ How donations are used:

« With the vast swell of generosity that followed the tsunami disaster, we proposed to our donors that we reallocate to our emergency budget the money that we were not going to spend in the regions affected by the tsunami. 98% of our donors agreed! This understanding on the part of our donors allowed us, this year, to carry out more emergency operations financed by our own resources. We have been able to care for over 40,000 severely malnourished children in Niger, with target distributions to nearly 50,000 families, an operation that is going to cost us nearly 14 million euros. This emergency fund is also allowing us to finance the operations that we are currently carrying out in Pakistan. »

Thierry Allafort-Duverger
Head of Emergencies

conditions. With such an influx of wounded, triage was impossible, and post-operative care very limited. This explains in part our difficulties in finding an appropriate medical positioning during the first two weeks. Without downplaying the difficulty of launching an aid operation in such a setting, I have the impression that by multiplying the evaluation sites, we spread ourselves thin, without managing to centralize our assistance to the injured. On the other hand, intervention in the most remote areas was faster. Distributions of tents and first aid supplies in particular began ten days after the earthquake; these distributions continue at sites where the victims have gathered.

It is important to stress, however, that the emergency phase is far from over; it could even "rebound", because of the harsh winter and the number of homeless. This is why international aid agencies must continue supporting local efforts while things get reorganized and funds from institutional donors set in motion the reconstruction process. This will take several months in Pakistan.

→ From an operational standpoint, what lessons do you draw from this catastrophe?

The earthquake in Pakistan has reaffirmed our determination to be reactive when there is a natural disaster, this remains an operational objective. It showed us that we must act quickly, that time is of the essence when there are so many wounded. Also, despite our positioning difficulties in the first few days, we must not disband our efforts. Given the number of surgical cases, sometimes requiring multiple operations, and the destruction of most of the local hospitals, we have set up a temporary tent hospital facility at Mansehra. This enables us to provide specialized care [reconstructive surgery]. This hospital, with 200 beds and 4 operating theatres, is now up and running. In the coming months, we will be able to continue to provide care for the injured and to respond to emergencies. New tools now available to MSF [inflatable tents, for example] also offer the possibility of devising new operational strategies in the future. We must look in detail into shelters and materials designed for winter conditions. Humanitarian standards in this area are low. It is up to us to improve them, taking into account the realities we encounter in the field.

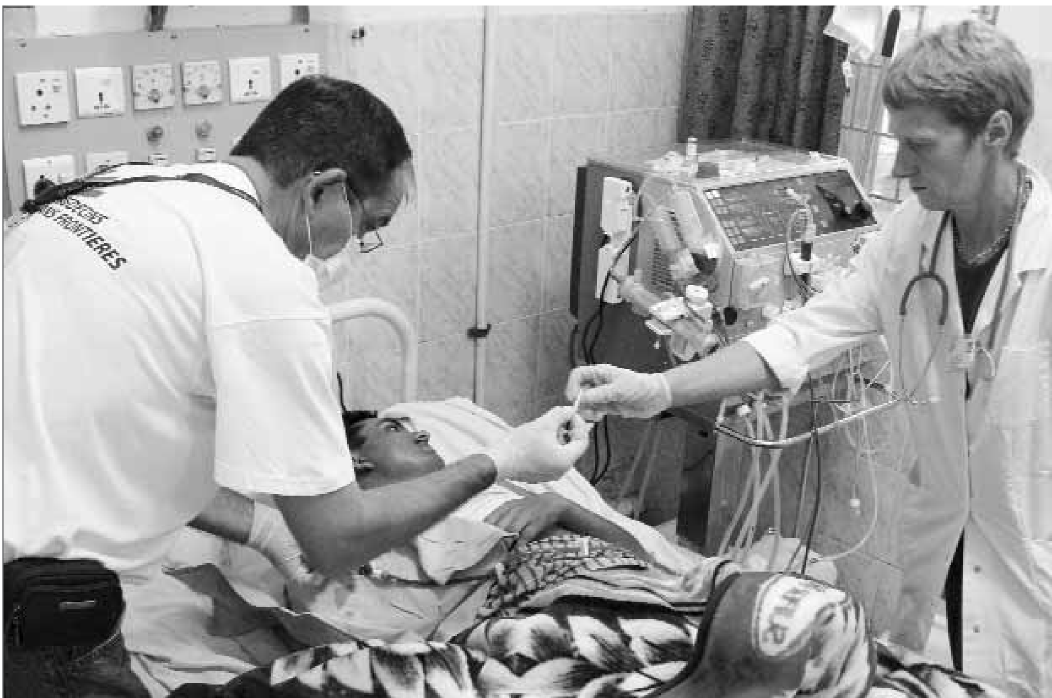
→ One year after the tsunami, the United Nations, as well as some media, have deplored the limited mobilization following this earthquake. What is your opinion?

The mobilization in support of the tsunami victims was «extraordinary».[2] But we cannot consider this tragedy as a point of reference, especially as the money collected following this catastrophe surpassed the ability of organizations to spend it. The United Nations, as well as other actors, would do well to acknowledge this. At MSF, re-allocated tsunami donations allowed us to respond to three major emergencies in 2005:

PAKISTAN - EXCERPTS FROM WEEKLY REPORTS BY SYLVIA CAUZZI, PSYCHOLOGIST

WEEK 5 At the beginning of the week, 2 young local psychologists joined our MH (Mental Health) team. Fozia is from Mansehra and Farzana is from Abottabad. Eighty patients have been seen or treated since the beginning of the program (24 October 2005).
Considering that the type of therapy is individual and not group, due to the cultural conception of psychological support. People prefer privacy and confidentiality: a secret has to be secret, even in situations of catastrophe.
The majority of the people assessed had symptoms like depression, anxiety, grief, tiredness, fear or sadness.
Physical and psychosomatic symptoms like pain, insomnia, migraine, restlessness, palpitation, tremor or sweating.

→ Pakistan © Bruno Stevens / Cosmos - October 2005



→ **Pakistan** © Stephan Grosse Rueschkamp/MSF - October 2005

support to the tsunami victims, assistance to children suffering from severe malnutrition in Niger who were in imminent danger of dying, and assistance to victims of the earthquake in Pakistan, with three times more injured to attend to than after the tsunami. In other words, we were able to bring aid to populations in danger in crises that were forgotten or had less media appeal, without having to appeal once again to the generosity of donors. We gave priority to responding to emergencies, because "reconstruction" is not our role. This lies within the responsibility of governments and international financial institutions [the World Bank in particular], rather than with NGOs [and hence private donors].
It must also be noted that mobilization in support of the Pakistan earthquake victims does exist. Approximately eight billion euros has been pledged by the international community. This is exceptional enough to be highlighted. The fact remains that pledges are not the same as help, with the experience from Hurricane Mitch as a reminder.[3] Obviously this must be deplored, but insofar as we are concerned, all we can do is furnish aid in accordance with the needs and with our skills and capabilities, whoever the victims may be.

→ MSF did not, however, intervene after Hurricane Katrina, which recently struck New Orleans. Why this difference in reaction?

Once again, reactivity does not systematically lead to an intervention. Our action may be limited to assessment of possible needs that we are apt to respond to. But when we observe on-site that these needs are being covered or that they will be by the time we are operational, why intervene? Our decision was simply the logical result of the on-site evaluation, as with our recent decision to intervene in the wake of Hurricane Stan, in Guatemala. That said, several points seem significant to me. The first lies in the difficulty of resisting media pressure. We saw it with the tsunami. Early on, our decision to stop fundraising was sometimes misunderstood; it ran counter to public emotion aroused by the images of the tragedy. It is strange, however, to see a spontaneous fundraising operation take place before needs are even assessed. Our teams in the field quickly reminded us of this. Nevertheless, confronted by pressure from our donors and having noted their exceptional mobilization, we have sometimes agreed to do "a bit more" by taking on projects whose relevance was the subject of internal debate. This was the case with the project of construction of small boats [about 150] that we carried out in Sri Lanka and in Indonesia for fishermen who had lost their only means of subsistence[4]. Did we do too much of this in the regions ravaged by the tsunami? The question must be asked, because with a bit more distance, we must recognize that the needs identified after the Pakistan earthquake are more significant. Nonetheless we must avoid separating analysis from field observations. If we were to decide on the launching of operations as a function of *a priori* factors or of dogmatic criteria [what is inherent to MSF and what is not] or on the basis of media coverage and public mobilization, we would be intervening out of an interest removed from that of the victims. Thus it seems to me important to preserve a certain leeway which will allow the organization to intervene beyond its normal sphere, when this meets the needs of populations in certain contexts. But we must also resist the urge to do too much of this, when it is up to governments or international institutions to fulfill their responsibilities. ■

1- 500 international volunteers from three sections [Holland, Belgium, and France] are providing assistance. In financial terms, the international budget committed to this emergency is approximately equivalent to that of the tsunami and represents about 24 million euros [5 million for MSF France].

2- Nearly 10 billion euros were pledged by governments in support of reconstruction, and private donations were virtually identical [6 billion euros], which was unprecedented.

3- In 1998 the international community had pledged 9 billion dollars for reconstruction in Central America. For the most part, this pledge never materialized.

4- Conversely we decided, at the same time, to not distribute money directly to affected populations.

"*A natural hazard can be characterized as the combination of an unpredictable event (that is, the causative geological phenomenon) with vulnerability (the effect on human settlements). Many large earthquakes go unnoticed when they strike uninhabited areas. What characterizes a hazard these days, in terms of impact — what makes it a catastrophe — is man's exposure. So much so that one of the conclusions of the International Decade for Natural Disaster Reduction (IDNDR), which ended in 2000, was that we should no longer speak of "natural catastrophes." While natural hazard-which cannot be prevented-exists, in fact it is social vulnerability that transforms phenomenon into catastrophe*"

Text of a presentation from a debate organized by Association 4D - Dossiers et Debats pour le Développement Durable - Paris, 27 January 2005 - reprinted by Jean-Pierre Dupuy in his book Petite métaphysique des tsunamis - Jean-Pierre Dupuy - September 2005 - Editions du Seuil

DOSSIER

Natural disasters
Lessons learned
in Pakistan

→ **On Pakistan:**

> *- Your interventions seem to underscore that the initial reaction didn't measure up... You seem angry, but at whom, exactly?*
> *- At ourselves, because I think we can do better.*

Pierre Salignon's response to a question by Marc Lavergne: **Excerpt from the minutes of the 25 November 2005 MSF-France Board of Directors meeting**

> *With such a large number-70,000 wounded-we've got to be realistic, and know that it will be very difficult to provide proper initial treatment. From my standpoint, it appears that we waited a little too long to decide treatment of the wounded a priority; this should have taken precedence over visiting remote villages.*

Dr Jean-Hervé Bradol: **Excerpt from the minutes of the 25 November 2005 MSF-France Board of Directors meeting**

→ **Pakistan** © Remi Vallet / MSF - November 2005

EMERGENCY IN PAKISTAN

Trial and error

MSF/ December 2005 / Rémi Vallet / Translated by Malcolm Leader

Following the earthquake of 8 October in Pakistan MSF teams set up hospital facilities in Mansehra. But a month and a half of effort and of stops and starts were necessary before this tent hospital finally became operational. We review here the difficulties encountered in getting this project up and running:

At the beginning of November, the situation in the district hospital in Mansehra was still far from satisfactory. Almost a month after the earthquake, patient hospital care conditions were still disastrous. Although we had installed six large hospital tents, latrines and a water supply system, almost 300 families were still crowded around the hospital outskirts, living in draughty tents and had no groundsheets. The few beds in the hospital buildings that were still standing were occupied by the injured. This being the case, the hospital's regular services (maternity, paediatrics, etc) were no longer able to cope with any new patients who presented. As for the operating theatre, which was provisionally installed in the former labour ward, hygiene conditions were deplorable and sterilisation questionable. Franck, the MSF surgeon, was afraid of contamination and the risks of patient post-operative infection. In short, proper standards of medical quality did not exist. This observation, which was shared by the whole team, generated a considerable amount of frustration.

→ INITIAL INTENTIONS

A number of elements explain this delay. First, there was a problem of availability of equipment. Because they were not in stock in Bordeaux but were still being produced by their Italian manufacturer, the inflatable tents did not arrive in Islamabad until the end of October. "Had they been available on the first day of the emergency, we could have put them up right at the beginning of our intervention," says Sinan, surgeon in the medical department and medical coordinator in Pakistan. But the fact is that this delay

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PAKISTAN - EXCERPTS FROM WEEKLY REPORTS BY SYLVIA CAUZZI, PSYCHOLOGIST

WEEK 6 In the OPD, (MSF tent for mental health consultation set up in the hospital grounds), we cannot treat people suffering from chronic psychiatric problems. It must be explained to them or their relatives that they must go to a local psychiatrist in Abbottabad. But it is not surprising to have such demands: this region devastated by the earthquake has no facilities specialised in mental health care.

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in supply increased the difficulty we had in establishing a workspace, which meant that we lost several more weeks. "From the beginning, we sought to work at the hospital in Mansehra," recalls Nick, Head of Mission at the beginning of our operation, "but the local authorities preferred at that stage to count on promises of aid from Saudi Arabia. Being unable to get a foothold, we then turned to the hospital in Battagram in order to reinforce its surgical teams, ensure post-operative care ...and also attempt to set up our inflatable hospital facility there. But when negotiations on this project came to a sudden end in Battagram, the Pakistani Ministry of Health contacted us again and insisted that we work in the hospital in Mansehra, where the Saudis never turned up." By the time the medical and logistics teams set up in the hospital in Mansehra, October was nearly over.

→ OPEN ONE TO CLOSE THE OTHER

Reoriented towards Mansehra, the team set about improving hospital conditions (installation of tents and sanitary equipment), while Sinan handled discussions with the hospital with a view to installing our hospital facility.

On the other hand, nothing was done to set up correct sterilisation in the operating theatre. Should we and could we have done it? "The operating theatre was in a deplorable state and of course it needed to be improved, but we cannot do everything," says Sinan. "The priority was to open our own surgical facility as soon as possible, so that we could close the existing theatre." His view was that getting a satisfactory solution in the theatre would take as much time as setting up the hospital, would tie down several volunteers on a full-time basis and would thus delay setting up the hospital.

And quick progress on this project was essential, both to re-establish proper patient care and also to prove to our local interlocutors that our promises were not just words - and thus to reinforce our margin for manoeuvre in negotiations. Putting to one side sterilisation for the operating theatre in the name of the paramount objective of setting up the hospital is an illustration of our limits and the difficulty of operational choices.

AT MANSEHRA, AN "INFLATABLE" HOSPITAL TO ENABLE TRANSITION

Nine inflatable tents - 1000 square metres in all -, four operating theatres, an emergency room, an intensive care unit, and 120 hospital beds. The hospital structure set up in Mansehra is impressive. Installed next to the district hospital, it works in close collaboration with this hospital in order to treat the injured and patients who have experienced complications, and to do so in correct conditions. In this phase of prolonged medical emergency, it also treats other emergency cases. Relieved of this part of its work, the district hospital is thereby benefiting from a period of transition in order to carry out necessary rehabilitation or reconstruction work, which will enable it to function normally once again.

→ PROBLEMS MOUNT UP

And human resources were limited. Especially as up until 6 November five volunteers were occupied on a full-time basis with the tetanus care unit. This was an operational choice that could have been very relevant, but as it turned out there were few cases of tetanus after the earthquake and the centre opened too late due to difficulties in the supply of equipment, so that in the end it received a grand total of two patients.

On 6 November the last patient was transferred to a hospital in Islamabad and our centre closed its doors.
The whole team then seemed to be re-mobilised for the hospital project, but its opening still seemed a long way off. On the land identified for its installation, 140 tents sheltered 250 families and more than 900 people - with at least one injured person per tent. Before being able to set up the hospital, space had to be found, and thus alternative housing solutions needed to be found, with a guarantee of access to relevant care for patients who still needed regular treatment.

In the case of families who wished to return to their villages, the team made available equipment (tents, blankets, and hygiene and kitchen kits) and paid transport costs. But some families left without dismantling the tents installed in the camp. In order to build the hospital on this spot it was going to be necessary to be stricter. Which was not without causing some friction in the team.

→ OPERATIONAL ON 21 NOVEMBER

Some team members feared that they would be turned into "bailiffs". Others doubted that our material aid would guarantee better living conditions for families, who did not always know what they would find back in their villages. "We are here to help people, not to free up space," insisted one nurse.
This was true, but in order to be able to set up the hospital quickly and to re-establish quality medical care, freeing up space was essential.

The opening of the first "medical village" (convalescent centre for the injured and their families), on 9 November, marked an acceleration of the process. On the one hand, 25 families moved out at the one time, and the dismantling of their tents near the hospital finally freed up some space.
Moreover, the satisfaction expressed by these first relocated people contributed to diminishing the concern felt in the teams and to attenuating the mistrust of local organisations, who had accused MSF of chasing people away. In the following days other medical villages opened and logistics work for the installation of the hospital commenced.

On 21 November, our hospital facility was finally able to open its doors in Mansehra, allowing in its wake the closure of the old operating theatre. Since then, more than 500 patients have been treated there. ■

PAKISTAN - EXCERPTS FROM WEEKLY REPORTS BY SYLVIA CAUZZI, PSYCHOLOGIST

WEEK 10 The majority of patients that come to the OPD have been affected by the earthquake but most of the time after 3-4 sessions the unstable or disturbed structure of the family life comes out. Sometimes therefore an individual session becomes a family session or a dyadic session. The earthquake gave the opportunity for old psychological symptoms to reappear. Now everybody is talking about trauma, because it is a reality accepted and evident, after the disaster. There is less reluctance to talk about old traumas or disturbed relationships and family psychological distress. Slowly, slowly the structure of the society is revealed. Enlarged family members and casts make up the society structure. Working with families gives me the chance to discover some strict rules about the traditions. Sometime these rules, especially for the new young generation patients, are against the inner personality of the individual, therefore the trauma appears within the pre-existing neurosis. The earthquake has been a way to reveal their own wishes, which are forgotten during daily life.

Jean-Hervé Bradol Interviewed by Arte (French television Channel) one year after the tsunami :

"*Money corrupts. This is as true for a humanitarian aid organization as it is for an individual or other institutions. When you have excess financial resources coming into your organization in an artificial way, it generally makes you inefficient, and that leads to waste. You then have teams in the field working backwards: not according to the needs they see on the ground-calling headquarters to ask for funds to respond to those needs-but getting messages from headquarters telling them, "You've absolutely got to use the money, because the money is there." And this inverted perspective for organizing aid, in the minds of those working to put the aid together, well, that's what you call working backwards. And when you work backwards, you get poor results...*"

Dr Jean-Hervé Bradol
Un an après le tsunami
[One year after the tsunami] - Televised interview - Arte - December 2005

"Wait and See"

MSF/ January 2006 / Raouf Abdellaoui

Raouf Abdellaoui, an MSF nurse who arrived in Pakistan two weeks after the earthquake, describes in his end of mission report the frustration he felt at the beginning of his mission and the relief after certain hesitations.

I arrived in Pakistan on October 25th and my mission was to set up, with another nurse and a doctor, an intensive care unit for tetanus patients outside Manshera district hospital. I was also in charge of buying a cardio monitor, oxygen and a ventilator in Islamabad, but I couldn't find a good ventilator.

We were sent on an emergency departure from Bordeaux (France), but we were surprised that we did not have any patients to admit to our tetanus centre after having set up the all centre...I think the decision to open a centre was taken too quickly without proper reflection.

This long period without a programme or activity was really stressful and I felt terrible seeing so many patients in need (...)

I don't understand how we spent so much money and energy setting up an intensive care unit (which received only 2 patients) when 1 km away there were so many wounded patients without proper care, drugs, dressing...
We had to wait for the change of the majority of the team to hear what we had been asking for for 10 days: to set up a place to provide correct treatment for patients.

This long period without a programme or activity was really stressful and I felt terrible seeing so many patients in need: we had so much material and medical items in the pharmacy, but we were doing nothing for them, always being told "please wait and see". For example the population wasn't vaccinated for tetanus, but we only started vaccination activities on November10th, more than one month after the earthquake, just like the dressings area, like physiotherapy, the follow up of patients...
In fact we began to have an activity when we decided not to follow directives and we opened a room for dressings, despite the fact that we did not feel supported in our decision. Setting up this dressings area helped us to really see the patients' hygiene conditions, the gravity of the wounds and to make new treatment plans (OT, skin graft, new antibiotics...) and finally to start working in the hospital and we really began to work.

With the new team, who quickly set up activities inside the hospital, things began to move quicker and I felt more comfortable. The overall assessment of patients, the presence of our surgeon in the operating theatre, physiotherapy, the dressings room and medical visits at the patients' bedsides helped us to build our arguments for setting up an inflatable hospital.

I am very proud to have participated in this project because it included a lot of challenges: the resettlement of a lot of patients in medical villages, organization of the hospital, sterilization, operating theatre, and for me to set up an emergency room using my own experience of work in ER in France was exciting. Quickly we came across various difficulties because we didn't really take time to understand everything before opening the ER: how they worked before the earthquake.

My principal difficulty was to find my place as a nurse in a system that doesn't offer good care for the patient because the MOH doctors don't take time to see the patients.
For a majority of MOH doctors, the diagnoses they make are not correct and the treatment is therefore not always adapted. I was faced with a dilemma "should I administer the treatment?" "Should I provide drugs if we know for certain that they will not be correctly used?"

Quickly faced with this question, we organized some meetings to exchange comments with the MOH doctors and some arrangements were agreed. I'm going home now and I have the impression that things are getting better and better. Now, for complicated cases, pain management, resuscitation, they don't hesitate to call us.

As concerns my collaboration with the dispensary staff, things are slowly improving. I tried to teach them basics hygiene rules; some staff were interested and attentive, other were not. As I was not their supervisor I couldn't push them too much, and I'm not sure it was in my objectives.

I learned so much in this mission than I felt sad to leave the team. This was the most interesting mission (setting up a programme from the beginning) of the three I have done with MSF. I really enjoyed it (even if I always complained) and I felt really comfortable in my relationship with all the staff and expat team, and I met some MOH doctors who were really good and it was a pleasure to work with them. Sure there were a lot of difficulties but if there hadn't been, it wouldn't have been interesting...
I met really interesting people in the team and I hope I meet them again in another mission...after taking a holiday... ■

I learned so much in this mission than I felt sad to leave the team. This was the most interesting mission (setting up a programme from the beginning) of the three I have done with MSF.

PAKISTAN

Helping Families Face the Winter

MSF / December 2005 / interview by Rémi Vallet

Nick Lawson served as MSF's head of mission in Pakistan until December 10. He arrived two days after the devastating October 8 earthquake and supervised the set-up of Doctors Without Borders/Médecins Sans Frontières (MSF) medical and material aid programs in the Northwest Frontier Province, which borders Kashmir. With winter arriving, he offered an update on the situation people face and their need for continued assistance.

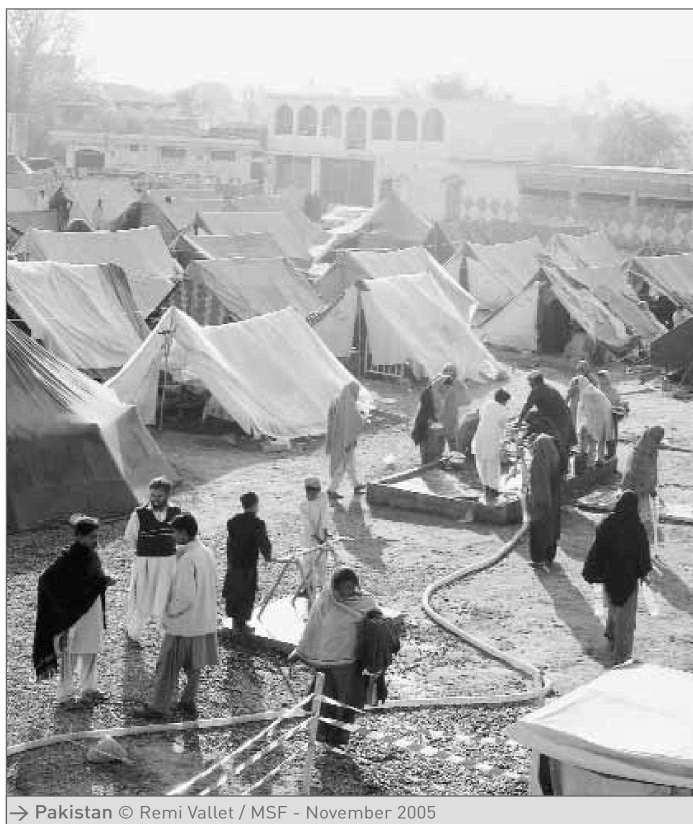
→ Nearly three months after the earthquake in Pakistan, what does the arrival of winter mean for people in the devastated regions?
Immediately after the earthquake, the major concern was that tens of thousands of people would lack shelter as winter arrived in this mountainous region. That concern was heightened by the logistical difficulties resulting from the destruction of roads. Their reopening has made it possible to deliver large quantities of material aid (tents, blankets, etc.). In addition, many families have come down from the mountain villages. In the Batagram and Mansehra districts, around 100,000 people settled in hundreds of camps spread out throughout the area.

The needs - in terms of health infrastructure, access to drinking water, quality of shelter and other issues - vary tremendously from one camp to the next, but all the families must prepare to face the cold. We identified those families that received poor-quality tents and exchanged them for ones suited to the climate. We also distributed additional blankets and other basic supplies, based on needs. Given the risks of fire - in late November, several people died in Mansehra when a candle set fire to two tents - the best heating solution we have found so far is a kerosene system. Our teams began distributing them mid-december.

For now, we have not observed a significant increase in the number of cold-related illnesses or deaths. The significant mobilization nationally and internationally has made it possible to distribute tents, blankets and a variety of aid items widely. But the precarious living conditions in the displaced persons' camps - people living in close quarters, limited health infrastructure, difficult climactic conditions - mean that all the organizations on site must be vigilant. If winter results in high mortality among earthquake victims, that would represent a failure for everyone providing aid in the region.

→ Are there still many people in the mountains? How will they survive?
Traditionally, more than 80 percent of people in the mountain villages come down to milder areas during the winter. This year, people will probably descend to even lower elevations than normal.

When families decide to stay in the mountains, it's because they know how to make it through this difficult period. When we first began working there, two MSF teams were stationed in the Allaï and Kaghan valleys, where they distributed tents and blankets and organized medical visits. Although they covered fairly extensive areas, certain isolated villages may not have received enough supplies. Unfortunately, we are unable to go to all these villages to distribute heating systems. It's even more difficult because regular return trips are required to re-supply the kerosene.
Nonetheless, if the usual strategies for dealing with the winter have been disrupted or if living conditions become too difficult for the families who have lost homes, they can still come down into the valleys. The Pakistani government has announced that it will keep the roads open throughout the winter so that those who want to move can do so. ■



→ Pakistan © Remi Vallet / MSF - November 2005

> *"Scaling aid to the needs of the victims, and not to the sympathy we feel for them, remains the essential role of humanitarian organizations."*
>
> **Rony Brauman, in Télérama No. 2915 - 22 November 2005**

DOSSIER

Natural disasters
Lessons learned
in Pakistan

→ How much does it cost?

The cost of aid operations for victims of natural disasters is always very high. A cargo plane [a "full charter" in MSF talk] costs between 50,000 and 200,000 euros, depending on the distance. The "winterized" tents that we are sending to Pakistan cost nearly 200 euros each, after price negotiations. We have to rent helicopters to get to the most remote locations: an hour of flight time is exorbitantly expensive...

Thierry Allafort-Duverger

NATURAL DISASTERS

Focusing on those most in need

MSF / November 2005 / Interview by Laurence Hugues / Translated by Marcy St John

Thierry Allafort-Duverger, Head of Emergencies, discusses our aid operations for victims of natural disasters. Although no two disasters are alike, the principles of intervention remain the same: identify needs unmet by local or international agencies and adapt the response to the populations most at need. Adapted means of assistance are essential, as is innovation in both medical and logistical areas.

Let's begin by recalling two important factors: first of all, local aid agencies are the first line of response. Moreover, no two disasters are alike, whether in terms of medical consequences or aid to the homeless. We have provided assistance to victims of natural disasters on several occasions in recent years: after Hurricane Mitch at the end of 1998 in Honduras, after the earthquake in Bam (Iran) on December 26, 2004, after the tsunami in Southeast Asia the following year, after the floods in China [several times], and just recently, following the earthquake in Kashmir. Based on our experience, we've developed operational logics and reflexes that we must adapt to each situation.
But we must also continue to improve our response capability, in regards to both our reactivity and our ability to adapt to the needs of the most weakened populations. The consequences of natural catastrophes are not the same for everyone: the populations most in need before will not be less so afterwards, on the contrary. Our attention must therefore be focused on those most in need.

→ When confronted with a natural disaster, what are the most important factors in our decision to intervene and in our choice of how to do it?

The scope of the disaster is of course a determining factor. Our operational procedures call for immediate response by teams onsite. We were thus able to intervene quickly after the Bam earthquake, in December 2003, and again this year in Guatemala after hurricane Stan. Likewise, teams from MSF-H and MSF-B present in Pakistan and India carried out the initial evaluations and shared with us their observation of the seriousness of the situation immediately after the earthquake last October. One day after the quake, official estimates were putting the toll of injured at tens of thousands. At that point we decided to intervene. As our evaluations progressed, we had to adjust our operational response accordingly from one day to the next, almost hour by hour, in response to the scale of what is now clearly one of the most serious disasters of recent years, both in terms of the number of victims - more than 60,000 in Pakistan-administered Kashmir- and the number of displaced persons. This was not the case in Bam, for example, where the earthquake caused a great number of deaths, victims suffocated in the collapse of earthen houses, but relatively few injured.
We also have to adjust our actions as other aid agencies come into the field-who's doing what, how, and where-and as a function of the dynamics of the crisis: what are affected people going to do, what decisions is the government going to make, etc. In other words, we have to carry out the most detailed field analysis possible. Once the first "standardized" emergency relief supplies distributions have been carried out, it is essential to ask the affected populations what they need.
It is not easy to accurately gauge the type of response we are going to be able to carry out, because we have to react quickly and at the same time define needs very precisely, rather than bring in a massive, generalized response. The nature of the government's response is also, therefore, a decisive factor.
A country with a well structured administration will of course respond in a more adequate manner than a country devastated by war. In Bam we worked alongside the effective efforts of the Red Crescent and the Iranian government. Similarly, if the tsunami had affected Somalia on a larger scale, the response of local aid agencies would have certainly been different from what it was in Indonesia. Following the floods in China, on the other hand, we did not find need for the "extra" assistance we might have supplied, since the Chinese army deployed a huge response to the needs of the thousands of persons who had to leave their homes.
In the case of Pakistan, the needs consisted in helping with hospitalization requirements for a massive influx of injured persons and supplying people with shelter and blankets against the cold weather. Even more importantly, suitable supplies were required quickly.
Another need concerns appropriate psychological care. In Indonesia, and especially in Pakistan, we set up a unit for psychological care for the injured, targeting in particular children.

PAKISTAN - EXCERPTS FROM WEEKLY REPORTS BY SYLVIA CAUZZI, PSYCHOLOGIST

WEEK 11 My personal activities amongst the hospitalized patients have reduced a lot, I'm focusing more on OPD patients — on the contrary Fozia and Farzana are focusing more on the dynamic and the reality of the wards in the Hospital. This week Fozia assessed 19 patients and 12 have to be followed up; Farzana assessed 14 patients and 4 have to be followed up. They are following up more patients than I do.
Within the last two weeks we have followed up 31 patients in total in the hospital, villages and OPD.

→ Honduras © illustrious - November 1998

→ Are the coordination and responses provided by aid actors always suitable?

These disasters generally get a lot of media coverage. Is it because they touch our collective conscience and because some victims are "more innocent" than others? This media promotion multiplies the responses, sometimes leading to bottlenecks in providing assistance. In other words, a large response does not necessarily mean an effective response. When we asked the director of the hospital in Aceh, Indonesia, what he needed most, he answered, "We don't need specialists; we need nurses." In the hospital in Meulaboh, there were a dozen surgeons in the ER, for twelve minor operations, but no one to provide regular nursing care. Everyone wanted to stay in the ER, to be in the photos! Media competition can lead to operational aberrations.

Moreover, despite appearances, these disasters do not affect everyone in the same way: populations that are already weak are going to be the most affected. After Hurricane Mitch, in 1998, we decided to intervene in Honduras, the country most affected, by rebuilding a complete water and sanitation network. But then we realized that in Choluteca, in the southern part of the country, the river had swollen by 300-500 meters, washing away with it the homes along its banks where the neediest people of the region lived. The victims had lost all their possessions, their homes, their jobs, access to water, not to mention their loved ones. They were the ones who needed us the most! We can cite another example: the psychiatric hospital in Aceh, Indonesia. When a team from the Dutch section of MSF proposed an emergency intervention there, the authorities refused because the Australian government had already lined up a more substantial long-term project. As a result, there was no immediate response. In practical terms, that meant, among other things, that the patients weren't getting any food...

We must therefore watch out for these issues of competing responses and focus on meeting the immediate needs of populations before planning the future. Despite the enormous mobilization after the tsunami, the survivors in Aceh had to wait 25 days before getting the first delivery of tents. MSF was late, that's clear, but we were also the first to do it...We must also be skeptical of empty promises made during the first days and left unfulfilled when the crisis disappears from television screens. And finally, we must be pragmatic.

This is a basic principle of MSF interventions, and it applies to the process of coordinating aid operations, which is particularly relevant at the local level, although open to discussion on a broader scale, when piloting different and sometimes competing responses.

→ What areas do you think MSF needs to improve?

We have a lot of upstream efforts to make to improve our responsiveness. For example, we're working on the use of an inflatable hospital, with an immediately operational surgical unit, which allows us to set up field hospitals very quickly. In Pakistan, for example, hospital facilities were very seriously damaged by the earthquake, and the frequent aftershocks made it impossible for care teams and patients to remain in buildings on the verge of collapse. In this case, a mobile modular unit is proving very useful.

PAKISTAN - EXCERPTS FROM WEEKLY REPORTS BY SYLVIA CAUZZI, PSYCHOLOGIST

WEEK 12 This week, on the emergency ward the MSF nurse and doctor had different cases to refer to us. Even in the past they were referring us cases like suicide attempts but unfortunately Pakistani doctors were not interested in keeping these patients under observation. As soon as the patients had their gastric cleaning, doctors discharged the suicide patients and we had no possibility at knowing the reason behind the act. We only had one the occasion to see a young boy, who had the courage to follow at least two psy sessions after he was discharged.

This little cooperative way of working made us understand how different the treatment of patients is. Some Pakistani doctors don't want to dig deeper, it looks like they are afraid of reaching the problems inside their community. Patients are numbers, and it is frustrating for us. We have little chance of changing this.

DOSSIER

Natural disasters Lessons learned in Pakistan

> *Great catastrophes cause a certain amount of confusion, and nearly all attract individuals from all parts of society. (...) You have a multitude of actors who aren't usually in such situations, beginners who don't know what to do, but want to "be in the photo," attracted by the atmosphere of collective distress and great emotion, and sometimes by institutional interests, because these big crises are a marketplace for these organizations, a marketplace for financing aid operations. Rarely does all this produce efficiency. And it's very hard to coordinate, when you have, in a small area, representatives from [many] different aid agencies; here again, coordination is simply wishful thinking-it's not feasible, if for no other reason than there are too many actors to coordinate.*

Dr Jean-Hervé Bradol
***Un an après le tsunami* [One year after the tsunami] - Televised interview - Arte - December 2005**

We are also considering the possibility of obtaining an aircraft more quickly, one in which we could send off, in a matter of hours, a medical-surgical team experienced in this type of intervention and equipped with necessary medical supplies. In medical areas, there are also capacities to be added, such as peritoneal dialysis, without requiring the usual heavy and unsuitable dialysis equipment. To have suitable temporary shelters in good time is another of the logistical challenges we must meet. When the emergency kits were introduced, their use allowed us to improve our responsiveness. We are continuing to work in this direction, in Paris as well as at the logistics center in Bordeaux.

In order to continue this logic of adapting response to the needs of the affected populations, we should also continue to consider the relevancy, or not, of distributing money. The question came up after the tsunami. Obviously, there are security issues that immediately come to mind, plus a total lack of experience in this area. But why not think about it?

As our experience is honed, our tools improved, and new ways and means become available, we can provide a broader response - even though the scope of a disaster and the logistical challenges it presents mean that an emergency response is always difficult. As the consequences of disasters are never the same, we must be inventive in order to continue to reach the affected populations. ■

PAKISTAN - EXCERPTS FROM WEEKLY REPORTS BY SYLVIA CAUZZI, PSYCHOLOGIST

WEEK 13 The OPD activity is running well. Two weeks ago we had at least 4-5 new patients per day coming for therapy. The harsh weather and the near Id festival led to sporadic consultations.

Patients in our consultation tent feel comfortable relaxed, contained and protected. Sometimes patients ask to stay and to rest for a while on our small mattresses: they close their eyes and they rest. Some of them need to stay away, far from family problems or far from the crowd of the refugee camps. We are pleased to host these patients and it is the demonstration that our space has become what was intended: to create a therapeutic room with all the respect for the privacy and the containment that people need in order to recover.

SRI LANKA

Local help and solidarity, determining factors in emergencies

MSF / December 2005 / Propos recueillis par Rémi Vallet

Vladimir Najman, an economist, has studied the coping mechanisms of the population in the district of Batticaloa (Sri Lanka) after the tsunami that struck on 26th December 2004. He underlines the determining role of local solidarity efforts in the immediate hours after the disaster, whereas international aid started arriving later with varying degrees of efficacy.

→ How did the population of Sri Lanka cope with the tsunami that struck on 26th December 2004 ?

With a toll of over 3000 dead, the district of Batticaloa on the east coast of the island was severely affected by the tsunami. Nevertheless, thanks to local help and solidarity, most survivors received a hot meal and had some form of shelter by the first evening. This immediate solidarity was possible, in particular, because of the geography of the catastrophe which only effected a strip 200m wide along the coast and that spared the rest of the country. In the days that followed, the government, non-governmental organisations already present before the catastrophe, and the population were able to address the main emergency needs. This reaction hinged on survival strategies honed during 20 years of conflict and previous natural catastrophes, particularly cyclones and floods.

> *In the days that followed, the government, non-governmental organisations already present before the catastrophe, and the population were able to address the main emergency needs.*

The information collected by NGOs and UN agencies providing assistance after the tsunami in other areas in the east and north of Sri Lanka confirm my observations in the district Batticaloa. Everywhere, the wave quickly receded and the populations were able to seek shelter in areas that had not been effected.

In short, the emergency response in Sri Lanka the first week after the tsunami is a model in emergency management. However the second

→ Sri Lanka © Aurélie Grémaud / MSF - January 2005

week saw the arrival of a mass of organisations of varying sizes whose actions, for the most part, were not very useful. The result of this flood of assistance was anarchy in distributions and healthcare, coordination problems between NGOs that were impossible to manage, a general feeling of waste, of excess of means employed compared with the needs of the population.

→ Did this overabundance of aid help the reconstruction process?

Installed in tents and shelters, the affected population very quickly received food and non-food distributions. The emergency phase was therefore very short. On the other hand reconstruction was very slow. This slow start, in part due to constraints inherent to this process, contributed to part of the affected population remaining in a relatively precarious situation.

The main actors poured over reconstruction plans and organised at length the coordination of their projects, without however actually getting to the concrete realisation. For example, the tsunami destroyed most of the fishing boats. Those in charge of providing the fishermen with new boats wanted to deliver them all simultaneously, which therefore postponed the start of distributions. This costly and laborious solution was abandoned in the end, but only after long procrastinations.

The result of this flood of assistance was anarchy in distributions and healthcare, coordination problems between NGOs that were impossible to manage, a general feeling of waste, of excess of means employed compared with the needs of the population.

→ Back from Niger, do you see any similarities between the crisis strategies of the Nigerien population and those you observed in Sri Lanka?

Niger has suffered a serious nutritional crisis this year, and it is still not over. Like in Sri Lanka, or anywhere else in the world when there is a crisis, the population has tried to cope using pre-existing social, economic and political networks. In Niger, during the hunger gap -the period between the end of food reserves and the following harvests- the poorest families have recourse to various mechanisms to get food: debt, seasonal exodus to large towns or Nigeria to find work, selling livestock or land etc.

Nevertheless the contrast with the situation in Sri Lanka is striking. In Sri Lanka local crisis strategies got them through the first week and quickly out of a life-threatening emergency situation. In Niger, a breaking point was reached this year because of the scale of the crisis. In this country where acute malnutrition is a recurrent problem, the fragile balance has been permanently destabilised. Free food assistance has been a determining factor for the survival of many many children. However, as the free distributions started late, certain families had already run up heavy debts and there is great concern for the coming year. Survival strategies have reinforced this economy of death that is developing in a country at peace. ■

“And that brings me to the intrusion into the humanitarian sphere, widely-covered in the press, of national and international political personalities, with their inevitable assortment of promises and empty hype. (...) For example, the idea of a “worldwide SAMU” or a corps of “red helmets,” which elicited lots of articles but which you don't hear anyone talking about anymore. Also, military and diplomatic intrusion into the humanitarian arena modifies the public perception of the humanitarian. We went from the image of a Red Cross stretcher-bearer to that of a French doctor, stethoscope around his neck, busy treating a black child. And now, it's that of a new breed of soldier, a victim in his arms. This imagery is no accident: when you force images on the public, it's done deliberately to convey or give a certain meaning to an action.”

Bruno David (Founder and President of *Communication Sans Frontières*, President of the NGO *Noir&Blanc*) in *L'humanitaire en catastrophe(s)*, Revue Humanitaire, Number 13, Winter 2005.

DOSSIER

Natural disasters
Lessons learned
in Pakistan

> *The mere concept of a secular NGO is beyond the comprehension of some Islamic humanitarian actors. They almost automatically confuse secular with atheistic. They don't understand, or don't accept, that the humanitarian gesture -no matter what its source- can be achieved outside the realm of religious values, and refuse to believe that they might be dealing, on one hand, with an atheistic framework, and on the other, with organizations having a transnational dynamic devoid of any religious inspiration.*

Abdel-Rahman Ghandour in *Jihad humanitaire - enquête sur les ONG islamiques.* September 2002 - Flammarion

Geological and political

MSF/ December 2005 / Interview by O.F. / Translated by Alison Keroak

Natural disasters cause both human distress and material damage; however, they can also be transformed into political issues, and can even change the course of history. While Pakistan faces a new catastrophe, in the following interview Rony Brauman reminds us of this dimension that earthquakes can reveal.

→ What events led you to make the connection between natural disasters and their political aspect?
First off, I'd like to point out that a natural event only becomes a disaster when it affects a society. Natural though it may be, this catastrophe then takes on a human and social dimension, hence a political one as well. The first time I realized this was at the time of the December 1988 earthquake in Armenia. The USSR opening itself up to international aid contained a political dimension because it was a first. There was in this act an explicit message of openness and détente. This was the "positive" part, that unfortunately went hand in hand with a darker side: that of the fate reserved for Armenian separatist committees, whose members were thrown in jail even though they were among the most active in the organization of assistance. However, we didn't find this out until later. The magnitude of the disaster itself - 25,000 dead - took up all our attention. In Leninakan, Armenia, I still remember a scene of devastation, in which the only building left standing was that of the KGB! More than just a symbol, the difference in the construction quality was a testament to the authorities' priorities at the time, and spoke volumes about the society's organization. From this point of view, Moscow has demonstrated a great sense of continuity ...

In preparation for this interview, you also mentioned the case of Bangladesh, born from the ruins of western Pakistan...
In November of 1970, western Pakistan was hit by a typhoon followed by a tidal wave, which caused 300,000 deaths. You had to reach across India to connect Pakistan to this province, which was enclosed in the northeastern corner of the Indian subcontinent. The government in Islamabad reacted very weakly, and help was provided essentially by the separatists, who were already influential. This incompetence, compounded by the elections that had been invalidated by the central government, unleashed a popular uprising that was violently suppressed by the authorities, who preferred to send in the army rather than mobilize aid in time. The massacre prompted a massive exodus: 10 million refugees fled to India. Looking back, it's not surprising that India could absorb, without outside help, the consequences of the December 2004 tsunami, when the country is capable of accommodating such an influx of refugees without any major damage! In any case, it was from these camps that Indira Gandhi launched the recruitment and training of dissident Pakistani troops who, one year later, would enter Dhaka (the modern-day capital of Bangladesh). Trained by the Indian army, the troops chased out the Pakistani authorities and put Awami League separatists into power. These events are part of MSF's history, since the newspaper Tonus, whose editors were also the co-founders of the association, put out a call for doctors and created Secours Médical Français (French Medical Aid), the precursor to MSF. It was also in the wake of this disaster that modern views of humanitarian 'ingérence' developed: Indira Gandhi, Indian prime minister at the time, compared these massacres to those of the Jews under Hitler, and the invasion of western

→ **Indonesia** © Greenpeace/Christian Aslund - January 2005

Pakistan was explicitly justified by humanitarian concerns and the defense of Human Rights.

→ Arrests, assassinations, exodus... Do you have an example of a positive event that occurred in the wake of a disaster?

The result in and of itself was not negative; far from it! Armenia and Bangladesh became independent states; the disaster served to accelerate the separation process. Conversely, there can also be a process of coming together in the aftermath of a disaster, such as is currently the case in Indonesia after the tsunami.

The province of Aceh was totally inaccessible for several years (MSF was expelled from it in 2002), and everything happened as though the presence of thousands of foreigners in the region had contributed to quelling the war of secession that had been in progress since 1976. In a way, the tsunami forced a political openness on Indonesia, and a year later, the inhabitants of Aceh province are breathing a sigh of relief. The (ex)separatists and the government are now negotiating an acceptable compromise. Geologically and politically, natural disasters can thus provoke or aggravate rifts, but they can also heal them!

→ In the context of strong suspicion of the West, it is not always easy for MSF to avoid being judged by preconceived amalgams. For example, our presence was not always well received at the beginning of our intervention in Pakistan last November. Are the motivations of aid NGOs free from all political considerations?

Pakistan's case reminds us that aid can have other motivations besides humanitarian ones. Islamic NGOs, for instance, build political legitimacy through their charitable activities and they must therefore assert their presence. They do this through their mutual aid networks and their usual social activities, which give them strong support to be effective. However in Pakistan they were not able to provide the assistance necessary for the scale of the catastrophe. Fierce anti-western sentiments, that are common in the region, therefore co-exist with the throng of foreign aid without interfering with it.

→ **Armenia** © MSF-H - December 1988

In Algeria during the last earthquake, which was far less destructive, the Islamic aid organizations were very active. It's not surprising, then, that their operations sometimes clash with those of other aid organizations, which can put us into competition with them. To my knowledge, there have never been any real problems, and in any case, there's no reason for us to do things they are already doing or that they want to do. In other words, we have no reason to compete with them, as opposed to local States who have to defend themselves against accusations of indifference or incompetence; States have to prove themselves useful. We know perfectly well that States never can and never will meet the expectations of the population in such circumstances. They're judged by their deficiencies, by what they don't do, while NGOs are touted for what they do and not for what they've left aside. The road to seduction is very unequal... In fact, the game is already lost in advance for States and it's because of this that aid organizations have a strategic dimension for religious NGOs, who set themselves up as challengers to States.

→ Does this strategic dimension only exist in Islamic NGOs, or is it even more significant in the "humanitarian" pretense exhibited by States?

It is important to make the distinction between what comes from the obligations of a State and what comes from choice. For example, the United States has an obligation to help the inhabitants of New Orleans, just as the Pakistani government must help the affected populations in Cashmere. They do not do it out of humanitarian concern, but because their populations believe they must do it. On the other hand, Pakistanis would not protest in front of the American embassy to demand aid, nor would Americans protest in front of the Pakistani or French embassies. This sort of aid, beyond national borders, is somewhat arbitrary. It's a paradox of humanitarianism. It's even a key component of humanitarianism, since otherwise this aid would be a public service. ■

> *" [Jean-Pierre Dupuy in Petite métaphysique des tsunamis] Once certain thresholds of atrocity have been crossed, the moral categories we use to judge the world become obsolete. Then it seems as if we can only account for evil in terms that evoke irreparable harm to the world's natural order." This would explain why the term finally accepted to express the moral catastrophe that was the extermination of European Jewry-the Hebrew word, Shoah-means natural catastrophe; and why survivors of Hiroshima and Nagasaki refer to these nuclear massacres using the word...tsunami. "*
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> **Vincent Rémy, author of an article entitled "*Après nous, le déluge!*" published in Télérama No. 2918 - 15 December 2005**

→ **Cambodia** © Espen Rasmussen – January 2004

EPICENTRE

Operational research on AIDS

DEBATES

MSF/ December 2005 / Interview by O.F. / Translated by Nina Friedman

With more than 56,000 patients currently receiving treatment, MSF programs offer an extraordinary opportunity for study. At the NGO's request, Epicentre regularly undertakes such research. Dr. Laurent Ferradini, head of AIDS research at Epicentre, talks about the questions MSF is asking, the significance of Epicentre's responses, and how this information is being put to good use.

→ What are Epicentre's main AIDS-related activities?

Epicentre's work focuses on two main areas: operational research projects and monitoring-that is, regular patient follow-up and collecting information on the programs. For the latter, we have developed a software program called Fuchia[1], which allows data collection on a daily basis, in collaboration with MSF-France and the Aids Working Group [the working group in charge of AIDS within the international MSF movement - ed.]. Epicentre helped the teams set up and improve the system to permit analysis, use, and distribution of all available data from the programs. The size of the MSF programs thus documented not only lends them a certain legitimacy, but also allows them to sustain this legitimacy and "promote" results that are useful to other actors. For example, our multi-center analyses [carried out by several MSF sections - ed.] are closely followed by the international scientific community. So, they also benefit others. This information is crucial for improving the way that patients are treated. The paucity of studies on treating AIDS in precarious settings only increases uncertainty.

Here, MSF is really on the front lines, and it is why we carry out our operational research projects.

→ What are these research projects?

The goal is to answer the questions that MSF is asking itself, and that relate to reality in the field. Using a targeted study, for example, we will attempt to validate the strategy of "scaling up" [increasing the number of patients on ARV treatment in a program - ed.] instituted by MSF-F in Chiradzulu, Malawi. What does that mean, in practical terms? It means that in going from a few dozen inclusions per month to 250 inclusions per month in the space of two years-between 2001 and 2003-MSF has made a certain number of choices: to base inclusion on clinical criteria, to administer triple therapy in the form of a single, fixed-dose drug, to simplify lab follow-up, etc. The idea behind this is to rapidly treat more patients by adapting to existing conditions, using both financial and operational solutions. To demonstrate that these choices are both appropriate and reproducible-not just at MSF, but also outside its programs-it's important to validate these procedures. This is where we come in. In this particular case, and with support from the field, our study lasted three months, and utilized all the necessary tools: field visits, sampling, adherence assessment, questionnaires, blood samples for virologic analysis, etc. We should emphasize, in passing, that these studies are expensive; they are limited in size and duration, and sometimes require outside funding[2].

→ Is the urgency of keeping the greatest number of patients alive compatible with the principle and duration of a study?

We are at the crossroads of numerous dilemmas stemming from the need to do something, do it quickly, do it well, and validate what we're doing, all at the same time! Because, sadly, AIDS does not wait. Even so, are we more obsessed with the quality of care than with the quantity of patients to be treated? Actually, the two are inseparable. Of course, we're not satisfied when we decide, for example, to prioritise the most severe cases while many others await treatment. But the time frame of this emergency and that of a study are complementary. Decisions are made to prevent death for the maximum number of patients. They produce their results, with all necessary rigor for patient follow-up, and we conduct studies to validate these decisions, even while operations continue. In the case of the Chiradzulu district, in Malawi, we were able to demonstrate that 84% of the 400 patients we followed for more than six months of treatment showed an undetectable viral load. This result is extremely encouraging, and the conclusions of this work should be published soon in a major scientific journal. It's to be hoped that this type of example (among those of others working in the same field) will rapidly benefit others, and encourage them to treat more patients more quickly with ARVs.

→ **Cambodia** © Espen Rasmussen – January 2004

→ What are your most recent noteworthy studies on AIDS?

The studies to be carried out are decided on together with MSF (with a given section, or internationally with the Aids Working Group), in order to answer MSF's prevailing questions! For example: Up to what point are first line treatments effective? Do patients comply with treatment in the long term? How widespread are the side effects we're now seeing? Can we define certain criteria for treatment failure? In an attempt to answer this last question, between late December 2004 and April 2005 we conducted a survey[3] of 416 patients in Cambodia who had been under ARV treatment for more than two years. The results there were, again, very positive. Once patients survive the initial months on anti-retrovirals-66% of deaths occur in the first six months-they show very good adherence to and acceptance of the treatment; the survival rate at 24 months is over 85%! Furthermore, almost nine out of ten patients present an undetectable viral load. These results are so good, they fall within the upper range of clinical trial results from developed countries! Beside reassuring MSF and demonstrating to others the relevance of these programs, they have prompted Michel Kazatchkine, former director of the ANRS [France's national agency for AIDS research - transl.] and France's current Ambassador on HIV/AIDS, to say that our cohorts "should be cultivated." Because these data are essential, not only to the future of MSF programs-and thus to patient survival-but also to all those trying to improve patient treatment. We are going to undertake a series of studies of this type in Arua (Uganda), in Homa Bay (Kenya) with MSF-France, and in Cameroon, at the request of MSF-Switzerland.

→ Speaking of the future, what exactly are the questions AIDS now poses to MSF?

Some of the questions follow from those we just mentioned. We're currently trying to identify adherence-related failure or success criteria after two years of treatment, without having to use viral load testing. Because the emergence of resistance is inevitable, we've got to identify the group of patients at greatest risk of short term failure, so that we can offer them an alternative at the opportune moment-that is, neither too soon, nor too late. When to switch? That's what we're asking ourselves at Epicentre, and at MSF-to know when to go to second line treatments. The stakes are considerable, and in my opinion, in the end we won't be able to do it without measuring viral load. But this is an issue that is still being debated, especially given that, at the moment, this test is expensive, tedious, and can't be done on everyone. This is, moreover, the reason why MSF decided to provide financial support for the development of a rapid viral load test, which Epicentre will validate, probably sometime in 2008. In the meantime, we still have to offer an alternative to those who need it, determining as best we can the patient groups affected by these changes, based on appropriate "immuno-clinical" criteria (i.e., predictive of virologic failure)-especially since the price of second line drugs remains prohibitive [over 1100 dollars per patient per year - ed.].

→ Are other avenues of research being considered?

Questions arise at MSF as programs go along, as the number of patients increases, as experience is honed, and

DEBATES

PRESS REVIEW

MSF / January 2006 / R.V.

→ Tsunami: frog scale

« This catastrophe marked a step forward in international solidarity, (...) and has engraved solidarity in the long-term. » wrote *Le Monde* in its editorial of December 23rd. And the debate on the rift between « emergency aid and reconstruction » has also became entrenched... On this point, the book by l J-F. Mattéi on «sustainable humanitarianism» received «overall positive» reviews: « once we have saved people from drowning we can't abandon them on the riverbank » he insists. « If the Red Cross was competent in construction we'd know about it », replies Jean-Hervé Bradol in *Témoignage Chrétien*. In the January 4th edition of *L'Humanité*, the deputy treasurer of Médecins du Monde cuts the debate short in his own way: for Pierre Micheletti, « No NGO can claim the ultilmate definition of what humanitarian aid should or should not be » recalling that « the budget of the largest French medical NGO » is equivalent to the budget of the hospital of Roanne, he concludes that « a frog should not mistake itself for an ox ».

•••

as new difficulties arise. A multicenter study by the Aids Working Group in Abuja looked at children. While we still have very few children in our programs-currently less than 2000-the lack of appropriate formulations and the cost of paediatric treatments oblige us to think about better treatment approaches. How can we reduce premature death, better diagnose and treat opportunistic infections, better manage patients with TB/HIV coinfection?
What might be the benefit of early nutritional intervention in the most malnourished patients? This is another series of questions for which our help has been sought. In the hopes of improving long-term adherence to treatment, we're also going to try to assess alternative first line drugs that are less toxic and-we hope-longer lasting [such as tenofovir - ed.]. We're also beginning a study on the side effects of d4T [stavudine] at the Homa Bay program in Kenya. This list is not exhaustive, and these studies will take some time. They nevertheless show that Epicentre is interested in "neglected research," as others are in "neglected diseases"-activities that are complementary, but also essential, to MSF operations and, we hope, of benefit to others. ■

→ **Cambodia** © Espen Rasmussen – January 2004

1- **Follow-up and care for HIV infection and AIDS**
2- **A large part of this study was funded by Sidaction**
3- **Study conducted in collaboration with several partners, including the Pasteur Institute of Cambodia.**

« La Mancha » Interim Report

MSF / January 2006 / Interview by Anne Yzebe

In June 2005, the nineteen presidents of each national association agreed to "support the "La Mancha" process of defining the roles and responsibilities of MSF in order to strengthen the International Movement and its Governance.". During the following six months, La Mancha collected 760 paired interviews[1], over one hundred voluntary contributions and some forty commissioned articles. In three months time, an international conference will be held to come up with recommendations for the redefinition and the drafting of "principals of action" and "operating rules" of the International Council. The national sections will have the opportunity to discuss the recommendations before letting the International Council know if they accept them or not. Discussions have begun, but they are far from over. Update with Dr Jean-Hervé Bradol, president of MSF.

→ The limits of the International Council

In spite of a few setbacks, the results of the International Council (IC) have overall been positive, even though much work remains to be done. The IC is already involved however in much more than it can really handle. For example, every IC member co-signs the annual consolidated accounts, which means co-signing the operational expenses of other sections. So responsibilities are already being shared, despite the fact the information presented in the accounts on the nature and efficiency of operations is still very incomplete. The International Council representing the MSF international association, which is made up of the 19 national associations, was devised in the beginning to share resources and ideas within the international movement and to resolve differences among the members. Ten years after the Chantilly document, the IC continues to run into two main difficulties. The first is the different views on the role of MSF on basic issues such as access to health care, the protection of refugees, the need or not for armed intervention, public health, etc. The second is a modus operandi focused mainly on shared resources (the name, personnel, ideas, money, techniques) and the settling of disagreements among sections. The fact is, as evident in the consolidation and certification of accounts at international level, we have evolved to the stage of co-responsibility without having set up piloting or follow-up measures. This is why it is necessary to reform the operating rules of both the IC and all the international MSF bodies.
The La Mancha process is intended to give the international institutions the

means to carry out the following tasks: pilot the main operational directions, evaluate and report on the efficiency of operations, and assess the relevancy of public statements. To do this, it was necessary to re-launch discussions, to re-define what it is that we agree on and the issues on which we can move forward together, and to provide the international institutions with the means to accomplish common goals.

→ The debate: Very practical questions

Three main themes were identified: principles, actions, and governance. But we must not forget that we are in fact discussing very practical questions, problems which arise in the field. When we talk about things like international justice, it is so that we can study cases like Uganda. What did it mean for MSF when the International Criminal Court began its inquiry in January 2004 into the actions of the Lord's Resistance Army (LRA)? Did it mean providing them with information? Can we really maintain the same access to patients if we are seen as potentially helping the International Court? It is clear that the way we define our responsibilities in the area of international justice can have a real impact on our ability to remain present in the field. Those who commit crimes will become particularly sensitive to the nature of the relationship between aid workers and international courts. Similarly, if we speak of abuse, it is because there are many such cases every year. Discussions about this issue have already started. On November 26, the International Council passed a resolution stating that individuals are personally responsible for their conduct , that the systems of complaints must be described and widely publicized throughout the movement, and that the use of these systems and the decisions taken must be reported in an annual report, while respecting the privacy of those involved, especially the victims. But there are also important questions that remain unanswered, especially regarding the social mission role of MSF - Should we feel responsible for all cases of unequal access to care? Is it the role of MSF to find overall solutions? It is very reassuring to know that there are different ideas in the movement. Our discussions are already becoming more and more interesting.

→ Aspirations: Operational innovation and human resources

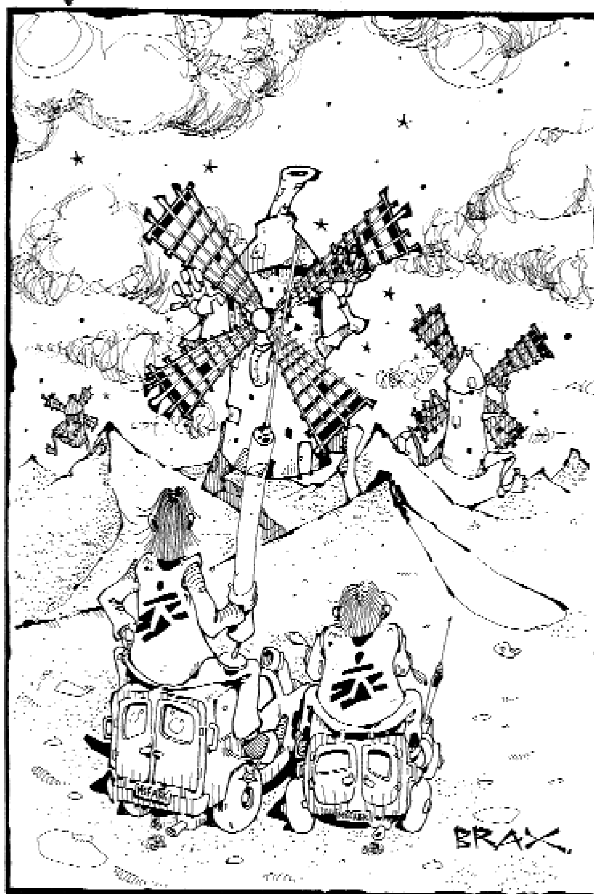
MSF is already one of the most innovative medical institutions in the world. From providing care to people with AIDS, to treating the severely malnourished, patients with malaria in Africa, sleeping sickness, leishmaniosis, meningitis - we have proven we can get good results. But if we do not put more emphasis on research and development, we will not be able to keep an acceptable number of our patients alive, given the potential knowledge and techniques that are available. One section alone cannot afford the costs associated with innovation: the DNDI represents five million euros a year!

Another challenge is to improve the management of the different categories of personnel in order to improve the quality of our operations in the future. The system as it is now is discriminatory. Nurses or doctors who are recruited in their own country currently have less opportunity to take on roles of responsibility than others, meanwhile we still have a lack of good coordinators. If we deal with this issue at international level, we may be able to develop an overall policy, thereby reducing implementation costs. The International Council may be unanimous on certain issues, but the work has to be carried out, and we need to be able to afford to move it forward and provide follow-up in order to concretely apply the board's recommendations.

→ "La Mancha": Is it utopia?

Our goals are set high, and the challenges are great. Some misunderstandings will be cleared up, other divergent views will remain. We will succeed only if our divergent views do not prevent us from accepting collective responsibilities (for actions and public stands that succeed or not, and quality of staff and resource management). As we continue to grow, these responsibilities can no longer be taken on solely by national sections alone.■

1- One-third of the interviews were from expatriates, one-third from headquarters and one-quarter from national staff.



PRESS REVIEW (CONT.)

MSF / January 2006 / O.F.

→ Pakistan: sustainable humanitarianism ... version MSF

It was difficult to find articles on the situation in Kashmir in January ...

The tsunami of December 26th 2004 continues to take up all room, the situation at the beginning of 2006 for the populations affected in Pakistan remains however worrying. The daily newspaper *Libération* recalls in an article dated January 9*th*: «Hygiene conditions vary from one place to the next, but there are a lot of makeshift, overcrowded camps that do not have latrines or access to water ».

Ouest France in its edition of January 16th describes, through an interview with the head of mission, the difficulties the MSF teams had at the beginning. «We quickly realised we needed more resources», he explained. «The inflatable hospital will be necessary for at least a year» ends the article, adding that «the number of consultations has stabilised at 700 patients per week».

→ Chechnya © Eddy Van Wessel - October 2003

CHECHNYA

Normalization-beneath the façade

MSF / November 2005 / Dr Denis Lemasson, Deputy Programme Manager / Translated by Nina Friedman

While the first Chechen war, from 1994 to 1996, did not prompt a population exodus, the resumption of the conflict in 1999-and its brutal bombardments-did succeed in provoking mass flight. Grozny was emptied in a single month; some 300,000 displaced Chechens fled to Ingushetia, and many others to Azerbaijan and Georgia in the South Caucasus. Since then-despite appearances, and in sharp contrast to the "normalization" heralded by Vladimir Putin-the war in Chechnya continues.

At the end of 2000, the bombing was stopped and a pro-Moscow government installed, marking the start of the "normalization" process-a reign of terror-that continues today. From 2002 to 2004, under the combined pressure of Ingushetian authorities and federation forces, Chechen refugees were forced to return home. These returns were meant to symbolize Kremlin rhetoric, and prove that the war was over. What the Chechens found was a country in ruins, where no preparation had been made for their return.

Housing and sanitation resembled what they had experienced in Ingushetian camps, and security conditions were those of a country still at war. Even today, clashes are a daily occurrence. There are 80,000 Russian troops there, and 20 to 25 of them are said to be killed each week. "Cleansing" operations haven't gone out of style-the number of kidnappings and disappearances may even have increased in recent months-and impunity is still the rule. Humanitarian aid, extremely piecemeal, does not meet the need. Security, which is tightly controlled and relies on the granting of passes, is the primary factor limiting the number of relief workers and their activities in Chechnya. Ordinary crime is also on the rise. The assassination of Aslan Maskhadov, democratically elected president of the Chechen Republic in a vote overseen by the OSCE, has seriously jeopardized any chance for a political solution to the conflict. Every family has been-and still is-"physically" affected by the violence, whose exact toll is very hard to establish. Estimates range from 75,000 to 160,000 dead since 1995, compared to today's total population of approximately 800,000-close to 10% of the population has disappeared. Socioeconomic conditions are catastrophic. According to a study by the Russian Ministry of Economic Development and Trade, 91% of the population lives below the poverty line, on less than 72 euros per month. In addition, the Russian strategy of "chechenizing" the conflict by delegating the most violent acts (torture, cleansing operations, etc.) to pro-Russian Chechen militias is taking a huge toll. The fear of others-of neighbors, friends, cousins-weighs heavily on the whole of Chechen society. It's an extremely effective technique for destroying the social fabric. And if the situation in Chechnya isn't bad enough, the violence is now spreading to the entire North Caucasus. If these refugees are asking for asylum in Europe, it's because they feel they no longer have a future in Chechnya or Russia. Only the destruction of Chechen social identity could make flight the sole solution. ■

→ In Chechen refugee camps in Poland: Health care, the last expression of political and social space?

There are no other international actors in these camps. Has health care become the last arena for talking about social issues? While MSF has a tendency to portray the person as a suffering body, these people have another realm to conquer-that of citizenship. This is beyond the scope of our actions. All we can say is that, sometimes, the recognition of their suffering helps some gain entrance to the civic life from which they had, until then, been excluded.

Dr Denis Lemasson

POLAND

Chechen refugee camps at Europe's edge

MSF / November 2005 / Dr Denis Lemasson / Translated by Nina Friedman

Thousands of Chechens flee, and come seeking asylum in Europe. As they cross the borders, they are placed in camps, particularly in Poland. Only 8% of them[1] obtain refugee status. Condemned to illegality, they cannot stay in the camps under precarious conditions, and so they 'roam' Europe. If stopped and questioned by the police, they are sent back to the camps in Poland under the Dublin II regulation.

Early November 2005, there were 3,524 Chechens in camps for asylum-seekers[2] in Poland: since the beginning of 2005, 5,200 had passed through the camps. In most cases, the migration was prompted by some violent event, a physical threat to the person or a member of their immediate family. The Chechens in these camps, and the story of their flight, are a reflection of Chechnya today. Suspected of terrorist activities and under increased pressure in recent months, widows of combatants have come with their children. Young men arrive as well, sent by their families to protect them from forced enlistment in pro-Russian or separatist militias. Entire families also flee targeted persecution. And there are others who, witness to one too many acts of violence, end up in the camps after losing all hope for a peaceful future in Chechnya.

→ **Poland** © Kartazina Petrovskaya/YumeVision - October 2005

→ HEMMED IN

Thanks to corruption, the richest are able to buy visas that allow them to go directly to Belgium, France, or Germany; this drives the price up. The rest, poorer, use networks of smugglers to cross the border by the longer, and more dangerous, land route. Slipping from one country to another is complicated and illegal, and carries the risk of arrest, detention, and return to Russia. The Chechens leave from Ingushetia or Chechnya, via countries they imagine they will only be passing through-Belarus, Ukraine, Poland, Slovakia, the Czech Republic-on their way to Austria, Germany, Belgium or France, each paying between 1000 and 3000 USD. The majority of Chechens cross Belarus to get to Poland. Those who are checked at the Polish border are registered and sent to a transit camp, where they apply for asylum, before being transferred to another camp, where they are supposed to remain until they get a response to their request for refugee status. Poland has sixteen camps for asylum-seekers: eight near Warsaw, four near Bialystock, and four near Lublin. Their purpose is to limit the flow of migrants and arrange repatriation for foreigners denied admission. The European Union's border control policy, which is fundamental in the fight against illegal immigration, is to increase surveillance of its external borders, which results in the creation of holding areas. While Poland strengthens its borders with Belarus and Ukraine, the Schengen zone-smaller than the EU-is also stepping up police control of its frontiers, creating an internal border on its eastern flank. Asylum-seekers are thus caught between the Polish-German and Polish-Belarusian borders. Too close to Russia, the Chechens view Poland

THE "DUBLIN II" REGULATION AND ROAMING EUROPE

Since the beginning of 2005, 1,491 Chechens have been sent back to Poland from another EU member country. Article 10 of the Dublin Regulation (Council Regulation (EC) 343/2003 of 18 February 2003) provides for the readmission of the asylum-seeker to the Member State by which he or she first entered the Community. This country is the only one competent to examine the application for asylum. This means that if they are stopped and questioned in another member country, Chechens who were registered when they first entered Poland will inevitably be sent back there. Asylum-seekers are subject to deterrent checks using SIS and EURODAC, European Community-wide electronic database systems that store and compare fingerprints with a view to the effective application of the Dublin Convention. EURODAC, which applies primarily to asylum applicants, began operating on 15 January 2003. Application of the Dublin regulation often condemns Chechens to illegality, driving them to roam Europe. They go from country to country until caught by the police, who send them back to Poland. With no future in Poland, where they've already been denied refugee status, they head off to yet another EU member country.

MISSION

PRESS REVIEW (CONT.)

MSF / January 2006 / O.F.

→ "Collateral damage" in Haiti

The suspicious death of general Bacellar, military commander of the UN stabilisation mission in Haiti (Minustah), was reported in various newspapers. Le Figaro underlined the scathing criticisms that have been made about the UN forces. It quoted a report by the Inter-American Human Rights Commission that reads «often, victims are not collaterel damage of operations, the are intentionally killed by the police and the Minustah», the journalist added that the latter has been «incapable, since it was created 18 months ago, of restoring calm in the country». The next day, *Le Monde* described that general Bacellar already feared there would be «collateral damage among the civilian population [which he was opposed to] during crackdown operations in the slums of the capital».

ONE THIRD OF PATIENTS SUFFER FROM POST-TRAUMATIC SYMPTOMS

Since the August 2005 launch of MSF's psychological support program in the Polish camps, psychologists have been focusing on the trauma that has been building up in these patients for the past 10 years. Migration is usually prompted by some violent event, and according to the psychologists, one third of the patients coming in for consultation suffer from post-traumatic stress disorder. Flight and the conditions of their exile keep Chechen patients in a state of distress (recurring memories of events, nightmares, anxiety, sleep problems, various somatizations, etc.). Living conditions in the camps are not conducive to the development of new relationships, either with oneself or with others. Overcrowding, the persistent fear of others, the inability to see an immediate future for oneself, and the need to be clandestine are all unfavorable factors.

as a transit country in which they have no desire to live. They say they haven't made it that far just to stay there. Their El Dorado is somewhere else, farther west, where they hope to find help and the means to live in dignity.

→ CAMPS FOR ASYLUM-SEEKERS

The buildings used are retired barracks, old hotels or boarding houses, or former workers' quarters. Housing conditions are "acceptable," meeting minimum standards; some of the camps have sanitation problems. Access to medical care has improved since our teams' first assessment in November 2004; it's now comparable to that of a typical Polish citizen: primary health care with essential drugs, hospitalization when a person's life, or functioning, is at stake. Overcrowding is a reality in these camps where, overall, the Polish authorities do not have the resources to deal with a large number of asylum-seekers properly. Poland's Interior Ministry explains that the EU does not have a budget line dedicated to the health of these refugees.

→ AN ADMINISTRATIVE ABSURDITY

In 2005, only 8% of Chechen asylum-seekers were granted refugee status. Poland's Interior Ministry is thus providing very few of them with the protection they need. Recognizing the danger that returning to Russia would pose for them, it isn't sending them back, either. The temporary status being granted on a wider scale doesn't confer any real rights in Poland, and besides, the Chechens inevitably turn it down. This administrative absurdity condemns the refugees to a lawless situation, thrusting them into the margins of a Europe they idealize. Trapped in these camps, the number of Chechen asylum-seekers is growing. Without legal status, they can only cross borders, farther to the west, covertly. The Poles working in the camps are forced to tolerate (or encourage?) recourse to illegal means, via networks of smugglers-most of them Chechen. Cars arrive in the camps on a regular basis, in the evening at a set time, to arrange "transfers." These rings are well organized. This explains the high turnover in asylum-seekers at the camps. Polish authorities recognize that they would not be able to cope with a greater influx of refugees.

→ A EUROPEAN STRATEGY

Since 1995, the progressive erasure of Europe's internal borders has been accompanied by a corresponding strengthening of its external ones. The Polish camps for asylum-seekers are part of a wider strategy to control the migratory flows within the European Community. With each country trying to make its own practices the general rule and despite being under UNHCR control, the harmonization process for asylum policy is actually leaning towards the least advantageous conditions. In an attempt at compromise, the norms have been adjusted to the lowest common denominator, and the events of September 11, 2001-by making the fight against terrorism a major issue-have no doubt contributed indirectly to this new standard. Control measures have been strengthened, also affecting those seeking asylum. The result has been an amalgamation of illegal immigration, terrorism, and delinquency, thus legitimizing the camps and detention centers. In its original proposed directive, the European Commission provided a guarantee of "well-being" for asylum-seekers. The revised version promises only to ensure their "subsistence." Article 15 stipulates that asylum-seekers must receive medical care that includes, at the least, emergency care and essential treatment of illness. There are no specific provisions for pregnant women or children. Nor is there provision for treatment of physical and psychological effects of violence (rape, torture, etc.). Unlike the migrant, the refugee does not choose to leave his country-he is forced to do so, to safeguard his life or his freedom.

→ DENIAL

The entire mechanism for controlling migratory flows reveals the extent to which the asylum-seeker is equated with the migrant-both considered suspect. Over the past thirty years, the image of asylum-seekers has changed from that of victims to be helped to that of offenders to be rounded up into camps. Thirty years ago, the geopolitical context of the Cold War was more favorable. The Geneva Conventions were more easily applied, insofar as they didn't involve member States' public funds, and they contributed to an ideological war. Exiles rarely requested asylum, and they didn't need it to settle in countries that were open to them. Today, however, victims of the Chechen conflict, fleeing violence in their homeland and having no future, are stuck mid-course in these Polish camps, in a structureless space-time-a bizarre prolongation of the conflict that forced them to take flight. They are being turned back by a Europe that doesn't want to see this conflict at its doors. How can Europe grant refugee status to victims of a conflict that it doesn't even recognize? The "Chechen conflict" reflected in these camps is the internal manifestation of an external reality that the European Union continues to deny. ■

1- Source : Polish Ministry of the Interior - 2004

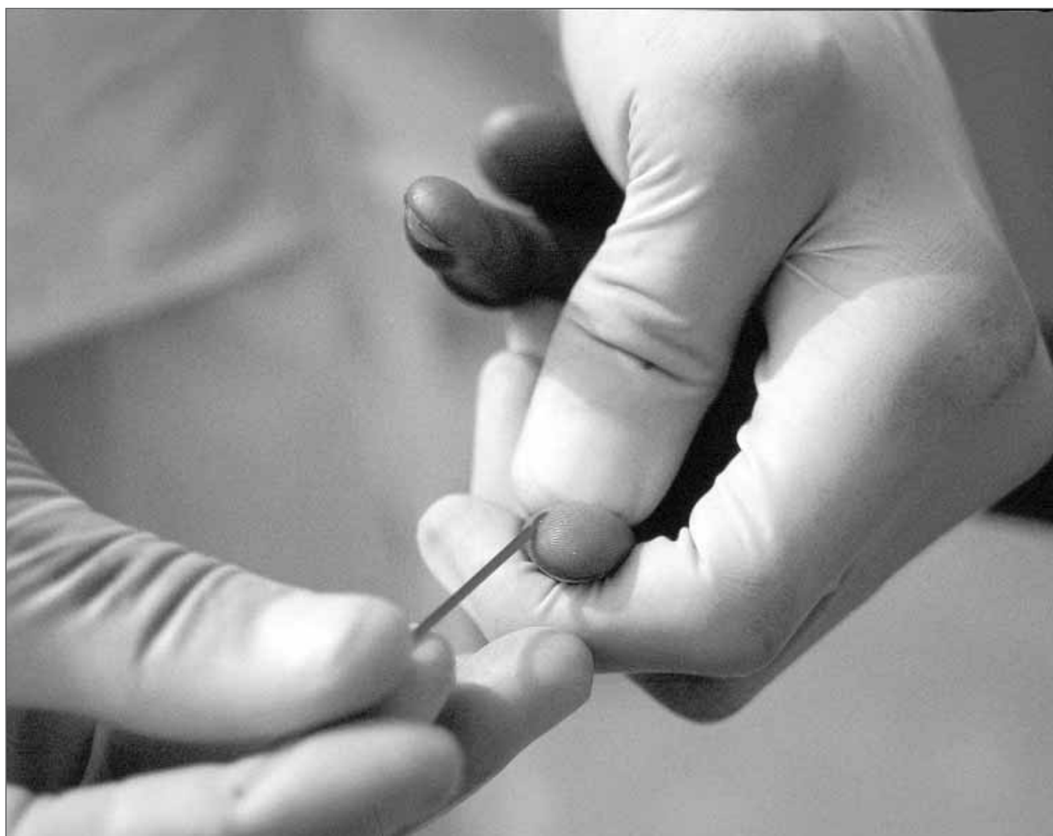
2- Chechen refugees represent more than 95% of the total population of camps in Poland.

ANGOLA

A closure and its shortcomings

MSF / December 2005 / Laurence Flevaud (last Head of Mission) and Isabelle Merny / Translated by Alison Keroak

Reconstruction and the development of health services have been on the agenda in Angola since 2002. As MSF did not wish to be a part of this process, 2003 was the chance to change course by launching "major endemic disease" projects. Two years later, while the malaria programme in Kaala achieved its main objectives and was able to close under satisfactory conditions, the same cannot be said for the trypanosomiasis programme in Camabatela, which had mixed results and a more difficult closure.



→ **Angola** © Roger Job - October 1997

The French section of MSF pulled out of Angola after 22 years of activity in the country. All our nutritional activities[1] had been progressively closing since 2003, as well as activities designed to support the healthcare infrastructure, since the situation had markedly improved and the goals met. MSF then decided to focus on two projects; one in Kaala, the other in Camabatela...

→ MALARIA IN KAALA AND ELSEWHERE

A study led by Epicentre in 2002 in Kaala (Huambo province) showed strong resistance to chloroquine. Data collection at the hospital in Kaala and in three city health centres, conducted in parallel to this study, confirmed a worrying increase in the number of serious cases and deaths due to this disease. We decided, therefore, to open treatment programmes in 2003-2004, introducing ACTs[2] in all the functional health facilities in the zone to reduce mortality during the peak of the epidemic, but also, and above all, to provide arguments for a change in national protocol. The French section of MSF started working in thirteen health centres: supply of ACTs and training Angolan health personnel to use combination therapies, as well as in rapid tests. At the same time, a lobbying campaign to change the national protocol and a study on the efficacy of ACT treatment were carried out to support this effort.

In October 2004, the MOH agreed to change the national treatment protocol, but chose Coartem as the first line treatment, with all the supply problems that ensue. Although the use of ACTs was approved as an alternative (with financing in large part from the 25 million dollars allocated by the Global Fund), the government could not guarantee its supply. This raised the question: do we stay until ACTs arrive in the provinces - particularly in Kaala - or do we consider the change of protocol a sufficient argument to decide that our objectives have been met? The second option was the one we finally chose. Waiting until the ACTs arrived in Kaala would have prolonged our presence for months, even years. The latest information we have heard, in September 2005, predicted that Coartem would not arrive until mid-2006 in Angola, and therefore not until the second trimester of 2006 in the provinces. A disengagement strategy was drawn up; however, before pulling out, MSF finished training local personnel, made donations (ACTs and medical equipment for six months) and equipped all the health posts with installations for the treatment of medical waste.

On July 30th 2005, after the yearly seasonal peak, the malaria programme in Kaala closed.

→ A PROMISING TRYPANOSOMIASIS PROGRAMME...

A trypanosomiasis exploratory mission was conducted in May 2003 in different municipalities of Kwanza Norte, and foci were detected in two towns (prevalence higher than 0.5%). Our mission: to set up a diagnostic and treatment centre in the town of Camabatela; this project was accepted by the *Instituto de Combate e Controlo da Trypanosomiase* (ICCT) and the governor of the province in November 2003.

Opened in January 2004, the programme had the following objectives:

- to increase patient identification through a passive screening programme, but also by developing active screening programs within our intervention areas;
- to raise the awareness of and to recruit the populations through a better understanding of the terrain and its demographics, to have health educators convince potential patients to go for a screening;
- to propose an operational research terrain for the improvement of diagnostics and of treatment quality in terms of efficacy and feasibility;
- to maintain epidemiological and therapeutic follow-up tools in order to better understand the prevalence distribution in different towns;

MISSION

→ **Activities in Camabatela (April 2004 to June 2005)**

12 386 persons screened

6 666 (53,8 %) by passive screening

5 720 (46,2 %) by active screening

215 patients treated

No deaths reported.

- to continue developing patient case management, by facilitating the use of more effective and less toxic medications.

→ ... BUT FEW PATIENTS AT THE CENTRE

Six months after opening, the results were mixed: the centre was almost empty. The exploratory mission forecasted a monthly average of thirty patients; in reality, there were only fifteen per month. There were several explanations:
- the prevalence rate turned out to be lower than expected (by studying the geographic distribution of patients and the respective prevalence rates in these zones, we found that prevalence rates were generally around 0.5%, and were often lower);
- a change in the ICCT's operational policies that decided to carry out screening activities in the summer of 2004 in the area where we had planned to send teams two or three months later;
- the presence of mines hindered access to possible foci (although the main roads were safe, secondary roads were still risky);
- the insufficient number of health educators and abundant rainstorms limited the implementation of active screening;
- the Marburg fever epidemic in Uige in March 2005 became the priority, effectively putting our trypanosomiasis activities on "standby". We were no longer sure we would be able to resume active screenings as initially planned.
- there were a few internal "glitches": there were human resource problems at coordination level (no head of mission/medical coordinator for eight months, therefore no direct liaison with the ICCT in Luanda), there was insufficient support for the field team, and we did not take advantage of other MSF trypanosomiasis experiences to adapt the strategy to the context of Camabatela.

→ **Angola** © Aurélie Grémaud / MSF - February 2002

The situation no longer justified continuing our intervention. In addition, the ICCT possessed the operational means to continue activities in the region. The decision to close the programme was taken at the end of June 2005. The ICCT was authorized by the administrator of Camabatela to pursue the activities in our centre (taking on some of the staff, donation of furniture, as well medical equipment and enough medication for the programme to continue for 12 months), and we contacted all our patients individually. The official handover occurred on August 17, and all the activities were effectively handed over in September 2005.

→ CLOSING UNDER BAD CONDITIONS, BUT STILL CLOSING

After July 20, a clearly insufficient number of expatriates in the field lead to a delay in closing. The logistical issues turned into a coordination headache. Furthermore, the pharmacy had far too much stock, including certain items that were completely inappropriate (sutures, locally purchased medications, etc.). The complete data had been erased or were never recorded in the field computers. It was also very difficult to reintegrate national personnel with Congolese diplomas, which are not recognized in Angola. Despite the uncertain future of the programme, all the fixed-term contracts were renewed for six months during the weeks prior to the closure decision, which led to significant overspending at closure time (the total cost of ending contracts came to over $100,000 USD).

In a context that the Angolan government itself defined as "a rehabilitation and development phase" (even if the investments are essentially concentrated in Luanda), it is not our role to make up for the lack of health care provision in the rest of the country. Malnutrition remains present but not worrying, particularly in Huambo and Kaala. Other actors are active on the question of refugees (the UNHCR, and OMI [Organisation des Migrations Internationales, the International Migration Organization]) and the number of repatriates is in sharp decline. There are therefore no longer any specific needs that require our intervention.

On September 25, 2005, after 22 years of activity in the country, the French section of MSF closed its programmes in Angola. Four other sections remain present and continue to lobby for ACTs. ■

ANGOLA: HEALTH STATISTICS

3 Angolans in 1,000 have been victims of mines (mutilations or deaths).
In 2005, the budget allocated to health represented 5.66% of the total budget.
Health services are primarily provided by NGOs in many provinces.
The most common illnesses are malaria, diarrhoea, and respiratory infections. Epidemics occur regularly (measles, meningitis, and more recently, Marburg fever).
Angola is one of the last African countries where "sleeping sickness" is still rife.
The official prevalence data for AIDS (0.5%) seems under-estimated.

1- MSF opened an emergency nutrition programme in 2002 during the famine
2- Artemisinin-based combination therapy

HUMAN RESOURCES

International remuneration project

→ RDC © Gary Knight / VII - June 2005

MSF / January 2005 / Anne-Louise Jacquemin, project coordinator

After four years of protracted negotiations between sections, the international remuneration project has at last resulted in common political and technical solutions aimed at improving remuneration and social welfare conditions for MSF's international staff. The "International Remuneration Project" (IRP) will provide international volunteers with more equitable and better adapted conditions.

Strongly supported by partner sections when it was launched in late 2000, the aim behind the IRP was to increase loyalty amongst international staff by taking better care of them. The political motivation behind the project was soon reinforced by an imperative: that MSF better fulfil its obligations as an employer, and provide social and medical cover that was better adapted to the diverse origins of its international staff.

The international remuneration project is thus a project aimed at MSF's international staff and encompasses both their remuneration and social security protection, and an international private insurance scheme (complementing what is available through national systems).

→ REMUNERATION

Up to now, two nurses with the same experience earn salaries that can sometimes vary considerably depending on which operational centres they leave with. The IRP thus set about defining a coherent system of remuneration for the whole movement, that would reflect the need for equity in the treatment of volunteers. In autumn 2005 agreement was finally reached on an international salary scale for four of the five operational centres and all partner sections.

Only the Belgian section has for the time being not accepted this scale, which it does not consider to be adapted to its recruitment and retention policies, which place more emphasis on seniority and experience outside MSF than on the level of responsibility.

→ SOCIAL WELFARE

As a general rule, the best method of accessing the social welfare system in a person's country of residence is through a "local" employment contract which allows the recognition and easier retention of social welfare rights and advantages. It was thus decided that, where possible - that is to say in countries where MSF has a section - expatriates will have a contract in their country of residence.

Each MSF section, including the operational sections, will thus take over

•••

→ What about national staff?

The general objective of providing better benefits and conditions also concerns our national staff. These, efforts, started in 2003, have been on-going. Functional and salary scales, as well as benefits and medical coverage have already been reviewed in half of the countries of mission. This work, which is just as long-term as the IRP, is not yet completed and remains a priority for 2006.

→ How much will it cost?

According to current estimates, the cost of the IRP represents an increase of one third in the total salary bill for international staff in our section, that is to say approximately €2.5 million.

The global cost of parallel measures aimed at national staff has not yet been finalised but it is clear that they will also represent a significant financial effort for MSF France, one that we accept.

I AM ON A MISSION WITH MSF FRANCE: WHAT WILL CHANGE?

- A new salary from 1 January and a new transfer amount in my bank account as of 30 January 2006.
- New insurance arrangements, and in particular a new address to which requests for reimbursement of my medical expenses need to be sent.
- If I come from a CEE country, social security contributions (Social Security, retirement) will be paid systematically by MSF, regardless of my status, my experience and the length of my mission (today this occurs only after one year of mission or if I am salaried worker).
- For my next mission, since the calculation of experience has been done temporarily, on the basis of information in my file (CV, etc), I will need to supply an updated CV as well as supporting evidence (preferably work certificates) so that this experience can be taken into account again and confirmed.
- If I am resident in a partner section, starting sometime in 2006, I will have a contract through my section (or for my next mission) : MSF USA - February 2006; MSF Germany - March 2006; MSF UK - May 2006; MSF OZ - May 2006; MSF Japan, MSF Canada - July 2006, etc)

RESOURCES

PRESS REVIEW (CONT.)

MSF / January 2006 / R.V.

→ (Sero)positive Communication

« This year's UNAIDS report is even more depressing that previous years" said Le Figaro on November 22nd. In 2005, Aids led to 3,1 million deaths (including 570.000 children) and 5 million people were newly infected. Concerning treatment, the report is just as catastrophic: «current estimates are that 1.2 million people are under treatment, whereas there are 10-11 million patients in need of ARVs» recalled Le Figaro. These figures are far from the 3 million promised by the end of 2005 by the WHO. The director of the WHO's Aids programme that ran the '3 by 5' campaign therefore finishes his mandate on a failure, and is asking for a 'humanitarian corridor' for the production of generic ARVs. While admitting failure, he continues to tote the message announced by the WHO last March in its report 'Three scenarios for Africa'. From now on, instead of talking about patients on treatment, and therefore risking the announcement of results below the objectives set, they are going to talk about the number of deaths, numbers of newly infected avoided. That's called 'positive communication'....

contracts for all their residents. Any French resident working for MSF in the field will henceforth have a contract signed with the French section, any American resident will have a contract with MSF USA, etc. Those who are residents of a country where MSF does not have a section will remain under contract to the operational centre for which they work.

→ SOCIAL SECURITY COVER AND INTERNATIONAL INSURANCE

The IRP has also redefined all the elements of cover that MSF intends to offer to its expatriates in addition to remuneration: medical coverage, short and long term disability insurance, invalidity and death benefits, vacation, as well as retirement, access to unemployment benefits (these will vary according to the practices in national systems).

Since social security rights vary according to countries, this cover will be offered partly through national social security systems and partly (or entirely if necessary) through international private insurance schemes common to all MSF sections (medical cover, disability, death and invalidity cover, etc).

In short, MSF will thus provide similar cover to all international staff, while at the same time guaranteeing access to their local social security system to staff who reside in a country where MSF has a section.

→ **Haiti** © Gael Turine - October 2005

→ WHEN?

The project is beginning with the following "pilot sections:" MSF Germany, USA, UK, Canada and Austria, and will be implemented there by summer 2006. The other partner sections will follow progressively from summer 2006. As for operational sections, they are implementing this systematic composite system from the beginning of 2006. ■

WHAT DOES THIS MEAN, IN PRACTICE, FOR MSF FRANCE?

1.A NEW SALARY SCALE STARTING ON 1 JANUARY 2006

- Based on the common international scale:
  1) A first-year with the status of indemnified volunteer, regardless of the position (as before
  2) Access to salaried status as of the second year, regardless of the position (new)
  3) More substantial integration of experience acquired elsewhere (humanitarian as well as professional)
  4) Increased recognition of seniority with MSF (up to 10 years), which is now counted regardless of the position held
- For individuals, this new scale generally represents an increase in remuneration
  1) The benefit for the first year increases from €610 to €700
  2) Salaries for positions in the field and for intermediate coordination positions (FieldCo, etc) in particular have also been re-evaluated.

2.IMPROVEMENTS IN SOCIAL SECURITY COVER

- For French citizens, better coverage starting from the first mission:
  1) Better medical cover and access to the Social Security system (CFE);
  2) Retirement contribution from the very first day of the mission
- For everyone, new insurance arrangements as from 1 January 2006, providing:
  1) 100% medical cover for everyone (to date this has been limited to salaried staff)
  2) Better death and disability cover, with re-evaluated lumpsums and pensions.
- Vacation: accrual of two days per month of paid or indemnified vacation, according to status (this amounts to five weeks annually). Up to now, persons with volunteer status did not actually accrue leave, although in the field they were granted the usual one-week's break per quarter.
- For volunteers coming from partner sections: progressively during 2006, the possibility to access contracts in their country of residence with, in certain cases, a scale adapted to the standard of living.

THE *FACE TO FACE* EXPO

Face à Face, another kind of mission

MSF / January 2006 / Olivier Michel / Translated by Marcy St John

Reaching out to the public, in Paris and in the provinces, presenting the work of Médecins Sans Frontières, defending and explaining the standpoints of our organization, asking and convincing people to participate in our actions with us by taking part in the "1 euro per week" operation... That's the objective of the recent campaign to recruit regular donors, a campaign better known as "Face to Face", which has just finished up its second year.

The results of the exhibition have overall been positive, with regards to communication as well as fundraising: we were able to detail MSF's standpoint after the tsunami to the public, the situation in Niger [and the reasons for it] was revealed well before media attention focused on it, the problematic issue of lack of access to medicines and the necessary care of AIDS patients was explained...The operation required three teams [45 persons participated in this "mission" in 2005, including 5 former MSF volunteers]: two to work the street and one to run the "Acteurs d'Urgence" exhibition. The teams visited 46 cities this year, about one per week. Nearly 9,000 new donors were enlisted and are now giving 1 euro [or more] per week. About 30,000 people visited the traveling exhibition. At year's end, we also took our actions onto a TGV train, turning a train carriage into an 'MSF area'; we will repeat this effort in 2006.

This campaign did not come off completely without a hitch, however. Some of the difficulties encountered bore a strange resemblance to those in the field. Although on mission the aim is to assist as effectively as possible the greatest number of vulnerable people, here we had to present our work effectively to the greatest number of potential donors without, however, making a crass monetary pitch. The key word is the same 'commitment'.

In order to accomplish this, we trained over 40 'facilitators' active in various associations. Some experienced field volunteers even joined our teams and greatly enhanced them. The support of volunteers from the regional offices in particular, and the network of volunteers in general, proved to be essential.

Human resources management [working harmoniously is not always an easy thing!], administration [selecting and obtaining from municipal authorities the best locations for our expo], communication [getting the word out as quickly as possible that our teams were in a city during a particular week], and logistics as well [trains, hotels, and also dealing with climate conditions not always predictable when working outdoors]-do not make *Face to Face* a particularly relaxing mission. But is there such a thing as an 'easy' MSF mission? The financial independence of Médecins Sans Frontières must be earned, and Face to Face has contributed greatly to it.

The 2006 tour will run from March to October. The fundraising department is recruiting facilitators [volunteer with field experience and others]. We are counting on your strong support for the appeal from this other field endeavor.

→ **Please contact Olivier MICHEL, tel. 01 40 21 29 18, or via e-mail: olivier.michel@msf.org**

INFOS

→ Contributions welcome: Do you have any footage?

The production company MAHA, in Paris, is making three documentaries based on the book, « Médecins Sans Frontières, la biographie » published by Fayard.

In these films the author, Anne Vallaeys, and the director, Patrick Benquet, will retrace the history of MSF from its creation in 1971 up until the present day. They are looking for any amateur films, super 8 or videos etc., made by MSF volunteers. Field operations, AGMs, scenes in the various headquarters in Paris, in the field, emergency missions - anything would be useful.

If you are have any footage please do not hesitate to contact Anne Vallaeys.

E-mail : Anne.DUGRAND.VALLAEYS @wanadoo.fr
Tel. : 01 64 41 60 48

INFOS

→ AVAILABLE IN THE PHOTO LIBRARY (and database int.) - MSF / January 2006 / Alix Minvielle

New photos sent to DBI :

China: Nanning, Sida, novembre 2005 / Ashley Gilbertson - Aurora

Pakistan: montage de l'hopital sous tentes gonflables + campagnes vacci, novembre 2005 / Rémi Vallet - MSF

Iran: situation des réfugiés afghans dans les villes de Mashhad et de Zahedan, oct-nov 2005 / Sibylle Gerstl - Epicentre

Côte d'Ivoire: hôpital de Bouaké, septembre 2005 / Carl De Keyzer - Magnum

Sudan: Akuem, programmes + construction du nouvel hôpital, août-septembre 2005 / Marie-Pierre Barre - MSF + autres MSF

Photo Library :

Indonesia: logistique dans la province d'Aceh, oct-nov 2005 / Etienne Quetin

Guinea: chirurgie, septembre 2005 / Khaled Menapal et Valleri - MSF

News from Etat d'urgence production

→ ACTUALITY

Drug management, which includes all medical supplies, is a crucial part of every MSF program. The objective is to ensure patients have access to quality treatments when and where required. In order to achieve this, MSF checks every stage within the supply chain, from drug sourcing all the way through to the dispensing of drugs to patients.
The supply chain is implicitly linked to efficient stock management and the appropriateness of orders made in relation to the medical activity carried out within the program. To complete the chain, MSF must also ensure that patients receive their medication with a full understanding of how to administer and follow their treatment correctly.
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→ PROJECT FOR 2006

2 films are due to be completed at the beginning of the year. The first is on organising of a vaccination campaign (in French and in English) and the second is a short, 10 minute film introducing Médecins Sans Frontières with essential facts and figures. This latter film will be available in French, English, Arabic, Spanish and Japanese. We are going to provide the field with an operational video library which wil consist of roughly 40 films. Several other productions are due to be go ahead during the course of the year: a film on pain management, surgery and the cold chain as well as a film presentating a new approach to a malnutrition emergency. Together with the Swiss office, we are going to make three 20 minute films on raising awareness and providing care for vitims of sexual violence. There will be a significant increase in the use of video material on the MSF website. And last but not least, the huge task of conserving our video archives, some of which date back more tahn 20 years, is due to get underway. ■

WATCH AND READ

New books available in the documentation centre (december 2005-january 2006)

MSF / Christine Pinto (01 40 21 27 13)

→ MEDICAL

DICTIONNAIRE CRITIQUE DES TERMES DE PSYCHIATRIE ET DE SANTÉ MENTALE / SOUS LA DIRECTION DE SIMON-DANIEL KIPMAN. AMÉLIE AMSLEM-KIPMAN, MONIQUE THURIN ET JOSPEH TORRENTE. - Paris : Doin Groupe Liaisons SA, 2005. - 479 p.

PROTOCOLES ET ÉCHELLES D'ÉVALUATION EN PSYCHIATRIE ET EN PSYCHOLOGIE / MARTINE BOUVARD, JEAN COTTRAUX. - Paris : Masson, 2005. - 4e édition. - 327 p. - collection Pratiques en psychothérapie.

THE SANFORD GUIDE TO HIV/AIDS THERAPY / MERLE A. SANDE, GEORGE M. ELIOPOULOS, ROBERT C MOELLERING, DAVID N GILBERT. - USA: Sanford Guide, 2005. - 14th Edition. - 143p.

TRAITÉ DE PSYCHOLOGIE DE LA SANTÉ / SOUS LA DIRECTION DE GUSTAVE-NICOLAS FISHER. Paris : Dunod, 2002. - 675 p.

→ GÉOPOLITIC

BÉNÉFICIAIRES OU PARTENAIRES. QUELS RÔLES POUR LES POPULATIONS DANS L'ACTION HUMANITAIRE? / SOUS LA DIRECTION DE FRANÇOIS GRÜNEWALD. - Paris : Karthala, 2005. - 429p. - collection Pratiques humanitaires.

CÔTE D'IVOIRE, LA FORMATION D'UN PEUPLE / PIERRE KIPRE. - Fontenay-sous-Bois : Sides Ima, 2005. - 291p. - collection : L'Afrique dans tous ses états.

GÉOPOLITIQUE DU NOUVEL AFGHANISTAN / PATRICK DOMBROWSKY ET SIMONE PIERNAS. - Paris : Ellipses, 2005. - 110 p. Collection Références Géopolitiques.

HANDBOOK FOR SELF-RELIANCE / Genève: UNHCR, 2005.

JÉRUSALEM OU LA COLÈRE DE DIEU / UGO RANKL. - Paris : Editions des Syrtes, 2005. - 345 p.

LA CRISE EN CÔTE D' IVOIRE : DIX CLÉS POUR COMPRENDRE / THOMAS HOFNUNG. - Paris : La Découverte, 2005. - collection Sur le vif. - 140p.

LE DISPOSITIF HUMANITAIRE : GÉOPOLITIQUE DE LA GÉNÉROSITÉ / EMIL COCK. - Paris : l'Harmattan, 2005. - 176p.

L' URGENCE HUMANITAIRE, ET APRÈS? POUR UNE ACTION HUMANITAIRE DURABLE / JEAN-FRANÇOIS MATTÉI AVEC LE CONCOURS DE JEAN-PHILIPPE MOINET ET DE PIERRE KREMER. - Paris : Hachette Littératures, 2005. - 235 p.

ONG : LES PIÈGES DE LA PROFESSIONNALISATION / SOUS LA DIRECTION D'ANNE LE NAËLOU ET JEAN FREYSS. - REVUE TIERS MONDE N°180, OCTOBRE-DÉCEMBRE 2004, T. XLV. - Paris : puf. - pages 724 à 953.

POVERTY, INCOME DISTRIBUTION AND LABOUR MARKETS IN ETHIOPIA / ARNE BIGSTEN, ABEBE SHIMELES AND BEREKET KEBEDE. - Uppsala: The Nordic Africa Institute, 2005. - 200p.

TRAINING COURSES

→ RESPONSE TO EPIDEMICS

6-10 March 2006 at MSF Paris office
Duration : 5 days 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
- Second line of recruitment: Field coordinators with at least two missions in this position
- Committed for at least another 12 months (for the expatriate in one or several missions)

By the end of the course, the trainee will be able to:
- Carry out an outbreak investigation
- Detect an outbreak
- Define necessary strategies and organise effective management of epidemics

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

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

TURN OVER

FIELD HR

- **→ Laurence RAVAT** joined the department as Human Resources Officer in December
- **→ Cécile AUJALEU** is back, since the beginning of January, as National Staff HR Coordinator

OPERATIONS

- **→ Marie Madeleine LEPLOMB** left her position as Programme Manager in November

MEDICAL DEPARTMENT

- **→ Geza HARCZI** started as Nutrition Officer at the beginning of November
- **→ Sylvaine BLANTY** has been working on the health policy for national staff infected with HIV since mid-November
- **→ Sophie LAUZIER** has been working on our nursing care protocols since October

COMMUNICATIONS AND FUNDRAISING DEPARTMENT

- **→ Olivier MICHEL** started as 'Operational Coordinator' of the «Face à Face» operation at the end of January
- **→ Renaud CUNY** started as deputy webmaster at the beginning of January

LOGISTICS

- **→ Pennie VERSEAU** has been working on the development of self-training modules in logistics since December
- **→ Anabelle GAZET** started as Logistics supervisor mid-January

RECEPTION AND GENERAL SERVICES

- **→ Salma LEBCIR** was recruited as a receptionist in October

FINANCE DEPARTMENT

- **→ Rémi OBERT** started as deputy director in January

LEGAL

- **→ Françoise SAULNIER** has taken on the position of Legal Director
- **→ Clémentine OLIVIER** started as legal assistant in mid-January

FUNDATION

- **→ Judith SOUSSAN** is working on MSF's responsibilities in matters of protection, started in January
- **→ Xavier CROMBE** was appointed Research Director in December

IN MEMORIAM

MSF / December 2005

The news of the tragic death of two its colleagues plunged Médecins Sans Frontières into deep shock and sadness. Hawah Kamara, 49 years old, and Thomas Lamy, 30 years old, were among the victims of the plane crash in Nigeria on Saturday November 10th. They were travelling from Abuja, the capital, to Port-Harcourt where MSF has a surgical programme. We miss them terribly.

Thomas Lamy, logistician MSF France

→ Thomas Lamy © MSF - D.R.

Thomas was born in 1975 in Annecy, France. He joined MSF in 2003. After two months with general services at headquarters he very quickly become passionate about MSF. Thomas left on his first mission in August 2003 to Côte d'Ivoire, as a supply logistician in our logistics base in Abidjan for the emergency programme in Liberia during the war. It was his first mission, but his capacities, commitment and determination to overcome challenges were already impressive.

He quickly became a key-person in our Liberia programmes, where he was responsible for supply and aircraft hire, as well as negotiating with the local authorities. From then on he was always ready to help in major crises and to take on responsibilities for the team and the projects - but above all for the populations that we assist. Thomas returned to Côte d'Ivoire in 2004, this time to Toulepleu and Guiglo, where he once again proved his capacity to take on new responsibilities and to adapt to a very different and complex context.

Beyond his role as logistician, he was the interlocutor with the Ivorain and French military as well as the militias in the region. In December 2004, Thomas worked in Darfour: first in Nyala, then in El Genina, where he stayed up until June this year.

In August 2005, Thomas left for Nigeria, to work in the emergency nutrition programme in Katsina. Less than a month after arriving he was appointed logisitics coordinator of all the MSF projects in the country.

He was a great revelation for MSF; a committed, always motivated volunteer, that could be relied on.

He is going to be greatly missed. ■

IN MEMORIAM

Hawah Kamara, Human Resources Officer MSF USA

→ Hawah Kamara © MSF - D.R.

Born in Liberia, Hawah fled the civil war in her country in 1989 with her daughter to find refuge in Sierra Leone. She returned to Liberia two years later to join the MSF office in Monrovia. First working as a secretary, she then moved on to become administrator before immigrating to the United States.

In 1999, she started working in the Human Resources department of the New York office where she recruited many many volunteers and then became Human Resources Officer on the desk for our programmes in Haïti, Guatemala, Uganda and Nigeria. Hawah often represented MSF, in particular at the press conference launching the 'Refugee Camp' exhibition in Central Park in 2000, where she deeply moved the audience - including the journalists- present.

Her story «Our World» was published in a manual designed for American high schools. In 1999, Hawah also represented the American section of MSF in Oslo during the Nobel Peace Prize ceremony.

Hawah was loved by all those whose knew her -at headquarters and in the field, volunteers, national staff- and appreciated for her enthusiasm, humour, warmth and generosity. ■

IN MEMORIAM

Patrice Pagé, Executive Director MSF Canada

We have learnt of the death of Patrice Page on December 12th in Toronto We are shocked and devastated by this news. We grieve the loss of this bright young man who was such a passionate and committed humanitarian. We share this loss with Patrice's family and his girlfriend.

Patrice Pagé joined Médecins Sans Frontières (MSF) in 1999 as a field coordinator in southern Sudan after working for two years with UNHCR in Rwanda . He went on to work as field coordinator for MSF in Sierra Leone and Kosovo, and as Head of Mission in Eritrea, the Democratic Republic of Congo, Guinea, and Liberia.

Patrice joined the New York office of MSF in 2001 as a Program Officer. He was deeply involved in the Arjan Erkel case, pushing for and achieving meetings at the highest of levels with the US government and the UN; he was also instrumental in advocating for the UN Security Council resolution (1502) on the protection of aid workers that was passed in August 2003.

He left MSF in 2004 to head up UNICEF's emergency operations on the Chad/Darfur border. In September 2005, he was appointed Executive Director of MSF Canada.
A lawyer who graduated from the Université de Sherbrooke and the École du Barreau du Québec, Patrice also held a degree from the Institut International des Droits de l'Homme, Strasbourg, France. He practiced labor law with the Montréal Confédération des Syndicats Nationaux / Confederation of National Labor Unions for two years.
A dynamic advocate on behalf of populations in danger, Patrice brought a sharp intelligence and insight, a keen sensitivity to the causes of MSF's patients. He demonstrated his passion for justice in everything that he did. He was 33 years old. ■

→ Patrice Pagé © MSF - D.R.

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For further information:
- on the activities of the French section of MSF: www.msf.fr
- on the activities of the Other MSF Sections: www.msf.org

messages

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