messages

→ N° 140 / March 2006 / Médecins Sans Frontières internal newsletter www.msf.fr

DOSSIER

MISSIONS

DEBATES

INFOS - RESOURCES

MEDICAL ACTIVITIES

Medics on the couch

→ **Democratic Republic of Congo** © Per-Anders Pettersson/Getty Images - December 2005

MSF, February 2006

Most of the interviews in this dossier were written to complete the 2005 analysis of our medical activities. In spite of some of the provoking titles and questions, the reflections are meant to encourage us to take a critical look at our activities and to highlight not only the progress we have made but also the limitations and weaknesses we are confronted with. A number of diseases and their related activities are examined, from AIDS to meningitis and from training to vaccinations. The medical department questions the quality of our operations and spurs us on...

Our progress, as well as a number of obstacles and possible improvements, are discussed. Operations are examined in terms of their quality and limits, as is the role of each sector in the internal structure (e.g. support from other departments or MSF satellites) and that of other organizations, highlighting the "inconsistencies" of some. The articles each address three perspectives: the current situation, questions we need to ask about our practices and the direction in which we are heading, and the challenges we face.

→ REVIEW OF 2005

Some trains always arrive on time (or nearly)! E.g. the progress we made in our response to epidemics of meningitis. There was real progress made in terms of the

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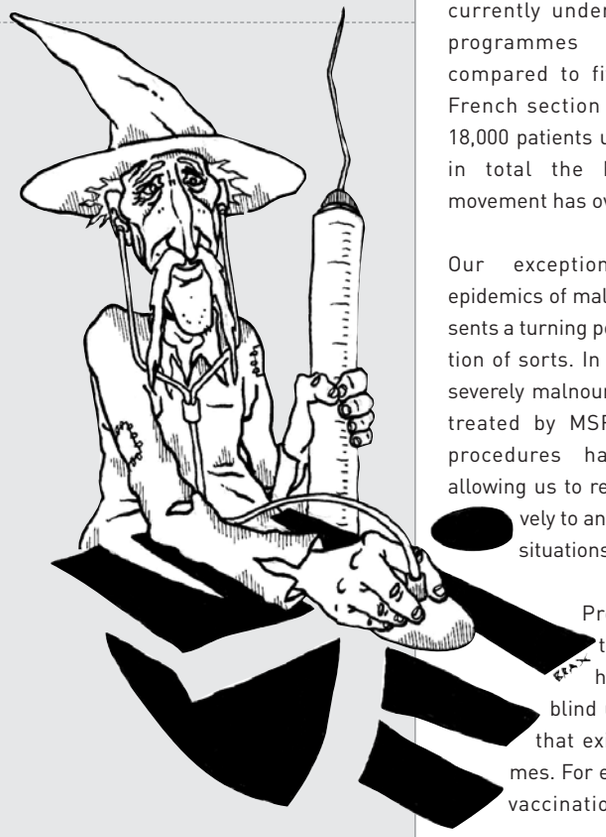
Number 140

There are many questions at the moment -perhaps more than ever?- on the definition of humanitarianism in general and Médecins Sans Frontières in particular. Along these same lines, the 'La Mancha' process is gathering together this month our 19 sections to debate these issues. We therefore thought it useful to see the concrete application of these 'theoretical reflexions' through a clinical and critical analysis of our activities. The idea is to illustrate and anchor certain debates in the reality we are faced with (e.g. the issue of access to healthcare). Perhaps this will also reveal-a posteriori -the coherence in the choices made by our medical department. The aim is to question and try to improve MSF's activities which, in the light of its resources, could so easily fall into the trap of doing too much while failing to question its existing programmes.

DOSSIER

Medics on the couch



availability of tools and vaccines, and coordination between different organizations was relatively effective - especially when compared to other illnesses such as tuberculosis, AIDS or malaria.

In terms of the progress made at MSF, AIDS is the first to come to mind. The number of patients currently under treatment in our programmes is phenomenal compared to five years ago. The French section currently has over 18,000 patients under treatment and in total the MSF international movement has over 50,000.

Our exceptional response to epidemics of malnutrition also represents a turning point for us - a revolution of sorts. In 2005, nearly 60,000 severely malnourished patients were treated by MSF France. Surgical procedures have also evolved, allowing us to respond more effectively to an increasing variety of situations and contexts.

Progress made in these areas, however, should not blind us to the difficulties that exist in our programmes. For example, the issue of vaccinations is not being adequately addressed in the everyday activities of our field missions. Patients who present with multiple illnesses do not always receive the proper treatment, especially HIV/TB co-infected patients.

According to the medical department, another area needing attention is the whole issue of patient education. It seems healthcare staff receive excellent training but this is not always reflected in the information patients receive.

→ QUESTIONING OUR PRACTICES

These discussions indicate a number of weaknesses in our practices and our techniques (incomplete follow-up of patients' medical files and the questionable quality of our TB medication in our AIDS programmes, for example), and raises questions as to the relevance of our actions or why we choose certain interventions. For instance, is the psychological treatment approach currently used by our teams the best way to alleviate the suffering of the populations we assist? Do we set up activities just so that we can begin a programme or even just to continue it? Do the satisfaction rates that we receive (which are validated by a number of studies on AIDS, especially those conducted after two years of treatment), prevent us from anticipating the changes in the contexts where we work or in our patients' behaviours?

In this context, do we have the most appropriate practices to motivate patients to continue with their treatments? There too, many questions are posed by the medical department which indicates a real need for debate.

But there is also a real commitment by everyone to move beyond certain vertical programmes, to adopt a more comprehensive case management approach to patient care - one which takes the physical, as well as the psychological components, into account.

From the pre-operative phase to the physical rehabilitation centre, AIDS patients who need treatment for tuberculoses or malaria, from addressing the issue of making routine vaccinations and others vaccinations available in our missions, all of this means a demand for an ever increasing range of medical services. But, reading between the lines, does this not pose another question, that of the difficulty of handing-over our activities?

→ To readers :

The margins alongside this dossier are excerpts from the internal document 'My sweet La Mancha', a collection of contributions written between July and October 2005 and published by MSF in February 2006. The aim of this collection is to further the 'La Mancha' debate process, which includes a three-day meeting of the 19 MSF sections in March 2006.

→ **Democratic Republic of Congo** © Alixandra Fenton

→ FACING UP TO CHALLENGES

"When to switch?" is the question posed by doctors in charge of AIDS, those at the Epicentre, as well as at MSF. The question is beginning to haunt us. Medical staff are warning that the appearance of resistances, the price of second line drugs and their effects on patients, must all be taken into account. There is also the question of the availability of tools or how to obtain them. The rapid test kit for viral load is currently available but other diagnostic tools are sadly lacking, such as for opportunistic infections brought on by AIDS and other illnesses.

"Nothing new before 2010" sums up the future for tuberculosis treatment. "Back to square one" is the title (not without provocation) to indicate the lack of availability of the most effective anti-malarial drugs. The medical department would like the Access campaign to re-invest in aids, tuberculosis, malaria and vaccination.

The challenges are also great when it comes to "attacking" so-called 'moderate' malnutrition, or when it comes to supplying intensive care units with appropriate equipment. Furthermore, the observations made by Emmanuelle Chazal, who is in charge of patient education, say a lot about our uncertainties and the means employed to keep patients who are on anti-retroviral drugs alive.

[...] do we have the most appropriate practices to motivate patients to continue with their treatments?

These interviews do not represent an exhaustive list of issues and is not a summary of last years' activities and do not cover all the activities of the medical department. In the coming year, we will therefore try to address other subjects in a similar fashion.: women's healthcare, sexual violence, pain management, pharmacy, etc. As our investment in certain diseases is a result of an operational choice, we will also try to list the choices which we have avoided making, such as those diseases which are being neglected...by MSF. ■

Olivier Falhun
Translated by Marg McMillan

TRAINING

"Patients won't respect treatment unless we respect patients"

MSF / December 2005 / Series of interviews by O.F. - Translated by Nina Freidman

Emmanuelle Chazal: "We focused on two major patient education efforts this year: our contribution to the new tuberculosis guide on treatment adherence (effort to get away from DOT) and, especially, management of HIV-positive children, since announcing to our youngest patients their diagnosis remains problematic on our missions, as it is everywhere else in the world. As for training health care personnel, 2005 looks much like previous years. Right now, training is simply a means of serving our programs, our objectives, and the quality of our operations. This is in contrast to the way things were up until the early 2000s, when training was still a end in itself. Some 80% of our activities are one-time trainings, which makes things difficult."

→ Why?

The biggest problem is that, ultimately, everyone knows how to do training! All you have to do is master your subject, in order to teach it to others. But you can't just decide to be a trainer, without thinking about the consequences of your actions. And it's not unusual to find a "teacher-student" attitude in some programs, even though we're dealing with adults. Trainers swing back and forth between elitist language only they understand, and oversimplification- both produce very poor results. When someone talks to the Clinical Officers about HIV immunization using language that almost no one who isn't a virologist would understand, you start to wonder why they even bother... Yet everyone applauds at the end, even though they didn't understand a thing. Conversely, when a doctor talks about the clinical signs used to diagnose AIDS to traditional midwives who don't do that kind of work, and sum up the diagnosis using the three cardinal signs of diarrhea, weight loss and cough... When you realize, moreover, that of the few midwives taking notes, one of them retains only one of the three criteria, and concludes that a bad cough is enough to start thinking AIDS... The first thing you question are the doctor's skills! I should emphasize that these are only two anecdotes; the reality is certainly more grim-though it's hard to assess, since I make so few field visits each year.

→ What tools do you use to remedy these problems?

Among them, the "training of trainers" sessions are essential, but they're only held once a year. They take time and human resources. I've tried to do these in the field twice, in Malawi and Uganda. But it's really cumbersome. We also have to look into writing new Guidelines tailored to

> *"Someone once noted to me that MSF's constant self-questioning might have the side effect of inoculating it against external criticism. Certainly there is a risk of learning only partial lessons from familiar sources. Even worse, the movement might succumb to a common academic disease, assuming that because an issue has been discussed it is therefore solved. The central problems MSF tries to confront are open-ended, and extend far beyond the limited moments of its engagement with them."*
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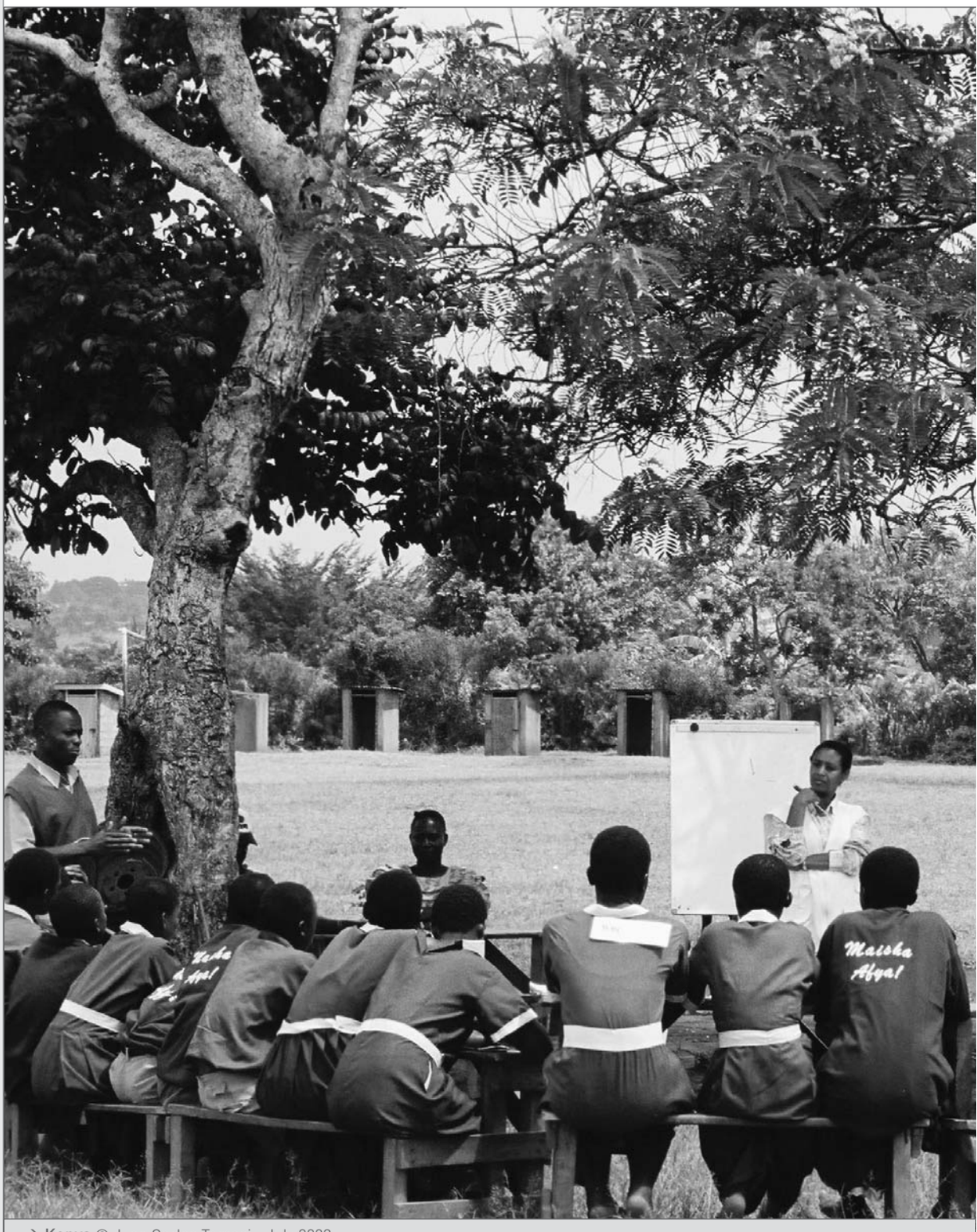
> **A contribution for La Mancha from Peter Redfield, Associate Professor, Dept of Anthropology - University of North Carolina, Chapel Hill - September, 2005**

continuing education, because the one we're using now is a bit outdated... It still strongly reflects our orientation from the time when we still had programs devoted to training. But the question of tools gives me a chance to bring up a frequent confusion between training tools and other means: needs might be incorrectly identified, or have more to do with internal organization than training. There are many people who request training in response to defective methods or organizational structure. And it's easier to do, or suggest, training-even if it's useless-than to be a good manager, by figuring out how things should work.

→ So shouldn't we consider devoting more human resources to training?

We can always follow the example of other sections, like MSF Holland, which works with a pool of people dedicated to training. We've also had experience with a field position in Southeast Asia, which lasted ten years, and which worked very well. At a mise à plat meeting on AIDS, we talked about creating such a position, spanning Kenya, Malawi and Uganda. We might consider a pool of trainers

On one program, I heard that patients have stopped coming in for treatment because they were being told off.



→ Kenya © Juan Carlos Tomasi - July 2003

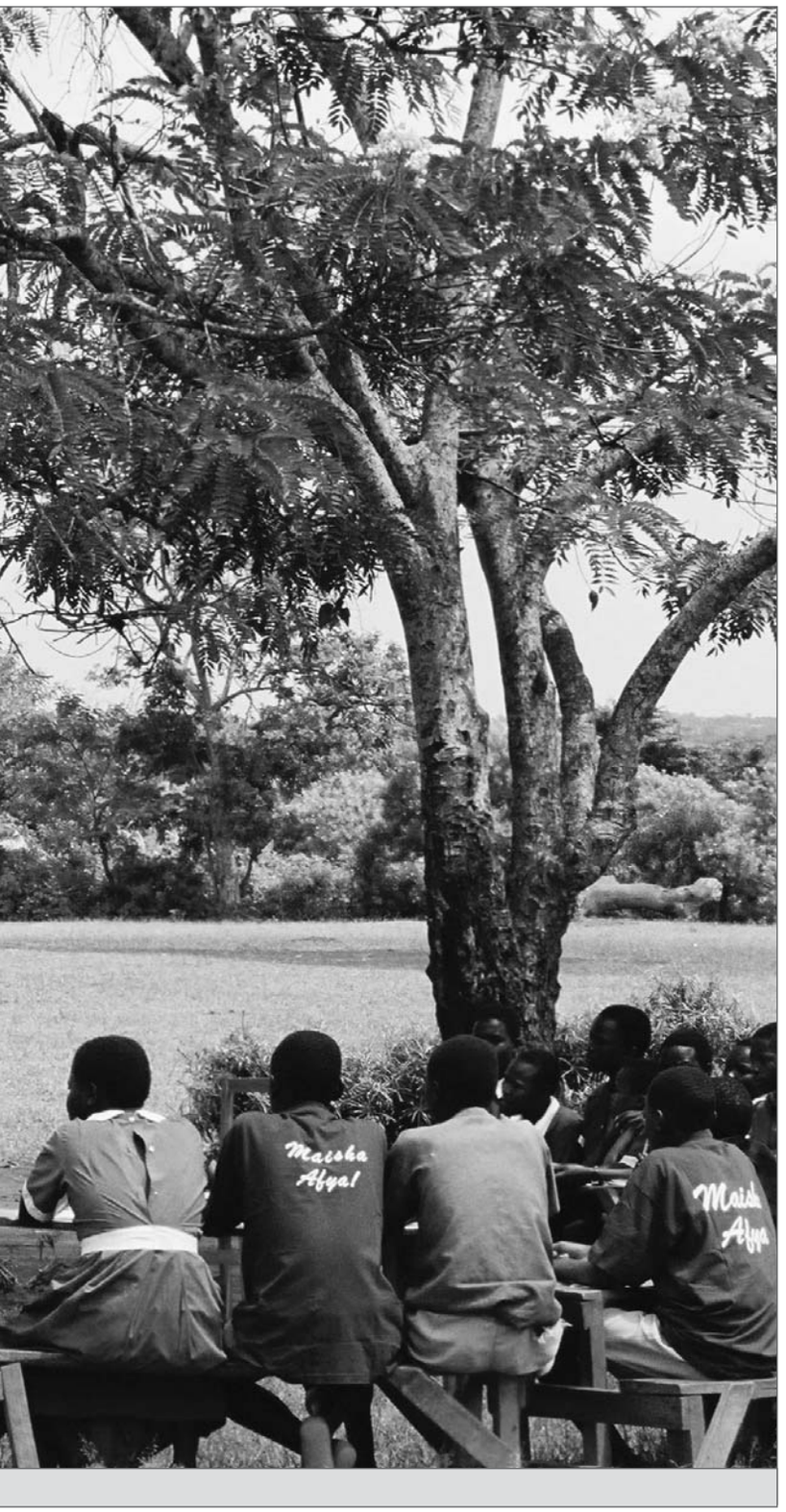
"The day we announced objectives of "scaling up", we trapped ourselves in the contradictions of such an approach: if not critically revised, it carries in itself the extinction in the very near future of our HIV/Aids programmes, suffocated by numbers. (...) The first contradiction is that we cannot even cope in high prevalence areas (...). The second contradiction is linked to the nature of HIV/Aids treatment : it is life long, whereas institutional and reactivity constraints force MSF to restrict its involvement in time for a particular geographical area. In the eighties, even TB programmes were not accepted in the MSF portfolio for the same reasons."

A contribution for La Mancha from Eric Goemaere, HoM MSFB in South-Africa - September 2005

that would do visits, needs assessment, and planning, and provide guidance for carrying out training projects. These solutions will never see the light of day, however, if training remains a low operational priority. Unfortunately, I'm a little disillusioned about this, and I don't have the heart to fight anymore...

→ Let's talk about patient education. In the last issue of Messages it says, "Fostering patient responsibility isn't an end in and of itself..." You wanted to respond to this. Why?

Because I think the exact opposite! When a patient has a chronic illness, it is indeed a matter of placing the responsibility in his hands, if you don't want to end up in a position of control. If your goal is to foster responsibility in the patient, you need to avoid an authoritarian-even repressive-relationship, and encourage the patient's confidence, respect, and understanding. This isn't a merely theoretical discussion! On one program, I heard that patients have stopped coming in for treatment because they were being told off. At another, they've started using a written contract with patients stipulating, in black and white, that if you forget even a single dose of your anti-TB treatment you'll be put back on DOT! At yet another, they focus almost exclusively on counting pills-with all the risk of error that involves-and afterward they argue and give you a lecture if there's one left! We accept all that at MSF! We need to understand that people forget, that the burden of the treatment is discouraging enough to patients, and that it's our job, on the contrary, to encourage them. Already today, but especially in the long term, patients won't respect treatment unless we respect patients-which puts the good results seen in our cohorts into perspective, particularly with respect to AIDS.



What's going to happen over there when the dead and sick become less visible? One thing that's certain is that the day will come when patients will get tired of taking their medicines.

→ Do you mean that the good compliance results currently seen need to be put into perspective?

Yes. Because while we can really be happy about these results, we should continue to question the means and techniques that we use to "educate" our patients-not in order to change our practices, but to make sure they evolve in the long run. This year, while working on adherence and HIV with children in France and Belgium, I became interested in adolescents who had been put on treatment before the disease manifested itself. The medical staff I met explained that, sometimes, some of them end up stopping their treatment and putting themselves at risk, to the point of developing severe opportunistic illnesses. But does a taste for risk or even being fed up suffice to explain this behavior? Not worrying, or not knowing, about the ravages of AIDS-don't these also come into it? Because here people no longer die of AIDS, and are starting treatment before the disease manifests itself. Over there, people continue to die *en masse*, or begin treatment when they've already got one foot in the grave. What's going to happen over there when the dead and sick become less visible? One thing that's certain is that the day will come when patients will get tired of taking their medicines. What type of help will they need then? How will we intervene? We're going to have to start talking soon about patient support, and place more emphasis on psychological follow-up, which is now handled primarily by the Health Educators. So we're really just getting started.

→ As far as training and patient education are concerned, isn't it all about chronic illnesses?

You've got to be very careful not to combine the two. Training and patient education are two different things! Naturally, when it comes to training, every MSF mission gets my attention! But training should not be considered a reason for starting a program (which has happened!), and even if my opinion sometimes doesn't count for much... So when someone asks for one or two extra ACT training sessions in Burundi to ensure continuity in malaria treatment, we're told there's no point to it... And a few months later, everyone's surprised that medical personnel are using ACT as a second or third line treatment...

As for "patient education," yes, the expression is only used when talking about chronic disease. There's a real notion of continuity that doesn't exist in acute disease. That doesn't stop me from taking an interest in treatment compliance in other programs-like at Akuem (South Sudan), when you question a patient being discharged from the hospital to see if she really understands her treatment and she answers that she's supposed to dilute a medicine in a liter, but of course doesn't know what a liter is... From prescribing to issuing drugs, it's clear that patient information is essential-but what's even more clear is that we don't pay enough attention to it. ■

Read more, in *Messages* No. 139: Operational research on AIDS interview with Laurent Ferradini December 2005

Interview with Emmanuelle Chazal , Training advisor

PSY

"Supply and demand"

MSF / January 2006

Claire Reynaud: "If I had to capture a picture of the year 2005, there's no way I would have the perspective to get everything in, since I've only been doing this for a year and a half. It's safe to say that there's been an appreciable increase in the volume of activity, linked-no doubt-to the creation of my position. The Operations department had formulated this request to get day-to-day support on these issues. Perhaps my availability reinforced the dynamic allowing MSF to expand so-called "psy" activities in its programs."

→ So isn't it possible that supply itself encouraged demand?

Perhaps... What is the right way to evaluate needs? Unlike an epidemic, or the physical consequences of a natural disaster, the prevalence of mental suffering is fairly difficult to evaluate objectively. We know, for example, that rape, violence, or population displacement are going to generate psychological suffering in individuals. But it is feasibility, in terms of context, that will determine whether or not intervention is possible. So if there are no mental health programs in Africa right now, except for Mygoma (Sudan), it's primarily because there are very few professionals trained in psychological support, unlike in Pakistan or Indonesia, for example. We might also mention Darfur, a program where there is not only a lack of qualified personnel, but also teams on the ground who aren't explicitly requesting our presence, despite large-scale rape and violence. They must sense that the population would not respond well to this kind of care. Yet I don't think the cultural dimension is an obstacle to psychological support. Suffering can always be listened to. Also, it's up to the psychiatrist or psychologist to take cultural and linguistic barriers into account. Thus, and in contrast to the surgeon who can stay a week and then leave, the caregiver will have to stay a long time and show openness and a willingness to listen-qualities necessary at MSF, anyway.

→ Don't "*psy*" projects sometimes serve as a pretext for opening or continuing a program?

While I don't have the historical perspective to answer that question, I have heard that said...and that's not a very pleasant thing for the psychologists working there! In the Occupied Territories, for example, the Palestinians are very responsive to the care offered them. We've been there a long time, and if you were to ask a psychotherapist, he would say that we'd be abandoning these populations if we decided to leave. The psychologists working in Colombia would say the same thing. They know that their presence is useful. So, above all, it's a question of MSF's priorities and the defined operational objectives. We must then take them on or do some explaining, since neither the teams nor the populations would understand a sudden about-face. Both are convinced that our work is relevant. And while there might be some (completely legitimate) reticence, it perhaps carries less weight than the enthusiasm that I've seen as well. The problem is that we could-or would like to-have psychologists everywhere. "*Psy*" activities arouse real interest and a great deal of

→ **Palestine** © Olivier Lassu / Arte - February 2004

"*(...) the movement as a whole urgently needs to debate to what extent it is willing to commit its resources to the HIV AIDS pandemic, because if the current impetus towards HIV AIDS projects is left unchecked, the identity of the movement will be changed beyond recognition and the Nirvana of HIV AIDS treatment for all will turn into the nemesis of the movement.*"

A contribution for La Mancha from Nigel Jenkins (MSF) - September 2005

curiosity within MSF. It also allows real contact, where the physician sometimes experiences frustration. It's extremely nice, and even exciting-but is it really within MSF's realm? To exaggerate a bit, doesn't MSF sometimes indulge itself, even if it means putting aside its objectives? I think this is more the issue, if we're willing to accept that mental health care truly belongs at MSF. And I believe that's now the case.

→ You've mentioned Palestine and Colombia; let's talk a bit about Poland... What is your feeling about starting this program?

Now we're back to the notion of feasibility. What really steered us toward Poland was the impossibility of launching a program in Chechnya. What matters is taking an interest in Chechen populations wherever they are, and whenever we can get to them. But what's more important is that the refugees have suffered-and continue to suffer-very painful experiences. For all that, the definition of our objectives might raise some concern. While we can help them while we are present, we should be careful of the gap that could arise between our promise of care and the reality. What might be difficult is to acknowledge that the Chechen refugees now find themselves not on a path, but at a dead end! Doesn't our intervention give them false hope? This is something we have to look at closely. We're already being questioned on the results we've gotten. A more thorough investigation on the benefits of our action will help us see it more clearly, and we'll try to understand-for example-why some people have decided not to come back for further consultations.

And while there might be some reticence, it perhaps carries less weight than the enthusiasm that I've seen as well. The problem is that we could-or would like to-have psychologists everywhere.

→ It also seems as though there's a preference for vertical programs. Are psys useless in other projects?

We have a psychologist in Abkhazia who works with a team of counselors to support MDR-TB [multi-drug resistant tuberculosis] patients. In Armenia, as well, a position with a psychosocial component was created to offer support to patients in our TB program. Similarly, we're working on the AIDS issue, in Cambodia and Guatemala, by supporting the Health Counselors in their ability to provide care for patients. In AIDS programs, we hope to develop these listening and support components to help patients live with their illness. I have clearly noted a willingness to strengthen this aspect of our activities, and to rely on my help, for example, in defining objectives or looking for suitable human resources. Since we know that it's hard to find qualified personnel in this field in Africa, meeting such an objective will require some creativity. These issues are already coming up in our Chiradzulu program, in Malawi.

→ Let's be technical for a moment.... In support of the notion of PTSD-which was recently the object of some criticism at MSF-isn't there a tendency to want to classify mental suffering?

The notion of PTSD is a western concept that emerged in America and, in particular, enabled Vietnam veterans to objectify their suffering in order to obtain compensation. So it's not very useful in the field; unless you consider a case of PTSD in the same way you consider tuberculosis, which makes no sense. On the other hand, by giving a name to trauma-related suffering, hasn't this acronym allowed us to sensitize MSF to the notions of psychological care? In other words, if PTSD has encouraged the entrée of psychiatry at MSF, that's not such a bad thing! The fact remains, however, that our data are loaded with nosographic elements-sometimes too many. Finding just the right dose isn't an easy thing, but perhaps we should move away from this sort of classification-particularly if we want to show, on a universal level, that it's still possible to respond to mental distress.

→ What is it, exactly, that makes a patient better, and what are the "measurement indicators" of the effect?

Above all, it's taking care of and listening to the patient. Drugs play a very small part. Anti-depressants or anxiolytics are auxiliary, to reduce suffering when it's intolerable. While therapy is generally thought of as a long term process, it's primarily useful for our good old deeply-rooted neuroses. Whereas, in the contexts of our interventions, both the nature of the suffering experienced and the time frame of treatment forces us to work in a different way. With trauma, we make it clear to the patient that we're going to do short term therapy. Faced with this unexpected proposition, many nevertheless show a rapid, and fairly positive, response. I don't think this usurps the notion of optimizing the treatment space, but perhaps we're deluding ourselves. How will we prove it? Admittedly, our data mention a certain number of objective criteria-How did therapy end? By mutual agreement? MSF withdrawal? Patient withdrawal?-but also subjective criteria: Has the patient improved? Has he resumed some activity, for example? What afterwards? The Operations department occasionally says, "Prove it!" And that's the whole problem...

→ So there's some skepticism within the Operations department?

Before answering, I have to give a brief review of the two main schools of psychological treatment. The standard "Eurocentric" approach, on the one hand, takes its inspiration directly from psychoanalysis, from listening and being open to the other's uniqueness. It's a sort of "philosophy of caring" of which we are the heirs. In contrast to this so-called "psychodynamic" approach, the Anglo-Saxon school advocates a "cognitive behavioral" approach that claims to be more effective and measurable, and which focuses on modifying behavior. This is exactly the debate we should be having! Does MSF want to favor an interpersonal approach-that currently practiced-or does it prefer to bank on the behavioral approach? At the moment, MSF isn't having these options explained, and doesn't know their implications... Yet-and with good reason-the Operations department is pressing us to give them answers, to justify why we're sticking with our psychodynamic approach. Since I'm a product of this school, I confess that I don't know another way of practicing my profession. But if I want to be able to openly defend this choice, it is, above all, because it seems to me more consistent with the humanitarian idea-even if it means less emphasis on results... ■

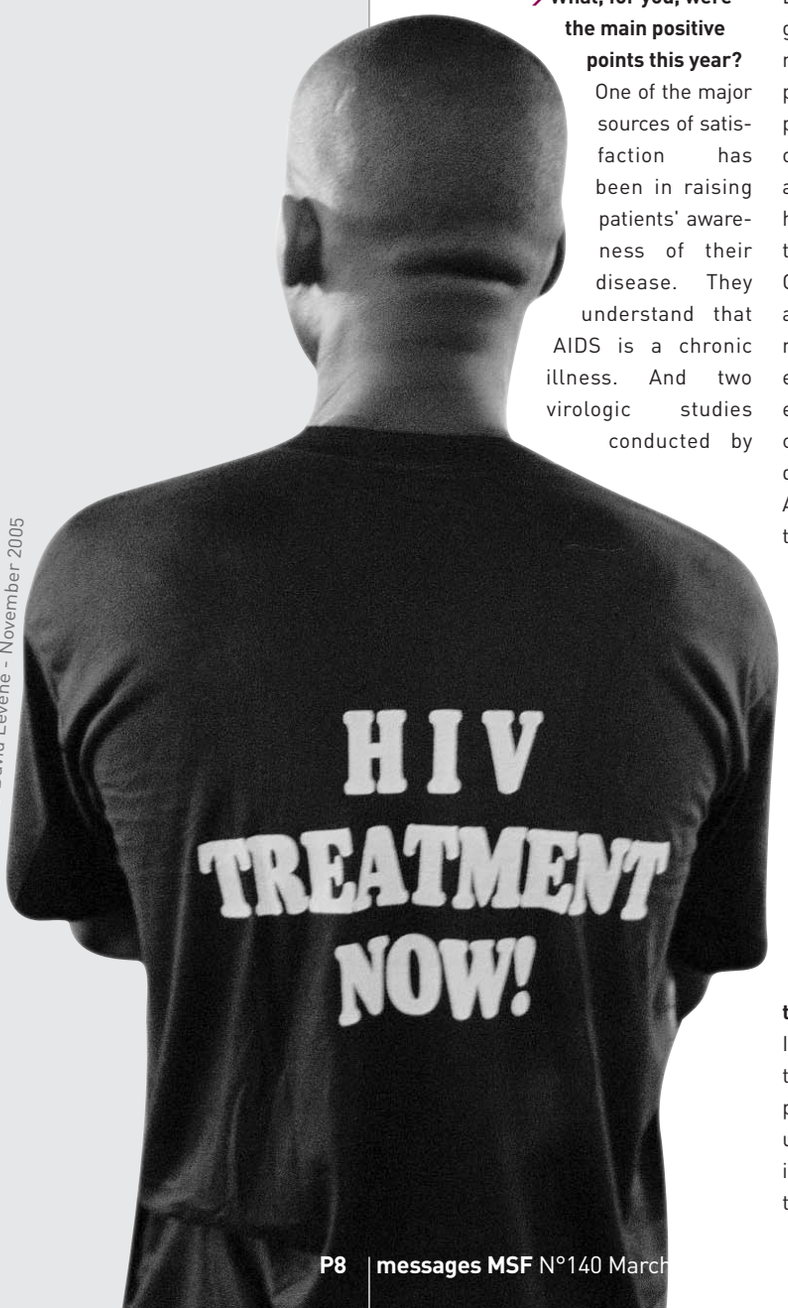
Interview with Claire Reynaud, Advisor for Mental health programmes

AIDS

A "healthcare" utopia?

MSF / December 2005

Dr. Elisabeth Szumilin: "For me, the year 2005 was marked by attempts at national management of patients in Cambodia, China, Kenya and Malawi. Global Fund money began to make an appearance in the countries where we work, resulting in growing government pressure on hospitals to start treating patients themselves. This was not without its problems-the health ministries are ill-prepared for the case management of these new patients. The result? The ARVs arrive, but there is a lack of trained, supervised personnel. It's somewhat chaotic... Some governments acknowledge the obvious disorganization of their own programs, and have asked for our help in the locations where we work. The problem isn't so much the established protocols, but helping patients adhere to their treatment; because specific staff positions aren't created for this, the task falls to the clinicians-who do it badly. This is why we have to do more work with patient-and other-groups, training them and allowing them to take the load off the clinicians, who are already overwhelmed by their daily tasks. All work deserves to be paid, however, and there's the rub. There just aren't enough human or financial resources."



→ Nigeria © David Levene - November 2005

→ What, for you, were the main positive points this year?

One of the major sources of satisfaction has been in raising patients' awareness of their disease. They understand that AIDS is a chronic illness. And two virologic studies conducted by Epicentre proved it. But we must not give up. Patients are only on their 13th month of ART, on average[1], for all programs. If we start thinking that patient awareness of the importance of treatment adherence is a fait accompli, vigilance might slip. And yet, have we placed too high a priority on the counseling aspect? I don't think so. On the one hand, taking medicines on a daily basis is still far from being a natural, integral part of their existence. The only previous experience we've had with treatment compliance is with tuberculosis, where dropout rates are much higher than for AIDS, even though the duration of treatment usually isn't more than eight months. On the other hand, I should also say-given the current limited number of treatments available in our programs-that we really have no choice but to "gamble" on good compliance. And so far, we've been winning. Better yet, the tuberculosis programs have been learning from the HIV programs.

→ Hasn't the Malawi experience overshadowed the problems encountered by our other programs this year?

It's true that there has been a lot of talk this year about the Chiradzulu program. The limits that the teams are up against there and the context of the intervention play a large part. We're talking about a district with 220,000 to 250,000 people, a central hospital, and ten satellite health centers-but with a terrible shortage of health care personnel. We have therefore had to reinvent a coherent operational policy adapted to these circumstances. In the health centers there are also "health surveillance assistants," whose existence enables us to work on a new model of care. For a long time now, the government has been training them to follow patients being treated for tuberculosis. And it's not going too badly. Now they are thinking about training them to deal with AIDS-related issues, an idea that we would like to "pilot." In Kenya, on the other hand, patients come from three different districts, which presents more problems in terms of inclusion criteria and consistency in our operational approach-not to mention patient transportation! This is why the Malawi context and the problems currently faced by MSF are motivating us to look again at the idea of operational districts-for HIV, at any rate, and certainly from the standpoint of innovation. Can we prove that decen-

(...) the Malawi context and the problems currently faced by MSF are motivating us to look again at the idea of operational districts-for HIV, at any rate, and certainly from the standpoint of innovation.

tralized management of this disease is possible by mobilizing those affected to support each other, using the simple yet effective health surveillance assistant model, despite a terrible shortage of nurses and doctors?

→ What, in your opinion, needs to be improved?

"When to switch?" This is the crucial question we're now facing. We're beginning to see first line treatment failures in some patients. And second line drugs are much more restrictive. Not only does the patient have to take 14 pills a day, but there are dietary restrictions as well! On top of that, patients experience a great deal of anxiety. Soon we'll be able to offer them a slightly simpler treatment, but the switch from first to second line therapy is definitely still a major difficulty. There's also the question of children, for whom there's no appropriate pediatric formulation, and who need special follow-up. The will to focus on this problem now exists. Given the growing number of children in our programs, we now have a clearer picture, and can define a more coherent approach. As far as research is concerned, we're also facing some dilemmas. Diagnosis and treatment of opportunistic infections is an area in which it seems important to invest more, because it's being neglected. It's these infections that kill patients. Lastly, we've have got somewhat behind in the community approach favored by our friends in the Belgian section. We have not, unfortunately, looked in depth at the possibilities of working with members of such and such a community of patients. It has taken a while, but it is now back on the agenda. ■

Interview with
Dr. Elisabeth Szumilin,
Advisor for Aids-STD and
Leishmaniosis programmes

1- This is a median

- **Read more about this at www.msf.fr :**
MALAWI / SIDA : Donner des traitements anti-rétroviraux ne suffit pas -
28 November 2005 (in French)
- In *Messages* n°139:
Operational research on AIDS - interview with Laurent Ferradini - December 2005

→ **Nigeria** © David Levene - November 2005

> *There are still far too many challenges to be faced, ranging from medical care to the setting up of programmes in extreme situations (refugee camps and regions at war). The cost of the medicines remains high, and the application of the TRIPS agreements (...) will not simplify the action that needs to be taken in order to reduce the price of these treatments. The medical research is still struggling to take into account the problems facing the carers working in Africa, in Asia or in Latin America.*

A contribution for La Mancha from Alexandra Calmy (a doctor formerly working with AIDS patients, head of the Access Campaign for Essential Medicines / MSF's AIDS working group) - September 2005.

TUBERCULOSIS

"Jealous!"

MSF / December 2005

Dr. Brigitte Vasset: "What I remember most about this year was the decision to centralize bacteriological testing-cultures-at a single laboratory. Soon, all requests from field missions where the French section works will go to same site. We'll assume the cost of these tests, and pay someone to do them. This laboratory is also supposed to participate in training lab technicians and evaluating field labs. Unfortunately, the other sections didn't want to come in with us on this for now."

Dr. Francis Varaine: "Like you, I think the creation an "MSF Tuberculosis laboratory" is good news. But what I'll remember most about the past year is MSF's avowed determination to focus more on the tuberculosis issue. I think this is real progress and a truly international effort. The creation of my position-"TB Club" coordinator-is proof of that. "

BV : Clearly, that's a very positive thing, which has helped us improve our representation outside MSF and construct a more consistent position-particularly within the international movement, with Rowan Gillies as our spokesperson. This job position should also help us get things moving in the area of HIV-TB co-infection. Reports and collected data only become meaningful once you can analyze them, and now that's possible. And we already have some examples...

FV : Like the drugs we're using in the field! We now realize that nearly 95% of anti-tuberculosis drugs available in our HIV programs do not come from pre-qualified sources. So we have doubts about their quality. Proof that tuberculosis management is still a black hole in our AIDS programs!

→ It sometimes seems as though AIDS has taken priority over everything else at MSF. Haven't we neglected TB management in favor of AIDS?

FV : Our Homa Bay program in Kenya shows this. This started out as a 100% TB program, and has gradually changed into a 100% HIV program! And we're only now getting back to tuberculosis in Kenya. We need to move forward on the whole co-infection problem. But we have to recognize that, in general, tuberculosis has become a bigger part of our programs. More of our programs now treat tuberculosis patients, and that's progress.

BV : That doesn't mean there's no reason to be jealous of the resources available in the HIV programs. Up until last year, there wasn't much interest in tuberculosis-within MSF or elsewhere. But awareness of the two diseases, how they're managed, and the tools used to fight them, are not the same...

FV : There are AIDS treatments in the North. That's what's outrageous! What affects the South concerns the North as well. Yet while tuberculosis treatments are the same everywhere, all of the patients are in the South. What's shocking is the lack of research, and it's harder to mobilize around this issue.

BV : Besides, if the Access Campaign's arguments made an impact, particularly regarding AIDS, it's no accident. The only things that get rich countries' attention-relative attention-are things they think affect them. And this just isn't the case with tuberculosis...

FV : There is some hope, though... For example, new treatments are promised by 2010. TB Alliance-a group which MSF participates in-is trying to get several drug manufacturers to work together on this. But funding is still a problem-especially when it comes to developing new diagnostic tools.

→ What about the WHO strategy and the criticisms expressed by MSF?

→ **Thaïland** © Sofi Marchand / MSF - October 2004

Do you think our position made enough of an impact?

BV : First of all, it should be emphasized that it's not always easy to criticize a strategy that we ourselves have been using for a long time. Besides, not all the DOTS recommendations are bad! But with the advent of combination drugs and our desire to get away from "one size fits all" treatments, we have to do something. So, depending on the situation, we're now trying to adjust our treatment methods, even if it means going against the authorities, who continue to follow the old WHO recommendations. Unfortunately, in some programs, we've got to admit that we're still sometimes hesitant about confronting the authorities...

FV : This is also why the French section is now trying to disengage from vertical programs. Favoring more individualized treatments allows us be closer to the patients. In our work, whenever we can, we try to use cultures. We should clarify by saying that another thing that has changed since 2004 is that we're recommending six-month, rather than the previous eight-month, treatment, thanks to rifampicin-a drug now used throughout the entire course of treatment. As for the WHO's position, it's still evolving-despite their denial... Particularly in continuing to call DOTS-a dogmatic acronym with certain connotations-a series of new recommendations that emphasize research, diagnostic methods and even pediatric treatment. The WHO also acknowledges-but only as a postscript!-that tuberculosis is on the decline around the world, except in Africa and the former USSR, and thus that the current methods are not appropriate to HIV or drug-resistant tuberculosis.

[...] tuberculosis management is still a black hole in our AIDS programs!

→ Where do you think MSF isn't measuring up?

BV : We don't always treat all of a patient's diseases. When we treat tuberculosis, we miss the fact that the patient has HIV, and vice versa.

FV : : On the subject of co-infection, the patient should receive both treatments, at the same site-and this is not always the case! HIV management should give TB treatment a boost, rouse it from its lethargy. Finally, I would emphasize improving diagnosis. We can't wait until 2010 for that. Right now we have a choice between a 2CV-direct microscopy-and a Rolls Royce-cultures... Until something better comes along.

BV : And we won't wait. We'll tinker, as we always have. ■

Read more at www.msf.fr (in French):
TUBERCULOSE - Refuser l'impasse - 19 October 2005

Interview with Drs. Brigitte Vasset and Francis Varaine , Advisors for Tuberculosis programmes

"The laboratory is a very good illustration of this deadlock. An MSF doctor in the field should be able to count on diagnostic resources and biological follow-up just as much as on medicines. What contribution can be made by the only laboratory technician available in his/her section? The sciences, medical or not, have always been a team effort. Where is the team of MSF laboratory technicians and biologists? We are no longer in the era when 'the laboratory' was simply a matter of a few analyses under microscope for a standarised medicine practised in refugee camps!"

A contribution for La Mancha from Jacques Pinel (MSF) - October 2005

MALARIA

"Back to square one"

MSF / December 2005

Dr. Suna Balkan: "By 2003 we had attained most of our objectives with regard to malaria-that is, treating patients in all our missions with ACT, and optimizing diagnosis through systematic use of the Paracheck method. So, in 2004 and 2005, most of our activities focused on consolidating these diagnostic tools and on treatment. With these gains assured, we were also able to improve our epidemic warning system. The year 2005 also represented a sort of high point. Thanks to pressure by the Global Fund and others, all of the countries in which we work have changed their national protocol and now offer-theoretically, at least-ACTs. We should also note the emergence of Coartem-the drug promoted by the WHO and chosen by many governments. In partnership with Novartis, which made a commitment to produce sufficient quantities of these combination drugs at a cost of US$2.40 per treatment, the WHO did, in fact, exert pressure to promote this drug-despite its denials. While it has the advantage of being a co-formulation, this choice raises numerous practical reservations and criticisms."

"I often hear that we are political actors who have a responsibility to provoke political and social changes. If this is true, our ultimate goal would be to fight for access to effective treatments, or, more widely, to health services, for all the patients in any one country. Or even, why not, for patients in all the developing countries. (...) Improving a population's health, and choosing and financing the health systems in order to do so, falls under the responsibility of governments. This is not an incantation but a reality. MSF is a non-governmental medical humanitarian organisation under private law. We have no legitimacy beyond that stemming from our operations."

A contribution for La Mancha from Karim Laouabdia, Director of the Access to Essential Drugs Campaign - October 2005

→ So everything isn't going that well, then?

That's just it-no! In order for Coartem to be effective, it must be taken with a meal that's rich in fats, which isn't always easy, especially in the contexts of our interventions. What's more, there are contraindications to its use in pregnant women, which the WHO lifted, without telling us the reasons behind their decision. As a result, Epicentre is going to conduct a study on Coartem in pregnant women in Mbarara, Uganda. Let me say, in passing, that it seems to me that here we've reached the limit of projects that MSF can conduct via Epicentre... However, there are other therapeutic co-formulations[1] that are just as effective, and sometimes less expensive, but that are not promoted by the WHO. And what is even more scandalous is that Novartis didn't keep its promise. There isn't close to enough Coartem available. As a result, both Angola and Uganda have actually gone back to the old protocol. In Uganda, MSF-Switzerland has had trouble getting permission to use an alternative treatment for its own patients. This year, it also launched a campaign under the slogan, "Novartis breaks its promises." The drug company fought back, stubbornly defending its good faith, and the attack turned against the WHO, which only got what it deserved...

There isn't close to enough Coartem available. As a result, both Angola and Uganda have actually gone back to the old protocol.

→ Doesn't the WHO deserve some credit for the limited quantity of *Artemisia annua*-the Chinese plant essential to the manufacture of the various ACTs, which takes years to grow-that is available?

Yes, but then why encourage demand for one treatment, to the detriment of others, when it's clearly Coartem availability that's the problem? We might well wonder about this shortage-is the quality of the artemisinin produced by Chinese labs satisfactory? Does the lab that makes Coartem need to be brought back up to standards? Have the raw materials gone up so much that Novartis can no longer make a profit? The company isn't giving a clear explanation for the shortage, and we can only guess at the reasons, which are hard to elucidate. The effect in the field, however, is instructive. In Angola, for example, which can't get Coartem, we've been authorized to use an interim treatment[2] at the Caala district health centers where we work. But we withdrew in early 2005, leaving enough artesunate/amodiaquine for 12 months. What's happening now, with Coartem still unavailable? There's also Uganda, which has gone back to its old protocol, and Kenya[3]...

Things aren't all that rosy for countries who chose other co-formulations, however. In 2004, Epicentre conducted a study in Burundi's Makamba region on patient access to ACT[4] after MSF's departure. The result? Either the health centers didn't have any, or they were using them as a second- or third line drug! There really is reason to be pessimistic. With just a bit of exaggeration, we can sum the year up as "Going back to square one."

→ Listening to you, one gets the impression that MSF stopped in mid-stream...

No! We had set ourselves clear goals. The first was to provide good treatment for our patients-that is, using effective diagnostic tools and drugs-and the second was to see if, given the opportunity, we could encourage governments to change their national protocols. And these goals were met! Knowing whether they were respected after we left, well, that can't be an operational goal for MSF. Who are we to do that? Within MSF, it's the Access Campaign's job to exert pressure to make these drugs available, and to be on the front lines. MSF's role is to show, for example, that there are alternatives to Coartem, or to artesunate/amodiaquine, since resistance rates to amodiaquine-for example in Kenya or Uganda-are high. If needed, there are possible alternatives such as the pyronaridine-artesunate combination, or artekin, a promising Chinese co-formulation

used in Vietnam and Cambodia. Less expensive than Coartem, this treatment is also more practical, because it only needs to be taken once a day. We're going to do a comparative study on its efficacy, also at Mbarara.

There really is reason to be pessimistic. With just a bit of exaggeration, we can sum the year up as "Going back to square one".

→ What are the other directions being considered by MSF in the months and years ahead?
HIV-malaria co-infection is a real issue... Though we're still at the data collection stage, we're focusing our attention on malaria management in patients on anti-retrovirals. We don't know much about possible drug interactions between anti-malarials and ARVs. In this area, the issue of prevention is particularly important, since a patient with AIDS is at greater risk of contracting severe malaria. The case of pregnant, HIV-positive women with malaria raises several issues for us. Especially since in this particular case, it's likely that they transmit the virus more easily to the child. So, those are some other studies that need to be done, but it will be difficult, without partners... ■

Interview with Dr. Suna Balkan, Malaria advisor

1- artesunate/amodiaquine, artesunate/fansidar, artekin, etc.
2- artesunate/amodiaquine
3- Kenya blithely goes along using amodiaquine monotherapy, thereby "blowing" their chance to use the artesunate/amodiaquine coformulation.
4- artesunate/amodiaquine

Read more about this at www.msf.fr (in French):
- *PALUDISME - Deux millions de décès par an, et des médicaments efficaces toujours peu disponibles en Afrique* - 25 April 2005
- *PALUDISME - Nouveau traitement, nouvel espoir* - 11 April 2005

> *"(...) making sure that MSF gives priority to those actions that are most likely to result in the most, and whenever possible long-term, benefits could make its action too heavily dependent on elements of the local setting such as infrastructure or political will. In practice, this reintroduces "borders" around the places where MSF can be active."*
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> **A contribution for La Mancha from Samia Hurst, Bioethics Institute - Geneva University Medical School, Switzerland - October 2005**

MENINGITIS

When the trains run on time

MSF / January 2006

Dr Cathy Hewison: "though MSF intervened in Chad, Darfur, and even the Blue Nile, Sudan, there were no major meningitis epidemics during 2005. And while we're really happy about this, we also know that meningitis strikes the sub-Saharan "meningitis belt" in a cyclical pattern, at the rate of approximately one large epidemic per decade. We can expect a major crisis in the near future-but where, when, and how? That's the question. So, rather than go over our interventions, I'll talk about how we've improved our tools-immunization, diagnostic methods, and treatments-over the past year."

→ Let's begin with immunization, then. How are these activities coordinated, and what progress has been made?
MSF is a member of the ICG[1], which is in charge of monitoring, manages the stock of available vaccines, and is very quick to respond to epidemics. They are able to respond very quickly to our requests, then send the vaccines once we've determined the strain. This swift reaction is all the more important in that it contributes to the efficacy of the response to meningitis epidemics. Nevertheless, in the sub-Saharan meningitis belt it's Meningococcus A meningitis that does the most damage, and the vaccines now available to us are effective for a period of at most three years. What's promising is the study now going on in Africa to develop a vaccine that should last more than ten years. We're now at the beginning of phase 2, and the so-called "conjugate" vaccine should be ready by 2009. It will then be possible to launch a wide-scale immunization campaign that could significantly reduce the risk of epidemic. The English experience reassures us that this is the way to go: in England, they conducted the same type of campaign, against Meningococcus C meningitis, in people under 21. The results are surprising. Not only did the number of patients decline considerably, but the vaccine seems to have caused a drop in the number of people carrying the bacteria (called "carriage"). So we can only hope that the effect in Africa is the same. But there is an obstacle-we have to conduct a study to estimate the carriage rate and to be able measure the end results of such a campaign.

→ And diagnostic tools?
We've got serious hope there, too. We had already made progress with the arrival of the Pastorex rapid test, and with TransIsolate, which enables us to get valuable information, particularly on the micro-organism's genotype. We can now "trace" epidemics better, and have a bit better understanding of their trajectory. However, Pastorex requires a cold chain, we have to do a lumbar puncture on the patient in order to get a diagnosis, and the results are not easy to read. In addition, training on its use is essential. Well, the Pasteur Institute, in collaboration with the CERMES laboratory, has just perfected a strip that's much easier to use, doesn't require special storage or transport conditions, and allows diagnosis from a single drop of blood. Given these excellent results, we're going to test this new tool right away under epidemic conditions, with Epicentre's support. We'll also take this opportu-

There is also investment in meningitis at all levels, thanks to an effective network of actors: the WHO, the ICG, private pharmaceutical companies, universities, African doctors, etc.

nity to run trials on Pastorex itself, by simplifying the procedure-even though I'm more reticent on this point. The only problem we've run into is that, not knowing where and when the next epidemic will strike, we can't prepare medical personnel to use the new test.

→ And regarding treatment, are the trains running on time there, too?

Here we've got to pay tribute to the work of Nicolas Nathan, who died in 2004 and who-along with the Epicentre team-had already done the groundwork for us. A study published in *The Lancet* in July 2005[2] had demonstrated that during epidemics, ceftriaxone was an excellent alternative to oily chloramphenicol-whose continued production was uncertain-and also less expensive. The study came just in time. While oily chloramphenicol is still being made-thanks particularly to technology transfer in India-the first stocks of available drug were not the best quality, and it will take a few months to reconstitute a new stock. As a result, this year we're going to start using single-dose ceftriaxone, which we're beginning to pre-position it. Especially since the WHO is planning to put together an expert committee soon, with a view to publishing an official recommendation on the use of this single-dose treatment. There again, there's been progress, unlike what's happening with tuberculosis, for example.

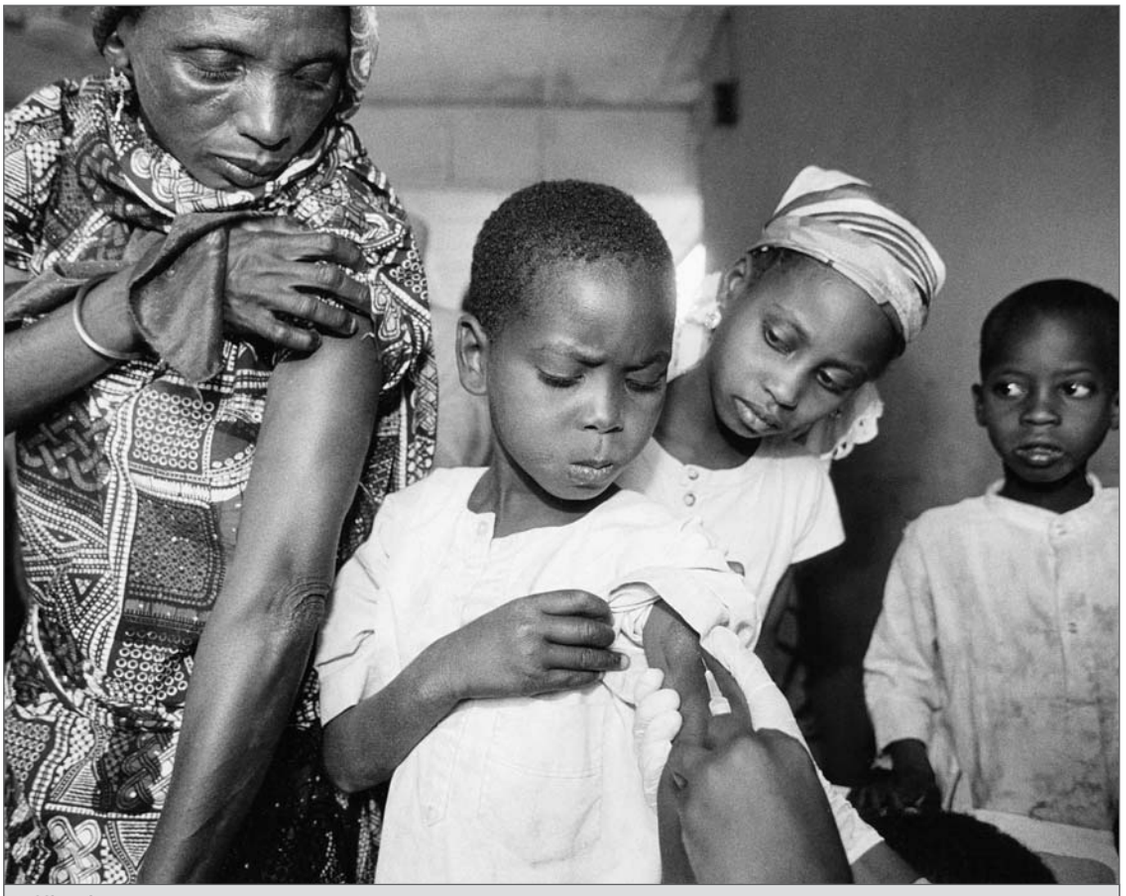
→ How do you explain these advances in meningitis treatment?

Vaccines exist, because the disease affects the developed countries as well. There is also investment in meningitis at all levels, thanks to an effective network of actors: the WHO, the ICG, private pharmaceutical companies, universities, African doctors, etc. It's well-coordinated. But there are still real problems. And I have to stress the difference here between epidemic and endemic meningitis, which involves difficulties in training medical personnel. Single-dose ceftriaxone should only be used during epidemics. In endemic conditions, treatment lasts five days. So the two situations require different management. Furthermore, because ceftriaxone is a very good antibiotic-against pneumonia, for example-it will be hard to resist prescribing it to other patients. And there, again, you can't use a single dose. So medical personnel must be properly informed. As for Meningococcus W135 meningitis, we also know that the effectiveness of vaccines is very limited in duration. There's work to be done there, as well. Finally, a 2009 deadline for developing a conjugate vaccine is both very short and very long-we can only hope that no large-scale epidemic hits the meningitis belt in the meantime. ■

Interview with Dr. Cathy Hewison, advisor of Tuberculosis and Méningitis programmes

1- *Ceftriaxone as effective as long-acting chloramphenicol in short-course treatment of meningococcal meningitis during epidemics : a randomised non-inferiority study* - Epicentre - publié dans *The Lancet* - juillet 2005

Read more at http://www.msf.fr :
Ceftriaxone as effective as long-acting chloramphenicol in short-course treatment of meningococcal meningitis during epidemics: a randomised non-inferiority study - EPICENTRE - Published in The Lancet - July 2005
Méningite - *Un traitement alternatif en situation d'épidémie* - 11 July 2005 (French only)



→ **Nigeria** © Remco Bohle - January 1996

"(...) it is not because other organisations put out the same messages as we do, after we created awareness, that we are good. We are not good if we are late, we are not good if we do not perform low-cost, simple interventions that are important to the people we are supposed to assist simply because we did not think of it or not believe we could do it."

A contribution for La Mancha from Barbara Kerstiens (MSF) - October 2005

"A steady course..."

MSF / January 2006

Dr. Sinan Khaddaj: "Since the re-launching of surgical activities three years ago, growth has been steady and progressive. And while there have been some obstacles, this growth has always remained on the same track: providing the most relevant response possible to operational demands. So I'll remember 2005 as a period of continuity."

→ Isn't this initial impression of the past year a bit "politically correct?"

On the contrary, it would be wrong to think it political cant... the Medical Department's-and in this case, surgery's-job is to respond to the various operational demands with the best possible technical support. In this sense, surgery has provided impetus to the operational plan-the number and variety of surgical activities opened and closed prove it! It's amazing indeed to be able to intervene simultaneously in such widely diverse programs, yet still be effective. From Rutshuru to Kaina-by way of Port-au-Prince and Pakistan-we now have a much broader operational approach, which enables us to find responses as specific and relevant as the situations are different.

→ There were some delays evident in the recent intervention in Pakistan-despite the arrival of inflatable tents, which some hailed as revolutionary...

MSF did not invent inflatable tents-the military has been using them for years! Why is it only this aspect that people remember? This was a functioning hospital that we set up, under emergency conditions, in Pakistan: 120 beds, two operating rooms, an emergency room, an intensive care unit, a triage room, and all the necessary ancillary facilities... There's a whole "arsenal" hiding behind the 1000 square meters of inflatable tents, and it went up relatively quickly! Of course, this first experience in Pakistan had its problems. The equipment didn't arrive until three weeks after the earthquake; it took us 15 days to prepare a suitable site, then 10 more to put up the hospital and make it operational. But experimenting with new ways of doing things is how you learn. We now know that we need better upstream preparation. The Emergency Department is thinking about how to improve our responsiveness, as well. The design of the surgical kits also needs to be improved. So there are many things that need work, but eventually we should be able to set up an operational hospital like the one in Mansehra in four or five days. Which is no small feat!

→ So what you're trying to say is that we learn from our mistakes, but that these new tools still represent major progress?

No! Once again, the major progress we made this year was less about tools and more about the general policy of our surgical programs. We avoided the mistake of trying to apply the same intervention model everywhere. And that's what's really new! We've raised the technical level, certainly, but also introduced new surgical practices, like neurosurgery in Port-au-Prince, and orthopedics in Pakistan. The physical therapy we're doing at these two missions also demonstrates our interest in comprehensive case management of the patient. And who doubts the relevance of our current presence in Kashmir? Thanks to the results we've achieved, each passing day in Mansehra not only reminds us that we've chosen the right direction, but has the secondary effect of allowing us to reaffirm MSF's decision to respond to natural disasters. And I'm not the first person to say that!

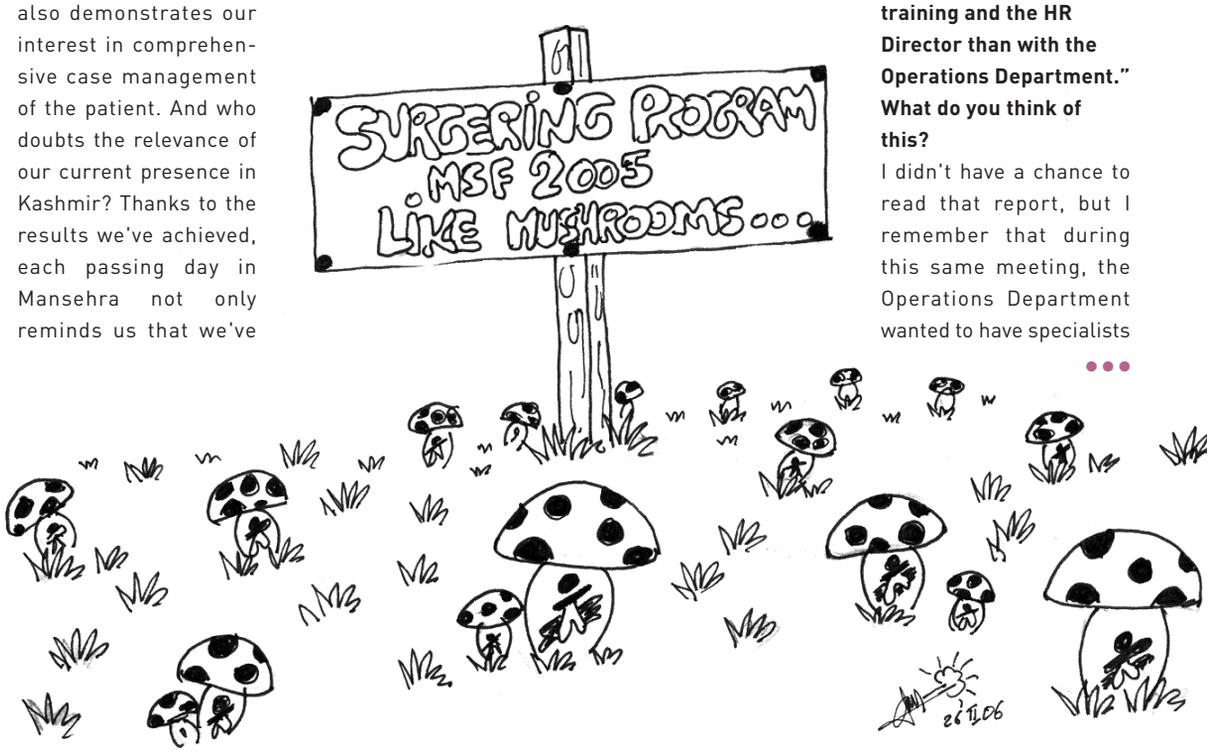
→ What about post-operative follow-up-does it seem satisfactory to you?

I prefer to talk about continuity of care, rather than post-operative follow-up. The treatment process should be understood as a whole. Post-operative follow-up isn't a separate activity... Because, for the criticism to be meaningful, you need to know the quality of the pre-operative phase! Even without this, there are, obviously, improvements that can be made in both patient follow-up-primarily by way of the medical chart-and the availability of certain tools, particularly in the intensive care phase. The problems simultaneously reflect the heterogeneity of training and the degree of our teams' involvement in patient follow-up, stemming as they do from certain persistent weak points-especially in intensive care. Because it's hard to set up ICUs and the equipment that goes with them. We won't be able to do it everywhere. On another subject, it would be good if the physical therapy we do in Haiti could eventually be offered at other missions. Though we don't hope to offer all the services of a university hospital, the guiding principle is still to improve patient care.

Because it's hard to set up ICUs and the equipment that goes with them. We won't be able to do it everywhere.

→ Regarding fistulas, the following sentence appeared recently in an Operations meeting report: "The team refused to launch this project, given that it's a project that would have more to do with training and the HR Director than with the Operations Department." What do you think of this?

I didn't have a chance to read that report, but I remember that during this same meeting, the Operations Department wanted to have specialists



doing fistula repair surgery. So no one wants to shut the door-on the contrary! What I also understood was that the job of training of surgeons and other professionals (functional rehabilitation, etc.) belonged to a department other than the Operations department. What counts, above all, is the willingness to get into this subject, now that we've touched on it, and not just let it go. The willingness is there, the principle established-all we need is time to convince people, because MSF is an ocean liner that takes awhile to turn. But we'll get there, holding steady to the course we set three years ago. ■

Read more at http://www.msf.fr (in french) :

- Journée chirurgie 2005 (Surgery Day 2005) - Presentations - 21 December 2005
- Urgence au Cachemire - A Mansehra, un hôpital MSF pour soigner les blessés dans la durée - 7 December 2005

Interview with Dr. Sinan Khaddaj, advisor of surgery programmes

"Definitely fistulas, VVF (Vesico-Vaginal Fistula) and RVF (Recto-Vaginal Fistula), will be one of our medical challenges. MSF should train surgeons and other team members (who should search for these patients, something that can be difficult due to shame and stigma)."

A contribution for La Mancha from a group of MSFH medcos - October 2005

IMMUNIZATION

"MSF torpor"

MSF / January 2006

Florence Fermon: "Measles, measles, and more measles! Major outbreaks in Chad and Nigeria, and obstacles to intervention-due mainly to recommendations from the WHO, which continues to insist that once an epidemic has started, it's too late to vaccinate... That's what has really mobilized us this year. And we've made progress! In Chad, in any case, where we've been able to intervene on all fronts, from the immunization campaign to the treatment of patients. More problematic was our action in Nigeria, which was slowed down by Ministry of Health stumbling blocks, and by the lack of support from partners like the WHO. Also, while I'm satisfied with the treatment aspects of our Nigeria operations, the inability to vaccinate after the start of the crisis will be this year's great failure."

→ To what do you attribute the WHO's inflexibility, and what can be done to soften it?

In terms of immunization, there are two branches coexisting at the WHO. One is in charge of the Expanded Programme on Immunization (EPI), while the other deals with epidemic response. You can't ask the EPI people to respond quickly to epidemics. So you end up with stumbling blocks-on top of it based on old theories. Confronted with this "conservative" point of view, MSF has continued to document the situation, as we've been doing for three years, with support from Epicentre. Thanks to this groundwork, we can now present solid conclusions. The concrete, precise arguments we've gotten also enable us to formulate several suggestions, which should ultimately lead to a change in the official recommendations. In Washington, recently, we presented the lessons to be learned from our response to measles epidemics. Both the WHO and the CDC[1], in attendance, expressed a keen interest in our conclusions. We'll stay in contact with them, and plan to arrange a meeting among the various partners involved in epidemic response. The goal? To change the recommended approach.

(...) we're so inertial that we forget to question either our activities or their context. We wait for emergencies...

→ What about us-are we responsive enough when it comes to prevention?

As a matter of fact, no! We could get going sooner, but we're so inertial that we forget to question either our activities or their context. We wait for emergencies... And yet, gathering information in order to better understand the risk of epidemic doesn't necessarily mean intervening, or launching immunization programs that could, if necessary, be handled by others. It only encourages us to look ahead, to ask ourselves whether a risk exists, if immunization is assured, by whom, under what conditions, and for what vaccine coverage... This way we would avoid seeing numerous tetanus cases show up at certain missions, without any analysis or decision-making having

been done to document the situation or get involved in possible immunization programs. Let's talk about Angola, too. In 2001, there were a large number of IDPs living in Caala. We were working at the hospital, when the Ministry of Health was handling immunization. Unfortunately, despite the high risk of epidemic, we never thought to determine the extent of measles vaccine coverage-and it wasn't even 50% for either the residents or the IDPs. And we didn't dodge the epidemic! Just like the way we do between 4,000 and 5,000 deliveries a year at the Bouaké Hospital in Ivory Coast-a context where the prevalence of hepatitis B is extremely high-and never even think to vaccinate the newborns... We're really missing the forest for the trees, when we spend most of our effort on treatment, and forget prevention. And the cases above are only a few examples!

We're really missing the forest for the trees, when we spend most of our effort on treatment, and forget prevention.

→ How to do you explain this narrow approach?

I think we're paying the price for 1987 years, when we got involved in the vertical EPIs. We were just doing technical support programs, intended to fill various needs, with-perhaps-some vague desire to do everything. So the pejorative view of immunization activities might come from a propensity to revive this legacy, when instead it's a matter of changing how people think, of making immunization a reflex in the field. To do this, we would have to redefine so-called "immunization activities" at MSF, and systematically ask ourselves what's going on, with a view to deciding whether assistance or action on our part could be undertaken. Because today, while we're being told that there's tetanus in southern Sudan, we're also being told that the national program is responsible for immunization. If we then ask why they're not taking care of it-suggesting that we might be able to find a solution-few people

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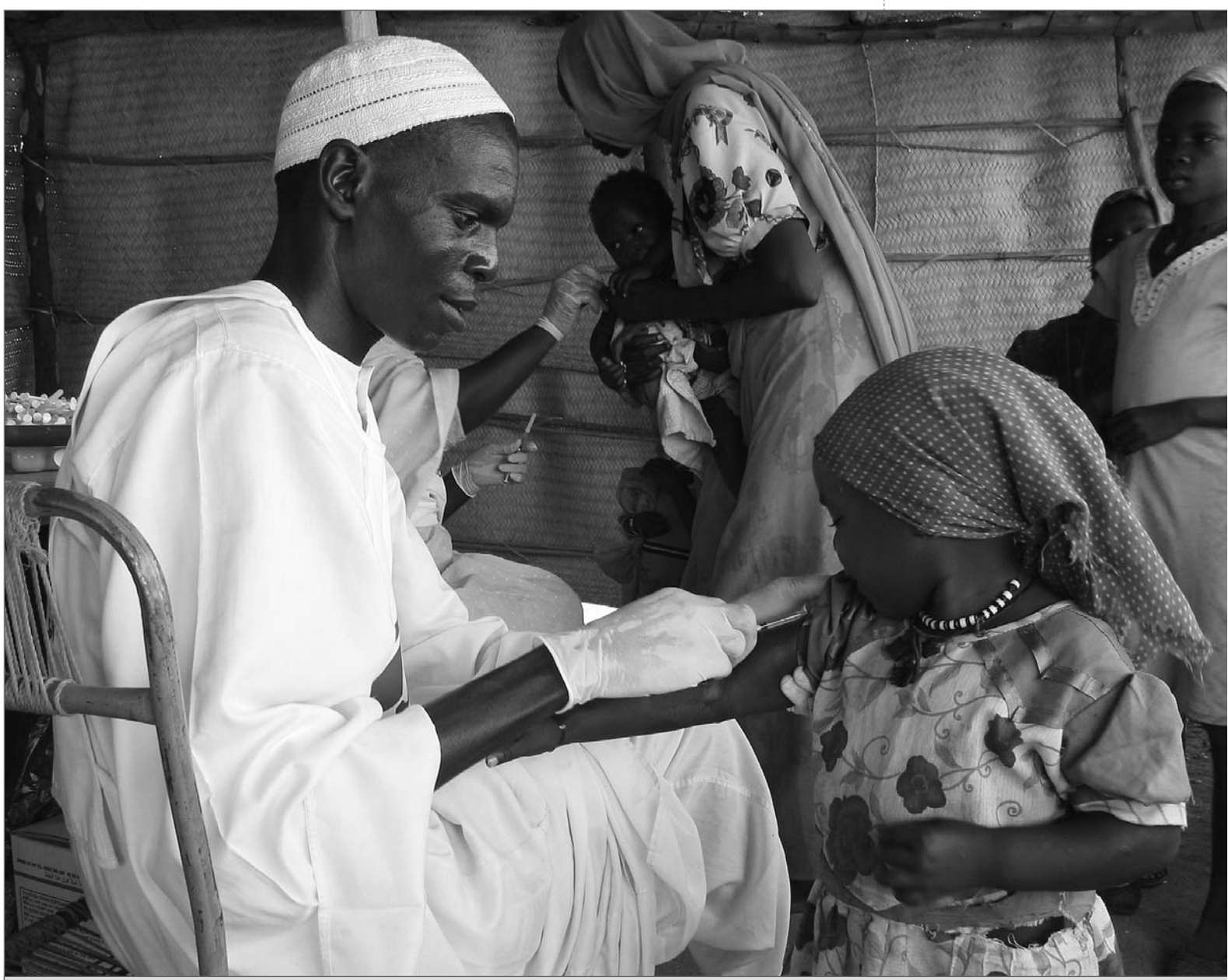
"Where are we with our reflections on antibiotics resistance, vaccination strategies and vaccine availability, pain-killers and treatment for the cancers we see in the field?"

A contribution for La Mancha from Karim Laouabdia, Director of the Access to Essential Drugs Campaign - October 2005



→ **Sudan** © Kris Torgeson - October 2004

→ **Indonesia** © Francesco Zizola for MSF - January 2005

know what to say... The same is true for HBV, Haemophilus or rotavirus-vaccines we're behind on, and which are expensive. Because the WHO doesn't systematically recommend them, we avoid thinking about using them, too. And I include myself in this! Especially since I'm only rarely informed about what's being done in the field! Proof that there's no tendency to question at MSF.

→ Following the example of what we did with measles, shouldn't the future of immunization at MSF involve more of a marked lobbying effort, too?

The two are inseparable. But that remark goes back to the questions that MSF should now be asking itself. And the successful experience with meningitis convinces me even further of this. Shouldn't we start "boosting" our partners so that they'll ensure the supply of certain vaccines? Should we fight the pharmaceutical industry to get the most affordable prices? Should we get the Access to Essential Medicines campaign involved, and if so, in what way? Above all, and without suggesting how it should be done, we have to have internal debate on these issues. Similarly, the question of combination vaccines (more recent vaccines that protect against several diseases) should be on the table starting next year. This is another basic question that MSF needs to get a handle on-is it our job to push for them, or not ? Be that as it may, our interest in immunization also requires fuller communication within MSF We're going to make various presentations, both in Paris and internationally, to the people concerned. In the end, the goal is to offer a simple, clear picture of current immunization activities. Because, while it's the program managers' job to push us to meet operational objectives, it's our job to convince them that a more proactive immunization policy would be both well-founded and simple good sense. ■

Should we fight the pharmaceutical industry to get the most affordable prices? Should we get the Access to Essential Medicines campaign involved, and if so, in what way?

1- Centers for Disease Control and Prevention: the epidemiological surveillance system in the United States

Read more at http://www.msf.org.au/e-news/sep05/story-4.html:
Nigeria: breaking the deadly cycle of measles and malnutrition - September 2005

Interview with Florence Fermon, Advisor for Immunization prog.

The other "scaling-up"

MSF / February 2006

Geza Harczi: "there's real determination to invest the necessary means to do better. A nutrition sector has been set up within the medical department, with a variety of skills: doctor, nurse, food relief, quality and supply of nutritional and therapeutic products. It's a very technical area which requires specialists and team management in the field. For a long time we focused only on emergency nutrition, with simplified protocols and standardized reasoning. There were classic procedures: alerts/nutrition surveys/hospitalization of the severely malnourished in a TFC (therapeutic feeding center) and, if possible, treatment of moderate malnutrition in an SFC (supplementary feeding center). Today, MSF has decided to develop better monitoring of situations of nutritional insecurity and nutritional interventions."

Dr. Milton Tectonidis: "everyone has finally seen the advantage of ambulatory treatment, a strategy which consists of outpatient monitoring of severely-malnourished children who do not have medical complications and have maintained their appetite, instead of hospitalizing them automatically. Although outpatient management began four years ago, the unexploited potential of this strategy wasn't fully recognized until 2005. From 1992 to 2004, nothing had been done! For twelve years, we had stuck with the same traditional format. Now we're changing. In major crises, we will use the outpatient strategy, but this is not a new definitive strategy, destined to last another ten years. We will probably go further, redefining our interventions for other malnourished patients and perhaps even those under age five!"

→ **It has been said recently that one of the major advantages of outpatient treatment is taking patients away from doctors! What do you think about that?**

GH : By being treated at home, children are not exposed to nosocomial illnesses and treatments which are sometimes the result of a excess of zeal. A doctor in the field does not become competent in the case management of complicated malnutrition with just a simple protocol. This is a highly technical field which requires a specialised doctor, documentation and team discussions. So case management can be improved at all levels. F75 therapeutic milk formula has long been recommended in the first phase of renutrition, but it is not always used, because in an emergency it's simpler to have a single formula for both phases rather than offer the more appropriate one. The weighing scales we use are not suitable for the low weights of our patients, even though precision is needed for patient monitoring, even more so for monitoring rehydration.

MT : It's especially vital to give resources to the patients and their families. We have what we need for our children, but they don't have anything. Nobody does anything for them! The only thing the world offers them is slogans like: wash your hands, breastfeed, stop making babies, educate your daughters! We need to do more active research and provide better care, such as with

The only thing the world offers them is slogans like: wash your hands, breastfeed, stop making babies, educate your daughters!

→ **Niger** © MSF - May 2005

> *"MSF is best grounded in its medical practice and in a clear awareness of the transient nature of its action – it is uniquely anxious to reflect on where a cult of action, prioritising interventions at all cost over any form of reflection, might lead in terms of ingérence – and it should remain anxious in that respect. To be big but think oneself small, to be a power and think oneself a counter power is an interestingly precarious standpoint but it has to remain. MSF cannot pretend to be the answer beyond primary medical care."*
>
> **A contribution for La Mancha from Bertrand Taithe, Professor of Cultural History, University of Manchester - October 2005**

Plumpy'nut. It's state of the art, everything you need in a condensed, low-volume form. We should give them this product instead of continuing to provide pounds of Unimix, which comes with a mountain of recommendations.

→ You mean that the same treatment should be adopted for severe and moderate malnutrition?

MT : The important distinction is between malnutrition with medical complications, where hospitalization is required, and malnutrition without medical complications, which can be treated on an outpatient basis. Afterwards, for both severe and moderate malnutrition, they all need treatment with an effective therapeutic product, such as *Plumpy'nut*. Simply giving the moderately malnourished a nutritional supplement doesn't work. It's been done for twenty years and it's a failure. *Unimix* is not a therapeutic product, it's only a little bit better than other foods.

GH : We have better things to offer patients. For the malnourished but also for those who are vulnerable. In the context of targeted distributions or 'supportive food' rations, we can give therapeutic products combined with fortified local food. This would be more appropriate than *Unimix*, which is expensive and comes with restrictions and problems with quality, storage, deterioration after cooking, etc. Local alternatives can be found to provide higher-quality nutrition.

The principle of MSF is to intervene according to excess mortality, not mortality. Even with a very high mortality rate, if it's the norm for this population, we don't go in. Because if we were following a purely medical logic, we would be India, where twenty million people are suffering from malnutrition!

→ What are the criteria for intervention?

MT : It's not technical issues that guide us but politics, the context of the crisis. The principle of MSF is to intervene according to excess mortality, not mortality. Even with a very high mortality rate, if it's the norm for this population, we don't go in. Because if we were following a purely medical logic, we would be India, where twenty million people are suffering from malnutrition!

GH : On the other hand, by setting an example with ready-to-use therapeutic products we can open people's eyes, like "scaling up" with AIDS.

MT : This year, 60,000 children were treated in Niger. Imagine if 200,000 could be treated.... Nigeria or India would not be able to ignore what was being done, we would have proved that it's possible, in very large populations.

→ Nutrition made up a major part of operations, and the budget, in 2005. Will this trend continue in the coming years?

MT : It's impossible to predict, it's connected to emergencies. In 2002 in Angola, we also spent a great deal. It's the targeted distributions that double the budget for a nutrition intervention, and they are growing: we distributed 1000 tons in Angola, 2000 in Darfur and 4000 in Niger. Because our capacities and our competencies are increasing, we want to do more each time, and it costs more.

GH : More than half of the ten million annual preventable deaths in childhood may be connected to malnutrition. By offering a variety of procedures, by working on the quality and especially the accessibility - and thus the cost - of treatments, it will become possible to diversify the modes of response, to expand our coverage to the zones and patients who need it. Nutrition programs will very probably grow.

→ Isn't MSF behind in treating malnourished AIDS patients?

MT : With AIDS, there have been other priorities. First it was essential to introduce the treatments, and then to fight tuberculosis; there needs to be further decentralization in the monitoring of stable patients. Treatments are being introduced for malnourished patients, but the real challenge is to give everyone nutrient-dense supplements to delay the progression of the disease and the destruction of the immune system.

(...) by working on the quality and especially the accessibility - and thus the cost - of treatments, it will become possible to diversify the modes of response (...)

GH : There have been initiatives in the field, we have to support them, improve quality and capitalize on the results... The medical efficacy of nutritional support for AIDS patients is obvious, but our work needs to be documented in order to move everyone forward.

→ What are your main objectives for 2006?

GH : First, supporting the Niger project, an ambitious and innovative effort, but also expanding the provision of therapeutic nutritional supplements for patients in our AIDS and tuberculosis programs, and for pregnant women. All hospitalized patients can benefit from it.

MT : Proving that we can treat everyone in Niger. Treating global malnutrition in an entire vulnerability zone. We're giving moderately malnourished people the wrong product because it's less expensive, and they don't get better. We're going to treat all of them with the right product and show that it works. Then it will be a matter of proving that this has an impact on mortality. ■

By Anne Yzebe
Interview with Geza Harczi and Dr Milton Tectonidis

> *"Concern for action to alleviate the health needs of the most vulnerable provides a vantage point, an objective, a terrain, for political strategy, not a code of solutions. Humanitarian strategy should be guided by principle, by ethical commitment, by organization, personal and professional ethic, but it should not become doctrine, or dogma. Strategy requires innovation, experimentation. You can, and should, change your mind. Experiment. Backtrack. What is required is a clearly understood strategy of engagement - for this disease, for this population, in this circumstance, we have done this. (...) We are not sure it will work, but we are committed to giving it our best shot."*
>
> **A contribution for La Mancha from David Kennedy Manley Hudson Professor of Law, Harvard Law School, Cambridge, Massachusetts.**

→ Niger © Alexandre Godard - October 2005

MISSION

DEMOCRATIC REPUBLIC OF CONGO

DRC - TERRITORY OF RUTSHURU

Snapshot of the resurgence of war

MSF / February 2006 / Kate de Rivero, with Jean-Sébastian Matte, coordinator in Nord Kivu

→ North Kivu

Even since the official end of the war in 2003, North Kivu has been the theatre of violence, fighting and looting by a mixture of armed groups operating in the region. In 2005 alone, MSF treated over 1200 rape patients in Beni, Kayna and Rutshuru areas, where men in arms committed most rapes. In December 2005 military operations in the territory of Beni provoked the displacement of 36000 people, leading MSF to open an emergency project providing primary health care and medical treatment for victims of sexual violence the town of Linzo (north of Beni), where 2200 displaced families are now residing. A second emergency project was opened in January this year in Kanyabayonga, after 60 000 people were displaced from Rutshuru. MSF currently has 3 projects in North Kivu: Beni/Linzo, Kayna/Kanyabayonga and Rutshuru.

→© Jean-Sébastien Matte / MSF - February 2005

On the 19th of January, combats erupt in the eastern side of Rutshuru territory as armed groups fight over the control of several towns and villages. The violence and fighting rapidly spreads to the north and west of Rutshuru territory. In the western side of Rutshuru the population hides in the bush close to their villages, but many are then forced to flee to other towns when armed groups directly target them. Over 60 000 people flee to the mountain towns in the north, while others flee to Goma or to Uganda. During the fighting, MSF teams evacuate from the towns of Rutshuru and Katwiguru. The MSF team in Kayna opens an emergency mission in Kanyabayonga as 35000 displaced people arrive. Though the large-scale combats are over for now, violence continues in certain areas, as armed groups roam the region looting and attacking villages.

KANYABAYONGA : 35 000 DISPLACED PEOPLE

60 000 displaced people arrive to the towns of Kanyabayonga, Kirumba and Kayna. They have fled by foot, and have spent 1 to 2 days walking, taking the belongings they can carry. 35 000 displaced people find refuge in Kanyabayonga, doubling the size of the town, so that 1 in every three houses is hosting a displaced family. In February more families arrive fleeing violence in the villages south of Kanyabayonga.

The MSF team sets up a provisional water system providing 150 000 litres of water per day doubling the amount of drinking water available in the town.

In the first ten days of the crisis 44 women who were raped come to the health centres to receive appropriate medical treatment. (Before the crisis, an average of 50 people who had been raped received medical care every month in MSF clinics in Kayna and Kanyabayonga together). In 10 days, a total of 2830 consultations are carried out by MSF and 52 patients are referred to the hospital in Kayna where MSF is also working. 89% of referrals are displaced people coming from Kibiridzi. The hospital in Kayna is overloaded with the new influx of patients, so a new tent for hospitalization is set up. The World Food Programme organizes a food distribution for the displaced families, but does not have enough resources to provide food for the host families.

KATWIGURU - MSF LEAVES

In January, the MSF team working in the Katwiguru health centre evacuates. A week later 10 health centres on the axe between Katwiguru and Ishasa are closed down due to the lack of medicine. Prior to the evacuation, MSF carried out an average of 300 consultations a week in Katwiguru, with 50% of consultations being due to malaria. Nearly 20 patients a week were transferred to the hospital in Rutshuru. Several weeks after the evacuation MSF returns punctually to supply the health centres with medicine.

RUTSHURU TOWN- FIGHTING, EVACUATION AND RETURN

In January most of the population flees as fighting erupts. 1000 people find refuge in the general hospital, whilst thousands of others flee to Goma, to Uganda or to the bush. The MSF team working in the hospital evacuates. For the next three weeks MSF returns twice to Rutshuru to supply the hospital with medicine and medical material. Confusion reigns as to which group controls the area.

In mid February the team returns to work in the hospital, by which time most of the population has also returned. However, there is a decline in hospital activity as insecurity limits people's ability to travel. The team continues to receive phone calls from health centres needing to transfer patients to the hospital, but the MSF ambulance is unable to access many of these villages. Previously, the ambulance transferred an average of 50 patients a week to the Rutshuru general hospital. In February, though the fighting has stopped, sporadic violence against the population continues in certain areas, forcing the population to flee again.

Since the beginning of MSF's intervention in 2005, an average of 100 surgical operations have been carried out every month in the hospital, of which 89% are emergency surgical interventions. 26% of interventions are due to violence related trauma.

"HUMANITARIAN ACTION PLANS" AND MEETINGS IN GOMA...

A "Humanitarian Action Plan" for the DRC is launched in Brussels on the 13th of February by the UN and the European Commission, asking for 681 million USD for the year 2006. The action plan contains a package of objectives aiming to solve the main social and health related problems for 30 million people in Congo, representing half of the country's population. 330 projects are presented in the action plan; half of them are by NGOs. So far various countries have promised 156 million USD. Meanwhile in Goma, 60 organisations, (national NGOs, international NGOs and UN agencies) get together for the weekly humanitarian coordination meeting. There is a big discrepancy between the number of organizations present and those carrying out emergency relief operations. There is little mobilization for the newly displaced in Rutshuru. There are few donors who are ready to finance emergency projects, as the international community shifts its attention to the normalization of the situation in the DRC and to the financing of development programs.

VIOLENCE IN KIBIRIDZI : TRAPPED IN THE BUSH

In one week the town of Kibiridzi changes hands four times between the warring groups. Houses are burnt, people are tortured, beaten up, and gang raped. The health centre is burnt and pharmacies are looted. The population starts to flee, but for two weeks many people are unable to reach Kanyabayonga. People who remain trapped in the bush use mobile phones to contact the MSF team in Kayna for help; they are desperate to find a way to reach Kanyabayonga. Finally, a total of 60,000 people flee Kibiridzi and other villages in the area, to find refuge in Kanyabayonga, Kayna and Kirumba.

In mid February, an MSF team goes to Kibiridzi. About 4000 people are in the town; many of them are displaced families from nearby villages

Before the fighting, 30% of admissions to the MSF Therapeutic Feeding Centre in Kayna came from Kibiridzi. (An average of 15 severely malnourished children were transferred every week from Kibiridzi.)

MISSION

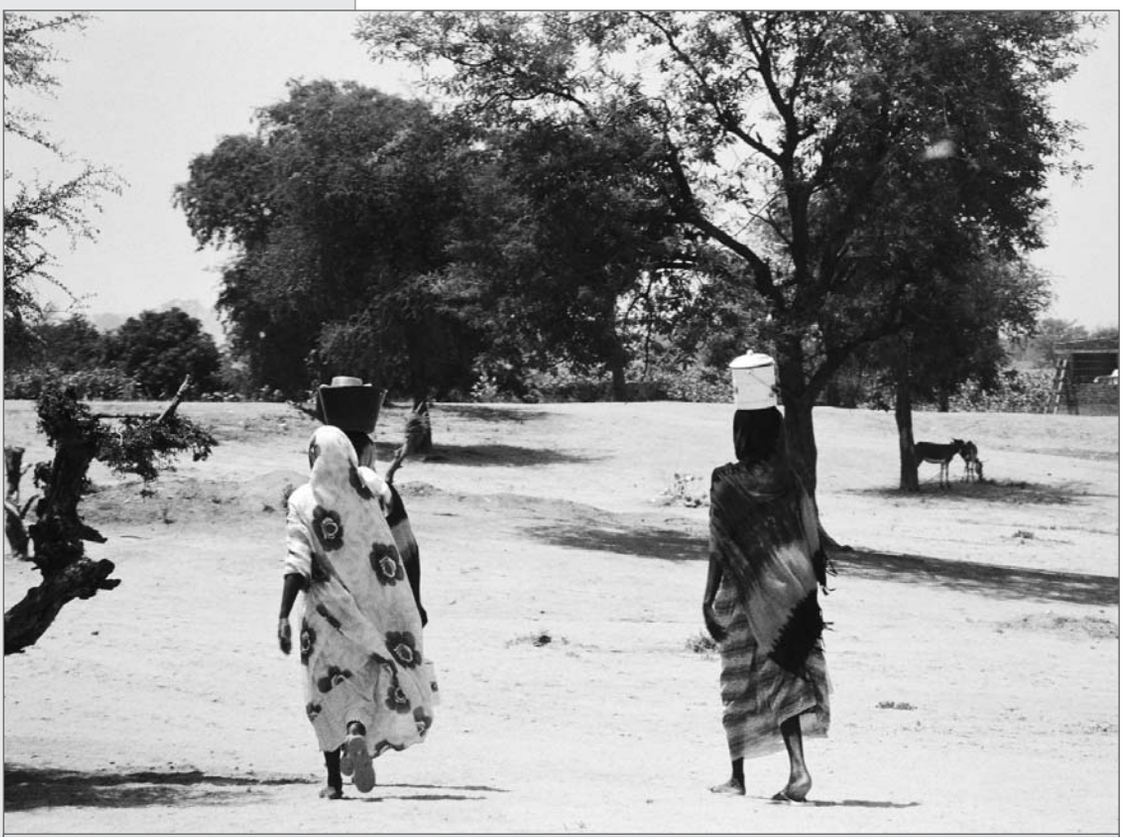
SUDAN

SUDAN / DARFUR

Trapped in Precarity

MSF / February 2006

In Western Darfur, the violent confrontations of 2004 have given way to a situation of chronic instability characterized by persistent violence affecting all those living in the province. For MSF, the challenge is to continue to provide medical assistance to people with on-going major needs, to remain responsive in the event of new emergencies and, despite the insecurity, to provide high-quality assistance. Dr. Pauline Horrill, MSF's program manager for Sudan, and Fabrice Weissman, head of our Darfur mission, offer an update.



→ **Chad** © Corine Villette / MSF - October 2005

→ How would you characterize the current situation in Western Darfur?

Fabrice Weissman : Since 2005, Darfur has no longer been the scene of major confrontations and massive violence that threw the province into a state of unrest in 2003 and 2004. As a result of those confrontations, hundreds of thousands of people were driven onto the roads from their looted and burned villages, having lost all their possessions and their crops. In some places, they were fleeing killings that left one person in 20 dead[1]. Since last year, the situation is now more aptly described as one of chronic instability.

Pauline Horrill : However, certain areas of Western Darfur province, where we are working, are experiencing periodic resurgence of violence. These events are linked to the current situation near the border with Chad (see the article), to recurrent fighting among the militias, the government army and rebel groups, and to tensions among nomad clans that have degenerated into bloody confrontations. This chronic instability, punctuated by violent episodes, has direct impacts on the population and has led us to redefine and step up our activities.

→ What are the displaced persons' living conditions?

FW : Almost all of them -totaling some 2 million, or one in three Darfur residents - continue to live at the sites where they sought refuge nearly two years ago. In these towns controlled by government forces -- like garrison outposts - the living conditions, although improved, remain prison-like. The people living in these open-air jails still cannot - and do not want to -- return home because of the continuing insecurity outside these sites. Few of the displaced persons venture outside the camps to find firewood, forage or thatch for their personal needs or to sell to earn some income and improve their situation. Some slightly better-off individuals have managed to buy plots of land on the outskirts, but working on them is still dangerous because of the violence experienced by people who venture outside the camps. The displaced persons continue to be crammed inside makeshift shelters, and this overcrowding is unhealthy. Finally, violence continues even within the camps. This is characteristic of every displaced persons' camp, where traditional structures have been shaken by flight and violence - including intra-family violence and prostitution undertaken for reasons of survival. Epidemiological indicators suggest that the health and nutritional situation is stable, but it remains fragile.

PH : I last visited in December 2005 and, before that, in February 2005. I was struck by the fact that nothing had changed in 10 months even if, at first glance, everyday life seemed to have resumed. In Mornay, for example, children attend school and goods are traded in the market at the center of the camp. However, this activity masks considerable fragility, as revealed by our medical work, which continues at a high level. In Mornay, with its 5,000 inhabitants and still home to 74,000 displaced persons, nearly 5,900 patient visits are conducted every month and the

major illnesses - respiratory infections, diarrhea, and a variety of physical ailments - are obvious signs of that fragility. We saw another sign of this instability in July, when the general food distribution had to be postponed after disturbances related to the displaced persons' registration process and the number of children suffering from "moderate" malnutrition then shot up. Simply reducing or delaying the supplies to a camp can almost immediately worsen families' nutritional status. But most importantly, there is a continued suffering that affects all the displaced persons in the camps: the lack of hope that their situation will change.

→ Is the Assistance Provided Adequate and Appropriate?

FW : We continue to provide significant medical assistance, but living conditions remain unacceptable. And because we have reached the limit of our operational capacity, we cannot ensure that certain treatments are adequate; for example, care for women who are victims of sexual violence. As in other similar situations, women do not seek treatment easily because they are afraid of being ostracized or subjected to police repression. In addition, this issue is highly politicized - the authorities want to make the case that this form of violence does not exist or exists only marginally, while other organizations tend to exaggerate it, hoping to provoke the international community to take stronger action in Darfur.

Similarly, we have not set up mental health programs, although from what we hear from our Sudanese employees and patients, people are deeply traumatized by what happened to them in 2004.

PH : In the end, keeping the population of the camps alive represents a real challenge - in human as well as financial terms. We are still talking about tens, even hundreds, of thousands of people who need water, medical care and food. Humanitarian aid organizations have a significant presence in Darfur with 1,200 international volunteers. But what is more critical is the quality of the assistance and the ability to respond to emergencies that may arise, whether related to resurgence of violence or to epidemics, as the Darfur region is at great risk for epidemics of yellow fever, meningitis and malaria.

→ What are living conditions like outside the camps?

FW : In the rebel-controlled areas - essentially in the Jebel Marra, the mountainous region in the center of Darfur - living conditions are markedly better than those in the displaced persons' camps. However, they are still difficult because the army and the militias surround these regions, thus limiting people's opportunities to find food and seek medical care. The few health care facilities that existed in this region no longer operate. The only way for the population to receive health care is to travel to towns held by government forces, but at the risk - particularly for men, who are systematically suspected of being rebel fighters -- of arrest, although it is the who must endure living side-by-side with the rebels. Traveling also means crossing through areas of confrontation. In Niertiti, for example, at the foot of the Jebel Marra, where we work, people travel only on market days. That is why last July, we launched a mobile clinic, once and then twice weekly, for residents of Kutrum in the rebel zone, where 25,000 people still live. The long-term goal is to have an ongoing presence so that we can provide high-quality care and improved referrals for those patients who require hospitalization.

→ Are the nomadic populations affected?

FW : While the nomadic populations are less affected, they are not spared because rebel activities interfere with traditional migration routes. Confrontations among clans, which have continued over decades, are more frequent - and bloodier --today as a result of the high level of arms in the region. In mid-December in Zalingei, following clashes between two nomadic tribes, our teams treated 52 seriously-wounded people in the hospital over three days. This fighting also resulted in the displacement of 3,600 people to Alamedia, one of the two displaced persons' camps near Zalingei. But these nomadic populations could not move into the camp because the other displaced persons believed them to be close to the Janjaweed militias. Their access to the range of services, and specifically to medical care, was thus limited.

→ What is the outlook for our programs in Western Darfur?

PH : We have four programs in Western Darfur, covering some 300,000 people (displaced persons and others). Our team is made up of 27 international volunteers and more than 580 Sudanese. Our projected budget for 2006 is 3.8 million euros ($4.5 million), or nearly 20% more than 2005, which reflects new activities (mobile clinics and additional activity in the Zalingei and El Geneina hospitals).

Our enhanced presence in the Zalingei hospital is a good example of the problems we face today. Built to meet the needs of a population of 30,000, it must now serve 90,000 people, following the influx of displaced persons. The hospital could not respond to the flow of wounded people in December and as a result, we became involved.

Although we have already made a significant commitment of human and financial resources to Darfur, we must also be prepared to react in the event of additional emergencies. ■

Interview by
Caroline Livio

AN OVERVIEW OF OUR ACTIVITIES IN DARFUR

The French section of MSF has been working in Western Darfur since December 2003. Our team in the field currently includes 27 international volunteers and 583 Sudanese. We have projects (primarily medical and surgical) at four sites -- El Geneina, Mornay, Zalingei and Niertiti - in displaced persons' camps and with other affected population groups in the region.

- El Geneina

We provide support for the operating room and post-operative care at the Health Ministry hospital.
From November 05 to January 06, we treated 288 wounded patients, including 150 in November.

- Mornay Displaced Persons' Camp

The Mornay population includes 5,000 residents and 74,000 displaced persons.
The clinic and hospital that we established treats an average of 5,900 people/month
and houses 195 hospitalized patients.
In 2005, our therapeutic feeding center treated 264 children suffering from severe malnutrition.

- Zalingei Displaced Persons' Camp

The Zalingei population includes 30,000 residents and 60,000 displaced persons.
We are responsible for pediatric hospitalizations at the Health Ministry hospital (with an average of 182 children admitted/month), as well as the operating room and post-operative care (which received an influx of 52 wounded patients over several days in December).
In 2005, our therapeutic feeding center treated 952 children suffering from severe malnutrition.

- Niertiti Displaced Persons' Camp

The clinic and hospital that we established treat an average of 3,200 people/month and can accept 100 hospitalized patients.

- Mobile Clinic in the Niertiti Area

To provide medical care to at-risk individuals living outside the camps and in areas with limited access to care, we launched a mobile clinic in June 2005 that travels from Niertiti.
In Kutrum, in the rebel zone, we conducted 4,622 patient visits since July 2005 (an average of 770/month).
In Thur, in the government-held region, we conducted 4,700 visits since June 2005 (an average of 670/month).
Finally, since November 2005, we have targeted nomadic populations at a dozen sites (593 patient visits conducted as of this date).

1- Violence and Mortality in West Darfur, Sudan (2003-2004) - epidemiological evidence from four surveys. Epicentre and Médecins Sans Frontières. Report published in *The Lancet* in October 2004.

MISSION

PAKISTAN

PRESS REVIEW

MSF / February 2006 / O.F.

→ Hope beyond reason

The Journal of AIDS devotes a long report to generic medicines. "Medicines developed from 2005 on will have patent protection for at least 20 years. This means that it will be very difficult to get access to second- and third-line treatments," says Annick Hamel with alarm in the magazine's interview. Still, she points out two ways to get out of the impasse. "The first consists in getting the WTO to reexamine its code by proving that the mechanisms which it set up are not working." The second plays on national programs financed by the Global Fund: what alternative will they choose when it gets to the point of a response to the failure of first-line medicines? Abandoned patients and budgets increased ten-fold, or easier exportation and the manufacture of generics? The 2001 WTO conference in Doha emphasized that "the interests of public health take precedence over intellectual property rights," as the magazine reminds us.

→ **Pakistan** © Guy Smallman - December 2005

PAKISTAN / MANSEHRA

The long-term challenge of rehabilitation

MSF / january 2006

Courtland Lewis, MD, an orthopedic surgeon from the University of Connecticut, spent three weeks in Mansehra, Pakistan, where he worked in the Doctors Without Borders/Médecins Sans Frontières (MSF) field hospital. The field hospital, composed of nine inflatable tents, serves as the main orthopedic referral center for the wounded in Mansehra district in Pakistan's North-West Frontier Province. The hospital, which also houses four operating rooms, an intensive care unit, and an emergency room, has carried out more than 500 surgical interventions since opening on November 24 . There are also 5 hospital wards with a capacity of 90 beds. A total of 750 patients are currently receiving physiotherapy treatment in the hospital and in three "medical villages" inside Mansehra town for patients who no longer require hospitalization and who cannot go back home, but still require medical follow up. Dr. Lewis talks about his experience working in the MSF field hospital.

I left for Pakistan on December 8, 2005, joined by Sulahuddin, MD, an anesthesiologist from Las Vegas. It took three days to get to Mansehra where we found the MSF team taking its first day off in six weeks. Although frustrating, given our enthusiasm to get to work, the day became an opportunity to put the whole trip into perspective as five members of the team traveled to Balakot, one of the hardest-hit towns. It created an unforgettable impression.

We drove into the mountains north of Mansehra, where occasional small tent villages caught our attention. Traveling over the pass and into the river valley, we first saw cracks in buildings, then collapsed walls and houses; large tent complexes replaced whole villages. As we drove into Balakot, we were shocked by the complete devastation of the town.

As one of the colorful Pakistani trucks passed us, my colleague Sulahuddin (who speaks Urdu), turned to me and said, "That truck had a saying on it: 'The world is made of glass; people are made of stone.'"

Upon entering Balakot, there was a tremendous cloud of dust generated largely by workers breaking the concrete with sledgehammers to retrieve the steel rebar reinforcement rods. It was almost surreal to simultaneously see people dealing with the devastation while getting on with their lives . . . selling fruit by the roadside, giving a haircut in a barber's chair perched in the ruins, loading their trucks. Their resilience was remarkable, doing what they needed to survive and rebuild their lives. Truly, I had the sense that the

world is made of glass and people *are* made of stone.

→ BEGINNING TO WORK

I started working in the hospital the next day. From an orthopedic perspective, this was phase two of the emergency-phase one being the initial triage and treatment of thousands of injuries. By two months out from the earthquake, a certain percentage of these fractures had become infected or were not healing properly and virtually all injured patients required rehabilitation-just as one would expect from high-energy trauma injuries in New York or Paris.

There were 88 beds in the field hospital. On any given day, between 55 and 75 beds were filled with orthopedic patients (and their designated family member), most of whom were earthquake victims.

The orthopedic operating rooms were where the action was. I operated with the MSF team, which included international and Pakistani staff, for 6 or 7 hours a day, performing between 8 and 18 procedures; these included cleaning up infected wounds, taking cultures, doing skin grafts, and occasionally, performing amputations.

MENTAL HEALTH

An MSF team of three psychologists working in Mansehra district provides care for patients suffering from trauma following the earthquake. Four hundred patients have been followed up since October. Currently 200 patients in the hospital and medical villages receive psychological care, but the needs far outstrip the organization's capacity

We created long-term treatment plans for 25 to 30 patients who had really complex problems and needed some continuity in their care. It will take six months to a year or more, in some of these instances, for the patients to heal their fractures.

In the afternoon, I spent an hour or two examining patients the assessment team had brought back to the hospital from outlying areas: these were patients who could have casts removed, needed further surgery or most often, required immediate physical therapy to regain function. It would then take three or four hours to round in the hospital with Cathy Pappin, the MSF hospital nurse, and her translator, Waqar; the quality of care they provided and their dedication to their patients were truly inspiring.

→ OVERWHELMING THE HEALTH SYSTEM

The sheer number of people injured was amazing. You could have half a dozen orthopedic surgeons working their entire careers in the Mansehra district hospital to care for the long-term problems related to earthquake injuries-fractures that didn't heal right, arthritis because of fractures into joints, contractures of the affected joints. The level of resources available in Mansehra, provided by the Ministry of Health, will just not be adequate to do that. But to be honest, if that many thousands of people were all hurt at the same time in the United States, it would overwhelm us too. The long-term needs are difficult to fathom, just as those for immediate shelter and health care seem right now.

The patients with the most acute orthopedic needs today are those who require physical therapy. By six, eight, or ten weeks after major orthopedic injury, most bones are healed but the joints on either side of the bones and the muscles going across the joints need rehabilitation; physical therapists and trained therapy aides are available in very limited numbers and one can see they will be overwhelmed in the next several, all important months.

→ HIGH NUMBERS OF RARE INJURIES

There were very interesting patterns of injuries. For example, if you're driving in a car and somebody hits you from the side, it compresses your pelvis, creating a characteristic injury called a lateral compression fracture. One might see one or two of those a year in most American orthopedic practices. I probably saw 25 or 30 during my short stay in Mansehra. These were people who were lying down, taking a rest, when the ceiling or wall fell on them and crushed their pelvises. Elbow injuries in young children were typical, potentially affecting their growth plates and causing permanent damage. There were many, many open fractures of the long bones which, not too long ago, would have been limb or even life-threatening injuries even in the US and Europe due to serious infection.

What struck me early on was that every person I saw was in the same stage of orthopedic recovery since all their injuries happened within a few seconds of each other. You didn't have to take a medical history-everybody got hurt in the morning of October 8.

→ PSYCHOLOGICAL WOUNDS AND PHYSICAL PAIN

The biggest problem for many of the injured people-and this is true anywhere and at anytime with orthopedic conditions-was the manifestation of psychological stress as physical pain. Anxiety and depression only make an orthopedic problem worse. I see this every day in my practice at home. It is difficult to imagine the stress level for a person who is trying to recover from a serious injury while at the same time, cope with the fact that half the people in their town died instantly, a number of them likely family members.

Many of the patients presenting with stiff joints-shoulders, elbows, wrists, knees, and ankles-really needed psychological support to help them realize that they could use their limbs again. And they needed aggressive physical therapy to address the musculoskeletal limitations. Both counseling and physical therapy will be required for many to regain the functional use of their limbs.

Beyond the tent hospital, beyond the amazing efforts by expatriates and Pakistani health teams working together, beyond the logistical support for shelter, food, and healthcare is the long-term challenge of making rehabilitation available to vast numbers of people who sustained physical and psychological injuries in the earthquake. ■

Interview by Jason Cone

PRESS REVIEW (CONT.)

→ Denial of crisis in the DRC?

In its February 18 issue, Liberation points out that since the Katanga region abounds in copper and cobalt, "Talk of war here means economic suicide for the regime. The big mining majors, headed by the Americans, have returned to set up contracts with state-run companies...As for the government's position, [...]MONUC has been asked to stay out of things," states the reporter. The daily *La Croix* refers to the flare-up of violence in North Kivu [55,000 people have been forced to flee the fighting] in order to point out that with upcoming elections set to take place by June 30, the European Union could propose that "a force be placed in wait, perhaps pre-positioned in the region." "It would be a way to anticipate a possible crisis," writes the reporter, quoting a source close to Javier Solana, High Representative [EU] for the Common Foreign and Security Policy.

COTE D'IVOIRE / GUIGLO

The conditions of non-departure

MSF / February 2006

In Guiglo, five young people were killed and about thirty were injured in a confrontation between hundreds of young demonstrators and United Nations peacekeepers. All UN agency and NGO personnel evacuated the town on the morning of January 18. The offices of humanitarian organizations were ransacked and burned or destroyed, along with 35 vehicles. The WFP[1]-Unicef depot was completely ransacked. The MSF team stayed in Guiglo and activities are continuing. Margaret Wideau was field coordinator in Guiglo, Cote d'Ivoire, during the demonstrations on January 17 and 18. Her account follows.

"There were three of us expatriates: Jana, a doctor, David, a logistics officer, and myself, none of us being French. At the beginning of the morning, as the convoy departed, we all agreed not to evacuate with the others. It wasn't at all clear that leaving would be safer than staying put! The anger of the demonstrators was very targeted, directed against the UN, so there was more danger in meeting up with them than in staying in the town... It was also very sudden. I was stunned, all the elements were there, but until then, it had always been calm, without any problems. We would travel around alone in this town of about ten thousand inhabitants, we were never singled out. And we thought we could be useful, we sent medications to the hospital and we received two injured people at the clinic.

We did not leave, we kept abreast of what was happening in the demonstrations in the town. Ransacking, vandalism, sometimes burning of the vehicles, offices and houses of OCHA[2], the IOM[3], Unicef, HCR[4], Caritas and the WFP. The demonstrators were not violent, even though they were destroying everything.

CONTEXT

Cote d'Ivoire has been cut virtually in two for three years, the South being under governmental control and the North under the control of rebel forces. In mid-January, the IWG, the international body charged with monitoring the peace process, took note of the expiration of the mandate of the national assembly (since December). After this, the Young Patriots (a political movement close to president Laurent Gbagbo) denounced the interference of the international community and labeled as occupying forces the 7000 UN peacekeepers and 4000 French soldiers deployed in the country. Several thousand people took part in sometimes-violent demonstrations - lasting several days - in Abidjan and in several other towns and cities in the south. The main targets were the UN installations.

→ **Cote d'Ivoire** © Peter Casaer / MSF - May 2003

PRESS REVIEW (CONT.)

→ Violence, ongoing ills...

Using the occasion of the elections in Haiti and the victory of candidate René Préval, ex-president and ex-prime minister of Aristide, the newspapers are talking again about a country in the grip of multi-faceted violence, although the press concentrates on the attacks of armed gangs, called "local authorities, in diplomatic language", states *La Croix*.

The special envoy from the daily paper handed us the official statement of the Aristide supporters, for whom "the violence is above all an expression of the social poverty."

The envoy also gave us an opposing explanation, which sees in the violence a political-based dimension, like the one that "handed out weapons in the slums during his [Aristide's] presidency, to transform men into shock troops, playing on the populist sentiment of an angry population."

A large group of very young men - thirteen, fourteen years old - came to our feeding center in the morning. We were alerted by a radio call from a panicked nutrition assistant. They broke the fence, the water pipelines, stole a bit. A second group of young people, slightly older, met up with them. They saw that it was a hospital and they all left. The mothers had been hiding in one room, they came out and some of them were afraid and chose to leave. But they came back the next day.

We locked ourselves in the house. Two drivers, Robert and Ouattara, the guard, Bony and a nurse's aide, Salifou, chose to stay outside. The noise was alarming, there was screaming. About two hundred demonstrators were at the gate, about thirty of them had already climbed it. Robert spoke to them, he explained who we were, what we were doing in Guiglo. In our clinic, we treat patients from the two displaced-persons camps (about 6000 people in all) but also people from Guiglo who cannot pay for treatment at the hospital. The local population represents about 40% of our patients. And the malnourished children treated in the feeding center come from all the surrounding areas. In the crowd, people were heard saying "it's true, if something happens to us, it's MSF who will take care of us." I couldn't see anything. To me, it felt like hours, but I imagine that it was only a few minutes. They left. All in all: a big scare and a little coffee stolen from the guard's cabin station!

The police commissioner came to see us, then soldiers from the Ivorian forces to offer to take us with them. They had been alerted by a member of our team. We hesitated. A bit later, a small group came back to threaten the guard: they said they would return that night, in a bigger group.

→ © Margaret Wideau / MSF

For the first time, I saw that Robert, our driver, was concerned. We decided to leave. We were preparing to evacuate when the chief of the militia appeared. While Hiam, the head of mission in Abidjan, and I had tried in vain to reach him all day, another member of our team had alerted him. It was not our first meeting, Hiam and I had gone to see him several weeks earlier. He said he guaranteed we would be safe, several radio appeals went out to say don't touch MSF and he sent six armed guards to the front of our building! We then had to explain that no weapons could be accepted on MSF grounds... In the end they stayed outside, in front of the house.

We had to face the same problem the next day: everyone wanted to protect us, with an armed escort, the chief of the militia and the soldiers from FANCI[5]. It was a delicate situation but we were able to cope on our own. The teams were at full strength, about fifty people, everyone wanted to keep working. In the end, the feeding center operated without interruption and the clinic was closed for only one day.

After these events, the situation is still precarious. About 13,000 people largely dependent on humanitarian aid find themselves with limited assistance, and MSF is not in a position to do everything[6]. ■

By Anne Yzebe

OUR ACTIVITIES

We are active on both sides of the line which cuts Cote d'Ivoire in two. MSF still has two projects:

- A medical-surgical program was launched in October 2002 in the Bouake hospital, in the rebel zone. This is the only referral hospital for the city (about 400,000 inhabitants) and the surrounding areas. A majority of the Ivorian employees have not returned to their positions. MSF is still running the general medicine, pediatrics, surgery and maternity wards . In 2005, we had an average of 4700 consultations/month and 900 hospitalizations/month.

- We have been present in the Guiglo region since May 2003. Populations driven from their land in 2002 (mostly of Burkinan origin) are still grouped in Guiglo and the surrounding areas. The two Nicla camps each house 3000 people. We offer primary care to the displaced persons and we treat severely malnourished children in a therapeutic feeding center. In 2005, we had an average of 3200 consultations per month (52% for malaria). The feeding center had an average of 52 admissions per month.

The Maca (Abidjan detention center) project closed at the end of 2005.

1- World Food Program

2- Office for the Coordination of Humanitarian Affairs

3- International Organization for Migration

4- United Nations High Commissioner for Refugees

5- National Armed Forces of Cote d'Ivoire

6- One month after its departure, the WFP shipped 288 tons of food supplies covering the nutritional needs of some 13,000 displaced persons and refugees in Guiglo. The United Nations agencies are studying the possibilities of returning to the region.

PRESS REVIEW (CONT.)

→ Discontent over patents for Nut'?

In its February issue, the monthly Sciences et Avenir looks at the fight against malnutrition by considering the various therapeutic food products currently available. Here the reader learns that Plumpy'nut [manufactured by Nutriset, a French company] has a quasi-monopoly, despite the existence of BP100 [developed by Contact, a Norwegian company] and of another food supplement developed in Senegal called spiruline, an aquatic micro-organism which has not yet "proven to be effective." "Compact is reportedly ready to market a mix similar to Plumpy'nut this year, but it fears legal repercussions from Nutriset, whose product has patent protection. Will the French company be able to guarantee indefinitely the protection of its product, which seems to have become the centerpiece of the fight against malnutrition throughout the world?" asks the reporter.

DEBATES

HAÏTI / PORT-AU-PRINCE

To be or not to be in Cité Soleil?

MSF / March 2006

Contrary to the French section, MSF Belgium decided to initiate a programme in the Cite Soleil neighbourhood of Port-au-Prince where violence rages. The MSF Belgium operations' coordinator in Rome, Kostas Moschochoritis, explains the reasons behind this choice whilst Marie-Noëlle Rodrigue, Programme Manager in New York for the French section, explains her disagreement.

KOSTAS MOSCHOCHORITIS : ICRC and MSF France were cautious about our intention to have a permanent presence in Cité Soleil. Our analysis was different and since we began our operations ICRC has changed its analysis and reinforced its activities in the slum. In July 2005 when our team managed to visit Cité Soleil we saw an enclave where people live surrounded by MINUSTAH tanks, prey to the violence of local armed groups. There were no functioning health facilities, and even if there were, the population could not afford to pay the fees. In addition the population was faced with a warlike situation due to fighting between local armed groups and MINUSTAH, who were not, in our view, taking enough precautions to prevent civilian victims.

Working in remote-control mode, like MSF-France was doing in a safe zone hospital outside Cité Soleil was not the best solution for us. It was reinforcing the enclave-nature of Cité Soleil by sending a message that it was impossible to work with this abandoned population. By operating in a remote-control mode it was not possible to cover all the population's needs as not everybody was able to leave Cité Soleil. Lastly by being present in Cité Soleil gave us a stronger position to witness violence carried out by local armed groups and, most important, by MINUSTAH.

We held discussions with all actors involved before entering Cité Soleil; we continue to be in daily contact with them in order to ensure appropriate understanding of the context, maintain our humanitarian space and guarantee the security of staff and patients. For example, it happened that kidnap victims were brought to the hospital by the kidnappers, for treatment. That was a major problem for us, but, in conjunction with the Haitian staff, we obtained the release of the victims. In Choscal Hospital, regardless of the fact that it is a public hospital we have imposed appropriate rules that, in general terms, are respected. Some incidents are impossible to avoid but so far they have not affected our credibility or, more importantly, our patients. Even if it was a purely MSF hospital we would have faced the same problems due to its location. The essence of our intervention is to assist those who are completely excluded from health care as closely as possible to where they are. The media coverage that our intervention achieved both in the local and the international media also helped our image. We never denied that by operating in Cité Soleil we were taking a risk, a risk that falls mainly on the shoulders of our team. Zero-risk operations do not exist in a situation like Port-au-Prince; however we do believe that these are risks worth taking.

Until now, events have proved that our analysis is valid. We have been able to work consistently, we have been able to save lives, we have directly witnessed how it was to live in Cité Soleil during the conflict period. Today, Cité Soleil is calm, but we know very well that the situation can change quickly.

Interview by Alessandra Oglino

MARIE-NOËLLE RODRIGUE : In my opinion, a permanent and exclusive presence in Sainte-Catherine Hospital (nicknamed Choscal) in this neighbourhood of Port-au-Prince poses several problems. Setting up a project in a fixed structure right at the heart of a violent zone means unnecessary exposure to danger for both our patients and teams. We saw it for ourselves when bullets passed through one of the wards and the head of mission's room. No one was hurt on that occasion. But if anything happens in the future, all the MSF projects in Port-au-Prince - in Cité Soleil and elsewhere - will be jeopardised.

I also know from experience that we cannot offer quality surgical care on the front line, we can stabilise patients. We cannot start long and technical interventions, for example, when there is a risk that they will be interrupted by gun shots.

We should not deceive ourselves on the impact of a permanent presence in Cité Soleil on the 300 000 inhabitants of the neighbourhood. View the context, I have strong doubts that people from all over Cité Soleil have free access to the hospital. The activity data in Choscal (12 000 consultations in 6 months) confirms that MSF Belgium does not cover the entire population of this slum. We are fooling ourselves when we think that Choscal hospital escapes all control. The issues and alliances at hand are beyond us, and we risk not being aware of them at all. The clashes between armed groups on one hand and the Minustah and the PNH (Haiti National Police) on the other must not obscure the bitter battles raging within the different zones of the city. We are also fooling ourselves if we think that all the victims can access the hospital.

Intervening in urban contexts is very complex, especially in a town as explosive as Port-au-Prince. MSF is used to negotiating its working/humanitarian space with different actors. However, things become much more complex when are actions are limited to one town. Here, the geographic concentration of the different participants in the conflict complicates the perception of our work. It becomes extremely difficult to convince people of our independence when we fix ourselves in one place.

In my opinion, these risks are ill-advised because other options exist. We have opened a trauma centre in Saint-Joseph hospital in the Turgeau area next to Cité Soleil. It is accessible and close to the zones most affected by the violence. As it central, victims of violence from all over the city can access it. The Haitian Red Cross refers patients here when security conditions allow, with the hospital receiving patients from all over the city, including Cité Soleil - even since the MSF B project in Choscal opened. We can practise specialised, quality surgery (orthopaedic, abdominal etc) in calm conditions in our structure.

And even if we could and should improve our response to outbreaks of violence, we have a responsibility to avoid exposing our patients and teams to danger. I do not consider our teams as military personnel, mercenaries or missionaries.

Interview by Rémi Vallet

ANNUAL PLAN 2006

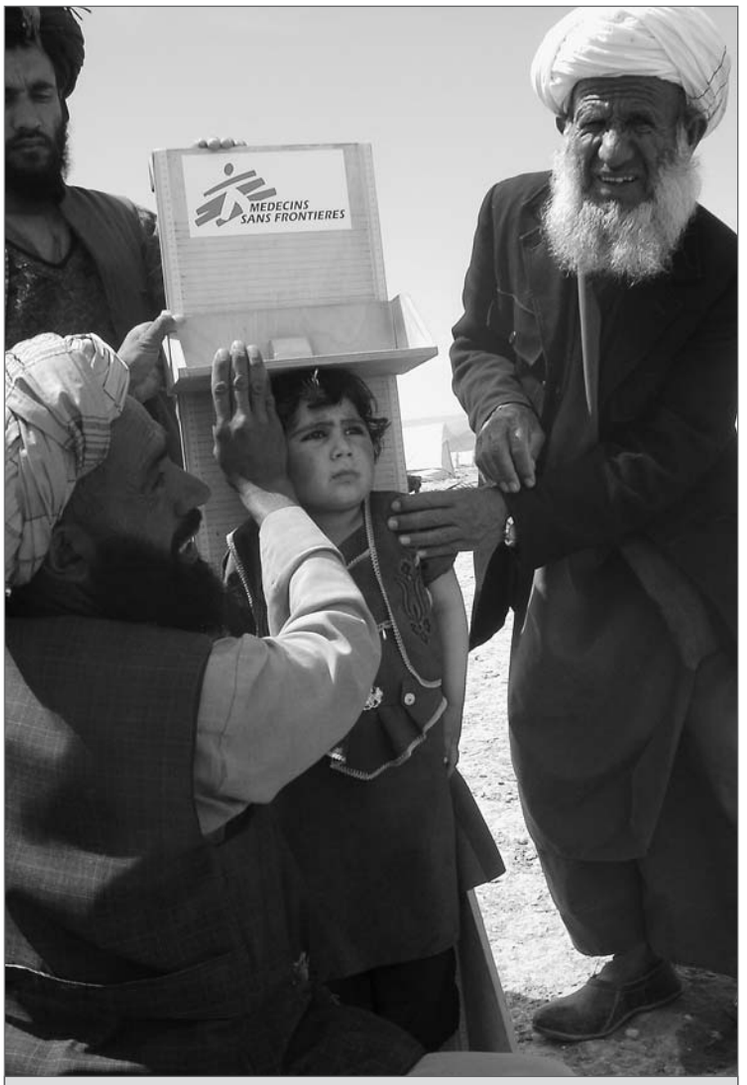
Controlling growth

MSF / March 2006

Médecins Sans Frontières' budget has doubled over the last five years. Operations and the average cost of projects have increased by 60%. Human Resources represent 40% of our missions' budget. There is therefore a pressing need to organise this tendency. But growth cannot be calculated by considering just the number of projects or the costs: quality and its implications, the volume of human resources and also the standards we apply in emergencies must also be included. Nonetheless, quality must not become a pretext to deploy ever-increasing means in the field. This, in short, is the conclusion of the annual plan for 2006 that was presented to the Board of Directors by Pierre Salignon, General Director of MSF. Interview:

→ Is the fact that MSF has more financial means a problem?

Not if those resources are used in a relevant way. And that is precisely what is at stake here. Two figures come to mind: 50 million in 1998 and 120 million in 2006. Our budget has more than doubled in eight years! Most of it is used on our field missions. Having more money gives us greater freedom, and we cannot complain about that! This luxury allows us to produce some good results. But when one has more money, it becomes more difficult to fix limits. Headquarters and the field must avoid the sentiment of being all-powerful, looking to do everything. We risk continual enlargement of our field of responsibilities, deploying multiple "services" without identifying the humanitarian issue they address, forgetting the world around us (MSF is not the only actor on the crisis sites), dispersing our resources to such an extent that we no longer control where and how they are being deployed. It is essential that we continue questioning the relevance of our operations, increase the efficacy of our action, and make better use of the means available, by checking expenditure for example.



→ **Afghanistan** © Mattias Ohlson / MSF - April 2002

→ Is MSF distancing itself from it social objective?

The association's social mission has not stopped developing since its creation. It is essential to always *reflect* on the humanitarian nature of our action, without which we will become a commonplace service provider responding to needs. We must therefore examine the nature of our activities on a case-by-case basis. And that is where the sticking point is. It is not by chance that we decided to create a centre to reflect on humanitarian issues, the « CRASH ». It is a complicated exercise. The sphere of our responsibilities is a subject of constant debate. In Niger, should we prevent malnourishment through general food distributions in certain areas, before we reach the peak number of patients in our feeding centres? I do not know how to reply to that question straightaway. I have to reflect and envisage all the implications of an operational choice of that nature. It is not a question of declaring what MSF is and what it is not either. The attitudes we adopt sometimes can be dangerous. They prevent us from innovating, taking risks, and they kill the operational creativity that benefits populations in danger. That is why the operational policy must be fed by discussion, such as the discussion we will have soon on our operations in Calais and more generally in France. Thus for example, the situation of the migrants in Calais is shocking in human terms. But does that make it a clear humanitarian problem to which we must respond? Personally I have my doubts. But though there was some disagreement expressed, operations have nonetheless been started in Calais. It is therefore not a question of postponing decisions, nor of impeding their implementation once the directors of operations have arbitrated. And though I am glad that the operational projects have been redefined during the last few years, there is also room for innovation. Once again, today it is not the size of the means used that causes problems, but the pertinence of our operational choices. It is also our ability to keep the association informed of these choices and guarantee the monitoring and management of the means mobilised.

→ Can you give us some examples, among the operations in 2005, of this « temptation to do everything »?

I can use the example of Pakistan, where winter was approaching. We distributed tents to the victims, then there was the problem of whether to provide fuel for heating. It was a good question, and my reaction was not to say no but to ask: Are we the only ones able to do that? We are not alone in Pakistan, we are rarely alone, there are other organisations. Perhaps they are not as reactive, perhaps they do not have the same quality standards, but we cannot do everything.» Moreover, that is what happened. We started supplying fuel then others took over. And that is just one example, because the problem arises more or less on all our programmes. We wish to be more demanding concerning medical standards, we feel humanitarian standards are not sufficient. We are seeking to improve the quality of care for our patients and

PRESS REVIEW (CONT.)

→ Along with grand causes... grand intentions

Finding papers on tuberculosis is a bit like finding effective treatments in a pile of care practices.
In its January 19, 2006, edition, the daily Liberation devoted an article to this, to emphasize the involvement of public and private donors in the effort to save 14 million lives between now and 2015. While "tuberculosis is a pandemic that should be part of the past," the article points out specifically that no new medicine has seen the light of day for 40 years. This highlights the goals of the plan: "to supply anti-retroviral treatment to three million persons presenting a co-infection [...], to introduce a new anti-tuberculosis medicine by 2010 [...], to shorten the length of treatment to one or two months by 2015, and to better screen for the disease."
The cost? 56 billion, states the reporter, who concludes that it involves "triple the amounts projected in the previous plan", but more than double the amounts on which we can now rely...

provide, as far as possible, comprehensive case management (e.g. by treating AIDS and tuberculosis, as well as nutrition in the same programme). But we will not be able to extend our activities *ad infinitum*. Moreover, the relative weakness of the other assistance actors and their inability to take over some of our activities because of standards that are too high must make us reflect. We should no doubt think more about the consequences in the longer term of this isolation, which might well go against us sooner or later. Each time we must consider several criteria: what is our « added value », who are the other assistance actors, and what are the financial implications?

→ Several projects in favour of persons « victims of social violence or exclusion » have been closed in 2005. Does this type of project go beyond the framework of our social objective?

I have no standpoint on the issue. Most of the programmes that were closed in 2005 were coming to an end. Though in the future, projects with a social element must not mobilise the majority of our resources, they are nonetheless part of our operations. Everything depends on the project. There have been some relatively successful experiences, such as in Madagascar with the *street children*.

Each time we must consider several criteria: what is our « added value », who are the other assistance actors, and what are the financial implications?

But these projects are lengthy programmes, which raises several problems. After a time, they may not still be as relevant. In Sudan, in the Mygoma orphanage, we took action in a context of high mortality. Today we are thinking of withdrawing, without being able to solve the more general problem of adoption in Sudan. It is also true that at headquarters, more often than not, we do not give the same attention to these operations. When I was desk manager, because of the work load, I dedicated less time than I would have liked to the street children programme in Baoji; the teams suffered from that. We were useful for the children we took charge of (forty or so) but we did not manage to reach out beyond the centre itself. We did not succeed in making the situation develop. And the programme could have been closed earlier. During the first six months of 2006, an assessment will be made of these projects in favour of persons who are « victims of social violence or exclusion ». There again we have to consider the means committed and our ability to turn these long-term operations into positive examples that have a significant impact on the populations.

→ Some countries mobilise major human and financial resources. In 2005, there was Niger (15 million euros), Sudan (11.6 million), the DRC (6.1 million), the tidal wave (5 million) and also Pakistan (5 million). Do you wish these operations to be reduced?

No, that is not an objective in itself. But managing so many means is a problem, at all levels: from the different actors' perception of MSF to reporting on our action. In countries such as Sudan or the DRC, I wonder if we are capable of managing such extensive means in these extremely complex environments. The quality of our operations could suffer from that. It is not automatically a question of reducing our activities, even if we can envisage withdrawing when we do not consider them a priority, or when the maximum mortality level has been passed. In the case of the DRC, the operational priorities are relevant. But we have to organise ourselves in a different way. To do so, we need to monitor our activities in a sufficiently structured way. The case of Sudan is unusual. It is the country where, all sections together, MSF's budget is the highest. The Sudan question must thus be discussed at international level, with a wider view.

Emergencies remain a priority and the means have been strengthened. We wish to improve the quality of our operations, which is also reflected in budgets that are often very large during the initial phase. But once the emergency is over, the other actors do not have the ability to take over our activities and the budget impact in the following year remains high (for example 6 million euros earmarked for Niger in 2006). That is not a criticism, just an observation that must make us reflect and take decisions, because such a trend may have harmful effects in the future (loss of reactivity, use of abundant resources which are not related to new priorities or new emergencies etc).

→ Doesn't the will to develop medical and operational strategies that enable us to treat the greatest number of patients where we intervene, such as in Niger and Malawi, imply new costly programmes?

Perhaps in certain cases. But though we are inspired by the strategies developed in Niger and Malawi, that does not mean we have to multiply programmes of such a size. Because we must have a general balance of operations and also field realities are different. Though the strategy implemented in Niger was also efficient in Nigeria, that does not mean we are going to use it everywhere.

In Malawi, in the AIDS programme, the problem was to treat more patients and treat them in a satisfactory way. In Kenya, there is the same wish to adapt to the reality of the patients by simplifying the procedures for treating and monitoring them. However, although certain elements can be applied in other programmes in technical terms, a strategy is elaborated above all in relation to a given context and at a given time. It is also always difficult to anticipate the development of a programme. If we had been told two or three years ago that we would treat 40 000 severely malnourished children in Niger in a satisfactory way (91% cure rate), we wouldn't have believed it! Medical innovation, the development of the price of medicine and also health policies and their funding modify the contexts in which we intervene. Several years ago, we wouldn't have believed that we would pass on a whole AIDS programme, like the one in Surin in Thailand, to the Ministry of Health either, or that Malawi would receive funds and medicine from the Global Fund to start up its own treatment activities. That is the proof that if we try out new strategies, we do not know all the consequences in advance. ■

Interview by par Anne Yzebe

BOARD OF DIRECTORS

Call for Applications

MSF / March 2006

At the Annual General Meeting to be held on May 13 and 14, we will hold elections for several positions on the Board of Directors of Médecins Sans Frontières, including for the presidency of the organization.
The outgoing board members this year are:
- François Bourdillon
- Jean-Hervé Bradol (President)
- Marie-Christine Férir
- Philippe Houdart (Treasurer)
- Elise Klément (Secretary)

We invite you to send your applications for the position of board member as soon as possible. The closing date for applications is April 13, 2006 (i.e. one month before the date of the Annual General Meeting) so that all members can familiarize themselves with the candidates.
Please do not hesitate to send your curriculum vitae and letter of motivation to Odile Hardy (executive assistant) at the following address: 8 rue Saint Sabin - 75011 Paris; or via e-mail to: odile.hardy@msf.org ■

The Board of Directors

Annual general meeting 2006

Dear Members,
Based on the modifications to our articles of the association approved at the last extraordinary general meeting, we are pleased to announce that it will now be possible to vote directly, either by post or electronically, to choose your representatives to the Board of Directors.
The aim of this measure is to give each of you the ability to express your opinion on the directions your organization will take in the future, whether you are here in France or in some remote corner of the globe. Since, as you know, reasons related to our operations prevent many of our members from attending the annual general meeting, you will understand how important this measure is.
It is crucial that each member take advantage of this new opportunity to expand the basis of our organization's democracy.

In mid-April, you will receive the list of candidates for the Board of Directors as well as all the procedures and conditions for distance voting

Please note: in order to be able to vote, your must have paid your annual membership fee by the date you vote (date your letter is received if voting by mail; date of connection if voting electronically).
We therefore advise you to mail your membership fee as soon as possible so that you can take advantage of this opportunity.
Please send all correspondence to Christiane Gesquière at MSF/, 8 rue Saint Sabin - 75011 Paris or cgesquiere@msf.org

Reminder: to vote on-site, membership fees must be paid by 8:00 pm May 13, 2006. ■

For more information:
E-mail: afredaigue@msf.org
Phone: (33) 1 40 21 29 05

The Annual General Meeting Team

WATCH AND READ

Acquisitions (February 2006)

Christine Pinto (01 40 21 27 13)

→ MEDICAL

CRITÈRES DE RECEVABILITÉ POUR L'ADOPTION ET L'UTILISATION CONTINUE DE MÉTHODES CONTRACEPTIVES - Genève : OMS, 2005. - Guide essentiel OMS de Planification Familiale.

GUIDE PRATIQUE DES MÉDICAMENTS 2006 - Dorosz. - Paris : Maloine, 2005. - 26ème édition, 1890 p.

→ GEOPOLITIC

A DEATH IN JERUSALEM - Kati Marton. - New York: Arcade Publishing, 2005, 321 p.

BARNUM - Pierre Brunet. Paris : Calmann-Lévy, 2006, 250 p.

GÉOPOLITIQUE DU CONGO (RDC) - Marie-France Cros et François Misser. - Bruxelles : Editions Complexe, 2006, 142 p.

JUSTIFIER LA GUERRE? DE L'HUMANITAIRE AU CONTRE-TERRORISME - sous la direction de Gilles Andréani et Pierre Hassner. - Paris : Presses de la Fondation Nationale des Sciences Politiques, 2005, 359 p.

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TSUNAMI : LA VÉRITÉ HUMANITAIRE - Richard Werly. - Paris : Editions du Jubilé, 2005, 272 p.

VOLONTAIRE EN ONG : L'AVENTURE AMBIGUË - Amina Yala, Paris : Editions Charles Léopold Mayer, 2005, 237 p.

INFOS

→ AVAILABLE IN THE PHOTO LIBRARY
Alix Minvielle

New photos sent to DBI:

DRC : déplacés à Kanyabayonga, hôpital de Rutshuru, CNT de Kayna © Jean-Sébastien Matte / MSF (30 images) - CNT de Kayna + Béni , 2005 (c) Michael Neuman / MSF (10 images) - déplacés Rutshuru, février 2006 © Frédéric Delmavoisine / MSF (7 images)

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INFOS
WATCH AND READ

BOOK REVIEW

Penser dans l'urgence *Parcours critique d'un humanitaire*

Rony Brauman - Interviews with Catherine Portevin

Rony Brauman, a doctor, born in 1950, has been involved in international aid since 1977. From 1982 to 1994, he was president of Médecins Sans Frontières, and he is still runs the organization's training center and think tank. He is also professor at the Paris Institute of Political Studies (Institut d'études politiques de Paris). Beyond his countless field missions around the world, Brauman has made a name for himself through the critical reflections he has developed over the years regarding humanitarianism and its limits. For Rony Brauman, this line of questioning intersects other very contemporary concerns: medicine and public health, totalitarianism, the political uses of memory, the status of victims. His personal history and his testimony on these subjects are truly unique. In this book, Brauman's lengthy career is recounted in the form of interviews with Catherine Portevin, a journalist at Télérama, and author of *Devoirs et délices, entretiens avec Tzvetan Todorov* (Seuil, 2002). ■

Penser dans l'urgence - *Parcours critique d'un humanitaire* - Rony Brauman - Interviews with Catherine Portevin. 272 pages - Editions du Seuil, march 2006.

RESOURCES

Press Contact:
anne.yzebe@msf.org
kate.rivero@msf.org

Reactions and contributions:
olivier.falhun@msf.org

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

messages

Médecins Sans Frontières
8, rue Saint Sabin
75544 Paris Cedex 11
Tél. : +33 (0) 1 40 21 29 29
Fax : +33 (0) 1 48 06 68 68
www.msf.fr
Editor in Chief: Bénédicte Jeannerod
Editing: Olivier Falhun
Drawing : Brax - Guy Jacquier
Translation: Caroline Serraf / TSF
Photo librarian: Alix Minvielle
Layout : Odile Malassis /tcgraphite
Design: Exces communication
Print: Artecom.

TURN OVER

FIELD HR	
→ **Franck ELOI**	Started working on the revision of field job profiles and function scales in February
COMMUNICATIONS AND FUND-RAISING	
→ **Nicolas BEAUDOUIN**	BEAUDOUIN started working on events organisation in January
→ **Gilles FASBENDER**	started working in February on the analysis and development of 'association side' of MSF
LOGISTICS	
→ **André SARDO-INFIRRI**	started working in February on finalising the mobile hospital kit project.
RECEPTION AND GENERAL SERVICES	
→ **Caroline RABEMANANTSOA**	has replaced Mathieu Jacquet as general services assistant.
FOUNDATION	
→ **Alain DELAUNAY**	started work in February on updating the 'Manuel des Acteurs de l'Aide'.

TRAINING COURSES

→ NUTRITION / IMMUNIZATION

From Wednesday 7 to Wednesday 14 June 2006 at MSF Paris office - Duration : 6 days - French speaking session

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

By the end of the course, the trainee will be able to:
Epidemiology
Define, calculate and use epidemiological indicators

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

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

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

THE EPICENTRE/MSF SCIENTIFIC DAY
The Epicentre/MSF Scientific Day is scheduled for Friday 12 May 2006. We sincerely hope you will be able to attend
The programme will soon be sent to you and will be available at MSF France reception.