messages

→ N° 141 / July 2006 / Médecins Sans Frontières internal newsletter www.msf.fr

DOSSIER

A NEW APPROACH TOWARDS MALNUTRITION

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RESOURCES

→ Kenya © Dieter Telemans - March 2006

A new approach towards malnutrition

MSF / April 2006

Considered the only solution to the persistent famines and food shortages in Sub-Saharan Africa, economic development has not succeeded in reducing malnutrition. Nevertheless, progress in science and technology has made available a new medical approach towards the cure and prevention of malnutrition. Successfully tested by MSF in Niger, this breakthrough opens promising perspectives and shows that is it possible to avoid the death of thousands of children. By Dr Jean-Hervé Bradol, president of Médecins Sans Frontières.

The year 2005 allowed light to be shed on several key elements responsible for the recurrent nutritional crises in Niger and the testing of a new nutritional approach leading to a large scale reduction of mortality.

These recurrent crises are not due to droughts or plagues of locusts. They are rarely linked to food production deficits. The problem lies mainly in the distribution of produce and revenue within society. According to government figures, the 2004 harvest recorded an overall cereal deficit of 10% that was more than compensated for by the 2003 surplus. In fact, food is produced in sufficient quantity, but large segments of the population do not have the means to buy it. Thus, the level of food production no longer bears any relation to the annual incidence of acute malnutrition - as the intensity of the

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In 2005, we treated over 60 000 children suffering from malnutrition in Niger. In 2006 we estimate this will increase to 100 000. Like ARV treatment for Aids at the beginning of 2000, ready-to-use therapeutic foodstuffs (RUTF) open new therapeutic possibilities. Given this major medical breakthrough, MSF has two responsibilities: to optimise, in both quantity and quality, its response to malnutrition and to lobby aid organisations to promote widespread use of these products. However, like in our Aids projects, there are still many question and apprehensions : how long are we prepared to keep these activities running? How far are we prepared to go concerning case management? What campaigns are we ready to take on? Are our programmes reproducible? The questions in Niger have shaken up our practices - and it is our practices that will help us find answers to all these questions.

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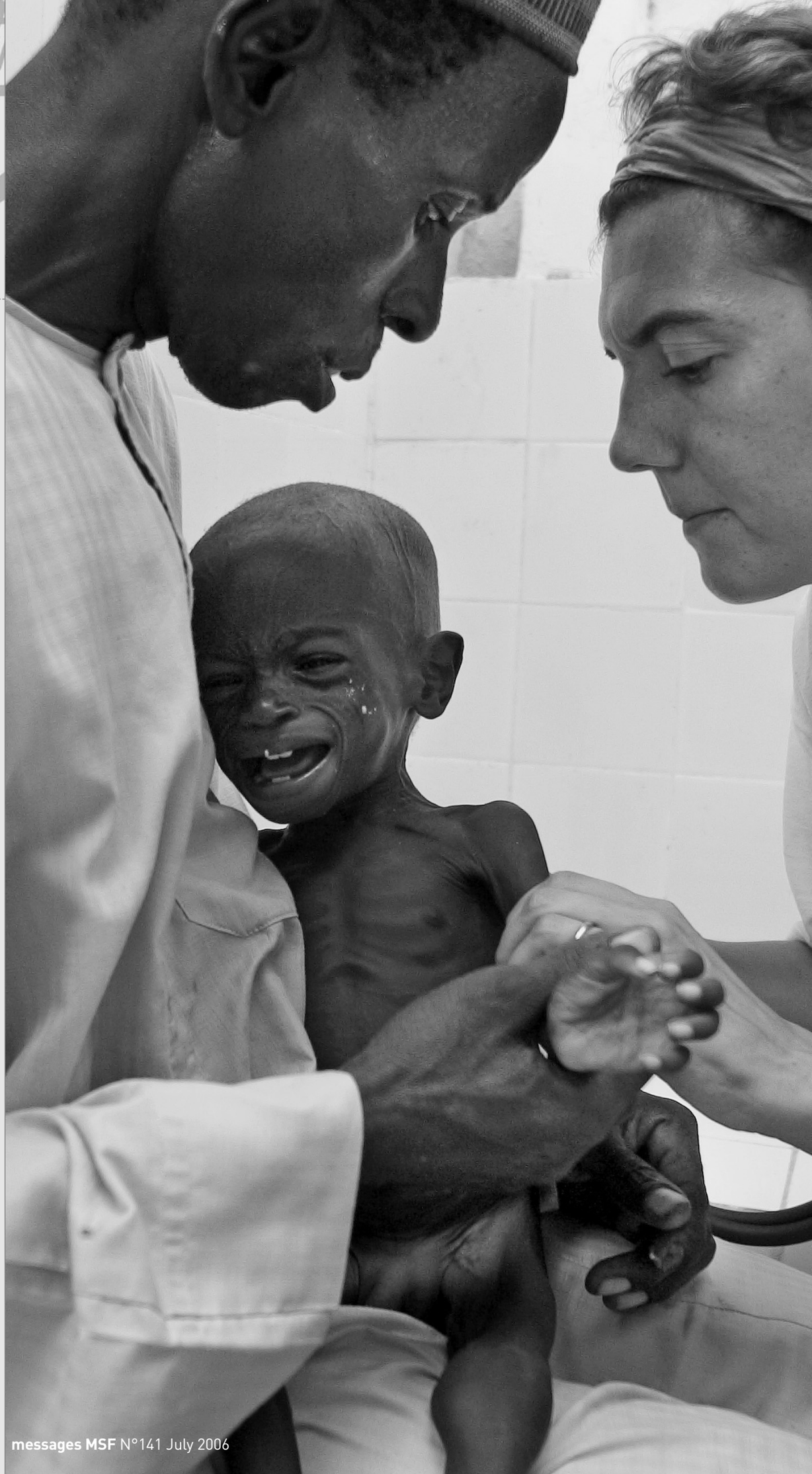
A new approach towards malnutrition



→ Note

Most of margins in this issue of Messages are taken from the 2005 Annual Report presented by Jean-Hervé Bradol, president of Médecins Sans Frontières, and voted on during MSF's Annual General Meeting on May 13, 2006. The President's Annual Report and the Financial report are downloadable in their entirety on www.msf.fr

→ Niger © Henk Braam - August 2005

nutritional crisis in the border region of Maradi, one of the most fertile regions in the country, attests. Poverty, debt, exorbitant interest rates, misery and children dead from hunger and migration are at the heart of this matter. The situation in Niger resembles the contexts described by Amartya Sen, who won the Nobel Prize in economics in 1998 largely for his work on contemporary famines.

The public health consequences of this phenomenon are horrifying. The most severe and deadly forms of acute malnutrition affect over 100,000 children each year. Most of them are under three years old. These figures partially explain why infant and juvenile mortality remain so high in Niger where 190,000 children, more than one in four, die before the age of 5. Unlike stunting, acute malnutrition is a pathology resulting in rapid (within a matter of weeks) and significant weight loss. Acute malnutrition affects 60 million children under 5 years old worldwide and causes 5 million deaths.

Every year Niger suffers a paediatric emergency with a critical peak in the middle of summer, during the months preceding harvest. Before the summer of 2005, the care offered for children suffering from acute malnutrition was very restricted, technically obsolete and economically out of reach for the majority of affected families. The crisis of the summer of 2005 will at least have facilitated the revision of the national protocol for the treatment of severe malnutrition, integrating recent advances in this domain.

[...] despite all these efforts the results are disappointing; according to the United Nations the number of under fed people in sub-Saharan Africa increased by 34 million between 1990 and 2002.

Uncomplicated forms of infantile severe acute malnutrition were quite simply not considered. Up until the end of July 2005, the distribution of food –sold to the families at subsidized prices- was irregular, insufficient in quantity and did not contain elements suited to the nutritional recovery of young children. The emotion provoked by the catastrophe and its media exposure during the summer of 2005 brought about free healthcare for children, often targeting uncomplicated acute malnutrition. But the food provided to these children still did not contain enough nutrients suited to nutritional recovery in early childhood. Furthermore, the food distributions fixed targeting priorities in the regions with the lowest annual rainfall, and not the regions with the highest incidence of acute malnutrition.

The prevention of malnutrition has depended principally on stimulating the growth of family incomes, economic development, education of mothers as to the nutritional needs of their children and in particular the importance of breastfeeding. In reality the net increases in agricultural productivity have not been followed by better access to quality food for many poor families. The economy is developing, politics are becoming more democratic, but the incomes of the poorest members of the population are still insufficient to prevent acute malnutrition, particularly in children under 3 years old.

Confronted with this sadly unoriginal situation when one considers poverty throughout history, until now the doctor or public health professional could only hope for improvement in economic conditions. Therapeutic milk -up to now the central element in prevention and treatment- is ill-adapted to precarious environments. Animal milks cause intolerances and have a propensity for bacterial contamination, thereby rendering them of limited interest. As for specialised formula milks: their high cost, the necessity of adding potentially contaminated water and their administration using containers of doubtful cleanliness are all arguments against recommending their use.

Therapeutic and preventive options have now been enriched by several decades of scientific research that have led to the development of ready-to-use therapeutic and prophylactic foodstuffs, and their efficacy is proven. Changing from treatment based on liquid food (milk) to individually pre-packed paste in sachets, jars, and biscuits, means water and bottles are no longer necessary. Moreover, the addition of micronutrients, minerals, vitamins, amino acids and vegetable based calories all considerably accelerate recovery to a satisfactory nutritional state.

These new protocols mean that 70% of costly and long (several weeks) hospitalisations may be avoided for more severe forms of malnutrition. But this is provided a bit of time is taken to offer mothers the necessary information allowing her to care for her child at home. In a rich country, a child in these circumstances would be treated in intensive care at a daily cost several times higher than the average yearly income in Niger. The efficacy of these new models of care for the treatment of acute severe malnutrition is such that it allows the number of cases treated to increase tenfold whilst maintaining a cure rate of over 90%. The Nigerian mothers' culture, accused of being partially responsible for the childrens' malnutrition, has not prevented them from becoming the best possible therapists according to the data available in medical literature. The transfer of medical information and responsibility for treatment administration from the doctor to the mother, and from mother to child, is the key element for the success of this revolutionary strategy.

[...] whereas international food aid in Niger represented 20% of national production in 1984, it is now down to no more than 2% twenty years later.

It was demonstrated during the 2005 crisis that it is possible to avoid the deaths of a very large number of children. In Niger last year, Médecins Sans Frontières treated 57,352 children suffering from the most severe forms of acute malnutrition. 89% of children were cured, 4% died and 7% abandoned treatment. Such results also open promising perspectives in treatment, as well as prevention, of common forms of acute malnutrition.

Despite these advances, when the states of the region (Mauritania, Mali, Niger, Chad, Burkina Faso, Senegal, Gambia, Cap Vert and Guinea Bissau),

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A new approach towards malnutrition

> *Protein-energy malnutrition (PEM) is a problem in more than 60 countries. Here, looking at what causes it is crucial. The most common cause of PEM is parents' poor child feeding and caring practices, and the corresponding solution is growth monitoring and education about breastfeeding and weaning, as well as better diets for pregnant and lactating women. But if disease is an important cause of malnutrition, then health, water, or sanitation interventions can be as important; and if food security is a problem, then indirect interventions against malnutrition should be considered...*

Excerpt from Repositioning nutrition as central to development: A strategy for large-scale action. World Bank 2006, page 203.

international donors and the United Nations met in Dakar in November 2005, they expressed strong hostility to emergency humanitarian aid. "Conscious that humanitarian aid is only a temporary, inappropriate and expensive palliative in this kind of situation, we thought that the time had come to engage in real dialogue with all governmental, international and community partners to work together for a better tomorrow in the Sahel" declared Margareta Wahlstrom of the United Nations Office of Coordination of Humanitarian Affairs (sic) in a press release at the end of the conference.

Behind the generic term "humanitarian aid", it is free food distribution that is being stigmatised. Our United Nations colleague's concern is unjustified however; the figures even show that it is invalid: whereas international food aid in Niger represented 20% of national production in 1984, it is now down to no more than 2% twenty years later.

Since the end of the 1980s, emergency food aid has been accused of hindering the economic development that is considered to be the only solution to the persistent food shortages and famines in sub-Saharan Africa. As a consequence, national and international efforts have concentrated on stimulating growth which in turn should generate the disappearance or even the eradication of the extreme poverty associated with malnutrition. But despite all these efforts the results are disappointing; according to the United Nations the number of under fed people in sub-Saharan Africa increased by 34 million between 1990 and 2002.

Do rich countries apply this kind of logic at home? A priori, given the overall wealth, it should be easy for all families to have sufficient incomes to cover the food expenses necessary for the survival of the most fragile members of the family. But free restaurants, food banks, public and private social services still distribute tens of millions of meals per year (70 million for the Restaurants du Coeur alone last winter). 12% of the French population is classed as poor according to European standards, and if they had to buy foodstuffs for young children at market prices no doubt the country would be faced with an epidemic of acute malnutrition and increased infantile mortality. But the international aid system and governments ascribe food self-sufficiency as the objective for the rural population of Niger – the country ranked bottom of the UN human development index.

In rich countries severe poverty is still associated with malnutrition. It has not disappeared, even though it is not present on such a massive scale as in Niger. But poverty no longer automatically means excess mortality in very young children, thanks to prevention and treatment networks (mother-child protection, in the French example). Social welfare policies have negative effects that must also be taken into account. So why do the richest recommend to the poorest solutions that they are unable to apply at home? The poor of Maradi have to acquire food self sufficiency, but not the poor of Paris?

Logically, the priority for the concerned states and donors should be to generalise access to new ready-to-use therapeutic food products.

The 189 member states of the United Nations have committed themselves to reduce extreme poverty and the proportion of the world 's population affected by hunger by 50% by 2015. It is the main priority of the millennium development objectives. For now, the positive results obtained in Asia have been counterbalanced by a clear deterioration in sub-Saharan Africa. Without pretending to eradicate extreme poverty throughout the world, recent scientific progress offers the concrete possibility of reducing the number of deaths due to insufficient dietary intake in poorer countries by millions. Logically, the priority for the concerned states and donors should be to generalise access to new ready-to-use therapeutic food products.

This cannot take place in the current production and sales conditions. There need to be more production and distribution centres in order to produce the required quantities, reduce prices and expand the range of these products (that can be considered medications). The range of products required - given the large diversity of tastes and cultural norms in different regions and countries- must be carefully explored. The development of generic products and a pertinent approach to intellectual property will be crucial to obtaining the indispensable price reductions: daily treatment currently costs almost as much as antiretroviral therapy for AIDS.

More consideration must be accorded to the reservations of governments with limited resources that prefer to invest in their countries' futures through economic development rather than social welfare (of a nutri-

→ **Niger** © Anne Yzebe / MSF - July 2005

tional nature). If not, national authorities will harbour the same initial strong reticence demonstrated when the possibility of treating HIV became a reality.

To this end, emergency humanitarian aid actors must try to understand that if this progress is to expand outside of the "humanitarian bubble", it will require longer term international financing over and above poor countries' existing budgets and not the re-allocation of existing resources.

The Global Fund to fight AIDS, Tuberculosis and Malaria has opened up possibilities from which the treatment of malnutrition could equally benefit. Attempts to ensure the financial stability of this initiative through the creation of new taxes - the French initiative to tax airplane tickets is an interesting example - may convince the governments of affected countries governments that the fight against malnutrition is pertinent and feasible. UNICEF and the World Food Program could establish key roles for themselves in the fight against mortality caused by inadequate food.

[...] if this progress is to expand outside of the "humanitarian bubble", it will require longer term international financing over and above poor countries' existing budgets and not the re-allocation of existing resources.

Science is offering us a new opportunity to make ground in the domain of malnutrition. But outdated notions including food self sufficiency for the poorest, the stereotype of the farmer made lazy by aid distribution, and the adequacy of breast feeding alone, must be abandoned. In this domain, the futile confrontation of partisans of economic development and those supporting emergency food aid has in reality been overtaken by technical and scientific progress: the evolution from liquid milk to a solid paste enriched in calories and micro-nutrients essential for the prevention and treatment of malnutrition. ■

Dr Jean-Hervé Bradol,
president of Médecins Sans Frontières

"*It is primarily because of better nutrition and not because of access to health care, clean water and soap, that stunting and wasting, and all the child mortality that goes along with them, have largely disappeared in the better nourished populations of the world. And yet, as has been true throughout history, the message of the fortunate to the less fortunate remains, "do as I say, not as I do"*"

Dr. Milton Tectonidis
Nutrition background paper - CAME Barcelona, April 2006

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A new approach towards malnutrition

OPERATIONAL POLICY

Developing a new approach

MSF / May 2006 - Translated by Karen Tucker

More than 39,000 children suffering from severe malnutrition were admitted to our feeding programmes in the Niger region of Maradi alone in 2005. In 2006, we have already admitted more than 8,000 children and the most difficult months are yet to come. A new approach to acute malnutrition, made possible by medical innovation, allows us to provide a more suitable response for a larger number of people. We're working on new operational tools but the full potential of this nutritional revolution cannot be implemented if access to therapeutic products remains limited, particularly because of price. Interview with Dr Guillermo Bertoletti, director of operations, and Graziella Godain, deputy director of operations.

→ Since January 2006, we have been treating global acute malnutrition, both the moderate and severe forms, in the southern areas of the Maradi region. What changes does this imply?

Guillermo Bertoletti : The number of children we're treating is much larger because we are no longer treating just the most serious cases but all children suffering from acute malnutrition. The strategy we are now applying is the same for all cases. Talking about severe or moderate acute malnutrition is an indicator of the severity of the individual's nutritional status. Whether a child weighs 20% less ("moderate" stage) or 30% less ("severe" stage) than what they should weigh for their height, the treatment is the same: a ready-to-use therapeutic product that will allow them to gain weight rapidly. We no longer distinguish acute malnutrition based on its severity but through its medical prism – complicated or non-complicated. A malnourished child who has an appetite and who does not have any medical complications related to malnutrition can follow the treatment at home without the need for close medical supervision. However, a child who has no appetite or who has medical complications related to malnutrition needs to be hospitalized and to also receive treatment for the medical complication (diarrhoea, acute respiratory infections, severe malaria, etc.). This strategy, which involves outpatient treatment of all children for whom hospitalisation isn't necessary for medical reasons, cured tens of thousands of severely malnourished children in Niger in 2005. This year, we're applying this strategy to all children suffering from acute malnutrition.

Graziella Godain : A few years ago, we still treated patients differently based on the distinction between severe and moderate acute malnutrition: severely malnourished patients were hospitalized in a therapeutic feeding centre (TFC) and moderately malnourished patients were treated in a supplementary feeding centre (SFC). The former consumed a therapeutic nutritional product in the form of milk that had to be stored, prepared and given under medical supervision. The latter received food rations. This system was very cumbersome for both us and the families and the results were unsatisfactory. Since 2001, we have been using a new therapeutic product in the form of a peanut paste packaged in individual rations in packets or jars and whose complex composition, particularly in micronutrients, allows the child to recover rapidly. This product, tailored to the nutritional needs of children under five, has proven its worth. We finally have something else to offer children suffering from malnutrition at the so-called moderate stage other than kilos of grain!

The strategy is to reduce the number of children who risk suffering from acute malnutrition by giving them an appropriate product before they lose weight.

→ Why did we wait until January 2006 to include moderately malnourished children in our treatment programmes for acute malnutrition in Niger?

Graziella Godain : In 2005, there was a very high prevalence of acute malnutrition, so the scope of the crisis led us to concentrate on the most serious form of malnutrition. However, in the region of Maradi alone we admitted more than 39,000 children suffering from severe malnutrition or from moderate malnutrition with related pathologies. We also distributed 130,000 food rations (flour enriched with vitamins, minerals and oil) to 53,000 infants and children suffering from moderate acute malnutrition in three departments in southern Maradi. Furthermore, sick children under five received medical care free of charge. Was any other response possible? In 2005, I don't think so. We're currently working on avenues of operational research to find other tools that will help us provide massive coverage during a nutritional emergency.

Guillermo Bertoletti : If we hope to reach not tens of thousands but hundreds of thousands of people, we have to find an alternative to targeted food distributions. The strategy is to reduce the number of children who risk suffering from acute malnutrition by giving them an appropriate product before they lose weight. In Niger, where it is young children who are affected, there's a research programme on ready-to-use therapeutic products. If, instead of distributing large quantities of food rations, we could give out dozens of packets, that would represent an enormous simplification of our nutrition operations! Is it feasible? We don't know yet; we have to test this approach in the field. The prospects are very interesting; we could have a major impact on global acute malnutrition.

"I have to go over the problem areas that arise during our activity. Despite the overall success of the operation in Niger, there are nonetheless a few remarks to make.
The first concerns our comprehension of the mechanisms within Niger's society that lead to large numbers of acute malnutrition in young children. We criticized the blindness of other aid organizations and their non-stop references to the drought and locust invasions whilst explaining the crisis. We considered it to be initiated by other objective factors including price evolution, market evolution and the development of the social circumstances of the rural population. These all demonstrate that explanations behind the malnutrition phenomena lie not in nature but in the functioning of society, in the relations between different human groups and various economic influences."

Excerpt from the 2005 Annual Report

→ Is this a revolution in the approach to global acute malnutrition?

Guillermo Bertoletti : It's not only a new strategy but also a completely new concept. The whole view of malnutrition is being questioned; if you approach it from the perspective of a lack of food, you provide the wrong response and develop inadequate programmes. It's not tons of grain that are going to reduce the prevalence of acute malnutrition, but suitable therapeutic products. We have to separate the medical response to acute malnutrition from the food issue that affects the entire population. Medical innovation and new strategies clearly simplify the response to this disease. This is not a miracle solution or magic formula, but in an environment like Niger, this approach has already proven its worth and the concept can be applied to other countries characterized by a strong prevalence of malnutrition among young children and a high population density.

Graziella Godain : The mothers in Niger mothers have understood before many experts and international organizations that they can now find the resources to care for their malnourished children. They don't consider it "normal" for their children to die of malnutrition; they know their children can recover so they go to feeding centres for the appropriate treatment. Our results in 2005 in the Niger programmes prove it: more than 9 out of 10 children recovered after completing treatment. Our method relies on mothers taking responsibility and they showed they could care for their children if they had the appropriate resources. Now the question is: how can we make this product more accessible?

→ What obstacles prevent the massive use of ready-to-use therapeutic products?

Guillermo Bertoletti : Medical research has opened new prospects and operational research is exploring new possibilities. This revolution is posing many questions and we are currently in the process of working on new tools consistent with this strategic approach. Years of research were necessary to finalise this therapeutic product and it will take years of research to adapt our operations. It's a long-term strategy. The first results are in and are extremely encouraging, but to develop this concept there needs to be a much greater effort that goes well beyond MSF.

Graziella Godain : In addition to operational research, there are two major focuses to our work: raising awareness among the other organisations about the value of this product and exerting pressure to lower prices and expand the offer. This approach cannot develop if intellectual property problems block the work of other manufacturers and if the cost prevents countries from making it widely available. The Campaign for Access to Essential Medicines has led to major breakthroughs, allowing effective treatments to become available – ACT for malaria and ARV for AIDS, to cite just two examples. Regarding malnutrition, the challenge is similar: we have an appropriate treatment, which is currently being offered to only a small number of patients. Malnutrition affects 60 million people worldwide; why not envisage the distribution of generic treatments at an affordable cost and the creation of an international fund that would allow countries facing a high rate of acute malnutrition to respond to this public health problem? ■

Interview by Anne Yzebe

→ **Niger** © Christiane Roth / MSF - September 2005

"It is high time for a change in direction. Beyond the never-ending discussions concerning prevention, behavior change, exclusive breast feeding and access to health and clean water, MSF must aggressively hold forth, as we did previously for the HIV pandemic five years ago, that the only responsible attitude is to treat patients at high risk of death, treat as many as we can and treat them with the best products available."

Dr. Milton Tectonidis
Nutrition background paper - CAME Barcelona, April 2006

ACCESS TO TREATMENT

The peanut worth its weight in gold

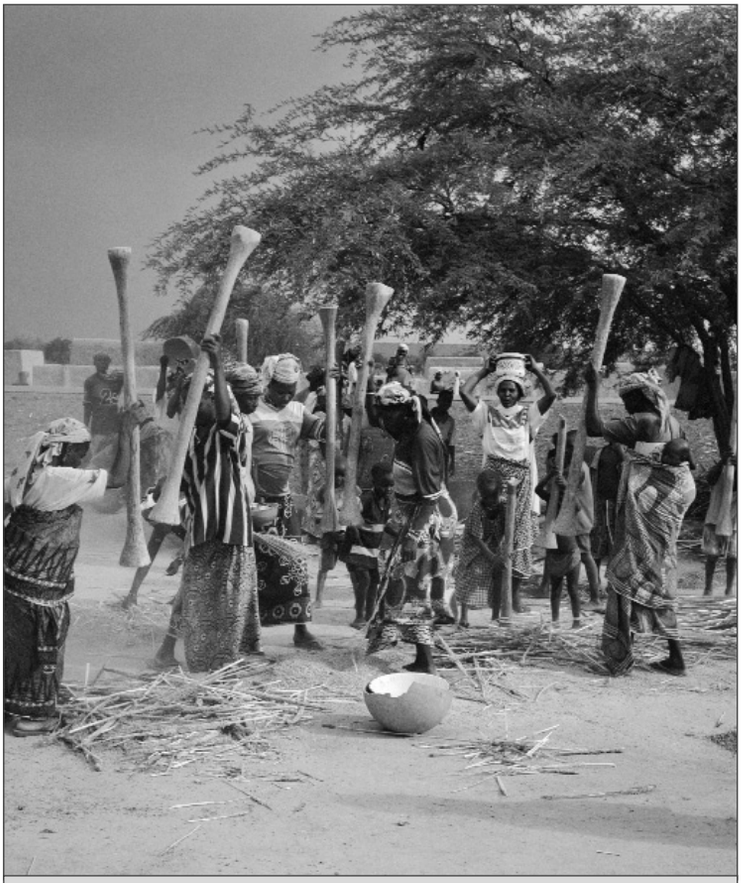
MSF / June 2006 – Translated by Steven Durose

Ready-to-use therapeutic food offers the prospect of treating acute malnutrition on a massive scale. Before this potential can be turned into reality, two major obstacles remain to be overcome: limited access and high product costs. Guillaume Sauvage, quality and agri-food products purchasing manager at MSF Logistique, explains why a less expensive alternative to *Plumpy'nut*© is still out of reach, and how a major effort is required from all sides to bring about change.

→ A packet of *Plumpy'nut*© costs less than 0.30 euros. The average cost of treating a child with two packets a day for thirty days is 18 euros. Multiply this figure by tens of thousands and you reach a sum that's far beyond the means of many aid organizations. Is it possible to find an equivalent or cheaper product?

MSF Logistique alone spent more than 2.2 million euros on *Plumpy'nut*© last year. But we had little choice. The ready-to-use therapeutic food (RUTF) market is currently almost exclusively dominated by Nutriset, the company that produces *Plumpy'nut*©. The only alternative - BP100 from Compact - features nutritional qualities similar to those of *Plumpy'nut*©, without the same practical advantages. Easy for an adult to eat, the biscuit is unsuitable for children as it is. In order for children to benefit, it needs to be soaked in a bowl of water before being mashed up. *Plumpy'nut*© is better suited to the circumstances in which we work, since there is no need for an additional water supply or container to prepare the product for consumption. The child consumes it directly from the packet – and enjoys eating it. Let's not forget that, in addition to its nutritional and practical qualities, the taste and texture must be acceptable to children. There is, as a result, still no alternative to *Plumpy'nut*©. However, it was only last year that we were effectively able to measure the potential of such a product, with home treatment applied on a large scale. Obviously, there is now heightened interest in the area and numerous manufacturers are working towards developing an alternative.

→ Given the potential market for these products, are we likely to see other manufacturers emerging in the very near future?



→ **Niger** © Christophe Calais - September 2005

There are plenty of manufacturers, in South Africa, Europe, and the US, who are capable of producing an equivalent of *Plumpy'nut*©. But none of them have been able to get around the patent issue. Nutriset has registered two patents[1] covering an extremely wide field that protect both the food product (the format and packaging) and the preparation process and its uses. In addition to developing this sachet of therapeutic food in paste form, Nutriset has basically appropriated the concept. *Plumpy'nut*© lies halfway between an agri-food product and a pharmaceutical product. Patents benefit from a high level of protection in both fields, so it's hard to make any headway! There are also major financial issues involved. A German manufacturer did try to copy *Plumpy'nut*©. It was a pretty crude attempt, since the name - "pasty-nut" - and the colour of the sachet were very similar to the original product. But Nutriset immediately filed a complaint for violation of patent and won the case. The patent is a block to competition, but it also puts a brake on the use of nutritional products that are better suited and targeted according to the context and the pathology. The research and development projects of various manufacturers aimed at producing a specific range of nutritional products, along the same lines as RUTF's, are therefore limited by the constraints placed on producing or marketing the outcome of their research.

→ Extract of the application for patent N°2815825

The present invention concerns a complete food or a nutritional supplement rich in lipids, the weight of which should not consist of more than 10%, or preferably not more than 5%, or even more preferably not more than 2% of water, offering low osmolality and stable oxidation, and comprising a mixture of quality food products in powdered, granular, particulate form, containing at least one milk product and, if appropriate, at least one product offering digestible carbohydrates, with added vitamins and minerals. This mixture should be coated with a substance rich in refined vegetable fats free from indigestible proteins and carbohydrates, and oilseed minerals, and should contain an emulsifier and, if appropriate, an anti-oxidant.

→ Can't certain countries produce or market a similar product without regard for the patents, along the same lines as certain drugs?
Nutriset has registered patents in most European countries, but also in the US, Canada and Australia, and in numerous African countries, including Niger. If Nutriset does not wish to authorise other companies to manufacture *Plumpy'nut*© those companies can only produce it after requesting a compulsory licence from their respective government, as happens with drugs. We are currently testing another RUTF product that, if the results are positive and the company manages to market it, should offer an alternative. The company is well-known and we're already familiar with its other products, but the planned price is more or less the same... Although a few cents less does makes a difference, if you're buying two million items, the reduction is still very small!

→ *Plumpy'nut*© is partly produced locally. MSF Logistique purchases *Plumpy'nut*© exclusively from Nutriset, which is based in Normandy. Isn't it possible to buy supplies directly in Niamey, for example?
Yes it is possible, but remember we're not talking about just any peanut spread... It's about a technically advanced product for children in a weakened state of health for whom an unsuitable therapeutic product could have the same dramatic consequences as an incorrect medication. This underlines the importance of "quality" monitoring of the production process, and local producers rarely possess the means to implement reliable checking procedures. Several other factories already exist in Niger

Nutriset has registered patents in most European countries, but also in the US, Canada and Australia, and in numerous African countries, including Niger.

[see following page – ed.], Malawi, the Democratic Republic of Congo and, in the near future, Sudan. Production is monitored by Nutriset, and it's the parent company which trains the teams, provides advice on equipment, sells them supplies of the essential component contained in *Plumpy'nut*© (vitamins and minerals), and ensures the implementation of a quality monitoring process. We can feel confident about the quality of the product, but it's not necessary cost-effective. Production costs are high in Niamey, Niger. For regular shipping orders, it's less expensive to buy the product in Normandy and send it out to Maradi than to buy supplies locally.

→ Isn't there a need for a mass campaign to achieve widespread access to an effective product, as for epidemics such as AIDS and malaria?
Millions of people could benefit from this type of product and its derivatives. It's a question of political will and the Campaign for Access to Essential Medicines (CAME) should be working towards that goal. But the task shouldn't fall exclusively on the CAME's shoulders: when affordable alternatives are available on the market, these products will require testing - possibly extensive testing. The product will improve over time, leading to the development of a treatment that corresponds to nutritional needs, practical limitations and the taste of different groups of people. This process requires even greater effort both in the field and in headquarters, but also strong political will across the board. ■

1- FR2771259 and FR2815825

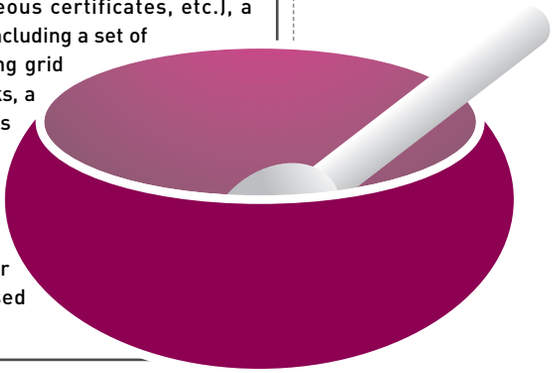
Interview by Anne Yzebe

VALIDATION PROCEDURES FOR FOODSTUFFS (Translated by Robert Corner)

MSF Logistics insists on clear validation procedures for products and suppliers from the food industry as elsewhere. There is no formal standardisation framework for the agri-food industry however. The Codex Alimentarius (the international standardisation commission created for the food trade by the FAO) provides a framework for risk management, and producers are free to choose their own strategies for quality management. These may be based on the ISO standards, for example (ISO 22000 for example, created specifically for the food and agriculture industry) or on systems such as those used in the retail sector (IFS, BRC, etc.), or indeed on their own customised systems.

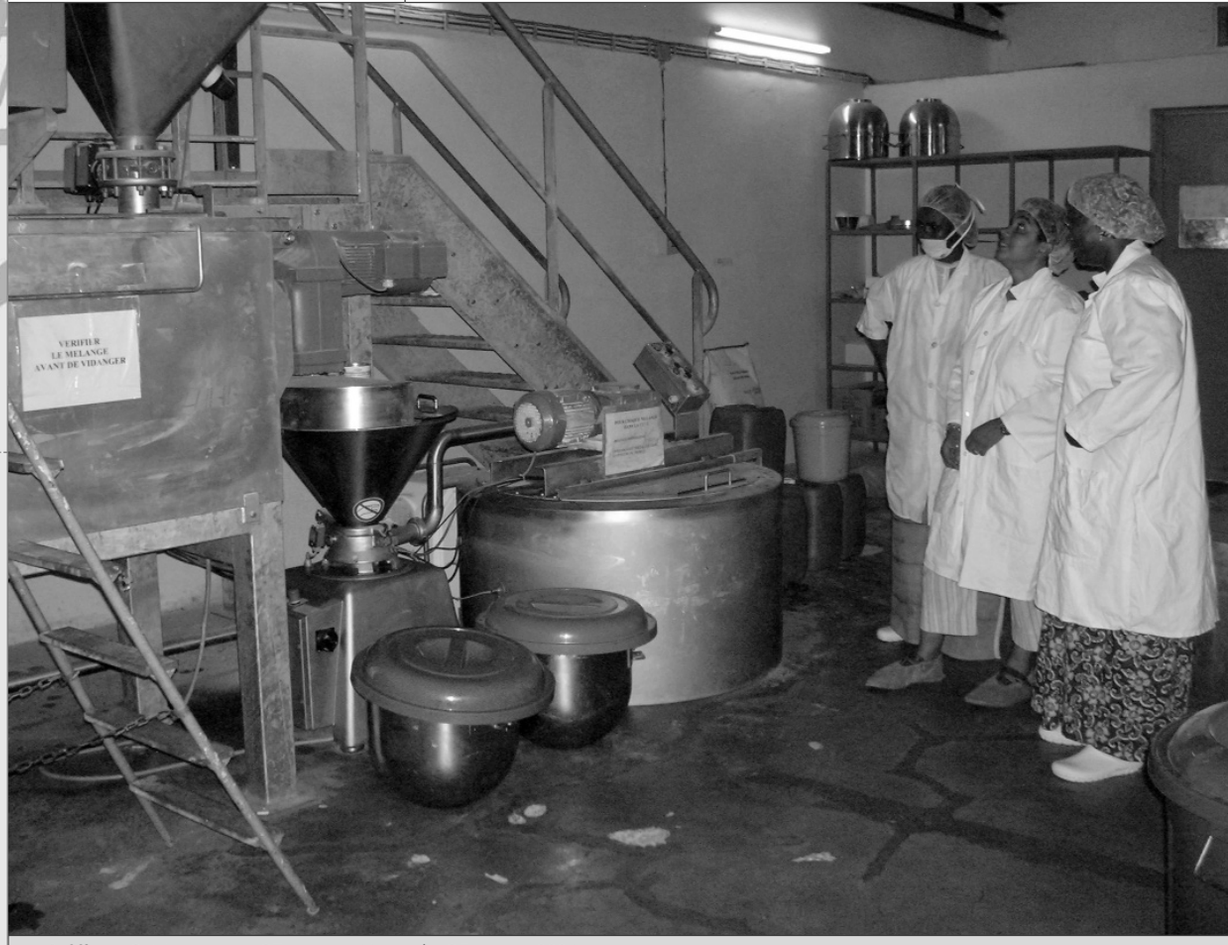
MSF buys its staple foodstuffs (cereals, pulses, vegetable oils, etc.) mostly locally (thus minimising transport costs) through international trading companies. The quality of these is monitored by independent international organisations, who inspect, sample and analyse products following the strict guidelines in the purchasing specifications defined by MSF Logistics.

For processed products MSF Logistics buys from agri-food firms that do not generally sell on the European market; they are therefore not ISO-certified nor covered by retail industry standards. For these MSF Logistics carries out its own checks on product sources, following a validation procedure similar to that for medical products. This starts with a technical visit or audit of the site where the particular product is manufactured. Once the manufacturer has been approved, the product itself is given a fine screening: MSF Logistics prepares a technical dossier (product questionnaire, miscellaneous certificates, etc.), a product risk assessment (including a set of batch analyses) and a rating grid (with, depending on the risks, a stability study, guarantees on the quality of the raw materials, etc.) in compliance with detailed technical specifications. The approved product / supplier combination is reassessed every three years at least.



"[...] food crises are rarely due to an overall food shortage but more to how food is distributed within a society.
We hesitated ourselves over this question. It shows in the way we deployed our teams in the field. The theory of natural disaster would suggest a deployment in the zones situated in the northern part of the country. The explanations mentioned above would encourage a deployment in the big population concentrations in the south.
During the intensification of our deployment, we were opening projects in areas such as Dokoro or Keita.
We should ask ourselves with hindsight if it would not have been more pertinent to open in Zinder in the south.
We cannot write the script for complicated operations in advance, and these decisions are extremely difficult to take in emergency circumstances. If I allow myself to make such remarks, it does not in any way mean that I am scandalised by the hesitations we experienced in our operational deployment. But nonetheless, we need to take note of our acts. We could have probably saved more children by increasing deployment in the south."

Excerpt from the 2005 Annual Report



→ **Niger** © Niamey, the STA - Anne Yzebe / MSF - June 2006

> *We are emerging from the 2005 crisis with some good news. It was an opportunity to test, in particularly difficult circumstances, the potential of a new therapeutic approach founded on a new generation of food stuffs. They are ready to use and integrate the totality of essential nutrients in the form of a paste. The cure rate we obtained in Niger and the fact that we managed to deliver ambulatory treatment to more than two thirds of the severe cases amount to extremely encouraging results.*
>
> **Excerpt from the 2005 Annual Report**

LOCAL PRODUCTION

Plumpy'nut® made in Niger

MSF / June 2006 / Niamey - Translated by Alison Keroak

A small Nigerien company has been producing *Plumpy'nut*® locally for the past two years. The Société de transformation alimentaire (STA, Food Processing Company) now supplies several NGOs, including ACF and Concern, and may soon supply UNICEF.

Local production of *Plumpy'nut*® in Niger began with a big blender. Mrs. Cissé remembers having made the first batches the same way she'd experiment with a new recipe. It was a very homemade approach to a high-tech product. Gather the basic ingredients (peanut paste, milk, and sugar), add the complex of vitamins and minerals, mix thoroughly, and don't forget to taste! A corner of the table and the blender used for the first batches were quickly replaced by a production floor of approximately eighty square meters and a mixer that can produce three tons per day. Today, STA produces 15 tons per month of *Plumpy'nut*®.

The clauses of the contract stipulate that Nutriset is responsible for employee training and quality control, and that Nutriset validates all equipment purchased by STA.

At the start of the process, two employees sort the peanuts, which are then roasted twice before they are ground to a paste. Standing in front of a machine that takes up a dozen square meters, the production manager watches over the mixing in progress. A ramp leads up to the hopper into which the paste, sugar, milk powder, CMV (complex of minerals and vitamins), and stabilizer are added. At the end of the machine, a fourth person packages the resulting mix into small 92g tubs. With this equipment, the STA can produce up to 30 tons a month. The main limit in terms of technical capacity is, for the moment, the packaging in tubs, which slows down the production capacity. However, Mrs. Cissé is thinking of switching to packaging in sachets next year.

→ CONTRACT TERMS

"Médecins Sans Frontières were the ones who promoted this activity", she remembers. Ainga, the logistics field coordinator for MSF in Niger, met Mrs. Cissé in May of 2004. At that time, Mrs. Cissé was the manager of a company that produced one ton a month of Vitamil, a weaning product for children under six months. She

contacted Nutriset, the company that produces *Plumpy'nut*®. "Everything happened very quickly", recalls Mrs. Cissé. "Nutriset was the co-holder of the patent, along with the IRD - l'Institut de Recherche et de Développement. Both were very interested in supporting the technology transfer to countries where the therapeutic product could be used."

The clauses of the contract stipulate that Nutriset is responsible for employee training and quality control, and that Nutriset validates all equipment purchased by STA. In return, STA buys certain ingredients (the CMV and the stabilizer) from Nutriset. Local companies however do not pay royalties for the patent, and can use the name and design chosen by Nutriset for *Plumpy'nut*®. Each company in the franchise (a second company is located in Malawi, and a third in the DRC) can set its own selling price.

→ LOWERING THE COST

A 92g tub produced by STA is sold at 33 euro cents, 6 euro cents more than the Nutriset selling price. "UNICEF said it was too expensive, that it would be more expensive to buy it here than to bring it in from France", admits Mrs. Cissé. "My problem now is to reduce the price." She remains deliberately vague about STA's figures, but tells us that the cost of purchasing the CMV and the stabilizers from Nutriset represents "significant" fixed costs. "It is possible to reduce the cost of the raw materials," she states. "With good treasury, I think we could reduce the total production costs by at least 15%." The STA does not currently have the funds to buy peanuts at harvest time, when the prices are lowest. "I pay 35,000 CFA francs for a 65kg sack of shelled peanuts right now," explains Mrs. Cissé. "During harvest time, I would pay 10,500 francs!"

The STA does not currently have the funds to buy peanuts at harvest time, when the prices are lowest.

Eventually, with a possible production increase and some working capital that would allow her to buy the raw materials at a lower price, the production cost should decrease.

Eventually, with a possible production increase and some working capital that would allow her to buy the raw materials at a lower price, the production cost should decrease.

Although the STA fixes its price, the contract with Nutriset stipulates that the franchise company may only sell *Plumpy'nut*® to NGOs who work to treat acute malnutrition. "It's a therapeutic product, you can't let it circulate just anywhere", explains Mrs. Cissé. STA continues producing Vitamil, a daily porridge that needs to be reconstituted and cooked for 10 to 15 minutes. Packing 456 kilocalories per 100 grams, this weaning product is sold over-the-counter in pharmacies, mainly in the capital, at a cost of 215 CFA francs (1.03 euros) per 500 grams. This amount makes eight meals. However, this widely-available product has not seen the same rapid growth, and production has stagnated at one ton per month. ■

Anne Yzebe

→ **Niger** © Anne Yzebe / MSF - June 2006

"We have attributed much of the success to the product itself. It's true that it played a major part, but we should not overlook another factor that allowed us to provide ambulatory treatment. At the end of the day, such ambulatory treatment implies a transfer of responsibility. The mother and child become the principal actors in the treatment administration. This is the strength of these new protocols, in my opinion. The possibility to delegate treatment administration to patients makes all the difference. It is a formidably effective weapon, and entirely merits the cost of the small effort involved in transferring knowledge and responsibility to patients."

Excerpt from the 2005 Annual Report

PERSPECTIVES

Prevention can improve treatment

MSF / June 2006 - Translated by Isabelle Andrews

From June through to October, MSF will distribute *Plumpy'nut* to all children under five in around twenty villages in Niger in an attempt to prevent malnutrition. Within MSF this pilot project has prompted debate on the issue of prevention. Although these discussions often highlight valid points, they focus attention away from the matter in hand: that of improving our case management of malnutrition. Comments by Dr Isabelle Defourny, Deputy desk manager :

MSF has been working in Niger since 2001, and in 2005 came up against a large scale nutritional crisis. Over the years we have come to better understand where, when, how and why this acute malnutrition wreaks havoc in the country each year.

We know that in the lean period between harvests (June to October) in certain districts of the Maradi region, malnutrition will hit a large number of children, particularly those under the age of three. This is because they are not getting those foods young children specifically need; a millet-based diet simply isn't sufficient. So this year we have decided to distribute a suitable food supplement to these children before they start suffering from malnutrition.

Using patient information from last year's programme, we have selected approximately twenty villages – home to around 1,000 children under five – of which around a quarter had experienced periods of severe acute malnutrition last year. During the lean period this year we will provide the children in these villages with *Plumpy'nut* through monthly distributions: the mothers will be responsible

> *"We have decided to start a campaign to raise awareness of these new therapeutic foodstuffs and increase their distribution at lower prices. Even if we can rejoice at their existence, it remains clear that we need a wider range of them, probably including products that are conceived in the same way but are made for slightly earlier, preventive use, when a child is at risk of acute malnutrition. Preventing the deterioration of a child's nutritional status is a basic component of a routine paediatric consultation and these new products provide us with perspectives for gaining effectiveness in this domain. But their prices have to drop, and they need adapting to the food tastes of the different populations requiring them."*
>
> **Excerpt from the 2005 Annual Report**

→ In Our Other Programs

IN THE DRC – WHAT ARE OUR CURRENT TREATMENT STRATEGIES?

In the Democratic Republic of Congo (DRC), we treat severely malnourished children as well as moderately malnourished children with associated pathologies. Seventy percent of malnourished children are admitted for kwashiorkor. They remain in the Therapeutic Feeding Centres (TFCs) for at least three weeks, where they receive *Plumpy'nut*® when they are in phase 2.

We had to open TFCs in three of the six projects on which we currently work: in Ankoro, Mukubu and Kayna. At the other sites, either there are few cases of severe malnutrition and they are treated in one of our medical facilities, like paediatrics, or we refer them to other actors that have nutritional programmes available. In the hospitals, we supply *Plumpy'nut*® as a nutritional supplement to undernourished patients (in surgery, in paediatrics, etc.) and to tubercular patients. Even though we have had an outpatient care strategy in the past, as in Gbadolite (Equator) in 2004-2005, today we do not have such a strategy in the DRC.

On the one hand, hospitalisation of children in the TFCs does not overburden us (five admissions per week on average), we maintain good follow-up of all the children and our exit indicators are acceptable. Moreover, contrary to other situations, very few patients default. Mothers are not opposed to remaining at the Centre for several weeks.

On the other hand, we work in a very unstable and insecure setting. From one day to the next, incidents can prevent mothers from returning regularly for outpatient follow-up. When we were responsible for SFCs, the mothers organised themselves to find lodging near the site, so as not to expose themselves to the risk of robbery, rape or assault by the militia when travelling the roads from their villages. An ambulatory care strategy must be set up in a stable context. In contrast, the main concern related to hospitalisation for several weeks is the risk of nosocomial infections. This is of particularly worry in Katanga where there is a lot of tuberculosis.

Dr Chantal Gamba, ex-medCo.
DRC (for a year and a half)
By Kate de Rivero
Translated by Adele Parker

IN CHIRADZULU, MALAWI: FOR ALL PATIENTS

For more than two months, MSF has been treating malnutrition in all patients already being treated for AIDS with antiretroviral drugs.

There are two reasons for this. The first is circumstances: we observed more malnutrition during a critical food shortage about three months ago. The second reason is medical: an HIV-positive patient who receives micronutrients as nutritional supplements has, apparently, more chance of survival in the first three months after beginning antiretroviral treatment.

All the patients with HIV we treat who are malnourished or at strong risk for malnutrition receive RUTF (Ready to use Therapeutic Foods), a sort of local *Plumpy'nut*®. We count six distinct categories -- severely or moderately malnourished adults and children, pregnant or nursing women, children younger than 24 months, patients losing weight or with an opportunistic infection -- who will receive different doses of RUTF depending on whether it is used as prevention or cure. At first we had also implemented

for giving one sachet of the food per day to each of their children.

When we visit the villages for the first time, in mid-June, we will identify those children already suffering from malnutrition and will admit those who need medical treatment to our programme so they can either be hospitalised or receive outpatient care.
All remaining children, including those suffering from moderate malnutrition but without any medical complications, will remain at home where they will be provided with *Plumpy'nut* the same as all the other children.

The first mention of this project provoked a fairly negative response at MSF; prevention is not considered to be within the remit of a medical NGO such as MSF. It is nevertheless is an essential part of medicine, and MSF has always worked in prevention. In 2004, for example, in the refugee camps of Darfur we carried out vaccinations, ensured the supply of drinking water and distributed food provisions; along with our curative activities, we also focused on prevention – justifiably – to avoid the situation deteriorating.

But at MSF, the term 'prevention' evokes the failure of large public health programmes such as mother-child healthcare programmes or the EPI (Expanded Programme on Immunisation), which have been costly and have failed to deliver the expected results. MSF has sometimes been involved in such programmes, so a fear of making the same mistakes probably explains these reservations. Concerns that the project will consist simply of hygiene enforcement also bear the hallmark of past projects. But in contrast to the view of malnutrition as having cultural and behavioural causes - many cite insufficient breast feeding and dietary taboos as being key factor in Niger's problems - this pilot project provides an adapted food, and delegates administration of it to the mothers.
It is far from being another vague, large-scale, blinkered programme providing ill-adapted advice.

The high numbers of Nigerien children affected by acute malnutrition each year, together with the existence of a preventative strategy that is potentially more cost-effective than that of treatment, make a clear case in favour of our pilot project. Many children die each year from malnutrition, even those who receive quality care; last year of the 43,000 children admitted to our centres in the Maradi region, 1,213 died. Though this is a relatively low mortality rate (2.8%) it is nevertheless a serious situation.

To wait for children to be suffering from malnutrition would be medically aberrant considering the alternative we have: an effective preventative strategy costing just ?40 per child – compared to an average of ?80 for treatment. We would of course need to examine the impact of our distributions on malnutrition and mortality rates. Some have claimed there is a risk of us focusing on preventative work to the detriment of treatment. On the contrary, treatment remains our priority and the programme's budget attests to this: ?9.5 million for curative care as opposed to ?100,000 for the pilot project.

protection rations for the families of the sick, but we stopped because the nutritional situation has considerably improved these last few weeks.
Patients receive their rations of enriched groundnut paste once a month when they come to their appointments to receive antiretroviral drugs. We did not wish to burden them by adding visits to the current antiretroviral treatments, and we acted on the assumption that they would return between visits if their condition deteriorated, but that is only a supposition. We do not yet have enough hindsight to know if this spaced out follow-up will have good or poor results.

As for the cost, a kilo of enriched peanut butter comes to US$3.60 (2.85 euros). If we take the example of a malnourished child – between 6 months and 130 cm - - his or her treatment will come to about 20 dollars a month (15.80 euros), and that of an adult will come to 25 dollars (or 19.80 euros).

Dr Sylvie Goossen,
Medical Coordinator
By Isabelle Ferry

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

> *Packaged, essentially anhydrous, ready to eat, energy and nutrient-dense, therapeutic foods (RUTF) with specifications adapted from those of therapeutic milks have applications well beyond the treatment of severe wasting and edematous malnutrition that are not being exploited. The CAME, in cooperation with other partners, could be extremely useful in helping reduce the cost, increase the variety and publicize the effectiveness of RUTF products designed for rapid weight gain, thereby stimulating a much more extensive use of such products both within MSF projects and beyond.*

Dr. Milton Tectonidis
Nutrition background paper - CAME Barcelona, April 2006

In 2006 we expect 80,000 - 100,000 admissions and estimate that we'll be able to treat a maximum of 20,000 children simultaneously. With such numbers, an obvious concern is whether the most serious cases will receive the medical attention that they need. Yet prevention could ease this problem. By reducing the number of children suffering from malnutrition it will also lessen the number of admissions to our programme.

What is more, if we are able to cater for those children suffering from 'moderate' malnutrition and those without medical complications through the monthly distribution of specially adapted food, we may be able to review our case management of malnutrition altogether. Not only would lightening the workload like this enable us to concentrate on the quality of care offered to the children who need it most, it is precisely the dynamic needed if we are ever to hope to hand over our programme to the Nigerien government.
The point of the pilot project is not to demonstrate the superiority of prevention and start applying it in every case and everywhere while neglecting our treatment work, but to improve our handling of acute malnutrition. In this, the project echoes the campaign, which we want to lead, for wider use of ready-to-use therapeutic foods (RUTF) such as *Plumpy'nut*. Though used as a treatment for severe cases, these foods are still not recognised as a solution to moderate malnutrition. As for their pre-emptive use, as a food supplement for children at risk of malnutrition, this has not even been discussed.

RUTFs could also be given to patients with AIDS or tuberculosis who are suffering from weight loss.
We need to think about how we use RUTFs in our own programmes, explore new avenues, and bring the debate out into the open – especially as widening the scope of their use will contribute to a much-needed lowering in prices and will make these therapeutic foods more accessible. ■

Interviewed by Rémi Vallet

→ In Our Other Programs (next)

IN SOUTHERN SUDAN - AKUEM: CRISIS PREVENTION

Every year during the hunger gap in Akuem in the Bahr el Ghazal province, the most vulnerable sections of the population face real food insecurity. In this region, which was destroyed during the north-south conflict, the repercussions of the war and a lack of health infrastructure continue to weigh heavily on the food situation. Malnutrition is therefore both chronic and predictable. There are two possible solutions: wait for the crisis, or work further upstream to minimise malnutrition.
"It is this second solution that we have been prioritising since last year, because clearly we cannot let children become malnourished", explains programme manager Pauline Horrill, "especially since, for half of them, malnutrition is caused by disease." So in 2005 two-thirds of the malnourished children were treated in two outpatient centres, linked to a therapeutic feeding centre for children requiring hospitalisation. Two blanket feeding programmes were also organised, each catering for 15 000 people and targeting families at risk because the WFP's general food distributions were late.
In 2004 we had set up a first outpatient centre. But the drop-out rates were high. We had followed the example of what had worked in Darfur – an experience which was not adapted to the situation in Bahr el Ghazal. Instead, it is the success of the experience in Niger, with new protocols, adapted products and new inclusion criteria, which has given us confidence in this type of innovative response. We have managed to adapt our response to the needs and constraints of the populations involved. By the end of May, 2 000 children had already been treated in two outpatient centres and one therapeutic feeding centre. The outpatient centres are as close as possible to the families at risk – locating the target groups is therefore very important – which enables the mothers to look after their other children and prevents them dropping out of the programme. "Supplementary and therapeutic feeding centres are cumbersome to manage and are often poorly adapted. Using this very simple approach, people can be treated for acute malnutrition as outpatients. The recovery rates (above 80%) are excellent, as Pauline Horrill points out. It also shows that acute malnutrition can be treated differently and that others could easily reproduce this success.

Caroline Livio

CÔTE D'IVOIRE: IN GUIGLO, FAVORING OUTPATIENT TREATMENT

While the outpatient protocol using mobile clinics dates from 2004-2005, this operation was interrupted in January 2006 before making a timid return over the past few weeks. To begin with, the safety risks and traffic problems produced by the operation (in particular on the two main roads leading to Guiglo) forced the teams to stop the circulation of the mobile clinics at the beginning of the year. Still, they were able to continue to provide outpatient treatment to children seeking assistance at the Guiglo TFC. Between January and April 2006, no children were admitted directly as outpatients. Most children were hospitalized at the beginning of treatment, either for an associated pathology, or due to problems of access to the TFC or social problems. Thus, out of the 257 children hospitalized at the TFC during the last four months, 88 (34%) were in a state of moderate malnutrition with an associated pathology requiring hospitalization, 123 children (47%) were hospitalized with Kwashiorkor, 213 children admitted (83%) had a positive paracheck test, and 149 children (57%) were monitored as outpatients following the hospitalization phase.
Because the safety situation has improved, the team will resume nutritional monitoring at several sites, giving preference if possible to the direct inclusion of children as outpatients.

Dr Annette Heinzelmann, Deputy desk manager

→ **Sudan** © Sven Torfinn - January 2006

Controversial Project proposal

DEBATES

MSF / June 2006 - Translated by Malcolm Leader and Vanessa Martin

MSF's operations in France are frequently the subject of passionate discussion and the proposal to create a project entitled "*Mission for Homeless Rejected Refugees in Paris*" was no exception. The proposal was presented at the operations meeting[1] on 21 March 2006; but the initial recommendation was criticised by Dr Jean-Hervé Bradol before being discussed in the management committee meeting. The latter recently indicated its support for the project, although it expressed a number of reservations which *Messages* will report on shortly. For readers' information, our coverage of this discussion begins with extracts taken from the proposal. However two important limitations should be noted regarding the following summary. They relate to:
- the nature of the documents: this was an operational proposal seven pages long and our summary is necessarily selective and subjective since we have chosen the passages that were most queried by MSF's president in an e-mail dated 28 March 2006, which we have also summarised;
- the time that has elapsed since this exchange took place: the project has evolved since then, taking into account questions raised in the operational meeting and bt the management committee. Once it has been finalised, the "*Mission for Homeless Rejected Refugees in Paris*" will be the subject of an article in *Messages*.

EXCERPTS FROM THE PROJECT PROPOSAL[2]

The proposal for a "*Mission for Homeless Rejected Asylum in Paris*" begins with a series of nine examples of cases seen at the Paris Medical Centre. We have selected three of them (see the box on the next page).
These examples conclude with a series of four points which are developed in the proposal:

- *What are the humanitarian issues?*
- *Who are the people concerned?*
- *What are the medical requirements?*
- *The operational proposal*

1 → WHAT ARE THE HUMANITARIAN ISSUES? THE REFOULEMENT (FORCED RETURN) OF REFUGEES

After a series of useful reminders set out in the initial sub-point of this first part (Geneva Convention, humanitarian law and the principle of "*non-refoulement*" or no turning back), the second point is entitled "*Asylum denied in France.*" It is based on *OFPRA data for 2004; in that year, out of 65,000 applications for asylum only 6,400 individuals obtained a favourable response on a first hearing, and 4,900 on appeal.* This second point concludes: "*the 45,000 whose asylum requests were dismissed during the year are not all pool-owning*

Cameroonians. Is the situation of the "wrongly rejected refugees," who are reduced to beggar status by the system, a humanitarian issue?" The document then goes directly to a final point which asks the question "*are refugees one of MSF's concerns?*" and replies by a series of statements (concerning *de facto refugees - who have suffered violence as a result of conflicts in their country of origin and who suffer violence in France as a result of a policy that denies the right of asylum*, etc), concluding with: *the legitimacy of MSF's action internationally and in countries of origin: these are the same people.*

2 → WHO ARE THE PEOPLE CONCERNED?

The document makes it clear that the people concerned are *homeless persons whose requests for refugee status have been dismissed and who*:

- *are having problems linked to the restriction of the right of asylum in France (first generation immigrants, "wrongly rejected refugees");*
- *are in a very precarious situation (accommodation indicator);*
- *are isolated (do not speak French).*

3 → WHAT ARE THE MEDICAL REQUIREMENTS?

An evaluation of unmet medical needs reveals two aspects:

- *A somatic medical aspect*, based on the last 18 months of activity of the Paris medico-social centre (CMS);
- *mental health*, bolstered by the experience of the CMS and by a clinical evaluation which, in respect of the patients encountered, concludes notably that there is a *need for a reactive system to provide immediate care, and the possibility of short-term therapies (an average of 10 appointments).*

There follows an evaluation of existing arrangements, mentioning *inadequate public care and an overstretched community system.* This is illustrated by comments from various partners (Comede, Avre, Primo Levi, etc). This third part concludes with the following paragraph:

Psychological problems specific to rejected refugees:

- *Traumas suffered in the country of origin;*
- *Situation of exile which is different from chosen immigration (return is not possible);*
- *Possible confinement in a refugee detention centre - seen as a prison and not understood;*
- *Very great fragility of their situation in France.*

In reality persons who are the most traumatised will be ineffective in the actions they undertake (notably as concerns administrative steps relating to refugee status).

4 → AN OPERATIONAL PROPOSAL

The proposal for the "*Homeless Rejected Refugees in Paris*" mission

●●●

1- Readers are referred to the official report of the 21 March 2006 operations meeting – see in the margin.
A first version of the minutes were distributed before this date and concluded that the proposition had been "unanimously approuved by the operations department" and that it would be "discussed at the next management committee meeting" - these minutes however did not mention or reflect the debates that were held during the meeting.

2- The passages in italics are taken directly from the proposal

→ Mission in France. Questions arising from the presentation:

- Are the same intervention criteria used when MSF plans a project in France?
- Should the French citizenship status of the subject affect our decision as to whether or not to intervene in France on projects that go beyond medical help, as has been the case over a number of years?
- Do we want to become involved in projects in France that have a major socio-political component, with the accompanying tension with the French authorities?
- Are we agreed that we should say that treating these rejected refugees, particularly offering them mental health treatment, is humanitarian assistance?
- Given the particular difficulty of people who do not speak French, we propose starting mental health consultations with a Russian interpreter for the many Chechen refugees that are refused asylum. Why start with this specific population that is already the focus of many militant associations in France (Comité Tchétchénie etc.).

Extract from official summary of operations meeting, 21 March 2006

EXAMPLES OF CASES SEEN AT THE PARIS MEDICAL CENTER

M. B. from Guinea Conakry (aged 29)

He arrived at the medical centre in a state of shock. A political activist in Guinea; arrested twice and violently tortured. His father was assassinated. His sister was raped and his mother beaten in front of him. Experiences a great feeling of guilt. Was unable to submit a request for asylum as he was arrested the day he arrived in France and was issued an expulsion order. His appeal was managed carelessly by a lawyer and the expulsion order was confirmed. He has made a new appeal, this time handled by a lawyer appointed by MSF. He could be expelled at any time, as the appeal does not put the expulsion order on hold. He is homeless and finds a bed through the homeless emergency number (115). Has no resources. Eats in the emergency facilities for homeless people. Is extremely depressed, confused and anxious. His interview with Claire was interrupted because he was so distressed he was unable to continue. His case is being followed by AVRE (torture and francophone). He is on antidepressant drugs.*

O, a Turkish Kurd, aged 35

Has been in France for six years. Speaks some French. Former PKK member who was very violently tortured. Rejected by OFPRA and the Appeals Commission. Is trying to have his situation re-examined via a lawyer. Was apparently homeless before being taken in six months ago by a French family and the community network in his town. Has never had social security cover or any psychological assistance. Suffers from an anal abscess, has various physical sequelae, is enuretic, pulls out his hair, spends his days playing with the light switch in his room.... Very anxious and depressed. Tried to seek assistance at the Stains CMP**, which at first apparently said they could not help as they were full. Refused also by the Minkowska Centre, similarly full. Refused by a private practitioner recommended by Minkowska, who normally accepts CMUC*** cases and who speaks Turkish: "I am a private psychiatrist, what do you expect me to do with a case like this?" Rejected also by AVRE, whose translation budget is currently exhausted. Rejected also by Primo Levi, currently full. Following referral by an MSF doctor, the CMP has finally agreed to give him an appointment soon; he is to be accompanied by an interpreter.*

T, a Chechen aged 35. A woman with a young child

Part of her skull is missing and trepanation. Suffers from epilepsy and is partially paralysed on one side. Very significant memory problems, notably short-term.
Although she has been properly treated for her various medical problems, keeps making the rounds of the different health facilities hoping to find a doctor who will have a miracle remedy. Is unable to accept she will not recover her previous state of health. Is suffering greatly. Is not receiving any psychological assistance.
Her case was rejected by OFPRA, but an appeal is pending.

** AVRE = Association pour les Victimes de la Répression en Exil (Association for exiled victims of oppression) [Trans. Note] - * OFPRA = Office français de protection des réfugiés et apatrides (French office for the protection of refugees and stateless persons)[Trans. Note] - ** CMP = Centre Médico-psychiatrique (Medical-psychiatric centre)[Trans. note] -*** CMUC = couverture maladie universelle complémentaire (complementary sickness cover) [Trans. Note]*