messages

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MENTAL HEALTH ACTIVITIES

Freud in the field

MSF / July 2006 / Translated by Nina Friedman

The editors of *Messages* decided to contribute to the reflection currently underway on the relevance of MSF mental health programs by holding a round-table discussion[1] on July 7. The purpose of this debate was to expose the issues, criticisms, difficulties and limits surrounding our mental health programs in their current form. The discussion centred on two major themes: operational policy, and the tools used to implement it. What follows is a partial transcript[2] of this lively debate:

→ **Moderators[3]: What factors lead us to set up mental health programs, and what questions do they now raise?**

Graziella Godain: Our mental health care programs were once oriented toward social violence and exclusion, four years ago however there was a shift —reflecting the shift in the operational plan— toward contexts of instability: war zones, of course, but also natural disasters —as illustrated recently in Pakistan and Indonesia. The questions raised today concern operational relevance and the mental health care approach we offer, particularly in our vertical programs. Perhaps these issues come up less when these activities are ancillary to a medical program, like in Haiti, or when mental health care is part of expanding treatment for the wounded— from war or other forms of trauma The

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On August 6th the bodies of seventeen Sri Lankan members of Action Contre La Faim were found in Muttur. They had been murdered, like the local population there had been trying to help. In the face of this massacre, almost without precedent in the history of modern humanitarianism, recent press releases calling for the respect of security for humanitarian workers –in Darfur and Lebanon to mention but the latest– strike a particular chord.

Danger is intrinsic to many of our activities. Although it is impossible to totally protect ourselves from it, we can try and evaluate the impact of our actions in order to ask ourselves: is it worth it? The question comes up frequently, and may well come up again soon after a new assessment mission in Somalia. But in Colombia and Palestine, where the risks our teams take are coupled with the difficulty of evaluating our mental health activities, we find ourselves incapable of answering the question.

problem we have in the operations department, however, is our inability to interpret, criticize, and challenge these choices, and thus assess the impact of such activities. Because we still don't have any real tools for comparing diagnoses, treatment responses, or the different approaches of the different actors (psychologists or psychiatrists) — which moreover vary from one mission to another.

Marie-Rose Moro: Still, the very first programme was Armenia—i.e. after an earthquake, when the doctors realized that the help people were asking for was clearly more psychological. I would also like to add that—aside from Palestine—when mental health becomes the primary, or majority, activity in the field, it usually has more to do with how a program evolves than with an initial decision. There are exceptions, though.

GG: Poland!

MRM: Yes, Poland — Palestine isn't the only one. But in Indonesia, for example, where we have opened a mental health activity, we still do surgery, even though there's little interaction between the two activities (it would be better if there were more!).

So doing mental health alone is not a goal in and of itself. But the teams sometimes swallow goals like that!

→PPV

GG: One of the big problems is maintaining the connection I think necessary between the medical approach and mental health care. Because, quite often, we find ourselves with two "sub-activities," which causes real problems with relevance and choice. But there are also contexts in which we have decided to stay on just for that. Bosnia, for five years, and also Kosovo. So you can't really say these are exceptions.

Pierre-Pascal Vandini: The Field Coordinator decides on the response. Because to start with there are several possibilities. And the decision is a tactical one. Bosnia is a good example, because we were doing anesthesia there for a long time. Once the Dayton Accords were signed, the question was, do we do reconstruction, something else, or leave...? At the time, the Belgian section in particular threw itself into reconstruction, using funds from institutional donors. That bothered us—not for so-called "humanitarian" reasons or because of expertise, but for tactical reasons! And what we found in Gorazde was, primarily, enormous needs of a psychological nature—the response had to be along those lines. As for Palestine, from what I remember, the first program—in Jenin—was very theoretical. There was a war, which caused mental health problems. We found the problems and responded to them, after having explored all the other medical needs. So we focused on helping children at a centre for families and children.

MRM: And the first children were suffering from enuresis. It wasn't until we began treating bed-wetting that children who had experienced extremely severe situations came in. So it happened very gradually.

PPV: The second project we started was in the Terre des Hommes feeding centre. They told us, "The mothers are crying, the children aren't gaining any weight." So our objective was to make the link with malnutrition—an objective that got lost somewhere along the way. So doing mental health alone is not a goal in and of itself.
But the teams sometimes swallow goals like that! And there are other examples! I've visited villages where the Field Coordinator said, "We're here to do mental health," leaving out the medical activities. That's a departure from the objective, too.

Rony Brauman: It's clear what leads us to set up mental health

OUR OPERATION IN ARMENIA (1988-1989)...

MSF / July 2006 / Translated by Frank Elliott

We delved into the MSF archives to look up the records of our operation in Armenia after the 7 December 1988 earthquake. What were the driving forces of our intervention? Here are two elements of the reply: an excerpt from the editorial of Messages dated 14 February 1989, some two months after the disaster. The second is an excerpt from *Psychiatrie humanitaire en ex-Yougosalvie et en Arménie* (Humanitarian psychiatry in former Yugoslavia and Armenia) published in 1995 under the direction of Marie-Rose Moro and Serge Lebovici:

« 7 December 1988 : one of the largest seismic shocks to take place this century wiped out the lives of several thousand people. Unbelievable, distressing, shocking images (...). The Brussels, Paris, Amsterdam, Barcelona and Geneva sections has mobilised all possible resources, with the assistance of the EEC Emergency Fund. An all-out effort has been launched jointly with SOS Armenia and the Union of Armenian Doctors in France. After the initial emergency phase, Médecins Sans Frontières proposed a medium and long-term aid programme. It has been agreed with the Soviet authorities. 38 MSF doctors are still in Armenia. It is impossible to summarise in just a few lines everything we have felt, experienced or shared. Soon a book containing a collection of personal accounts is to be published. If I had to encapsulate everything we have experienced since the 7th December 1988 in one word, this word would be 'emotion'».

Antoine Crouan
Editorial of Messages – 14 February 1989

« Right from the start of the humanitarian operation, the doctors reports' mentioned signs of psychological problems amongst the affected population, especially amongst the children. An MDM study noted, though the semiology was not clearly defined, that 70% of the children in the affected zone presented serious signs of trauma. Reports from psychologists and psychiatrists sent by MSF in the field at the time confirmed this. It quickly transpired that the psychological therapy administered on a one-off basis was insufficient. The Armenians asked MSF to consider setting up a healthcare facility that could provide longer term healthcare for children and their families that had been victims of the earthquake. But what kind of arrangement could we set up in this particular context? That's how I was asked to set up a healthcare facility that was able to respond to such an acute situation and to the specific needs of the Armenian people. (...) This was the first time MSF had decided to mount an operation to provide treatment for psychological problems. This need was dictated by the amount of psychological distress found in the field».

Marie-Rose Moro, *in Psychiatrie humanitaire en ex-Yougosalvie et en Arménie*
– PUF publications, December 1995.

programs. It's no mystery; it's an initial traumatic event that leads to a series of symptoms grouped under the name "post-traumatic stress disorder," or PTSD. What Marie-Rose said is that we began with the earthquake in Armenia, that that was an event that could indeed be described as traumatic. After that, if we look objectively at MSF's history, ignoring the particularities of the various missions, we see primarily that category of pathology. — In passing, we should note that this traumatic event is even theorized, since in *Soigner malgré tout*[4], which is like MSF's mental health bible, it is even recommended that populations in danger be classified as level 1, 2, or 3, according to the intensity of the violence they were exposed to. Now, there's a problem right from the start, and it's a problem for which I feel partly responsible for; I had a different take on Armenia than Marie-Rose, because what I saw at the time was MSF asking to stay in what was an extremely compelling situation emotionally both for the French, with regard to Armenia, and for MSF, with regard to the teams. The emotional commitment took place within a new framework that was starting to emerge, and which took shape at that moment—victimology. That's what led us to set up this type of activity. Moreover, we can draw a parallel with surgery. If, at certain times in our history, surgery has been part of a greater whole, integrated into other medical activities, it can also from time to time become autonomous, and exist

Indonesia © Sebastian Bolesch - August 2005

1- Participants: Rony Brauman (Fondation MSF), Graziella Godain (deputy director of operations), Annette Heinzelmann (deputy programme manager), Marie-Rose Moro (mental health advisor), Claire Reynaud (mental health officer) and Pierre-Pascal Vandini (member of the Board of Directors).

2- We were unable to reprint the entire discussion here for lack of space. In the interest of readability and coherence, we have summarized the original transcript. The entire transcript of the debate is available on the Association website at www.msf.fr/asso.

3- Bénédicte Jeannerod and Olivier Falhun

4- *Soigner malgré tout* T1 et 2 MSF/Editions La Pensée sauvage - 2003

on its own—there are, after all, reasons for making that choice. And in the same way, we do this kind of "mental surgery"—that is how I describe it critically—on its own, in various missions. Besides, unlike Graziella, I do think we assess it, because I read the articles! We assess, and we find excellent results—results that should be the envy of everyone! On average, two thirds of our results are good or very good; we truly have invented a magical treatment, because getting such good results with no side effects, that's really remarkable. There's a method we should be sharing! Obviously, I'm being ironic...

MRM: That's an understatement... Because no one said we weren't trying to assess...

RB: What I mean is, my response to what Graziella said when she stated that we had a problem with assessment is that, judging from what we write, it doesn't look like there's a problem.

GG: I was talking about the operations dept., because we're not comfortable with that kind of assessment. Right now, the operations dept. is not capable of accepting and taking responsibility for those assessments. We're in a black hole!

RB: That's just what I meant! There's a sort of growing conflict between these figures, this highly constructed, even soothing, discourse, and a reality of questioning, of doubts on the content, form, methods—in short, a general uncertainty. If there wasn't all this uncertainty, there wouldn't be so many of us around this table!

[...] we truly have invented a magical treatment, because getting such good results with no side effects, that's really remarkable. There's a method we should be sharing! Obviously, I'm being ironic...

→RB

PPV: In that case, Rony, can you tell me what you think the traumatic event was that pushed us into the Gorazde program?

RB: Of course! In the framework of this magical treatment, we realize that early intervention is admittedly preferable. But what's magic is precisely that it still works even years later! e.g. the intervention in Sierra Leone in 2000. And you can't say that Gorazde is an area that has been free of violence. So any event—not necessarily violent—any traumatogenic, inaugural event, is enough to provide an almost automatic justification.

→ Moderators: What do you think about Rony's criticism, and about the issue of trauma, the basis of our mental health activity?

PPV: I have a problem with it. And with how the debate is being handled! We all began by saying that that wasn't MSF's history. I also gave examples, adding that we do not focus on trauma every time, and that it isn't a question of MSF asking to do it, but of responses to requests coming from elsewhere. And Rony comes in saying "I say that it's the other way around," without any explanation; that's why I asked the question about Gorazde, because there were thousands of traumatic events, so he needs to define exactly what he is talking about, to support his hypothesis—especially since we intervened at a time of peace.

RB: Just like in Sierra Leone! "Intervenir à distance du trauma, une

"*The other 'vulnerable' group most targeted by humanitarian aid agencies is 'traumatized children.' However, Richman (1993) observes that the emotional well-being of children remains reasonably intact if the parents, or the other people they know, are with them and offer a reasonably reassuring and stable presence. If they lose this presence, the well-being of the children can rapidly deteriorate and the rates of child mortality increase. It is not so much about knowing whether the orphans and other children without protection need attention, but to ensure that this attention is provided on a social rather than psychological level.*"

Derek Summerfield in ***L'impact de la guerre et des atrocités sur les populations civiles : principes fondamentaux pour les interventions des ONG et une analyse critique des projets sur le traumatisme psychosocial*** **– (The impact of war and atrocities on civilian populations: fundamental principles for NGO interventions and a critical analysis of psychosocial traumatism programs)– Emergency Aid and Rehabilitation Network, Thematic report #14 – April 1996**

IN SUDAN, AMONG THE ABANDONED CHILDREN OF MYGOMA

"Mygoma is a broad medical care programme (nutrition, psychosocial...) aimed at abandoned babies and children under six years old. The mental health activity is defined by the very nature of our programme. We came to the orphanage of Mygoma because infant mortality was very high, particularly because of problems of malnutrition. But treating these children by simply giving them food would not have been enough. We knew that the problems of malnutrition were also connected with the situation and the environment of these orphans. Furthermore, the orphanage represented an institution, which, by its very nature, did not offer them the mother-child contact which is essential to their development. It was, therefore, unimaginable not to include a mental health aspect in our care package. So right from the start we chose a multidisciplinary approach.

The first objective was to optimise the environment of the child in order to avoid delayed psychomotor development or emotional difficulties. That can be achieved through prevention. Indeed we encourage the nannies to detect difficulties in the child but also to stimulate the infant. The second objective relates to the individual care given to the children once they have been targeted.
So we must define the initial objective and the approaches, to identify the populations and their specific psychological needs and to adapt the objectives according to the priorities. In the Darfur region, for example, there are definitely psychological needs in the people we are treating. But in this case psychological needs do not seem to us to be a priority today. In contrast to these adults, the children of Mygoma do not have the means to overcome their difficulties on their own.

As this programme is closing at the end of 2006, we are going to transfer our activities to the authorities. The psychological treatment must continue after we have left. That is why we have established links with the university medical faculties and the students and we hope that the authorities will take over our team of psychologists."

Dr Pauline Horrill, programme manager – Interview by Irene Nzakou.

→ **Sudan** © MSF/Caroline Livio - May 2004

urgence en Sierra Leone [*"Intervening long after trauma, an emergency in Sierra Leone."*] That's what it says in *Soigner malgré tout!*

PPV: You can argue with the book if you want, but here this is a debate with people who are telling you something different, and you're not listening to us...

GG: About Gorazde, if you say that there were many, many traumas and that wasn't why we intervened, then why did every other page in the report, signed by Karine Le Roch, say we were working with trauma? In most of today's projects, the teams and the psychotherapists are focused on trauma—that's what I have a problem with! When psychotherapists tell you that they're busy trying to fit patients into a grid, rather than having a grid that corresponds to the state of the patients, I have a real problem with that, too. And yet that's what we're being told.

MRM: First of all, I want to respond to Rony's criticisms, because otherwise it's not really a debate. One doesn't rewrite history. I was in Armenia, too, and I really didn't see the same thing you did. The request was extremely clear, both from MSF and the people themselves, who easily identified the issue, in direct relation to the event. And then, gradually, we began to see cases of depression, or anxiety that was getting worse, rather than better. We have never said we were doing victimology! And in my first meetings for the programme, there was nothing emotional going on. Rony says that the teams absolutely wanted to stay—that's not true! MSF was monitoring the situation, and mental health care became conceivable for MSF when it started considering feasibility and available resources. It was only afterwards that we looked for the human resources to support the programme.

When psychotherapists tell you that they're busy trying to fit patients into a grid, rather than having a grid that corresponds to the state of the patients, I have a real problem with that, too. And yet that's what we're being told.

→GG

Secondly, yes, we go places because there are events, like war, a string of acute events or chronic breakdowns... But these interventions are closely linked to MSF policy. In the same way, if MSF decides to stop focusing on exclusion, we'll stop doing mental health in situations of exclusion.

As for the trauma issue, unlike other actors or other sections, we have always favoured carrying out therapeutic consultations to deal with situational suffering, which excludes serious, structured psychiatric disorders. But while there are, in fact, things directly related to traumatic events, and we probably should have done a better of job of resisting the pressure to want to put everything under the heading of trauma, Karine's report [after Gorazde – ed.] shows that treatment was not limited to post-traumatic situations...

PPV: That "traumatic event/response" logic is just what I'd like to pull apart. Because in Gorazde, in the beginning, we were responding to people who were having problems, not to an event.

RB: Psychiatry is the only treatment technique at MSF where we put out

> *"The question of témoignage is an important one. In fact, there are several kinds of témoignage. ... We try to find forms adapted to the experience of the place, the time, and the environment: accounts, films, expositions of children's drawings, anything that can enable the witnessing to be as close as possible to what we have seen, heard, and understood. Furthermore, there is direct testimony that the people themselves confide in us as witnessing. In this case, the NGO, the entirety of the association, tries in a multidisciplinary way to find a possible form for these words, drawings, or denunciations; for instance, when there is an official report or when someone has witnessed something very serious. The form has to be reinvented every time as a function of the content, and as a function of what we imagine is capable of giving account and of touching those who were not that in that place, at that time."*
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> **Marie-Rose Moro, extract from *Soigner malgré tout – Volume 1* MSF / *La pensée sauvage* – April 2003**

→ On the discontinuity of care in Gaza: *It is important that the absence be explained, and that the absence is justified (the absence must also be understood and accepted by us, so as to avoid any inner conflicts we might face). However, there are paradoxical situations where one is not able to respond to the most obvious needs. The premise of quality that MSF has made its own - reaching inaccessible populations - 'may' at times not exist. We must consider this and take it as it is.*
All this to say that the ideal has always been and remains to try to be in the right place, *which will allow us to reweave the symbolism and give meaning back....*

Maryvonne Bargues
MSF Psychiatrist in Gaza – Palestinian Territories

ready-made lists of signs and symptoms. And while Graziella talked about psychotherapists in the field having to tailor their practice to conform to certain categories, personally I have a bit harsher view of this carving away at psychological signs so that they fit into the category of trauma. And we really do have to talk about the consequences of this, because it has enormous consequences...

PPV: In that case, I'd really like to know what our tools for malnutrition are, if not a list of tables and techniques? It's useful, because after your training in France, you've never seen a malnourished child! It's the same thing for mental health.

→ Moderators: Annette, based on your experience in Colombia and Palestine, for example, what is your view of these programs?

Annette Heinzelmann: The questions I have are less about Palestine—where there's a much clearer humanitarian issue—than Colombia: are we relevant there? Does what we offer correspond to the needs of the population? Do the results justify the risks that our teams are taking? Etc.

This is where I concur with Graziella: we feel that the means at our disposal don't allow us to evaluate these questions. And there's also the issue of knowing how.

Because we're asked to take operational responsibilities and make operational decisions, based on data that, to me, don't mean very much.

→ Moderators: Is it the mental health program itself that's being called into doubt, or is it not, more broadly, MSF's presence in this type of context?

GG: Both! The purpose of our being in Colombia is, above all, to provide assisatance to a population that is victim to war. Yet most of the problems with which the teams are confronted are socioeconomic in nature, and are not specifically war-related—though the war doesn't help matters. This insistence on treating, no matter what—which in this case involves mental health care, but which could just as easily involve mobile medical clinics—results in care that is inappropriate and ill-suited to the context. The people who pass through the mission say they're looking for trauma, since the original objective was war, and "war equals trauma!" And they realize that they don't have much trauma! But it's the whole MSF organisation—not just mental health—that bears responsibility for this excessively interventionist, trauma-oriented interpretation, which has now created a significant rift. Because once again—and Colombia seems like a good example to me—I think we are fundamentally off the mark. Which leaves unanswered the basic question of whether there is a possible humanitarian response in this type of context?

[...] we're asked to take operational responsibilities and make operational decisions, based on data that, to me, don't mean very much.

→AH

PPV: Like you, I think it's not the psychotherapists who have insisted on trauma and who read every event in terms of it, it's MSF in general and it's historical, just like we've gone in search of physical trauma, as in "war equals surgery!"

Claire Reynaud: The trauma diagnosis is something that I wasn't acquainted with in my prior practice. I learned of it at MSF, unwillingly—because I was not comfortable with the notion, or with the victimological approach. My goal, when MSF began collecting accounts (I participated) was rather to show the operations dept. what we were doing and tell them how we were doing it, by describing the suffering that the patients were experiencing and how we were treating it—were we going to see them individually, in small groups (for children, for example), as a family, etc.? Were we going to do psychotherapy or psychological support...? The idea was to have something concrete, to have feedback on our activity, and then to be able to analyze it. The list of signs comes from the DSM-IV (American classification system of mental disorders – editor's note), and it's true that there are problems with the DSM-IV.

→ Moderators: Which brings us back to the notion of PTSD, which is also being questioned. Rony, what, in your opinion, are the consequences of using an approach based on such notions?

RB: PTSD is a very unique psychiatric classification in that it's the only one—and this is what distinguishes it—that is entirely defined by its etiology, that is, by its origin. There is a causal event, a situation deemed profoundly abnormal, and then the individual's reaction. PTSD is what some have called a normal response to an abnormal situation. While we're at it, we might well wonder at the objective of going to the other side of the world to tell someone that what he has is normal. But on

MENTAL HEALTH CARE PROGRAMMES MAINTAINED IN GAZA

Translated by Penny Hewson

"Despite the deterioration in security conditions (there are fewer and fewer foreigners in Gaza), we have decided to maintain our mental health activities. Because the targeted assassinations cause a lot of civilian casualties, people being in the wrong place at the wrong time, stress and nervousness are making themselves felt more and more within the population. The noise of explosions is constant and terrifying, particularly for children. The violence, the consequences of daily incursions and shell fire can generate psycho-pathological reactions which need to be dealt with quickly. Thus, despite how difficult it is to travel around, some patients – particularly those from the areas most affected by Operation Summer Rain – have made their way to us, asking to start consultations again as soon as possible. These had been broken off when the expatriates who were in Jerusalem at the beginning of the military operations had not been able to return to Gaza. They have been taking place again since 18 July which saw the return of our psychologists and the resumption of the treatment – at home and at fixed points – when security conditions allow. Nevertheless, access remains particularly problematic in the zones to the north of the Gaza strip near the bombardment zones. "

Laura Brav, Head of mission in the Palestinian Territories
Interview by Isabelle Merny

→ **Palestinian territories** © Alexandre Sargos - May 2004

the theoretical level, since what defines PTSD is the event, the unconscious is taken out of the reaction—which puts us in the category of what's called cognitive, or cognitive-behavioral, therapy. But what I don't like is trying to have it both ways at once. That is, we claim to take a psychodynamic approach, therapeutic listening to patients, but at the same time we're developing techniques that belong to CBT—cognitive-behavioral therapy—and in my opinion, it's this sort of clumsy syncretism that makes this approach seem fairly shaky... Because I don't know how we can talk about analytic listening when the unconscious is disregarded, and we give a series of 4 or 5 sessions on average. But what's also annoying is that the conscious mind is disregarded, too! Since when you read about Indonesia, for example, you read that there were 500,000 potential victims of trauma, among whom we had to go find the ones who were asking for help. And we realize that

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A PROJECT CALLED INTO QUESTION IN POLAND

"In October 2004, MSF carried out an exploratory mission in Poland, a country that had just joined the European Union, to assess the situation of the Chechen populations who were arriving in Europe to request asylum there.

In August 2005, we decided to open a mission and to develop a psychological assistance program there in the 14 centers for asylum seekers spread across three geographical regions (Warsaw, Lublin, and Bialystok). This intervention was justified because it was aimed at Chechen refugees who were fleeing from the violence they had suffered in Chechnya, but also because their mental suffering had not been treated, neither by the Polish authorities nor by anyone else.

In February 2006, I wanted to question not only the relevance of the MSF operation, but also the program that we chose to develop, namely a vertical mental health program.

Although I did not in any way deny the mental suffering of this population, it was our "raison d'être" in Poland that posed a problem for me. Where is the issue? To my eyes, it is elsewhere.

The Polish authorities, with the resources they have available, are providing the Chechens with assistance – medical care, lodging, food, social services – more from the viewpoint of integration into Polish society than with a will to grant refugee status. The Chechens are not being sent back to Russia or turned back at the Polish border; they are not stigmatized, they are not in danger.

On the other hand, the Chechens do not wish to stay in Poland, and are trying to reach the more Western countries, particularly Germany, Belgium, and France. Despite their efforts, more and more of them are being sent back to Poland under the Dublin II regulation. For this population, Poland is an isolated country, surrounded on the East by the new reinforced European border between Russia and Poland, and on the West by the Schengen border with Germany. We are facing the issue of European policy on controlling immigration flows and asylum seekers, and its consequences in terms of travels, confinement, etc.

Beyond the question of vertical mental health programs, what place is there for MSF in the twists and turns of policies on asylum seekers?

The Poland mission will be closing at the end of 2006."

Malika Saïm, programme manager

MOBILE "MEDICO-PSYCHOLOGICAL" CLINICS IN THE REGION OF TOLIMA (COLOMBIA)

"In 2001 MSF opened a programme of mobile clinics to supply the people affected by the conflict which is raging in the region of Tolima. The objective was to go places that the hospital staff cannot reach, unless an international organization can ensure their protection.
In 2003, the conflict evolved. The intensity of fighting between the armed combatants decreased and the health services were able to reach rural areas more easily. Nevertheless, the climate of generalized violence against civilians, used as a means of controlling territory, continued. It was during this period that the doctors reported that behind the everyday ailments they treated were hidden the effects of violence (somatic illnesses). Indeed, a study carried out by our doctors, and confirmed by an evaluation carried out by a psychiatrist, showed that 10 % of the patients presented significant signs of psychological distress, most of them linked to a trauma or a direct event of the conflict.
Thus, since the end of November 2003, a psychologist has been part of each mobile team in order to be able to treat patients suffering from problems connected with the conflict. This objective was, however, limited since the clinics only went to a zone once and therefore there was no possibility of follow-up of patients. Given the situation, we rectified our mode of operation in 2005. Thus, we doubled our psychological team to meet demand and started returning several times to the same place when we registered patients who had been psychologically affected by the violence and whom we needed to follow up. The choice of intervention zones was made according to the violent events which had recently taken place there. The trend was therefore reversed. At present, it is the medical care which goes with the psychological and which serves to "identify" the patients. But the interaction between the medical and mental health activities is interesting. It allows us to treat the pain and distress of the same patient, even if the diseases are often benign.
Regarding the impact which we are having on the people in our mental health activities, we offer them the opportunity to unburden themselves by offering them a space for talking and listening, taking into account the suspicion and mistrust which exists between the members of a community, sometimes even within a family. As for the patients who are followed up, we help them to connect their suffering with an event or a situation which caused it, in order to try to alleviate some of their distress. Although it is little when viewed on the level of a department, it is a lot when one puts oneself in the position of the patient who comes through the door of our surgery with this enormous need to get rid of his distress and when he no longer knows how to deal with it."

Stéphane Doyon, Head of Mission in Colombia

"*M. is a woman who experienced a violent incident four years ago. In her village, many people were murdered, including (...) her friend and the godfather of her son (...). Three months ago, there was armed fighting in her village. This had a strong emotional impact on her whole family. She was discouraged, suffered from insomnia, had breathing problems, and 'psychosis', a term that she used to describe a state of anguish and permanent concern at the idea that more armed fighting could break out at any moment. During consultation, M. realized the benefit of being able to talk to and especially to be able to place trust in someone. When she was asked at the end of psychotherapy if she understood the reason for her improvement, she responded that* if one does not let go of what is attached, one cannot relax"

Diego Fernando Mercado, MSF Psychologist in the Tolima region in Colombia. Extract from "*La psychologie clinique auprès des populations affectées par le conflit Colombien.*" (Clinical psychology among populations affected by the Colombian conflict.)

we're going out looking for clients! So I have a theoretical/practical problem with that.
The second thing that seems questionable to me is that all this is based on the liberating power of talking, which several studies are calling into question. Armed with this instrumental technique of using talk as a release, we can intervene indefinitely. This explains the widely-held impression that when we don't know what to do, we do mental health!

MRM: I don't agree that we let confusion take root. With regard to Colombia, if we think that the risks are too great and the benefits secondary, then it is urgent that we ask ourselves about the humanitarian response overall. Because this issue isn't just about mental health, it's about MSF's ability, will and policy in this particular context. An issue which is also evolving.
On the question of lists, we have used lists throughout our history—lists of symptoms, for example. Some are obsolete; others have stood up quite well. We have also evolved, with MSF as a whole, on this point: at some moment in time we have to describe where we start from with patients and where we end up—it's the same for all the missions. I well remember countless meetings on the subject, which Epicentre later joined in on. Of course, they [*these lists – transl.*] are open to criticism, but they aren't intended to describe the whole of one's mental life. They supplement the record, the clinical history.

With regard to Colombia, if we think that the risks are too great and the benefits secondary, then it is urgent that we ask ourselves about the humanitarian response overall.

→MRM

As for the unconscious, of course it's not disregarded! Each person has a mental representation that includes all dimensions, but the framework simply would not allow us to work on unconscious fantasy and to offer interpretations on unconscious fantasy, it's just not possible! Besides, the 500,000 people Rony mentioned is a figure I took from the WHO for one of my exploratory mission reports, but we never set up a system for 500,000! We set up an extremely individualized system: a consultation, attached to a hospital internal medicine service, where either patients or doctors requested mental health care. Let me also remind you that the only condition for going is to treat—unlike, for example, the Dutch, who do prevention. They are the ones, for example, who give out little sheets saying "These are normal reactions to an abnormal event." We have always offered individual therapy, or group therapy in certain cases, and we don't impose any conditions other than that of the clinician. The psychotherapists can have different types of training. If they don't agree—that is, if they don't feel qualified to provide individual therapy, then they don't go.

→ **Indonesia** © Sebastian Bolesch - August 2005

Finally, there's the issue of liberation through talking... It's not about liberation through talking; it's about the importance of narrative. To establish a relationship with a patient—which is the basis of all individual psychotherapy—you must share a narrative. Of course, the patient will often say to you, "It does me good to talk." There are also patients who say, "I can't talk about that!" But it's less a question of obligation than of necessity, in order to begin a therapeutic consultation. Yet is everything based on the notion of talking that frees? Yes, in the sense that it is necessary for the patient to be able to say a certain number of things related to what he has experienced, his suffering, etc. There again, however, we respect the fact that, in certain cases, in the interest of self-protection, it is better not to talk, and to be able to develop inner resources.

PPV: I find it outrageous to focus the debate on the issues that Rony brought up, which are theoretical issues for specialists. Where is MSF's responsibility, where are the RPs when it comes to making decisions and choosing directions? You get the impression from this debate that the psychotherapists have taken over MSF! The implication is that MSF has allowed itself to be manipulated! This denies MSF's involvement and history, by ignoring the responsibility and the uncertainties—both past and present—of the heads of mission, the RPs, the MSF actors.

RB: I began by saying that it was a question of collective responsibility, and I include myself, because back then in Armenia, I thought this approach had some validity. I also said that there was a problem with the fundamental concept upon which we have based a whole series of interventions and operations, that's all!

MRM: But we didn't base it on a concept of diagnosis. That's just where I don't agree either with what is implied...

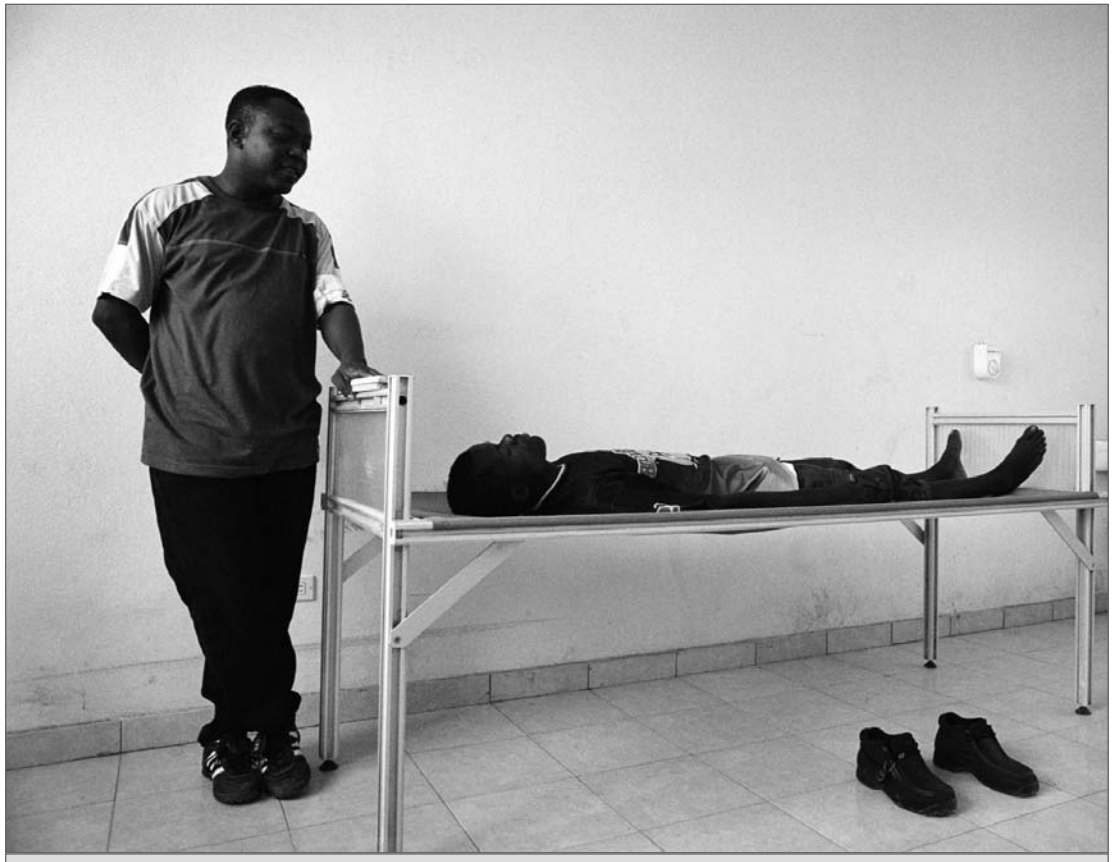
GG: Be that as it may, all this has brought us to a rigid interpretation centered on a single issue, involving operational choices with which we're extremely uncomfortable. Most of the time, we're faced with no-choice situations, which are unacceptable, since I myself am incapable of having either a positive or negative opinion on the impact of our activities. That's the reality! Though it's also true that when the concept of trauma came along, it made everyone more comfortable—including the operations dept.—because it made things simpler for us, and allowed a direct relationship with the operational reorientation. The fact that, afterwards, the operations dept. pressed to get tools, didn't follow the tools that were created, wasn't necessarily involved or didn't involve itself in those tools, that's a reality, too! What we can say now about the dynamic between the operations dept. and psychotherapists at MSF is that it doesn't exist. We can't say that the work we're doing on this issue, together, is adequate. And we will already have accomplished something if this debate helps us re-establish a number of ties—specifically, one: operational aims and why we do this program; two: how we do it; three: how we assess it; and four: when do we stop doing it...

Because up until now, we never close because we think we've treated the people we wanted to treat, or because we've gone all the way to the end of our intervention.

You get the impression from this debate that the psychotherapists have taken over MSF! The implication is that MSF has allowed itself to be manipulated! This denies MSF's involvement and history, by ignoring the responsibility and the uncertainties—both past and present—of the heads of mission, the RPs, the MSF actors.

→PPV

PPV: I agree with the problem as you've stated it. But what does the notion of the liberating power of talk



→ **Haiti** © Dieter Telemans - October 2004

> *"What should we do if certain patients, despite everything, through everything, remain the same and slowly die before our eyes? Well, at least we will have succeeded in alleviating their suffering and not profiting from the care we gave them, compelling them to face 'normalisation' obligations that overtake them and wound them. Let us not add to their pain and accept, humbly, as health-care workers, to comply with the first Hippocratic principle: First, do no harm"*

Extract from Patrick Declerck: Les naufragés, (The shipwrecked), Terre Humaine collection, Pocket, Plon - 2001

have to do with this debate? This is an attack, which doesn't resolve the problem and which implies that there's a malign psychiatric influence at MSF.

GG: Yet these are day-to-day issues! For example, as part of the operational plan we are now looking to treat victims of sexual violence. The reality is that some expatriate or national health staff have a problem with trying to get a woman to talk—particularly about what she's been through—and that the benefits of this talking are questioned by these expatriates or national staff who believe, on the contrary, that it is counterproductive. People today tell me, "Sorry, a rape victim, I'll do a medical examination, I'll do a gynaecological examination, if it's less than 72 hours I'll give her emergency contraceptives, but I've got a real problem with the rest!" So there's a real problem of commitment to these issues.

PPV: That makes me wonder about the training that doctors are getting, more than anything else!

→ Moderators: For those of you in the operations dept., what, in practical terms, are your expectations from the psychotherapists?

AH: First, there's a real need to seek out a dialogue, and to have a closer relationship with the psychiatrists and psychologists, similar to that which we have, as a matter of course, with the medical dept.. For the moment it feels like our discussions just go round and round, without any resolution of recurring issues. Result: our actions suffer, between the fear of setting up some excuse for a program and not knowing which elements would allow us to stop our activities. We also need to demystify the mental health programs. We don't really know what's going on, how it's happening, etc., or why it is that

IN OUR TUBERCULOSIS PROGRAMME IN ABKHAZIA:

"Psychological counselling began in the second half of 2005 in Abkhazia, where we were running two programmes: one providing access to health care, mainly for the elderly, and the other concerning the treatment of tuberculosis, including multi-drug-resistant tuberculosis (MDR). Initially, MDR patients were to be the primary focus of psychological therapy, with some therapy devoted to the health care access programme, particularly palliative care for patients in the last stage of their illness (such as cancer). But at the present time, we are mainly concentrating on the TB/MDR programme.
The major objective of psychological counselling for MDR patients is to help them scrupulously follow their treatment regimen and handle all the difficulties imposed by this chronic disease. The drugs they take have many side effects. Recent analyses conducted by our psychologists show that 77% of MDR patients suffer from severe anxiety and 58% from moderate depression. The main goal of this psychological support is to help patients overcome these problems.
We have just begun and are counselling patients who have been receiving medical care for more than two years. We should therefore wait a little longer to evaluate the impact of psychological support on their quality of life. The patients are, however, very interested in working with psychologists and are happy with this new aspect of the programme. I think that counselling plays a key role in resolving problems related to TB patients adhering to their treatment regimen and preventing others from abandoning treatment."

Dr Babak Abbaszadeh – Medical coordinator in Georgia

these programs occupy such a specific place within the projects. If we want to do it—and here I'm getting away from any theoretical discussion—in that case, what is the best way to get there, and to integrate it? And why is it so hard, like this discussion? The fact is we wouldn't be fighting so much if we were talking about malaria!

GG: The various RPs involved in these projects also do comparisons, and when they compare Colombia and Palestine, saying, "Marie-Rose told us that in Colombia, two or three sessions do the trick!" Then we plan eight to ten sessions in Palestine, etc. We can't work that way! The operations department can't play its critical role, can't assess the quality of what's being done, or make real choices on operational strategy, it's not possible. This leads the operations dept. to throw up its hands, leaving the psychotherapists free to practice as they like, and no one understands anything about what they're doing. That's where things stand!

IN HAITI, MENTAL HEALTH INTEGRATED INTO THE PROJECT

"Psychological assistance for patients emerged naturally in March 2005 thanks to a local partnership with the organization Healing Hands for Haiti (HHH) which had a Haitian psychologist at its disposal. MSF wanted to further in the care provided to its patients, whom were mostly victims of serious traumas. The creation of the Pacot rehabilitation centre, combining psychological help and physiotherapy, has allowed this ambitious step to become reality in terms of medical quality and complements our traumatology centre opened in 2004.

The first objective was to create an environment which would promote the physical and mental rehabilitation of our patients. The centre was installed in an enormous Creole building from the beginning of the last century, situated in the heart of the residential district of Pacot. Moving the patients into this relatively calm place – most of them come from shanty towns where violence is omnipresent – helps create a beginning of serenity which is ideal for this type of care. Psychological support, based on listening, is given to the victims of trauma (victims of aggression, gunshot wounded, amputees, raped women), and also to their families. This helps to alleviate some of their distress and to reassure patients who have been particularly badly affected.

The mental health care activity in Haiti is integrated into the traumatology centre; otherwise it would have no sense in my opinion. To recognise and treat the mental distress of victims who have undergone great physical traumas seems to me to be ethically very relevant and allows us to widen the range of care we provide and therefore the quality of the medical treatment. Furthermore, this significantly improves the patient/carer relationship by humanizing it, which is obviously important in a humanitarian approach. One can however question the limits of the psychological intervention. I think it would be difficult to include mental illnesses of a psychiatric nature in the programme, although we frequently come across them. On the other hand, I am personally sceptical about the universality of mental health practices, even more so in a country where voodoo beliefs are widespread. That is why I am not sure that this activity would have been able to function without the presence of local psychologists, which are not available in all our intervention countries. Some of the victims are also perpetrators of violence. Apart from the problems of cohabitation between victim and aggressor which sometimes occur, I wonder what our mental health options are in trying to address the perpetration of violence in a healthcare approach. Can violence be cured? "

Yann Libessart, Head of mission in Haiti

MRM: But the conditions in which we work in Colombia are different!

CR: I think we should to try to come up with treatment diagrams or methods. It's true that these books have a lot of theoretical stuff in them, but there are few practical elements. We've put together a working group with the operations dept. that should improve the interface between the two entities. Because there are many experiences, and many issues for which we should try to offer some guidelines. And there will no doubt be some debate. For example, I am more comfortable talking about distress, or suffering, but perhaps we'll have to talk disease... The working group consists mainly of physicians.

→ Moderators: What, exactly, are the different approaches? And what is MSF's approach?

CR: There are big debates, at the international level, regarding the most effective approach. Is it the cognitive therapies (more Anglo-Saxon in origin) or psychoanalysis-inspired psychodynamic therapies (more francophone in origin)? Personally, I don't think it can be resolved. Unlike the psychodynamic approach, which depends much more on the individual's reaction and commitment, the cognitive therapies are presented as extremely structured, with a beginning, an end, a progression, a practice, a tactical approach that's highly compatible with measurement, assessment, forecasting, predictability—everything the psychodynamic approach is not! But I don't see MSF choosing one method over the other. I think a certain eclecticism is possible, and that there should be a certain pragmatism, as well. Because it seems to me that the person doing the therapeutic work is more important than their theoretical origins. However, in terms of preparation, training, or recruitment, these approaches raise a lot of questions for me.

PPV: But that's the way it is at MSF! The guidelines have been very useful, and have absolutely not stopped any doctor leaving for the field from questioning their contents, when treating a case of malaria or pneumonia. Practices differ from one doctor to another in a given mission, and it's the same for mental health.

MRM: Is it a problem that there are people with different training? What's an even bigger problem are actually the personalities! And that's why we need a serious effort—not specific to mental health, but really very important for mental health in terms of the recruitment issue—while still being somewhat practical. There is, though, something that connects us all—the psychotherapists, the RPs, etc.—and that's the matter of providing treatment. If, for example, an American tells us that he wasn't trained to do individual therapy, then he won't go. In other words, our actions will be based more on the goal, and factors the various therapies have in common, than on specific factors, such as training in psychoanalysis, CBT, or something else... So I think we need to make an effort on the common factors and objectives. It's obvious that there's a real need for the operations dept., for links, interactions and discussions on these issues. But it has to go both ways, and I think that if this debate actually contributes to that, it will be a good thing.

For the moment it feels like our discussions just go round and round, without any resolution of recurring issues. Result: our actions suffer, between the fear of setting up some excuse for a program and not knowing which elements would allow us to stop our activities.

→AH

There is another element implicit in this debate, which is—I've had this position for a long time at MSF—having to defend psychology as part of medical action. I agree completely with Pierre-Pascal when he says that it's part of medical training! I'm going to take the example of talking when caring for a woman who has suffered sexual violence. Of course you can refer her to the specialists, but that comes later. In the beginning, it's up to everyone. Even with drugs, I hear remarks all the time such as, "I don't want to prescribe antidepressants, because I'm not a specialist." Yet antidepressants are available and easy to prescribe. That's something that is everyone's problem—improving our

> *We seem more comfortable in our missions when we offer mental health care in the same way that we do other care included in the wide range of health care we provide, which is what we seek to develop in the future. We are less comfortable when a project is based only on mental health care. This is perhaps an arguable statement, but it is as if this reminds us that mental health care by itself cannot be the reason for beginning a project in situations where the needs are difficult to define: this may be because the humanitarian nature of our actions is difficult to prove, or because other local and international actors are present and active. (...) We must also not forget the other domains of our medical practices in which mental health is not yet very developed, which seems unacceptable. I am thinking of treatment for HIV patients or victims of sexual violence. These are examples that merit discussion. Is the mental health approach as well integrated as we would like? It is doubtful*
>
> **Pierre Salignon, General director**

ability to practice medicine in all its dimensions. The psychological dimension is part of medicine, too—general medicine! You can't say that it's the realm of specialists only.

As to talking, don't we use talking when dealing with someone who has been through something really serious? We inevitably incorporate talking, in wondering how far to go and when to ask for a specialist—that is, in deciding at what point we think the patient's suffering—and the quality of our actions—demands further action on the part of a psychologist or psychiatrist. But before getting to that that point, the question is, "Should we or shouldn't we try to get this person to talk?" That depends. It's true that you can't generalize. It's true that you must be willing to hear difficult things in order to have a relationship in which the person can say what's hurting him. Again, this comes up before the question of technique.

As for deciding when to stop our activities, it's true that this needs to be discussed; not because there is no longer a need for mental health care, but because there are no longer enough reasons to stay. I repeat: we will never be able to say that a need no longer exists. But when we close a tuberculosis program, it's not because there's no more tuberculosis. We stop because the conditions are no longer sufficient to continue. Otherwise, it goes from being rigorous to being extremely rigorist—it would be rigidity!

→ Moderators: To conclude, how do you see the position of mental health care at MSF?

RB: I'd like to go back to the question of the general choice made by MSF. It was not completely made, since there was actually a desire to take into account the specific constraints on an NGO that recruits on an international level—Marie-Rose was right to emphasize the personality issue—but that is practically an unsolvable issue. On the other hand, what is solvable, in a way, is the choice of framework. This choice was made, and one of my criticisms is that the consequences are not accepted. We are driven to make a choice, without which we end up with this sort of theoretical ambiguity, causing the anger and irritation that Annette spoke of a little while ago. Confronted with this *mélange* where two incompatible approaches are artificially made to be compatible, we end up choosing the easiest, the one that squares best with MSF, based on the causal event, using the DSM-IV for diagnosis, and brief individual, family or group therapy. It's the type of treatment that I oppose at the very root. But there's no doubt, in my mind, that there's a place for psychiatric treatment at MSF in "multidisciplinary" programs. I want to say it again, because we're almost at the end of the discussion.

These kind of activities need to be better integrated into MSF's operational plan. There also needs to be discussion and exchange on this subject. This is a goal to which I'm going to devote myself at MSF, starting from the principle that mental health care isn't just the psychotherapists' problem.

→CR

GG: For me, this debate is a preliminary to the working group. The idea isn't just to discuss the question of technique, but also to explore the original intention; to see why we choose to intervene and treat people, and how we might assess these interventions and improve them. For years there hasn't been the space or the time for this discussion. Result: from the field to the program managers, more and more people want to stop taking responsibility for this type of activity. And while I think that these programs have a place, it is important that they have the same place as others—that is, that they are debated, critiqued, and looked at in the same way as others. The same is true for communication around mental health activities. The "technique, communication, operation" triptych has not worked, at least not well enough, from my perspective. How do we talk about these activities, how do we get them across, and how do we explain them? The working group needs to deal with these questions, too.

MRM: I don't think the issue of whether MSF should do mental health is really up for debate. It's one of the services we provide. That's not what this discussion is about. What it is about is our ability to think much more collectively about the issues raised earlier. And we won't move forward on this if we think of it as just the psychotherapists' problem, and frame the debate ideologically, as Rony is doing. Besides, the positive feedback from the people in the field and from the populations—I'm thinking of Guatemala, for example—should calm, to some extent, these ideological quarrels.

GG: I don't agree with your apparent assessment of our action in Guatemala.

PPV: Just recently, when listing the topics to be discussed at the Board of Directors meeting, the wording used in talking about mental health programs was really different from the rest, which shows that they are poorly integrated within MSF. It was Marc Le Pape [*member of the BoD – ed.*] who pointed out that we were talking about the problem of psychiatrists/psychologists at MSF, and not about mental health care at MSF, before also mentioning some work that Rony is currently doing. Again, to me it seems that that's ignoring the program managers, Claire's existence, and our presence here at this table. And again, I agree with the operational assessment, with the fact that the RPs cannot monitor, that they don't have tools to help in decision-making... But I also think there's a recurrent problem at MSF, of no longer knowing how to make decisions. The fact that we're demanding to make them is rather positive, at least. Now we'll have to find ways of working together that will allow us to share our experiences.

CR: It seems to me that MSF has failed to take ownership of mental health, and that it has been kept outside a bit. These kind of activities need to be better integrated into MSF's operational plan. There also needs to be discussion and exchange on this subject. This is a goal to which I'm going to devote myself at MSF, starting from the principle that mental health care isn't just the psychotherapists' problem. ■

Summarized by O.F.

The limits of the PTSD concept

MSF / August 2006 / Translated by Anne Wiles

Although humanitarian psychiatry and emergency intervention provide fertile ground for development of a response focused on post-traumatic stress disorder (PTSD), they also experience the risks and limits of its implementation. With extensive field experience, Jacky Roptin, a psychologist working with MSF since 2002, tells us about the risks of overusing this concept at MSF.

Right from the start the concept of PTSD came up against an impasse. Encompassing all trauma situations, it tended to give all suffering the same significance without differentiating between the nature and issues of natural violence and inter-human violence.

By focusing the description of trauma on the fact that "the patient continually re-experiences the traumatic event," PTSD made it the common denominator for trauma (by citing nightmares, for example) and relegates many other psychological and social consequences to the background. It does not represent all post-traumatic pathologies however; far from it. For example, after five years of continuous violence in Palestine, the symptoms have moved away from the PTSD model.

The problems faced by teams can take the form of severe parental depression (with possible outbursts of violence) as much as severe emotional deprivation in children or risk-taking behaviors in adolescents, sometimes with clearly expressed talk of suicide. We can also cite the program for victims of sexual violence in Congo-Brazzaville, where we have seen a high rate of anxiety and major depression, a low rate of reliving the trauma, and significant somatic complaints associated with an intense decrease in libido. Here also, for lack of a match with certain symptoms described in PTSD, we risked inferring that there were no problems and denying very real suffering.

→ THE THRESHOLD EFFECT

By focusing on the symptoms considered specific to trauma, one also risks brushing aside any other form of psychological injury and making PTSD a diagnosis that highlights a deeper suffering and legitimizes therapeutic action. After a war or natural disaster, it is not uncommon to see organizations like MSF centre on PTSD to initiate, legitimize, or perpetuate action or to justify definition of a target population. Although it may seem logical to pay more attention to violent events, the "race to the event" resulting from the trauma approach presents real risks to our programs. Crisis intervention is not always appropriate for the circumstances. Again with the example of Palestine, our intervention is sometimes extremely close to the violent and media-generating event and can hinder periods of mourning for families and contribute to talk of victimization or martyrs or the construction of good victims.

This leaves aside those who are sometimes more vulnerable but suffer far from the media and out of sight of the community..

→ CONTROVERSIAL CONCEPTS AND CONTROVERSIAL THERAPY

Trauma and PTSD became the choice concepts through their "easy" diagnosis and consequent action. In an organization like MSF, and beyond the oversimplified and reassuring view that these concepts can bring, they presuppose the idea of action based on treatment that functions like a protocol – the "short-term trauma therapy." As soon the notion of PTSD was defined, psychic trauma very quickly benefited from development of therapeutic practices that were supposed to respond to PTSD, or at least to prevent it. From there came the recommendation for early intervention whose aim, beyond the triage function, is long-term prevention of more disabling symptoms. These practices have found some legitimacy in specific situations such as natural disasters or accidents, because the events are acute, time-limited crises.

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DIAGNOSTIC CRITERIA FOR POST-TRAUMATIC STRESS DISORDER (PTSD)

(SOURCE: SOIGNER MALGRÉ TOUT, T1. MSF – LA PENSÉE SAUVAGE, APRIL 2003)

A. The subject was exposed to a traumatic event that included the following two factors:

1) The subject experienced, witnessed, or was confronted with an event or events in which individuals died or were very seriously injured or were threatened with death or serious injury or in which the subject or others were physically threatened;
2) The subject reacted to the event with intense fear, helplessness, or horror.

B. The traumatic event is persistently re-experienced in one or more of the following ways:

1) Recurrent, intrusive, distressing recollections of the event including images, thoughts, or perceptions.
2) Recurrent distressing dreams of the event.
3) Sudden feeling or acting-out as if the event would reoccur.
4) Intense psychic distress when exposed to cues evoking or resembling an aspect of the traumatic event.
5) Physiologic reactivation when exposed to cues resembling an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness as indicated by at least three of the following manifestations:

1) Avoids activities, places, or people that arouse memories of the trauma.
2) Avoids thoughts, feelings, or conversations associated with the trauma.
3) Unable to recall an important aspect of the trauma.
4) Clearly less interested in important activities or less participation in the same activites.
5) Feels detached from others or becomes estranged from others.
6) Restricted range of affect.
7) Sense of foreshortened future.

D. Persistent symptoms of increased arousal as indicated by at least two of the following manifestations:

1) Difficulty sleeping or staying asleep.
2) Irritability or outbursts of anger.
3) Difficulty concentrating.
4) Hypervigilance.
5) Exaggerated startle response.

E. The disturbance (criteria B, C, and D symptoms) lasts more than a month

F. The disturbance causes clinically significant suffering or a change in social, work, or other important area functioning.

Specify if:
Acute: for symptoms lasting less than three months.
Chronic: for symptoms lasting three months or more.

Specify if:
Delayed occurrence: for symptoms starting at least six months after the stress factor.

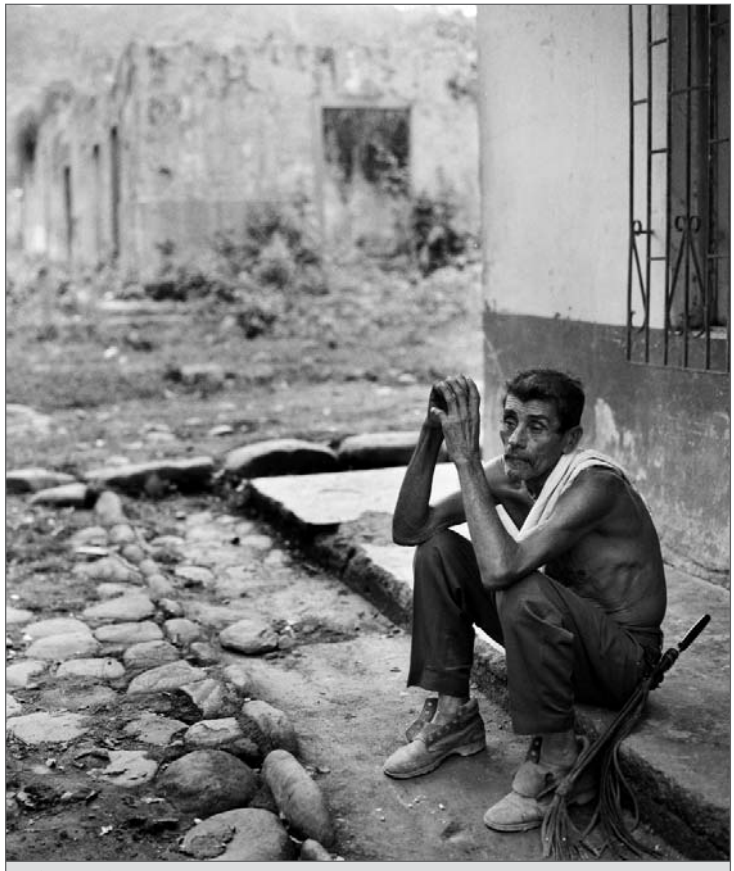
DOSSIER

Freud in the field

→ The consequences of identifying Vietnam veterans' psychiatric disorders as PTSD.

'For the first time in the history of post-traumatic disorders, the authors of aggression figure beside 'their' victims as victims themselves. PTSD offers this possibility of diagnosing anybody presenting a psychological disorder after an abnormal event, whether he be the aggressor or the victim. The auto-traumatised aggressor, to use Young's wording, is a victim practically like any other. The parallel with medical trauma also works, to the extent where a north American psychiatrist publicly affirmed that the question of the direction of violence -i.e. whether inflicted or suffered- was not any more relevant to a psychiatrist than to a surgeon, as 'the treatment of a fractured leg is identical - whether the patient has inflicted or received the blow'.

R. Rechtman in *Etre victime, généalogie d'une condition clinique – L'évolution psychiatrique,* éditions scientifiques et médicales Elsevier SAS - 2002.



→ **Colombia** © Stephan Vanfleteren - October 2005

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The psychological practices in question would therefore only be of interest in the time immediately following these events. With the exception of these specific situations, many MSF patient injuries stem from chronic crises or chaotic lives. It thus seems difficult if not illusory to distinguish the psychological suffering related to a recent event from consequences related to a course of life events.

In the case in point, the suffering of these patients cannot be reduced to the PTSD grid and to therapeutic methods that are more like a magic formula in their situation. With an approach focused on PTSD and crisis intervention, the ability of Palestinians to grasp the clinical aspects described above in the opening paragraph was quickly limited or exceeded. In the case of Congo-Brazzaville, the social and family disruption after rape was considered one of the main sources of suffering for many women seen between 2002 and 2004. In addition, a study of 178 patients during the same period showed that 80% of them had been seen more than a month after the aggression, demonstrating that it is difficult in practice to act immediately after the event.

→ FROM REALITY TO MYTH

Early and specific situation (described above) intervention aside, are short-term therapies a myth? Not if we consider that they do not draw their legitimacy from this concept (PTSD) and that our practice is primarily defined by its goal – to care, to provide relief, and to console. From a therapeutic standpoint, however, our interventions are structured around defining priorities and viable treatment objectives for the patient, taking into account the operational constraints of insufficient resources, the need for minimum impact, and the short length of missions of psychologists.
Consequently, our ambition for action cannot exceed the associated constraints. In its unifying tendency and simplified descriptions, however, the trauma and PTSD approach opens up the prospect of a perfect match between our mental health activities and epidemiological principles[1] - at the risk of distorting reality and overestimating the impact of our intervention.

→ TOWARDS A NEW DESCRIPTION OF SUFFERING

In its most ideological version, the trauma approach approved and implemented by a professional or an institution can result in the de-politicization of suffering by diluting its political or social origins in individual psychic functioning. The Vietnam War demonstrated this. The request that was made to us in Palestine by the Minister of Health demonstrated it again when it meant managing adolescents who were throwing stones on the Israeli forces and the Minister considered them "traumatized by war." Here again, the trauma approach tends to place the pathology label on behavior whose logic can also be in keeping with both political analysis (response to the violence and the occupation) and sociocultural analysis (adult ambivalence when faced with violence, which is condemned within the family but sometimes contradictorily legitimized on the outside).

The trauma and PTSD approach thus finds its source not only in the dominance and diffusion capabilities of DSM-IV (U.S. system for classification of mental disorders) but also in the tacit complicity that our institutional constraints impose on us (urgency, transparency, and optimization). By succumbing to the current climate and sometimes becoming the fascinating mirror of reality and the vocabulary of war and emergency, this approach functions as circular self-justification.

Freezing the perspectives of humanitarian psychiatry, it reduces the approach while magnifying the effects of the response it generates. If we do not wonder about the motives of our mental health programs, this approach can therefore go from opening doors for our operations to hindering our mental health activities, where psychological practice is alienated and devitalized. ■

Jacky Roptin

1- With overdeveloped diagnosis, development of therapy that resembles protocols, defining the number of sessions, or evaluation and optimization of programs.

From victim status to the notion of resilience

MSF / August 2006 / Translated by Alison Keroak

Other questions are regularly debated and raise, particularly in specialized literature, a certain number of criticisms. From the victim's condition to the limits of témoignage, while touching on the notion of resilience, here is a glimpse of some of the criticisms levied, some of which go beyond the framework of our mental health programmes. We have attempted to summarize them here succinctly.

→ **Palestinian territories** © Alan Meier - September 2005

One of themes addressed in the debate, which we were not able to publish in full due to lack of space, concerned the issue of *témoignage*. Rony Brauman points out the affinity that exists between psychiatric practice and *témoignage*, in order to highlight their limitations. Drawing from an example in *Soigner malgré tout*[1], he laments that the psychological reality of the patient is sometimes transformed by psychologists into a historical fact, leading to significant theoretical confusion "between the sign and the event, the view and the facts". Marie Rose Mono challenges this analysis, clarifying that it is only a matter of "retracing the patient's theory, retranscribing the patient's psychological life in order to give it a (sometimes partial) meaning, but that allows the patient to rediscover his or her life force" [Marie Rose discussed at length the question of *témoignage* in a chapter of *Soigner malgré tout*, an excerpt of which has been printed on page 5. – Editor's note].

→ THE CONDITION OF THE VICTIM

Beyond the question of *témoignage*, there is the larger issue of the role of psychiatry and of its possible [editor's emphasis] 'traps'. Richard Rechtman, psychiatrist and anthropologist, in his article entitled "*Etre victime, généalogie d'une condition clinique*" (Being a victim, genealogy of a clinical condition), recalls the beginnings of an approach focused on PTSD, which, according to him, changed the way in which we set about trauma victims. For Rechtman, the process of legitimizing victimology " is based more and more on the clinical approach to the victim. ... From the certainty of a human condition, we have passed to a diagnostic certainty ... at the cost of a profound change from the system of truth attached to the narration of the trauma". Thus, according to Rechtman, the condition of the victim depends now on the event and on "the granting of victim status by the psychiatric clinician". An echo of this can also be found in an anecdote provided by Derek Summerfield[2], psychiatrist and expert council for Oxfam. He cites the example of an expatriate fro

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> *"Saida remains standing and screams to resist. She relates that sometimes she screams, even alone, to release the anger and the agony that seize her. There was this one time when a young neighborhood boy, who could have been her son, the son she never had, this young boy set off a land mine left voluntarily by the Israeli military during one of their so-called "punitive" nighttime forays. His body flew through the window of Saida's house. ... It was upon her return that she discovered the body, the blood, the horror. She had seen far worse things, but this event made all the rest unbearable. ... According to her own terms, she had lost her dignity – as a woman, as a wife, as a Palestinian, and doubtless as a potential mother..."*
>
> **Marie-Rose Moro, extract from *Soigner malgré tout – Volume 1* MSF / *La pensée sauvage* – April 2003**

1- In an example from *Soigner malgré tout* (see in margin), Rony Brauman, without denying the psychological reality of Mrs. Saida's remarks, criticizes how they were used. He claims that the mines left voluntarily by the Israeli army in Gaza, and the effects that they produce when a child steps on one – projected as if from a catapult – are two facts that could not exist, and thus he disputes the way in which Marie Rose expresses them.

2- "L'impact de la guerre et des atrocités sur les populations civiles : principes fondamentaux pour les interventions des ONG et une analyse critique des projets sur le traumatisme psychosocial", by Derek Summerfield – *Réseau Aide d'urgence et réhabilitation*, Dossier thématique n°14 – April 1996

> *Freud in a famous observation described the game of a child who was trying to control his anguish linked to the absence of his mother. The child was throwing a bobbin, that he held by a thread, far away out of sight. The child shouted, in German, "fort" (far, gone). Then, pulling on the thread, he would make the bobbin reappear. When he saw it reappear he laughed and cried "da" (there, here).*
> *Through this observation Freud asked what sense could a repeated microtrauma have, in the framework of the theory of a psychic functioning of the primacy of pleasure.*
> *This led him to rethink the psychoanalytical theory and, later, the formulation of a hypothesis on the death wish.*

Patrick Declerck, excerpt from: Les naufragés, collection Terre Humaine, Pocket, Plon - 2001

m an NGO in Rwanda who strove to gather information on sleep disturbances (one of the characteristics of traumatic neurosis), while the local population believed that no matter what the response, that was not the issue, anyway.

→ "NEITHER PATIENTS NOR VICTIMS"

This is what both Arthur Kleinman and Robert Desjarlais tell us[3], both of whom are activists "for an ethnography of political violence". The two anthropologists sometimes blame psychologists and psychiatrists for creating "the notion of violence as an event that can be studied independently of the context in which it happened, under the pretext that its effects on people are supposedly universal". Kleinman and Desjarlais ask the question: "What sense is there in conferring a victim status or a patient status on those who have been subjected to political violence?" For them, it is more a question of viewing those who suffer from violence as "social sufferers" in order to, in particular, "clarify the way in which large-scale forces alter interpersonal relations". While they do not dispute the need for medical institutions to consider those who suffer as patients first, they are nevertheless skeptical when "the medicalization of suffering goes beyond the hospital compound, and becomes an integral part of ordinary discussion on violence and its consequences". According to them, the wounds and scars or the tragedy of suffering then become the object of appropriation for others, which allows them to be made visible according to the criteria imposed by the media, who have a taste for the sensational, at the risk of "masking the commonplace forms of daily violence".

→ "UNIVERSAL" RESPONSES TO "UNIVERSAL" EFFECTS

Another striking point raised by Summerfield concerns the origins of elaborating the response to traumatogenic situations. For a psychiatrist, the majority of projects are in fact inspired from the hypothesis of a "universal" response. He says, "Western diagnostic systems, mainly concerned with classifying illnesses rather than patients", pose serious difficulties when applied to other populations. While a certain number of safeguards exist to compensate for this problem, Summerfield relates nonetheless the words of one his colleagues, close to MSF, who observed that the local staff often had a tendency to "overemphasize Western psychology and underestimate their own cultural contexts". Noting that the local professionals had received—almost by definition – a mainly Western education, this colleague presumed that "this brings them closer to their Western colleagues, but alienates them from the communities that they serve". Summerfield carries the criticism even further: while affirming that Western psychology concepts are presented as authoritative knowledge, he stresses "the risk of unintentionally perpetuating the colonial mindset in the Third World". According to him, the irony of history is that patients bet on receiving aid by presenting themselves as a "modernized" victim, by minimizing their own knowledge, their own potential, or even their own fury...

→ RESISTANCE TO RESILIENCE'?

Paul-Laurent Assoun, psychoanalyst, addresses the question of "resilience put to the test by psychoanalysis" in his October 2003 article "La résilience à l'épreuve de la psychanalyse" in *Synapse*. Going back to the metallurgic definition of *résilience* as the ability of a material to withstand shock, he notes that the notion of resilience, which has now found its way into everyday usage, emphasizes the possibility of the individual to not only resist a traumatogenic event, but to derive suggestions from it on the individual's capacity for post-traumatic restoration, and on his or her potential for "creativity"; in other words, on his or her capacity to "make the best out of a bad situation". For him, Nietzsche's famous expression, "Whatever does not kill us makes us stronger" is given a new twist by believers in resilience, since rather than see a "will to power" (title of a work by Nietzsche), which could very well express itself as a death wish (see in margin), they only see in it a life force. By turning the former towards the exterior, one of the most successful forms of resilience would be delinquency and crime, inconceivable for believers in resilience, who favor instead a tendency to sublimate the subject, drawing from its symptoms "resources for the benefit of society".

→ MOURNING

In their 1994 article, Kleinman and Desjarlais mention mourning to point out that, according to the DSM, suffering must necessarily come to an end. "We must come to the end of everything, even memory," they write. The two anthropologists questioned this, suggesting that it would be preferable to "celebrate the memory of traumas rather than to evade them". They continued that "commemorating collective traumas is one of the ways by which countries cultivate memory". Assoun[5]also comes back to this idea of "successful mourning", or of "mourning well done"; a believer in resilience will give substance to the idea that the work needs to be done for the subject to heal. However, drawing from the works of Freud[6], Assoun insists on the fact that mourning is done in any case. It is a reactive and unconscious process of disinvestment from the lost object, subjected to the vagaries of narcissism and the relation to the lost object. We would not know how to attempt to mourn "well", he tells us. And rather than "crow about the expression of pathological mourning" regarding a subject who has the tendency to relive the original loss in such-and-such context, we must question precisely what conditions cause the subject to relive the initial grief. For a psychoanalyst, the ideal of resilience reinforces itself at the cost of a distortion of the Freudian theory. ■

O.F.

3- "Ni patients ni victimes – Pour une ethnographie de la violence politique." Arthur Kleinman and Robert Desjarlais, Actes de la recherche en sciences sociales, n°104 – 1994.

4- The French word résilience only translates to "resilience" in English within the context of psychiatry. The French word is usually translated as the technical term "impact resistance". The French term as used in psychiatry seems to have taken on the connotations of the English "resilient", as in a material that can not only withstand or resist the shock of an impact, but also "bounce back" from it. – translator's note

5- Op. cit.

→ To read:

We drew from a number of articles and publications to write this article:

- *Psychiatrie humanitaire en ex-Yougoslavie et en Arménie*, by M.-R. Moro et S. Lebovici – Presses universitaires de France, December 2005

- *Soigner malgré tout, Volume I et II*, by T. Baubet, K. Le Roch ; D. Bitar, M.-R. Moro – MSF, éditions La pensée sauvage, April and october 2003

- *L'impact de la guerre et des atrocités sur les populations civiles : principes fondamentaux pour les interventions des ONG et une analyse critique des projets sur le traumatisme psychosocial*, by Derek Summerfield – Réseau Aide d'urgence et réhabilitation, Dossier thématique n°14 – April 1996

- *Effects of war : moral knowledge, revenge, reconciliation and medicalised concepts of « recovery »*, by Derek Summerfield – Article in le British Medical Journal – November 2002. (sélection du Crash)

- *La résilience à l'épreuve de la psychanalyse*, by P.-L. Assoun – Article in Synapses n°198, october 2003

- *Ni patients ni victimes – Pour une ethnographie de la violence politique*, by Arthur Kleinman et Robert Desjarlais – Article in Actes de la recherche en sciences sociales, n°104 – 1994.

- Etre victime, généalogie d'une condition clinique, by R. Rechtman – Article in L'évolution psychiatrique, éditions scientifiques et médicales Elsevier SAS - 2002.

- De la charité hystérique à la fonction asilaire, Patrick Declerck, extract from Les naufragés, Patrick Declerck, collection Terre Humaine, Pocket, Plon - 2001. (sélection du Crash)

→ **Guatemala** © Thierry Buignet / September 2003

LEBANON EMERGENCY

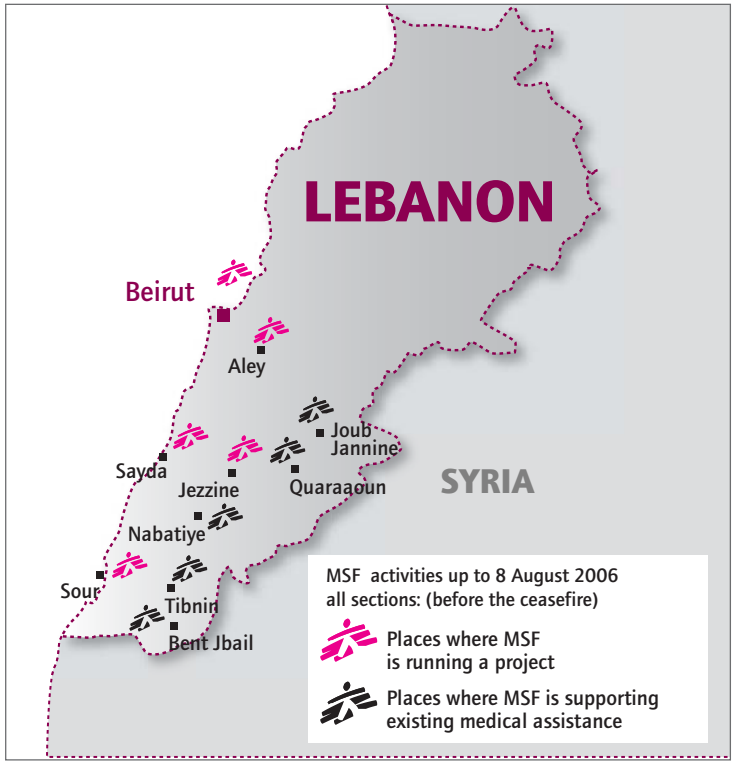
First assessment after the ceasefire

MSF / 14 August 2006 / Translated by Steven Durose

→ Lebanon © Kadir Van Lohuizen/Agence VU - August 2006

MISSION
LEBANON

A ceasefire recently brought relative calm to Lebanon and Israel, one month after the outbreak of hostilities. Just hours after the agreement came into force, thousands of people started the journey back to their home regions. Mercedes Tatay, a doctor and Emergency Desk manager, looks back on the work of the French section of MSF during the month-long conflict.



→ What were our main priorities in Lebanon?

A few days after the Israelis first bombed Beirut airport, we sent a team into the area, although we were aware that the Lebanese, [who disposed of] support networks, a healthcare system, and Lebanese medical teams, had adequate resources for responding to this type of crisis, and that we would only play a supporting role. And that's what happened: most displaced people were given shelter by their families or were housed by communities in public buildings and reception centres, while overall the medical system continued to function. After assessing the needs not being met by the Lebanese on the ground, we focused our operations on two areas: we supplied equipment to displaced families who had been hit the hardest in the Aaley and Chouf regions, where

certain villages – such as Kayfoun – had seen their population triple in size; in addition, we administered follow-up medical care to people suffering from chronic conditions. These people had fled their homes and were no longer in a position to receive care from their treating physicians... We therefore provided them with a bridging service and supplied any necessary medication.

→ What role do you expect the MSF to perform now that a ceasefire is in place?

Since the ceasefire took effect, large numbers of displaced persons have quickly returned to their regions, including villages in the south, some of which have been partly destroyed, while others have been completely flattened. The Lebanese have responded well to this latest development, just as they did at the start of the crisis. Those who have lost their homes will be taken in by their family or neighbours. Both doctors and the health service were able to operate throughout the conflict, so there's no reason why they shouldn't do so now. There's also a very strong political interest for the Lebanese government and political organisations such as Hezbollah to occupy the area and to ensure these people are resettled as efficiently as possible.

The United Nations is also currently deploying major resources in the area. If the truce holds, Lebanon will soon enter a period of reconstruction during which, as an emergency medical organisation, we won't have a major role to play.

→ Does that mean that we're leaving Lebanon?

It's still too early to say, but our teams in Chouf have wrapped up their activities for the time being. We're going to monitor the situation and keep an eye on families as they return to see if the medical support we provide is still required. As for the future, we're still ready to intervene in any new emergency that arises before a multinational force is deployed in the area.

→ What's your take on the MSF operation? Did we provide real added value?

We have reason to be humbled by the Lebanese who, once again, provided the lion's share of the response. But we intervened in two highly specific areas of the crisis, and I think that we provided a really useful service.

Our activities had a far from insignificant impact in another respect: by transporting large amounts of equipment into the interior of the country, the MSF movement managed to break the blockade of Lebanon and weakened the stranglehold on the country. We also tried to make the belligerents respect a space for medical care and to provide civilian populations with access to medical care during the fighting. The Lebanese people we met told us that the presence of these international teams was a source of comfort for them. By working in close cooperation with populations and providing a supportive presence, while maintaining a space in which to carry out our work... it seems to me that we fulfilled our humanitarian role. ■

Dr Mercedes Tatay
Interview by B.J.

REVIEW OF MSF ACTIVITIES 14 AUGUST 2006 (ALL SECTIONS):

310 tonnes of relief supplies were sent by MSF to Lebanon and neighbouring countries to help displaced Lebanese populations.

The supplies included a variety of equipment:
- hygiene kits
- kitchen utensils
- blankets, mattresses and tents
- dialysis equipment, medication, surgery kits
- sanitation equipment for ensuring a supply of water, water tanks, vehicles, etc.

6 teams have been deployed on the ground:
- in Beirut
- in Aaley, in the Chouf region
- in Sidon and Tyr
- in Jezzine
- in Damascus, Syria
- in Cyprius

An estimated total of around 45,000 displaced people in Lebanon and 8,500 refugees in Syria have received cooking equipment, mattresses, blankets, cooking stoves and hygiene kits containing soap, rasors, tooth brushes, etc.

PRESS REVIEW

MSF / 21 August 2006 / O.F.

→ Speaking out and keeping silent in Lebanon

Just before the ceasefire in Lebanon, Jan Egeland, Under Secretary General for Humanitarian Affairs at the UN stated indignantly, "it's an absolute disgrace." Egeland was quoted in the Dauphiné Libéré on 11 August. The newspaper was reporting on his comments that humanitarian organisations were unable to gain access to southern Lebanon. A journalist writing in the same edition quoted an MSF press release from the day before, which reported MSF's intention to "work around the Israeli embargo on travelling around southern Lebanon". At the same time, the president of the Secours Populaire described the conflict as a "humanitarian tsunami", a statement that was ellipitical, to say the least, but at any rate *effective*, since it was taken up by numerous media organizations. It did not, however, prevent the organisation from delivering 80 tonnes of relief supplies... by boat.

→ **Lebanon** © Kadir Van Lohuizen/Agence VU - August 2006

→ Is it difficult not to take sides in a conflict? Taking Lebanon as an example, doesn't Israel need assistance too?

We asked the Israeli authorities if they needed outside assistance in providing relief to displaced populations. But knowing the situation in Israel, we were acting out of principle, because fortunately the Israelis are able to manage their own assistance to the civilian population and wounded military personnel, and it works pretty well. Lebanon, on the other hand, is experiencing interruptions in relief supplies, while shortages of medication, food and fuel are starting to be felt almost everywhere...

Jean-Hervé Bradol, President of MSF, interviewed on the radio station, RMC, 10 August 2006

→ Palestinian territories © Laura Brav/MSF - November 2005

MEANWHILE...

New incursion in Gaza

MSF / 2 August 2006 / Translated by Colin Smith

Following the kidnapping of one of its soldiers, the Israeli army has once again entered the Gaza strip. This operation, referred to as 'Summer rain', started on 28th June 2006 and has caused extensive damage to people and property. Our head of mission Laura reports:

"On the 6th of July I managed to get into the Gaza Strip with our field coordinator, one doctor and a logistics specialist. We evaluated the situation in order to plan the assistance required.

Operation 'Summer rain' is still underway, with movement of Israeli tanks and heavy shelling of the north of the Gaza strip. Meanwhile, 'Qassams' (home-made Palestinian rockets) are being fired daily into Israel from Gaza.

→ THE RAVAGES OF 'SUMMER RAIN'

In addition to loss of life (between the 28th of June, when 'Summer rain' started, and the 18th of July, 101 people were killed in Gaza, more than half of them civilians; more than 300 have been injured during the incursions and attacks) 'Summer rain' has caused extensive damage to infrastructure. Gaza's only power station, which feeds the hundred or so water pumps supplying the area, was destroyed in the bombing. Since the electricity supply has still not been fully restored (the power lines have been repaired but are regularly destroyed again) some areas find themselves cut off from the grid for days at a time (Rafah was without power between the 7th and 13th July). Without electricity or fuel, water can

CONCERNING THE SITUATION IN GAZA AND OUR ACTIVITIES (AS OF 2 AUGUST 2006)

- Power is restored, on average, for 6 to 8 hours per day; water for 2 to 3 hours per day
- There are 22 hospitals and 58 Health centres in Gaza. 75% of hospital services are operational, 22 centres have their own generators, 21 have been set aside for emergencies, 12 are working around the clock, 4 for 12 hours per day.
- MSF has made donations to the main hospitals and specific orders (especially for treatment of chronic psychiatric conditions) have been placed. Urgent medicines and medical equipment have been donated or lined up for hospitals located in the front line and handling the injured.
- Storage tanks and water have been supplied to a group of refugees (40 families, about 400 people) fleeing the shelling of Al Shoka (a district close to the airport). A water supply system (two storage tanks connected to a well) is going to be installed for a community at risk in the north-east of the Gaza strip. Food supplies will be distributed by UNRWA, the WFP and the ICRC.
- A surgeon will be dispatched to Gaza in order to provide short and medium term support to hospitals in the area.

neither be pumped nor stored. Supplies to the north-west of the Gaza strip were suspended for a long time after pipes were destroyed: with each incursion, new water storage tanks are destroyed and access to wells made impossible. The reservoir holding waste water (in the north) is full as it can no longer be drained (again due to lack of fuel and electricity). Nor has refuse been collected for several weeks in some areas.

→ SUPPLY PROBLEMS

The Karni Crossing, a major transit point for goods, is not always open, and all the junctions are partially or completely closed. Under pressure from the US and the UN, access has been improved, but remains nevertheless strictly controlled by the Israeli army, which maintains a constant presence around Karni.
Health workers have not been paid for five months. In spite of this, and shortages of medical equipment, electricity and fuel, doctors and nurses carry on working. However it is difficult to provide care at all levels, especially for less urgent cases. The problem of dealing with the chronically ill (cancer, diabetes, etc.) also arises, since these cases can no longer be referred to neighbouring countries such as Egypt, Israel or Jordan for treatment with the appropriate equipment or medication, which doesn't exist in Gaza. We have made contact with the hospitals in the region. For the time being, electricity generators allow hospitals to continue to operate. The injured receive correct medical attention, operating theatres are functioning and surgeons are available... We have made some donations, but it is difficult for the hospitals to operate in this manner, waiting for the next donation, without knowing when it will come and what it will consist of. We are maintaining close contact with the hospitals, so that we can respond to medical shortages, and any requirements for medical staff, emergency services, or supplies for intensive care units.

→ AMONG THE POPULATION

From a logistical point of view, on occasions MSF comes to the aid certain groups of population displaced by the incursions – within the Gaza strip – and to some communities affected in particular by the lack of water and electricity: in the El Fara towers, where we had already worked in 2005, in the Bedouin village of Siafa, situated next to the waste water reservoir and cut off from the electricity grid, and in the north-east, where a community is unable to move due to continuous shelling.

At the beginning of June we met and assisted 200 families living on or near the front line and shelling zones. Since then they have been regularly under shelling and explosions.

Today, MSF is monitoring the situation closely (numbers of injured, houses destroyed, people fleeing the region, patients suffering in particular from psychological problems and people who have received – or not –food and equipment) and remains ready to intervene."■

Laura Brav,
interview by Isabelle Merny

→ **Palestinian territories** © Bruce Frank / MSF - August 2005

MISSION

JORDAN / IRAQ

JORDAN / IRAQ

Amman, a window to Iraq

MSF Amman, Jordan – July 2006

On August 3rd our teams in Jordan went to Amman airport to pick up the first seven patients from Baghdad. The first plastic surgery operation was carried out three days later. A look back at how this project came about and how MSF is back in Iraq, without being there....

→ **Iraq** © MSF / Ismaël Fouad - July 2006

THE CHOICE OF JORDAN

Although Syria, Kuwait and the Iraqi Kurdistan all represent potential intervention countries, the choice of Jordan as a base of operations was made for many reasons. The principle factor was that Jordan already has a high level of medical care that has been developed in this country over many years and it undeniably represents a platform for professional exchanges especially with MSF's new surgical approach. Moreover, due to this level of medical care, Jordan offers possibilities of locally available quality drugs and medical materials. The implementation of the MSF free of charge surgical platform will also be accessible to the most vulnerable patients who would not have access to the hospitals in Jordan as they remain expensive. In addition, the partnership that we have established with the Jordan Red Crescent hospital will make it acceptable and possible for Iraqis to come and be treated in a culturally friendly environment. These first contacts have paved the way for a fruitful ground for common understanding. Last but not least, within the framework of this project we aim to assist patients coming from the Palestinian Occupied Territories who may need the same kind of reconstructive surgery. The proximity of Jordan and the willingness of the authorities to facilitate the implementation and operation of this project make it easier to envisage its establishment in the Hashemite Kingdom where 60% of the population is of Palestinian origin. Although we have chosen to base our operations in Jordan, we will not exclude the fact that we will need to further develop constructive relations with each of these countries, to reactivate our ties where possible and to develop field contacts in order to study other potential intervention areas.

Three years after the Iraq war of 2003, the evolution of the situation in the country and the increasing violence has had dramatic consequences on the population. The situation in Iraq has deteriorated, especially following the bomb attack in February this year against the Shiite mausoleum of Samara that further marked the road to civil war and sparked a particularly large outbreak of violence. This violence varies from medium to large-scale armed conflicts in certain localized areas, to terrorist bombings in crowded areas that result in mass casualties. According to evaluations by health professionals from Iraq, the public health facilities, emergency rooms and key hospitals are finding it difficult to deal with the increasing numbers of causalities. The operation rooms, the specialized medical, surgical, gynaecological and paediatric departments all over the country continue to lack sufficient diagnostic and therapeutic equipment resulting in the loss of lives that could be saved. Due to insecurity, lack of access, limited ability to collect reliable information, inadequate emergency response capacity of national and local institutions and lack of adequate funding, the collective national and international response to emergency health needs in Iraq remains insufficient. Hundreds of civilians have been killed or wounded because of blind attacks, targeted murders and military operations. Many people have had to leave their homes, displaced by force or by fear of sectarian violence. In addition, this trend of deterioration of the health system coupled with the increasing violence is pushing a growing number of highly qualified doctors to leave the country. Those remaining in Iraq are in need of support in order to accomplish their medical endeavours in assisting the victims of violence.

→ RETURNING TO IRAQ IN PARTNERSHIP

Although MSF withdrew from its activities in Iraq in November 2004, it remained in contact with members of the Diaspora, especially through the UAE office. Through these regular contacts, MSF was contacted in November 2005 by a number of Iraqi surgeons and medical doctors who offered to provide their services to help during the earthquake in Pakistan. These same doctors were met by MSF teams in Pakistan where a first discussion was held to assess the possibility of working together in the Iraqi context. By April 2006, a meeting was organised between MSF members and certain doctors who had worked in Pakistan. These doctors told us that it was not advisable for MSF to open a project inside Iraq, given the violent security situation that is a risk for foreigners and Iraqis alike. We discussed possibilities of collaborating together and came up with the idea of a partnership, with MSF covering administrative and logistical matters and our Iraqi colleagues the operational side. The project would also include a surgical project in Amman for patients that cannot be treated in Iraq, due not only to lack of surgical material but also to the violence and forced departure of qualified human resources to treat patients requiring orthopaedic, plastic and maxillofacial reconstructive surgery. Militiamen do not respect the right to treatment of the wounded, and they indiscriminately burst into hospitals to arrest patients or health professionals. These patients cannot therefore be properly treated because they prefer to leave the hospitals as soon as they have received the first treatments.

Within this partnership agreement there is also the project of supplying much needed basic surgical and emergency medical material and drugs to selected hospitals in Baghdad to start with and later gradually to hospitals in other areas in Iraq. This component of the project is as important as the surgical component. Refurbishing the hospitals will give our colleagues in Iraq better means to address emergencies and to tackle the growing demand for treatment of wounded people and of casualties due to violence.

THE ORGANISATION OF THE SURGICAL PLATFORM

MSF established a coordination office in May 2006 in Amman. It has signed a memorandum of understanding with the Jordan Red Crescent (JRC) in order to establish the surgical platform within the operation theatre of the Jordan Red Crescent Hospital (JRCH) which is based in Al Wahdat, a popular Palestinian quarter of Amman city. The cooperation with the President of the JRC, who is also the Chairman of the Standing Committee of the Red Cross and Red Crescent in Geneva, seems very promising. MSF have already undertaken in-depth evaluations of the operation theatre (OT), the intensive care unit (ICU), and the recovery rooms with an anaesthetist doctor and an OT nurse. The JRCH will make available 20 permanent beds in the in-patients ward, which can be extended by an additional 60 beds if needed. The MSF team has evaluated the hospital capacity of accommodating a maxillofacial, plastic and orthopaedic surgical platform from a technical, protocol and human resource point of view. It has negotiated all the administrative, logistical and legal issues that will allow the smooth transport, entrance to Jordan and stay of the patients and the people accompanying them. The team has evaluated and studied the importation and local purchase possibilities for the drugs and medical materials needed for the project.

→ A POSSIBILITY FOR PALESTINIAN PATIENTS

Coupled with this project, which is geared towards Iraqi patients, and taking into account the recent evolution in the Palestinian Occupied Territories after the election of Hamas and the subsequent decision of the donor community to restrain from cooperating with the newly elected government, MSF is also envisaging the possibility of setting up a referral system to Jordan for Palestinian patients who might need corrective surgical treatments. Meanwhile, the MSF mission in Palestine has conducted a similar survey and is assessing the eventual medical needs. Once the initial phase of the project established, we could –if the event arises- work closely with the MSF teams in Palestine for the referral of Palestinian patients who might need this kind of surgery.

→ THE CONSTRAINTS

It was quickly decided to set up our reconstructive surgery programme in Jordan. Given the insecurity and chaos in Iraq, it was impossible to envisage referring patients requiring emergency attention. In order not to endanger further our Iraqi colleagues, who are already risk their lives daily, we will have to develop at least at the beginning, simple and discreet mechanisms for the identification and referral of patients. The same will be set up for the supply of the pre-selected hospitals, for which we will have to find suppliers who have offices and warehouses in Amman and Baghdad. Using these suppliers, we will have a direct line of supply from the suppliers to the hospitals. This will also be possible thanks to the Memorandum of Understanding that was signed between MSF and the Iraqi MOH allowing this framework, provided that the MOH is informed about the evolution of the project. Several hospitals are already doing this type of direct supply.

This project set-up may seem atypical compared to other MSF projects. We are far from the 'proximity to the patient' interventions that characterises MSF's programmes. But at the same time, the current situation, especially in Iraq, does not allow any immediate in-country intervention for MSF. Nevertheless, through this new working framework, we are aiming to assist patients in need of reconstructive surgery but who do not have access to it due to the non-respect of health facilities by warring factions in Iraq today. Furthemore, through the supply of emergency medical material and drugs to pre-selected hospitals in Iraq we will be able to help our Iraqi colleagues carry out their medical duty in this volatile context. This type of partnership will open the door to new interventions in the region. So far, the first contacts in the region has proven positive. The Emirates Medical Association has also expressed its interest in the project and other supports are in the process of being explored. This initial phase should give us the opportunity to broaden our network of contacts within the Iraqi communities, which, if the possibility arises, will help us intervene in Iraq itself. ■

Ismaël Fouad
Head of Mission MSF-Amman

PRESS REVIEW (CONTINUED)

→ Darfur: still a cause for concern

"Forgotten causes" was the headline of an article featured in the 17 August edition of the French weekly *La Vie* devoted to the crises currently "causing concern for humanitarian organisations". Although the article makes no mention of the nutritional situation in Niger, or the prevailing climate of insecurity in North Kivu (DRC) and northern CAR, it does refer to the conflict in Darfur; a crisis described as being "held at arms length by international relief efforts" and which, quoting Guillermo Bertoletti, "will not be resolved until a political solution is found to the conflict". Ten days earlier, the UN expressed its concern "in the face of rising violence in Darfur, in the west of Sudan, which has caused the death of more humanitarian workers in the last two weeks than in the previous two years", reported the French daily *Le Monde* in an article published on 8 August. "Increased insecurity hampers MSF medical assistance in Darfur," declared MSF in a press release dated 3 August.

MISSION

DEMOCRATIC REPUBLIC OF CONGO

DEMOCRATIC REPUBLIC OF CONGO:

Rape as a Weapon in North Kivu

MSF / July 2006

In the Democratic Republic of Congo (DRC), rape forms part of the daily reality for women living in the North Kivu province, where violence has reigned for several years. In 2005, Médecins Sans Frontières (MSF) teams admitted 1,292 women who were victims of sexual violence and as many again in the first six months of 2006. These figures are extremely disturbing; however they only reflect a very small part of reality in this eastern region. Malika Saim, MSF programme manager for the DRC, outlines the response our teams are providing to the situation..

→ Democratic Republic of Congo © Jodi Bieber - October 2003

→ How do you explain the extent of sexual violence in the North Kivu province?

Sexual violence is embedded within the general context of violence perpetrated by the several armed groups present in this region. This violence takes many forms: rape, but also looting, crime, and armed fighting for the control of villages or roads. In this environment, where armed groups are always harassing the population, women are particularly at risk. More than three quarters of the women that we have treated have been raped by unknown armed soldiers.

Rape is used as a tool to terrorize the population, and the number of cases increases with each new outbreak of fighting and attacks. While young girls under 18 are particularly targeted (close to 40 percent), the most affected age group is between the ages of 19 and 45 (53.6 percent). These are the women who work in the fields in order to provide for their families. The acts of aggression against them take place mainly in the fields but also on the roads used to get there. Consequently, women limit their travel. Thus, in our supplementary feeding centers in Kayna, mothers have preferred to find accommodation in the direct vicinity rather than returning each week to get rations for their children. In the eastern regions of the DRC, while rape is etched into the general framework of violence, it's also seen as fully legitimate "additional retribution" by the armed groups.

→ What is MSF's response to this violence?

On an operational level, we must adopt a transversal approach and systematically try to offer specific care in all our medical programs (whether primary or secondary care). To begin with, it's essential to work with community groups and existing health facilities to increase awareness about the issue. On a medical level, early consultation after rape is vital, and must be undertaken within 72 hours. In this period of time, it's actually possible to administer to the woman an antiretroviral (ARV) prophylaxis, which makes her less susceptible to HIV infection —a very significant risk factor to take into account. Then, within five days, we offer the morning-after pill to avoid unwanted pregnancy. Medical treatment also involves prophylactic antibiotics against the most common sexually transmitted infections (syphilis, gonorrhea, and chlamydia), and tetanus and hepatitis-B vaccinations. The treatment of physical trauma such as lesions, wounds, or other injuries is also recommended. Follow-up is extensive and the total duration of medical treatment is at least six months. When setting up this type of medical care, it is essential from the very outset to identify a facility where women can be referred to for an abortion. Abortion is illegal in DRC, so we have negotiated the possibility of carrying it out at local level, with the head doctors in the health zone, as well as also with our practitioners.

[...] several aspects are still to be improved and questions remain concerning the need to test —or not — the victim's serology before giving an ARV prophylaxis, the addressing of psychological suffering within medical treatment, and also the limits we apply regarding legal procedures.

Additionally, on a legal level and for reasons of protection, a medical certificate attesting rape is systematically issued and offered to the patient. In 2005, in our North Kivu projects, 17 percent of women accepted the medical certificate and 21 percent filed a complaint with the

local authorities. It is essential we strive to guarantee our two main principles — confidentiality and free health care.

→ What is your assessment of our activities?

In 2004 we treated 270 rape victims in one year in North Kivu —today this figure corresponds to the average number of cases we receive in one month. The number of rapes has not increased— it is access to treatment that has improved. The message is beginning to be delivered widely. The proportion of treatments in the 72-hour period is also clearly increasing, reaching 47 percent in certain projects, like in Rutshuru.

However, several aspects are still to be improved and questions remain concerning the need to test —or not — the victim's serology before giving an ARV prophylaxis, the addressing of psychological suffering within medical treatment, and also the limits we apply regarding legal procedures.

But beyond these recurrent issues, this type of response in a context like that of North Kivu creates other problematic questions. For example, rape, considered a weapon of war against civilian populations, also raises the issue of its political objective. Abortion is an issue that remains completely unresolved in a country like the DRC. Abortion — systematically available in all our projects— is nonetheless forbidden in this country, as is the importing and usage of the abortion pill. ■

Malika Saïm.
Interview by Kate de Rivero

CENTRAL AFRICAN REPUBLIC

In the midst of turbulence in the northern CAR[1]

MSF / August 2006

MISSION
CENTRAL AFRICAN REPUBLIC

Médecins Sans Frontières has been working since March 2006 to improve access to medical care in the area around the town of Paoua in the northern Central African Republic (CAR), where residents are victims of a conflict between rebel groups and government forces. Our teams face a difficult situation and security is a major concern. Francisco Diaz, MSF logistics director, spent a week in the CAR to meet the authorities and groups in the region and evaluate the security risks.

→ What is the current situation in the northern CAR?

The northern CAR is a politically-charged region. The border with neighboring Chad is open, which makes it easy for poorly-identified armed groups to filter into the CAR. To combat this development, the Central African government has authorized Chadian soldiers to enter the CAR. There are often, therefore, many armed men on the roads of the CAR: Chadian, Central African Republic, or rebel soldiers etc. Confrontations between rebel groups and government troops create a climate of warfare that has forced part of the population to take refuge outside villages to escape the violence.

These individuals are living in difficult conditions and lack access to the health care system. Our work thus follows two tracks. One team conducts medical consultations at several sites (schools and other locations) via mobile clinics. A second team works at the 70-bed Paoua hospital, including treating patients referred by the mobile clinics.

→ After four months of work where are we in operational and medical terms?

In operational terms, the team is in the consolidation phase. At the Paoua hospital, we still need to organize the pharmacy management, set up a cold chain, and review the collection and compilation of medical statistics. With respect to the mobile clinic, we need to make improvements at the sites we visit by building latrines and basic shelters, for example, for patients in case of rain. We also need to take a close look at how transport logistics and installations are organized at each site.

Our medical activities give priority to the most vulnerable individuals (primarily children, pregnant women, and the elderly). The goal is to provide access to emergency care to people who have taken refuge outside the villages by referring them, if necessary, to the Paoua hospital. For now, the main reason for coming to the outpatient consultations is malaria (more than 50 percent), which makes sense during the rainy season when the significant increase in the mosquito population sharply increases the risk of transmission to humans. The other reasons are parasites, non-bloody diarrhea, various kinds of infections as well as a small proportion of other diseases. More than half the hospital admissions are to the pediatrics department.

→ One of the goals of your visit was to evaluate the security conditions in which our teams are working. Can you tell us more about that?

The civilian population in this northern CAR region is experiencing a very difficult situation. Soldiers regularly carry out reprisals against villages suspected of harboring rebels and the residents must thus flee to find shelter. There are also a great many armed bandits on the roads in the region. These groups—primarily former mercenaries or soldiers—add to the confusion and create additional risk for our activities. For all these reasons, regular skirmishes occur. While they are not a direct threat to our teams for now, they create a context of insecurity that we must

→ Is the Lebanon context more dangerous than any other war?

No, there are currently a number of other very dangerous wars. Seventeen colleagues from "Action contre la faim" (Action against Hunger) have been assassinated in north-eastern Sri Lanka. This is the most shocking massacre in the history of modern humanitarian action. Operations in Darfur are also very dangerous. While it has been less in the news lately, there has recently been an increase in the number of attacks against relief workers in Darfur.

Jean-Hervé Bradol, President of MSF, interviewed on RMC radio, 10 August 2006

MISSION

CENTRAL AFRICAN REPUBLIC

take seriously. Several weeks ago, an ICRC vehicle was fired on along a road near Paoua. Luckily, no one was injured. While the circumstances do not suggest a premeditated act against the ICRC as a humanitarian organization, such an action is still unacceptable. It is very important to explain the principles of our work very clearly so that the civilian and military authorities understand that treating patients does not mean supporting the rebels. The message seems to have gotten through.

→ What are the main conclusions of your visit?

Regarding the current tensions, it is critical that we understand the larger context. First, I would point to the need to constantly explain our work and engage in dialogue with the various actors in the area. Being transparent with respect to our activities and objectives and restating our principles of impartiality and neutrality will make it easier for us to do our work and reduce the risks of misunderstanding. We must also regularly explain to the populations themselves why we are there so that they understand our operational choices. For example, our priority of assisting the most vulnerable often raises questions, so we have to know how to respond.

The second key point involves the concrete measures that can be taken to limit risks during our daily activities and, in particular, when we travel by road. We must not travel at night, always include an expatriate in a vehicle making a long trip and follow the teams' movements by radio. These are relatively simple security measures that will considerably reduce the risk of incident.

Last, it is essential that the work of our teams not expose civilian populations to additional danger. Recently, on two occasions, residents of Betoko were attacked by official armed troops after our mobile clinic had stopped there. Perhaps this was just an unfortunate coincidence, but it reminds us that we need to take maximum precautions and communicate with the population about these risks. ■

Francisco Diaz.
Interview by Renaud Cuny

1- Other MSF sections present in CAR
- Dutch section: Markounda, Boguila
- Joint Spanish-Belgian mission: Kabo-Batangafo axis

MISSION

SRI LANKA

SRI LANKA

Sri Lanka: MSF is deeply shocked by the killing of members of Action Against Hunger

MSF / August 2006

Médecins Sans Frontières (MSF) is deeply shocked and outraged by the news that 17 members of Action Against Hunger have been murdered in Sri Lanka. MSF is concerned about the turn this conflict is taking. Since hostilities resumed, the level of violence directed at civilian populations and humanitarian aid workers has increased daily. Gabriel Trujillo and Denis Lemasson, program officers of MSF missions in Sri Lanka, react to the news.

→ What was your reaction to the murders of the Action Against Hunger members in Sri Lanka?

Everyone at MSF is stunned and horrified. This concerns the entire international humanitarian community. These targeted killings are unprecedented in the contemporary history of humanitarian work, and words are not strong enough to describe these odious acts. We share the pain of the victims' families and that of all members of Action Against Hunger. We strongly hope that an independent investigation will quickly bring the circumstances and the people responsible for this tragedy to light.

→ What was the context in which these killings occurred?

Since the conflict resumed, the general climate in Sri Lanka has been extremely tense, with suspicions and accusations on all sides. There are tight restrictions and draconian controls on aid organizations in the field. After these killings, we are worried about how this conflict is going to evolve: it has already reached a very serious level of violence affecting civilian populations and humanitarian organizations.

→ Is MSF prevented from working with the victims of the conflict?

Over the last two weeks the populations in the Muttur region, in eastern Sri Lanka (where the bodies of the 17 Action Against Hunger members were found), have been victims of military incursions and it has been impossible to provide assistance in the area. Several tens of thousands of people are still there, without medical care. MSF has been trying to set up two emergency projects for more than two months. One is a surgery project at the Point Pedro hospital on the Jaffna peninsula and the other would provide medical assistance to people living between Muttur and Batticaloa. As yet, however, government authorities have not granted the authorizations required to carry out these programs. It is currently impossible for us to access the civilian populations in the eastern part of the country. ■

Gabriel Trujillo
and Dr Denis Lemasson.
Interview by Isabelle Ferry

DANGER AND RISK TAKING

Realities that need to be accepted

→ Angola © MSF / Oscar Serrano - February 2006

MSF / August 2006

Thierry Allafort, head of emergencies, and Gaelle Fedida, programme manager, continue the debate on risk taking at MSF. They discuss, in particular, the role of individual risk taking in our work and the fashion in which the association decides on rules about it.

DEBATES

Risk is intrinsic to MSF mission work given its medical nature and the complicated contexts in which it takes place. Not all medical workers expose themselves to Marburg or blood exposure accidents; special determination and precautions are required. Over and above the collective decision to intervene in these kinds of programs, field teams are made up of members that have engaged themselves as individuals.

The second category of risks concerns the conflict contexts in which we work. In and around war zones we take special precautions. Once again field team members must engage themselves individually.

For these reasons the motion proposed and rejected at the Mancha that the association would not accept individual risk taking appears so out of touch with reality. Risk taking is everyday practice in the field.

The security of an action is a function of the individual qualities of MSF personnel, starting from their sense of responsibility. One important objective during volunteers' apprenticeship of security is performing the most objective evaluation possible of the situations they are confronted with. The apprenticeship of risk taking and active security planning occur through confronting reality and through the acquisition and mastery of skills. One should not confuse risk taking and lack of security. The former is active and the latter passive, but to avoid or escape poor security may depend upon the individual's capacity to take risks.

Different situations are not necessarily comparable and each must be evaluated as though unique. One must avoid evaluating risks run in purely political analysis, not forget our past experiences, build pertinent networks and relevant activities and adapted teams both in head office and in the field.

Better-guaranteed security demands that each individual proposing a project prove its risk limitation to the group. It is imperative to limit,

framework, or hinder certain potentially dangerous actions without waiting for the danger to be precisely evaluated. This process applied broadly and maximally could provoke inaction. How far to go in risk taking, but also why? The limits are linked to the efficacy of the action that is possible given the constraints, otherwise it is no more than bluff or empty declarations that have no concrete impact on patients. Delegation and confidence are primordial. Overly strict mechanisms of risk management between the field, the executive, and the board should be avoided, and should permit those involved to improve their understanding of the contexts and situations they are working in, and to have maximal support when decisions are taken collectively.

[...] to agree that the board could be an authority in better understanding of risks might be dangerous. The board serves to accept risks together or not; it is the safeguard of the principle of precaution.

The board plays its role when it speaks out about the return of MSF teams to Chechnya, but that the decision is voted is absurd. Its like the "twelve angry men"; the subject is too grave and the sharing of responsibility within the association must be without ambiguity, a unanimous vote must support the decision, and over and above institutional responsibility, it is about members engaging their individual responsibility.

To caricaturise Pierre Salignon in his article, he opposes a reckless volunteer with a wise institution. In giving a maximum of decisions to the latter MSF's actions would be less at risk. But to agree that the board could be an authority in better understanding of risks might be dangerous. The board serves to accept risks together or not; it is the safeguard of the principle of precaution.

On the contrary the institution may sometimes incite its volunteers to take disproportionate risks, notably during media exposed political crises. The president, the communications officer, the operations director and the emergencies director leave during the first days of the Kosovo war. They get lost in the middle of shellfire and didn't treat many people.... and at the same time the MSF institution refused letting a nurse and a doctor go to Congo Brazzaville on the pretext that that the zone was dangerous.... Thousands of living dead are coming out of the forest every day...

Kenny Gluck is right when he states that MSF must be careful not to wish to define risk-taking criteria from the point of view of organisation hierarchy. The security of our teams would suffer as a result.

One fundamental dimension of MSF is the individual's engagement that builds the collective. It is the essential pillar – each one of us constructs MSF over the years. Profound uneasiness occurs with expressions such as "exposing teams" or "temptation of martyrdom". If some members are motivated and competent to confront extreme security situations without recklessness and of their own will, then the association should listen to these initiatives. It would be unhealthy if our missions only depended on individuals. And it would be just as irresponsible not to do some operations when we have the required resources that are voluntary and capable of putting the action in place. ■

Thierry Allafort Duverger, Gaëlle Fedida

1- *From taking risks to putting lives in danger?* by Pierre Salignon, general director of the French section of MSF. Contribution to La Mancha, October 2005

2- *Of Measles Stalin and Other Risks* by Kenny Gluck, director of operations of the Dutch section of MSF. Contribution to La Mancha, September 2005

PRESS REVIEW (CONTINUED)

→ Elections in the DRC:
The Democratic Republic of Congo is preparing to live through a second round of presidential elections, scheduled for 29 October. This follows the provisional results of the election supervised by MONUC (the UN Mission in DR Congo), announced on 20 August by an Independent Electoral Commission, which placed Joseph Kabila in the lead with more than 44% of the vote, to Jean-Pierre Bemba's 20%. "UN Secretary-General Kofi Annan welcomed the announcement of the provisional results of the presidential election on Sunday evening, describing it as an *historic event* representing a vital step in the country's peace process (...), but the announcement of the results saw an outbreak of violence in Kinshasa," noted the daily *Le Monde* in its on-line edition dated 21 August. At least three people were thought to have been killed and ten or so wounded in Kinshasa, according to the journalist. "There is every reason to fear that the campaign for the second round will become even more bitter than in July," notes for its part the daily *Libération*, also on 21 August.

A CRITICAL LOOK AT SURGERY

Surgery off track?

MSF / August 2006 / Translated by Aaron Bull

Xavier Lassalle, advisor for anaesthesia in the medical department, looks at our directions and operational choices in the area of surgery. He is not convinced about the relevance and quality of our surgical programmes, or how they are evaluated, and as a result, he questions our practices, calling for greater cohesion in our surgical activities.

Because the need for "medical treatment" throughout the world is infinite, the operations department is required to select for MSF, based on the priorities set by the association, the areas where we wish to intervene and the types of activity we will carry out there. For a number of years, in addition to its initial objective of providing treatment for life-threatening emergencies, MSF has been offering programs aimed at improving quality of life.

Like the mental health and pain management programs, the surgical programmes were developed with this in mind. However, the rapid growth in surgical activities and MSF's introduction of elective surgery and surgery aimed at improving quality of life (not directly related to a life-threatening condition) raises a number of questions.

→ ELECTIVE SURGERY

Surgery in the broad sense of the word, including anaesthesia, resuscitation and post-operative care, is a high-risk activity (in terms of mortality and morbidity). Follow-up of peri-operative mortality, conducted for the first time by MSF last year based on mortality reports provided by teams of anaesthetists and surgeons in the field, revealed very high figures: 1 death in 34 procedures [see margin – ed.].

Given the many constraints related both to resources (e.g. human resources, budgets) and conditions (particularly with regard to security), we have had to adopt a minimal technical and organizational standard that seems to be an acceptable compromise for life-saving surgery. However, what may appear to be acceptable for "vital" surgery is much less acceptable when it comes to elective surgical interventions and those aimed at improving quality of life. So we need to ask the question: what level of risk do we accept for our patients to be exposed to when they undergo an operation for an inguinal hernia, or reconstructive orthopaedic surgery?

→ A QUESTION OF QUALITY

Unfortunately, an increase in the volume of activity without a strategic plan has resulted in a decrease in quality. This is clearly the case with regard to anaesthesia. In contrast to earlier years, the past few months have seen missions opened with no consultation and without meeting our defined minimum acceptable standard. We have also noted a reduction in pain management (from 60% of patients in February/March to 30% in May/June), an increase in the interim periods during which anaesthesia is administered by unqualified staff, and a decline

[...] what level of risk do we accept for our patients to be exposed to when they undergo an operation for an inguinal hernia, or reconstructive orthopaedic surgery?

in the follow-up of mortality. In this context, what is MSF's strategy for the development of surgical programmes? Furthermore, in this environment of expansion what is our mechanism for assuring quality?

→ EVALUATION

The lack of evaluation of surgical activities poses a real problem. Last year, there was a discrepancy of 20% in the figures reported by the department of operations and the medical department regarding the number of surgical procedures performed. With this level of inaccuracy, it is difficult to imagine what criteria could be used to evaluate the usefulness of our procedures. The equation surgery (+ *anesthesia*) = benefit for the patient simply does not always hold true. We must document early and late operative complications, such as infection, morbidity, mortality, in order to assess whether a programme has genuinely been beneficial for the target population. *Primum non nocere*.

Unfortunately, it seems that within MSF, evaluation is still seen by some as putting a damper on enthusiasm or simply adding another level of red tape. Personally, I am not convinced that there is the will at MSF to carry out a systematic evaluation of our activities. In many respects, the problem of evaluation parallels that of pain management: naturally, everyone is for it, but among the desks or in the coordination team, how many people are actively promoting it?

How can we make decisions today about expanding our surgical missions — particularly where they involve elective surgery — without first having assessed the risk and benefit for the patient and established the means for evaluating it?

→ SPECIALIZED SURGERY AND THE RESOURCES NEEDED FOR IT

The development of specialized surgical programmes without first setting up the necessary technical conditions in terms of both human resources, equipment and organization, and alternative solutions for surgical activities in the community, raises serious ethical problems.

Take Sigli, for example. In May, general surgery was suspended to make way for reconstructive surgery, in theory to address the needs of victims of the tsunami and of the violence that had occurred over the previous few years. In the first stage of this reconstructive programme, a maxillofacial surgeon specializing in treating children born with cleft lips and palates was sent, without liaison with our specialist advisors. This type of surgery is not at all straightforward when performed on young children, and it cannot be done without teams of specialised professionals (surgeon, paediatric anaesthetist, post-operative physician and nurse). Planning and conducting this activity at a hospital with very low overall standards, under very unsatisfactory safety conditions (no functional recovery room, no pain management, etc.) reflects a worrying lack of medical responsibility. Is it really MSF's role to treat congenital malformations, when there are many specialized international teams already involved in this work, such as Chaîne de l'Espoir or Operation Smile? Is it worth performing these high-risk complex elective procedures

Personally, I am not convinced that there is the will at MSF to carry out a systematic evaluation of our activities.

in makeshift conditions just to maintain a presence in the region? More generally, what resources are we able and prepared to invest in order to perform this specialized surgery in more appropriate conditions?

Clearly, when an activity is developed, there needs to be a balance between those who push for going ahead ("the details will look after themselves") and those who are often seen as naysayers, who want to put certain facilities in place first. Unfortunately, it does not follow that a surgical programme will benefit all patients. The capacity to do great harm must be understood. The "technical" prerequisites are not designed just to put obstacles in the way of our teams, but to ensure the well-being of our patients. They have proven themselves in developed countries, and it has been demonstrated that they can be adapted to the conditions we work in, and are effective there. These technical constraints (as defined by the consultants) need to be accepted, and the programmes must be not viewed purely from a quantitative perspective. Furthermore we must provide the means to measure their quality in a completely transparent way.

Let's stop spreading our limited surgical resources too thin, and start having a meaningful discussion together around how we can set up the management and evaluation systems we need, without diminishing the professionals' enthusiasm and responsiveness, which are vital to our work.■

Xavier Lassalle

→ On peri-operative mortality

Between January and September 2005, of 7,698 surgeries performed, 4,712 (66%) were followed up for mortality. It was found that 138 of the 4,712 patients, or 1 in 34, had died.

- for emergency surgery (60% of our activity), there were 136 deaths in 2,830 procedures, or 1 in 20. Emergency surgery included what are called "acute" emergencies (e.g. uterine rupture, multiple trauma) and "tepid" emergencies (e.g. procedures secondary to emergency surgery, dressing under anaesthesia, skin grafts).
- for scheduled, elective surgery (e.g. hernias, varicose veins), which made up 40% of our activity, there were 2 deaths in 1,888 procedures or 1 in 944. These deaths could have been avoided.

There were a variety of causes connected with the patient's general condition, insufficient resources, the surgery, the anaesthesia, or more often all these factors.

The anaesthesia-related causes were analysed in a presentation given at the last surgery day.

Xavier Lassalle

INFO

→ The Gulf War Turning Point

In 1991, the Iraq War marked an important moment. A large operation, involving all MSF sections, was launched to assist Kurdish refugees near the Turkish border. For two months, MSF Logistique managed the dispatch of 56 planes. Most of them left directly from the country where the necessary equipment was available: Germany for blankets, Pakistan for tents, Denmark for Compact Food. For several days, a regular service ran between MSF Log and the field: orders from the field were sent in the afternoon, a plane was loaded by MSF Log the same evening which took off from Toulouse in the night and arrived at the Iraqi border the next morning. Demands were extremely changeable because of the refugees' changing situation, but also because of the launching of a massive, but anarchic response, by the international community. Adapting itself extremely quickly to the evolving situation, avoiding duplication... I think that MSF, is a model to emulate in this type of situation. The joint working of ground and the logistics teams was a key part of this flexible response."

Jacques Pinel

It's not everyday you're 20 years old

MSF / August 2006 / Translated by Penny Baker

She may have put on some weight but there's not a wrinkle in sight. Born 1986, MSF Logistique celebrated its 20th birthday on the weekend on the first of July. Several of local representatives, who had helped to buy the site, came to Merginac to join in the celebrations. The Boards of Directors of MSF-France and MSF Logistics took the opportunity to meet and discuss MSFLog's activities and to debate its future. The next day there were games, stalls, refreshments and dinner infront of the stage set up for the occasion.
To celebrate this anniversary, we would like to recall the genesis of MSF Log, which has grown and diversified continually since its creation and to look at the challenges with which it is confronted today.

Log story...

MSF / August 2006 / Translated by Penny Baker

Jacques Pinel[1] participated in the birth and growth of MSF Logistique. He describes us its history, from the purchase of its first vehicles in the eighties to the impressive logistic platform that it is today. Its 20 years of existence have made MSF Logistique "much more than just a purchasing centre."

→ Before it used logisticians, who was in charge of logistics on the first MSF missions?
Until 1980, members of the medical team took it in turns to take care of logistics. In Thailand, MSF's first large-scale mission, we started to create 'supervisor' positions- we didn't call them logisticians at that time- in the nine camps where we were active to support the teams' work. In fact, despite the size of the mission (100 expatriates providing assistance to Cambodian refugees), these posts were relatively straightforward because the country was already well developed. It took half an hour for us to hire or buy a vehicle for the teams, the local telephone network worked and drugs were available locally.

→ How did logistic arrangements evolve after this?
In 1982, headquarters asked me to structure logistics for all of our missions from Paris. In Africa, unlike in Thailand, the phone network was almost non-existent and problems in finding vehicles and equipment, or even basic drugs, held up the work of the medical team.

To begin with, we concentrated on communications, provision of medicines and vehicles. We set up a radiocommunications network, standardised lists of drugs and constituted a vehicle pool - limiting ourselves to Toyota Land Cruisers, a model used by ICRC and the UN. Not so we could be like them, but so we could use their garages!

→ When did MSF Logistique come into being?
Between 1982 and 1986, it became clear that to conduct emergency operations we not only needed financial resources and a pool of people available, we also needed

MSF LOGISTICS: CHRONOLOGY

1980 : first supervisors in Thailand
1986 : Birth of MSF Logistique in Narbonne
1989 : Pre-storage of drugs
1992 : MSF Logistique moves to Bordeaux-Mérignac
1993 : Bonded warehouse
1999 : MSF Logistique is licensed to stock pharmaceuticals by the Ministry of Health
2003 : Extension of the warehouse from 2 000m² to 5200 m²

→ Bordeaux - Mérignac © MSF / Irène Nzakou - July 2006

suitable equipment. So on 19 October 1986, we created MSF Logistique, which we envisaged as a procurement and pre-storage centre for logistics equipment. Three people were based in Narbonne in the south of France, and then in Lezignan, where we were supposed to stay for a year. In the end, as one emergency mission followed another, we stayed several years.

→ What were MSF Logistique's initial activities?

We started to stock ready-to-go vehicles. Toyota made solid vehicles which were well adapted to the difficult conditions of Africa, but they were only available on order.

So MSF Logistique pre-brought the vehicles and parts in Japan. For several years, the procurement centre was not involved in pharmaceuticals and therefore turned to turn to large NGO's like IDA, Action Medeor for these. In 1989, we started to stock drugs and hired a pharmacist to work on site.

→ Why did it move to Merignac?

At the beginning of the 90s, we looked for a new site, more suitable to what MSF Logistique had become. We wanted to be close to an international airport, but we also wanted to be large enough to benefit from the flexibilities necessary to deal with emergency operations. We decided not to go for the gigantic sites like Paris-Roissy, because we would have been drowned in the plethora of companies already located there. The Bordeaux-Merignac site offered the most advantages, particularly concerning customs and transport, and also offered good installations for the 30 people who worked there.

→ How has MSF Log evolved?

MSF Logistique has had to adapt to the change in the type of missions carried out by MSF. As well as supplying medical teams, MSF Logistique has expanded to respond to the basic needs of populations in crisis: the provision and treatment of water, sanitation, shelter, food...It's a lot more than a procurement centre!

Today, MSF operations have a generalist operational tool at their disposition, designed to respond to the needs in the field. But to keep this tool up to date, a direct and permanent link between the operations departments, missions and MSF Logistique is needed.■

Jacques Pinel.
Interview by Irène Nzakou

1- Jacques Pinel now works for the Access to Essential Medicines Campaign

MSF LOGISTIQUE

Keeping In Step

MSF / August 2006 / Translated by Chrissy Schmiedel

As operational activities increase, MSF Logistique (MSF-Log) has no choice but to keep up the tempo set by operations. The question is: how will it keep it up, and for how much longer? Site director Gérald Massis and Supplies Coordinator Philippe Cachet sat down with us to talk about it.

→ What are the difficulties facing MSF Logistique today?

MSF-Log always keeps pace with growth in the operational sections, which has been booming across the board. Our volume of activity has therefore been rapidly increasing. Because of our operational restrictions, we can't take a just-in-time approach like some logistics firms do. We have to operate on a stock system (including MSF-France, MSF-Switzerland and MDM emergency stocks), which brings with it a whole host of management restrictions. These supplies have to be consolidated, so that we can be sure all of our missions will have what they need, particularly in terms of specialty items that are harder to procure (TB, neglected diseases), keeping in mind that storage is not a magic solution. So we constantly have to strike a balance between the constraints inherent to the supplies, the diversity of products and sources, and our operational needs. We expanded the warehouse in 2002 and already we are running out of space again, not to mention that the MSF-Log staff are stretched to capacity.

→ What approaches are being considered to keep up with this growth?

For the logistics products, decentralization is a possibility. We could pre-store the equipment that doesn't need to be ordered or prepared in Bordeaux. We already run a decentralized storage facility in Dubaï (Arab Emirates) that we could make greater

INFO

MSF LOGISTIQUE IN FIGURES (2005)

- 15,200 tons dispatched to 70 countries
- 165 tons (750m³) of emergency supplies
- 14,100 listed items
- 2,500 items stored
- 3,801 kits assembled in-house
- 350 orders per month, on average
- 66 salaried employees

use of. We're looking into a couple of possibilities. We also need to develop our intelligence on suppliers in other countries and set up a network that delivers supplies quickly and in accordance with our own quality standards. Our Bordeaux facility will also need to be expanded.

Supervision of kit assembly operations, which represent a strong added value, requires our continued presence at the site. Human resources will need to be stepped up. We have also been thinking about taking a more international approach to our supply policy and consolidating cross-center collaboration, particularly with MSF Supply (supply center in Belgium). Should we be moving towards a common supply policy for each product type? Should we outsource our products? This is the kind of food for thought that should rapidly lead to action.

→ When he first became head of MSF Logistique in 2003, Gérald made a statement denouncing what he called the "automatic French autarky". Is that still the case today?

Gérald: I'll admit it was a bit inflammatory--but I wanted to remind people that the center is not, statutorily, a tool meant for the sole use of the French section, but rather that it is supposed to be used by all sections in the same way. For the record, six years ago 70% of MSF Logistique turnover was devoted to the French section. Today, its portion represents less than 60%. So, things have changed in a fundamental way. Now, it is a given that all sections are entitled to the same MSF Logistique services, and everyone at MSF knows that there is a lot more to our day-to-day work than talking to Operations at the French section. This is the direction in which the center will be moving in the future, and the international framework is one of the strategic points that should be mapped out fast. ■

Gérald Massis and Philippe Cachet. Interview by Irène Nzakou

→ VOLUME OF ACTIVITY (2005)

45 million Euros (33.3% Medical, 19.3% Logistics, 30.1 Freight and 17.3% Food)

→ RATIO BY SECTION, OTHER NGOS

59 % MSF- France
20.9 % MSF- Switzerland
8.6 % MSF- Spain
9.7 % Other MSF Sections
1.8 % Other NGOs

→ **Bordeaux - Mérignac** © MSF / Irène Nzakou - July 2006

INTERNAL PUBLICATION

Finally a document on nursing care!

MSF / August 2006 / Translated by Frank Elliott

We were somewhat «has been» when it came to good nursing care. There was even practically nothing on the subject in the Field Library. Comments made by nurses who shared their views with the medical department were to provoke a response. A project started two years ago has now been completed. After the recent publication of the sterilisation guidelines, – «Nursing care: a handbook for MSF missions» will be available in November. About time too !

Our health care practices in the field have developed in line with the type of projects undertaken by MSF: an increasing number of hospital projects have opened, leading to field staff frequently asking for previously non-existent documents on nursing care and which required time to answer. One of the many comments was the fact that equipment for carrying out increasingly complex medical treatment was either obsolete, unsuitable, or quite simply lacking. Could it be that nursing was the last thing to be considered by MSF? Not quite, but it is a rather neglected area where the consequences of minimal care do not seem to present too many problems. You could overstate the case by saying: « no deaths occurred ». How many nurses in the field have found themselves in the in the situation where they have had to create make shift solutions or approximating procedures, while at the same time MSF insisted - and with good reason - on ACT or ARV treatment procedures? In the end you tend to forget the standard benchmarks: « it's normal to work like this on humanitarian missions; it's not like at home ».

→ THE OBJECTIVES

The aim of «Nursing care: a handbook for MSF missions», is to:
- help nursing teams provide quality care by, for example, providing field staff with technical procedure sheets.
- define set quality standards for certain techniques –e.g asepsis criteria– using as a basis international recommendations
- assess existing equipment, identify what materials are lacking and improve the standard of care by replacing obsolete items

These guidelines should come out in November in French, then in English, and will be included in the Field Library. They describe basic nursing care procedures such as observation and monitoring, administration of drugs, transfusion, emergency procedures, hygiene, dressing of acute wounds, taking samples and carrying out rapid tests, as well as useful annexes on daily nursing care. The document will be accompanied by a CD-ROM with technical procedure sheets; this will provide nursing staff with a basis from which to start and which they can then adjust to their specific operational setting.

Also, a DVD film called « Healthcare Techniques » will be available for the

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→ **Democratic Republic of Congo** © MSF / Pascale Zintzen - March 2006

PRESS REVIEW (CONTINUED)

→THE AIDS EQUATION

In relation to patients suffering from AIDS and who are treated by MSF, "immune system restoration is equivalent to that in wealthy countries. Survival rates are at 74% after two years," explains Dr Alexandra Calmy to a journalist from the daily *Libération*, in the newspaper's 17 August edition. Coinciding with the International AIDS Conference held in Toronto, the pandemic has been the subject of many articles this month. In an interview with the daily *La Croix*, Dr Arnaud Jeannin notes: "Do the maths yourself: if there are three to five million new cases to treat, something like 230-380 million euros need to be provided annually. And as more people are saved expenditure rises from year to year, which means there is an increasing need for funding." He is worried about the cost of medicine, but also about industrial property laws, which constitute "a major source of uncertainty."

MSF / Alix Minvielle / August 2006

Available at the photo library

New photos sent to international Database

→ **Palestine**
Destructions of Beit Lahya and social worker, July 2006, (c) Laura Brav / MSF (15 images)

Mental health care, medical care and social work, September 2005, (c) Alan Meier (29 images)

→ **Thailand**
Maesot, tuberculosis, April 2006, (c) Antoine de Changy (27 images)

Hmong refugees, July-December 2005, (c) Sylvie Cusset / MSF (22 images)

→ **Indonesia**
Inflatable hospital in Iogiakarta and mobile clinics around Bantul, Island of Java, June 2006, (c) Kaltoum Romdhani / MSF (18 images)

Inflatable hospital in Iogiakarta and mobile clinics around Bantul, Island of Java, June 2006, (c) MSF (13 images)

→ **Niger**
Treatment of malnutrition in the region of Maradi, June 2006, (c) Anne Yzebe / MSF (28 images)

→ **Sudan**
Orphanage of Mygoma, March 2006, (c) Stephan Oberreit / MSF (8 images)

training of staff. Produced by a team of specialists from Belgium, the film deals with certain aspects of nursing care (intravenous injections, insertion of a urinary catheter etc).

→ FROM THE THEORETICAL TO THE PRACTICAL

The work to produce the document has helped us assess our procedures. It seems that hygiene is somewhat neglected by field nurses, and we therefore felt it important to stress this aspect by devoting a chapter to it. As far as equipment is concerned, the MSF catalogues now include several new items:
- Alcohol based solutions for disinfecting hands. These will be introduced gradually over the next few months, with written instructions on how to use them.
- Sterile urine bags. Although their use and the insertion of a catheter and a « closed system » bag have been recommended by international protocols for some ten years now, we were still inserting catheters with non-sterile bags, even though the insertion of urinary catheters can contribute significantly to nosocomial infections.
- Infusions:
- 3 way taps (at last !) to avoid «injecting» into the tubing ,
- Occlusive catheter dressings (being tested in the field) so as not to have catheters held in place with bits of sticking plaster...
- Where dressings are concerned, we should choose two kinds, one for acute wounds (alginates) and another type for chronic wounds (hydrocolloid). A number of tests in the field should help us to respond more effectively to the needs and kind of equipment required according to the type of mission (surgery as opposed to outpatient services for example).

→ THE FIELD'S ROLE

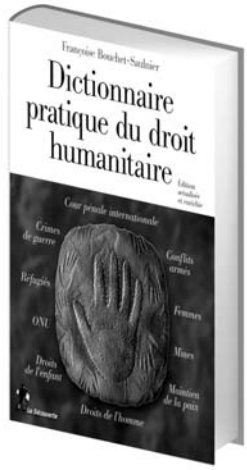
This document is the result of several months' work. It must now be put to test in the field and we are relying on you in the field to send us your comments and criticisms so that we can improve it and update it on a regular basis.
Other nursing care practices will be added to the document in the future. These will include the dressing of chronic wounds, monitoring of certain pathologies frequently encountered in the field (malaria, meningitis, tetanus, etc..), post-operative care and everything relating to hospital management and health-care organisation. The medical department welcomes any suggestions.
Nursing care has long had a low profile, it must develop according to the types of field programmes, practices and equipment must be continually adapted to the specific settings we work in and new resources must be made available to the teams. ■

Emmanuelle Chazal[1], Training Advisor (and on occasion nursing care advisor) in the medical department

1- With Sophie Lauzier, Florence Fermon, Coralie Léchelle, Marie-Noëlle Rodrigue, Véronique Grouzard, Geza Harci, Thomas Diste, Corinne Lejeune, Laurence Bonte

NEW EDITION

Practical dictionary of humanitarian law



Françoise bouchet-Saulnier, Legal Director of MSF, has developed a reference work for professionals in the field of international relations and humanitarian action (including non-governmental and international organisations), journalists, students and lawyers, but also for those who want to understand the issues involved in this new law and the resources it offers.
From Adoption to Wounded and Sick Persons, this dictionary delineates the field of humanitarian activity and the responsibility of the various actors who manage crises and conflicts. It offers a legal definition and practical analysis of more than 300 key concepts, including assistance, Central Tracing Agency, children, civilians, detention, embargo, genocide, Human Rights Council, International Criminal Tribunals, medical duties, peacekeeping, prisoners of war, refugees, terrorism, United Nations, war crimes, weapons, and women.
This new edition, which has been updated and expanded, incorporates recent legal and political changes related specifically to the war against terrorism and the operation of international tribunals. It now includes summaries of recent international case-law, included at the end of the key relevant headings. A cross-referencing system, bibliography, organisations' contact information, indexes and a list of relevant texts for each country complete this essential tool for humanitarian actors, decision makers and concerned individuals.
The dictionary has been translated into seven languages. ■

Practical Dictionary of Humanitarian Law -Françoise Bouchet-Saulnier, Legal Director of Médecins Sans Frontières, La Découverte publications.

FILMS AND DVD

News from EUP

MSF / August 2006

Two important pieces of news this time round :
The much awaited film « Organising an emergency mass vaccination campaign » is now available on DVD in French and English. Clearly presented and brilliantly filmed, training films take on a whole new meaning with this state-of-the-art 'A to Z' on how to set up and carry out successfully a vaccination campaign. Let word spread of this film's release, it should and deserves to be discovered by medical teams far and wide.
The 'Operational Video Library' equally took a while to see the light of day but we got there in the end. It is a collection of 65 films - medical and training films, reports on MSF programmes, documentaries on humanitarian aid... All the films are presented on DVD ; all are in French and over half are in English too.
We're not trying to compete with Hollywood, nor are we condemning the fact that Johnny Depp and Uma Thurman appear on your screens from time to time... we're simply offering an alternative and an opportunity for all our staff to enhance their knowledge and understanding of MSF and the environment we working in.
The collection will be arriving on all field programmes in September. ■

François Dumaine and Sara Mc Leod

AVAILABLE IN THE DOCUMENT LIBRARY

Acquisitions July 2006

Christine Pinto (01 40 21 27 13)

→ MEDICAL

DEVEAUD, B.,LEMENNICIER, B. L'OMS: Bateau ivre de la santé publique: les dérives et les échecs de l'agence des Nations Unies. Paris: L'Harmattan, 1997, 177 p.

LOVELL,A-M. Santé mentale et société. Paris: La Documentation française, 2004,119 p.

OMS, MSF, and UNHCR. Malaria Control in Complex Emergencies: an Inter-Agency Field Handbook, Genève: OMS, 2006. 218 p.

OMS. Guide to Health Workforce Development in Post-Conflict Environments. Genève: OMS, 2005, 141 p.

→ GEOPOLITIC

IACHOURKAEV,S. Survivre en Tchétchénie. Paris : Gallimard, 2006, 383 p.

LACOSTE,Y. Géopolitique: la longue histoire d'aujourd'hui. Paris :Larousse, 2006, 335 p.

TISHKOV,V. Chechnya : Life in a War-Torn Society. Berkeley: University of California Press, 2004, 284 p.

Election of the president of the I.O.

MSF / August 2006

Dr Christophe Fournier has been elected president of the International Office of MSF, replacing Dr Rowan Gillies who is at the end of his mandate. Christophe started working in the humanitarian field with Médecins du Monde in 1989 as field doctor on a six month mission in Peru, then as field coordinator in Chili until 1993.
After four years working as a general practitioner in France, he joined the French section of MSF in July 1997. After various field positions –medical coordinator in Burundi, head of mission in Uganda and Honduras, then two assessment missions in Mexico and Venezuela- Christophe joined the headquarters staff in May 2000 as programme manager. Four years later he joined the decentralised desk in New-York as programme manager there before becoming Programme Director in July 2005. Aged 42, Christophe will officially start his new position at the beginning of December 2006.

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New photos sent to international Database (cont.)

→ **France**
Full charter in Bordeaux Mérignac leaving for Indonesia, 30 May 2006, (c) Laurent Theillet (5 images)

Mission among illégal immigrants in Calais, February 2006, (c) Julien Lévêque (10 images)

→ **Southern Sudan**
meningitis vaccination campaign around Akuem, April 2006, (c) Kevin Phelan / MSF (6 images)

→ **DRC, Katanga**
Upemba, distribution of NFI kits, March 2006, (c) Bruno Berson / MSF (13 images)

Upemba, cholera + health centre, February-March 2006, (c) Hichem Demortier / MSF + MSF (9 images)

MSF moble clinic in Mitala Zambia et Kisungi, février 2006, (c) Corentin Fleury / Deadline Photo Press (23 images)

→ **Sudan, Darfur**
refugee camps, February 2006, (c) Stephan Oberreit / MSF (24 images)

Photo library

→ **Armenia**
Erevan dispensary in repair, MDR TB, February 2006, (c) Elisabeth Poulet / MSF

→ **Nepal 2006 + Niger 2005**
(c) William Martin / MSF

RESOURCES

TURN OVER AT HEADQUARTERS

FUNDRAISING & COM DPT

→ **Gilles FASBENDER** ended his contract on 02/06/2006

→ **Nathalie CAILLOT-TRANCHARD** left her position as Assistant on 14/08/2006.

→ **Brigitte BREUILLAC** started as communications officer on 4/08/2006. She is replacing Isabelle MERNY-ENGEL who is away on maternity leave.

IT

→ **Nadia AYANE** left her position as headquarters IT officer on 30/06/2006.

FINANCE DPT

→ **Mickael LE PAIH** left his position as Field Financial Controller on 03/08/2006.

→ **Thierry LE GALLAIS** left his position as Head of Field Financial Management on 13/07/2006. Chantal MIR, who has replaced him, started on 26/06.

→ **Francie SADESKI** started as Field Financial Controller on 21/06/2006. She is replacing Irina LARGUIER who is on maternity leave.

→ **Clémentine THENAULT** started as assistant field financial controller on 20/07/2006.

→ **Anne EVENO** started as Field Financial Controller on 10/07/06.

LOGISTIC

→ **Gwenaël BERRANGER** started as Logistics supervisor on 16/08/2006.

MEDICAL DPT

→ **Milton TECTONIDIS** left his position as doctor in the medical department on 20/07/2006.

→ **Sophie LAUZIER** ended her contract on 23/06/2006.

OPERATIONS

→ **Filipe RIBEIRO** let his position as deputy programme manager on 13/07/2006.

FIELD HR

→ **Franck ELOI** ended his contract on 30/06/2006.

TRAINING COURSES

→ POPULATIONS IN PRECARIOUS SITUATION

From 17 September to 1st October 2006 in Saint-Prix (Val d'Oise), near Paris
Duration : 12 days , Language: English

→ GOAL OF THE PSP

Train participants to answer to medical humanitarian emergency situations in an appropriate way and in accordance with MSF policies.

→ TARGET POPULATION

- Priority to expatriate medical personnel who are or could become field coordinator and national deputy coordinators (field or capital coordination)
- Second line of recruitment : medical coordinators and head of mission
- Between 12 and 20 months of MSF experience within at least two different types of intervention, one of which in emergency
- Committed for at least another 12 months (for the expatriate in one or several missions).

→ TRAINING OBJECTIVES :

By the end of the PSP trainees should be able to:

- Evaluate the population needs (medical and essential: WatSan, shelter, food, security)
- Define intervention strategies adapted to health problems, to the context, to the population and to MSF objectives and policies
- Plan the implementation of program's activities
- Ensure follow up of population health status
- Ensure program monitoring and re-orientation according to context evolution

→ NUTRITION / VACCINATION

From 8 to 15 November 2006 in Spain
Duration : 6 days, Language: English

→ TARGET POPULATION

Medical background staff who will be involved in nutritional programs and/or take part in the setting up of vaccine activities.

By the end of the training course, trainees should be able to:

→ EPIDEMIOLOGY

- Define, calculate and use epidemiological indicators

→ NUTRITION

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

→ IMMUNIZATION

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

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

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
Translation : Caroline Serraf / TSF
Photo librarian : Alix Minvielle
Layout : Sébastien Chappoton / tcgraphite
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