messages

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DOSSIER

PANDEMIC DESPERATELY SEEKING SOLUTIONS

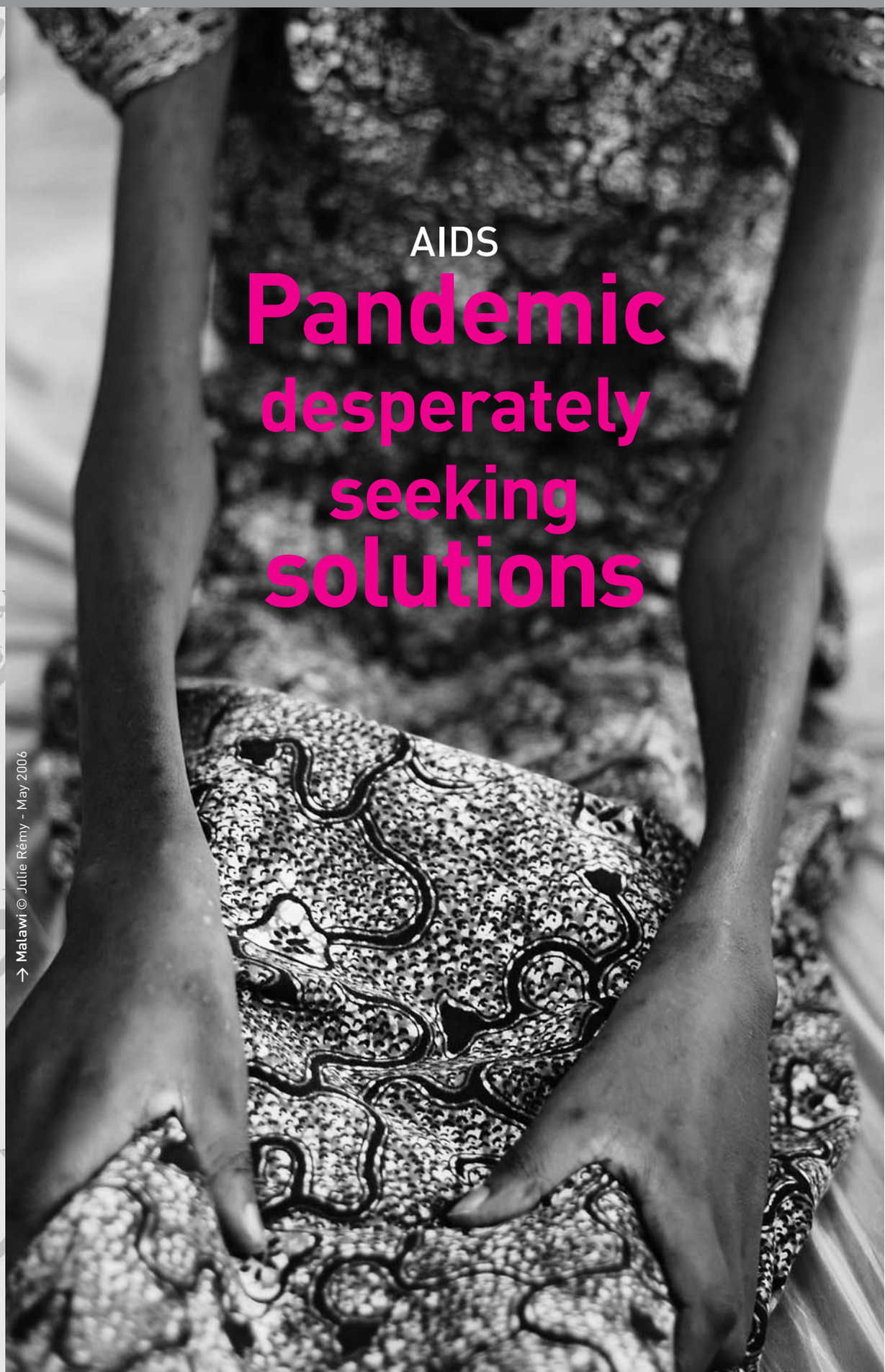
MISSIONS

DEBATES

INFOS

AIDS

Pandemic desperately seeking solutions



→ **Malawi** © Julie Rémy - May 2006

Number 143

WE CAN ALWAYS DO BETTER

Although we procrastinated at length before starting, MSF is among the 'pioneers' treating Aids in developing countries. Thanks to its experience MSF, alongside other organisations, helped initiate a response to the pandemic and compelled others to become actively involved in the fights against Aids. MSF is now innovating an approach to try and treat as many patients as possible. Our teams are already helping 60,000 patients to survive.

Ok, but what next? 'No hailing of victory" is the message in this dossier. Above all we must not fall into the trap for which we criticised the WHO concerning tuberculosis: soothing self-satisfaction in order to conceal our failures and difficulties. Our programmes have their failures, and they are considerable: treatment is given priority over prevention, especially in mother-to-child transmission, the ever neglected element of our Aids programmes. The treatment of TB/HIV co-infected patients is the next challenge for MSF. A complex challenge that will call us to rack our brains.

It is because we have made progress that our weak points and where we need to better ourselves are all the more visible. That's all par for the course. MSF can only be considered a 'pioneer' if it continues to break new ground and improve treatment for patients. MSF must not be a hero clinging to past success, but a clinician in the field continually inventing new approaches.

AIDS

Inventing as we

MSF/November 2006/Translated by Alison Quayle

"To treat as many of the AIDS patients who come to us as we possibly can." This is the objective of our HIV/AIDS programmes, especially in Africa. We must now turn our efforts towards covering the needs as widely as possible. It is a very unusual concept for Médecins Sans Frontières to say, and above all a radical step forward, five years on from the start of our first AIDS programmes.

In late 2000 and early 2001, MSF's objective was to start treating AIDS patients with antiretroviral (ARV) therapy, and to show that it was perfectly possible to treat poor patients in developing countries. At the time, patent-protected triple therapies cost over 10,000 dollars per person per year. And there were many sceptics – major sponsors in particular – who believed that it was impossible, and even pointless. Then the context changed. The Global Fund to Fight AIDS, Tuberculosis and Malaria was set up in June 2001. With generic versions coming onto the market, in 2001 triple therapy was available for less than 350 dollars per patient per year.

For MSF, two years on from the first patients, the objective was no longer starting individual treatment, but moving on to "scaling up", increasing the number of patients on ARV therapy. This meant identifying all the bottlenecks that were preventing us from making the move to treating larger cohorts. It led to a simplification of treatment: initiating therapy without a CD4 count[1], longer periods between patient visits, new allocation of tasks, with a start on training nurses to take responsibility for some patients.

In parallel, the "global response" to the pandemic was making slow progress: the Global Fund was having trouble getting enough funding to match the needs, and national programmes were taking a long time to set up, or were even non-existant. "*The World Health Organisation's "3 x 5" initiative launched in December 2003 – 3 million patients under treatment by 2005 – certainly gave it a boost by mobilising the various players*" says Annick Hamel from the Operations Department. Even if the WHO "3 x 5" was widely disparaged, and not only by MSF (see the Win Van Damme interview on p. X), there were more and more initiatives being set up in the field, and national programmes are gradually starting up.

"*Decentralisation of care is now under way in a great many countries, in the sense of increasing the number of places where treatment is available, to get closer to the patients and offer therapy to everyone who needs it. It's the only way to cope with the high demand, especially in high-prevalence countries*", Annick Hamel explains. The question is therefore: how should it be done? In MSF programmes, implementing decentralisation also depends on the political will shown by the countries and the constraints they have to face. "*Some countries, such as Uganda, have set up a decentralisation policy that is mainly aimed at meeting target figures. Here it is harder for MSF to get involved in the process because it has to be done by improving the existing system. In Malawi, where there is a willingness at national level, the government is encouraging MSF to implement the decentralisation so they can learn from our experience.*"

But in practical terms, the dynamic is the same as for "scaling up". "*It's only the scale that changes. And one of the*

EPIDEMIOLOGICAL RESEARCH
TRANSLATED BY AARON BULL

We are conducting a series of cross-sectional surveys to determine the efficacy of treatment for patients being treated by MSF. MSF has a responsibility to be credible, demonstrating that its treatment strategy is effective.

Our work involves taking a blood sample of patients who have been receiving antiretroviral treatment for 12, 24, 36, or even 48 months. If the viral load is detectable, we study the genotype of the virus in order to determine the most frequent viral mutations. At the same time, we try to measure how consistently patients have been following the treatment and assess the side effects they have experienced. We also try to identify clinical signs of treatment failure by comparing viral load values with possible clinical signs that may appear during treatment.

This will allow us to make more accurate assessments of our programs, i.e. to measure treatment failure rates, adherence problems and treatment toxicity. For patients experiencing treatment failure, analysis of the genotype allows us to determine the most suitable second-line combination. The first studies on adults show immuno-virological results that are comparable to those in economically developed countries, taking into account the patients' health condition when MSF began administering their treatment.

Dr Mar Pujades, epidemiologist, Epicentre.
Interview by Olivier Falhun

go along

→ **Nigeria** © Ton Koene - July 2006

main issues is the lack of medical personnel. But it's possible to care for more patients by asking for help from other patients or people in the community, to look after the patients close to their home." Hence the experiments in Malawi, for instance, or in Kenya (see also p. 4).

Nevertheless, not everyone wants to treat all patients and provide everything needed to ensure they survive. "*We must keep repeating that everyone must be treated. And at the same time, it's important not to forget that treating an AIDS patient is not just a matter of making drugs available*". It also involves making a diagnosis, being able to treat opportunistic infections, detecting and dealing with treatment failure, adapting therapy if there are side effects, working on compliance, having enough trained staff, having a reliable supply of drugs, and so on. While quality of care is of vital importance, it is not incompatible with quantitative objectives.

And what about tomorrow? What is the future for MSF programmes once all the requirements for treatment at population level are covered? "*It will never be MSF's job to treat all a country's patients*", Annick Hamel insists. MSF has a clear lead over national programmes. Once we are able to transfer our activities to national programmes that are capable of offering good-quality care for stabilised patients, we hope MSF will be further ahead: for instance in treating children, or complicated medical cases in outlying health centres.

There has never been a chronic disease quite like this, so there is no referring back to earlier practice. We have to invent it, country by country...

There remains the question of treating patients outside the vertical HIV/AIDS programmes. Although MSF says it wants to treat HIV/AIDS patients within other programmes where possible, this is still not happening everywhere. At the moment it is done in Liberia, Sudan, the Democratic Republic of Congo, Thailand, Georgia and Ivory Coast. But as Annick Hamel points out, "*treating AIDS patients is not that complicated. There are guidelines[2] available now, which the teams have found very helpful. We have learnt from the experience of the first few years. Even if some teams still feel that treating Aids is complicated, treating a few patients as part of their programme is no longer anything out of the ordinary. What is extraordinary is having to 'make it up as we go along'. There is no care model for large cohorts of patients. There has never been a chronic disease quite like this, so there is no referring back to earlier practice. We have to invent it, country by country, to suit their specific requirements and constraints, so we can treat all the patients who come knocking on our door*". ■

Caroline Livio

1- the CD4 or T-lymphocyte count indicates the level of immunosuppression.
2- *ARVs for dummies*, available on MSF medical service.

→ A showcase which suits everyone

In the fight against Aids, Uganda has often been presented as a model, not without an ideological ulterior motive. The national prevalence has been reduced from 28% in 1988 to 6.4% in 2005, even if large regional disparities still persist. This success has been attributed by some to abstinence and fidelity, whereas the credit should rather go to increased use of condoms and the death of a large number of patients. The moralistic approach to prevention has concrete repercussions. Last year there was a period when Uganda ran out of condoms. And between 2003 and 2005 the prevalence of AIDS in the country went back up from 5.6% to 6.4%. The other trump card which Uganda has in terms of image is to have exceeded the objectives assigned by the WHO's "3 by 5" plan, which was a point of optimism in the overall results of failure. There are now over 80 000 patients on treatment, and the rhythm of inclusion is accelerating with more than 200 district hospitals and health centres giving out ARVs. There are doubts however about the quality of care dispensed.

→ **Uganda** © Jean-Marc Giboux - July 2006

THE UGANDAN MODEL

A reality check

Translated by Penny Hewson

Often quoted as an example, Uganda is showing a declining prevalence and more than 80 000 patients on treatment. This outward appearance masks a more complex reality. The hospitals and health centres are short of staff, financial means and materials. Nevertheless, MSF is treating 2 700 patients in Arua and supports the decentralization of HIV care by the State in the West Nile region. Report.

It is 5pm in the HIV clinic of Arua hospital in the north west of Uganda. Patients have been there since early this morning; and the public is a bit tired. But when Helen begins to harangue those present in Lugbara interspersed with English words, she achieves the feat of making laugh everyone by deploying her acting talents. "*The main thing,* insists Helen who has herself been undergoing treatment for two years, *is to leave with your medication. Interrupting your treatment is just too dangerous. Do not let yourself be discouraged by the wait.*"

In 2002, MSF started treating aids patients here. "*We are have 4 603 HIV positive patients on our registers, of whom 2 704 have begun triple therapy,*" explains William Hennequin, field coordinator in Arua. This Tuesday, more than 150 patients have appointments. They come to collect their medication for the month or months to come, and for a medical consultation. They can also discuss with a counsellor any difficulties they may have in taking their treatment regularly and see how they can remedy it. A young woman on reception calls 4 or 5 patients at a time. On her desk, between the school exercise books which are used for health records, sits a yellow flag with the MSF logo where you can read "*2 pills a day, treat HIV/AIDS now!*" Sometimes patients turn up who do not have appointments but whose health has suddenly got worse. Such as this man, being treated since October 2004, who is continually convulsing and will die two hours later. A sad reminder that AIDS still kills.

Since the launch of the project, 244 patients have died (i.e. 7% of the patients having started treatment has

well as, doubtless, some of the 426 patients lost to follow up (12%). Caring for AIDS patients well involves giving them antiretrovirals, making sure of their compliance – regularly taking the prescribed medication – but also timely diagnosis and treatment of any opportunistic infections. The work carried out to improve follow-up compliance is beginning to bear fruit. The proportion of patients lost to follow up has fallen, as also has the death rate. The team has also renovated the tuberculosis clinic and has started providing integrated care to co-infected patients. On the other hand, MSF no longer intervenes directly in the other departments whose functioning is burdened with many problems: the roof of the main building containing 80 beds which has been threatening to cave in for four years, the paediatric ward where the women are all piled together, ministerial credits which are a long time coming...

"*We need to strengthen our links with the other hospital departments, to improve the quality of care of the patients in hospital and identify other sick people who need ARV treatment,*" notes William. Working better with the paediatric service would allow us to increase the number of children treated with ARVs which is still too small (only 3%). MSF tries to reinforce the different wards with MSF stuff, but without succes. "*We would prefer the medical staff at the hospital to come to the MSF clinic for training in the care of opportunistic infections,* explains William. *But we are having difficulty in setting it up.*"

For it would first be necessary to reorganize the MSF clinic to reduce the work load and be in a position to take in more patients. At the moment, about 3 600 patients come every month for their follow-up appointment. "*We are beginning to space out the appointments of stable patients every 2 or 3 months, and we are hoping that they will be followed up by the nursing staff to ease the burden on the clinicians,* explains William. *That will also allow us to devote more time to complicated cases.*"

For a long time, Arua hospital was the only facility in the West Nile region offering free antiretroviral treatment. Patients flooded in from all over the region and even beyond, since more than 600 patients live in DRC and some of them have more than a day's journey every month to come and get their medication. But things have begun to change. The process of decentralization of HIV care launched by the government goes as far as the West Nile where ten or so public facilities are putting patients on ARVs. Indeed, the rhythm of patient inclusion is accelerating. But the quality of care dispensed leaves a lot to be desired. A visit to some ARV centres in the West Nile region is enough to see that the difficulties encountered in the MSF project in Arua are there multiplied tenfold by lack of means. First of all, the lack of staff limits the number of patients who can be treated. "*We have only six qualified staff for the whole hospital. If the HIV clinic opened more than one day a week, the other departments could not function,*" states the Director of the Hospital of Nyapea. Because of this, the number of HIV-positive patients followed up in July 2006 in the whole of the West Nile peaked at 3 000 of whom 800 were on ARVs – and counselling was kept to a minimum. The overburdened medical staff give reminders about the importance of taking the treatment properly but have scarcely the time to give more advice. "*To reinforce the counselling, patient associations is a new route,*" considers Patrick Anguzu, the Director of Health for the Arua district.

Another difficulty is supplying the health centres with medication. "*In the West Nile region, there have been incomplete courses of treatment delivered and supply shortages, and this is very dangerous for patients,* says William. *To limit the damage, we have given several loans or one-off donations thanks to our emergency stocks.*" At national level, following management errors, the central purchasing agency National Medical Store (NMS) was in September relieved of supplying ARVs to the benefit of the World Health Organization's office in Kampala. It remains to be hoped that the ordering system which is finally starting to work in the health centres will not be changed completely.

Caring for AIDS patients well involves giving them antiretrovirals, making sure of their compliance – regularly taking the prescribed medication – but also timely diagnosis and treatment of any opportunistic infections.

Medication for opportunistic infections poses another acute problem. The health facilities purchase medication for opportunistic infections from the NMS. Not without problems. "*Deliveries are late and you are lucky if you get 50% of what you ordered,*" deplores a district doctor in the West Nile region. At the end of September it was supplies of Cotrimoxazole which were beginning to run out. Cotrimoxazole is a the preventive treatment which is given to all HIV-positive patients followed up in public hospitals. In theory, the money from the Global Fund should also be used for the purchase of medication for opportunistic diseases and make up for the deficiencies of the NMS, but this funding is only just being set up.

→ For lack of treatment available in their area, 600 Congolese come to Arua.

Marie-Jeanne's t-shirt reads "Sida nous te vaincrons" ("Aids, we will beat you,"). To come to her follow-up appointment in Arua, for this Congolese woman it took first of all a day to get from her village to Aru, the border town. Then, this morning, she pedalled for 3 hours to get to the clinic. "Of course, I would like health centres near my home to give free ARVs, she said, but that isn't happening for the moment,"
The Ugandan government agreed to accept a few years ago that Congolese patients could be treated in Arua, but on the condition that, beginning in 2006, they would be referred to facilities set up in their own country.
The process however has not started yet. And the team at Arua is trying to support the setting up of treatments in Aru, on the other side of the border, without yet sending patients there.

But this is still not the case and there is resistance on the part of the NMS which is afraid of losing part of its revenue with the reduction of its prerogatives. "*We will have to make up for the lack of medication that is essential to treat opportunistic infections,*" thinks William.
Furthermore, the ARV programmes do not include an evaluation or a precise follow-up of the results obtained. There are said to be 80.000 patients on ARVs in the country, but it is impossible to know the exact number of patients who have died or lost to follow up. Very few treatment centres study the levels of viral load or the resistances developed by their patients. The initiatives in this area are manifold and sometimes concurrent. The WHO and the programme financed by PEPFAR (The Quality Assurance Project) are working on two different systems of data collection.

In Uganda, and perhaps even more so in the North and the rural areas, the quality of care for HIV-positive patients must improve quickly before they die of opportunistic infections which could be treated. Before incomplete or intermittent ARV treatments accelerate the appearance of resistances, making it necessary to prescribe second-line treatments which are more complex and more expensive. In the West Nile region, in addition to prompt donations of medication to prevent stock shortages, the Arua team is thus supporting the facilities of the Ministry of Health who are putting patients on ARVs. "*I shall go regularly to 4 centres to share with the care staff my experience of the care of AIDS patients*," explains Julien, a doctor. The support will also apply to the organization of the counselling for compliance and the administration of the pharmacy. A few months from now, the impact of this aid will be evaluated for the possible redirection of our support to other facilities. "*The objective is that the quality of HIV care becomes good enough to transfer the patients being followed up in the MSF clinic to hospitals or health centres nearer where they live*," concludes William. ■

Rémi Vallet

→ Participants present at the meeting in Arua

Present at the meeting were Renaud Leray, William Hennequin and Johnny Byarugaba, head of mission, field coordinator and assistant medical coordinator, respectively, in Uganda; Christine Genevier, head of mission, Isabelle Gerneron, field coordinator in Mathare, and Bintari Dwihardiani, medical coordinator, representing Kenya; Chantal Saint-Arnaud, head of mission, and Sylvie Goossens, medical coordinator, from Malawi, as well as Annick Hamel, wearing her two hats from the Operations department and the Essential Medicines Campaign; the Epicentre team in Kampala, represented by Laurence Ahoua, epidemiologist, and William Watembo, regional manager for AIDS projects.

ARUA MEETING

Doing more, without sacrificing quality

Translated by Nina Friedman

The first regional field meeting dedicated to AIDS took place on 27 – 29 September in Uganda. The heads of mission and coordinators for our three AIDS programs in sub-Saharan Africa met in Arua for discussions; here we present the main points of these discussions.

At first glance, things seem to be off to a good start. The number of patients on antiretrovirals (ARVs) continues to grow a bit faster, and the dropout rates observed in 2004 no longer apply. In MSF projects, the number of patients under treatment—and still alive—has markedly increased: 2,704 patients in Arua, Uganda; 5,293 in Malawi's Chiradzulu district; and 4,886 in our two projects in Homa Bay and Mathare, Kenya. And the virologic results are comparable to those obtained in the developed world (see sidebar, page 2).

The discussions at the Arua meeting showed, however, that we can't claim victory yet. Presentation of the many advances quickly gave way to concerns and questions. Questions about our own work, first of all: how do we improve patient follow-up and quality of care, and how do we get the resources needed to treat more patients? Next came questions about the quality of care in national health care systems.

Our projects' goal is to continue improving treatment for our patients, to keep them alive as long as possible. But also, if conditions are right, to maximize the number of patients being treated. There is much to be done.

→ A DIFFERENT COMBINATION DRUG THAN TRIOMUNE?

The first-line ARV for the vast majority of our patients is Triomune, a generic drug that combines d4T, 3TC and nevirapine in a single tablet. We aren't questioning this choice—overall, the results are satisfactory. The tablet, taken twice daily, makes it easier to follow the treatment.
In some patients, however, d4T causes loss of sensation in the limbs (peripheral neuropathies). And resistance to treatment can develop after several years, requiring a switch to second-line therapy. For now, only about a hundred patients in our four sub-Saharan Africa projects are on second-line treatment. This number could go up, though. More than ever, we need a more effective first-line drug—one that is less toxic, and delays resistance for as long as possible. To improve the quality of the ARVs we prescribe, AIDS program coordinators expect the Medical department, with help from the Essential Medicines campaign, to be on the lookout for new drugs, so

Our projects' goal is to continue improving treatment for our patients, to keep them alive as long as possible.

→ **Kenya** © Andrew Njoroge - January 2003

that our patients can benefit from the most effective treatments.

→ STEP UP TB DETECTION

Better management of opportunistic infections remains a priority for us. Operational research projects on Kaposi's sarcoma and cryptococcosis are now underway. On the other hand, our programs for TB—the most common opportunistic infection—are farther along, though much remains to be done, particularly on management of multidrug-resistant tuberculosis.

The three AIDS programs have **integrated care** so that patients with HIV/TB coinfection can use a "single counter." Instead of going to the TB clinic, and then going to the HIV clinic, patients receive treatment and follow-up for both diseases in a single facility.

This new approach may seem simple, but it's running into resistance. In Kenya, for example, it took two years for the team to persuade all of the actors—that's how firmly entrenched habits were. Yet the impact on patients can be dramatic; separate treatment sometimes leads to serious confusion, even a total lack of understanding, about the drugs to be taken for one disease or the other.

This integrated approach is now showing convincing results. The Arua team's efforts to step up TB detection (routine screening of our patient cohort, better quality lab tests) has quickly paid off. "*The number of patients in whom coinfection was diagnosed went from 256 in 2005 to 712 for the first 9 months of 2006*," notes William Hennequin, field coordinator in Arua.

And **TB diagnosis** in AIDS patients continues to be a problem. Microscopic examination of sputum doesn't always diagnose the disease in AIDS patients. Caregivers must have a faster, simpler diagnostic tool. A study was done in Mathare, in 2006, to find a more effective technique. One method—FASTPlaque—was evaluated, but as it stands doesn't seem to be an attractive option. A new study to look at bleach plus auramine is planned.

And the results from Homa Bay highlight the importance of **detecting AIDS in TB patients**. "*The national program in the district, which gets a lot of MSF support, puts an average of 218 patients on TB treatment each quarter. Of these, 72% agree to the HIV screening test, and 90% turn out to be positive*," explains Bintari, the medical

MULTI-DRUG RESISTANT TUBERCULOSIS: THE NEXT BIG THREAT

Two confirmed cases in Arua, three in Homa Bay (two of whom died before the results came back), six in Mathare. The appearance of patients coinfected with the AIDS virus and the multi-drug resistant form of TB is worrying teams in the field. "*It's the next big threat*," says Annick. "*MSF can't fight it alone, we have to push for a stronger international response.*" In the meantime we have to try to treat our patients.

In Mathare, a Nairobi shantytown, MSF is trying to set up an outpatient treatment system, asking patients to come to our HIV clinic twice a day. In this precarious social context, the most vulnerable are offered shelter, on a case-by-case basis, for the duration of their treatment. "*It's a gamble, because we're not sure how effective such an approach will be*," Christine explains. "*But we really don't have a choice, because there are no treatment programs for multi-drug resistant tuberculosis in Kenya. The government has a waiting list of 50 patients. It has the funding, but setting up a dedicated inpatient unit in the national reference hospital will take a year or two, at least.*"

→ Monitor patients closely to assess the quality of care

Monitoring & Evaluation—M&E to insiders—is of major concern to everyone. Detailed follow up of patient outcome (prescribed treatment, side effects, opportunistic infections, etc.) is the only way to evaluate program quality. MSF uses cards, which are quick to fill out and easy to enter in the FUCHIA software. With the process of decentralization, this system—very thorough, but cumbersome to manage with increasing numbers of patients to follow—cannot be maintained. Should we create a light version of FUCHIA, or think about a new tool...or rely on the monitoring systems used by the national programs? Ultimately, this last option seems inevitable—which is why we have to advocate for high quality monitoring systems in the countries where we work.

→ Lost to follow up

In addition to the adherence effort, better monitoring involves quickly looking for patients who don't show up for their visit. Because interrupting ART for a few days can be dangerous, the projects in Kenya, Malawi and Uganda are setting up an early search system in the days following a missed visit.

→ Local organizations and patient groups: precious allies

To cope with the shortage of medical personnel, all the projects believe it necessary to strengthen their networking efforts with local organizations or patient groups, for help with adherence counseling and locating patients lost to followup. In Kenya, they plan to hire a social worker trained in community organization to identify and train local helpers. In the Arua region of Uganda, MSF supports four patient organizations.

coordinator in Kenya. *"At the moment, we're only managing to test five patients a month in the Arua hospital's TB unit,"* regrets William.

Finally, **six-month TB treatment** (instead of eight) has been in place in Chiradzulu since April, and Malawi adopted it as its national protocol in July. In Arua, the Ministry of Health has agreed to let us use this protocol for our patient cohort, and wants to follow the results closely, though for the time being it continues to use the standard DOTS (Directly Observed Treatment) protocol for its own patients. The situation in Kenya is more complicated, because local authorities would be on board if we committed to providing this treatment regimen to all TB patients treated in the district. Negotiations have just gotten underway.

→ INTEGRATE NUTRITIONAL SUPPORT

All four AIDS programs now include a nutritional component for malnourished patients or those at risk for malnutrition: children, and certain extremely vulnerable adults, such as hospitalized patients. Prescription of Plumpy'nut—a ready-to-use therapeutic food—is aimed at reducing the mortality rate. "T*his is an issue that MSF has been slow to address*," emphasizes Christine Genevier, head of mission in Kenya. This effort is too recent to allow its impact to be measured, but all the projects will be closely following the results.

→ PROMOTING ADHERENCE

Adherence—that is, strict compliance with the prescription (the amount and timing of medication taken), is essential to maximizing the effectiveness of ART and delaying the appearance of resistance. Unfortunately, for lack of a magic recipe for convincing patients to follow their treatment to the letter, and reliable tools for measuring adherence, our practices provoke a mixture of anxiety and confusion. *"Pill counts, patient interviews, and the adherence scale are biased methods; patients may be tempted to cheat out of fear of being reprimanded by the doctor or counselor,"* Christine explains.

Encouraging results on survival rates indicate, however, that despite its flaws, our system functions well overall. But this argument doesn't sweep aside all doubt, especially regarding long-term adherence; when patients feel better, they might be tempted to become more lax. *"It would be interesting to look at what's being done in countries that started ART a long time ago,"* suggests Annick Hamel. *"We should take a look at adherence practices for other chronic diseases, as well."* Diabetes might be a particularly interesting example, because it too affects children, and adherence is even less well controlled in children than in adults.

→ **Malawi** © Julie Remy - May 2006

→ LAUNCHING DECENTRALIZATION

While improving the quality of treatment and follow-up, increasing the number of patients who receive treatment is our only other weapon against the epidemic. This means getting involved in a process of decentralization, and coping with the lack of qualified medical personnel.

In **Malawi**, for example, we would have to accept 250 patients a month to cover needs in the Chiradzulu district. *"We already support the district's ten public health centers, with mobile teams and a training plan for these centers' nursing staff, so that eventually they'll be able to initiate ART and follow stable patients,"* explains Sylvie Goossens, medical coordinator. A pilot project—the "village unit"—goes even further by identifying, at village level, a person with no medical background who is capable of re-supplying very stable patients with their drugs, and referring them to a medical facility if their health deteriorates. *"This will allow us to focus on the complicated cases, while at the same time increasing treatment capacity,"* she adds. But for the time being, the inclusion rate has topped out at between 150 and 200 patients a month. *"We should also be treating more children, approaching them by way of their family, get more involved in mother-to-child transmission prevention, and figure out why only half of patients diagnosed as HIV-positive come in for treatment*," Sylvie reckons.

This project, with its goal of covering overall needs, truly reflects MSF's 2005-2008 AIDS objectives. In several ways, however, Chiradzulu remains a special case.

The situation in Uganda and **Kenya** seems more complex. *"In Homa Bay, it's still premature to talk about covering needs. With projects focused on the hospital and a prevalence of over 30%, the demand for treatment greatly exceeds the capacity of MSF and the Ministry of Health combined,"* points out Christine Genevier, head of mission. For the past three years, MSF has been providing nursing staff follow-up of stable patients in three decentralized health centers. *"The Kenyan authorities are interested in this approach, but it's taking a long time to turn talk into concrete decisions,"* Christine continues. So delegating responsibility to nurses, so that they can follow patients on ARVs, is not always formalized by directive. *"The Ministry of Health very much needs our support, but wants to know the extent to which MSF is planning to commit. It's up to us to decide if we want to get involved in new health centers, and if we're ready to train public health personnel."*

In **Uganda** (see report), decentralization has been underway in the West Nile region since the summer of 2005. But it is still going slowly, and there are doubts about the quality of care. So we've started by supporting four centers, in order to assess the impact after three months and, if necessary, redirect our support to other centers.

In the end, to varying degrees, all the national programs are running up against the same obstacles: a lack of qualified personnel, inadequate public health infrastructures (especially in rural areas), problems ensuring a regular supply of ARVs and drugs to treat opportunistic infections, etc. We have advocated for a greater global response to the crisis, repeated over and over the slogan "two pills a day," and documented the results from our programs to prove that rapid "scaling-up" was possible. Now that the number of HIV treatment centers is increasing, our teams' goal is to continue to come up with innovative approaches, to show that quantity and quality can go hand-in-hand. And to take up this demand for quality in both our speaking out and in our relationships with the national programs. ■

Rémi Vallet

KAPOSI'S SARCOMA AND CRYPTOCOCCOSIS: TWO OPPORTUNISTIC DISEASES

Kaposi's sarcoma is a cancer that exists in endemic form in Africa, and develops especially in individuals coinfected with HIV. In 2005, more than 8% of patients seen in our African AIDS projects had it. It usually occurs in the form of skin lesions, and is thus relatively easy to diagnose. To treat it we use ARVs in combination with a single chemotherapeutic agent, bleomycin, administered by intramuscular injection once every two weeks, 20 injections maximum. After this treatment, however, we have nothing else to offer, because there is a very high risk of pulmonary fibrosis, and relapses are common. MSF wants to test another drug, taxol, although it's cumbersome to administer (several IV injections that must be administered in a hospital setting), and expensive (1,600 euros). The feasibility study will start off in Ouganda and Malawi.

Cryptococcosis is a mycosis that occurs in very immunocompromised individuals, and often manifests as meningitis. Its prevalence among patients admitted to the Phnom Penh hospital, in Cambodia, is 30%. While diagnosis, by lumbar puncture, is relatively simple, its treatment with Amphotericin B causes significant side effects. Above all, it is very hard to implement, because it requires a two-week hospital stay and is toxic. Doctors therefore have a tendency to rush the switch to the second, oral, phase of treatment, which is less effective. In view of this, MSF should be starting a clinical trial in Cambodia to test a new two-drug oral protocol (high dose of fluconazole + fluocytosine).

→ **Malawi** © Julie Remy - May 2006

→ To be continued?

The Arua meeting provided an opportunity to share an overall view of the problems, and the teams from Kenya, Malawi and Uganda would like to continue this exchange on prevention of mother-to-child transmission, pediatric care, treatment adherence, the role of local and patient organizations, and training. A second regional meeting may take place in January, in Nairobi, with members of the Medical department, Operations, or outside participants invited to contribute to the discussions.

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For further information:

- on the activities of the French section of MSF: www.msf.fr
- on the activities of the other MSF sections: www.msf.org

CAMBODIA, A LOW-PREVALENCE COUNTRY, WHERE WE MUST CONCENTRATE ON THE MOST DIFFICULT CASES - TRANSLATED BY ALISON QUAYLE

With prevalence in the country at 1.9%, the Cambodian National Programme estimates that out of 120,000 people with HIV, between 25,000 and 30,000 urgently need ARV therapy. At the end of 2006, taking all programmes together, 16,000 patients have access to triple therapy. Nearly 7,000 are receiving treatment in Médecins Sans Frontières programmes (MSF-France and MSF-Belgium).

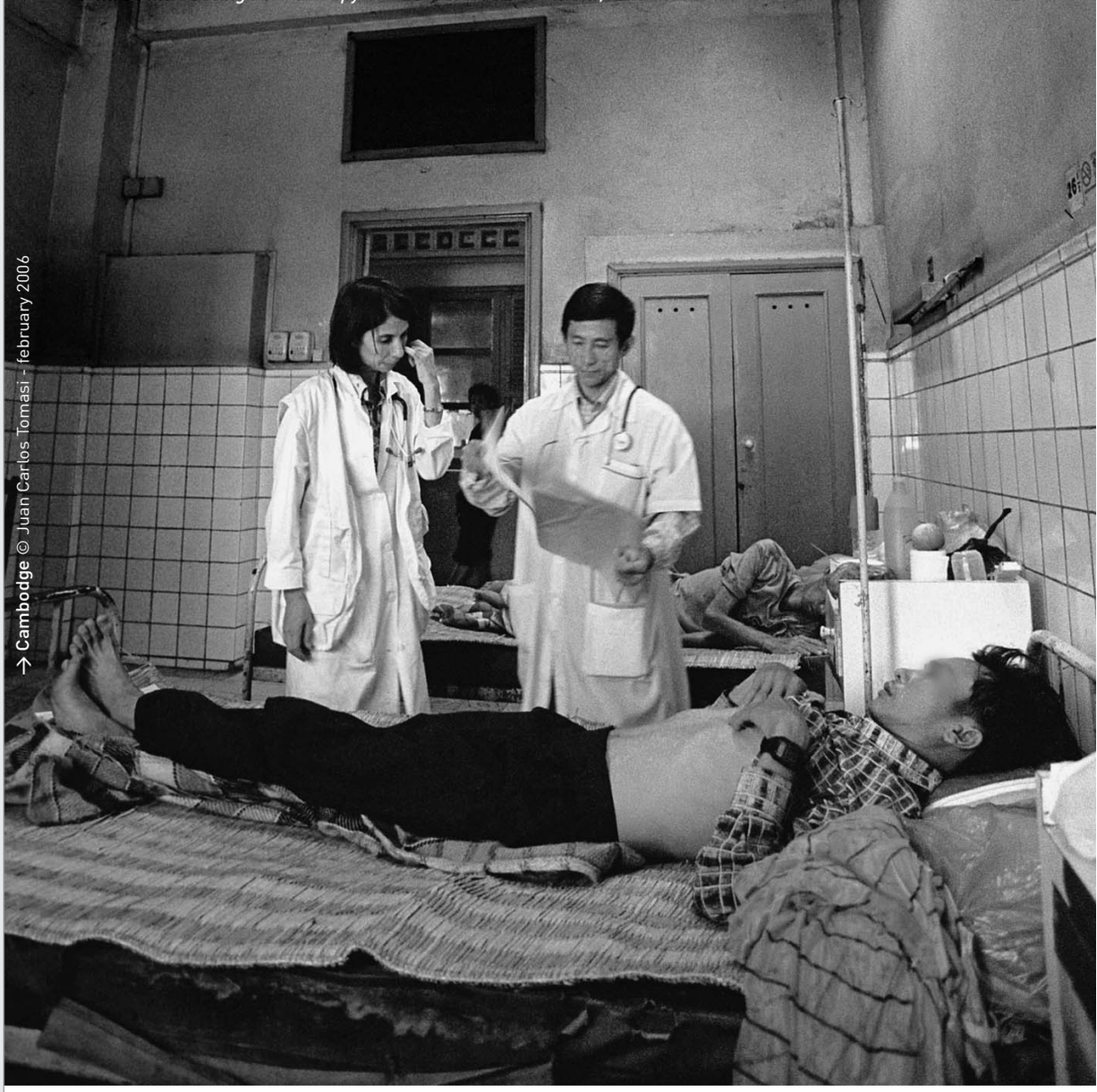
"*Cambodia is going through a transition period in the fight against AIDS*", says Dr Jean-François Corty, deputy programme manager. "*When we started our programme, we were more or less the only people involved. Now there's a political readiness to commit to the issue, and national policy is becoming a reality, particularly with large numbers of health centres introducing ARV therapy*".

A major problem remains: are patients surviving after a year of therapy? "*There's still a skills gap in all aspects of quality of care and keeping patients alive*", Jean-François Corty adds.

Nearly a thousand NGOs are working in Cambodia, including 200 involved with AIDS, most of them concentrating on preventive programmes or support for orphans. MSF still has an important role in the treatment and follow up of AIDS patients and in treating tuberculosis.

"*We are thinking about gradually handing over part of our activities to the National Programme*" says Jean-François Corty. The first stage is to assess the treatment capacity of the Cambodian organisations, so that stable patients can be referred to them, and have access to first-line therapy in good conditions. In parallel, MSF is concentrating on treating the more difficult cases – children, pregnant women, or patients on second-line therapy (around a hundred people) – and on monitoring hospitalised patients, particularly those who are coinfected with HIV and TB, who make up 60% of the hospitalised patients in our two programmes. "*Especially because we're now seeing cases of multiresistant TB – three patients have been on MDR therapy since July and there is a fourth suspected case. No-one else is working on multiresistant TB, which is a real time-bomb in this country. Tuberculosis is not being adequately treated, and there are an estimated 2000 cases of multi-resistant TB. So our involvement in this area is vital.*"

C.L.



→ **Cambodge** © Juan Carlos Tomasi - february 2006

A weak link in our programmes

MSF/November 2006/Translated by Alix Hague

Reducing child mortality due to AIDS requires addressing mother-to-child transmission as well as screening and treating infants. These two approaches are essential but little implemented in our programmes. An interview with Dr Myrto Schaefer, paediatrician at the Medical Department of MSF, and head of the project unit in MSF Sydney.

→ Nine out of ten children with HIV contracted the AIDS virus from their mothers. What can MSF do to combat the problem?

These children contract the AIDS virus during pregnancy and above all during labour and delivery, as well as during breastfeeding. And almost one out of two children who contracts the HIV virus during pregnancy or at birth dies before the age of two. This is what happens if we do not diagnose early enough in order to provide appropriate treatment. Treating children with HIV is therefore a challenge for MSF, but we must also try to combat mother-to-child transmission by breaking the "transmission chain". Otherwise, we are only dealing with one side of the problem.

→ What exactly can we do?

We need to do two things. First of all, we must reduce mother-to-child transmission. Secondly, we must identify HIV children early enough along to provide appropriate treatment. Otherwise, we are not attacking the problem completely, and we will not be able to keep the majority of infected children from dying.

The new challenge will be to establish contact with those women who do not know if they are HIV positive or not.

In order to reduce mother-to-child transmission, action must be taken during women's pregnancies. This will not be easy, as there are very few centres for prenatal care in the countries where we work. Yet I think that we should, first of all, offer AIDS tests in the prenatal consultation centres around where we are presently working. In certain areas, we are already conducting mother-to-child transmission prevention for pregnant women we are treating in our AIDS program. The new challenge will be to establish contact with those women who do not know if they are HIV positive or not.

Once a diagnosis has been made, appropriate care can be offered to women, including triple-therapy, prenatal care and advice on breast-feeding. There are also women who are not at a point in their illness requiring triple-therapy. In this case, prescribing ARVs can put them at risk of side-effects of these drugs. In order to prepare for this, we can implement a strategy consisting in reducing mother-to-child transmission during labour and delivery and providing care for newborns from birth.

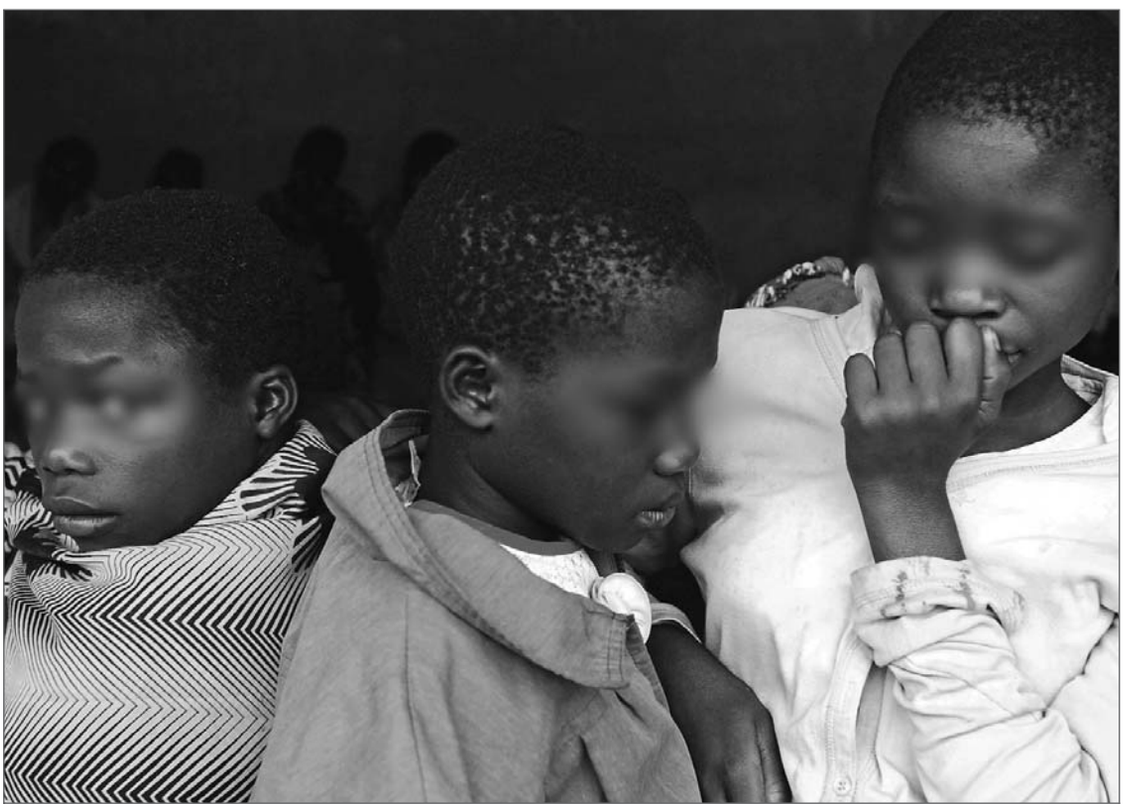
After birth, we need to provide prophylactic treatment for one week to these babies, then monitor them for infection. If, despite everything, these babies are infected, we must be able to offer treatment. In Mathare, in Kenya, where we do mother-to-child transmission prevention, we have begun testing babies whose mothers are HIV positive. At present, we have found one HIV positive baby out of 26 tested. Unfortunately, this number is probably not representative of the whole, but it shows that we can do something against transmission.

« [...] Treating children with HIV is therefore a challenge for MSF, but we must also try to combat mother-to-child transmission by breaking the "transmission chain ».

→ In your opinion, does MSF do enough to prevent mother-to-child transmission?

We are doing something. But it's not enough. A few years ago, it was too complicated to set up ARV treatment for adults. But we did it anyway. And I think that we have what it takes to deal with mother-to-child transmission of the virus during pregnancy and for the treatment of newborns. ■

Interview by Sally McMillan and Philippe Tanguy, MSF-Australia



→ **Malawi** © Julie Remy - May 2006

A COMPREHENSIBLE RESPONSE

"There is a glaring lack of long-term political vision"

MSF/October 2006

Over the years the battle against AIDS has seen considerable changes. The comprehensive response to the epidemic seems to be stalling, despite the optimistic statements of international organizations. Below is an interview with Professor Win Van Damme of the Institute of Tropical Medicine in Antwerp, Belgium, by Dr Arnaud Jeannin, MSF Deputy Programme Manager in charge of Malawi.

→ Money from the Global Fund and PEPFAR

• Global Fund to Fight AIDS, Tuberculosis and Malaria

Since its creation in 2002, 3.1 billion dollars have been allocated to programs conducted in 127 countries. In the latest allocation decision, total funds to be allocated were increased to 1.039 billion dollars distributed among 52 countries. Programs specifically related to HIV/AIDS increased to 469 million dollars in 27 countries.

• PEPFAR (President's Emergency Plan for AIDS Relief)

In 2006, PEPFAR's budget increased to 3.2 billion dollars, 868 million of which is dedicated to antiretroviral treatments. 561,000 people are currently being treated through this funding in 15 countries: South Africa, Botswana, Ivory Coast, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Uganda, Rwanda, Tanzania, Vietnam and Zambia.

→ Arnaud Jeannin : What actions are currently being taken at international level against the HIV epidemic? With regards to funding, has the emergence of bilateral and multilateral funding sources produced any sustainable solutions?

Win Van Damme : Funding remains an important issue. For the treatment of people living with AIDS, the two main funding sources today are the Global Fund to Fight AIDS, Tuberculosis and Malaria (see inset) and PEPFAR (President's Emergency Plan for AIDS Relief), launched by George W. Bush. The Bill and Melinda Gates Foundation is becoming an important actor, too (allocating 100 million dollars to the Global Fund in 2006, for example), but it invests more in the search for a vaccine and on microbicides. The Global Fund intervenes in all countries, while PEPFAR concentrates on 15 countries where the prevalence of HIV/AIDS is very high.

The problem with PEPFAR funding, which was stated from the start, is that its funding operations cover a limited period of only five years. The US president is probably convinced that this type of action is necessary for the national security of the United States. And US evangelical Christian organizations have seized the opportunity to exert their influence with, for example, the "ABC" strategy: Abstain, Be faithful, and Correct and consistent use of condoms, which is at the heart of PEPFAR-funded prevention actions. With regard to the Global Fund, the funding dilemma is twofold. It funds a high number of countries that are largely dependent on those funds for their national programs. At the same time, Global Fund donors do not provide sufficient funds to cover the estimated needs (5-10 billion per year). And promises and funding are reviewed every year. The system is therefore very unstable. There is no assured continuity over the years. The prevailing global funding strategy is a very short-term one, which is dangerous.

→ A.J. : Can the situation change?

W.V.D. : The percentage of total North-South international aid (i.e. approx. 80 billion dollars a year) allocated to AIDS is still low—about 5%. UNAIDS, notably, argues that this percentage must increase radically by pointing out the uniqueness of the battle against AIDS. But other problems exist. Other actors receiving international aid also claim unique measures for education, water or the reconstruction of Iraq. At the same time for international institutions like the World Bank, AIDS and health in general do not merit a unique status because they are not profitable

The system is therefore very unstable. There is no assured continuity over the years. The prevailing global funding strategy is a very short-term one, which is dangerous.

investments. Therefore, there is an especially fragile balance of forces between those who argue for increased aid and those who believe that this type of aid is a bottomless well. The danger is that sooner or later donors will stop increasing their aid and could even decrease it, especially now when embezzlement scandals at the Global Fund have started to appear.

→ A.J. : Speaking of "investment effectiveness," some countries, like Brazil, are deemed more "profitable" because they have implemented a national policy for treating all people living with AIDS with the idea that it's in the economic interest of the country - the treated people no longer being a burden to society because they can re-enter the labour market. Doesn't this model demonstrate the effectiveness of large-scale national treatment policies?

W.V.D. : The Brazilian authorities were not thinking in terms of profitability but rather of how to manage Ministry of Health money better. The cost/effectiveness argument is meaningless anyway because it is very short-term thinking. Some studies, like the one published in *The New England Journal of Medicine* dealing with 10,000 hospitalized AIDS patients, make that clear. Calculating the cost of taking care of these patients for a year—not treated with ARVs—is simple, and so is calculating how much their ARV treatment would cost, which is almost the same or even less. That's the "honeymoon" period, when it is worthwhile to treat with ARVs. In the second year, the calculation is different. Non-treated patients don't cost anything because they're dead. Treated patients cost money. They can develop opportunistic illnesses and resistances and will cost even more then. So, of course, treating more and more patients is far from profitable. The cheapest... is that patients die. To find solutions, we can't think in economic terms.

→ A.J. : Today, nearly 1.6 million people living with AIDS are under treatment. Looking back over the past few years, what lessons can be learned from implemented international strategies, in particular the World Health Organization's (WHO)

→ **Malawi** © Julie Remy - May 2006

"3 x 5" initiative (3 million patients on ARVs by the end of 2005)?

W.V.D. : In the long term, the most important variable is the number of patients being treated who survive. And the news is good there. Where it isn't good is in the disease's expansion because infections continue to increase. In the future, there will be ten or twenty million people in need of treatment. I have criticized the 3 x 5 initiative from the start because it is a very short-term strategy as far is funding is concerned. It was necessary to find some way to start the process, but the initiative was presented as a final objective without anticipating the future or providing the means to reach that objective. And this strategy has shown its limits.

→ A.J. : In fact, isn't it three million people who need to start treatment every year?

W.V.D. : Yes, or 10 million in 2010 and 20 million in 2020.

→ A.J. : Nothing long-term has been considered?

W.V.D. : There aren't any long-term strategies or funding initiatives. In Toronto [at the 16th International AIDS Conference in August 2006], the discussions mainly focused on technical aspects: resistance phenomena, HIV/TB co-infection... However it seemed as if talking about reality were censored. There was a glaring lack of long-term political vision. It was a little like, well, we have to convince the international community to continue to contribute, but let's avoid talking about the bad news that won't serve our cause.

→ A.J. : However, ARV delivery models are essential in order to treat patients on a large scale and for coming up with more comprehensive political solutions. Are things progressing in this direction?

W.V.D. : Up to now it has mainly been clinicians who have started treatment programs, focusing on the doctor-patient relationship. These first treatment programs had limited objectives, such as: *"to treat 1,000 patients and then stop taking new ones because it would not be possible to maintain a good doctor-patient relationship."* Two years ago, nobody was thinking in terms of global coverage (treating all those suffering with AIDS in a given area). The clinicians developed responses, but they did not consult public health experts, for example, to imagine more comprehensive solutions. However, few public health actors are interested in AIDS... Even at the WHO.

It is MSF and what it's doing in Thyolo and Chiradzulu in Malawi that is cutting-edge. It is based on the experience of pilot projects, [...] that could result in really innovating responses.

→ A.J. : To what extent do technical difficulties affect the search for comprehensive solutions?

W.V.D. : At first, the price of medications was the main obstacle, but then prices decreased. Pilot projects showed that it was possible to treat patients in developing countries, and so then the issue of funding arose. Today, money is no longer a problem, although it will become one again in a few years. The main issue is rather the lack of human resources to register, treat and monitor thousands of patients. There the solutions are yet to be found. But it will difficult to apply comprehensive responses because each country's problems are specific.

→ A.J. : Are there any national programs proposing innovative solutions?

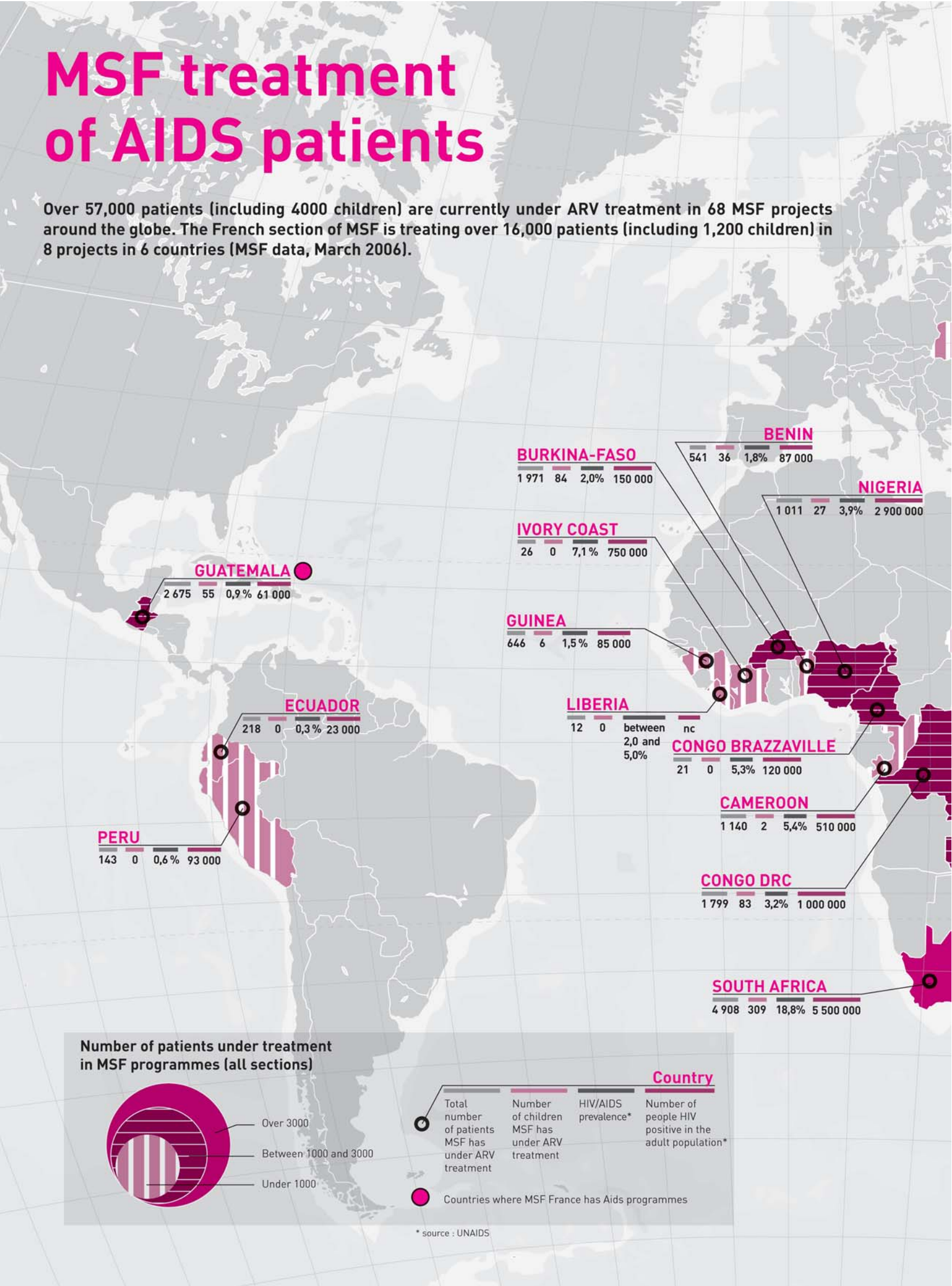
W.V.D. : Malawi and Uganda, with very different environments, are good examples. Malawi, in its national program, despite enormous restrictions (lack of medical personnel and an under-developed health system), has set up an extremely simplified system: no laboratory, the same first-line treatment for everyone. In a health centre I visited in August, they are treating 800 patients. Consultations take place three mornings a week. In Uganda, the national program is certainly poorly coordinated, but there are interesting initiatives, like "expert patients," patients who are stable in their treatment and who monitor other patients, or "field officers," treated patients who distribute ARVs to homes each month.

But, in fact, it is MSF and what it's doing in Thyolo and Chiradzulu in Malawi that is cutting-edge. It is based on the experience of pilot projects, in which the work was done on a district level and that could result in really innovating responses. MSF may propose innovations, but it may also be restricted by its own limitations. In an organization of doctors, any methods that do not put doctors at the centre of the process may generate internal resistance. However, we must continue to consider other methods to achieve real advances. ■

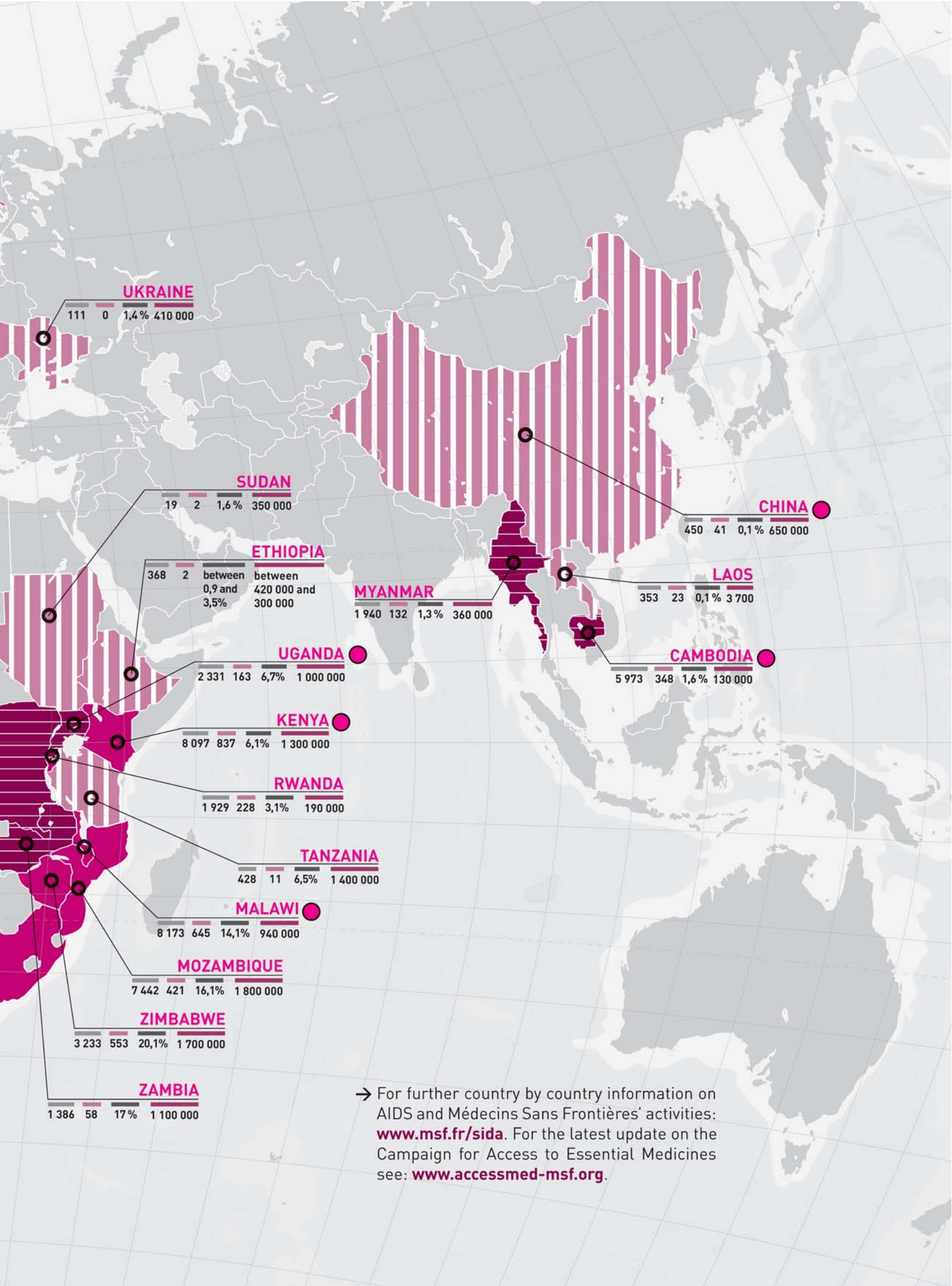
Transcribed by Caroline Livio

MSF treatment of AIDS patients

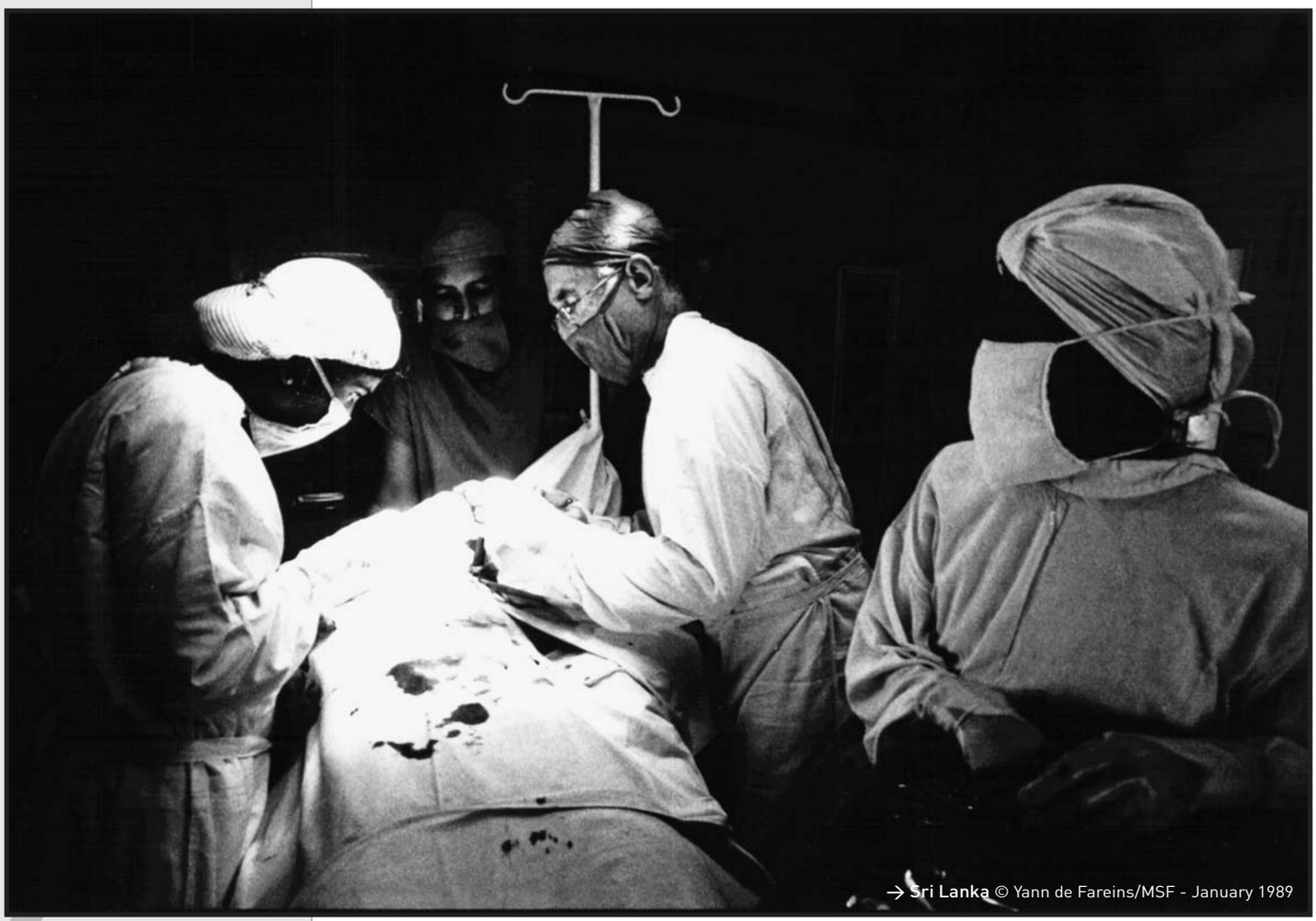
Over 57,000 patients (including 4000 children) are currently under ARV treatment in 68 MSF projects around the globe. The French section of MSF is treating over 16,000 patients (including 1,200 children) in 8 projects in 6 countries (MSF data, March 2006).



* source : UNAIDS



→ For further country by country information on AIDS and Médecins Sans Frontières' activities: **www.msf.fr/sida**. For the latest update on the Campaign for Access to Essential Medicines see: **www.accessmed-msf.org**.



→ Sri Lanka © Yann de Fareins/MSF - January 1989

MISSION
SRI LANKA

SRI LANKA

MSF withdraws from Jaffna peninsula

All medical activities of MSF are suspended in Sri Lanka

MSF/October 2006

An increase in violence and fighting in 2006 led Médecins Sans Frontières to return to Sri Lanka to provide medical assistance to the war affected population. Since August of this year, approximately 200,000 people have been displaced by the fighting. Despite requests from the Ministry of Health for MSF to provide assistance to several hospitals in the North, we had so far only been allowed to start activities in Point Pedro Hospital on the Jaffna Peninsula. However, MSF teams have now had to suspend their medical activities and withdraw from the only hospital we had been permitted to work in. Explanation by Dr Guillermo Bertoletti, director of operations.

→ Why has MSF suspended its activities and withdrawn from Jaffna Peninsula?

Since the 30th of September, false allegations have been leveled in the Sri Lankan media accusing MSF teams of participating in the conflict. We have been cited as a 'threat to national security' and have been accused of actively supporting the Tamil Tigers. Simultaneously we received a letter from the government canceling our existing visas and asking us to leave the country, followed shortly by a second official letter saying we could stay in the country until 'further notice' stating we are under investigation.

Though we have not been officially accused of anything, the false allegations made in the media combined with a lack of clear support from the government as a whole, have made the risk for our personnel unnecessarily high. As a result, our team in Point Pedro has ceased providing medical assistance, and has left the Jaffna Peninsula.

→ Seeing as the government has now said MSF can stay, isn't it an overreaction to stop medical activities just because of some articles in the media?

This is not a decision we have taken lightly! It was extremely hard to leave the patients and to stop the collaboration with our colleagues in the hospital, knowing that the situation on the peninsula continues to deteriorate and that currently there is heavy bombing in the area. Throughout 2006 the security situation in the country has greatly degraded, creating acute needs for the civilian population as well as increasing the risk taken by humanitarian organizations. The assassination of 17 members of ACF was a terrible shock to us and illustrates how dangerous the situation can be for humanitarian workers also.

Within this context, like in any armed conflict, our independence and neutrality must be respected. If we are to help the civilian population affected by the conflict, we need the false allegations and inaccurate statements made in the media cleared up. We need a strong message that the government as a whole and that authorities at all levels are ready to welcome and facilitate the work of an internationally recognized, independent and neutral medical-humanitarian organization. Without these assurances, we cannot send our teams to provide medical assistance to those in need.

→ Why were these accusations leveled against MSF? Maybe this is just an misunderstanding?

The accusations are absurd and completely unfounded! MSF has a long record of impartial and independent action in all the major armed conflicts of the last 30 years. We speak out on the humanitarian issues we face, but we don't take sides in a conflict. We worked in Sri Lanka during 17 years of armed conflict, and have proved that we are a medical emergency organisation responding to the needs of the population. This situation is all the more puzzling taking into account that the hospitals we had proposed to support are all government hospitals, in government controlled areas, following requests made by the Ministry of Health. Yet, thousands of people living in the LTTE controlled areas are also in desperate need of assistance.

Many foreign entities [...] are perceived as being pro-LTTE (Tamil Tiger) or as profiting from the war. This is why it is extremely important for us to explain our action and to be publicly and officially recognized as being independent, neutral and impartial.

However, there are a series of factors that may help to understand why this has happened. The accusations and restrictions on MSF, and other humanitarian organizations, are occurring in a context of increasing distrust and sometimes outright rejection of the involvement of international actors in Sri Lanka. On the one hand the general disappointment and frustration with the reconstruction efforts following the tsunami has translated into a profound disappointment and mistrust of NGOs. On the other hand, there is a strong opinion against the involvement of foreign organizations in the conflict. Many foreign entities, be they international organizations, states, or international NGOs, are all grouped together and perceived as being pro-LTTE (Tamil Tiger) or as profiting from the war. This is why it is extremely important for us to explain our action and to be publicly and officially recognized as being independent, neutral and impartial. Finally, it may be that the government does not want an international presence in the areas where war is being waged.

→ Following your visit, do you think this situation will be resolved? What will MSF do if there is no progress?

We have made a commitment to work in Sri Lanka, and are prepared to honour that commitment. We have grave concerns for the population living in the war affected areas. Fighting is increasing. Heavy bombing has displaced tens of thousands of people who are in need of assistance. Hospitals are in need of support in order to meet the demands. It is deplorable that we are not allowed to bring medical assistance to the population living in areas where heavy fighting is underway.

Following several meetings we had in Colombo, the capital of Sri Lanka, I believe there are members of the government who are concerned by the need for medical assistance in the north and east, and would like MSF to provide this assistance. However, this needs to translate into concrete actions. MSF surgeons, nurses and other staff have been on standby for months in Colombo and in Europe, ready to provide care to Sri Lankans. Nevertheless, we cannot keep our teams on standby indefinitely. Today our name is not cleared up and we are not granted permits and authorizations to carry out our work. This means that we remain blocked, with no security for our teams and no humanitarian space to carry out our activities. If this doesn't change soon, if the government as a whole doesn't show that we are welcome to work in Sri Lanka, then I will consider that we will be forced to leave the country. ■

Dr Guillermo Bertoletti
Transcribed by Kate de Rivero

POINT INFO

→ 20 october 2006 Niger : 61 000 admissions since the beginning of the year

The number of admissions is not decreasing but is stable, with 2300 admissions for the month of September, and a total of 61,000 admissions since the beginning of the year. The great majority are moderately malnourished children. This corresponds to the number of admissions we had excepted for the whole year, between 75,000 and 80,000 for 2006.

→ 3 November 2006 CAR : Explo mission to Birao

On Monday 30 October, the city of Birao – located in the north-east of the Central African Republic, the region on the border with the south-east of Chad and the west of South Darfur – fell into the hands of rebels. Birao is a city of 15,000 people, and there are about 50,000 people living in the zone. A team is going to try to go to Birao. This is not easy, as the zone is difficult to access whether by road or air.

Around Paoua, where we're undertaking our activities, violence erupted again at the end of the rainy season and there have been more villages burned down. People are leaving again to hide in the bush, and the number of consultations in our clinics is slightly decreasing. However, our activities within the Paoua hospital itself remain consistent and for now, admissions haven't declined.

SOUTHERN SUDAN

"NGOs and the United Nations cannot serve as subcontractors for this enormous reconstruction project"

MSF/October 2006

Dr Rony Brauman, former president of Médecins Sans Frontières (MSF) in France and research director of MSF Foundation , recently returned from Southern Sudan. He describes the situation nearly two years after the peace agreement was signed, and also raises questions about the position aid organizations have taken in the context of reconstruction.

POINT INFO

→ 13 october 2006, DRC – North Kivu, opening of an emergency project in Nyanzale

Since August the number of victims of sexual violence coming to our programme in Rutshuru has increased considerably. From an average of 60 new cases per month the first 7 months, we're now up to 220 cases for August and 316 cases for September.
A large proportion of the victims are referred from Nyanzale health centre. Violence broke out in the periphery of Nyanzale, in the north and south-east, during fighting between various armed groups in the area after the first round of the elections on 30th July 2006. The population sleep in the bush and return to their villages during the day.
50 severely malnourished children were registered.
We will start by providing treatment for rape victims in Nyanzale, and will carry out further evaluations of the nutritional situation.

In January 2005, after 20 years of war interrupted occasionally by short-lived ceasefires, the south Sudan rebels and Sudanese government signed a peace agreement. It took three years of negotiations, sponsored and guided by the U.S. government, to reach a compromise acceptable to both parties. Trust is hardly to be expected among former warring parties, particularly in a country so deeply wounded by an endless history of violence. Indeed, the human cost of the war has yet to be determined: One million people, perhaps more, have died, and three to four million have been displaced, mostly around the capital city, Khartoum. These numbers begin to describe the disaster from which Southern Sudan is emerging and the problems that await it.

The new government authorities must organize a power-sharing arrangement among the movements that fought in the war or that have substantial forces at their disposal.

However, Juba, the southern political and administrative capital, is not in mourning. The city is very much alive. A match has been scheduled between two local soccer teams and their respective supporters spill out into the streets, wearing team jerseys, blowing whistles and waving flags. We could be in Nantes or Manchester. Shops and restaurants have multiplied, the markets are well-stocked and crowded and the bus stations are teeming. That is all as it should be. The city's population has doubled in a year, so merchants are pleased, but housing has not kept pace and rents have skyrocketed.

→ HUMANITARIAN AGENCIES HAVE A MASSIVE AND VISIBLE PRESENCE

The massive international presence is visible as soon as your plane touches down and you set foot in Juba international airport. More than 10 huge white trucks bearing the logos of various U.N. agencies are parked outside. Everyone is here: from the World Food Program (WFP) to UNICEF, the UN High Commission for Refugees to the World Health Organization (WHO), as part of the United Nations Mission in Sudan (UNMIS), a major deployment of 6,000 Blue Helmets and 4,000 civilians. They have been assigned to back up the peace accord, and, more specifically, to support the integration of rebel forces and the regular army, to help refugees return home, to participate in protecting civilians and to restore part of the road system.

Dozens of NGOs and government aid agencies are here, too, based in Juba and operating throughout the South. Hospitals, schools, roads and bridges have been rebuilt, thanks in part to aid groups and, also, to oil companies (primarily Chinese) that are prospecting and drilling in the major oilfields located on the border between the North and South. However, these projects constitute only a small share of a huge undertaking, most of which remains to be carried out.

The new government authorities must organize a power-sharing arrangement among the movements that fought in the war or that have substantial forces at their disposal. These talks are tense, particularly when long-serving combatants are pushed aside latter day supporters. The authorities are also working as best they can to establish an administration, which for the moment is

→ **Sudan** © Kevin Phelan/MSF - April 2006

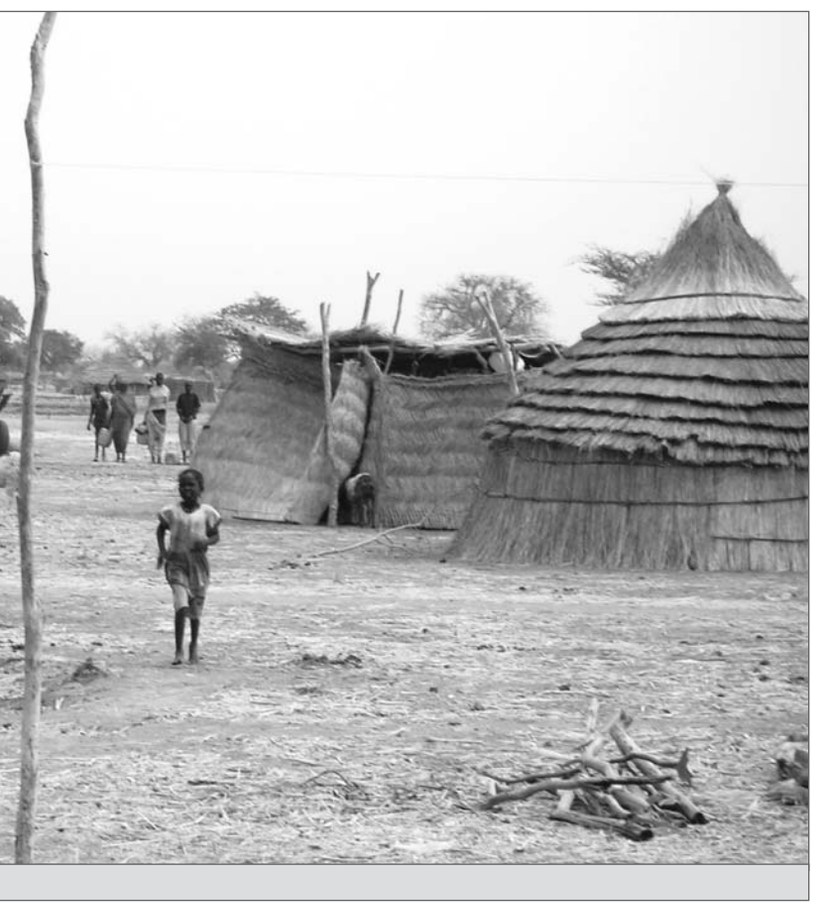
non-existent, in the ten states that form the new South. The distribution of jobs is, naturally, the subject of difficult negotiations.

Nonetheless, everything remains to be (re)built from scratch. This is the program to which NGOs have been invited to contribute. Some have already gotten down to the job. Norwegian People's Aid (NPA) flags and stickers are visible on many public buildings and an endless fleet of vehicles. This large NGO has decided to serve as the Juba government's intermediary for a range of functions, from de-mining to rebuilding hospitals, supporting the press and providing professional training. This is a paradoxical choice for a non-governmental organization. Where is the "non-governmental" in this role? However, it is a respectable position because it is being done openly.

→ RECONSTRUCTION THROUGH THE AID SYSTEM IS AN ILLUSION

Despite appearances, however, NGOs and the United Nations cannot serve as subcontractors for the enormous reconstruction project facing the South Sudanese. Public goods—health, education and other community facilities—cannot be cobbled together from piecemeal contributions from aid organizations, whether private or U.N.-based. These groups have neither the mandate nor the means to become the government's human resources agency or its operational administrators. The government would be unable to orchestrate such a disparate collection, with its host of constraints and diverse skills—and not only for lack of resources. Rather, the more important reason is that it is impossible to coordinate a group of heterogeneous institutions. These are not temporary employment agencies. It is also impossible to exercise real authority over them. However, this illusion that the international aid system will carry out reconstruction seems to be one of the most widely-held beliefs in South Sudan.

MSF has not yet determined what form our activity will take. However, it is already clear that we must avoid the trap of involvement in public health systems, despite their deficiencies.



It calls to mind the unrealistic statements issued by the same actors after the tsunami. One might well suggest that the country consider recruiting the managers it needs from today's very open international labor market. Such an approach would certainly be more expensive but thanks to oil income and outside aid, government coffers are not empty—not by a long shot.

→ ADAPTING OUR PROGRAMS TO THIS NEW CONTEXT

Does this mean that aid organizations are no longer necessary? Certainly not. They provide a range of services and will continue to be useful in supplementing government activities. MSF has not yet determined what form our activity will take. However, it is already clear that we must avoid the trap of involvement in public health systems, despite their deficiencies. The government and the WHO would very much like us to respond to chronic and acute epidemics, given our expertise in this area. That is where we can provide concrete assistance, particularly because it would involve adapting and refocusing existing programs. Regardless, we will have to make major changes to our programs as they are no longer appropriate to the population's needs.

As mentioned above, the political context has, indeed, changed. And even though peace is the order of the day, the future remains unclear. Hatreds and resentments have not disappeared, violent incidents are frequent, oil income stirs up envy, and the various armed forces throughout the South have not been integrated. In short, the political outcome of the peace accords is unknown. Critical moments are already on the horizon, including the census and elections in 2007 and the referendum in 2011. Violent flare-ups—and worse—could occur, but as of now, there is no way to know what course events will take. This uncertainty alone is hardly a reason to remain in South Sudan because humanitarian aid focuses on today, not on the future. But it does offer one more reason. Let's hope that this one remains in the realm of the hypothetical. ■

Rony Brauman

POINT INFO

→ 3 november 2006, Chad - Extensive fighting in the east

In the last week of October a rebel division made an incursion in Chad and penetrated as far as the centre of the country, without encountering opposition.
But even though this armed group then retreated towards the border, it was ambushed by the Chadian National Army. Extensive fighting took place, causing many wounded who flocked towards Goz Beida and Abéché. Some of these wounded have now been referred to N'Djamena after they stabilised.
In Adré, the situation has been rather calm and in the main part, the city is empty of soldiers, who have left for the front.
In Koloye, where the team has been preparing to close the project, the renewal of tension has accelerated our retreat and the team has been evacuated towards Dogdoré. In Dogdoré the team has been reduced for security reasons. They received a few wounded patients, but were able to run activities almost normally.
In Goré, the hospital continues to operate and the number of admissions is more than significant.

DARFUR

Humanitarian aid held hostage

MSF/October 2006

→ **Sudan, Darfur** © Michael Zumstein/L'Oeil Public - August 2004

DEBATES

A shorter version of this article was published, under a different title, in *Le Monde* dated 3 November 2006.

Humanitarian organisations find themselves hostages between the Sudanese government and the international community. Op-ed Fabrice Weissman, CRASH.

The intensification of fighting in Darfur and the general increase in insecurity have forced Médecins Sans Frontières (MSF) to drastically reduce its activities over the last three months.

Since July 2006, gangs and militias operating in cities and along government-held roads have stepped up their death threats, beatings, sexual assaults and killings, along with the ransom of aid organizations. The army and paramilitary forces control roads providing access to the Jebel Marra mountains, but they have become so dangerous that MSF and other humanitarian organizations have had to suspend activities in the mountain regions under rebel control. At least 100,000 people, including a large number of displaced persons, have been deprived of assistance, while several cholera outbreaks have been recorded and the number of wounded has increased sharply. Other assistance missions in the government-held region have had to close. Vital services, like the transfer, via roads, of patients who require emergency hospitalization, have been suspended. However, MSF can still work in the large displaced persons' camps, which together house close to 2 million people who are almost entirely dependent on outside aid.

→ XENOPHOBIE PROPAGANDA

The Sudanese government bears grave responsibility for the mounting insecurity along roadways and in towns it controls. First, the serious, repeated attacks underway could only be carried out with the complicity—if only passive--of the regime's imposing security structure that controls Darfur. Second, Khartoum responded to United Nations' threats of military intervention with xenophobic propaganda, likening all foreigners to "new crusaders" motivated by hatred of Arabs and Islam. In all likelihood, the increased violence of the attacks against humanitarian workers is part of a government strategy to confine aid organizations to garrison towns. That way, the government can conduct its counter-insurgency campaign without hindrance or witnesses and resist the threat of international intervention by holding humanitarian workers hostage. "If

The Sudanese government bears grave responsibility for the mounting insecurity along roadways and in towns it controls.

you move ahead with the plan to send in blue helmets, you will the pay the price in the deaths of aid workers." That, in so many words, is what the gangs and militias operating with the regime's endorsement have said.

Fighting has resumed in western and northern Darfur, outside the areas under Khartoum's control. The hostilities pit supporters of the Darfur Peace Agreement against its opponents. The government and just one rebel faction signed the agreement under strong international pressure on May 5. In the Korma and Tawilla regions, that faction has killed more than 70 civilians. Up to now, the areas currently affected by fighting are those that have been less dependent on international aid. However, the resumption of violence could produce many wounded people, as well as new population displacements.

It has been nearly impossible to conduct an independent evaluation of needs because effective security guarantees are lacking. The splintering of the opposition into some 10 factions, often without logistical networks and operational chains of command, requires aid organizations to negotiate with a growing number of fluctuating territorial- and militarily-based groups more interested in pillaging aid resources than in setting up aid operations.

We wish to emphasize that the current situation involves resumed hostilities, not the implementation of a program intended to systematically exterminate a portion of the Sudanese population. From a purely legal perspective, the atrocities committed in Darfur may fall under the 1948 Genocide Convention. However, historically speaking, they are more akin to "pacification campaigns" carried out by European armies during periods of colonial conquests than to the Rwandan state apparatus' methodical destruction of part of its citizenry in 1994. As the war in southern Sudan illustrated, Khartoum has always managed its outlying areas with the brutality of a colonizer--destroying villages, burning harvests, killing men and rapid women--to punish and control those who refuse to accept its authority.

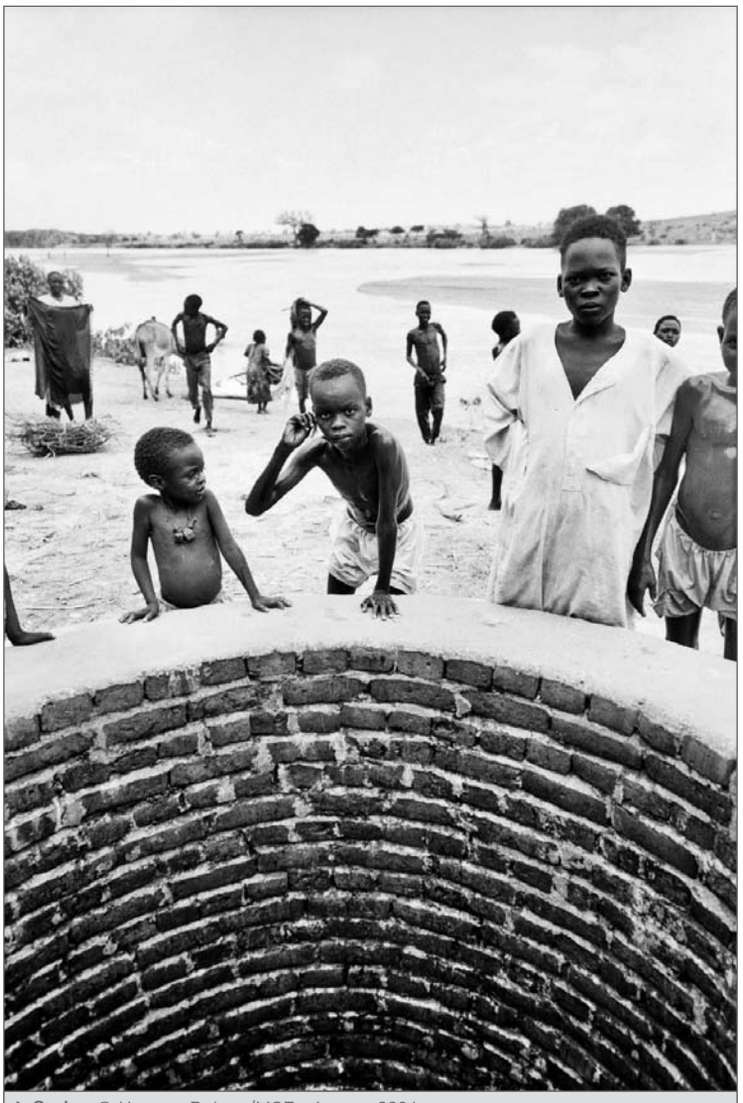
In the face of this renewed, widespread violence, the United States, Great Britain, France, the European Union, the African Union, the highest leadership in the United Nations and many Western advocacy groups believe that sending U.N. troops is the best way to assist the Darfur populations. The war has left 200,000 victims, one-quarter to one-third of whom have died in the violence. According to U.N. Security Council Resolution 1706, approved on August 31, the 7,000 soldiers currently deployed by the African Union are to be replaced by 20,000 blue helmets. The latter will be authorized to use force to implement their mandate, defined as ensuring compliance with the peace agreement, protecting displaced persons and international workers and disarming the belligerents.

→ A WAR AGAINST SUDAN

Khartoum now refuses to accept this deployment. At this phase, Resolution 1706 provides for a war against Sudan and military invasion of its western region. However, no nation appears ready to take that on. Assuming that the Sudanese government ultimately agrees to accept U.N. troops, no country is willing, either, to provide the 20,000-person force that Resolution 1706 calls for. Nearly 80,000 blue helmets are already deployed around the world and the U.N. is struggling to find an additional 15,000 soldiers to strengthen UNIFIL contingents in southern Lebanon.

But most importantly, nearly all the rebel factions—as well as the displaced populations—reject the peace agreement whose implementation the U.N. troops are supposed to guarantee. With the resumption of fighting and the opposition of many armed groups to the U.N.'s deployment, it is difficult to imagine how the blue helmets will carry out their mission. As deputy U.N. secretary-general for peacekeeping Jean-Marie Guehenno emphasized on October 4, "When peacekeeping is confused with enforcing peace, you run into major problems... Anyone who tells me that a 500,000-kmÇ area can be pacified by a foreign force, and that law and order can be restored that way, is mistaken." Countries are well aware of that and balk at providing troops to a U.N. mission that they voted to support. Despite its own doubts, the international community continues to suggest to the people of Darfur that their salvation will come from a U.N. military intervention—one that, today, is highly unlikely to be deployed or to succeed. Some humanitarian actors, like Jan Egeland, U.N. deputy secretary-general for humanitarian affairs, are participating in this campaign. Moreover, they are embroiling aid organizations in the "just war" camp and contributing to exposing them further to reprisals by Khartoum and its militias.

The neutrality required to intervene in a war zone prohibits aid workers from making judgments about the recourse to force or from speaking out on the international pressure that could prompt warring parties to respect the requirements of international humanitarian law. Furthermore, the international community's current strategy cannot stem the resumption of violence against civilians as long as it endangers the vital aid operations that more than one out of three Darfur residents depend on. This observation is not, of course, intended to exonerate the warring parties from their primary responsibilities. They alone can ensure that the lives of non-combatants are respected and that humanitarian agencies can provide impartial assistance to the victims of the conflict. ■



→ **Sudan** © Hugues Robert/MSF - August 2004

Fabrice Weissman

FOR OR AGAINST

Debate on Somalia : should MSF

MSF/October 2006

Denis Gouzerh returning from an exploratory mission to Somalia, accompanied by Marie-Noëlle Rodrigue[1], lobbies for the French section to return to Mogadishu, 10 years after withdrawing from the country. Dr Guillermo Bertoletti does not agree: the security conditions are still uncertain and the proposed activities are little relevant.

FOR

I THINK THAT AN ORGANISATION LIKE OURS SHOULD BE PRESENT IN MOGADISHU TODAY. *When the French section of Médecins sans Frontières closed all its projects in Somalia in July 1997 following the assassination of one of its staff in the hospital in Baidoa, the civil war in progress since the early 90s was still weighing heavily on the population. Everyday violence, consisting of rapes, kidnappings and extortion, marked the daily existence of Somalian citizens. It gave them no respite, even between two skirmishes between opposing warlords trying to conquer a few square metres from their adversary.*

The death of a member of MSF forced us to leave – a period of mourning was necessary. Since the early 80s, however, MSF had been present in Somalia almost without interruption, which put the Somalian mission at the heart of MSF's project. Our departure could only be permanent if the civil war ended.

Almost ten years later an exploratory mission was sent to "regain our footing in the Somalian context". A deliberately evasive expression which allowed the two members in charge of the visit to propose reopening a project in the country. As far as can be seen, working conditions have not changed. They differ significantly from those in other countries where we have operations and require particular vigilance on the part of the teams in charge of the mission. Violence against civilians also continues unabated. Emergency aid organisations involved with the local populations and working on relevant projects are rare. Only the ICRC, other MSF sections and a few isolated NGOs can claim to be anything more than "remote, but without control". The great majority of Somalians have to fight on a daily basis to find the water and food they need to survive. In Mogadishu, the capital city torn apart by various warlords for years, those who are severely ill have few alternatives to simply dying in their houses.

→ **Somalia** © Espen Rasmussen - May 2006

The only private not-for-profit hospital in the town begins registrations at three o'clock in the morning as there are so many requests and the capacity to treat them is so limited (around one hundred beds). The public hospitals which in the past were able to accommodate over 500 in-patients, are now just enormous buildings, either entirely empty or populated by displaced persons (200,000 displaced persons in Mogadishu, out of a total population of one and a half million) and the private commercial clinics are obviously completely unaffordable, except on the one day a week when free consultations are offered to indigents. It's a gloomy picture and the future looks no better.

The only private not-for-profit hospital in the town begins registrations at three o'clock in the morning as there are so many requests and the capacity to treat them is so limited.

Since June 2006 a new political power has taken military control of Mogadishu and a few neighbouring provinces: the Islamic tribunals. Daily violence has suddenly dropped a notch and the fighting has moved away from the capital, but the fragility of the new régime can be felt. The threat still exists that fighting in Mogadishu and for the control of a few key towns will return. Once again the populations will be caught up in the fighting and again their struggle for survival will be made more difficult.

There can be no doubt that Mogadishu should be at the core of MSF's concerns, even if this means developing a special operational framework as it did in the 90s, requiring everyone's commitment to the project. ■

Denis Gouzerh

1- Marie Noëlle is programme manager (in New York), Denis in charge of coordinator follow-up and Guillermo is operations director for the French section.

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For further information:

- on the activities of the French section of MSF: www.msf.fr
- on the activities of the other MSF sections: www.msf.org

open a programme?

IN THE CURRENT CIRCUMSTANCES, I DO NOT HAVE A CLEAR VIEW OF THE REASONS WHY WE SHOULD DECIDE TO INTERVENE IN SOMALIA. *Following the return of the exploratory mission we have, however, discussed the matter at length. The discussion was deliberately focused less on the proposal for opening a project in the maternity department of a hospital in Mogadishu – an idea brought up by Denis and Marie Noëlle Rodrigue and which would allow us to "regain our footing" in Somalia – than on the issues at stake and the "room for manoeuvre" that exists for an emergency aid organisation like MSF. Although the presentation clearly describes the way the hospitals work, or don't work, it doesn't give us precise information on the health situation of the population – displaced or not – which would justify our intervention.*

First of all I should stress that there are already four MSF sections in Somalia. Even if they are not all present in the capital, their presence is nevertheless proof of an operational willingness to become involved in situations of conflict. So we wouldn't be going into virgin territory, devoid of any humanitarian aid.

But beyond these operational considerations, which are fully compatible with my perception of MSF, the discussion surrounding this decision to intervene cannot avoid a certain number of questions concerning the risks taken by the teams, our working environment and ultimately the resources needed to fill it.

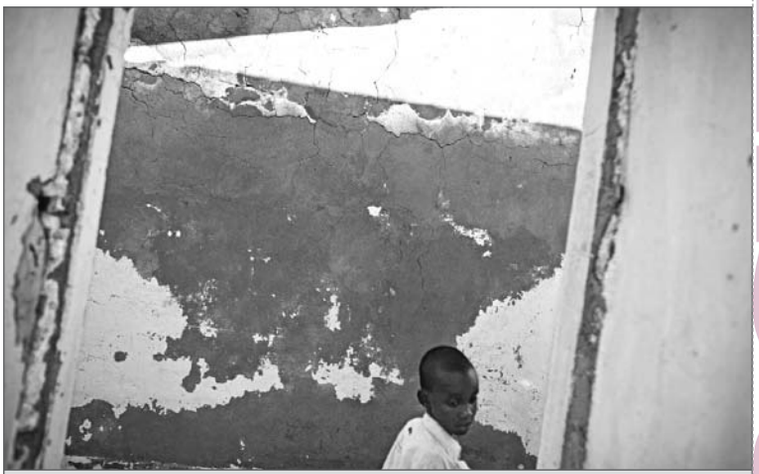
When I mention the danger for the teams, I first think of the tragic death of one of our volunteers in 1997, which led to our withdrawal. The recent assassination of a nun working at the only private hospital offering free care in Mogadishu – for reasons which appear to have been related less to religion than to an internal human resources problem – is an additional factor, which, if it doesn't constitute an insurmountable hurdle, at least leads me to believe that the situation in the capital has not changed. Of course one can say that we are different, especially in terms of our independence, but when one knows that any intervention would have to be with armed guards accompanying our teams, then this concept also becomes relative.

This is where the question of our working environment comes up, and in view of the presentation made in the operations meeting, I do not think that we are capable today of clearly and reliably defining the issues at stake and the motives for providing assistance that would allow us to intervene, bearing in mind the risks taken and the means required to deal with them. In other words, the relation between the risks connected to the presence of a team in Mogadishu and the medical "needs" that can be satisfied by an organisation like MSF, does not, having seen the presentation, allow us to decide to open a project.

Finally, I must stress that this type of intervention is not possible without the human resources capable of sustaining it. This means that we need experienced individuals, capable of working under the more or less permanent protection of armed guards and of staying in the country long enough, despite the risks.

[...] the relation between the risks [...] and the medical "needs" that can be satisfied by an organisation like MSF, does not [...] allow us to decide to open a project.

These resources are rare, and are already sufficiently exposed in other areas, in Darfur, in Congo or in Haiti. Without a magic wand to propagate them, I can't see myself suggesting a mission of this kind to our volunteers. What for? And at what price? Those are the questions that need to be examined in greater detail if we're not to fall prey to a feeling of omnipotence. Because at the moment and looking at the presentation given in the operations meeting, as director of operations I will not take responsibility for the return of our teams to Mogadishu. ■



→ **Somalia** © Espen Rasmussen - May 2006

Dr Guillermo Bertoletti
Interview by Olivier Fahlun

messages

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INFOS
WATCH AND READ

6TH SURGICAL DAY

MSF is organising its 6th Surgical Day on the 9th December 2006 on its Paris premises. The topic will be training.

Presentations and debates:

- Surgeon training on mission
- Getting across knowledge in humanitarian situations or co-building ? Transcultural aspects
- Developing self-evaluation
- Choosing what to teach/train ?
- E-training in surgery
- The point of view of the surgeon being trained
- Hand trauma resulting from mine explosions
- Training in Africa: the paradox of vesico-vaginal fistulas
- The art of surgical companionship
- The difficulties of training programmes: the case of Ethiopia

9th December 2006,
MSF, 8 rue Saint Sabin,
75011 Paris.
For further information, and to confirm attendance, please contact Dr. François Boillot, MSF medical department.
Email : fboillot@msf.org

DOCUMENTARY « *L'AVENTURE MSF* » (*THE MSF ADVENTURE*)

Following her book on Médecins Sans Frontières, **Anne Vallaeys** has now released a documentary called, *L'aventure MSF* , which covers the main events in the world in the past 35 years viewed through the eyes of MSF. Following field teams, Anne Vallaeys shows how MSF *"sharpens its criticial analysis through its activities and the conflict situations it is confronted with"*. In two parts, the first retraces the period between 1968 and 1989 (from Biafra to the end of the cold war) and the second covers the 90's (Rwanda, Kurd exodus, Somalia, war in Afghanistan and Iraq).

To be shown on France 5, 17th December at 8.40pm.

MSF SPEAKING OUT

Violence against Kosovar Albanians, NATO's intervention 1998-1999[1]

MSF / September 2006

The "just published" seventh volume of the "MSF Speaking out" collection's case study[2] is dedicated to the dilemmas met and to the stances during the 1998-19999 Kosovo crisis.

From March 1998, attacks on Albanian villages by the Federal Yugoslav army and the Serb police increased: the violence was exacerbated by the guerrilla action of the Kosovo Liberation Army (UCK). Several thousand people were killed and tens of thousands more fled into the interior and over the border.

In autumn 1998, conscious of the deteriorating situation, MSF, which had been working in Kosovo for several years, decided to inform European public opinion and to increase awareness by publishing communiqués and refugee eyewitness accounts. This campaign was widely reported in the press.

In Spring 1999, after several months of fruitless negotiations, violence and population movements continued increasing.

On 24 March 1999, NATO began aerial bombardments of Serbia and Kosovo. The Serb forces responded by increasing terror, forcing hundreds of thousands of Albanian Kosovars to flee to neighbouring Albania, Macedonia and Montenegro. MSF organised a number of relief operations for these refugees at the borders of Kosovo. At the same time, NATO mobilised military assets as a means of organising and controlling aid.

In April and May 1999, MSF on several occasions publicly denounced both the control being exercised over the refugee camps by NATO - which was a party to the conflict - and the marginalisation of the United Nations High Commission for Refugees (UNHCR). MSF underlined the need to provide refugee protection and warned about what was happening to the Albanian Kosovars who were still in the province, under the control of Serb forces. Throughout the period of military operations, MSF managers actively refuted the notion of "humanitarian war" promoted by NATO.

On 30 April 1999, MSF published a report entitled "Kosovo: Accounts of a Deportation." Compiled on the basis of refugee accounts and an epidemiological study, this report showed that the Kosovar Albanians were the victims of a systematic process of terror and expulsion, described by MSF as "deportation."

These different stances were taken in the context of an armed conflict in which western countries were participating directly and which they justified by evoking human rights and humanitarian requirements.

This particular political environment considerably reinforced the dilemmas and difficulties for MSF:

- Should it speak out to denounce violence being committed against the Kosovars, at the risk of seeing itself excluded by the Serb authorities from access to these people?
- By denouncing and describing the violence against Kosovars, was not MSF a party to encouraging/supporting the NATO intervention?
- Should MSF take a position on the NATO intervention, or not?
- What sort of relationships (financial, cooperation, etc) should be established with countries that were committed either militarily (such as NATO members) or politically (Greece) in the conflict?
- By raising the alert about UNHCR's absence/withdrawal/lack of effectiveness in managing the refugee camps, was not MSF taking the risk of reinforcing this marginalisation?
- Is it justifiable, by invoking an interpretation of the impartiality principle that implies a responsibility to assist victims on both sides of a conflict, to carry out an exploratory mission that sacrifices the principles of operational independence?

Your comments are very welcome: lbinet@paris.msf.org ■

Laurence Binet

1- ***« Violences against Kosovars Albanians, NATO's intervention 1998 – 1999 » MSF Speaking Out – Laurence Binet – CRASH/MSF International, September 2006, 324 p, internal document.***

2- **In the same collection "MSF Speaking out " : "Salvadoran refugee camps in Honduras (1988) "; Genocide of Rwandan Tutsis (1994) ; Rwandan Refugee camps Zaïre and Tanzania (1994-1995); "The violence of the new Rwandan regime (1994-1995) ; " Hunting and Killings of Rwandan Refugee in Zaïre-Congo (1996-1997) ; "Famine and forced relocations in Ethiopia" (1984-1986). Available in English and in French through the documentation center, the CRASH – distributed in the field and headquarter – orders through the operational library strongly encouraged.**