messages

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DEAR READER

This issue of Messages, n° 146, is the last issue in this format.
The newsletter is going to change name and format in the coming weeks. The contents is also going to evolve in order to try and improve the frequency and quality of the debates, as well as the reflection on our actions.

→ **Armenia** © Tim Dirven - August 2004

ESV

Other projects

MSF / May 2007/ Translated by Edwin Turnill

Mention the "exclusion and social violence" (ESV) missions and one almost inevitably finds oneself called on to debate them. Apart from the France mission, the discussions have difficulty getting off the ground and the re-examination of these projects turns out to be difficult. By Anne GUIBERT[1], member of the board.

Where does this difficulty in talking about EVS missions again come from: from a certain weariness faced with an old debate? From the impression that the fate of these missions is already sealed (they have practically all closed)? From a lack of the data that would enable arguments to be developed for or against, based on the effective results of these missions? Or from the difficulty in seeing what this 'misfit' category of missions really brings together? Should we conclude from the lack of debate that the "desire" to run these programmes isn't there? The first difficulty comes in defining what the category we are talking about includes. ESV missions are undeniably a category with very blurred contours, as their changes of name show ("medium long-term missions", "aid missions to people excluded from care due to their particular situation within their society" ...). What do the missions in Madagascar, Armenia, the La Maca prison, Poland or more recently Niger have in common? Meaning by that: what else do they have in common other than the fact that

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1- **This article mentions several issues concerning the 'exclusion' projects debated over the past few years. A number of points mentioned are no longer relevant given the new directions decided by the operations department, particularly in Haiti or Colombia. These projects will be discussed in other articles.**

Number 146

This year the Annual General Meeting discussed MSF's 'exclusion and social violence' projects. This aim of this issue of Messages is to present a few examples of these types of programmes. Whether in an orphanage or a prison, among homeless or migrants, the projects we describe raise the issue of our limits, our competencies and our ambitions. Are there 'humanitarian issues' involved in these interventions? If the answer were based solely on medical criteria the answer would be clear. But when patients' health raises economic and social factors things are more complicated. How far should we go? In attempting to answer this question we are trying to define the contours of humanitarian action. But if the definition is too narrow, is there not a danger of turning away from contexts of concern?

DOSSIER

Other projects

→ **Madagascar** © Rip Hopkins/Agence Vu - July 1996

> *We expressed our intention to review and analyse these projects during 2006 on the basis that we do not consider access to health care for all an adequate intervention criterion. We needed to clarify the motivation behind these interventions (...). We must continue initiating reflections on this issue within the association in order to clarify and detail a working framework for the years to come. Questions on the relevance of our involvement with economic migrants and asylum seekers in Europe should be taken into consideration during these debates.*

Excerpt from the 2007 Annual Plan (Operational project 2005/2008)

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they don't fall into the category of wars, epidemics or natural catastrophes[1]?
The latest operational project tells us that these missions address populations that are discriminated against, excluded, victims of violence due to their political or religious beliefs, ... They have social and legal components, from the outset they involve intervention approaches different to classic programmes (period of intervention, relations with others involved). One could add that they have often been initiated on an emotional impulse and are driven by strong personalities... but is that enough to give them a common identity?
As for the objective elements suitable for characterizing the results of ESV missions, these are impossible to assemble. And without evaluation, it is difficult to point precisely to true successes in these programmes (the children who have left institutions in Armenia or Madagascar, the prisoners of La Maca who have not died of cholera or hunger, the work with local associations to set up therapeutic crèche in Guatemala) or to ones that have undeniably failed...

Beyond the few formal results, what are the recurring reproaches to which exclusion missions are specifically exposed?

- The absence of humanitarian issues: changing the internal rules of an institution for children, working with actors in civilian society in Sudan on the question of the status of abandoned children, is that humanitarian work? Answering these questions today is not the same as answering them 15 years ago, our definition of "humanitarian" having become narrower. Since 2003 in particular, the president's reports presented to the annual general meeting underline that notions of discrimination, exclusion and loss of dignity take us beyond "humanitarian" action.

- The attempts to interfere in the political domain to dictate reforms, to attack dysfunctions in society, or to decide on lifetime projects for the individuals with whom one becomes involved: for all these projects, there seems to be an attempt to modify the environment, the context, to find a solution to the causal, political and economic problem. Can MSF's teams legitimately question the functioning of a society that is not their own? Was it the role of MSF to organize a demonstration of street children to modify the way society sees them, was it our role to participate in the writing of the universal health insurance law in France?

[...] when the population suffers the same fate as the excluded people that the MSF programme is designed to address, how do you set operational limits?

- The preponderant part that the social and legal aspects of these programmes have occupied has been at the expense of medical activity. At Baoji in China, or at Rescate in Guatemala, MSF doctors treated minor daily ailments - "aches and pains". The core of the programme otherwise had to do with the offer of social or legal support proposed. For certain missions, the medical side has ended up being an alibi. What was, within this framework, our added value in relation to the actions of multiple associations with more experience than us in social and legal issues?

- The difficulty of placing limits in terms of protection: where does MSF's responsibility end in these contexts, in which teams are confronted on a daily basis to phenomena of individual violence against excluded populations? Faced with the confirmed rapes, ill treatment that children are victims of in closed institutions, should we bear witness, complain, physically protect the people in danger? The limits have often been difficult to define for the desks and impossible to keep to for the teams in the field. These have often got involved beyond the mandate of MSF and the assistance that MSF could effectively provide.

- the difficulty of limiting our action in operational terms: when the population suffers the same fate as the excluded people that the MSF programme is designed to address, how do you set operational limits? The

end of the programme in Madagascar shows the difficulty in identifying the target populations when there is need everywhere.

- The demanding search for partners: to avoid accusations of interference, colonialism, ESV missions have sought to work with local partners. Never

not tooled up to ensure the effective monitoring of EVS missions (in human resources, experience, capacity for reflection).

All these criticisms rightly question both the role of MSF in this type of programme and the way in which they have been managed, in fits and starts[2], between a bit of ambivalence and considerable indifference. But these criticisms also demand to be reproduced and debated...

Because, at the end of the day, we should not leave ESV missions with the image of programmes that all went astray, stuck in 'charity', managed by nice but rather naïve MSF people. There are notable differences between long-term missions, the objectives of which were to say the least ambitious ("to return to individuals their capacity to choose", "to promote the application of the Children's Charter", "to provide protection...") and the way in which certain ones have been managed with more limited, reframed daily objectives... Lessons - insufficiently shared ones, without doubt - have also been drawn from the wrong turns encountered by the teams. MSF's

has been able to offer genuine added value compared to the actions of more traditional actors.

In addition, the arguments used against the ESV missions are not specific to them and also concern missions designed to combat epidemics or aid those in conflict situations... Was it the role of MSF to provide financial aid to the family of the street child to help them regain a certain stability, is it up to us to give aid to the family of this man suffering from tuberculosis to compensate for the loss of revenue linked to his hospitalisation? If the issue is not the same (combating illness on the one hand, exclusion on the other), the questions are nevertheless similar. Yet the social support sections of the Aids and Tuberculosis missions - which doubtless benefited from the experience of the ESV programmes - today represent one of the paths of improvement of the quality of these programmes,

At the end of the day, the problem of the criticisms listed earlier is that they could lead people to believe that by bringing an end to exclusion missions,

understand the reasons behind that exclusion and to benefit from internal reflection on the subject.

To conclude, let's look at the problem from the other way around: it is certainly legitimate that MSF should streamline its actions, tighten its operational project around projects that the association masters best, close to its medical identity. And nobody is fighting any more to try to make sure that exclusion missions represent a significant part of our activities. But can we close ourselves completely to the approaches of the ESV missions?

Won't there always be, within the range of MSF programmes and alongside our principal activities, missions in which we will be confronted with exclusion issues? Shouldn't we say to the teams that they have to remain attentive to it and that a restricted space exists so that creative responses, with set time limits and structured around medical aspects, can be provided. There will be other programmes like the Mygoma one, the Sudanese orphanage where MSF got involved to reduce infant mortality rates. A programme where, to make the action a little more long-lasting, medical action was accompanied by the setting up of a task force. Bringing together actors from civil society, this force enabled modifications to be made to the status of abandoned children and their adoption to be favoured. Mygoma is the most recent ESV mission to date, questions have been asked among the teams, in Paris, while undeniable - without doubt fragile - progress has been achieved for the fate of the orphans. Mygoma, perhaps, positively emphasises the pre-requisites to need be integrated in order to guarantee that missions of this type do not end up getting bogged down. ■

Anne Guibert, member of the board of Directors

→ **Guatemala** © Mika Tanimoto - June 1998

without difficulties: the programme in Egypt never got going due to a lack of relays, the Baoji mission suffered from a lack of convergent interests between MSF and the local partners.

- The insufficient attention accorded to these programmes: it's a fact. MSF is

positioning has, moreover, had a certain originality compared to traditional actors in the struggle against exclusion The postulate that the street was not, in itself, an illness, or the fact of not conditioning MSF's action to the will of the beneficiaries to re-insert themselves, means that MSF

one would solve for MSF the problem of confrontation with exclusion. However in our war, post-conflict, epidemic or malnutrition missions, our teams care for and treat on a daily basis, during periods of crisis, those who are excluded. It is important to have the curiosity of trying to

2- Relaunch period in 1997 : these missions were considered as new challenges. Then stand-by periods since 2000: these projects sometimes playing the role of adjustment variables in operational volume.

SUDAN/MYGOMA

Life looks up at Mygoma

MSF/May 2007

When MSF intervened in the Mygoma orphanage in April 2003, the organization found the situation there disastrous. At the time, 75 % of children received at the centre died from lack of care. Once inside the orphanage, the children were simply not being properly looked after. MSF stayed for over three years.

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

"It was a Canadian organization, FAR , which alerted MSF to the fate of the Mygoma children" recalls Suzanne Bradol, sent to the field in 2003 to investigate the situation and to hold discussions with the authorities. While the majority of the infants were being picked up on the street immediately after birth and arriving in good health, the orphanage was failing at the time to keep them alive. Neglect led to children dying from malnutrition, infection or lack of care. Unable to control the situation, the Ministry for Social Affairs (MOSA) finally allowed MSF to intervene, making the most of the opportunity to reduce the resources it provided to the orphanage.

For MSF, the aim of the project was clear: to prevent the children from dying by implementing an appropriate programme of medical, nutritional and psychological care, to work with various partners to achieve recognition of the children's situation, and to ensure a future for them. The MSF team comprised doctors and nutritionists together with numerous "nannies" responsible for caring for the orphans, with the sick being referred to the children's hospital in Khartoum. The mortality rate quickly dropped, reaching between 13% and 20% a year later. However, the team soon found itself confronting a new problem: what to do with hundreds of very young, now healthy, children in a place that was too small to accommodate them. "Before MSF arrived, only 80 out of 300 children admitted to the orphanage were surviving," explains Suzanne. "The ratio was then reversed, creating another problem, namely one of capacity."

→ BEING AN ORPHAN IN SUDAN

As it set about obtaining funding to build new facilities - notably from the Japanese embassy - MSF turned to the question of adoption, something which was often slow to come about. Added to the particular circumstances of the Mygoma children was the way in which orphans are viewed in a Muslim country. In Sudan and within the Islamic faith, it is forbidden for parents adopting a child to give their name to the orphan or to leave the child a share in any inheritance. Whilst the suras of the Koran remain subject to interpretation, the Prophet Mohammed himself adopted a child who did not bear his name. Certain equally deep-rooted preconceptions hold that any family adopting a child conceived out of marriage is sure to suffer misfortune and that it is better

→ About Mygoma

"*This type of confrontation with political and socio-economical problems is inherent to this type of project. These projects push us into being a driver of social transformation, but does that mean the same thing as participating in social progress? No, in the first case, one has less ambition, one simply tries to find solutions on the scale of the project in which one is involved*"

Marie-Hélène Jouve, Extract from "*Elements for an evaluation of exclusion, social violence*" projects - 2006

to adopt girls than boys, who are considered less easy to control and less attentive to their elders.

The reputation of the orphanage also did not encourage moves to adopt. Most of the orphans abandoned and brought to Mygoma were born as a result of relationships outside marriage, a subject that is taboo in Sudan. Moreover, before the arrival of MSF, the place was hidden away and neglected by the authorities to such an extent that the inhabitants of the area did not know what went on there. The employment however of numerous Sudanese coming and going from Mygoma meant that the truth spread like wildfire: the orphanage housed underweight, sick children, a fact which did nothing to encourage adoption. A few months after starting work there, MSF set itself a new target: to try to break down such prejudices and to bring about a change in attitudes.

→ A VEHICLE FOR SOCIAL CHANGE?

The situation improved. Most of the children were in good health and there was growing confidence. "After a while, young mothers in distress even came in person to entrust their children directly to the care of the orphanage, feeling reassured," recounts Suzanne. The project became more widely recognized but MSF could not take on the authorities' role of promoting adoption even if the project had removed some of the prejudices. "Homes for the Future", housing orphans beyond the age of four, were supported by the Ministry and managed by other organizations, but provided only a temporary solution with places rarely available. The authorities therefore decided to find foster families who would be paid until adoptive families could be identified. The Ministry informed the population about the initiative in order to promote adoption. "Although it hadn't up until then been concerned about the fate of these children, Unicef nonetheless promised funding to the Ministry for Social Affairs to help publicize the project and promote adoption of the children," continues Suzanne Bradol. "Newspaper articles were followed by publicizing on radio and television."

"We saw a stream of religious leaders arriving at the rate of about fifteen a week. Once convinced by what they saw, they returned to raise awareness among worshippers following Friday prayers," recalls Suzanne.

Conferences and a special day devoted to the Mygoma orphans were also organized. More surprisingly, the Ministry invited numerous Imams from Khartoum to visit the orphanage. "We saw a stream of religious leaders arriving at the rate of about fifteen a week. Once convinced by what they saw, they returned to raise awareness among worshippers following Friday prayers," recalls Suzanne.

→ GROUNDS FOR SATISFACTION AND FOR DOUBT

In addition to most of the children surviving, the Sudanese population had been mobilized and funding earmarked by the Ministry for the foster care programme. The gamble seemed to have paid off and MSF withdrew at the end of 2006. "By showing the children in good health we were also able to give them the chance of being adopted or fostered by families," explains Suzanne. A shameful secret until just four years ago, the orphanage is now opening its doors. Moreover, legislation has been amended to facilitate adoption: a child whose parents were unknown was not previously considered an orphan, something which is no longer the case. All the Mygoma orphans have also been granted medical insurance and are entitled to free healthcare at Khartoum hospitals.

Remaining reservations centre on the authorities' intentions. Foster care placement targets are ambitious to the extent that they envisage the closure of the orphanage currently managed by a local association with the support of the Ministry. "It is essential to think of the consequences," Suzanne anxiously points out. "Will monitoring of the children be properly carried out and funded? Will families' salaries be maintained? While foster families do offer the best type of publicity for convincing neighbours to adopt, the risk that fostering might develop into a business is still a possibility." As for adoption, it needs a sustained awareness-raising programme among the Sudanese. This does seem to be happening today despite not always having been the case: "Joint efforts by Unicef and the Ministry were inadequate in 2005," says Suzanne. "Nobody watches Sudanese television and not enough messages were broadcast by radio. I met with the Ministry which deplored the poor level of support by Unicef. I then went to see Unicef which was ready to give more but saw the communication strategy as not convincing enough. The ball was always in the other's court." The figures do however indicate that adoption has now become more attractive: whilst 370 children were still living at Mygoma at the end of 2005, one year on that figure was only 70. Today, MSF maintains regular contact with the authorities and organizations caring for the children at the orphanage. ■

Olivier Falhun

1- **Fellowship for African Relief**

> *"The problem that comes with this type of "ESV" missions goes further than articulating the medical/social issues. Analysis made of ESV projects clearly shows that the medical problems we are confronted with result from defective social conditions which translate through into social or political problems or dysfunctions. One of the characteristics of these projects, when we get involved in ESV projects, is that one quickly gets caught up in a chain of causality that leads us to consider the social/political determinants and to go outside the traditional field of competence of MSF. The question that presents itself is how to know what limits to put on our involvement"*
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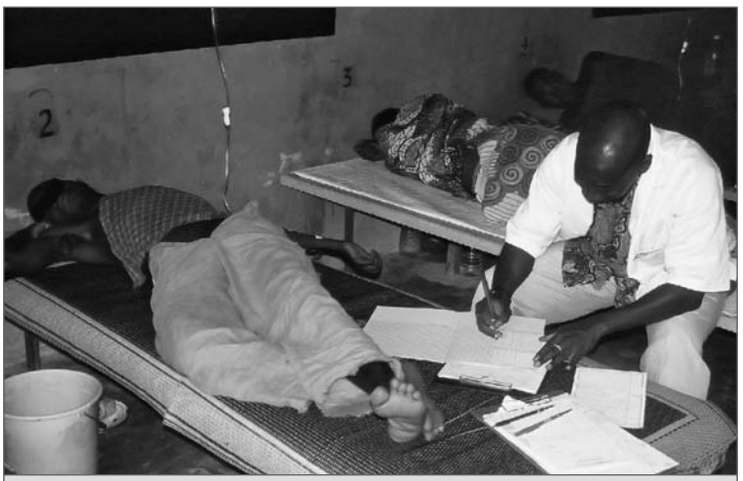
> **Marie-Hélène Jouve, Extract from "*Elements for an evaluation of exclusion, social violence*" projects - 2006**

IVORY COAST/ABIDJAN

Opening in a closed centre

MSF / May 2007

In 1995, MSF opened a mission at La Maca prison in Abidjan, in the Ivory Coast, following an epidemic of cholera. Its aim in this closed environment was to attempt to reduce the mortality rate. Its mission concluded, MSF left the prison, only to return two years later for the same reasons, but with more ambitious objectives.



→ **Ivory Coast** © Mathilde Berthelot/MSF - March 2003

"Social progress' comes principally from political and social action and not from humanitarian action. And even less the action of an organisation like ours, which is a rather unstable organisation by its very nature, more often than not a foreign organisation in the settings in which it gets involved and that does not have the stability necessary to be able to maintain its actions in the long term. It is not a question of no longer doing something when we detect a catastrophic situation, but it is, in my opinion, a question of being much better at applying limits to our ambitions in these domains."

Jean-Hervé Bradol
Extract from moral report of 28 May 2005

When its teams were called upon once more in July 1997 to fight another epidemic of cholera, MSF didn't just want to repeat the same exercise. At that time, the gross mortality rate was estimated at 2/10,000/day, an abnormally high figure for a population made up essentially of young adults. In this overcrowded prison, the nutritional situation was deplorable: detainees lacked water, hygiene and access to medical care. "We also noticed that many prisoners arrived in a terrible mess, victims of violence they had been subjected to at the police station," explains Florence Fermon. The objectives were reviewed upwards: to the struggle against cholera, improvement of access to medical care, refurbishment of the water supply system and other hygiene-related tasks were added to the list. MSF also decided to take action to improve the nutritional situation of detainees and to try to improve the precarious nature of their living conditions. "Prisoners were living without access to daylight. We therefore exerted great pressure to ensure that cell windows were no longer bricked up," continues Florence. The question remained of the violence suffered before arriving at La Maca and that sometimes led to the death of detainees. Faced with this situation, MSF reacted by setting up a systematic medical examination for all new arrivals. This examination would reveal any incorrect treatment and violence that they may have suffered at certain police stations and this could therefore be differentiated from violence meted out inside the prison. In these cases, MSF drew up medical certificates which were given to the detainees, the information was also transmitted to the director of the prison administration and this led to a significant decrease in these practices. MSF signed a working agreement with the authorities that clarified and protected the rules applicable to its medical mission within the prison.

→ ERRORS MADE

This was the first operation of its type for MSF and it brought with it difficulties of positioning. "Some people within the prison were working for the team," says Florence. "Sometimes, it wasn't the director but the team itself that took charge of identifying them. At times, roles became confused as we were adopting an approach which didn't correspond to our responsibilities. It was new for everyone and we had to learn as we went along". It's important to resist the temptation to do too much - in such confined and aggressive surroundings, in which tight coordination is called for and where pressures have to be dealt with. MSF made other errors, sometimes even serious ones. Some volunteers were fooled by prisoners wanting to be cared for in hospital where the living conditions were better, others sometimes allowed their relationship with prisoners to become too close. One case of abuse against a detainee was even confirmed. Yet by the end, La Maca was considered a model prison in the Ivory Coast. That's not to say that everything was rosy. For some, MSF went beyond its remit, and while relations with the prison administration director were good, those with the prison's medical director fluctuated. Nevertheless, MSF was able to succeed in convincing the Minister of Health to increase the number of doctors in the prison and to improve supplies of medication.

→ COULD DO BETTER?

By the time MSF departed in 2006, the situation had improved greatly. "A repeat offender shared his surprise with us when he saw the improvements that had been made in the sick room," says Florence, who, satisfied with the sanitary rehabilitation and the medical care in the prison, still notes - despite the improvements - an inadequate situation with respect to food, and regrets the absence of more proactive MSF intervention in certain domains, in an environment which she nevertheless admits is complex. "We provided a correct response to cholera and tuberculosis, particularly by addressing multiple resistance, but we were poor when it came to the question of Aids and victims of sexual violence," she admits. "We should have talked more objectively about Aids in the prison, calling on the

authorities to get them to take action". As for the sexual violence, however, MSF did take an interest in the case of minors, particularly vulnerable and exposed in this overcrowded setting. Major efforts were made to limit the number of minors in the prison. A white paper was even addressed to the authorities who, aware of the issue, listened to MSF in order to drastically decrease the number of young new arrivals, though without finding alternative accommodation for minors already incarcerated.

→ BIG BROTHER?

As for the protection of people exposed to violence, the question was not discussed as such. As Florence remembers it, the need for such an intervention was evident to the teams. At the time, police stations defended and justified their methods of torture. It was necessary to gather many data and submit them to the attentive eyes of the authorities in order to change things. "We were able to uncover facts that others merely noticed and moved on," says Florence, who remembers an aspect of the project led more by individuals than by a clear policy expressed within the NGO. But would the same thing happen again? "We have to reaffirm that we are not seeking to do it, but it's also not possible to ignore it either, especially when faced with vital consequences," argues Florence, who nevertheless believes that it is up to the International Prison Observatory, in the first instance, to record and denounce such abuse.

For Florence Fermon, a context such as that at La Maca calls for solid teams, capable of resisting routine and keeping perspectives in such overpopulated and violent surroundings. Florence also points to the project's successes, while regretting that an in-depth study has not been carried out since its closure. "In spite of all the difficulties, we were able to get those detainees needing hospitalisation out, we established medical certificates demonstrating the incompatibility of some patients with the detention centre. We finally made people recognise that the prison was grossly overcrowded and that that was generating major tension and risk". There is still, however, the question of limits, and of the place of MSF in an environment as complex as that at La Maca. "We learnt from our errors, but it's more than time to share this experience, to learn from it and clarify the contours," concludes Florence who, beyond its nature as an atypical project, sees in La Maca a capital intervention as much as an experience to be capitalized upon. ■

O.F.

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1 Abidjan central prison

JAPAN / OSAKA

A Question of Politics

MSF/May 2007

"To give back to the homeless their right to healthcare" Such was the objective of the mission in Osaka, which remained essentially unchanged until the project was halted in February, 2007. Eric OUANNES, general director of the Japanese section, describes the difficulties and dilemmas involved.

After spending nine years pondering the issue of homelessness in Japan (starting with Tokyo, then Osaka), and beyond any operational issues, the central question which we've yet to answer is the following: "Is the humanitarian problem in Osaka such that it requires the intervention of MSF?"

Ranked second as a world economic power, with an unemployment rate among the lowest in the world (less than 4%), Japan is a recognized democracy, known as a "peaceful Constitution" advocating mutual aid (by law, everyone in Japan is entitled to healthcare). The healthcare sector is highly developed and effective. The system however results in 'structural exclusion'.

→ **Japan** © Sayuri Ohkawa

Throughout the duration of the program, we studied this central question, without succeeding in sufficiently documenting the sociopolitical and sociomedical problems that we were up against. What we've learned doesn't amount to much: We know today that a certain number of homeless people have difficulty gaining access to essential care, that they're suffering primarily from chronic pathologies and sometimes live in very precarious conditions. We've succeeded in better understanding the mechanics of exclusion, the stigma and even disgust -sometimes purposely fed by politics- generated existence of the homeless population, in spite of public awareness.

As the project evolved, the teams found themselves up against numerous obstacles: twice neighborhood residents refused to allow MSF set up a clinic, strenuous discussions ensued with the city of Osaka over authorization to establish the clinic. Healthcare professionals had difficulty understanding our approach and what was at stake, and there was a lack of understanding regarding the humanitarian motive behind MSF's presence. We started the mission without an fixed facility, walking on eggshells, practically hidden, without speaking out publicly, as if we were afraid to talk about what we were doing. To their great satisfaction, municipal, government and other authorities closed the door on us, taking advantage of our inability to integrate into the sociomedical fabric.

In Osaka, we were not in the presence of a crisis, facing a deeply suffering population, living in a more or less volatile environment, in the absence of any health care system whatever.

We can pore endlessly over the strategic errors, errors of orientation, MSF's management of the affair, the occasionally pathetic errors with regard to the "joint" management of MSF's French and

Japanese sections, and the nationalist rants which discussion sometimes generated in our section. We can examine their meaning and the motives of those who defended the mission until the end without sufficient political support. We can also examine the choice of closing a project when our original goals haven't been acheived and few patients ended up being seen in consultation and treated (one of the reasons for closing the project was precisely this lack of activity), and many other questions - and occasionally bitterness - still persist.

The debate is in vain unless we grasp the fundamental question. It goes well beyond the mission in Osaka and concerns whether it's appropriate for MSF to include in its operational project activities related to the socio-political realm.

In Osaka, we were not in the presence of a crisis, facing a deeply suffering population, living in a more or less volatile environment, in the absence of any health care system whatever. We were far from meeting the standard, historical criteria for the intervention of MSF. We were far from the definition of a humanitarian crisis, even if at times the mortality rate generated a kind of charitable empathy, probably somewhat exaggerated, which might have lead to the creation and survival of our mission.

What's more, it's dangerous when a medical assistance organization such as ours allows itself to be seduced by the hypothetical power to modify "policy" in an extremely sensitive arena. We believed - undoubtedly there was justification initially - that by implicating ourselves in a national issue we would be able to help resolve the homeless problem in Osaka. It's possible that our ambition went even further. We thought that by positioning ourselves in this way, the Japanese section would gain recognition for playing an active part in Japanese civil society. This line of reasoning persisted. A good number of us succumbed to it, revealing a presumptuous point of view that is very characteristic of MSF.

In spite of everything, we learned a lot from this type of project, which, by and large, are quite apart from our standard activity. We learn a lot because we flirt with realms of activity beyond our usual sphere: politics, the Mafia, clandestine organizations, religious followers, etc. Unquestionably, projects must continue to exist first and foremost to save lives. In terms of operations, performing an act of care motivated by a crisis helps ideas to

> *"I think that if MSF decides to retain this type of programme in its operational project, it would be a good idea to enlarge the definition of what is called 'survival'. In a context of great social precariousness, it is a question of bringing aid that goes beyond medical care, in order that that medical care should make sense. It goes without saying that programmes having had as their objective to reintegrate populations that are discriminated against to make them full citizens are no longer relevant today and would only lead to reticence at MSF headquarters. Nevertheless, without setting out on a struggle against marginalisation or social injustice, one has to consider which social aspects should be developed so that our medical action can be a success."*

Marie-Hélène Jouve, Extract from "*Elements for an evaluation of exclusion, social violence*" projects - 2006

→ **Italy** © Francesco Cocco/Contrasto - June 2003

develop in a way that's contradictory and healthy (it's not the only way for them to develop), using methods of operation that are sometimes unusual or that have become obsolete because they've been sacrificed on the alter of quality or the great modern myth of zero faults. Projects need not be integrated into the classical structure of a standard mission, such as we know it. We must look at new ways of managing, at methods that are more flexible, more responsive, more open to different approaches, more humane. Undoubtedly, we must question the relevance of our political objectives. After all, don't they run the risk of contributing to the increasingly ambiguous definition of the word "humanitarian"? ■

Eric Ouannes,
General Director of
the Japanese section

→ **Japan** © Sayuri Ohkawa

ITALY / LAMPEDUSA

Migrants on Lampedusa

MSF/May 2007

The Italian section of Médecins Sans Frontières has been providing assistance to refugees and migrants in Lampedusa, an island 200 kilometres off the coast of Sicily, since 2003. Loris DE FILIPPI, coordinator of operations and former head of mission of the Italy mission, describes the objectives and relevance of this project.

→ Why did MSF decide to open a project on Lampedusa?

Over the past few years, the island of Lampedusa has become the first point of arrival for migrants trying to reach Europe by boat. Lampedusa also represents in a certain way the bottleneck for Italy and the European Union concerning the issue of migration.

MSF was aware that every year thousands of migrants arrive on the island after hazardous trips. On August 22nd 2002, around 500 people landed on Lampedusa and were transferred to the centre of the island, which had a maximum capacity for 80 people. An MSF team visited the centre to analyze eventual needs. The MSF team discovered that in the centre there was a lack of health care provided to migrants and that the living and hygiene conditions were unacceptable. In addition to this there were no other independent organizations working in Lampedusa at that time.

In 2002 the immigration policy of Berlusconi's government was based on the repression of migrants rather than on reception. Lampedusa, a tiny island located 80km from Libya and 200km from Sicily, did not have the capacity to treat or receive the hundreds of migrants landing on the island after risky trips aboard unsafe boats. Considering all these elements, MSF decided to start a project to provide health care and speak out under our mandate.

→ Can you describe the previous and current phases of the project?

In the beginning, MSF was working inside Lampedusa Temporary Detention Centre (TDC) with a medical team supporting the centre managing organization. In 2004 MSF denounced in a public report health inadequacies and law violations monitored inside all the Italian TDCs, including Lampedusa. Following our public criticism the Italian government did not renew MSF's authorization to continue working on the island. From March to October 2004 we were not allowed to work there. MSF increased negotiations with the Italian

Today there is a big question mark regarding the pertinence of our work in Lampedusa. Next summer we will probably end our intervention if our requests are addressed by the new Italian administration.

DOSSIER

Other projects

→ **Italy** © Francesco Cocco/Contrasto - June 2003

"Most of these projects have been already closed, and no others were opened during 2006. We continued working in Mygoma, Sudan and Tzité, Guatemala throughout the year, thereby respecting our commitments to the beneficiaries. The projects will be finished by the end of the year. Both projects in Paris and Marseille were closed, but at the beginning of 2007 a decision was taken to open a new one in France focusing on illegal refugees. Whilst we are aware that illegal immigration is probably not the most acute problem in France, we feel the need to follow-up our reflections on this subject via some operational experience. We hope this project will provide us with leads for future work, in places where the exposure of these people is no doubt greater due to political environments that are less stable than the Shengen zone."

Excerpt from the 2007 Annual Plan (Operational project 2005/2008)

authorities in order to again be operational. In October 2004 a new memorandum of understanding was signed and today our intervention is at the harbour. When a landing occurs our team is alerted and we intervene providing a first medical triage for migrants. Our team is composed of a doctor, a nurse and a cultural mediator. The MSF medical team is only allowed to enter the centre and visit patients for specific cases that need follow-up. On average approximately 20,000 people land on Lampedusa per year. The main pathologies are related to the trip: dehydration, chemical burns and traumas.

→ Have the objectives of the project changed?

The objective of the project has always been to provide first aid to migrants arriving in Lampedusa after risky trips. The project has changed over the past few years because the political scenario has changed too. Consequently our relations with the local authorities has also evolved. MSF is still convinced that the centre is not adequate to respond to migrants' needs in terms of reception and it has been closed to other organizations for a long time. Other organizations such as UNHCR, IOM and the Italian Red Cross, have had access to the centre since last summer and this is a good sign if these organizations guarantee the respect of procedures and denounce violations when and whether occurring.

Today there is a big question mark regarding the pertinence of our work in Lampedusa. Next summer we will probably end our intervention if our requests are addressed by the new Italian administration.

It seems that the structure of the centre will change and the new managing organization has declared that the quality of care provided to migrants will improve.

→ What have the major difficulties or constraints in Lampedusa been?

Working in complete isolation has been a major constraint for us. The other actors on the island have been the Italian Police or charities working in agreement with the government's positions. We have played two roles: one of watchdog and one of an inconvenient partner trying to contain abuses and mistreatment of migrants. During the expulsion of MSF from Lampedusa in 2004 no one helped us to get back to the island.

Another concern has been to find a balance between the health care provided and the need to speak out about the situations we have witnessed. When we decided to publish our report on TDCs we were aware of the risks we were taking. Over the years there has been an ongoing discussion among the Italy mission, MSF Italy and the OCB on how far we should go in terms of speaking out in a project like Lampedusa. We did the same when we denounced the forced repatriations of migrants to Libya as a clear violation of the principle of non-refoulement. We did it because there were no other actors ready to do it, not even the UNHCR that was on the same line as Berlusconi's administration.

We have played two roles: one of watchdog and one of an inconvenient partner trying to contain abuses and mistreatment of migrants.

→ What is MSF's current program in Lampedusa and what are the future challenges for MSF in the island?

Today the Italy Mission is at a turning point as the Italian government has to decide what kind of reception it wants to give to migrants landing on Lampedusa. The current structure of the centre must be changed. We have been saying this publicly for years and we still believe that a philosophical and structural change is needed. The centre has a maximum capacity of 190 people, whereas in summer the centre contains up to 700 or 800 people. The quality of health care has to improve, health care must be provided by the National Health System, not "subcontracted" to private organizations, which are not always competent, and clear protocols must be implemented. These are the forthcoming challenges in Lampedusa. If the promises of Mr Prodi's government become real, I believe that we will reconsider the relevance of our presence on the island.

→ In your opinion, is the Italy Mission an "unusual mission" compared to other MSF missions?

We started our intervention on Lampedusa when migrants' routes changed from the Albanian coasts, a few miles from Puglia, to the risky way of crossing the Mediterranean sea. There was a vulnerable population in danger and there were no other actors ready to intervene. On this basis we can say that the project in Lampedusa is a typical mission under the full mandate of MSF.

I believe that the impact of our *temoignage* in Italy has been extremely important and powerful: we have released two strong reports on health conditions of migrants detained in TDCs and on migrants exploited in the fields of southern Italy. In the last years an important role in the external communication of MSF Italy has been played by the Italy mission. We have had very good coverage on all major Italian and international media and MSF Italy has not registered a decrease in donors' contributions.

In 2000 MSF which normally works 8000 km from Europe decided to work and speak out here, at home. ■

Loris de Filippi, interviewed by Alessandra Oglino

1- High commissions for refugees
2- International organisation for migration
3- Operational Center - Brussels

→ Sudan © Caroline Livio/MSF - July 2003

→ Sudan © Kevin P.Q. Phelan/MSF | April 2006

MISSION

Southern Sudan

MSF closes a hospital and launches a new program in Akuem

MSF / April 2007/ Translated by Aaron Bull

Akuem Hospital in the Bahr El Ghazal region has been closed after seven years of operation. Médecins Sans Frontières has decided to close a resource-intensive program while maintaining its presence in southern Sudan in order to respond to emergencies. At the same time, an emergency team has arrived in Akuem to respond to an outbreak of meningitis.

Everyone still refers to the place as the "new site". But when visitors step through the entry gate, they find themselves in the ghost of a hospital, with no signs of the beehive of activity that filled it only a few months ago. The hospital closed just a week ago. It had become the referral hospital for the whole region; three hundred people were working there, and it was receiving around ten thousand patients each month. Two years ago, the decision had been made to build new buildings on several hundred square metres of land. The old site was kept open for outpatient consultation services, receiving up to 6,000 patients per month. Work on the new site was completed a year ago, and the X-ray machine for the radiologists arrived eight months ago. "*With these kinds of programs, the MSF facility quickly becomes the referral hospital. This is not a problem during a crisis period, when the needs are very great and the population cannot travel to a Ministry of Health referral hospital.*

But it does create an imbalance, and when the situation changes, we find ourselves becoming a substitute for the Ministry of Health," says Marc Gallinier, head of mission for southern Sudan. In the Aweil East region, for example, the referral hospital had the capacity to treat patients for tuberculosis, but no tuberculosis patients were arriving at the facility. Last year, the MSF facility provided primary care to 6000 patients; people chose to go to Akuem rather than the Primary Health Care Units, which were lacking in equipment, supplies and qualified personnel.

→ THE DECISION TO CLOSE

The situation in southern Sudan has changed: after twenty years of fighting, a peace agreement was signed two years ago. Mines are being cleared, roads built, and many U.N. organizations and NGOs are working in the region. In the Akuem area, the nutrition situation has improved, and while the flow of displaced people from Darfur has not let up, that has not contributed to the level of activity at the hospital. Enormous difficulties remain, and access to care in public facilities is still limited, but the situation today is comparable with that in other regions of southern Sudan. The mortality rate is high, but no higher than it is in other states in southern Sudan.

"We needed to get out of a resource-intensive program in order to maintain our capacity to respond to epidemics or other"

What role could Médecins Sans Frontières play in this new environment? Not managing a referral hospital in a remote rural area, the coordination team decided. In early December, the decision was made to close the program. *"First, we considered extending the closure over a year, gradually reducing the activities in the hospital,"* Marc said. *"But that just wasn't realistic. It would have meant gradually handing over responsibility for the different services to the Ministry of Health, with all the problems of collaboration that that involves. That just wasn't possible. Local health authorities made it clear that they didn't have the resources, staff or drug supplies to take over the hospital. After twenty years of war, the priority is to build a health care policy..."*.Other partners were approached, but they all declined; managing the program required more resources than they could put into it. The window of opportunity for winding down the program was narrow. It had to be done during a time when medical activities were slow, and when roads were passable so that equipment and supplies could be moved, which meant it had to be either in April 2007 or a year later. So the closure had to be completed in three months. The decision was discussed with the authorities. *"We explained that we were closing the hospital at Akuem but that we would still be maintaining a presence in Bahr El Ghazal, and that we were committed to supporting the Ministry of Health in responding to emergencies. We needed to get out of a resource-intensive program in order to maintain our capacity to respond to epidemics or other emergencies,"* Marc explained. For two months, the authorities procrastinated and no At that time, in early February, northern Bahr el Ghazal was the location of the largest outbreak of meningitis in southern Sudan. Evaluations were conducted and very quickly the decision was made to launch an immunization campaign in the area. *"It was an opportunity to confirm our promise that we would respond to emergencies. The authorities' confidence in us was restored. A new dynamic was created with the arrival of the emergency teams, and the problems with the closing of the Akuem Hospital evaporated,"* Marc said. Akuem became the base camp for the emergency team: part of the staff employed at the Akuem Hospital was hired on short-term contracts for the meningitis emergency. Meningitis-related activities made it possible to completely shut down activities connected with the Akuem Hospital and take the team out of the regular program. Paths crossed as the same plane took hospital staff to Juba, the capital of southern Sudan, and brought back those who were assisting with the meningitis outbreak. Ten-thousand-litre tanks were carried away on trucks while freezers and refrigerators arrived.

Vehicles were constantly coming and going through the entrance to the former hospital site. One building was used to hospitalize severe cases, and two teams circulated around Akuem to take supplies to the primary health centres, collect epidemiological data to monitor the outbreak, and transport meningitis patients who needed to be hospitalized. Where there were no health centres, an MSF medical assistant established a presence with everything required for rapid treatment of meningitis. Immunization teams went out to the sites and vaccinated thousands of people at a time. Local people began to go elsewhere for medical treatment, while continuing to benefit from the presence of Médecins Sans Frontières. Both the community and the local authorities got the message. ■

→ **Sudan** © Marie-Pierre Barre/MSF - September 2005

Anne Yzebe

ON GROWTH

For the attention of the International office...

MSF / February 2007

With a new MSF office having recently opened in Prague and with further openings under consideration (Mexico, Turkey, Lebanon, etc.), Frédéric VIGNEAU shares with us some reflections based on experience gained as head of the United Arab Emirates office for the past year and a half.

"The recent years have seen a continuous growth in number and size of sections. This dimension was already raised by the former president (Morten Rostrup, MSF an its unhealthy growth – ndlr), related to efficiency and accountability of MSF. In his view, quite agreeably MSF-funds should be as much as possible be spent on operations and not on overhead costs. Others (...), question the Euro-centric character of MSF. This is not only reflected by the fact that the overwhelming majority of offices are located in Western countries, but also because a substantial weight in decision-making is with the operational centers – all locate inEurope."

Max Glaser, board member of MSF Holland.
My sweet La Mancha, October 2005

→ **Sudan** © Sebastiao Salgado/Amazonas Images - january 1985

Some 15 years ago, the Emirates office was opened with the aim of communicating and debating with the Arabic world in general, not just about the activities of MSF but also on the questions that certain humanitarian crises or emergency support operations pose. At the same time, a fund raising department was set up.

For "new" offices currently planned, and despite little information being available on the subject, one can easily imagine that their creation reflects growing support for our operational projects, implying notions of responsiveness, quality and the appropriateness of our actions. That supposes setting up decentralized structural development and therefore the need to find spots across the globe not occupied by other MSF sections. It is a continuous logic that the movement has already experienced in terms of growth.

If certain new MSF offices also have as their aim to build an "image" in society or in the communities living in the country, it is important to know more precisely what is intended when MSF offices are set up. Vis a vis the section that is launching the initiative, but also by questioning the role and involvement of the International office or the International council in such developments. Have the true criteria and the choices of such decisions been made clear to the movement, with a view to avoiding the risk of unhealthy growth, taking us away from the operational heart of MSF?

Two reasons are often evoked to justify the opening of MSF offices across the world: the need to expand our opportunities to recruit and raise funds, with the infallible argument of diversifying our monetary flows. Another reason sometimes mentioned concerns the North/South (i.e. industrialised v. developing countries) balance, an 'in' topic in politics a the moment and particularly so for an organisation like MSF, which sees itself as having an obligation (a moral one, at least!) to reflect on it, given that the great majority of its emergency operations take place in the "South".

In relation to the two major arguments mentioned above, I confess I do not quite follow them. In respect of human resources, the problem is not the recruitment of volunteers to work with MSF per se, but keeping them with the organisation (loyalty building) with a view to having available experienced people to manage our projects, which often take place in difficult situations and that are sometimes complex to implement operations in. Moreover, there are other less burdensome ways than opening an office to address this insufficiency in as far as it has been detected. By recognising our collea-

gues, for example (over 22,000, we are told) and the particular attention we pay together to developing an appropriate assistance project The decision-making chain also has to be rethought and more flexibility has to be applied in the assignment of responsibilities so that these do not become concentrated uniquely in the capitals of the operational centres, to the detriment of the field.

As for the financial revenues that such an initiative can generate, they are not as evident as one might like to imagine. Indeed, it is not just a question of having a return on investment, but of setting up fundraising tools that are adapted to the local market, in the hope of gathering the substantial revenues expected, which have perhaps been overestimated (even involuntarily!) as regards their amount and, above all, the planned time frame. The impressive results achieved by the German and American sections, based in Berlin and New York, should not blind us to the difficulty of this activity and make us delude ourselves that a simple positioning based on the name and notoriety of MSF will be sufficient to open up to us the manna of a "treasure trove" in terms of fundraising. It is also justified to ask the question whether the MSF movement currently really lacks financial resources to the extent of imposing this type of expansion on ourselves as a policy requirement!

These questions are equally constraints for the operational centre that wishes to implement them, especially if the aim is not the opening of one but of several offices. This means significantly distancing from the initial objective specified, which was focused around operations. There is a serious risk of seeing ourselves embark for many years on having to perform institutional management, personnel administration management; in a word, bureaucracy, that like nothing else can take up the time of any committed employee. The other dimension that should not be neglected would be to see the aspiration come into being - quite logically - that these new offices should become a new MSF section after a few years of operation.

The third splinter and by no means the least is the spreading of the MSF principles and the debates that we can seek to create through our public stances. Most certainly, this must not be minimised. But if the weight of what MSF says has had and continues to have an impact, that should not necessarily be put forward as an established principle. Numerous factors need to be taken into account and, while it is certainly true that factors specific to MSF are at play in this domain, all evidence shows that it comes out of our activities in the field. One therefore has to be conscious that any office that may open under the MSF name will be confronted with a feeling of distancing from the "operational" reality of MSF, the reality of the field, of direct experience and sharing life on mission. This reproach, or at least this criticism, will quickly be formulated by the employees and volunteers (recruited locally) working in this office, and whose principal activity will consist of exhibiting and "selling" the humanitarian activities of Médecins Sans Frontières. In the end, this opinion should be fed by certain actors from civil society (local angle!) who we have approached directly (MSF donor) or indirectly (repeated promotion of our professional activity). And thus, over time, what could be more normal for an office located in Istanbul or Ankara than to develop a response to an earthquake that might occur in fine, or an MSF office in Mexico to draw up a programme with migrants or any other type of social project?

Isn't there room today to find ways of growing other than having MSF offices "mushroom" up? Might we not "play" with the group's logic and the existing network of partner sections? How are these new offices financed? On private funds from the section behind the opening, or through financial support provided by partner sections? What proportion of reserves are we assigning to them?
Above all, what is the "political" implication of the IO/IC in the functioning and in this mode of - relatively silent - growth of the MSF movement? ■

Frédéric Vigneau,
Head of the United
Arab Emirates office

RESOURCES

A farewell to "Admin" ...

MSF / April 2007/ Translated by Catherine Beverly

In the light of operational developments, we have had to review the composition of our administrative teams, along with the role of administrators and their career progression within MSF. The Field Finance department and Field Human Resources (HR) have been looking at the issues. Result? Goodbye "Admin", hello "Finance/HR coordinator".

→ What led us to undertake this review?
Over the last five years, our administrators' workload has seen a dramatic change. To quote a few figures: staff numbers have increased by 95%, the annual field budget by 72%, the average budget per project by 84%, and so on. Administrative duties have also become more complex, involving qualitative management of local staff, itemisation of budgets by activity, taxation, etc.
Despite this, the size of our "Admin" teams in the field has been shrinking in proportion to the rest of our staffing levels, from 8% in 2002 to 5.6% in 2006!
In general, the capital-based administrator, usually someone on his or her first mission, is taken up with day-to-day management, using an approach which is often technical and which offers little chance to delegate. These people have no time to stand back and focus on larger operational objectives: budget monitoring by activity, team composition, or the follow-up of individual staff members. They do not bring to their coordination teams the financial elements needed to help take operational decisions.
The outcome? After a tiring and frustrating first mission, the majority of capital-based administrators (56%) never embark on a second. Faced with the fact that the old system was not working, the Field HR and Finance departments, with the support of the Operations department, have worked to develop a better one. Getting it up and running in the field is a priority objective for 2007.

→ What are the features of this new system?
The first objective was to improve the organization and competence levels of administrative teams based in the capital. In most cases, they currently consist of one international, general administrator backed up by a local

assistant, also a non-specialist, who is usually expected to carry out instructions rather than make decisions. This varies according to the administrators in place, which demotivates staff and leads to inconsistent procedures and a fluctuating quality of work. In place of this arrangement, we propose to introduce teams of at least three people, with a clear division of responsibilities:

- Two posts as managers of specific activities: one with responsibility for staff administration (contracts, days off, pay, etc.) and the other for accountancy matters (establishing procedures, consolidation, closures, management of field teams, etc.). The level of competence expected for these posts is much higher than for that of assistant.
- The post of administrator is to be renamed as "Finance/HR coordinator". This is not simply a change of terminology. We hope, by using this new title, to highlight the changes in the nature and responsibilities of the post, towards an increase in supervision, analysis, qualitative management and operational support. In particular, the Finance/HR coordinator will be responsible for bringing to the coordinating team the financial elements necessary for operational decisions, and for helping to monitor HR objectives (appraisals, training, follow-up of managerial staff etc.).

Where necessary, there may be posts for additional support staff: an accountant and/or secretary, for example. The post of assistant is to disappear.

In order to facilitate the implementation of these changes, two posts of mobile trainers have been created. Their role will be to train personnel for the posts of HR administration manager and accountancy manager. An inventory drawn up by the desks' financial management controllers and human resources officers will help us decide which countries should take priority.

Each of these posts is open to international or national staff, the important thing being to maintain a mixed team.

Our second proposition concerns organization in the field. We need to take on some field administrators. More than a dozen projects have teams of over 100 people and budgets in excess of a million euros. Imagine the results when the person in charge of managing such a large-scale operation has no administrative experience and is also taking care of logistics! On large projects, therefore, we want to divide up the job of the logistician-administrator and make two separate posts. Establishing these posts is a matter of urgency!

→ What is the likely career progression for an administrator?

As far as possible, we hope to establish a career path for "first mission" administrators, offering them, to begin with, posts as field administrators before entrusting them with the role of Finance/HR coordinator.

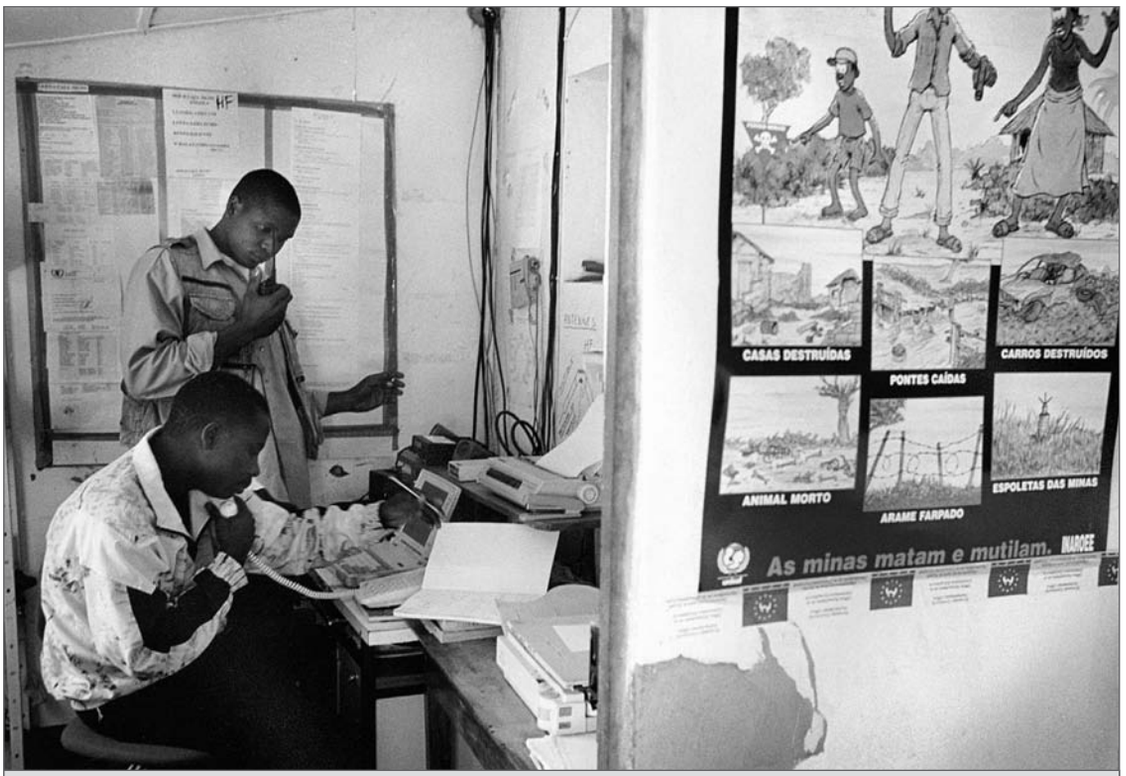
The experience gained in the field will give them a clearer understanding of MSF activities and let them acquire skills progressively, thus achieving the legitimacy needed on the coordination team.

Moreover, 79% of administrators who begin with a field mission undertake a second mission, (compared to 44% of those who begin by being based in a capital).

At the same time, training modules designed for these posts are being completely revised.

Having worked as a field administrator and a capital-based Finance/HR coordinator, someone could, if he or she wished, progress towards a post as project coordinator, for example. ■

Cécile Aujaleu, national staff coordinator and Chantal Mir, head of the field finance department



→ **Angola** © Alain Kazinierakis - July 2000

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messages

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