01/February-March 2008

MEDECINS SANS FRONTIERES

Sans frontières

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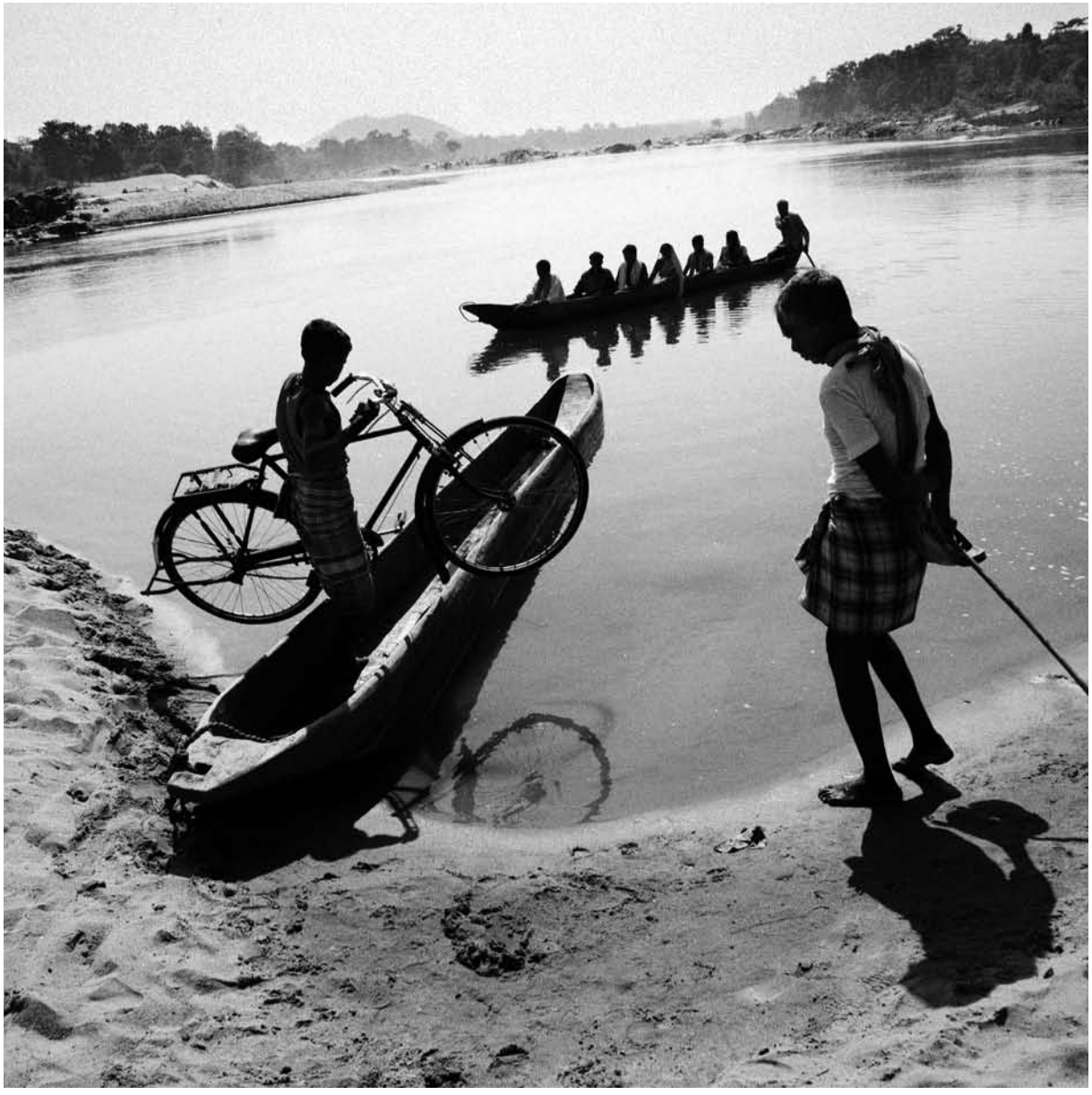

MOVEMENT ON INTERNATIONAL ISSUES

01 FEBRUARY-MARCH 2008

Sans frontières

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Cover photo
Inde 11/2007
© Kadir Van Lohuizen/NOOR

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EDITORIAL

By Dr Sinan Khaddaj
Director of Communications and Fundraising

"Sans Frontières" has replaced *Messages, to provide a new discussion forum for exchanging views focusing on our operations and humanitarian challenges. This new newsletter will open up its columns to a wider range of contributors, favouring a plurality of opinions relating to our activities.*

With this in mind, we have decided to start this first issue with a dossier on the international movement. The past year has been a difficult one. In addition to mounting tensions within the French section, other operational centres have encountered problems. As well as the inevitable questions about how matters are presented and exchanged, there are those posed about the substance of the issues themselves. Are our financial resources and the number of MSF branches sufficient to justify talk of growth? Does an improvement in the quality of our activities justify setting a limit on the number of projects? Can our human resources guarantee the necessary responsiveness in an emergency? For our operations to remain central to our priorities, each and every one of us must look closely at such questions. The associative structure of our movement is its strength; we must make sure that its size does not transform it into a weakness.

This issue is dedicated to the memory of Mohmed Bidhaan Ali, a Somalian driver, Damien Lehalle, a French logistician and Victor Okumu, a Kenyan surgeon. The three staff members of the Dutch section of Médecins Sans Frontières were killed in Kismayo, Somalia, on January 28th 2008.

Somalia

Up against our limits

After a 10-year absence, *MSF France is "relearning" the Somali situation. Some consider it a difficult, even impossible, setting for humanitarian work. For others, it is essential and a priority.*

Interview with Benoit Leduc
Programme manager for Somalia in New York.

By Guillaume Le Duc
19th December 2007

What are MSF's key challenges in Somalia today?

Hundreds of thousands of displaced people in 2007, the most violent fighting since the civil war began in 1991, fourteen peace plans in 16 years, virtually non-existent medical facilities and a series of military-humanitarian interventions with disastrous results – working in Somalia means confronting our limits as a humanitarian organization on multiple levels. The issue of security is, obviously, the most pressing. This is a critical discussion and the issue that prompted us to leave the country in 1997, after an MSF volunteer was killed in Baidoa.

In August 2006, we launched an initial evaluation mission in a political context that has changed radically since the Union of Islamic Courts took power. When the country went to war with Ethiopia in late 2006, the situation worsened. Two violent battles occurred in Mogadishu, one in spring 2007 and the other in the fall of that year. Those conditions posed difficult choices for MSF, including, for example, the presence of armed guards. In institutional terms, we had to deal with the problem of the organization's collective acceptance of risk. How far would we go to provide care? What mechanisms could we set up to reduce the risks?

The options included limiting the number of expatriates, limiting our movements, sending expatriates on an intermittent basis and maintaining a good network of contacts. We also faced issues in terms of human resources. In management positions, we need experienced people who can commit over the medium- to long-term, have a passion for this kind of setting and are excellent negotiators. This emergency coordinator profile is hard to come by.

We also had to adapt our operational methods as emergency workers. You can't set off with a full charter and get to work two days later. In Somalia, negotiations are often long and laborious. The smallest detail can pose problems. The slightest problem can become a source of insecurity. As a result, most expatriate evacuations are the result of simply not offering a candidate a position or of not choosing this or that car rental agency!

More generally, we are facing our limitations in terms of understanding the context. The operation of the clan system is complex and difficult to grasp. It would be reductionist to see all Somali relationships exclusively through the clan prism. An understanding of the situation is, therefore, key in our medical work. In the field, our teams have to know how to deal with political, clan, religious, geographic, financial and cultural barriers that can interfere with access to treatment.

In your view, and given these conditions, what justifies MSF's presence in Somalia?

Let's consider the lack of humanitarian actors. In Mogadishu, for example, apart from two hospitals that receive ICRC support, without expatriates, there is virtually no high-quality medical care. The fighting last March and April only worsened the situation. In Somalia, the international community stands out by its absence – or its inability to act.

Given this lack of assistance, the breadth of the needs is difficult to quantify in the absence of reliable data. However, MSF's significant presence is an indicator, though an imperfect one, of the terrible living conditions the population faces. Currently, MSF (all sections) is managing 14 projects, with more than 800 national staff and 60 expatriates and a budget of 20 million euros. In 2006, that translated into 300,000 consultations and 10,000 hospitalizations. Food security remains very fragile and every day, there are dozens of wounded in Mogadishu. Cholera is endemic and health conditions are poor. The number of displaced persons in Afgooye, where the Swiss section is working, is currently estimated at 200,000. Clearly, the standard criteria in terms of water, latrines, shelters and food are not being met. According to United Nations statistics – therefore, not necessarily reliable – the number of displaced persons in the country in 2007 totaled 850,000 - 1 million.

Given the nature of the situation and the absence of actors in this ongoing crisis, MSF has to be in Somalia. Mogadishu remains a city at war. We are doing war surgery. That seems to me to be the core of humanitarian work. Shouldn't we be asking, rather, Do we have a sufficient presence in Somalia?

direct

... FROM KENYA

By Filipe Ribeiro,
Emergency coordinator Kenya (MSF F)

Interviewed by
Julie Damond
22th January 2008

With the recent break out of violence in Nairobi, MSF has been treating several wounded in the slums of Mathare (MSF F) and Kibera (MSF B).
«The violence in Mathare started escalating on Friday 18th. The wounded we had treated up until then were above all victims of police violence. But over the past three days civilians have started forming into groups - inflicting indiscriminate violence with knives, machetes and even axes. In the facilities we have set up our teams have received seriously injured patients and have had to refer certain patients to reference hospitals. It is more and more complicated for our ambulance to circulate, but we can still reach all the neighbourhoods. The population knows MSF well, thanks to the Aids/Tuberculosis programme that we have been running for several years. Our teams have also carried out widespread information campaigns, including announcing two emergency telephone numbers. Because of the unrest the wounded cannot come to our centres. Our ambulance, the only one that can travel through the slums, goes out to pick up patients and take them to the necessary health facility.

With five sections in Somalia, a difficult context and five different sets of experiences, how does the intersection coordination work?

As long as the sections work on different projects and in different areas, there is no problem. Of course, the approaches may vary. But what is important is to have a presence in most regions. This presence in diverse locations also allows us to claim a certain impartiality, by explaining that we work with all clans in all regions. Five sections – that's even more human, financial and logistical resources.

Where intersectional issues pose huge problems is above all in the area of public communications. Positions are sometimes contradictory. To protect its area of involvement and ensure its security, one team in Mogadishu does not want to issue any communications. Another argument supports a systematic communications approach, even one that would involve speaking out in the way a human rights organization would. The incompatibility of these positions leads to an impasse. This raises the broader issue, for MSF, of speaking out in war contexts.

Does public communication protect us? They say that silence kills – yes, perhaps. But does communication treat the war-wounded? This is a discussion that should be carried out among sections, but also inside the French section. In Mogadishu, we face this dilemma: should we speak out at the risk of no longer being able to work? One thing is certain: for me, when a field team exposed to risk asks that we not speak publicly, their instructions take precedence.

1/ See August 2007 press release on www.msf.fr

direct

... FROM THE PALESTINIAN TERRITORIES

By Léon Salumu Luzunga
Medical coordinator recently returned from Gaza
Interviewed by
Isabelle Merny
10th January 2008

Following clashes between Palestinians in the Gaza Strip in spring 2007, MSF opened a project for post-operative care for the injured and has continued its mental health activities in Gaza and Nablus.
"The hospitals were overflowing and discharging patients too early. Post-operative care, dressings and physiotherapy were therefore not being carried out properly. MSF filled a gap by taking on more than 200 patients. The launch of an ICRC programme, which is complementary to ours (bolstering the capacities of health services and physiotherapy staff), should allow us to gradually withdraw."
"We are continuing our mental health programmes in Gaza and Nablus. Having finished my mission, I think this type of programme is still relevant in the Territories, but in the context of the permanent conflict and trauma which exist there, I wonder about the impact of these brief therapies, which are supposed to help people deal with an interminable situation. I think we should redefine the framework for our mental health activities in situations of permanent conflict and I am in favour of evaluating the impact of this type of work in these conditions."

Iraq
From Bagdad to Mosul

The media reports a decrease in the number of victims linked to the violence, but what is daily life like for Iraqi doctors now? We asked four colleagues present in Iraq[1] and collaborating with MSF's project to describe their working conditions in Bagdad and Mosul for us. Their impressions...

Interviews conducted on 1st December 2007 by Valérie Babize

Dr Ahmed[2] has been in Bagdad since the start of the conflict: *"Over the last six months patients have started to come to the hospitals again.*
The situation has improved. We use daily mortality figures to measure it. We've gone from an average of two hundred deaths a day to around five deaths a day in Iraq. A few months ago, two hundred wounded could arrive at the same time in Bagdad's main hospitals. This is no longer the case, and the emergency services are coping better with the situation.
Relatively speaking, the security has improved inside and outside the hospitals. The unofficial check-points have almost disappeared, and the military are more cooperative during inspections. Before, Iraqis would recite a verse of the Koran before going through, and could be killed or kidnapped just on showing their identity card. This hardly ever happens now, even if there are still some ghost check-points on the outskirts of town and in certain districts. Obviously, we're still not completely sheltered from targeted attacks. So even if our daily life has changed, the instability continues."

Shortages, despite this

Given the relative lull observed in Bagdad, factors that possibly explain past shortages cannot explain why they persist. Criticisms are starting to emerge.
"There is still a severe lack of medicines, doctors, anaesthetists and nurses", explains Dr Ahmed. *"When you hear hospitals asking you for soap or washing powder, you can imagine the scale of needs for other necessities. But security problems are no longer the only explanation for these shortages. Two weeks ago, a hospital director told me that the Health Minister had asked him to count exclusively on humanitarian organisations for his supplies.... But if the Ministry of Health cannot cover the supply of medicines in Iraq, no organisation can! The lack of specialists also remains a real issue, along with the shortage of sophisticated instruments or disposable materials.*
For elective surgery, patients who can afford it turn to private health care. But there is also a shortage of material in this sector, and emergencies are difficult to handle because capacity is limited."

Difficulties in practicing

Security problems are still an issue for doctors on-call in the hospitals. According to Dr Ahmed, *"Once night has fallen, most of the rare specialists that are still around return home and stay there until morning. Security is always fragile at night. The doctors on-call can be young interns or "resident doctors" but they find themselves having to handle emergencies alone, along with the nurses. Sometimes there is no doctor on-call at all. The nurses are doing a remarkable job, but if there's an explosion in such circumstances, who will take the medical decisions? What type of care will we provide the patients with? This is currently our biggest preoccupation: between nine in the morning and nightfall, five per cent of specialists are available for emergency response. Afterwards.... the medical body does its best, but the context is what it is. So medical decisions are postponed until the next day.*

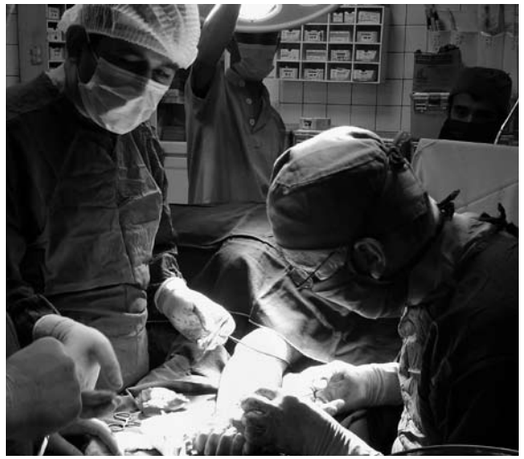
1/ The names of the Iraqi doctors have been changed. 2/ The Paris operational centre is running three projects for victims of the Iraqi conflict: in Amman (Jordan), in Iraqi Kurdistan and in Mehran (Iran)

Leaving Bagdad for Mosul

Dr Ahmed's observations in Bagdad differ to those of Dr Mounir, who left the capital to work in Mosul. Here, doctors deal with violence on a daily basis. *"I left Bagdad for the north of Iraq in February, because the situation there was too dangerous. We had got used to the daily explosions, but I was scared of being kidnapped because the roads were not safe. Then some months ago, the situation reversed. Last February Mosul was a safe town, but this is no longer the case. The insecurity is rising on a daily basis. We're going through a black period in terms of the number of explosions, murders and kidnappings. The director of one of the biggest hospitals in Mosul was recently kidnapped. Most of my colleagues have received direct threats, certain have chosen to live at the hospital to avoid having to travel around town. The presence of armed guards in front of the hospitals is reassuring, even if they're often asleep. There's no safe spot in Mosul. Few doctors accept contacts with foreign non-governmental organisations, and they're wary of their colleagues coming from Kurdistan. The tension is extreme, because many of them have been murdered."*

The exception of Kurdistan

People generally consider that Iraqi Kurdistan remains the solution for patients needing elective surgery. Dr Mounir confirms: *"Despite the tensions on the Turkish border and the threats hanging over the north, Kurdistan is still the safest place to be at the moment. The violence there is sporadic and far more health care is available. The general hospitals are well re-stocked. Nonetheless, experienced doctors work in the private sector. But this kind of health care is expensive.*
Like Dr Mounir, Dr Ahmed works in Bagdad and confirms this opinion, whilst pointing out that for those who do not have the possibility of reaching Kurdistan, the neighbouring countries provide the only solution.
"For the most complicated cases, the only chance of receiving treatment is abroad: Iran, Syria and Jordan, particularly for orthopaedic cases and cardiac or coronary problems." Meanwhile in Iraq the health care on



offer remains limited by the violence still raging on a daily basis. It is still better to head for the private sector for elective surgery, according to Dr Mohammed: *"Private health care remains the best solution for those without the resources to go abroad or reach Kurdistan. In the public sector, the waiting time varies between one and two months. In the private sector, there isn't one. But these hospitals also have to work with the means and competences available".*

6 views

WOUNDED FAMILIES

by V.B.

Hanane, a little girl of 4, was playing in front of her home in Mossoul when a mortar fell. Two and a half years later, her body still shows signs of damage from the explosion: stomach, shoulders, knee. Since the explosion, her father, a bricklayer, has accompanied her whilst her mother looks after her four brothers and sisters.
Treated in emergency, Hanane could not receive any elective surgery as it requires time and equipment that are currently unavailable in Iraq, because in addition to the shortage of specialists and means, it is often impossible to carry out long and complex interventions.
By delving into their savings, Hanane's parents put the family's only source of income on hold.
Her father took the difficult decision of leaving the country, juggling with his finances and the possibilities of health care offered by the different surgeons he met in Turkey, then Syria, before arriving in Amman, Jordan: "I cannot go back to Iraq until my daughter's body has been repaired". If our stay in Amman isn't enough, I'll go to the United States. In Iraq as soon as step outside death is lurking at every corner. We're just waiting for our turn, for the moment we'll be executed".
Outside the room, Hanane plays with Ahmed. Half of this little boy's face was ripped apart by shards from a bomb, during a suicide attack that took place just meters away from him in Bagdad. His father, who was also wounded during the explosion, no longer hides his distress. "The heads of families are weakened economically, and also have to accept that they are no longer able to offer physical or psychological protection to their families", explains Joséphine Antoine-Milhomme, MSF's psychologist. "I often see fathers going to pieces during my interviews."

MOVEMENT ON INTERNATIONAL ISSUES

FOREWORD

IN INTRODUCTION TO THIS DOSSIER, THE PRESIDENT OF THE INTERNATIONAL COUNCIL (IC)[1] DESCRIBES THE ORIENTATIONS OF THE MOVEMENT AND THE MEANS TO MANAGE ITS 'GROWTH'. WHAT DO WE MEAN BY 'GROWTH'? A LOGISTICS SUPERVISOR LOOKS AT THIS QUESTION THROUGH DATA COLLECTED FROM THE FRENCH SECTION. CLOSER COLLABORATION WITH THE SPANISH IS ENVISAGED, BUT HOW WILL THIS TAKE PLACE? THE GENERAL DIRECTOR OF BARCELONA EXPLAINS. ABSENT DURING THE LAST IC DISCUSSIONS, HAS THE HR SECTOR BEEN FORGOTTEN? NO, IS THE REPLY OF THE FIELD HR DIRECTOR IN PARIS. SHOULD WE OPEN NEW ENTITIES? THIS IS THE CONTROVERSIAL QUESTION THAT WE HAVE CHOSEN TO STUDY IN THIS DOSSIER?

Given the increase in operational expenses and the size of the MSF movement, the participants of *La Mancha* explicitly agreed to address the organisation of the movement's growth. Where are we in this process? What do we plan to do, and how? Here are some explanations from Dr Christophe Fournier, President of the International Council.

Interview with Dr Christophe Fournier,
President of the International Council

By O.F.

What are the main issues the International Council is working on at the moment?

Faced with the sharp increase in expenditure that we have difficulty "controlling", we decided to give ourselves the means to tighten our management of the movement's growth, and to optimise it. Using the premise that expenditure is legitimate if it responds to operational needs, we have agreed on the necessity for real operational accountability, allowing us to ensure that money is being spent as wisely as possible. Whilst we're not starting from scratch, there's nonetheless a lot of progress to be made in the operational centres and on an international level, where we're lacking an overall analysis. So we're trying to set up a mechanism allowing us to evaluate the quality of our assistance, and make comparisons between our operations.

We've also seen an increase in the number and size of our offices, despite the warnings delivered by Morton Rostup[2] in 2003, and without knowing if the resources required for our current and future operations were potentially available in the movement. We've concluded the following: if the increase in expenses corresponds to the requirements of a project or activity with proven qualities, we should give ourselves the means to respond by looking into whether the financial capacities exist already and by considering the best way to share out these funds.

**You mention the quality of our operations....
How can we improve the evaluation of quality?**

At present, a series of regular meetings allows the partner sections to be involved in the construction of the different operational projects. But we should now be trying to compare these five projects, using the existing international forums and without adding anything to the bureaucracy. It's possible, using the projects' typology. This exercise should include some concrete questions: what are we aiming for? What are our reference points? What impact are we aiming for? Can our projects be handed over? Etc. We would also like to evaluate a certain number of specific activities, with the aim of measuring the real effectiveness of our medical activities: we have already pinpointed AIDS, tuberculosis, nutrition, vaccination and hospital management for IPD, surgery and PMTCT as fields of study – we would like to know, for example, how many patients have been cured, the levels of comfort we

provide, how efficient we are in obtaining these results. We have at last begun the transversal evaluations of projects in Malawi and Angola. A third will begin in Myanmar soon. They are based on a simple idea: pinpointing comparable projects carried out by different sections in the same country in order to identify the most effective practices at the lowest cost, and to determine their pertinence according to the different contexts.

Doesn't the IC[3] also have a role to play in improving the management of operations?

This point has been raised by the Operational Directors, who share our questions concerning the efficiency of operations coordination on an executive level. We need to review the contexts of our intervention countries so we can form an opinion on the complimentary nature of our work when it involves several sections. You should bear in mind that in a third of the countries we work in, there are at least three sections present! There are also questions on how we should react in the case of an emergency. Over and above the coordination required between operational centres, we must aim to rationalise the means we use, as we tried to do during the intervention in Lebanon last year. To organise the work this involves between sections, the tasks could be divided up better: one section takes care of supply, another regional contacts, a third local purchase, etc. This would improve effectiveness and efficiency whilst reducing costs. Also, encouraging innovations to be shared throughout the movement allows us to learn from each other. Operational accountability, measuring the impact of our medical activities and common transversal evaluations should also help us in this respect.

Is this reduction in operational expenditure accompanied by an objective of increasing financial resources?

We asked all the fund raising managers to submit forecasts of their results up to 2011. We then compared all these figures with the sections' budgets, increasing them by 8%. Whilst this seems a lot – it corresponds to a two-fold increase in our expenditure in 8 years - it reflects the average annual increase in the cost of operations over the last decade. The Operations Directors were also asked to think about the following: what would happen if we continued our current operations, by improving their quality in terms of means, competences and efficiency with regards to the number of patients currently receiving case management? Their answer was clear: with this objective of "natural growth" alone, the expenditure would rise by 5% per year! So basing ourselves on an annual increase of 8% therefore seems reasonable.

Are you going to review the different partnerships between sections?

We have considered various different scenarios, with the aim of evaluating the capacity of each operational centre to raise the annual sum required to run its projects. If we stick to the current partnership model, which involves the allocation of money raised by partner sections to two distinct operational centres (in the hypothesis of distributing 70% of it to one centre and 30% to the other, in an attempt to respect the choices of the partner section), three of the five operational centres will continue to face a deficit each year. A third, fairer scenario has therefore been decided: whenever possible, it will attempt to respect the partner sections' choices but will also incorporate the notion of solidarity in order to balance the accounts of each of the five operational centres, whilst committing each section to paying 1% of its own resources into an international fund destined to promote operational innovation.

What about private institutional funds?

As we also aim to reduce these over time, we will look into the best way to manage such funds with the aim of providing a "security blanket" for our future. This is why we have created an *International Finance and Fundraising Commission* (IFC), which will help us to form a better idea of our fund raising capacities. This forum will identify those countries in which we could increase investment and obtain better returns – a necessary support when, generally speaking, a certain prudence or even conservatism still holds sway in MSF. Similarly, the IFC will help us to "drive" the new offices. It should be noted that its directives will continue to be submitted for approval by the boards of the headquarters concerned.

verbatim

Dr Christophe Fournier,
President of the International Council

AFTER OPERATIONS, THE STRUCTURE…

"We have decided to apply a maximum of 8% of growth per year, not just for operational expenditures but also for our headquarters' structural expenses. Yet these structural expenses currently reach 12%! There are definitely some economies of scale to be made on this level. We have to know how the headquarters and satellites are growing. We propose to draw up a comparison using ratios in terms of posts filled, performance, the size of this or that department, etc. Because there are serious questions on duplication, unnecessary expenditure or inefficiency. In addition, carrying out an evaluation on our potential to rationalise our operational support, in terms of human resources training, operational research, IT, private contracts (freight, the purchase of medicines, etc.) should lead to a considerable reduction of our structural costs. In the next 18 months, we have given ourselves the largely attainable objective of reducing these expenses by 1%, which represents six million euros."

THE ISSUE OF NEW ENTITIES

"Whilst we have a lot of data on the sharing of financial resources, this is not the case for the creation of new offices, which requires more in-depth discussion. At present we have a good overview of these new entities' intentions - their positioning, their financial and political strategies. But we are still at the propositions stage. The International Council will be able to decide whether these new entities should open or close, the nature and purpose of their main activities, and finally the distribution of the benefits they will provide. The ICB and the Excom[3] are now responsible for defining the criteria and categories required for their evaluation. These two forums will push parallel reflections on the direction the movement's structure should take over the next few years. Once evaluations have been carried out on existing offices, we will then decide on their future. But this will take some time because there are such diverse points of view on this issue. So we need common evaluation criteria in order to build up a good overview of the entire movement."

HR ON STANDBY

"In December 2007, the IC took an important step towards improving the distribution of our resources. Only financial resources have been involved so far, but it is already very satisfying to see that we can agree on such an issue, based on the principle of solidarity. The principles of real accountability for our operations and structural growth have also been drawn up and approved. This bodes well for the future, because there is still a great deal of work to do. Concerning human resources, we should soon be able to draw up forecasts, just as we did for financial resources. We are behind on this point, yet we need to evaluate our needs in terms of recruitment and loyalty building among coordinators and managers. All the MSF sections are keen to actively participate, but they need to decide on a method and the objectives to be set for the next few years."

1/ IC : Council is made up of the President of MSF International and the Presidents of the 19 sections. The ICB is the International Council's Board of Directors.
2/ Former President of the International Council, author of an article called " MSF and Unhealthy Growth ". 3/ Excom (Executive Committee) : is made up of the General Directors of all the operational sections and the movement's General Secretary.

THE GROWTH CRISIS

"Growth" is currently the subject of much debate throughout the MSF movement. François-Pierre Lemétayer takes a closer look at this fashionable word, using data collected from the French section.

By François-Pierre Lemétayer,
Logistics Supervisor

Everyone is talking about growth at MSF. A recent International Council meeting has just fixed a limit of 8% per year for the entire movement... But what "growth" are we talking about exactly? Financial growth.... Indeed, the figures we use to evaluate the development of our organisation are based on the variations of our annual budget. For the French section alone: just under 100 million euros in 2004, 150 million in 2007.... the figures speak for themselves, inviting our directors and boards to be more rigorous in their management, as well as adapting our various entities to this budget increase - which can be difficult to control.

Yet other indicators put this notion of growth into perspective. For example, here are some figures concerning the recent evolution of the French section.

- 31 intervention countries in 2004, 26 in 2007;
- 74 projects in 2004, 45 projects open in mid-December 2007;
- More than 445 volunteers in the field in July 2004, 371 on 17th December 2007;
- 350 vehicles at the end of 2004, 250 at the end of 2007;
- 6.800 tons dispatched by MSF Logistique in 2004, 2100 in 2007;
- 2.400,000 consultations in 2004, 2.000,000 in 2006;
- But.... 130 structural posts based in the Paris headquarters in 2004, 158 at present.

It is interesting to compare these recent indicators with others from the past. In 1994, for example, (intervention in the Great Lakes region), there were already 400 volunteers in the field, using 300 vehicles. These figures are not very different to those of today, but the budget at the time only stood at 450 million francs, i.e. 67 million euros.
We could multiply the indicators along with the periods under consideration: but nothing will reflect the state of our organisation or its development whilst there is such divergence in how to interpret them. It is true that the amount of our organisation's budget is without a doubt the easiest indicator to control, because it responds to strict norms, whatever the entity (project, section, the movement as a whole) or period in question. Yet should we be satisfied with using this indicator alone for characterising the development of the organisation, following the example of a multinational with a uniquely lucrative goal?
If the notion of growth relies – by definition – on "the increase of the principle characteristics of an overall entity's activity", the indicators of our field activities do not show any growth. At best they reveal stagnation, or even a reduction in the volume of such activities. It is true that the quality and cost of our work (norms in the case management of our patients, management of our personnel, for example) have increased, which partly explains the gap observed between financial and other factors. But does that justify using the term "growth"?

As for the development of the contexts we are working in, we need to ask ourselves some questions: are there more or less victims of conflicts, epidemics, natural disasters? In view of the growth (here, the use of the term is apt) in the number of organisations specialising in international aid, has our working space been curbed? If we want to talk about growth, shouldn't we re-consider our intervention criteria?

In the meantime, whilst certain indicators required to understand the development of the movement as a whole are still missing, talking about "growth" concerning the French section, when we actually have the impression of doing less, hardly strikes me as appropriate.

TOWARDS A NEW MODEL?

MSF Spain – Greece is the only section which has not created partner sections or opened MSF offices around the world. Following three years of strong operational growth, the Barcelona-Athens operational centre is proposing a stronger collaboration with the Paris group. Aitor Zabalgogeazkoa the general director of the Spanish section, explains why.

Interview with Aitor Zabalgogeazkoa,
General Director of the the Spanish section.

By Kate De Rivero

Why the need for a greater collaboration with the French section?

We approached Paris to see how we could optimise resources, but for now neither of us has a concrete proposal on how this will be articulated. We want to take a pragmatic approach, and propose projects according to needs, such as strengthening the capacity of MSF Logistique, or improving our daily work with Epicentre. Concerning operations, the interest is to look at the different ways we have of doing things and to capitalise on them. For instance, while there has been a tendency in MSF to close projects working on neglected diseases, Barcelona-Athens keeps some of these projects open and continues to treat patients suffering from these diseases; on the other hand Paris has opened trauma centres, which we haven't. Look at the earthquake in Peru, Paris decided to leave while we stayed on. We can lay our differences on the table and discuss them so that both operational centres learn something. We can share human resources to improve our response to emergencies. It is about a change in our day to day work with each other, but our operational centres would still remain independent from one another.

Can you expand on what you want to do with MSF Logistique and Epicentre?

We want to be involved in the development of MSF Logistique. Right now in Bordeaux they need more physical space, and are also looking into opening up in Dubai. Unless there is a greater development of MSF Logistique they will not have the capacity to meet our supply needs. Both the operational centres in Barcelona and Geneva have grown rapidly these past few years. So this is not just up to MSF France, other sections must take responsibility too. This is a priority for us.

We also want a closer working relationship with Epicentre, particularly to improve the gathering and analysis of medical data. Both Brussels and Geneva have regularly been more involved with Epicentre, while we have only asked for their services on a punctual basis. Our medical coordinators don't realise they have unique epidemiological expertise at their disposal. Epicentre has developed an experience we shouldn't and cannot replicate, so we should not work in isolation.

Were financial reasons important in deciding to collaborate with the Paris operational centre?

We see this group as the most international of the operational centres, and we could exchange much with the USA, Australian and Japanese sections. Also, when I asked our heads of mission which section they had most difficulties coordinating with on the field, most of them replied that it was MSF France. So this was a great opportunity to exchange the different ways we have of doing things, to take a closer look at the negative and positive aspects of our operations, and to expose ourselves to other ways of functioning. On the financial side there is the resolution of the International Council meeting in December which paves the way. We can have a more predictable, stable financial relationship with MSF USA and Japan.

What led you to take this initiative?

The financial aspect has received most attention, but it is really due to a series of factors. On the one hand we have *La Mancha,* the tsunami, and then a new cycle started in our office with the nomination of a new board, a new management team and general director. We did a critical review of our operations and it became clear that we were lacking certain capacities needed to improve our operations. We had to find new resources, either creating them internally or finding them externally. We decided to capitalise on existing resources within the MSF movement, rather than creating new ones in Barcelona.

What were the effects of the Tsunami?

Following the Tsunami, there was a huge increase in non-earmarked funds. We wanted to completely stop institutional funding, but this view was not shared by most of the sections in the movement, so we changed our position in order to reach an agreement. The amount of funds we received through the international movement doubled in 2005 and 2006. This allowed us to increase our operations, which grew not only in volume but also in complexity. However, the increased funding from the movement also limited possibilities to search for our own resources. In 2007 we found ourselves with a greater operational volume, but with a decrease in contributions from the movement. Compared to other sections, we don't have the fundraising capacity to fill in this gap, and need to find a stable solution in a short time. The problems were also felt on the field, where we had many people with little experience, leading to a difficulty in taking greater responsibilities, difficulties in building teams and we could see the impact on the quality of our operations.

Do you think this can have an impact on how the movement works on an international level?

Of course! To begin with La Manch is making us do things differently on an international level, seeking new partnerships, giving great importance to the international movement. We do not aspire to become a part of the Paris group, but rather to overcome the "group" logic. This may provide an interesting model on how to work on the international level. There are positive examples, such as MSF Holland who has searched for ways to grow outside of Amsterdam, and this year reports zero growth for the Dutch office. We also want to maintain a lighter structure in Barcelona, benefiting and contributing to the capacities which already exist outside, rather than"re-inventing the wheel".

HUMAN RESOURCES
PRIORITIES FOR THE NEAR FUTURE

Rarely discussed in international forums until now, the management of human resources is still a thorny subject throughout the movement. Director of HR in Paris, Loïck Barriquand refers to observations made in his own department to touch on objectives shared with other sections.

By Loïck Barriquand
Director of Field Human Resources for the French section
Collected by O.F.

The two major priorities are, in my opinion, teams composition and loyalty building (or retention). It is not only the Paris' operational group that is concerned by these issue, the entire movement is working on these points. The question of national personnel seems a good way to open up the discussion on team composition. When we look at the types of posts currently open in the field, we can see that national personnel still rarely occupy "coordinator" posts (between 10 and 15%), but they have been appointed to a third of the "activity managers" posts over the last two years, which signifies real progress for our operations. Around 90% of "supervisor/consultant doctor" posts and almost all the "skilled or non-skilled" posts are occupied by national personnel. We can draw several conclusions from this.

Widen the base

With 150 coordinators and 250 activity managers, MSF has too many Chiefs and not enough Indians. As coordinators should have wide field experience, these 250 posts are insufficient, but can be explained by the low average of projects per coordination team (1.7). It would be better to have more but our lack of "Indians" does not allow us to open new projects! We are particularly short of first mission posts (FM). In the operational centre in Paris, the number of international FMs has dropped over the last three years. 385 FMs left for the field in 2004, as opposed to 253 in 2007. We have lost 30% this year alone! The problem is that FMs start their career paths directly on an activity manager post, simply because they are expatriates. After several fruitless attempts at resolving this problem, the only solution with a chance of having a wide-spread and rapid impact consists of positioning our new recruits one level lower, meaning on "supervisors/consultant doctors" posts or as a nurse in a department (like in Amman) – posts which were almost exclusively occupied by national personnel until now.
This will allow us to offer more accessible posts, reduce the pressure on technical skills and re-open the door to younger people who are ready to commit to several years with us. Freed up from the obligation to open up FM posts at activity manager level at all cost, these posts can be attributed to national or international personnel in accordance with the competences required.

Two other objectives

To improve team composition, we also need to increase the number of national personnel occupying coordination posts. They currently occupy the posts of deputy – which are few in number – and there are only three national project coordinators (ex field coordinator), three experiences that have nonetheless been positive in Chechnya, Armenia and Darfur. It should be noted that in the latter, a particularly difficult and symbolic context where we would normally imagine that a national would be more exposed than a foreigner, it's the field team who took the initiative of taking this step, and it's been a success. We also have a tendency to underestimate the workload inherent in these coordination and activity manager posts.
We do not organise ourselves in such a way to cover absences for training, leave or exploratory missions (amounting to two to three foreseeable absences per year and per post) which is why we often curb training possibilities whilst at the same time complain of a deficit of competences. In addition, the work loads involved are often considerable and the people concerned are constantly having to review their priorities and abandon part of their objectives or tasks. This generates frustration, fatigue and finally de-motivation. So we need to find solutions to be able to replace everyone (even if only partially). Although this is an easy remark to make, putting it into practice is less straight forward, and involves a simultaneous review of all the coordination/management posts in a given project.

The issue of loyalty building

Improving individual follow up involves proposing a career path adapted to each person's wishes and competences, but this means we need to know about them. Whilst the operational centre in Brussels and the partner sections are ahead of us on this, all the sections are setting up individual follow up by pool. We are going to extend this follow up to all the coordinators and activity managers, with a reference person for each profession and a single contact point within the HR department. It's a little revolution in our way of working which should allow us to meet many expectations.
The other point for improvement concerns guidance, managing a team and accompanying people. The entire movement shares the observation of recurrent criticisms and dissatisfaction expressed by all our field personnel: overly intrusive management or a lack of support and a lack of participation in discussions. Yet, like defining objectives and implementing projects, guiding and managing a team and training by accompanying individuals should form part of coordinators' and desk teams' priorities. Let's take the example of sanctions: it is unacceptable that we can still sanction and sometimes dismiss someone without giving him/her clear and written reasons for this decision and a chance to explain his/her side of events and respond to the criticisms in question. We really need to insist about these issues, because certain of our coordinators and managers take no interest in them. Accompanying people should be at the centre of our preoccupations in this domain. The French section's Board supports the need to insist on taking on such responsibilities. Let's hope the International Council follows suit.

New entities?

From now on it is the International Council who will decide where and when to open a new MSF office. Opinions often differ. Below, the Swiss section argues for the creation of three new branches: the French section, however, thinks that things could be done otherwise.

By Christian Captier
General Director of the Swiss section

“The *La Mancha* process allowed us to take an important collective step in 2006 in the consolidation of the MSF movement. It should nonetheless be noted that the notion of groups (OCB, OCA, etc.) around which the daily support and organisation of operations is organised was missing, whilst in reality MSF is increasingly articulated around these groups, be they small or large, which conceive and coordinate operations in the field. Fortunately this mindset does not hold complete sway over MSF, and the international vision and impetus of *La Mancha* endures. As is the case in other operational centres, the operations run from Geneva over the past few years have overtaken the Swiss section’s capacity to support them alone. Whist continuing our commitment on an international level to increasing critical discussion, mutualising operations and improving the sharing of resources (human and financial), we have developed a partnership centred on our operational project with MSF Austria, then Germany, Australia, the United States and Canada. The creation of the Operational Centre of Geneva stems from this dynamic and the undertakings set up with these partners. Despite the recent developments in terms of sharing resources on an international level, it seems necessary to us, in order to consolidate and improve our operations on the medium and long term, to open up, like others have done before us, “new entities”. By doing so, we are investing in the recruitment of human resources with specific profiles, developing sources of regional support and reinforcing our operations in Central American and the Middle East. In the longer term, these entities could generate private funds, become full-blown partners of the OCG and contribute, through their reflections and diversity, to the movement as a whole. We are both making an investment and taking a bet. MSF Switzerland is sometimes criticised for not taking risks in investing in the development of its operations and the movement. Yet this is what we are currently doing, through our investment in the supply domain with MSF Logistique, epidemiology with Epicentre, or our operational and medical collaboration developed with several sections (e.g. nutrition with MSF UK or violence with MSF Canada) and externally through our new offices (Mexico, Turkey and Czechoslovakia). The development of any new entity now depends on the IC and this is an essential step forward, however it is also up to the International Council to ensure that the sharing of resources, in the widest sense of the term, takes place in the best and most reliable way possible. We are a willing and active party in the process, whilst investing with our partners to improve our operational capacity and continue to provide assistance to populations in the spirit of *La Mancha*.”

By Marc Sauvagnac
Deputy General Director of the French section

“After a difficult start, focusing too much on questions of structure and the technical and financial processes of resource sharing, the latest international agreements are laying the foundations for improved coordination of operational practices whilst preserving the diversity of standpoints within MSF. What we are now talking about is a common desire to improve operations, to promote innovation, to achieve better coordination for tackling the challenges we face, to compare achievements in order to build on successes and to rationalize expenditure. This consultative process has been drawn up under the heading of “accountability”, undoubtedly much too narrow a term. The combining of accounts at international level has revealed where we get our money from, where it goes and what is transferred between sections. We are now at the next stage where we have a better grasp of what lies behind the figures and can check whether our achievements match the orientation of our operations decided on at the start of the year, check whether medicine as we practise it meets our objectives and check whether the means we employ are consistent and rational. This stage is in itself essential to our operations, but it is also crucial for directing international development towards action, something which is not always obvious in a group comprising 19 organisations and involving 25 000 people. Recent years have seen new branches flourish in Argentina, Brazil, China, the Czech Republic, India, Ireland, Mexico and South Africa, opened in the form of delegate-offices and justified by the recruitment of international staff (even though only 10 % of the initial candidates are accepted to be sent on mission) and by the raising of funds from private sources. We are familiar with the history of delegate-offices: almost all those created at the beginning of the 1990s went on to become sections in 1997. But do we want a movement made up of 25 or 30 sections? Can we go ahead and mobilize experienced managerial staff when we already have difficulty in securing their continued loyalty to lead and support missions? At the same time we must engage in promoting the dissemination of ideas and innovation. The movement has weighed up these challenges and that is why the International Council will from now on be deciding where and when new offices open.We are now also able to respond in other ways to questions posed by fundraising – by better collaboration between sections and, as a result, by investing in those which have not sufficiently exploited their fundraising potential in the past. Resource sharing between sections – whether financial, medical or logistical – is possible if a common perspective already exists concerning the orientation of operations and the critical appraisal of achievements. Closer relations developing in this direction between Paris and Barcelona are envisaged. Let us hope that this form of development can become more widespread within the movement.”

AIDS

Target date: 08/08/08

The date is a bit of a gimmick but, nevertheless, it is the target set by the University of Cambridge for perfecting a rapid viral load test aimed at patients suffering from AIDS. Launched in 2005, the Samba Project is therefore close to a hopefully successful conclusion. An interview with the medical department's Dr Elisabeth Szumilin.

Interview with Dr Elisabeth Szumilin,
Medical department, MSF France
By O.F.

Can you briefly describe how MSF became involved in this project?

At a conference a few years ago, we met Dr Helen Lee of the University of Cambridge who at the time was looking for funding partners in order to develop a tool for detecting viral loads in AIDS patients living in precarious conditions. We quickly became interested in the project but the requirements of the Campaign for Access to Essential Medicines, in terms of technology and patent transfer, were such that Dr Lee preferred to look for support elsewhere. It should be noted that the Cambridge team is working with an American company, Diagnostics for the real world, whose aim is to produce tests at the lowest possible cost for the least well-off countries. The profit margin on the sale of these tests – at an estimated price of 8 dollars per unit – should be quite reasonable, a far cry from the profits made by the pharmaceutical industry.

"This test will also simplify the evaluation of our programmes and help improve the follow up of patients within our target populations after one or more years of treatment."

In addition, the test draws on molecular biology and the technology transfer is not straightforward. Given these factors, we considered it was worth following this project closely and we welcomed the request from Cambridge epidemiologists to carry out tool validation trials in our field missions.

What are the principles and applications of this test?

It involves a semi-quantitative rapid viral load test. In January 2006, we organized an expert round-table discussion to select two viral detection thresholds. The test will make it possible to spot patients undergoing treatment whose viral load is below 400 copies of RNA per millilitre – in whom virus replication remains low – and those whose reading is above 10,000, a sign of the development of drug resistance. It is important to detect any treatment failure promptly to avoid a build-up of viral mutations which make second-line treatments less effective. This test will also simplify the evaluation of our programmes and help improve the follow up of patients within our target populations after one or more years of treatment. The test will also facilitate diagnosis in children who very quickly develop viral loads well above 10,000 copies of RNA. We should therefore be able to extend the test rapidly across our mother-to-child transmission programmes.

Are there still improvements to be made before using this new tool?

The project is currently still in its development phase and we have been approached to test the handling of a prototype in order to improve its use. As such, there are still unanswered questions about staff training too. Then it will be a matter of validating the test by comparing it with lengthier and more demanding traditional forms of testing. And lastly, there is another considerable issue facing Dr Lee and her team: so far, the extraction of the virus from a patient's blood still requires human intervention, which requires time and qualified resources.

Until a solution to this is found, the test can only be used in district hospitals given that health centres do not have the necessary resources to handle this test. Nonetheless, the arrival of such a tool remains a real advance in facilitating the case management of AIDS patients.

Protection: slippery ground

Judith Soussan has just completed a study on protection that will soon appear in the series Cahiers du Crash. It is not without humour that she introduces her subject with an excerpt from the 1992 annual report. "If you want to bury a subject, write a 30-pages report on it. You can rest assured it'll be deliberately ignored for the next ten years."

Interview with
Judith Soussan
Crash project coordinator

By O.F.

Still, an odd introduction...

It's just a way to implicitly call attention to the conflicting expectations surrounding the study – between those who reject the idea that MSF has a responsibility concerning protection and consider the question settled, and those who believe we do have a role to play in terms of denunciation or témoignage*, or on behalf of people facing a specific threat. These conflicting expectations illustrate the problems inherent in the ambiguity of the word itself; because it holds so many meanings and is widely used, the notion of protection ends up being regularly invoked or rejected at MSF without our ever being sure what we're really talking about (*témoignage-*alert-denunciation? international military intervention? medico-legal certificates? political lobbying? evacuation of a person under threat? etc.).*

With this in mind, I opted for a strategy of circumvention; rather than asking "What are our responsibilities as regards protection?" I asked "What does MSF say and do in the face of violence, and how has this changed over time?" From this viewpoint, I have delineated three periods – which I call the witness era, the call to account era, and the disillusionment era – three overlapping phases related to the political environment and contexts of our missions.

How do you define these three periods?

The witness era goes from the beginning of MSF to the end of the 1980s. This is paradoxical, as directly witnessing violence during this period was rare. MSF was operating in a bipolar world, where many conflict zones were inaccessible to humanitarian organizations. Yet this was the time when MSF formed its identity as a witness – its birth, in fact, is described as a break with the ICRC over the latter's 'complicit silence' during World War II. This was when the notion of témoignage emerged, and the idea that by its very presence, MSF declares its solidarity with a population and can serve as an inconvenient witness to armed aggressors or oppressive regimes. What characterized this period, in short, was recourse to now-abandoned references such as human rights, violations of the rights of peoples, etc., which placed MSF in the anti-totalitarian camp. The fall of the Berlin wall marked, for MSF, the start of the call to account era. Once many countries at war became accessible, new actors began to crowd the humanitarian field – the UN with its peacekeeping forces and protection for humanitarian relief operations, state humanitarianism and its notion of the right of intervention, etc. During the crises of the early 1990s, MSF alternated between denouncing the hidden political agendas behind state humanitarianism, as in Somalia, and the abdication of political responsibility hiding behind the "humanitarian alibi," as in Bosnia and Rwanda. In the first, the intervention claimed to protect civilians but caused more death, and in the second, the international community went all-out to provide aid when what was really needed was firm intervention to protect populations. Going from hope to disillusionment, MSF recognized – within the space of a few years and with so many crises one after the other – its inability either to get protection of populations onto the agenda of the less-than-resolute international community, or to prevent the unbridled killing in Rwanda, Srebrenica or eastern Zaire. At MSF, the notion of protection took a serious blow...

You emphasize, in your report, that that was when the "emergency services" approach first emerged.

The failed attempts to elicit the desired response from the international community led MSF to become more realistic about its appeals to the outside. It continued, of course, to invoke the notion of protection in order to decry the very lack of it. But on the whole, since the late 1990s the

strategy of calling political actors to account has become progressively less self-evident, and this trend has only intensified with the new interventionism of the "war on terror" or "in the name of protection," from which MSF is constantly trying to distance itself.

"the constant insistence that MSF "doesn't do protection" might contribute to the idea that the issue is settled"

During crises, our priority became focusing our responsibilities on our own relief operations. This being the case, violence is increasingly approached as a medical/operational issue, as illustrated by the emphasis in recent years on treating the victims of violence. The change in how we are speaking out is further evidence of this, with press releases that are increasingly focused on our own relief operations and factors that endanger them. But again, what I'm describing are trends, not rules.

Beyond the study, what is your feeling about these changes in how we speak out?

I think – and I hope – that if a situation of massive, deliberate, systematic violence presented itself today, we wouldn't hesitate to speak out, even if our ability to bring help was not at stake. I'm not worried about that. But more generally, it seems to me that the "emergency services" image is starting to become an "MSF identity." There is a risk that if that role becomes too inflexible, so will the boundaries between what falls within our sphere of responsibility and what doesn't. And the constant insistence that MSF "doesn't do protection" might contribute to the idea that the issue is settled. But the study of MSF practices over time reveals, firstly, that we are constantly concerned with the fate of individuals over and above their medical care, and insist on not endangering them by our actions. Secondly, it is undeniable that today – in our programmes for treating individual victims of violence, in particular – the issue of going beyond medical care comes up on a regular basis. So what we thought our realism had chased out the door, reality is sending right back in the window.

verbatim

By Judith Soussan
Crash project coordinator

BEFORE AND AFTER ETHIOPIA

"There's another conceptual timeframe for the history of protection at MSF, based our own experience – in particular, the 1985 famine in Ethiopia. Time, for MSF, is divided into before and after Ethiopia. To greatly oversimplify, prior to 1985 MSF saw itself as having a responsibility "to the world", during war, and it was in the belief that it was doing good that it came to the aid of populations and occasionally spoke on their behalf. The 1985 crisis in Ethiopia turned this belief on its head. When the relief effort was used to attract people for forced transfer, we realized that our actions were not automatically beneficial. It was at that moment that the question of our complicity came to light, and with it the need to take a critical look at our own actions. From then on, the question of our role in the violence process has been at the heart of our thinking. Taking responsibility for our own actions and "doing no harm" have been constant requirements since 1985."

Malnutrition

Niger 2005, une catastrophe si naturelle

Under the supervision of
Xavier Crombé and Jean-Hervé Jézéquel

Collection
Les terrains du siècle

Published by: Editions
Karthala
Médecins Sans Frontières

296 pages / October 2007
24 euros (Europe)
Special price for Africa

An initiative of Médecins Sans Frontières, this collective work brings together researchers, consultants and practitioners of humanitarian action who propose different interpretations of the Niger crisis and the issues involved. A common conviction emerges: the death each year of tens of thousands of children, along with the pauperization and marginalization of a growing number of Nigeriens, are not natural phenomena. Still less are they inevitable.

Interview with Xavier Crombé and Jean-Hervé Jézéquel
respectively research director at the MSF Foundation and teacher at Emory University

By O.F.

How did the idea for this book come about?

Xavier Crombé: In 2005, Médecins Sans Frontières conducted the largest emergency nutritional operation in its history, in a nation at peace, far from the usual setting of its conflict-related interventions. As a reminder, the French section alone of MSF treated 40,000 children there and carried out free food distributions. Moreover, this crisis was the subject of numerous disputes, first about the reality of the situation, then its extent, and finally about its determining factors: was it a food or nutritional crisis, chronic or temporary, etc.? For us – and this is the starting point of the book- these debates have shaped the crises more than its so – called " natural " causes have. Each participant had a different interpretation, resulting in divergent response strategies. It was the tensions between these many viewpoints that created the exceptional nature of this crisis. Consequently, we felt it would be interesting to give it serious thought, not only to draw operational lessons from the experience, but also, and beyond that, to grasp the issues involved and share them with other actors in order to spark a long-term, far-reaching debate.

What are the main disagreements about how to qualify the crisis?

Jean-Hervé Jézéquel: For more than twenty years there has been a consensus on the mechanism of food security, essentially based on respect of market rules. As a partner in this mechanism, the State of Niger produced its own analysis, explained by Mamoudou Gazibo in his contribution. In Niger, the controversy first concerned semantics, i.e. the validity of the word "famine". The Niger government was reluctant to acknowledge the extent of the catastrophe, while insisting on the vagaries of nature and exploitation of the situation by the political opposition and certain outside actors... MSF also brought its own view, that of a major nutritional crisis identified by its teams in the field... This observation led MSF to denounce the inadequacy of the aid system in response to this situation. The confrontation between these different analyses, diffused by the international media, finally shattered the consensus. This allowed the organization of free food distributions and beyond that, led to the question of nutrition being taken into account in food security policies. That undoubtedly provides the basis for a new consensus, but the scope and permanence of the changes remain uncertain.

Doesn't a consensus risk bringing only minimum change?

Jean-Hervé Jézéquel: That is one of the questions raised by this book. By emphasizing the nutritional aspect – after all a victory for MSF – do we not run the risk of closing the door to more comprehensive reform? It is not MSF's role to answer this question. On the other hand, we thought it was important that the stakes involved in this debate be presented in the book. In their respective contributions, Kent Glenzer and Benedetta Rossi question the likelihood of significant changes in Niger, so long as the aid system does not allow victims to become political actors who can exercise their rights. For Benedetta Rossi in particular, it is precisely the debates opposing the development aid approach and the emergency approach that prevent this transformation. We agree with them that aid actors must be aware of these limitations. However, it is also this confrontation of interpretations that brings about policy change in that up to that point, anything was considered preferable to free food distributions.

The book also questions a number of preconceived ideas often brought up during the crisis: poor maternal behavior, for example.

Xavier Crombé: That's what the malnutrition prevention programs were implying: that the situation can be improved by changing the behavior of mothers. The cultural origin of malnutrition was a major argument against providing medical care for sick children. It seemed to us that in this approach, the question of whether the women had the financial capacity to obtain the recommended foods for their children was not considered. During the crisis, MSF defended the argument that malnutrition is first of all a problem of access to both medical care and to foods suitable for young children. Barbara Cooper tackles these questions and deconstructs the discourse that makes mothers the "scapegoats" of the Niger crisis. However, she goes further by stressing the importance of the social environment in which MSF intervenes: not enough thought is given to integrating the complexity of the choices confronting these rural women in their roles as daughters, wives or mothers. In parallel, Marthe Diarra and Marie Monimart look at the deterioration of women's status in terms of access to natural resources and property. "The defeminization of agriculture in South Niger" – the title of their chapter – implies a feminization of poverty in all its dimensions, cultural, economic, and consequently, nutritional...

Doesn't the MSF intervention in Niger also raise questions about the way it cooperates with other aid actors?

Jean-Hervé Jézéquel: The discourse advocating the need for better coordination between aid actors is spreading more and more. Very often, intervening parties are asked to work in a positive dynamic of active collaboration, allowing all concerned to work in the same direction. However, it seems to us that the 2005 crisis is particularly revealing of errors arising from this approach. Evidently, it is useful for aid actors to cooperate, but that should not become an end in itself. That is what happened in Niger, where the previous consensus allowed for no revision of the aid system. It would not have been possible to create an adapted response to malnutrition or to carry out free food distributions. In other words, without disagreement, there is no change, no reappraisal or challenging of measures currently applied. Therefore, it seems to us that debate must come before talk of collaboration. One of the lessons of the crisis is that discussions and disagreements are sometimes vital and it is in this spirit that we have produced this book.

For MSF, what are the lessons to be drawn from such a crisis?

Xavier Crombé: Since 2001, MSF has been asking itself whether or not it should provide a long-term malnutrition programs. Is it not a question of poverty and development? By applying emergency criteria, are we not neglecting the crisis in its cultural, economic and social aspects? For some of us, MSF could not act on these aspects. The crisis of 2005 has no doubt contributed to making us change certain of our views on these questions. It convinced us to place malnutrition among the public health issues in which a humanitarian actor can be influential- as for AIDS some years ago. It is the issue discussed in the last part of the book, entitled "faire vivre": for Isabelle Defourny, ready-to-use foods offer humanitarian actors the means to realize new ambitions, especially those linked to lowering the overall mortality of a population by distributing food to all children under the age of three as a "prevention" measure. There remains a question raised by André Briend in the last chapter: in terms of costs, is the operational method used by MSF in a few districts in Niger easily replicable on the national and perhaps even the international scale? In the postscript of this book, the president of MSF tries to be optimistic: on the basis of experience with Expanded Program on Immunization (EPI) he estimates that a reduction in the cost of ready-to-use foods is just as conceivable as in the case of vaccines.

01

First issue, first dilemmas... How to approach the subject of Somalia when we are divided between apprehension over the risks run by our teams and the conviction that we must go wherever needed? Despite the recent kidnapping and subsequent release of two Spanish section volunteers in Bossaso, we initially titled the article 'raison d'être and the reason for being there'. When finalising the issue we learned that three staff members of the Dutch section had been killed in Kismayo, southern Somalia. We decided to change the title of the article.

Looking at our activities in Iraq posed a further **dilemma**. Working on the fringes of the conflict, our projects are struggling to position themselves operationally. First we wanted to give our Iraqi medical colleagues the chance to speak, to describe working conditions in the hospitals and provide us with a view of the situation in Iraq as they see it. The operational approach of these projects will addressed in a future issue.

Choosing the theme and content of 'the dossier' posed another **dilemma**, soon dispelled by the intention to open up the newsletter internationally and to expose current debates. Does the result match up to the expectations? We didn't succeed in 'shaking up' all our contributors or bringing to light certain differences of opinion or issues put on hold. On the other hand, differences between sections are perhaps receding in favour of an increasing, overall willingness to make progress. The next issue will look into how the role of communication is perceived.

Another, more trivial, **dilemma** is what to call our operational centre in a movement combining sections, partnerships and various other bodies. Even though the organisation is already collapsing under the weight of acronyms, it is nevertheless difficult to avoid the "COP" tag – Centre opérationnel de Paris (Paris Operational Centre) –, somewhat unfortunate… **O.F.**

1/ DOSSIER L'INTERNATIONAL EN MOUVEMENT
Bangladesh 11/2007 © Veronique Terrasse/MSF

2/ 3/ 4/ EN DIRECT
Somalia 2007 © Guillaume Le Duc/MSF

5/ À VOIR, À LIRE
Niger 2005 © Henk Braam

6/ EN DIRECT
Palestinian Authority 2002 © Heidi Holzer