messages

→ N°136 / May 2005 / Médecins Sans Frontières' newsletter www.msf.fr

DOSSIER

THE INTERNATIONAL MOVEMENT: HOW MANY DIVISIONS DOES MSF HAVE?

DEBATES

MISSIONS

INFOS

RESOURCES

→ **Rwanda** © Roger Job - July 1994

→ **Sudan-Darfur** © Carole Payrissat - December 2004

→ **Amsterdam** © Peter Boer - March 2003

THE INTERNATIONAL MOVEMENT

How many divisions does MSF have?

MSF/ April 2005/ Interview by Bénédicte Jeannerod/ translated by Melanie Stallard

How is the international movement doing? Jean-Hervé Bradol, president of MSF's French section, discusses recent events and the differences between sections – underlining the issues at stake and ways of strengthening the construction of the movement.

→ What assessment would you make of the international movement in 2004?

To answer that question, we must first look at the facts. 2004 was the year that the Greek section was reintegrated, which shows that despite some people's fears of a scission, the movement is becoming stronger rather than weaker. Essential dossiers are also starting to give interesting results, such as the DNDI, the remuneration study and the decentralisation of operations in the partner sections for example.

→ The management of Arjan Erkel's kidnapping however caused a very major crisis. Some even spoke of the risk of a scission.

That was a completely imaginary risk! The Arjan Erkel affair was not the sign of a crisis in the international institutions, quite the contrary. With a little hindsight, we can see that the Dutch section finally came up against opposition from all the others when it wanted to give in to the Dutch government. In the end this was the position adopted by the whole of the movement. Intense

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Perceptions influenced by national specificities and the reflex to protect the institution inevitably create resistances. These resistances regularly come up in debates within the international movement and are particularly manifest in the reluctance to confront authorities, favouring diplomacy over an active political stance. From the Ethiopian crisis through to the tsunami in Asia, MSF's history serves as a reminder that, paradoxically, our independence and 'strict' interpretation of humanitarian action can only exist, resist and endure by publicly speaking out as perceptibly as possible and by dealing with the political dimension of tensions that arise. However, strengthening a concept like this cannot work without an organization that is capable of carrying it through. The international movement must ensure that MSF does not let national allegiances taint its fundamental principles.

DOSSIER

How many divisions does MSF have?

→ **Preamble**

This dossier was chosen to reflect the current and future debates on the identity and organisation of the international movement. Many people were contacted, but not everybody chose to reply to our questions.
This issue does not therefore contain all the different points of views that exist on these questions. If any readers would like to comment on the articles published here, please feel free to contact us.

→ **19 sections, 5 operational centres (in red):**

- Germany
- Australia
- Austria
- **Belgium**
- Canada
- Denmark
- **Spain**
- United States
- **France**
- Greece
- Hong-Kong)
- Italy
- Japan
- Luxemburg
- Norway
- **Holland**
- United Kingdom
- Sweden
- **Switzerland**

debates are held in MSF, even very heated conflicts, but I really believe that that shows the movement is in good health, rather than in agony. And when you consider the other reasons for tension between us (the commemoration of the genocide in Rwanda, the genocide in Darfur issue, etc.), each time these involved fundamental questions that deserved in-depth debate. They were not false problems. We have to stop being afraid of conflicting ideas, and stop dramatising as soon as discussions become a little heated.

→ **What do you feel are the major issues facing the movement?**
I would group them into three major "categories": MSF's relations with other actors involved in assistance operations and with political actors; the quality of assistance versus the social, cultural and political preconceptions in our organisation; and finally the procedures and the power balance within the movement. The first category poses the question of the political independence of our organisation in a context of numerous international military interventions and the support of international assistance organisations for the domination of the super powers. Sometimes even we are tempted to give in to States' reasoning, not because of an ideological choice but as a reflex in order to protect our institution. The Arjan affair is a striking example. During this affair, there were two tendencies within the movement: the main tendency that thought we should create a climate of political controversy against the Dutch and Russian governments; the other minority tendency that, so as to protect MSF, refused to put pressure on those states, thus becoming their ally. Our withdrawal from Afghanistan, our stance in the debate on present events in Darfur (genocide or not?), and the fact that we stopped raising money for the post-tsunami operations, etc. are expressions of our independence, and they are thus ways of breaking with the interests of the great powers. In our work, we resist

WHAT'S WHAT...

Today the international movement consists of 19 sections, 5 of which are operational centres. Various platforms gather on a regular basis and adopt resolutions that affect all the sections:
-IC (International Council): a council that consists of the international president of MSF together with the presidents of the 19 sections
-ICB (IC Board): a restricted international council that includes the presidents of the 5 operational sections, the international president of MSF, and the president of one other section (alternating)
-DG 19: assembles the 19 directors of the MSF movement and the general secretary
-Excom (Executive committee): groups the general directors of the 5 operational centres with the international general secretary

→ **Sudan, Darfur** © Pep Bomet - January 2004

THE INTERNATIONAL MOVEMENT

Redefine and apply

MSF / April 2005 / interview by Caroline Livio/ translated by Francesca Pegazzano

Marine Buissonnière is the general secretary of the International Office. Below she outlines the headway made by the organization, while pointing out its limits and reminding us of the dossiers in progress and the challenges which remain to be addressed.

→ **One year after your appointment, what is your general impression of your role?**
The role of general secretary is both one of observer of all the MSF sections and of privileged intermediary with the outside world (other NGOs, United Nations, institutions etc.) in the capacity of representative of the movement. It is therefore both a complex and fascinating role, and one that enables one to realize - at times when tensions arise with other institutions - just to what extent our internal differences are minimal when compared with those that divide us from other organizations .

→ **In what areas has the international movement been successful?**
In certain fields at the heart of MSF's medical activities, concrete and measurable progress has been achieved thanks to the work carried out by the international medical coordination and the medical directors platform, in collaboration with the Campaign for Access to Essential Medicines. This includes the development of new strategies (common policy and operational plan for tuberculosis, decision of the international council regarding reproductive health

attempts of political influence on a daily basis and thus maintain the quality of our operations. We must accept this risk at international level, and at all costs avoid defending our own institutional interests.

→ What do you mean by « the social, cultural and political preconceptions in our organisation»?

The quality of our operations is sometimes affected by preconceptions within MSF itself. For example, the reluctance some people had to introduce ARVs into the AIDS programmes; and the time it took us to address pain management and pay specific attention to violence committed towards women in certain war situations. Also the question of our national staff and the lack of room they are really given within MSF (in terms of responsibility). In my opinion this situation is the result of discriminatory preconceptions that makes our work less efficient because it results in inefficient use being made of the available human resources, and we all know that the lack of competent people is what limits the quality of our field activities most.

→ What are the international institutions' weaknesses and how can they be improved?

For me that is the third issue we have to face. To be strong, we have to take the risk of running things democratically: contradictory debates must be sanctioned by votes. Once voted, decisions must be taken and implemented. At the moment, however, we are at a difficult stage in our construction. Our institutions are not yet able to implement decisions even when they are supported by a large majority. It must be possible to express minority positions, such as that of the Dutch section during the Erkel affair, both inside and outside MSF. But minority positions must no longer have the power to bring the whole movement to a standstill using "procedure guerilla tactics" in order to prevent the movement taking and implementing a decision considered contrary to the interests of one section. We do not need more central bureaucracy, we need stronger orientations both to prevent our organization becoming too bureaucratic and to improve the quality of our assistance, while maintaining our independence and ridding us of the cultural and social preconceptions that lead us to accept poor-quality assistance. This ability of the international office has to be strengthened. I also think that the other sections should have presidents, full-time presidents for the operational centers, and remunerated. The persons who are accountable to their Annual General Meetings must be better informed, more determined and more consistent than they are today, and they need to be able to dedicate a certain amount of time to MSF for that.

→ You have mentioned a « Chantilly III » several times. What do you expect of a new international meeting of this type?

I believe that ten years after the Chantilly meeting, it is time for us to sit down together to discuss how we see our movement. After a year of very heated debates and conflicts about the vocation and role of MSF, it seems absolutely necessary to try to draw up a synthesis that would allow us to make use of the experience acquired over the last ten years. I see this as a renewed political agreement, so that international movement becomes more than a mere platform for sharing human and financial resources. ■

and abortion), progress in accountability for our medical practices (use of ACT to treat malaria, treatment of AIDS patients with ARV), and the definition of a common operational research agenda between sections.

Other international projects are now reaping results: the work concerning the quality of drug supply sources carried out by the international pharmacist and the organization's network of pharmacists; the financial transparency efforts which will result in the publication - for the first time this year - of the audited combined international accounts, collecting the financial data of all sections; the encouraging developments of the international remuneration project aimed at harmonizing the wages for expatriate personnel between

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THE IO : HOW DOES IT WORK ?

The International Office (IO) is a Swiss entity. Its members are the 19 national sections of MSF, each of which is represented by their president. The members meet twice a year in a General meeting (the International Council) and the International Council Board (ICB) constitutes its Board of Directors. The association elects a president (the international president, currently Dr. Rowan Gillies) and the International Council appoints a general secretary (currently Marine Buissonnière).

The IO is comprised of three permanent international committees - medical, information, and policy/advocacy - in order to ensure coherence and international exchanges in key areas, and in order to contribute to improving the quality of MSF operations. Projects are also initiated or approved by the International Council and are overseen by coordinators chosen for specific areas: international remuneration, international combined accounts, international supply, etc. International positions have also been created in order to ensure follow-up in certain area and the maintenance or production of tools intended for the movement as a whole :the international annual report, the international website, intranet, the photo database, protection of the corporate name, etc.

> *"MSF is an international project. It should, by its very nature, be a transnational project :our values are strong enough to not need to negotiate with specific interests. But reality is what it is."*
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> **Excerpt from « The board of directors has feeling too... », signed by the board of directors and published in Contact - September 2004**

DOSSIER

How many divisions does MSF have?

→ The « Chantilly » principles

Following the Great Lakes crisis (1994) and divergences that were spurned between sections because of it -particularly in terms of speaking out - two meetings were held in Chantilly in 1995 and 1996. First uniting members of different headquarters, then the "coordos," these two assemblies resulted in the definition of ten guiding principles and also specified operating rules for the MSF movement. These principles refer particularly to the idea of temoignage (as an indispensable element of medical action), as well as to the limits to our neutrality, defence of human and international humanitarian rights, and the voluntary and associative character of MSF.

sections on the basis of the principles of equity and social responsibility in order to improve retention of our staff; and the publication of a collection entitled 'MSF speaking out' which documents periods when MSF was faced with particularly difficult dilemmas concerning advocacy (Rwanda, Zaire, Ethiopia, El Salvador...).

Other dossiers have yet to find the necessary dynamics, such as the international supply project or the resolutions passed by the IC regarding national personnel. However, through all these international initiatives, and even if further efforts are required in order to improve results, we must not lose sight of the fact that the IO and its functions only exist to support and participate in improving operations of the organization as a whole.

→ Are there any resistances, or any contrasting expectations within the organization ?

According to some, the IO should promote and facilitate the dynamics of the international movement and "drive" the development of a shared vision for the entire organization. Others would prefer the IO to work more behind the scenes, being content with acting as an intermediary to facilitate the exchange of information between sections and act as a mediator. Some fear that the IO might turn into a kind of supranational body and impose its decisions on the national associations, which would thus slowly lose their sovereignty.

In my opinion, the matter is not so clear-cut. Interdependence between MSF sections is already a reality. Suffice is to look at the financial, human and technical exchanges between the various sections (and not only between operational centres and their privileged partner sections) to realize to what extent these exchanges underlie the operational capacity of MSF today. What is more - as the Greek example has shown - none of the sections could survive today isolated from the organization.

(...) we must not lose sight of the fact that the IO and its functions only exist to support and participate in improving operations of the organization as a whole.

Moreover, several key decisions for the organization are already made by our international decision-making platforms. The question today is to acknowledge and strengthen the transfer of some of these responsibilities internationally, and to continue to devise a functioning mode that prevents the pitfalls posed both by federations (dilution of identity, loss of operational quality) and by hyper-centralized systems. In other words, how do we maintain consistency throughout the organization while preserving what comprises MSF's richness and distinctive character, i.e. its national associations?

→ What changes need to be made, in your opinion?

MSF has evolved in recent years. The delocalization of desks or operational units to so-called "partner" sections

THE IO AND THE ARJAN AFFAIR

The IO was mandated by Excom (the general directors of the operational sections) and by the ICB (International Council Board) in a specific context : it was impossible for a consensus to be reached among the sections that were directly involved and this issue could potentially have an impact on two sections. The specific role, that is to say, the executive responsibility conferred on the IO in this case is viewed by some as an interesting option to consider in the future in sensitive international cases. Others see it as a dangerous precedent which carries the risk that the IO would lose the distance and the neutrality it requires in its role as intermediary. The debate isn't over.

EXTERNAL REPRESENTATION OF THE INTERNATIONAL OFFICE (IO)

MSF / April 2005 / Marine Buissonnière

Whether we like it or not, MSF has today become an important player on a global scale. The attacks fuelled by American think tanks or by the pharmaceutical industry attest to this fact. Thanks to its ability to call the status quo into question, to question medical practices, or to denounce situations based on realities in the field, MSF is respected, even feared, because it is perceived to be pertinent and often unpredictable. We must preserve this capacity to be at odds with the centres of power and maintain a critical approach by at times accepting institutional risks.

Our relationship with other NGOs is not always simple either! Today we are perceived, along with the ICRC, to be « guardians of the temple » and the protectors of an outdated doctrine which we refuse to abandon : neutrality, impartiality, and independence are no longer heard. But those that consider these principles to be ideological positions out of touch with reality are mistaken, for it is these very principles that are our primary tools and give us the capacity to act.

Its contact with the consortia of NGOs, with UN agencies and with certain state representatives puts the International office in a privileged position of interface. The International Offices' role is therefore to identify and at times to contribute to the spreading of MSF's message among the sections (which is not always easy). Its role is also to identify possible channels to carry our message or to intervene on more multilateral issues (like the confusion between military and humanitarian, codes of conduct, etc.) But the tsunami has shown us to what extent MSF is viewed by the external world as a one single organization. We will therefore find it increasingly necessary to speak out with a single common voice.

→ **Haïti, Port-au-Prince** © Kevin Phelan/MSF - February 2005

is deeply changing the form of our organization. The international structures that MSF set up about ten years ago no longer reflect the current reality of our organization in terms of its composition and prerogatives.

It will therefore be necessary to redefine our co-operation taking into account these evolutions and to review, for example, the representation of partner sections in executive platforms. It will also almost certainly be necessary to review the nature of the decisions taken by the various platforms, as well as decision-making modalities (voting system, implications of decisions, consideration of diverging opinions) and their restricting character. Indeed, one of the central issues today concerns the follow-up by national sections of decisions taken by international platforms. I have sometimes had the feeling that the application of certain non-consensus decisions could, at best, be slow and exacting, and at worst, never happen at all. Even so, our capacity to make common decisions is of little value if we do not have a mechanism to ensure that such decisions are acted upon. After all, isn't ensuring that we do well what we claim to do the first level of accountability we should aspire to? ■

ROLE AND PEROGATIVES OF THE IO

The international office serves as a centre for meeting, dialogue, consultation, collaboration, and the coordination of operations among the « Médecins sans Frontières » sections, as well as a place to defend and promote the common interests of its members. To this end, the office is responsible for :

- organizing cooperation among the sections in the areas decided upon by the international council (finance, information, human resources, etc.) ;

- coordinating studies and research ; organizing and coordinating the regular exchange and distribution of information and documentation within the movement ;

- promoting a common outlook among the different member sections ;

- promoting and defending the name « Médecins sans Frontières », « MSF », the spirit and the humanitarian principles associated with it, and defining the conditions in which the name is to be used;

- ensuring unity, respect for the MSF charter, and for any document relating to the identity of MSF which is approved by the international council, and particularly, ensuring that these documents are translated into different languages.

INTERNATIONAL MEDICAL COLLABORATION

Observations and extensions

MSF / April 2005 / Dr. Emmanuel Baron, Medical Director / translated by Nina Freidman

While collaboration is now a reality in the international movement, heavy workloads and a shortage of specialists in some fields still limit our ability to create a more effective common policy.

→ **Tchad, Adre** © Jean Marc Giboux for MSF - November 2004

> *« If we stick to our principle of only speaking out about emergency situations our staff have witnessed, we will be reduced to silence. We will be taking certain risks by failing to take a stance against the « war on terror », but we will also find ourselves taking risks if we do adopt a viewpoint. And as soon as we leave the country, we have no choice but to remain silent. Maybe we should learn to collaborate more with local agencies and networks that we could offer support to from a distance, perhaps even by speaking out on their behalf.* »
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> **Gorik Ooms, General director - MSF Belgium**
> **Excerpt from editorial published in Contact, December 2004**

There is a long history of inter-section collaboration at the medical department level, as evidenced by the existence of a coordinator for medical directors, and of working groups (WGs) that bring specialists from different sections together to draw up strategies and guidelines for a specific issue.

→ JOINT EFFORTS

This collaboration has led to progress on several fronts, including specification of how drug supply sources should be chosen, development of a common, annually-revised drugs list, guidelines for management of blood exposure, and policy papers on malaria and tuberculosis. Conclusions about abortion that came out of work on women's health care were also included by the IC in one of its resolutions.These working groups have been criticized in the past for taking too technical an approach to problems, and neglecting the political issues involved.

The creation and development of the Campaign for Access to Essential Medicines in 1999 and the formation of the pharmacist network in 2003 clearly signaled the general directors' commitment to pooling resources among sections on medical issues. In addition to making previously unavailable drugs accessible in the field, these two entities demonstrated the value and power of combining resources.

In 2003, the working groups had to articulate their annual goals. Made up of one representative each from the Medical Directors, the Drug Campaign, Epicentre, and the lab technicians' group, each WG thus serves as a discussion forum. They meet four or five times a year to take up the various aspects of a given issue: which treatment choices for which strategic approach, which diagnostic method, how to respond to agencies like the WHO, Unicef, etc.

→ DESIGNATED LEADERS

The creation of the WG leader position in 2004 represented a major new step. Prior to that, only the Malaria Working Group and the pharmacist network had had leaders, who acted as group moderators. The Tuberculosis and HIV Working Groups now have permanent leaders who are responsible for defining group objectives in the relevant domain, and for coordinating and facilitating the work of group

members. The leader defends the group's positions and represents it, both within MSF and to the outside world. While MSF claimed to be a progressive medical organization-justifiably, in many ways-the movement as a whole had never found it necessary to have even one of its doctors devote his or her time to reflection and research on any of the major diseases affecting the populations we profess to serve.

At the same time, the working groups-along with Epicentre-have been responsible for defining a joint operational research agenda. It's almost inconceivable that the sections won't work together on certain research topics.

→ STRENGTHENING COMMON POLICIES

While continuing to work together to create treatment tools, the medical directors would like to move toward stronger common policies. This will mean attempting to define the major directions for medical policy in the years ahead, on questions such as treatment strategies for HIV-infected patients, the role of supplementary diagnostic tests, supply modes, and medical ethics.It is essential that these be integrated into the Drug Campaign's efforts and the collaborative research with Epicentre. While these relationships have sometimes been stormy-perhaps due to everyone's determination to mark and protect their institutional territory-they are noticeably better today. And these debates do have a certain energizing quality.

It is important to remember, too, that the medical issues at MSF involve changes in medicine itself, and as such are larger-too large be tackled by one section alone. With MSF expanding the medical care it provides, medical department members simply don't have the time to pursue research and innovation efforts in their specific fields. That would mean traveling to conferences and forums, going to meet experts, surveying literature-in short, devoting an amount of time that would substantial and not always compatible with support duties vis-à-vis the field and headquarters, for which they are also responsible. Support for field missions and the pursuit of medical innovation for these same missions are closely connected. Medical department members do both, and sometimes this makes their job somewhat unmanageable.

→ AREAS FOR IMPROVEMENT

Acknowledging a consensus won't get us anywhere if the sections can't discuss their differences. They might disagree on how recommendations are to be implemented, or on the medical care options corresponding to different medical or operational choices. This will be the focus of future discussions, if we decide to continue on this path. But how will this stronger structure help our patients?

There's a willingness to collaborate now, in the interest of more efficient utilization of effort and resources. This is the only realistic way to go, given the complexity of the issues and the various demands in the field. But increased efficiency through collaboration with other sections can't solve every resource problem. For certain areas of medicine — the kind we practice daily — there isn't always a dedicated specialist available. There are no pathologists, for example, and very few pediatricians. ■

> *“...We become the object of ridicule when we claim that there is no genocide going on there [in Darfour]. In the case of Arjan Erkel, admitting that a ransom had been paid appeared extremely selfish to the public, which is what brought about the tumult that followed. In the eyes of many agencies it was damaging to aid workers' security to openly admit that a ransom was paid.”*
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> **Geoff Prescott - MSF-Holland New General Director, excerpt from « MSF is isolating itself in the humanitarian world », published in Ins & outs, February 2005**

OPERATIONS

Same name, same action?

MSF/May 2005/ Interview by Isabelle Ferry/ translated by Eurotexte

The operational projects undertaken by the various sections of Médecins Sans Frontières appear to be very similar (at least on paper). But differences do exist. What are they and how do they translate in the field? An interview with Guillermo Bertoletti, director of operations, and deputy director Graziella Godain.

→ What do you think is (are) the difference(s) between the French section and other sections?

If the question applies to the key principles for action, such as neutrality, impartiality and independence, there are no particular differences. On the other hand, one of the major differences, for us, lies in our definition of 'humanitarian' responsibility. Some sections consider that a "population without access to treatment" represents a reason for intervention in itself. We believe that it is a consequence of a humanitarian issue, such as an epidemic, a conflict, a natural disaster, etc. It is situations such as these which lead us to intervene to assist populations excluded from treatment as a result of a crisis. But if, at the end of the crisis, the population as a whole is still excluded from treatment because of defects in the health system or the collapse of the country's economy, for example, we do not consider it within our realm of responsibility, unlike other sections. Take, for example, our decision to withdraw from Burundi. The country is experiencing a post-conflict situation and suffers from widespread political and economic instability. This combination of events results in exclusion from treatment, which is made all the more serious because the population has to pay for that treatment. Is it our "humanitarian" responsibility to change the Burundian health system? For us, the answer obviously is no!

→ But haven't we also been subject to such temptation in the past?

We've even given in to temptation. In Yemen, for example, we prolonged projects in areas where we considered

> *We need private funding to allow us to remain independent, but we also need the public's moral support to enable us to stand and make our point and demand respect for victims of crisis. This is under threat at the moment due to generalised despair within NGOs and our particular problems in communicating about our position in the Arjan Erkel affair.*

Austen davis - MSF-Holland Former General Director, excerpt from Ins & outs, February 2005

there was inadequate access to treatment. We wanted to increase our understanding and to analyse the reasons for this shortage, while influencing future developments. We have 'strayed' from our policy other times too, such as in Guinea, where we remained for ten years to invest in the health system of an entire district in order to influence the system. It had no effect. On several occasions we have made the same mistake, of supporting a system in order to develop and improve it.

But over the last four to five years we have reached the following conclusion: "This is not what we should be working on, even if at some point we may have had the capacity to do it; it is neither our responsibility nor our role." To make the point again, working to provide access to treatment in a context where there is no longer an emergency – or a crisis – that requires a humanitarian response as we define it, raises issues about financial discrimination and about work on the problems surrounding poverty. This is beyond our responsibilities.

→ Do we share the same objective of providing "better treatment" but by different means?

It's not as simple as that. Although our primary aim is to intervene on a medical basis, other sections take a much broader approach to their field of intervention. This leads them to make different strategic operational choices. Our actions have to produce results as rapidly as possible – that's our conception of humanitarian aid. Providing treatment where it is needed most, without preconditions. We should not have to put conditions on access to treatment; we must provide it, whatever the constraints imposed by governments. If we take the example of of ACTs in Sierra Leone, all the sections shared the same view: "patients must be treated for malaria with effective drugs". We shared the same view, the same analysis and the same initial objective, but in practical terms, we did not make the same operational choice in the field. At the end of 2001, we decided not to wait for government authorisation or a change in national protocol before treating patients. In contrast, the first objective of other sections was to change the protocol to enable them to start treating their patients. Our first objective was to provide correct treatment to our patients; their objective was first to lobby the government. That vision of MSF action is a little too close to Bernard Kouchner's!

→ Doesn't that raise the issue of medical responsibility?

Yes – and it's a source of disagreement and even misunderstanding between the different sections. When we intervene, for example, in a refugee camp, and discover a high mortality rate, it is our medical responsibility to lower it. But other sections – and this was the case in Sudan recently – alert public opinion to these alarming rates without necessarily taking direct action.

There are a number of other examples. The latest report on sexual violence in Darfur made us furious. It is all very well to condemn violence against women, but what treatment are we offering them? Have we equipped ourselves with the resources to provide these women with long-term care? These women are not even able to benefit from a pregnancy termination on the pretext that the Sudanese government forbids it or that it is impossible to determine the number of unwanted pregnancies! Even though pregnancy termination is one of the actions specified by the MSF International Council! The same applies to the report on the Ivory Coast. The teams working from mobile dispensaries have noted alarmingly high STD rates and drawn the conclusion that the number of rapes has also increased. But nothing has been done to provide the "victims" with a space where they can benefit from specific consultations. There's nothing wrong with condemning these situations, but we feel it is essential to provide appropriate medical assistance.

→ **Italy** © Andrea Accardi/MSF - August 2004

→Why do you think we take a different approach?

The answer lies in our organisational structure. Medical procedures, the quality of treatment and closeness to our patients provide the obvious focus of our actions and decision-making. Here at head office, over 50% of the operations department are medical personnel. This is not the case with other sections. The same goes in the field. We have twice the number of doctors working on each project, on average. Out of all the coordinators from the various sections addressing the Marburg fever emergency (in the first few weeks), we are the only section with a medical member of staff on the team to deal with a pathology as difficult and sensitive as this! We do not invest our resources in the field in the same way. Some sections condemn a situation but often go no further in terms of taking medical action because their hands are tied by the health system in which they have invested their resources. They frequently support public health structures where doctors play more of a supervisory role with no direct influence over therapeutic procedures. In contrast, we try to work in or set up health structures that allow us to remain "in control" of our choices and responses. We decided, for example, to illegally treat our patients with ACTs in Sierra Leone and Burundi, and to perform pregnancy terminations in Congo-Brazzaville, despite the fact that the procedure is against the law.

→ Do you think it is possible to carry out a joint operational project, despite these differences?

An initiative was launched in 1997, led by the former General Director, Bernard Pécoul, and the project's manager, Jean-Michel Piedaniel. They ordered a detailed examination of all of the projects performed by the operational sections. They found many radically different projects, which were poles apart from one another. Everything and anything was included! In short, it was a wake-up call: apart from our name, we had little in common. The organisation's current view of the future is very different. We have tightened the focus of our activities, and any remaining differences will be ironed out over time. Each section moves at its own pace. What is now essential, it seems to us, is our ability to question the relevance of our operations and those of others - whether they involve a joint operational project or not. Exchanging views and discussing the direction of our missions will form the basis of the organisation's success in the future. And if this interview starts a debate, then we've already taken a step forward... ■

FINANCIAL ORGANIZATION

A Certain Way of Growing

MSF / April 2005 / Marc Sauvagnac, financial director/ translated by Maria Edstorm

Does the obsession with growth go hand in hand with its relevance? Operational policy must be based on a common definition of humanitarian action in order to escape overly bureaucratic financial logic, Marc Sauvagnac tells us.

If the building of MSF's international movement is not a goal, but rather a means serving operations, the 19 sections that participate in it are simultaneously international humanitarian players and national institutions. In the first case, they exhaust themselves trying to stay afloat in an environment that seeks to drown humanitarian action in the soft underbelly of State foreign policies. Within the movement, MSF's role, the definition of humanitarian action and independence with respect to the powers that be are also the subject of debate. As national institutions, the sections systemically and bureaucratically seek to maintain their influence within the movement and their civil societies.

→ RECIPROCITY AND ITS SHORTCOMINGS

Growth is the inevitable consequence-sometimes even the most important aspect-of MSF's project. The building of the movement and inter-sectional relations are becoming an imperative at the service of this growth. For the operational sections, it is a matter of maintaining good institutional relations with their private fund "contributors"-the non-operational sections-to "protect" their financial income. For the non-operational sections, the increase in the volume of mission financing and the search for openings within the movement (e.g. a non-operational section, partner to an operational section, seeks to finance the missions of other operational centers, without necessarily any kind of operational sharing) make it possible to guarantee the future growth of these institutions.

Financial policy, a strategic tool serving the implementation of a policy plan, is transformed into an accounting tool, with no objective other than the annual reporting of the accounts.

The resulting relationship of reciprocal financial dependence makes it possible to equalize the balance of power. Multiple contributions and financial flows run through the movement on the basis of bilateral relations which we might suspect are focused on the shared construction of the operational plan.

The international raising of private funds, which would be split equitably among the sections, has been proposed, so that sections can grow at the same rate, regardless of the nature of their plan. Operational policies and their diversity come second to the growth imperative.

Financial policy, a strategic tool serving the implementation of a policy plan, is transformed into an accounting tool, with no objective other than the annual reporting of the accounts.

"MSF is changing. We are getting more and more office-heavy, there are relatively less people working in the field, and the focus on our own civil societies, lobbying, and fundraising have been given greater priority. We are growing older, bigger and more bureaucratic. Moreover, this development is not taking place in a coordinated way; all the sections are planning according to their own priorities, which are based more on national interests than on a common international vision for MSF."

Excerpt from « MSF and its unhealthy growth », by Morton Rostrup - October 2002

→ Regarding temoignage (cont.) :

"*The French section is perceived as incontrollable, even irresponsible. The Belgians and Dutch dislike the French's "hell-raising" qualities, their immoderate taste for the spectacular, for provocation, for excessive media exposure, and their systematic attempts to profile a distinctive stance in the public eye. (...) MSF-F would sacrifice its identity in order to be heard above all the humanitarian brouhaha, and to be distinctive through exaggeration.*"

Pascal Dauvin in "Kosovo: histoire d'une deportation," article published in ONG et humanitaire, directed by Johanna Siméant and Pascal Dauvin - 'Logiques politiques' collection, L'Harmattan, April 2004

→ BUILDING A COMMON PLAN

The building of the movement only has meaning if it remains centered around operational projects. It is not a question of denying national logic; after all, each one of the sections is independently accountable to its annual general meeting as to its donors, and must remain in conformity with national legislation. Unless we imagine a totally integrated movement where the sections bow to the decisions of a parent company, this logic will endure. The answers will come from the sections' ability to build a common operational plan. Indeed, this is what we are in the process of experimenting with, as we create decentralized desks within the non-operational partner sections, under the management of operational sections. This initiative makes it possible, on the one hand, to seek improvement in operational quality by reducing the number of countries each desk follows, and, on the other, to re-introduce the operational plan as the central focus of non-operational sections.

The "operational center/partner sections" groups (for example, MSF France with MSF USA, MSF Japan and MSF Australia) are strengthened around operational plans and decentralized desks. On a financial level, the partner sections' contributions better illustrate the operational reality of this partnership. The partner sections finance a project the development of which they are increasingly helping to develop. Fundraising is better harmonized and planned more logically based on the resources needed for the plan.

→ SERVING OPERATIONS

From this point forward, one can imagine that financial policy is once again inscribed on the sections' political agendas, in the service of a shared plan. Group logic, even if criticized by some who see in it a device for safeguarding a manna of private resources, is, on the contrary, the only way of restoring order in the movement's finances, by putting them, first and

SPEAKING OUT

« Think Politics »

MSF/April 2005/ Olivier Falhun/ translated by Amanda McGurn

Before becoming the director of MSF's Spanish section at the beginning of 2004, Rafa Vilasanjuan was the international secretary of the MSF movement. Here he addresses and analyzes the main points of tension that have surfaced over the last few years regarding our public stances and the different perceptions coexisting within the MSF movement.

"I don't think that there are any real divergences in the movement in how we analyze and interpret the contexts in which MSF works. Speaking out however is more of an issue, both in terms of what is said and how it's presented."

→ THE AFGHAN EXPERIENCE

"Take for example Afghanistan 2001-2002 - the controversy brought to the surface recurrent tensions between sections. At that time the question came up of whether or not to publicly criticize the United States' propaganda policies, e.g. that coalition forces -with enormous media coverage- were dropping food rations that had identical colouring to cluster bombs. Even though everyone drew the same conclusion, the decision to speak out on this issue posed a serious problem to some of the members of the American section who did not accept the term propaganda; other members of other sections favoured placing the American troops' exactions- as well as their indiscriminate and disproportionate use of force- in the overall context, also making mention of attacks made by the Taliban. On top of being afraid to speak out unilaterally to denounce the American authorities' attitude, was the other sections' desire to further document these assertions and analyse the whole context through a more complete dossier. They also questioned whether it was the right time to speak out. It basically came down to two questions: "Was this the right moment to denounce the coalition forces' attitude? Could we focus on one party to the conflict without mentioning the other?" After having discussed the issue at length with many operational directors, the international office replied affirmatively to denouncing the purely propaganda and ineffective nature of these food drops - a position promoted by Jean-Hervé Bradol who had been in Pakistan when the events occurred and had discussed the subject with the operational managers on-site. However, we were at fault for not informing the American section in time of the message put forth by the entire MSF movement (October 8, 2001). They rightly reproached us for this action. However, looking back on these events, and even if MSF USA also later relayed the message, I am not alone in thinking that we made the right decision, but I think that this "slip up" allowed us to take a stance that the New York section would not have agreed to in the beginning, particularly given the context marked by the massacres of September 11th."

→ TWO VISIONS

"To me, the Afghan episode illustrates how a section may have to face being at odds with its own society. Though this is a fairly new phenomenon, it's been happening more and more. However I can also see (though sections regularly pass from one method to another) the caricatures revealed by different communication approaches: on one side, the Anglo-Saxon vision promotes in-depth

foremost, at the service of operations. So we can speak about well-understood policies with respect to institutional donors, and can justify and develop a reserves policy and regulate private fundraising as a function of a shared plan.

Beyond clarifying technical questions related to the presentation of the sections' social mission expenses, the combined international accounts[1] provide the means to understand the financial repercussions of political decisions and makes it possible to compare the nature and volume of the resources committed by each section to achieve its operational plan. With the combined accounts, we have at our disposal a good analytical tool to judge the accomplishments of each section's annual plan. Nevertheless, we must advance still further in defining common operational indicators. For example, we still do not have a common project typology that would make it possible to compare, through the accounts, the reality of the operational intentions of each section. It is this clear link between goals, activities and expenses that will enable us to build a financial policy that serves operations. ■

1- The funds that flow across the movement, the financing of missions, re-billings, etc. result in the exclusion or inclusion of certain expenses or resources in the national accounts that either return or not to each section. The creation of partner sections, for example, resulted in externalizing part of the fundraising expenses and artificially increasing the percentage of operational sections' mission expenses. It could be considered that the partner sections, as independent entities of the operational sections, are private institutional donors in the same way as public institutional donors. Nevertheless, the sections carry the same name, are part of the same movement and external players could reproach us for having organized our finances to suit us. This is one of the reasons MSF decided to combine all the sections' and their satellites' accounts. This presentation results in the elimination of reciprocal flows, as if MSF were a single entity. These accounts will be certified by auditors at the end of 2005.

analysis and the assembling of complete dossiers. They're oriented to report all the facts from all angles, and favour direct relations with authorities. This "silent diplomacy," or more accurately "parallel diplomacy" conflicts with the Latin vision (the most coherent vision in my opinion), which tends to bring a problem out into the public and assert itself despite tensions with authorities. From a historical point of view, this sort of opposition is not at all surprising when we recall that the French Revolution was brought about in the streets, whereas the English had theirs in Parliament!

Conflict with one's own society on one side, and "silent diplomacy" on the other...Then of course there were the recent discussions regarding the actions taken in the Erkel affair and the lawsuit between us and the Dutch government? Once again two visions collided, though this is not preventing the Dutch section from pushing for a common stance! This is obviously impossible! In wanting to remain ambiguous we will end up disappearing, and will lose the political dynamic that our action depends on. The "No comment" policy is not a solution at MSF!"

→ THE GENOCIDE DEBATE

"There are other things that remind us how important it is to cultivate our own distinctive stance and distinguish ourselves from conventional points of view. Let's take Darfur as an example. The Spanish section started their programmes later, and therefore did not take a stance at first in the genocide debate, unlike the French section who had been working there longer. But MSF-F fulfilled its role in denouncing what some were claiming to be genocide. As soon as you have a clear vision of what's happening, you have to make it clear, affirm your position, and pursue a political dynamic that serves the field missions. As for the Rwandan genocide we spoke out in a responsible and credible manner. We cannot forget that MSF's identity has been marked by the Great Lakes experience. The emotion surrounding the Rwandan genocide is still perceptible, and was evident when internal debates broke out at the commemoration. There again, even though we can look back and take stock ten years later, I doubt that MSF could have publicly joined in this commemoration after ten years of silence. Although this emotion is visible and legitimate, it must remain contained within our movement - externally we must privilege political analysis of current events."

→ THE INTERNATIONAL OFFICE'S ROLE

"It's this lack of political reflection that generates the most significant tensions. On an international level, our public communication -particularly press releases- clearly reflects this. The increasing multitude of authorisations necessary to formulate public messages is not altogether new, since national stipulations prevail over the global impact our communication could generate. In this sense, instead of battling to change one sentence in a press release, I prefer battling against the confusion of roles and responsibilities, against our present incapacity to develop clear political insight. There are numerous opportunities to collectively take a stance without taking away the opportunity for sections to formulate their own analysis. Many opportunities have also been missed.

Furthermore, MSF is evolving today in a world in which information circulates. Like us, journalists go into the field and expose themselves. They report the facts. Therefore we must - particularly on an international level- adapt our communication accordingly, favouring and substituting factual press releases, witness statements, and well-polished dossiers with clearly-stated positions and policies...despite tensions with authorities.

It is by touting the "activist" notions present in certain sections we will succeed: pacifism, "human rights-ism," feminism, etc., are tendencies that cloud our communication and are not our responsibility. It is up to the international office to arbitrate, and the ICB can drive this dynamic. However for this to be possible there must be both trust and the necessary resources adapted to the MSF movement's international dimension." ■

→ Regarding temoignage (cont.) :

"...The French feel that the Belgian and Holland conception of témoignage is too influenced by « human rights logic . » This logic is denounced on two counts. First of all, it requires legal intervention that proposes analyses that are not based on 'operational' elements and do not take into account the needs of the populations. Secondly, the alliance between medical NGOs and human rights associations appears to be, particularly to MSF-F's legal advisor, a "marketing alliance"..."

Pascal Dauvin in "Kosovo: histoire d'une deportation," article published in ONG et humanitaire, directed by Johanna Siméant and Pascal Dauvin - 'Logiques politiques' collection, L'Harmattan, April 2004

DOSSIER

How many divisions does MSF have?

MSF USA

Shared operations viewed from New York

MSF USA / April 2005 / Nicolas de Torrente, Executive Director of MSF USA/ translated by Melanie Stallard

How and why did MSF-USA embark on the adventure of sharing operations with MSF France? Can we make a first assessment, and what are the main challenges to be taken up? Nicolas de Torrente's answers:

→ **Nigeria** © Kadir van Lohuizen - May 2000

Treating TB-HIV co-infection in Arua, Uganda; ensuring access for wounded civilians to the trauma centre in Port-au-Prince; countering the impact of the Central America Free Trade Agreement (CAFTA) on the availability of generic medicines in Guatemala; or assessing the feasibility of intervening to meet the health needs of persons displaced by the violence in the Delta in Nigeria. These are just some of the current operational challenges faced by the New York Desk, a Desk similar to its siblings in Paris yet different due to its location within MSF-USA.

It is MSF's international development that has given rise to shared operations. Without it, MSF would not be what it is today, with its financial independence, the scale of its operations, the impact of its messages. International development has been accompanied by interdependence: today, no section can do without the others. We must thus acknowledge the visionaries who created partner sections like MSF-USA, even if they did not necessarily anticipate their development...

→ THE REASONS FOR SHARED OPERATIONS

Contrasting rationales are presented to explain the move towards shared operations. For some, an institutional logic is at play, whereby this represents a natural progression given MSF-USA's rapid growth as illustrated both by its role as a supplier of resources (particularly financial); its staff (more than 50 employees) and its 2004 budget (85 million dollars, 100% private funds). From this perspective, sharing operations is also a way to link MSF-USA to MSF-France, giving MSF-USA an operational outlet to avoid the "pressure cooker effect": overheating and ultimately explosion. Another perspective stresses the goal of improving the quality of MSF's programs. A Desk in the United States would lighten the workload of the other Desks in Paris and thus contribute to an overall improvement in program support and supervision.

In fact, the main reason is more simple and direct than that: operations are MSF's 'raison d'etre'. It is inconceivable to be MSF without participating in its core activity: programs. MSF-USA is jointly responsible for MSF's operations, particularly those of the French section with which it has privileged partnership (70 % of MSF-USA's private grants go to MSF France, which corresponds to 40 % of its operational budget). The US section aspires to participate in the definition and implementation of programs, and it potentially has the ability to do so. Conversely, it is certainly in MSF's interest to have its presence in the United States, where many policies directly affecting operations are developed, be embodied in a section with a strong medical and humanitarian identity, an identity deeply rooted in operational realities.

→ ALLAYING FEARS

This goal to build MSF identity in the USA - by being connected and contributing to operations - has therefore existed in New York for many years. But the creation of a decentralized Desk as an expression of this goal was not so straightforward. Many had reservations. In particular, many were concerned that a New York Desk would lead to a « nationalisation » of operations. American volunteers in MSF often make the deliberate choice of working for a non-American international organization. One participant at the 2002 General Assembly declared that he did not want to see "a cargo plane leaving New York with the US flag and the MSF logo". The prospect of an exclusive relationship with Paris also raised concerns. Some were apprehensive that MSF-USA's own "internationalist" identity within the movement would be lost, and that MSF-USA would be seen as an extension of MSF-France in New York. But with the launch of "shared operations" these fears have largely been allayed. The New York Desk is well integrated with MSF operations in Paris, under the authority of the Director of Operations. At the same time, MSF-USA has continued its cooperation with and support to other MSF Operational Centres in terms of human resources, funding, and communications..

It is of course too early to draw conclusions from the experience of having a decentralized desk in New York. Nonetheless, the key achievement during the first year was that the field teams and programs continued to receive the support they needed, allowing, of course, for the usual imperfections. A progressive and pragmatic approach was adopted to ensure this. Countries were added incrementally - first Uganda, followed by Guatemala, Haiti, Nigeria. Similarly, the desk team is being built one step at a time. The New York office has a critical mass of experienced people, and benefits of their involvement

→ **The moratorium on new sections**

"*Related to the growth discussion is the possibility of creating new partner sections, or open up offices in new countries linked to already existing sections. For the time being we have a moratorium on new sections. (...) Whether to change our current policy or not should be discussed in the movement. In my opinion the moratorium should be kept until we have a proper understanding of our current growth and some ideas about where we should go in the future. We should also set up a more clearly outlined international governance structure.*"

Excerpt from « MSF and its unhealthy growth », by Morton Rostrup October 2002

have started to appear, particularly at a medical level, with the Campaign for Access to Essential Medicines, and communication/advocacy. But the process of making operations the centerpiece of the New York office will not happen on its own: while the Desk Manager (RP) is a member of the management team and there is a great deal of interest in the Desk's activities, a deliberate effort will still be required to foster a general understanding of operational issues and to make the best use of existing resources.

→ THE NEXT STAGES

The Desk's priority in 2005 is continue to improve the quality of programs, but also to build operational know-how in the New York office and further improve integration with MSF France's operational team, working with all the support department, both in New York and Paris. The Desk intends to focus on developing relevant operational responses to the contexts in which it works (a good example is the trauma centre in Haïti) and to start putting into practice certain general objectives concerning the use of resources: to improve for example human resources management and the composition of field teams, and to develop tools to monitor our operational expenses related to our activities. The team is currently divided between New York (Desk Manager, Deputy Desk Manager, Human Resources Officer, Communications Officer, Medical Advisor) and Paris (Finance/Admin Officer, Logistics Supervisor), but we expect to soon have a complete desk team in New York with the recruitment of a Logistics Supervisor and a Finance/Admin Officer. Finally, MSF-USA's involvement in the definition and implementation of MSF France's operational project must be heightened, as its contribution goes well beyond the Desk alone. We must find non-bureaucratic ways of meaningfully sharing in the decisions about operational choices and means, both at the level of the office and the Boards of Directors. ■

MSF JAPAN

Is Japan fertile ground for MSF-style humanitarian work?

MSF JAPAN/ April 2005 / Armand Virondeau, general director of MSF Japan/ translated by Chris Scala

In order to explain and disseminate its notion of humanitarian work, it is important that MSF take into account the society it is addressing. Armand Virondeau gives us his take on the Japanese perception of MSF and what MSF can do to improve it:

Let's start with the basics: the Japanese dictionary does not contain a word for humanitarianism as we define it and understand it in France (let alone within the association). Turning to the glossary reserved for imported and scientific words, including emphases and onomatopoeia, we find that the word that is at the heart of our mission is associated with human help, i.e. a human, charitable and social act.
The cultural orientation of the word is in full evidence in the Tokyo office: "We have trouble explaining to the media this complex word which tends to have overtones of idealistic and sentimental humanism here"; "We are revising the translation of our charter, questioning it, working on a new version, struggling to find THE right expression".

→ THE CONCEPT OF HUMANITARIAN WORK

The foundations of humanitarian action are however ever present in Japan. These foundations however take a different form from than in the West.

For example, the assistance offered by the Self Defense Forces in Iraq, Japan's pacifist army, is a humanitarian act; the bilateral development assistance offered by the Japanese government, the world's second largest institutional donor, is "humanitarian".

Consequently, in the light of Japan's unique pacifist constitution, most Japanese people consider their government to be acting in complete neutrality, impartiality and independence in the conflicts in Iraq and Sumatra. Taxpayer yen are seen as reducing misery in the world. In short, Japan serves its cause - it serves good causes - to make itself heard,

> *"I think that we should focus our effort on the principles of partnership, co-responsibility, and solidarity, and clearly define what a Group is : partner interests become common interests, which implies making choices that may not correspond with national priorities but which will allow us to transcend certain national aspects to make choices together; a place where "non centripetal" voices and minorities can be heard; non-exclusivity; where there is representation and connection to the MSF movement, etc."*
>
> **Armand Virondeau, general director of MSF-Japan**

have a place, and buy recognition in the community of nations.
This caricature may lead to the conclusion that the Japanese public delegates to the pacifist government all social and human assistance as it is too complex to understand and too far removed. Yet at the same time, social action at individual, group and national level - the notion of community humanitarianism - is flourishing and is effective in the heart of insular Japanese society (e.g. many retirees get up very early in the morning to serve as crossing guards, even on deserted streets, to ensure that children can walk alone to school).

→ THE PLACE OF NGOS

In this landscape, the actions of NGOs are considered heroic, yet sometimes unrealistic and unclear, and are unfamiliar and poorly understood by the public. This sector is young, as the law on non-profit organisations dates back to only 1998. The large majority of the more than 18,000 registered NGOs were formed in the 1990s following the bursting of the economic bubble and the ensuing disillusionment, particularly among the young generations. During these years, there was notably increased interest and mobilisation in favour of humanitarian problems both in Japan (Kobe earthquake, 1995) and abroad (Great Lakes crisis, 1994).

The number of NGOs in Japan is quite small compared to the 180,000 sects, which have no real religious equivalent in Europe; only around twenty NGOs, including MSF, have acquired the state approved status 'of public interest'. All of the NGOs try to channel the limited support offered by a public that is disillusioned and too preoccupied with its own fragile daily existence (the ground trembles around 1,500 times per year!). As a result, many "Newly Governmental Organisations" are supported by the government, along with independent - and short-lived - micro-NGOs.
MSF is thus an intruder.

→ INVOLVING THE JAPANESE PEOPLE

MSF is very familiar with intrusion, because without it, our 'without borders' would mean nothing and our association would not exist. Intrusion must therefore be valued and cultivated. By adding a measure of chantilly to wasabi, we have whipped up some fusion cuisine, and it is good stuff indeed!
But for such interference to succeed, the ingredients must be chosen wisely and the Japanese and Western palate must be trained to savour it.

In Japan, MSF is attracting a growing number of people who are fighting for the idea of "MSF-style humanitarian aid" and who are personally committed to defending it with conviction. In response to this challenge, MSF must allow more Japanese to intrude on the association instead of closing itself off in a members-only club. The increasing involvement of Japanese people at operations level is more necessary than ever. Otherwise, the spread of MSF's message in Japan, the growth of our section and the increase in the Asian component of the association's development will all remain stunted, if not impossible. The risk: MSF will not be able to grow in Japan, Japan with MSF, MSF with the Japanese nor the Japanese with MSF. ■

"*We also need to be prepared to move some operational centers or parts of centers out of Europe. It does not make sense to have all our five operational centers in one continent. We need to challenge our organizational structure, which was more or less formed through an unplanned and coincidental historical development.*"

Excerpt from « MSF and its unhealthy growth », by Morton Rostrup October 2002

"*« Nationalism, which is difficult to justify in a movement like MSF, often forwards its hidden agenda behind the necessity to set up specific procedures justified by national stipulations. Thus nationalism and bureaucracy feed on one another*"

Jean-Hervé Bradol excerpt from « Roots and Butterflies » (MSF document - 2001)

MSF AUSTRALIA

Australia and its resources

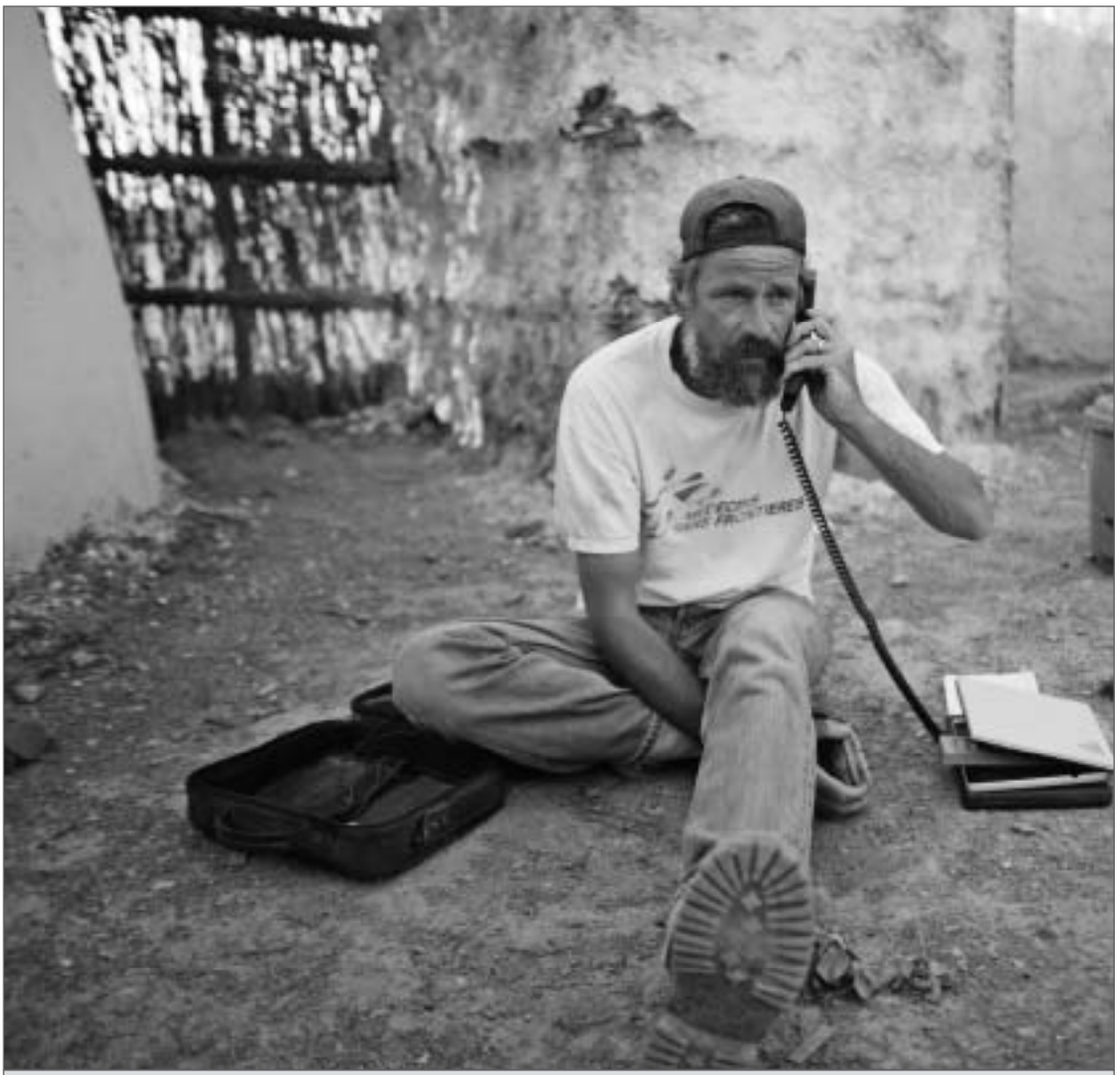
MSF Australia/April 2005/ Emmanuel Lavieuville, Head of Field Human Resources

Emmanuel describes the strength and possible improvements of the partnership with MSF France and MSF Australia, particularly in terms of human resources.

In MSF lingo, MSF Australia (MSFA) is one of the 14 Partner Sections (PS) of the 5 Europeans Operational Centres (OC). It was created in 1994 by Australian returned volunteers with the support of MSFF. More than 10 years after the opening of an office in Sydney the Australian section has been consistently growing and developing with the rest of the movement. Every year more than 100 volunteers from Australia and New Zealand are sent to the field (115 departures in 2004) and funds are raised from Australian private donors to support MSF field activities.
Historically linked to MSF Paris, MSFA is part of the MSF France (MSFF) group with MSF USA and MSF Japan. Translated into Field Human Resources it means that over 50% of MSFA volunteers go on missions operated by the French section, 25% go to the field through Amsterdam with the remaining of our departures spread among the 3 other OCs. From a Field HR perspective and beyond these figures, what is interesting here is to focus on what it implies today for the Sydney office to be a partner section. What are the current issues at stake for MSFA? What are our strength and constraints in field HR management particularly in our working relationship with Paris and other OCs.

→ IMPROVEMENT OF VOLUNTEER MANAGEMENT

Improvement of our management of field human resources remains of huge importance all over the movement. The quality of our volunteers and of our follow up of these volunteers impacts tremendously on the quality of our field projects. This spans from the recruitment until the placement on mission and then from placement to retention of volunteers for further missions. Being a partner section in this process just make things harder. The indirect nature of our position toward the field and



→ **Somalia, Rabdurreh** © Espen Rasmussen - June 2004

projects, and therefore of our management of expatriates make us highly dependent on the level of communication, exchange, feedback and evaluations we receive from the field and from the OCs.

Without any evaluation and feedback on a volunteer's mission, we find that we are far and away "down under" here in Sydney - a bit like being deaf, dumb and blind all at once... In order to support a volunteer to depart on subsequent missions and to adapt our management to his/her profile, we crucially need to be kept fully "in the loop" at all stages. How do we give a clear sense of who we are, what we do and what can be expected for a doctor or a nurse who has already completed 1 or 2 missions with us, if from the beginning to the end we are not consistent and coordinated in our messages? For example volunteer health, briefings/debriefings, training, career path, duration of missions and security rules. This also relates to our use of the main HR management tools (end of mission evaluation, job profile, projects information, etc.). In all these matters, being a PS can sometimes be like being at the end of the chain of command. Not to mention the specific constraint of the 10 hours difference between Europe and Australia, which makes it so difficult to have regular and basic phone conversations.

The International Remuneration Project (IRP) is another important aspect of the improvement of our management of volunteers. Beyond its principle of fairness for field volunteers (similar salary and social package) whatever the challenges, the IRP will also contribute to placing partner sections at the centre of managing their own field volunteers. Despite its focus on volunteer administrative related issues, the Remuneration Project could eventually help us to play a more useful and interesting role in the overall follow-up of field issues.

→ TEAM BUILDING AND ACCESS TO TRAININGS

When we place a volunteer in the field, the knowledge we usually have of their job profile and of the team they will work with, is vital and requires all possible improvement. Our role in matching an available volunteer with a field position is mainly based on the experience of our HR officers, but we also rely on what is provided by the field and Europe's HQ. Here once again communication between HR people plays a key role. Updated job descriptions and relevant information about the field projects helps to get the right person to the right job as well as increasing the input we have in choosing candidates and playing a pro-active & responsible role toward our volunteers. It is the difference between being a transit office where expatriates just get their visa, ticket, t-shirt, condoms etc., and being a Field HR department of a partner section. The borders between these status can easily be crossed, especially when placement issues cannot be internally discussed between the members of an operational desk and the field (as it is the case in Operational Centres). There is logically more depth in in Field HR management processes when there is a direct link with field projects and with other operational departments. MSF is a field driven organisation and has to remain so.

→ LANGUAGE BARRIER

Being conscious of the importance of the role played in the preparation, follow up and management of volunteers at all stages is certainly part of the understanding of our work here in MSFA's Field HR department. As partner sections whenever we have consistent and recurring feedback from our volunteers in the field, it is part of our role to take it to our Field HR counterparts in OCs. For example language problems in a field team is a common complaint among MSFA returned volunteers - we all know from experience how acute this issue can be, especially between French and English speakers. Therefore Field HR officers should take into account when building their teams that isolating one volunteer with a different language is counterproductive to the overall aim of the project and volunteer's experience. On the opposite side, it is our responsibility of PS to prepare volunteers without any former multicultural experience to give them the support that will help them to integrate a field team and to face the initial difficult emotions associated with a first mission.

→ ACCESS TO TRAINING

Retention of volunteers depends on many factors and language and team integration are certainly important. Giving our experienced volunteers the opportunity to attend training and take on more responsibilities is another part of the retention issue. The development of comprehensive career paths for experienced volunteers is a good step forward to accommodate the volunteer's wishes to develop their own profile and to plan their

> *The responsibility of the French, American, Australian, and Japanese sections in defining a common operational project is to incorporate the participation of people working on all different levels- even in creating this very definition. Different ties and involvement need to become interwoven, activated, and reinforced between our four sections: on human resources, field, and executive and associative levels (Associations and the Board.) Implementing a common operational project will simply be the practical application of this definition, which can be carried out in different ways within each section*

Armand Vironadeau, general director of MSF Japan

future. Over the past few years MSFF has already made a consistent effort to increase the amount of training courses available to English speakers. It is obviously crucial to our partnership with MSFF to have more training in English and it is logical then that Welcome Days are today commonly organised by PSs. Are there further options for other trainings organised by partner sections?

→ SHARED RESPONSIBILITY ON VOLUNTEER SECURITY?

The blurring of the lines between actors in the humanitarian field, and the increased risks for humanitarian workers highlights the need for defining who is ultimately responsible for the security of MSF volunteers in the field. As a partner section and as a sensible "employer" we cannot afford to sign any "blank cheques" to OCs when we send volunteers on mission, especially when it comes to security. It is part of our role as a partner, to participate in the operational policy and as such to interrogate/question the daily management of security. We are not talking here about the need for any kind of heavy procedure to be implemented, but more about the need for an integrated approach between OCs and PSs that can only be reached through transparency, communication and confidence.

After several months of working with MSFA, it is quite remarkable for me to see how well adapted Australian and New Zealand volunteers are to the needs of MSF missions. Indeed most MSFA expatriates already possess the high level of skills and qualities required in the field, and already have experience in practising health care in remote areas. Australia and New Zealand being large geographic territories that are not very populated (70% of Australia is desert), have developed through time a professional approach to the provision of health services in remote and rural contexts, not to mention the huge and acute health needs of aboriginal communities and the practice of tropical medicine in the northern part of Australia. It practically means that MSFA have at hand a great source of skilled and adapted professionals who are used to tough living conditions and who can easily demonstrate initiative and flexibility. ■

MSF GERMANY

The story of another partner section

MSF Berlin/April 2005/Ulrike Von Pilar

What is the vision of a partner section attached to an operational centre? Ulrike Von Pilar, formerly president then general director of the German section and today working in the international office, describes the creation, functioning and questions of MSF Germany that is attached to the Dutch operational centre.

MSF Germany (MSFD) today is responsible for projects in four countries in the MSFH portfolio: Nigeria, Banglasdesh, Chad, and Indonesia. This constitutes one of the biggest surprises of my life: We in MSF Germany never really dared to hope to become operational. It seemed inconceivable, and irresponsible, given the huge tensions - old and new - between the operational centres on the one hand, and between operational centres and partner sections on the other hand. Leaving my post of DG after eleven years in MSFD, first as president, then for more than seven years as DG, I am still hugely surprised at this unexpected and (for us in Germany) wonderful and challenging development. How and why did this happen? What does it mean? And what are the questions and problems this raises?

→ THE START AND EVOLUTION

MSFD has been founded by MSFH in 1993 with goals similar to those of all partner sections: Increase resources - personnel and money (not necessarily in this order); spread the MSF gospel - meaning témoignage; and: don't disturb the big ones - i.e. MSFF/H/B/CH/E. We were CREATED TO BE NON-OPERATIONAL - mere support sections for the operational centres, in order not to be adding to the existing chaos. Until MSF Sweden successfully pushed for it in 1994, we were not even allowed to be real associations (Chantilly then changed this once and for all). May be we were too timid at the time, but we were too aware of the existing internal tensions to aim at increasing those any further by pushing for becoming operational.

We in Germany were happy to exist, we worked hard to do what we were meant to do, and in soft summer nights (or after a couple of drinks) were dreaming of what it would feel like to be a "real" MSF - to be responsible for something more than for money and German public opinion: "have" our own projects. As mentioned above, this seemed totally unrealistic, and indeed irresponsible, since the internal conflicts, bordering sometimes at civil war, between the operational centres was, we felt, already more than MSF could, and the

→ **Somalia, Istorte** © Espen Rasmussen -June 2004

field should, bear. We would certainly not want to increase the chaos. I think we truly never lost sight of the needs in the field for whom headquarter fights have always been very detrimental and most of the time incomprehensible — in view of the needs on the ground. In addition we in Germany were really very international: Although attached to, and in the beginning mainly supported by MSFH, we always aimed at being "MSF" tout court — international in outlook and representation. This proved to be more difficult than imagined - since témoignage/advocacy, together with its political analysis and background, was the one issue on which intersection conflict was most of the time erupting. We remained stubborn - we wanted, and still want, to be international. This is one of the main characteristics that distinguish partner sections from operational centres (I believe - but may be I am wrong here?).

I think we truly never lost sight of the needs in the field for whom headquarter fights have always been very detrimental and most of the time incomprehensible

→ OPERATIONNAL SHARING

In addition, two factors were almost paradigmatic for the MSF discussion at the time: "MSF should not grow!" (it did anyway) — and: "It's the partner

→ Mea culpa:

"In regards to my frame of mind during the Belgian section's growth, to be honest, I simply and purely refused to say the words MSF-France at the time. 'When I go to the movies I don't say that I'm going to the talking movies;" this was my leitmotif. (...) I had, dare I say it, a colonial and humiliating perception of Belgium. It took me years before I could see the image I was projecting on the other side of the border: a long-winded, technical lesson-giver: typically French..."

Rony Brauman, quoted by Anne Vallaeys in her book : « Médecins Sans Frontières, la biographie », Fayard, October 2004

DOSSIER

How many divisions does MSF have?

> *In order for the entire movement to be directly implicated in the running of operations, it is now possible to divide up an operational centre's responsibilities between several sections.*
> *This should gradually materialize depending on how prepared each section is. There are several different ways of going about this, but the project does not make sense unless there remains one single director of operations.*

Jean-Hervé Bradol
excerpt from
« Roots and Butterflies »
(MSF document - 2001)

sections which are the problem. And HQ growth is unhealthy for MSF. Only operational growth is "good" growth." But we PSs were meant to be non-operational ... And we had become very good at what we were doing: Increase resources and public understanding and support in our own countries.

There was a danger of a two-class MSF-system emerging - operational centres vs. non-operational partner sections. In 2003 three things happened: The actual (HQ)growth pattern was judged dangerous (and PSs made responsible for this); big partner sections were increasingly seen as dangerous for the movement as long as they did NOT share the operational burden(change of paradigm number one - see above); and it was stated that MSF was continuing to grow, that this growth needed to be mostly operational growth, and that the PSs were NEEDED to shoulder that growth (change of paradigm number two).

That's when we grasped the moment, saw the chance - under this condition, the condition of being USEFUL rather than being a nuisance, we felt we could and should do it. And together with a very open and cooperative MT in Holland we managed to define a model of sharing operational responsibility which (so far) has worked better that one might have expected (see box).
As a consequence MSFD has changed, operations taking an increasingly larger place in our daily discussions - which is good. Still, major operational decisions are being taken in Amsterdam, which is good as well - since we are not yet ready and mature enough to take full responsibility of everything that can happen in a mission (see Afghanistan, Iraq and Chechnya). It is a gradual process of change, and I am not sure today of where it will, or should, end. But I think for me the main conclusion, after exactly one year of being operational, is very positive: MSFD has changed towards more responsibility; the field in general seems quite happy with the support Berlin can provide; we have contributed to MSFH/D reacting to more emergencies than normally possible (Nigeria, Bangladesh, Chad, Aceh); we have contributed to upscaling the HIV/AIDS programme in Lagos; we have established a positive cooperation with other OCs; and, together with the MT in A'dam, we pursue joint discussions about MSF's presence in the Middle East.

(...) Still, major operational decisions are being taken in Amsterdam, which is good as well - since we are not yet ready and mature enough to take full responsibility of everything that can happen in a mission...

→ QUESTIONS

There are, of course, a number of unresolved questions and problems, to be tackled in the coming one or two years: The question of governance within the A'dam group requires some good thinking - which role for the members, the boards? The GDs? The ODs? How much autonomy for Berlin vs. overall responsibility for A'dam? Which departments where? With which authority? How much growth in Berlin? What does this mean for A'dam and the A'dam group — which today is a reality as is the Paris group or the Brussels group? How can we support others to become stronger — according to needs in the fields and capacities in their home countries?

As important for me are questions affecting MSF as an international movement. MSFD has so much tried to remain an international section that we would hope not to forego this merely by becoming a "better" MSF section through being operational and thereby developing closer ties with MSFH. We remain committed to contributing to a more coherent, unified MSF movement without denying the value, and indeed necessity, of struggle and confrontation. OCs and PSs, both need to have space and freedom to delevop according to their individual ideas, needs and capacities - but within a commonly agreed framework and without ever forgetting what we are there for: Caring for, and where possible protecting, people in extreme danger. Being a big and visible organisation makes some of this easier. But the challenges are enormous - in the field and at home.

We cannot expect to remain a credible organisation for the people we care for without being a credible organisation for the people who work with us or who support us. ■

HOW DOES THE MSF GERMANY (MSFD) OFFICE WORK?

MSFD operates under MSFH operational policy and under the overall responsibility of Kenny Gluck, but the day to day management of the projects is placed in the operational department in Berlin. This operational department is organised differently from the one in Amsterdam, it is structured rather like a cell in Brussels: 2 ODs, 1 HRM field + 1 ESO, the medical advisor, the logistics advisor, and the communications-field advisor are all placed together in one big office. Finance-field is placed in Holland, but regularly present in Berlin.
The logistics, medical, humanitarian affairs, and procurement departments in Amsterdam are providing full support also to the Berlin run projects. The Berlin ODs (one medical, one non-medical) are part of both the MTs in Amsterdam and Berlin - a crucial part of the construction of this joint responsibility. Resources - money and personnel - are still managed in a common pool; which means that the danger of "your" (A'dam) and "our" (Berlin) projects is somewhat mitigated without completely negating the difference.

ANALOGY

Does it makes sense to compare?

MSF / April 2005 / Virginie Raisson, Deputy Secretary General of the Board of Directors/ translated by Lyn Lemaire

Policy or fiction? Comparing the construction of the international movement with that of Europe, Virginie Raisson proposes several guidelines that would help to set the foundation for a more coherent organization, less inhibited by the tensions that are now slowing down the movement.

While some propose opening the ICB to new members, just as others want to enlarge the United Nations Security Council, it is hard to stretch the analogy further. Unlike United Nations agencies, the MSF movement was created and developed not by its structures, but through its actions: building on its foundation in surgery and war medicine, MSF has since taken on the work of «témoignage», vaccination, aid logistics, epidemics, nutrition, training, psychological care, treatment for malaria, tuberculosis and AIDS, the campaign for access to essential medicines, and more recently, research (DNDI).

This progressive and intuitive accumulation of competencies and operational foundations has allowed MSF to increase the volume and impact of its global action; today, however, we can also measure its particular side effects : each operational center has its specialty, its priorities and its standards; each has its own procedures for establishing them and its own way of imposing them on others, and none of the common platforms have been sufficient to resist these centrifugal forces[1].

In the face of this situation, in the face of the risk of losing its soul (according to some) or its identity (according to others), new reforms are necessary to re-establish the objectives and mechanisms of the movement's international organization.

A second parallel immediately comes to mind, linking the current state of our movement and that of Europe, an incidental connection in its timing, but which, as such, would allow us to note several fortuitous similarities that might inspire other... more deliberate ones!

By establishing its mission and the guiding principles of its action, the MSF charter is to the international movement what the Treaty of Rome was to the European Economic Community : its founding text. And like the European treaty, the MSF charter even included a central act[2] that, nevertheless, was not ratified by all of the sections... notably by MSF France.

For like the construction of Europe, that of MSF confronted problems of diverging ambitions : Is Europe a political project in need of development, or a free trade zone in need of expansion? Does MSF's mission stop at emergency aid or does it also include a human rights aspect and/or a public health dimension?

Though the Treaty of Maastricht responds to the first question by uniting its member states around its famous three « pillars, » the no less famous text of Chantilly gathers MSF's 19 sections around a corpus containing no fewer than ten guiding principles and four rules of operation!

Nonetheless, just as the European states find themselves divided by their different concepts of secularity or by their respective visions of the role of the State, the MSF sections find themselves more and more at odds over different models and practices : while some prefer the dynamism of contradictory debate and the efficiency of a presidential regime, others privilege the proximity facilitated by decentralization and the influential power of a network of activity.

As such, common history also becomes that of common failures that set limits on what can be shared: the failure of the European Defense Community (CED) for some, that of the Emergency Team (ET) for others. Nothing serious in and of itself, unless one counts the increasing energy, time, and means that sections must appropriate to conflict resolutions that have become both disproportionate when compared with other activities and incapable of preventing the multiplication of both points of difference and the crises themselves. In the face of these difficulties, Europe has finally decided to give itself a Constitution. What about MSF?

If it does not make sense to compare the two, nor to endow MSF with a common Constitution, could the transposition give us some ideas? Could we, for example, imagine meetings of the International Board that would carry the same political force as summits of Heads of State and government? Meetings of the DG 19 set up like those of the European Council? Therapeutic protocols employed as criteria of convergence? Operational centers organized into zones of strengthened cooperation ? A DNDI whose success would equal that of the European Space Agency ? More seriously, couldn't we take up, in their intentions, the guidelines that the European states set for themselves when they adopted the principle of a Constitution : simplify, strengthen, democratize? Adapted to MSF, they could, for example, imply the following:

a. Simplify

- the texts: less our charter than the « principles » of Chantilly ;
- the architecture of the international movement : operational centers, partner sections (operational or not), offices, groups, OCB, but also BI, CI, ICB, Dircom, Excom, DG 19, etc.;
- the comptencies of the international movement : specify those which are exclusive, those that are shared, and those for which the CI only intervenes as support;

b. Strengthen

- the coherence of our movement's actions, with respect for the openness, debate, and plurality on which the growth of MSF is founded;
- the efficiency of our action with a structure and international decision-making mechanisms that would be clearer, simpler, and more efficient;
- the prerogatives and means of the president and the general secretary of the international movement with regards to the exercise and limits of the responsibilities that are entrusted to them;

c. Democratize

- with the close participation of the associations of different sections and their representatives in future debates and international reforms ;
- with the organization of the Boards' oversight of the question of shared competencies ;
- with the participation of the Boards in choosing an international president.

Evidently, at this point in our analogy between Europe and MSF, the question arises as to whether it is legitimate, useful, serious, or even too daring... For if we push it a bit further, it could also lead us to the following delicate questions :

- Europeans chose Giscard to preside over the exercise. Do we choose R. Brauman or B. Kouchner (if he is not selected as a candidate for the HCR)?
- In order for the United Kingdom to remain in the Union, the other European states conceded notorious exemptions, such as the reduction of its contribution to the European budget : are we ready to make the same concessions to MSF Holland for the DNDI?
- Each member state was able to choose between approving the European constitution by referendum or by parliamentary vote. France opted for the referendum. Would we choose AGMs or the Boards?
- Finally, faced with the rise of the « no » vote in the polls in France, J. Chirac allowed himself to be questioned by Fogiel, Delarue, Chain and 83 young voters on TF1. Will Jean-Hervé submit himself to questions from Drucker, Cauet, Castaldi before 83 first missions in order to anchor MSF France in the international movement? ■

1- Among numerous examples of disagreements, we could take as an illustration those regarding the decision to leave the camps in Zaire, the use of ACTs in Burundi, MSF's investment in the DNDI, or more recently, the classification of the situation in Darfour (genocide).

2 - « MSF is a private international organisation. Most of its members are doctors and health workers, but many other support professions contribute to MSF's smooth functioning.»

DOSSIER

How many divisions does MSF have?

→ Emergency Team: "ET"

Following the break-down of work relations between sections during the intervention in the Rwandan refugee camps in Goma, MSF made the decision after the meetings in Chantilly to equip itself with a new tool, christened "ET." Founded on a list of trustworthy people provided by different headquarters and approved by all, the system aimed to establish a common dynamic regarding emergencies, and also endeavoured to avoid tension between sections. "ET" operated for two years (until 1998) until the system reached its limits- particularly in terms of response capacity, responsibility, and quality control- causing the French section to withdraw, and the end of "ET".

THE BEGINNING OF THE MOVEMENT

Constructive disagreements

MSF / April 2005 / Interview by Aurélie Grémaud/ translated by Karen Tucker

The first charter of Médecins Sans Frontières stipulated that the association was "an international movement with temporary French legal status". With 19 sections today, that prophecy turned out to be accurate. But what were they thinking? Answers by Rony Brauman.

→ CARRIED AWAY BY ENTHUSIASM

The evolution of the international movement is linked to political trends in France and Europe. In the 1980s, MSF, still very small, entered a period of growth. From 1979 to 1980, the budget quintupled. In the field, in Cambodia, in Ethiopia, we had an increasing number of international volunteers and in France, our state of mind was resolutely European. 1979 marked the first election to the European Parliament by universal suffrage.

We fell in line with this European movement by creating "MSF sections", all in French-speaking countries at first because that was where MSF was known. We wanted to remain the majority party on their board of directors. That worked well during the 1980s in Switzerland, but in the Belgian section, we quickly moved toward a relationship focused on negotiation.

→ FIRST "FALSE NOTE"

The landscape quickly darkened, however. In 1983, we committed a huge blunder: two members of MSF-Belgium had been kidnapped in Chad. I found out from Charles Hernu, Defense Minister, who called me at MSF in the middle of the inaugural ceremony for our new offices. Malhuret and I immediately decided to alert the press and started to do so without even informing the head of the Belgian section, who was at the ceremony. He felt humiliated, which is easy to understand! This attitude reflected how we viewed our mission in Chad at the time and, more broadly, the association itself: only we could legitimately make decisions.
We paid for this for many years! The directors of the Belgian section waited for the first opportunity to pay us back, informing us of three new sections as a fait accompli: not only Luxembourg and Holland as natural expansions, but also Spain, where the vice president of MSF-B had many contacts.


Tonus

" MÉDECINS SANS FRONTIÈRES " EST DEVENU UNE RÉALITÉ

LA REPONSE A TOUS CEUX QUI DOUTAIENT DE VOUS

→ © François Leduc - 1971

→ DISTINCTIVE STRATEGY

We did, however, meet the founding members, speak with them, formally give our approval and participate in press conferences launching the new sections. From then on, we no longer controlled the movement at all. The difference in orientation was palpable in the field as well: while the Belgian section focused on development, we made the decision to concentrate on conflicts. In this respect, the Chad example is significant. Right from the start, we worked in the rebel area while the Belgian section focused on problems of access to medical care in the government-held area. When the war ended, we left, but the Belgian section remained and more than half of their resources were devoted to that country. The leaders of the Belgian section wanted to create a private alternative to public cooperation. War and insufficient medical care were given equal weight in the charter and was open to interpretation.

→ A CULTURE OF DISAGREEMENT

The creation of LSF and the 1985 colloquium on Third Worldism gave the directors of the Belgian section an opportunity to denounce our "politicking" and to pose as the true heirs of MSF's founders. It was at that moment that we committed another enormous blunder by suing the Belgian section to force them to stop using MSF's name. The lawsuit took place in Belgium and not surprisingly, we lost. The institutional ties between us were broken, but many personal relationships remained. A new executive director at MSF-B led to renewed ties after a few years.
In the late 1980s, we created "ET", a European emergency team. This reflected more a desire to work together and compromise than the true reality on the ground. But after the first Iraq war, we achieved our first great success. Together, the three "big" sections covered 80% of the Turkish-Iraqi border. We smoothly divided up the camps, did good work and managed to communicate in nearly a single voice. That was a new beginning as we began to respect our differences. And that was the end of our very own cold war". ■

VIEWED FROM THE OUTSIDE

« MSF, an International Movement? It remains to be seen. »

MSF / April 2005 / Interviewed by Rémy Vallet/ translated by Vanessa Martin

David Rieff[1] is a freelance journalist. In his last book[2], he confessed his affinity with "the concepts and practices of MSF's humanitarian action," and notably with those of Rony Brauman. An intellectual affiliation to keep in mind before reading his thoughts below: an external but not necessarily neutral view of the MSF international movement.

« MSF, an international movement? That remains to be seen. Certainly, there is cooperation between the different sections, which has, I would imagine, operational advantages. Otherwise, I believe there are major disagreements on the goals that are to be pursued.

« The debate pits those who defend the idea of MSF as something independent against those who conceive the idea of humanitarianism as only one of many tools in the toolbox of a global solution pronounced by Kofi Annan. This is like the debate between Rony Brauman, Xavier Emmanuelli, and François Jean on one side, and Bernard Kouchner on the other. That said, the kouchenerian ideas find favourable support in certain other sections. In all sections, including in Paris, there are those who say that only with a more global interference will we witness a true impact. This frustration at the limited impact of humanitarianism is understandable, but for me it is why truly independent humanitarianism no longer exists. « What I like about MSF France is its sceptical side in the face of power - in the face of all powers - including the European or United Nations' "good powers." MSF-F has always displayed the greatest reserve towards the politicisation of the humanitarian effort. And, given that MSF France succeeds in financing most of its activities by private donors, it can justifiably keep its independence and follow its own agenda.

As for the international office of MSF, it faces the same problems as all coordination organisations do, the UN foremost. It must evaluate and reconcile diverging points of view. Should MSF increase the power of the international bureau, revise the rules of decision-making within the movement and ensure that a decision passed by the International Bureau is imposed on all sections? I don't believe that will resolve anything, as I don't foresee MSF being able to keep quiet in the future. In the event of disagreement on a fundamental point involving MSF's identity, MSF France would be the first section to break the rule. ■

→ Cambodia, C. Malhuret, X. Emmanuelli, R. Brauman © MSF - 1979

> *« MSF is less involved in debates between agencies and less externally active, in Dutch society as well as internationally. MSF is only talking about MSF, looking at MSF, thinking about MSF, and therefore isolating itself in the world of humanitarian aid, and that is a dangerous thing.*
>
> **Geoff Prescott - MSF-Holland New General Director, excerpt from « MSF is isolating itself in the humanitarian world », published in Ins & outs, February 2005**

1- David Rieff writes for *the New York Times*, the Los Angeles Times, and the American weekly *Mother Jones*. He is also the author of several books, two of which focus on the practices and problems of humanitarian action - Slaughterhouse: *Bosnia and the failures of the West* (1996), *and A Bed for the night, Humanitarism in Crises* (2002).

2- *A Bed for the night, Humanitarism in Crisis, published in 2004* by Serpent à Plumes under the title L'Humanitaire en crise.

Cambodia © Jan Banning – 1997

DEBATE

MSF and its limits

MSF/December 2004/Pierre Salignon, General Director of MSF/Translated by Catherine Beverly

Pierre Salignon takes a look at the dilemmas currently facing aid workers. His observations touch on the role we choose to adopt, the limits to what we can do, safety for teams, and also the temptation we may feel to broaden the responsibilities of an NGO such as MSF.

In today's climate where 'humanitarian aid' has become a tug of war between multiple players (first-aid workers, lawyers, politicians, soldiers, etc.), it is important to specify once again the primary mission of an international medical organization like MSF. In the places where we intervene, lucidity requires us to see relief work and its optimisation as nothing other than an end in itself. In my view, our role is especially defined by tension with the political power, whether we're delivering assistance to populations in times of conflict, epidemics or endemic diseases. But even if what we do and the way we speak out in public are useful in increasing the help given to populations in need, and in drawing attention to them, we have to recognize that there are limits to what we can accomplish. Far be it from us to imagine that we can avert or take side in conflicts, and even less resolve them; the same applies in peacetime, we have to be careful not to take the place of state health institutions, or fight for the emergence of a universal right to medical treatment, for example.

→ RESISTING THE 'PROTECTION MANDATE'

Even if MSF is, in my opinion, neither a 'human rights organization' nor a 'victims' mouthpiece', there is a danger that the illusion of a supposed 'protection mandate' may lead to mistakes in our deployment of aid, not to mention the sometimes exaggerated expectations that we raise in the people that we are trying to help. MSF's role is much more modest. If our presence aims to create or conquer a 'space for humanity' in the midst of violence and exclusion, to help alleviate people's sufferings, even to reduce, indirectly, the level and the effects of the violence, then that's already saying a great deal. On the other hand, letting the people we treat believe that we are going to 'protect' them is pure illusion. 'Armed' with our medicines and good intentions, we don't have the means to shoulder such a responsibility. Remember Rwanda, Kibeho, and Srebrenica in Bosnia-Herzegovina: interventions where we were unable to protect either our staff or our beneficiaries. The feeling NGO members have of being 'all-powerful' (the feeling that we can protect the populations we help, and even stop the violence) bears no relation to the facts.

→ FREEING OURSELVES FROM PROPAGANDA

The illusion that we have a responsibility to protect also explains why we are repeatedly tempted to seek, and sometimes to formulate, solutions to conflicts to bring an end to violence against civilians. Is this our role? I don't think so. Yes, it's a source of frustration. But from Rwanda to Kosovo, from DRC to Liberia, examples abound of armed international interventions - that we have sometimes hoped and wished for - which have very often failed. Justified in the media as being 'for humanitarian reasons', the aims of these international military interventions are rarely 'the protection of populations' as such, but conform more to the laws of propaganda.

Similarly, making a call to arms means taking sides in the conflict, with the risk of losing our neutrality and becoming targets ourselves. The examples of Afghanistan and Iraq prove this. (There are many NGOs who have called, notably, for an extended ISAF and NATO mandate.) What is the point, then, of pursuing our mission if that simply means treating the wounded, 'without offering solutions'? The example of Sudan and the war in Darfur ought to convince us that it is our ability to do everything possible to bring relief to populations that is at the heart of our actions, despite constraints that can, at times, completely prevent us from pursuing our mission. When this occurs, we have to explain it such as when we were thrown out of Ethiopia in 1985, or when we withdrew from the refugee camps of eastern Zaire in 1994, from North Korea in 1998 and, more recently, from Afghanistan and Iraq. It is always about conquering our space to intervention. It is never easy, and that's why it is so important to have our own perspective on the crisis situations we observe.

→ THE TEMPTATION TO BE BLINDED

We find it hard to accept being absent from countries in the grip of violence. Talk of the 'war on terror', in particular, is having a destabilizing effect on us, and its excessive coverage in the media is pushing us to define our role exclusively in terms of it. True, some of those engaged in those conflicts are targeting and murdering us. We are seen as siding with the occupation policy of the international coalitions fighting 'against terror'. Although we will never forget the murders of September 11th 2001, they must not be allowed to blind us. No 'humanitarian space' exists in Iraq, and it is not the role of a humanitarian organization like MSF to participate in the supposed 'reconstruction' of the country while it is occupied by an international coalition led by the USA. We left Afghanistan following the murder of five of our colleagues. These reasons explain why we are no longer present in Iraq or Afghanistan. And the problems we encounter in the 'Arab and Muslim world' are not all that different from dilemmas confronting aid workers elsewhere.

(...) On the other hand, letting the people we treat believe that we are going to 'protect' them is pure illusion. 'Armed' with our medicines and good intentions, we don't have the means to shoulder such a responsibility...

→ THE RISKS ACCEPTED

Do we, like armies in a campaign, expect to lose a percentage of our personnel? Should our desire to help populations in the most extreme situations (without always knowing how) lead us to accept the unacceptable? To resign ourselves to that would be to change the very nature of our mission. We have said it again and again since the murder of our five colleagues in Afghanistan: we do not look for martyrdom. While we are aware of the risks involved in what we do, we must not resign ourselves to the disappearance of our own people, whether killed or taken hostage. In the Northern Caucasus, we have progressively reduced the presence of expatriates - especially vulnerable to the threat of kidnapping - by relying more on our local personnel. That doesn't mean we forget the dangers they also face, and this approach isn't totally satisfactory from an operational point of view (distance with the field, poor quality of supervision of any actions undertaken). The recent murders of local MSF staff in Darfur and Somalia are a sad reminder to us. We should never see the risk of death, for any of our personnel, as being just a normal risk, something that goes with our mission.

→ IN SEARCH OF A SPACE FOR INTERVENTION

How can we carry out our operations in the most inflamed (violent) situations? From an operational point of view, everyone recognises the need - where possible[1] - to try and obtain a minimum of guarantees from all sides in the conflict, in order to be able to work successfully in troubled areas. There's nothing very new in that. In the field, this involves the daily task of explaining our actions and the reasons for our presence, and making operational positioning choices that may at times be sensitive. As far as possible, we develop contacts with all armed parties, while refusing to follow their lead (making contact is not the same as offering support) or accept any 'conditions' they may wish to impose with regard to access to populations or the free assessment of needs. As we often say, 'there are no good or bad victims'.

At a time when countries in the coalition 'against terror', and the main donors of government aid, are pushing NGOs to take sides 'against terror', it would be contradictory - and in total contradiction of our charter - to take side in any conflict. MSF is not supporting armed groups, no matter who they may be. This is the assurance of our neutrality and of the respect of those engaged in conflicts. That all armed parties (whether local groups or coalition forces) try to manipulate us and divert the assistance we deliver is a fact. For all that, it would be dangerous to believe that, in future, we shall gain easier access to populations if we ally ourselves with this or that side in a conflict. There'd be no point in talking about humanitarian actions, in that case; we might as well agree to be just a support group for the established political powers. Our desire to help cannot be achieved at any price. Our history should teach us greater humility; we must realize how little room for manoeuvre we have, while trying wherever possible to expand it so as to give more assistance. In order to think through the limits to our actions, we must, first and foremost, resist the myth of a limitless mandate. ■

In order to think through the limits to our actions, we must, first and foremost, resist the myth of a limitless mandate.

1- Some armed extremist groups are currently murdering aid workers. Is it either possible or conceivable that we should develop contacts with them? And for what purpose? My own feeling is that, with tensions now at a peak in the 'war on terror', it is not possible. (This will surely change in the future.) On the other hand, we cannot accept being murdered without speaking out and denouncing those who kill us.

ARJAN ERKEL

Courtcase of the Dutch Government against MSF

MSF/April 2005/Interview with Rowan Gillies

One year after the release on April 12 2004, of Arjan Erkel, a Dutch volunteer for Medecins Sans Frontieres who was kidnapped in Dagestan and held captive for 20 months, MSF is now being dragged before a civil court by the Dutch government. The Dutch Government is demanding that MSF reimburse them for one million dollars – the sum they claim they contracted to loan MSF for the payment of Arjan's ransom. Yesterday in Geneva, Switzerland, the first public court appearance took place before the presiding judge.

→ What is the complaint of the Dutch Govt against MSF ?

At the end of July 2004 four months after Arjan Erkel was freed, the Dutch Government filed a case against the Swiss section of MSF (with which Arjan Erkel worked at the time of his kidnapping) in a civil court requesting that the money they paid for the release of their citizen be reimbursed. To be crystal clear, MSF never borrowed any money from the Dutch government and in addition, the Dutch government negotiated on its own the terms and conditions for Arjan's release. only informing informed MSF at the last minute. In fact, since March 2004, following a public information campaign led by MSF in order to get Arjan released, to which they objected, the Dutch government had severed all relations with MSF.

→ According to you, what is the true basis of this case ?

Officially, states don't pay ransom to release hostages. More realistically, they don't want to be seen to pay ransoms. We see this court case as an attempt to cover up that payment - in effect 'passing the buck' to MSF. The premise of this case is completely false, and is merely a smokescreen to save appearances before their parliament and the Dutch public

→ What is the position of MSF on this process?

MSF is now being placed as the defendant in a civil court in Switzerland over a case that has its origin in the ongoing conflict in Chechnya. It is difficult to reconcile the two. We are talking about, in effect, the traffic of a human being on the territory of the Russian federation, the kidnapping of an humanitarian worker, - a person who is supposed to have protection under international law and who should expect that law to be enforced by the countries that have signed it. For 20 months and in spite of numerous campaigns calling for the release of Arjan Erkel and for the mobilization of the international community, MSF has met with the inertia of states, particularly that of Russia and the Netherlands, which were unwilling for the kidnapping of an international humanitarian aid worker to put a tone of discord in an otherwise very sensitive political and economic relationship

. This is not an average criminal story nor it is a simple transaction between two parties. The Arjan Erkel kidnapping has many political implications, both when it comes to the responsibilities of states under International law, and the impunity surrounding attacks on humanitarian workers. While MSF is now portrayed as the defendant, there seems to be no serious investigation going on in Russia and Arjan's kidnappers are still on the run; violence against civilians in the North Caucasus region continues; and aid organizations that attempt to provide assistance still face tremendous risks. ■

→ Concerning the Courtcase

"The question of « how could this happen ? » needs to be properly answered, so that we will be well prepared for questions coming from the media about the court case and the book [at the end of year a journalist plans to publish a book about the kidnapping.] And we need to take these lessons to heart. Above all we need to remember that it is only as an international movement that MSF can play a meaningful role, and that all members of this movement need to contribute to this goal. »"

Lisette Luykx, President of MSF-Holland, published in In & Outs, september 2004

AIDS

AIDS : When Than Fiction

MSF / March 2005 / Annick Hamel, coordiantor of the Campaign for Access to Essential Medicines/ translated by Carina Klein

In its last report, « AIDS in Africa : Three scenarios for the 2025 Horizon » UNAIDS estimated that because of the « political decisions made today by African leaders and the rest of the world » AIDS will have killed 67 million Africans by 2025 according to the most « optimistic » scenario and 83 million according to the most pessimistic one. Judging by the facts, there is reason to fear that the political decisions already made are leading in the direction, not of a scenario, as pessimistic as it may be, but in the direction of truth that is stranger than fiction.

→ WHAT ARE THE FACTS SO FAR?

That in 2003, while six million people were in danger of dying if they didn't immediately receive the antiretrovi-

Truth is Stranger

→ Kenya, Nairobi © Sébastien le Clezio - March 2005

rals that would make it possible for them to survive, the World Health Organization set for itself the « ambitious » goal of only placing half of these people, that is to say, three million people, under treatment before the end of 2005. Less than a year before this deadline is reached, only 700,000 of these patients are receiving the promised treatment. The WHO continues to congratulate itself and...the epidemic continues to rage: each day, 8,000 people die from AIDS. That beginning in 2005, according to World Trade Organization (WTO) agreements on intellectual property, invented medicines will be systematically protected by a patent for twenty years in the countries that have the capability of making identical copies (in terms of both quality and effectiveness) of innovative medications. The patents will prohibit continuation of this production.

Given that the price of patented drugs are 30 to 100 times higher than the price of generic versions, in essence all future medical innovations will be denied to patients from poor countries. This does not only concern antiretrovirals (ARVs): all medications, vaccines, and laboratory tests will fall under the ax of this absolute protection.

That the WTO agreement of August 30, 2003, which was supposed to redress this feared inequality, set forth a generous principle: patients from poor countries have the right to medical care, they should have access to genetic versions of patented medications. But no sooner was the principle stated than it was contradicted by the absurd requirements of the

(...) only 700,000 of these patients are receiving the promised treatment. The WHO continues to congratulate itself and...the epidemic continues to rage: each day, 8,000 people die from AIDS.

application which will surely make it impossible to put the principle into practice. This agreement is furthermore interpreted in the most restrictive way possible by rich countries. In Canada, for example, the enactment of the August 30 decision resulted in the drawing up of a very selective list of eligible countries and of drugs that it would be possible to produce and export in their generic forms. Noticeably absent from this list are the fixed-dose combinations for AIDS which reduce the risks of resistance and are vital for developing AIDS treatment programs in developing countries.
Lobbyists of large pharmaceutical companies have been out in full force. Bayer for example, applied effective pressure so that its treatment for pneumonia, moxifloxacin, would not appear on this infamous list.

Not to be outdone, the European Commission plans to introduce measures which even the WTO excluded, such as a requirement to negotiate with the patent holder in the event of production under license for the purpose of responding to a health emergency or for government use.

Today it is India that has to bring itself into compliance with WTO regulations[1]. By producing triple therapy antiretrovirals for less than 200 dollars a year, the country has played a key role in supplying developing countries with affordable generic drugs: of the 700,000 AIDS patients receiving ARV treatment in poor countries, half today receive generic medications from India. For the 25,000 patients treated by Médecins Sans Frontières, this figure rises to 70%. But changes planned in Indian patent law will drastically restrict, and even prohibit the production and export of vital Indian drugs to other developing countries. What will become of these patients when, inevitably, they will be resistant to the current drugs and will need second-generation treatments in order to prolong their lives ? The price of these second-generation medications is 10,000 dollars per year per patient in the rich countries ! In countries where the average daily income does not exceed one dollar, who can hope to have access to these medications ?
We also see that the United States, which considers that the multilateral framework of the WTO is not sufficiently favorable to the U.S., uses bilateral and regional agreements to force the countries of the South to adopt measures which go well beyond those required by the WTO. In Guatemala, for example, beside the fact that patents can be extended beyond the 20 years required by the WTO, « data exclusivity » protects those drugs that are not under patent. We also note that on one hand France deplores « the lack of aid to people in danger » which makes it impossible for sick people in poor countries to

PRESS REVIEW

MSF/May 2005/ Jana Peters

→ Dutch government court case

MSF has been summoned to reimburse the ransom given by the Dutch government to free Arjan Erkel, who was held for twenty months in Daguestan. The lawsuit began April 21st in Geneva's civil tribunal. The Dutch government is demanding a reimbursement of the one million euros it claims were an "advance". "MSF is stupefied, claiming loudly and clearly to have never given authorization for the Dutch government to negotiate in its name" (Le Temps, April 15, 2005.) "They claim that this money was an advance. But an advance on what? We did not make any agreements prior to Arjan's liberation," clarifies Aymeric Peguillan (MSF Switzerland) in the columns of Libération (April 22, 2005.)

have access to affordable medications; but on the other hand, France puts pressure on the Dominican and Brazilian governments to disuade them from exercising their ability to copy Plavix® or Taxotere®. These two patented medications are the property of French pharmaceutical companies, Sanofi and Aventis.

On top of all this interest groups, affiliated with the pharmaceutical industry, have skillfully organized a public campaign to disqualify generic drugs: The WHO, which certifies the quality of these medications by means of a long certification process and through its reliance on the support of independent experts, is accused of promoting second-rate drugs. Despite the graveness of these accusations, they have never provoked the slightest reaction from the Director General of the WHO. As for MSF, which treats AIDS patients in its programs with generic ARVs, it is denounced as a murderous and irresponsible organization which is spreading resistances to the virus and mortgaging the future of part of humanity. What do these powerful lobbies offer ? The use of brand-name products out of the financial reach of the overwhelming majority of patients. In effect, this results in leaving them to die. Poor countries deprived of therapeutic innovations ; the pressures of policies in the defense of private interests, denouncement of the WHO, despite its being in charge of promoting « health for all peoples", a campaign to discredit generic drugs... Put in this perspective, these facts show that by continuing to protect the financial interests of a few to the detriment of the health of the majority, a discriminatory system has been put in place: at best, sick people from poor countries will be treated with outdated drugs. At worst, they will not be treated at all.
If only this could be fiction... ■

1- For more information see www.msf.fr

PRESS REVIEW (CONT.)

→ First success for the DNDI

Sanofi-Aventis and the DNDI international foundation announced the future launching of a medicine for malaria that will be sold for one dollar in underdeveloped countries. As the drug is not patented, third-world countries will be able to copy it immediately. This new formula combines two anti-malarials in one single pill. In the April 9th edition of Le Monde, it was referred to as a "breakthrough in the battle against malaria."

(cont. page 30)

MALARIA

Médecins Sans Frontières welcomes news of a new combination drug to treat malaria

MSF / April 2005 / Press release

Non-patented, user-friendly and low-cost, the new formulation is a step forward for treating malaria patients. It will be the first project to be completed by DNDi, a not-for-profit foundation created in 2003 at Médecins Sans Frontières's initiative.

Paris, 8 april 2005. Médecins Sans Frontières welcomes DNDi (Drugs for Neglected Diseases initiative) and Sanofi-Aventis's joint announcement of a new product for treatment of malaria. The product, combining in a single pill artesunate (a derivative of artemisinin) and amodiaquine, should be available to patients in 2006. Artemisinin-based combination therapies, or ACTs, are the most effective treatments for malaria.

The new formulation is particularly attractive for three key reasons:

- User-friendliness: the new product will only require patients to take one pill (combining artesunate and amodiaquine) twice a day for three days, whereas existing ACTs for adults consist of 24 pills. Paediatric formulations have also been simplified. With the two drugs combined in a single tablet, the risk of developing resistance is reduced, as it is impossible to take only one of the drugs at the time.

- **No patent:** the new combination will not be covered by any patent. This means that any generic producer is allowed to make a similar product. Because competition between manufacturers results in lower prices, this is a real step forward for access to essential medicines in resource-poor settings. DNDi and Sanofi-Aventis must actively participate in the transfer of technology and know-how required to enable generic producers to manufacture the drug.

- **Price:** set at $1 per adult per treatment course and at $0.50 per child, the new product is clearly cheaper than existing ACTs. But MSF is concerned that the agreement between DNDi and Sanofi-Aventis is in itself not a strong enough guarantee that the drug will be marketed under these conditions. For this target price to be achievable, there needs to be competition in the market, and international donors must commit to stabilising the markets for raw materials and to assisting developing

→ **Ethiopia, Gutten** © Cécile Menard/MSF - December 2003

countries in implementing protocol changes. The announcement of a new ACT co-formulation is good news, but it will not solve all problems related to addressing malaria globally. The parasite responsible for malaria evolves continuously in response to new treatments, and more R&D into new products remains essential. And even when ACTs are the most effective treatments that exist today, they are unavailable in the majority of African countries where malaria takes its greatest toll. Because of a lack of political will and financial commitment by governments, the WHO, UNICEF, and the Global Fund, old and ineffective drugs are still widely used, and 3,000 people still die every day because they have no access to more effective malaria treatments.

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DNDi was launched in 2003 as a collaboration between MSF, the Pasteur Institute, the Oswaldo Cruz Foundation (Brazil), the Indian Council for Medical Research, the Kenyan medical research institute, the Ministry of Health of Malaysia and the WHO's programme for Research and Training in Tropical Diseases (TDR). DNDi's mission is to address the lack of research and development in neglected diseases.

In 2005, Médecins Sans Frontières contributed 5 million euros to DNDi. MSF treats approximately one million people for malaria every year in nearly 40 countries around the world and has been advocating for ACTs since 2002. ■

HUMAN RESOURCES

"On the Road"

MSF/April 2005/Interview with Amanda Harvey, Director of Human Resources

After fixing the priorities in terms of organisation of field work and team composition, as well as the retention and development of coordinators, where are we two years down the road? Amanda discusses the first assessment.

→ Can you talk about the development of field coordinators before we get onto the subject of national staff?

Actually, national staff are also part of this development - an idea which has required a big mental adjustment within the organisation. We had no clear picture in Paris of the number of national staff in coordination positions when we first wrote the HR policy, so we couldn't really comment on their development. We spent 2004 centralising data on them, and the introduction of the HR database for national staff (which mirrors the one already in place for international staff) will soon allow us to have a comprehensive overview of who is who.

At present, encouraging national staff to take on management positions is not systematic in field teams. Their position and responsibilities often remain at the mercy of individual expat staff. We still receive organigrams which exclude national staff positions completely. And during our data collection, we often heard that while management positions existed, the people occupying them were not assuming all their functions, and so were not counted. In other words, there was a mismatching of people to positions all over the place. The cultivation of national staff in field leadership in such a "fragile" environ-

→ **Uganda, Akilok** © Chris de Bode - November 2004

→ A reminder of the HR policy

In order to improve the quality of our assistance, we should optimise the association of individuals involved in MSF's project.
2 points to focus on:

1) the organisation of field work and the composition of teams, aligning both to project objectives and bearing in mind the complimentarity of national and international staff, and

2) the development and retention of coordinators.

• • •

ment is not easy, as you can imagine! We have always had a better grasp on our international staffing of management positions because expats frequently pass through Paris and meet with the HQ team. But we still have had to be more proactive about identifying people with the potential to take on more responsibility in the field. The introduction of the "semaine environment" has helped.

→ So once we know who which individuals we are talking about, what measures have been introduced to develop them?

Denis Gouzerh writes below about international coordination development and the Paris training programme open to both national and expat staff. Unfortunately, we have not made much progress on locally-based training opportunities and this is unlikely to advance until there are more means deployed for such concerns in the field. Cultivation of national staff with potential to take on leadership roles has been even less of a priority in the field - sometimes because there are no obvious candidates, other times because no one has had the time. Perhaps there are some who contest the need for it all? Our remuneration policy for both national and international staff has been under review for the past year. The national staff salary policy has been tightened up - no more short term contracts for people who have worked for over two years for MSF. Salary scale revisions have taken place in 18 missions. The national staff medico/social policy has also been re-enforced. For international staff, the possibility of issuing contracts in their home countries, and thereby tying them in to their home social security systems is being developed, so coverage will improve. While the driving force behind these measures is MSF's will to take on more responsibility towards its employees, we will also see if the measures have a "secondary" impact on retention of strong field staff. They certainly can't harm it! In short, retention and development measures are on the rise. This has generated a lot of debate and discussion, but this is to be expected in an "emergency", expat-orientated NGO. In the meantime, our difficulties finding enough international staff with the requisite experience to cover all our coordination needs continues. Even when these positions are open to national staff, we will not always have enough qualified people to occupy them. So the need to develop these two types of staff remains urgent.

→ How about field organisation? What progress?

It's more difficult to measure progress on this part of the HR policy. But there has definately been some. Ankoro, the new hospital project in the DRC, is a good example. The team was not composed starting with a handful of expats with national staff added on around them as the work piled on. Rather, the team was built up position by position, according to the project's overall objectives. People were then matched to positions. Make no mistake, this was not easy! When people need urgent health care, we have to move quickly. This is not always compatible with the time required for more "structural", organisational questions. There were some terrible moments of tension when we could not find the people we wanted (national and international) for our positions. But the field and desks drove on regardless. As a consequence, there is a real understanding of the project and we hope we can solve problems as they come up and avoid "wasted resources" more easily. The dynamics in the DRC mission have changed in a very positive way. On an individual level, national staff have more opportunities to as more coordination positions have opened up to them. And expatriates have often extended their contracts in the field - always a good sign.

On a general note, if it seems that we spend disproportionate amounts of time discussing national positions and persons whilst looking into organization and team composition (see graph of field staff in October 2004). How can we be called demagogic when faced with these figures? Furthermore, we have always taken into account the welfare and organization of expats, one way or another. We need to do some "boosting" to get these same reflexes into place for national staff.

→ Are the numbers of expatriates dropping in the field as a consequence of such organization?

No! We cannot do without expatriates in the team. But we think we can't do without national staff either. We need both! That's the point. National staff are hired for their professional competencies. They also offer stability, mission memory, and an understanding of the local context. International staff offer impartiality in the mission. An objective, outside view of things. We fill some positions exclusively with expatriates for this reason. Expats are also volunteers - a misnomer, actually, because many of them are salaried employees with MSF. But in calling them this, we try and capture the spirit of their motivation and dynamism. The MSF exptriate's gesture of international solidarity (or perhaps an individual's simple curiosity to see how things work elsewhere... the motivation of our expats is the subject of vast debate...!) results in a huge capacity to drive things ahead. And then of course on a practical (but vital) front, expats often offer technical skills that are missing locally. Last year we sent out some 1187 expatriates to the field (12.4% more than the year before, which when added to the shortage of coordinators plus the changes required by the HR policy, resulted in a turbulent year in the HR department).

Expatriate recruitment also increased - in part in order to keep up with the demand in the field, in part because the recruitment teams in Paris and

partner sections are recruiting more. The expatriation procedure for national staff, which was clarified during the year, has also facilitated growing numbers of candidates for expatriate field positions.

But just because we are using a more structured mixed approach to team composition doesn't mean that things are easy. The problems are just different. Expat turnover on coordination positions can still be too high and disruptive (1.6 HoMs per position per year, 1.6 medcos per position per year, 2 logcos per position per year). There is still not enough attention paid to team management which means that those in coordination positions and the desks spend too much time dealing with team and individual problems. The working ryhthms of national and international staff are not always compatible. The list of difficulties could be longer still...

To call a spade a spade, ad hoc management based on personal likes and dislikes does not ruin MSF's impact in the field because the MSF volunteer dynamic can still carry the day. But we think that that if the field projects were just a bit more structured, then we could continue to profit from our volunteer dynamic but make so much more of the national staff. More organisation helps people on positions do a better job - expat or national. And better work means more quality in the care offered to MSF's patients . That's what counts. That's what the HR policy aims for.

→ So are our "decision making" teams more mixed?

Our field project teams: increasingly so. Our "core" coordination teams: very rarely. If we count such positions based in capitals in 2004, we had some 115 filled by expats. Just 10 were filled by nationals. Even if certain coordination positions should be filled by expatriates only, their work load is huge. Why don't they have national deputies? If we want these teams to be mixed, we have a lot of work to do - and most of it in the field. Why don't we give ourselves the means to do it? By opening up RRH positions, for example?

→ **Nepal, Rukum** © Myrto Schaefer/MSF - May 2004

In a nutshell, two years ago the association agreed on the road we want to go down (the HR policy). Afterwards, i don't think we agree on how far to go down the road (degree of mixing teams, extent of retention measures for coordinators). And I know we don't all agree on the mode of transport for the journey (organisation, individual development, evaluations, RRH positions....). But if you think it could be done differently, we are willing to listen! ■

HUMAN RESOURCES

Field professionals?

MSF / April 2005 / Denis Gouzerh, training coordinator/ translated by Julia Maitland

Would professionalising human resources be incompatible with the militant aspect of MSF volunteers' commitment to the association? A legitimate question when this is understood as invasive bureaucratisation, but one which must not hinder the progression in our human resources policy.

Everyone acknowledges the importance of the headquarters' role in assisting field teams and no-one can criticise its desks system, which calls upon qualified employees - with operational experience - selected by way of recruitment interviews and supervised by directors. This professionalising of the staff, for many years now at headquarters, has not been developed in the same way and in parallel in our field operations. Certain steps have been made, but overall, willingness, more or less voluntary promotions, chance meetings and subjective evaluations have substituted for a defined policy.

→ INCREASED RESPONSIBILITIES

Our operations, in terms of quality, have increased greatly, necessitating, of course, supervisory teams in the field who are more experienced than at the end of the 80s or early 90s, when we would probably not have been able respond to the Angolan or Sudanese crises (Darfur) as we were able to in 2002 and 2004. Similarly, hospitals like those in Monrovia, Ankoro or Bouake would never have been considered as possible intervention methods. This sharp increase in quality necessitates better training and preparation of our co-ordination teams. For several years, the Field Coordinator (Field Co) has no longer been the part-time supervisor of a team of three expatriates and around twenty nationals, but the head of a project that may comprise five or six different activities, supervised by a person known as "deputy Field Co", who is responsible for a particular activity (feeding centre, paediatric unit, victims of sexual violence unit etc.). Hence, the Head of Mission's task now involves supervising larger coordination teams that can be split into two main groups: the coordination staff (Field Co, MedCo or Log Co.) and the operational supervisors (deputy Field Co).

→ LONGER COMMITMENT

Recently, quantitative changes have been recommended and sometimes implemented in the field to lighten the workload of the co-ordination team by creating positions such as pharmacist or human resources administrator. But even though the Field Co or HoM may be assisted for certain specific tasks, they are still ill-prepared, in terms of operational experience and

training, to lead increasingly ambitious projects.
This has been acknowledged for several years and until now, rather fatalistically, due to the almost impossibility of creating a group of co-ordinators capable of making middle-term commitments. As David Rieff has commented, humanitarian aid is a short-term principle, but often this short-term can be measured in decades (thirty years of war in Angola).

Without losing sight of the need to imagine a probable and desired end to our intervention, it is important to plan ahead, beyond the coming weeks and months. Two elements of volunteers' profiles must be strengthened: the duration of commitment and the obtaining of skills during their time with us. To this end, it is important to suggest to those joining our association to no longer consider their joining MSF as a mere 'parenthesis' in their professional life. Often, still today, a few years at MSF have little worth in a career span, but they represent a choice that is part of a new kind of activism, a more professional activism. This middle to long-term choice (six years) should be suggested and offered after one or two missions and must be constructed together (volunteer and association).

→ A NEW STAGE

Last year a working group was created at headquarters comprising members of the operations and human resources department. This group has defined a framework of mutual commitment: enabling volunteers to be assisted at different stages when taking on new responsibilities, and enabling the association to lean on more experienced and better trained executives. This new contract, which, for those who wish, can take the form of an open-ended work contract, should help improve the quality of our coordination teams. This policy is based on several key elements in order to help volunteers take on new responsibilities: always encouraging a mixture of field experiences that include different types of intervention (hospitals, nutrition, emergency, HIV etc.); offering a position corresponding to logical progression in terms of experience; closer supervision when starting a new position (HoM or CoMed for example); increasing knowledge of headquarters (decision-making mechanism, how the departments work etc.); punctuating their time at MSF with internal training; encouraging time outside MSF and external training in order to take on co-ordination positions; and carrying out regular assessments to redefine and update the path planned out together a few months earlier.
Some aspects of this new policy have already been touched upon in the different training courses, meetings and individual interviews. It has taken several months to formalise a project taking into account the comments, criticisms, and proposals from headquarters and field staff. This has now been taken on and we have chosen to implement it initially (2005) using a test population: around 40 volunteers pre-selected by operations and HR having chosen (or who will choose) a specific path within MSF. This is the last stage to ratify the project before widespread use. In the meantime, volunteers are encouraged to discuss their 'careers' at MSF with those in charge (Field Co, HoM, MedCo, RP, ARP) of the projects in which they are involved or have been involved recently. ■

PRESS REVIEW
(CONT.)

→ Following the tsunami

Four months after the tsunami, French NGOs are carrying out a first evaluations of their actions. According to Le Figaro, a total of 245 million euros were collected in France. Newspapers are revealing some concern, particularly regarding the distribution/use of these donations and the amount already spent. Libération wrote on April 26: "(...) many of the NGOs present could pack their bags. Now that the emergency phase has passed, reconstruction will require skills that not all of them have. (...) Today Aceh is submerged by another tsunami- the tsunami of international aid. This situation proves that Médecins Sans Frontières did the right thing: in January this French NGO suspended its collection for the tidal wave's victims, provoking a general public outcry.

→ **China** © Dan Sermand - May 2003

Niger, Maradi District
© Anne Izebe/MSF – April 2005

MISSION

EMERGENCY IN NIGER

Alarming rise in malnutrition

MSF/April 2005/Anne Yzebe/ translated by Eurotexte

The MSF team has opened a second therapeutic feeding centre in the eastern region of Maradi in response to the worrying situation prevailing in Niger. A third centre is currently being set up further to the north, in the district of Tahoua. The teams in the field have more than doubled in size to combat the malnutrition crisis.

"We arrived in 2001 to treat an outbreak of measles and meningitis. We quickly realised that there were high levels of severe malnutrition - the harvest had been very poor that year so we opened a treatment programme. We planned to stay for six months. We're still here and we're opening two more therapeutic feeding centres! The peak period started in April, we've never witnessed this before!" says Issiaka Abdou, supervisor at the Intensive Nutritional Rehabilitation Centre (Creni) in Maradi, eastern Niger. Since the start of the year, over 3,000 severely malnourished children have been admitted to the programme in Maradi. There were around 300 admissions a week in the middle of April and more than 200 children were hospitalised at the Creni.

→ MILLET SHORTAGE

The admissions curve shows the abnormally high number of cases of severe malnutrition since January this year. The 2004 harvest was poor and, although the grain shortage on the national level is only moderate, it is markedly more severe to the north of the agricultural belt. Many villages only have 3 months of millet reserves left, sometimes even less.

Seeds are sometimes eaten, cattle and land sales have increased, and there is an earlier, larger exodus than in previous years. The daily consumption rate has dropped sharply. People in Niger usually eat three meals a day, consisting of millet, beans, spices, salt and oil or millet, milk and

PRESS REVIEW (CONT.)

→ Sounding the alarm

According to the results of the WFP nutritional survey in Niger that was published on April 21st, approximately 350,000 children under five years old are suffering from malnutrition. On April 26th, MSF sounded the alarm and called out to other aid organizations to mobilize. A press release expressing that "families are already suffering from lack of food, and yet the next harvests are not expected until October. Their nutritional state will continue to deteriorate if nothing is done urgently."

MISSION

NIGER

sugar. This is no longer the case. Amina Hassan, a nutritional assistant at the Creni in Maradi, talked to mothers of families in the region. "Their only meal consists of 'boule', a mixture of water and millet, without milk, because they do not have the money to buy milk; they feed their children on water and millet alone."

→ DIFFICULTIES WITH TRANSPORT AND ACCESS TO TREATMENT

Many families are no longer able to afford even the smallest expense. The problem is an everyday occurrence at the therapeutic feeding centre in Maradi. Dr. Innocent Ntumzimbona examines a child who will soon be leaving hospital. He should return once a week for a month for a medical check-up and to receive food supplements. But his mother does not want to leave. She explains that she lives 137 km from the hospital and transport costs 3,000 CFA Francs. She cannot return each week. Once the child has left, he will never return.
In the admissions tent, nurse Reina Jika sees disappointment on the faces of mothers whose children fail to meet the admission criteria. "They say they don't have enough money to go to a general health centre, which charges 300 CFA Francs per consultation without drugs, or that they visited the centre but it has no effect. They have no hope left."

In another tent, a mother explains how she was forced to sell her goat to bring her child to Maradi. She left her village, where there was nothing left - she had no business or any other source of income. These families do not have the means to buy food or medical care or to move away.

→ CONSULTATIONS AND FOOD DISTRIBUTION

The severe malnutrition programme in Niger includes an outpatient activity that enables us to limit hospitalisations to the most severe cases and to treat a larger number of patients. Seven weekly therapeutic nutritional outpatient centres (Crena) have been set up in Maradi and the surrounding region. A team of four nurses and three nutritional assistants identify cases of severe malnutrition and treat children admitted to the outpatient programme. Three outpatient sites are planned in the Dakoro area and three others around Tahoua. New centres will be opened based on the results of the nutritional survey carried out by Epicentre.

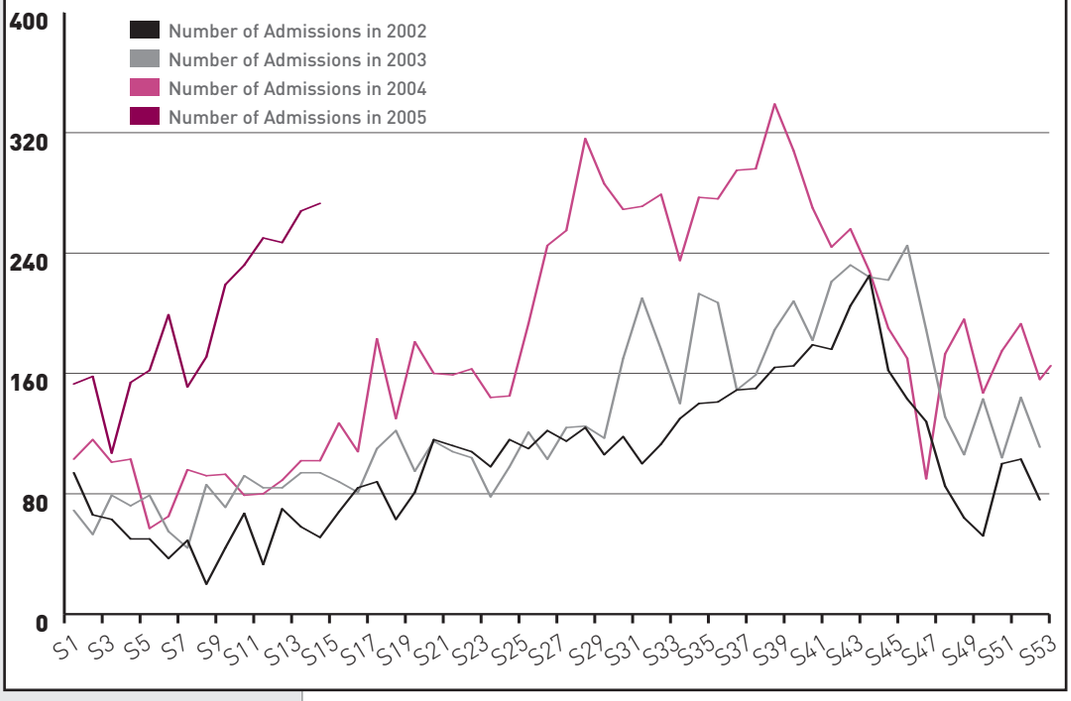
Médecins Sans Frontières works with health ministry personnel at a number of outpatient sites to treat moderate malnutrition and other conditions. Consultations and drugs are provided at the village health centres free of charge on days when Médecins Sans Frontières is present. This cooperation should be extended to other sites. The Dakoro centre – which has a 150-bed capacity –opened in mid-April. The Keita centre in the district of Tahoua is expected to open at the beginning of May.

→ CAPACITY TO TREAT 20,000 MALNOURISHED CHILDREN

In 2004, MSF treated almost 10,000 severely malnourished children. This figure could double in 2005. The programme has been adapted to cater for 20,000 admissions to feeding centres and outpatient sites. In comparison, MSF programmes provided treatment to a total of 30,000 severely malnourished children worldwide in 2004.

Médecins Sans Frontières has called on other aid organisations to mobilise their resources..■

NUMBER OF ADMISSIONS PER WEEK



PRESS REVIEW

(CONT.)

→ Angola/ Marburg Fever

"The outbreak of Marburg Fever in Angola is far from under control," reported Libération on April 20th, 2005. This epidemic, which has already resulted in 247 deaths, is continuing to worry MSF teams. "It is absolutely essential to isolate those infected immediately, but it has been difficult to do this locally," specifies Libération. It concluded by saying that "the risks are so high that on Sunday the Angolan Church decided to join the efforts of international organizations in encouraging its followers to overcome their fear of the hospitals."

→ INFLATION AND INADEQUATE AID

The markets still sell food, including millet and rice, but customers pay 22,000 CFA Francs for a 100 kg sack of millet, and 13,500 CFA Francs for a 50 kg sack of rice. Sacks of grain can be seen in trucks and warehouses. This is part of the harvest sold by farmers (one third is sold, one third is eaten and the remaining third is used as seed). Traders keep these stocks in order to profit from inevitably rising prices. Staple food prices have already doubled compared to 2004.

The next harvest is in October. Neighbouring countries (Nigeria, Burkina Faso and Mali) have been similarly affected. Both the emergency system set up by the government and the aid planned by various donors are totally inadequate and incapable of dealing with the emergency. Although food banks sell food at moderate prices, the quantities are very small. But even moderate prices are far too expensive.

→ **Madagascar, Antananarivo** © MSF UK - March 2003

MADAGASCAR

Reasons for closing

MSF / April 2005 / Laurence Binet/ translated by Anne Witberg

After working for over ten years taking care of children in difficult situations living in Tananarive, MSF has decided to close the project. Graziella Godain, the Assistant Director of Operations, explains why:

→ What are the reasons for closing this MSF Program?

First of all, we are closing because we have fulfilled part of the goals that we had assigned ourselves ten years ago, by opening this program to a particular population, that of children and families living in the streets of Tananarive.

Our program today no longer benefits this particular population alone but a larger population, the characteristic of which is they live in poverty.

This evolution is one of the effects of the 'clean up' policy implemented since 2002 by the Tananarive authorities, which has consisted in driving out from the center of town persons in precarious situations living in the streets, in order to "reinstate" them in rural settings. Many of these families, refusing to be displaced or not seeing their living conditions improve on the sites planned to that effect, came quickly back to the city, driven by lack of food, lack of money, or health problems.

We have demonstrated that these people living in the streets suffer genuine health problems, not just economic and social problems, and that it is possible to treat them.

The homeless that have remained in the city try to avoid harassment by the municipal police, and are therefore less visible in the streets. But their lot has not really improved since many have no better temporary shelter than

PRESS REVIEW (CONT.)

→ Mbeki mediator

The president of South Africa, Thabo Mbeki, who is mediating the unending crisis in Côte d'Ivoire, decided to allow Alassane Ouattara to stand as a candidate in the presidential elections. This former prime minister is one of the Laurent Gbagbo regime's main opponents. "After being mandated by his peers in the African Union to solve the Ivoirian deadlock, Mebki's decision seemed like a slap in the face to those in the Gbagbo camp and all the "young patriots" who view Ouattara as a foreigner (he was raised in Burkina Faso) and impostor." Gbagbo has nonetheless made it clear that "he considers the verdict from South Africa as a proposition, not an order." (Libération, April 15th, 2005)

MISSION

MADAGASCAR

cardboard boxes or paper bags. Moreover, these past years, the deterioration of the socio-economic situation in Madagascar has reinforced pauperization, particularly in Tananarive. Today, 70% of the population in the capital lives under the poverty level. The difference between poor families who used to live in the streets and the others is fading. If people no longer have access to health care services, that is because they are poor and no longer because they live in the streets and are being discriminated against. However, healthcare for the poor is an economic and social political issue, which is a matter for the authorities. Médecins Sans Frontières is a humanitarian organization and has neither the mandate nor in the skills to substitute itself for public authorities.

→ Madagascar, Antananarivo © Paula Llavallol/MSF - June 2003

It is not MSF's responsibility to provide access to healthcare for all of a city's poor population.

→ Having already confronted this type of problem on other missions, why question the role of MSF in this context?

In the last ten or fifteen years, MSF has participated in public health care reforms, and has set up projects aimed at improving the access poor people have to healthcare. This was the case, for example, in Yemen and Guinea. Unfortunately, these experiences have been failures, and have shown us that we're incapable – as a private humanitarian organization – of influencing, in any way, the improvement in access to healthcare.

→ What were the objectives of MSF's programme? Have they been fulfilled?

Our overall objective was to limit the risk of danger for the populations that lived in the violent setting of the streets and closed institutions, and to reestablish their common law rights, particularly access to healthcare.

We have demonstrated that these people living in the streets suffer genuine health problems, not just economic and social problems, and that it is possible to treat them. Nowadays they are no longer particularly stigmatized and should be able to be receive healthcare in the public medical system in the same way as the rest of the Madagascan population. We have participated in renewing applications for identity papers for all these persons who were living without identity and are thus unable to exercise their rights.

In collaboration with the authorities, we have worked towards improving living conditions in juvenile detention centers, even towards closing the worst centres. By identifying the malfunctions of the judicial system against minors, we have been able to reduce the number of arbitrary detentions and thus lower the numbers in centers and jails.

→ What critical points remain?

In practice, the most indigent find it still very hard to have free access to basic health care in the public health system. Consultations may be free, but medications remain unavailable or too costly. But the most acute problem remains that of the access to urgent medical or surgical care in hospitals. In the absence of a public system of free hospital care for indigents, people who up until now received treatment via MSF currently have no alternative. And neither does 70% of the population of Tananarive that lives in poverty and does not have the means to pay for the medications, additional tests and meals that they must pay for in the event of hospitalization.

In spite of marked improvement over the past years, the procedures for obtaining identity papers remain still too complex. The local city halls do not deal with them correctly and rely too much on associations. It is, however, the role of authorities to establish records of their citizens gratis, starting from birth.

Médecins Sans Frontières is a humanitarian organization and has neither the mandate nor in the skills to substitute itself for public authorities. It is not MSF's responsibility to provide access to healthcare for all of a city's poor population.

It is important that certain safeguards be put in place so that the legal measures that protect delinquent minors be truly functional. Arbitrary placements should not be allowed to resume and again crowd the jails.

→ Does MSF plan to continue to intervene in Madagascar?

As everywhere else, MSF will continue to intervene whenever possible in acute crisis situations, as in natural disasters or epidemics. Our past experiences enable us today to better understand the medico-nutritional dimension of these situations and be able to respond accordingly.

The fact of having or not having a program permanently open in Madagascar does not change in any way our willingness to come to the assistance of the Madagascan populations in the event of a major crisis. ■

IN MEMORIAM

For Aurora

Marie-Madeleine Leplomb

→ **Aurora Teixeira in Angola**, Camabatella, December 2004. © Séverine Laye

You have just shut your eyes for the last time in Luanda, when you had just a few weeks left on mission before returning home. A family gathering awaited you, one which you particularly didn't want to miss. 'Such is life' as the saying goes in the face of such an early departure, when there is no guilty party at whom we can express our disgust.

We were shattered by the news of your departure. Our desk staff had a little get-together to talk about you. We couldn't get back to our daily work without thinking of you, without bringing you back to life through memories or anecdotes of events we had with you. You have been close to us for years! For my part, we were neighbours in 2000-2001, you in the South Caucasus and I in the North Caucasus, working as medical co-ordinators. I often used to hear about you, but we never met. When I took up my position at headquarters in 2002 you were on your way back from China, where you had occupied - alone - a post in an isolated spot, far from the rest of the co-ordination team, and, despite that, I heard no word of complaint from you. The team you were working with returned satisfied with your support. Again, in 2003, we suggested that you go to Palestine to carry out the 'accursed' post of medical co-ordinator and, without hesitation, you agreed to take up the challenge and accept the job.

That was not going to be easy - several people had gone before you and had been greatly disappointed. I can still hear you saying 'I am neither a psychologist nor a psychiatrist but I am a doctor, I should be able to find a place for myself!' And you did, with much pragmatism and humility. The teams were grateful to you for your comforting, attentive and conciliatory role. On your return, you expressed no criticism of your mission but you completed it with much professionalism, your wishes and personal preferences taking second place to the role demanded by this mission. I took it that you even enjoyed this mission.
In November 2004 you accepted the post of head of mission in Angola, your great modesty having made you hesitate for a while before finally saying yes. And by December you were gone, to take up a post which had been vacant for over four months. You got to work very quickly, the mission took a different turn and the Luanda team, with whom your shared the job of co-ordination, expressed its relief at your arrival. By chance, I decided to go to Angola in January 2005 and met you in the field for the first time. I was surprised to see you - so unassuming at headquarteres - take a firm position during the course of a discussion, act as moderator between people and insist that we speak French so as to integrate better into the resistant little Gallic village, as you called them, of Camabatella, so as to be even closer to the teams. In Caala, they called you Madame Aurora or even 'mother', the team recognising in you an efficient person and a great support, always lending an ear. Florica (Field Co) never ceased to praise you and to thank you while we were there. Ever modest, you tried to water down her compliments. I have seen you deal, in silence, with the most tedious tasks to relieve Florica, who had arrived tired, at the end of her mission. Then on the long, bumpy, tiring road between Luanda and Camabatella, you rejected all of our concerns associated with the fact that you were in your late 60s. You would ask us, cynically, if we considered you so old as to deserve such concern. During these long hours spent on mined roads, you, indifferent, would read your book without the slightest complaint. Your composure and your dignity in the face of adversity delighted us to such a degree that Sylvie and I called you 'Lady Baroness'. When we arrived in Camabatella, the Gauls awaited us, and you were admired by them all and in particular by Roger, two years your senior, who found you in Olympic form after such an epic journey. You dressed up quickly for the meal and, kindly, tried to hush your evening's admirer. Then, in a very peremptory tone, you announced to the collegiate that, as of the next day, Portuguese or English would be spoken, given the arrival of a new ex-patriate who did not speak a word of French. Everybody respectfully agreed but did, however, show some apprehension at such a constraint. You reassured everybody, finding only positive points about this new arrival, then the subject was closed. For the rest of the stay you were able to alternate between your role as head and your role as mother to the teams, defending them when I was too critical of them.

When you returned to Luanda during meetings with Angolan authorities, who were tactless enough to speak French, you did not hesitate to hold out on them with much diplomacy and respect. There, again, I was able to remark on your conscientiousness

Franck is no longer with us

Franck Moynier passed away last March 31st at 39 years old.
Frank worked as a logistician with MSF as well as on various coordinating posts from 1995 to 2004. His contribution was particularly appreciated and we will miss him greatly.
Our thoughts go out to his companion Murielle, his family, and loved ones.

Suzanne Millet,

Who used to help in the documentation centre, passed away last month. We will never forget her smile.

Sad news from Ingushetia

In Ingushetia, a serious car accident resulted in the death of Said-Magomed Madaev. In the same accident both Roza Sukaeva our outreach officer and Zara Erzanukaeva our pharmacist suffered very severe injuries. Said had been working as a driver with us since the MSF-B presence in Chechnya during the "first" Chechen war, that started in 1994. The accident occurred while Said, Roza and Zara - also working with MSF - were on the road to Chechnya. Both Zara and Roza will fortunately recover rom their injuries.

Said leaves behind his wife, Leila and his two children Deni and Tavali.

Passing of Catherine Lepetit

Catherine Lepetit passed away last March 28th following a long illness.
Catherine had participated in Mission France activities on two occasions, and was also a head of mission in Yemen for a year and a half.
She was appreciated unanimously by the teams. All those who knew her at MSF share in the grief of her husband, her 4 year old daughter Lena, and her loved ones. Catherine was 47 years old.

and responsible attitude. I'm thinking now about Jean and Sylvie, your two acolytes who shared the posts of co-ordination with you : they must be so sad. Not for a very long time had I found such a friendly and good-natured atmosphere in a co-ordination team. Your daily exchanges were peppered with much simplicity, kindness and humour, and a little touch of irony spiced the whole, just to show that you were not altar boys. I still remember when you asked Sylvie, as an aside, whether you were so authoritarian that people should call you 'Lady Baroness' and Sylvie burst out laughing in response to your scorn. No, it was not your indubitably peaceful authority but your personality which made people say, in a slightly familiar tone, 'Aurora, a woman with class!' The other point, which I shall always admire, was your deep and respectable commitment to your missions. You gave me an important lesson, thanks.

I'm so sorry, Aurora, if I've spoken about you and about those little moments we lived during the mission which are normally private. I wanted to keep you alive with these simple memories which have shown me the extent of your sparkling, cultivated, optimistic and very touching personality. I was looking forward to seeing you again in Paris for your debriefing. You won't be there, so allow me to write these few words. ■

Marie-Madeleine

Aurora Teixeira died while on mission on April 10th. She was 67 years old and had worked for MSF for 8 years. Angola was her 8th mission with MSF.

INFOS

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olivier.falhun@msf.org

For further information:

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

- on the activities of the Other MSF Sections: www.msf.org

WATCH AND READ

New books available in the documentation center

MSF / Alix Minvielle - 01 40 21 27 13

→ MEDICAL

AMBIGUOUS LOSS: LEARNING TO LIVE WITH UNRESOLVED GRIEF / Pauline Boss.- Cambridge : Harvard University, 2000.-155 p.

WHO REPORT 2005: GLOBAL TUBERCULOSIS CONTROL: SURVEILLANCE, PLANNING, FINANCING / OMS.- Genève : OMS, 2005.- 247 p.

PRISE EN CHARGE THÉRAPEUTIQUE DES PERSONNES INFECTÉES PAR LE VIH : RECOMMENDATIONS DU GROUPE D'EXPERTS : RAPPORT 2004 / dir. J.-F. Delfraissy.- Paris : Flammarion, 2004.- (coll. Médecine-Sciences).- 264 p.

WAR WOUNDS BASIC SURGICAL MANAGEMENT : THE PRINCIPLES AND PRACTICE OF THE SURGICAL MANAGEMENT OF WOUNDS PRODUCED BY MISSILES OR EXPLOSIONS / R. Gray.- Genève : CICR, 1994.- 44 p.

→ GEOPOLITIC

JE REGRETTE D'ËTRE NÉ LÀ-BAS. CORÉE DU NORD : L'ENFER ET L'EXIL / M. Buissonnière, S. Delaunay.- Paris éd. Robert Laffont, 2005.- 192 p.

« LA RUSSIE DE POUTINE ».- IN : POUVOIR / Paris : Seuil, janvier 2005.- 219 p.

LA RUSSIE SELON POUTINE / A. Politkovskaïa.- V. Dariot (trad.).- Paris Buchet/Chastel, 2005.- 271 p.

REVUE DES DEUX MONDES : SPÉCIALE RUSSIE / Paris : Revue des deux Mondes, mars 2005.-192 p.

→ OTHERS

LES BÉNÉVOLES ET LEURS ASSOCIATIONS : AUTRES RÉALITÉS, AUTRE SOCIOLOGIE ? / dir. Dan Ferrand-Bechmann, pref. Jean-Michel Belorgey.- Paris : L'Harmattan, 2004-(coll. Logiques sociales).- 318 p.

→ AVAILABLE IN THE PHOTO LIBRARY (and database int.) - MSF / Christine Dufour

Burundi : march 2004, Makamba, Charles Edouard Leroy / MSF - Russia Chechnya et Inguchetia : february 2005, consultations gynéco-obstétriques et pédiatriques, Denis Lemasson / MSF - Kenya, Nairobi : april 2005, bidonville Mathare, Blue House+ HIV, Sebastien Le Clezio - Sierra leone : march october 2004, santé mentale, camp de Taiama et de Tobanda, Muriel Genot / MSF - Indonesia : april 2005 Nias, tremblement de terre, Bruno Kowalczewski / MSF - Niger : april 2005 Maradi, CNT, Anne Yzebe / MSF

RESOURCES

TURN OVER HEADQUARTERS

FIELD HR

→ Norah HAMMACHE	joined the emergency desk as human resources officer in March
→ Corine WAGNER	started as assistant HRO in April (fixed-term contract)

HEADQUARTERS HR

→ Catherine MELIN	since March, is coordinator of field HR administration
→ Cécile FAVARD	became field HR administration officer in March,
→ Agnès JOIGNY	became field HR administration officer in March
→ Jacques LOTTIGIER	started as field HR administration officer in March (fixed-term contract)

OPERATIONS

→ Gabriel TRUJILLO	joined headquarters as ARP in March

COMMUNICATION AND FUNDRAISING

→ Marie-Charlotte BRUN	started as marketing recruitment deputy in March (fixed-term contract)
→ Eric GOMEZ	joined the team as coordinator of donor management in April (fixed-term contract)
→ Anne YZEBE	replaced Isabelle Ferry (who is on maternity leave) in April (fixed-term contract)

FINANCES

→ Agnès DANIEL	has been financial controller since March
→ Guillaume OULD AOUDIA	resigned from MSF in April

MEDICAL

→ Laurence THAVAUX	(nurse) was appointed head of nutrition in March
→ Catherine HEWISON	(doctor) joined the department in March, and will be in charge of TB and meningitis.

LOGISTICS

→ Etienne GIGNOUX	joined headquarters in March as logistics supervisor (fixed-term contract)

RECEPTION AND GENERAL SERVICES

→ Pradeep DIVIEN	started as receptionist in March (fixed-term contract)

MISSION FRANCE

→ Julien BARTOLETTI	has been head of mission since March
→ Ali BESNACI	resigned in March

FOUNDATION

→ James ARKINSTALL	joined the Foundation in March (fixed-term contract)

POSITIONS TO FILL

→ FIELD VACANCIES

→ ASAP

- Medical coordinator, Russia, Moscow, 12-24 months
- Medical coordinator, Ivory Coast, Abidjan, 1 year
- Head of mission (nurse), DRC, Lubumbashi, 1 year
- Medical coordinator (portuguese-speaking), Angola, Luanda, 2 months
- Head of mission, Indonesia, Banda Aceh, 6 months
- Medical coordinator, Southern Sudan, Loki, 6-12 months
- Head of mission, Ivory Coast, Abidjan, 1 year
- Medical coordinator, Liberia, Monrovia, 1 year
- Head of mission, Haiti, Port au Prince, 1 year
- Medical coordinator, Northern Sudan, Khartoum, 1 year
- Medical coordinator, Uganda, Kampala, 1 year
- Nurse field co, Liberia, Monrovia, 6 months
- Nurse field co, Angola, Negage, 6 weeks
- Logistician field co, Liberia, Bong, 6 months
- Nurse field co, Niger, Maradi, 6 months
- Nurse field co, Haiti, St Joseph, 6 months
- Nurse field co, DRC, Kitenge, 6-9 months
- Nurse field co, Ivory Coast, Bouake, 6 months
- Nurse or midwife field co, Darfur, Niertiti, 6 months
- Nurse field co, Burma, Dudon, 6 months
- non-medical field co, Northern Sudan, Bentiu, 6-9 months
- Medical, Ivory Coast, La Maca, 9 months
- Medical, Liberia, Monrovia, 6 months
- Medical, Darfur, Mornay , 6 months
- Medical, Niger, Keita, 6 months
- Medical, Darfur, Zalingei, 6 months
- Medical, Angola, Negage, 6 weeks
- Medical, DRC, Ankoro, 6 months
- Medical, Ivory Coast, Bouake, 6 months
- Medical, Niger, Dakoro, 6 months
- Medical, Colombia, Tolima, 6-12 months
- Medical, Chad, Adre, 6 months
- Medical, Darfur, El Genina, 6-9 months
- paediatrics nurse, Nigeria, Numan, 4 months
- Physiotherapist, Haiti, St Joseph, 6 months
- Clinical manager nurse, Southern Sudan, Akuem, 6 months
- Nurse, DRC, Ankoro, 6 months
- Nurse, Chad, N'Djamena, 2 months
- Psychologist, Indonesia, Sigli, 2-3 months
- Nurse, Liberia, Lofa, 6 months
- Midwife, Liberia, MPH, 6 months
- Nurse, Nigeria, Numan, 3 months
- Nut Nurse, Niger, Adanawa, 3 months
- Psychologist, Occuped Palestian Territories, Nablus, 6 months
- Nut nurse, Nigeria, Yola, 3 months
- Special education teacher, China, Baoji, 1 year
- Nurse, Northern Sudan, Bentiu, 6-9 months
- Food coordinator, Niger, Niamey, 3 months
- Capital logistician, Haiti, Port au Prince, 6 months
- Logistician, Niger, Tahoua, 6 months
- Logistician, Sierra Leone, Kenena, 9 months
- Logistician/admin, Ivory Coast, Bouake, 6 months
- Logistician field co, Angola, Luanda, 6 months
- Logistician, Chad, N'Djamena, 2 months
- Logistician, Burma, Mudon, 6 months
- Logistician, Southern Sudan, Akuem, 6 months
- Field co, Southern Sudan, Akuem, 6 months
- Logistician, Darfur, Niertiti, Tahoua, 6 months
- Logistician, Niger, Dakoro, 6 months
- Logistician, DRC, Kitenge, 6 months
- Logistician, Nigeria, Adanawa, 3 months
- Logistician, Uganda, Patango, 6 months
- Field administrator , DRC, Kitenge, 2 months
- Financial administrator, DRC, Kinshasa, 1 year
- Administrator, Nigeria, Abuja, 4 months
- Administrator, Angola, Camabatella, 1 year
- Administrator, Uganda, Epicentre, 12 months
- Administrator, DRC, Beni, 1 year
- Administrator, Niger, Niamey, 6 months

→ JULY AND THE NEXT MONTHS

- Head of mission, Liberia, Monrovia, 1 year
- Head of mission, Georgia, Tbilissi, 1 year
- Head of mission (non medical), Chad, Abeche, 6 months
- Head of mission, Darfur, El Genina, 12 months
- Medical coordinator, Darfur, El Genina, 12 months
- Nurse field co, Darfur, El Genina, 6 months
- Nurse field co, Niger, Dakoro, 6 months

(cont. following page)

POSITIONS TO FILL

→ FIELD VACANCIES (CONT.)

- Nurse field co, DRC, Ankoro, 6-9 months
- Nurse field co, Uganda, Patango, 6 months
- Field co (non medical), Occuped Palestinian Territories, Nablus, 6 months
- Field co, Darfur, Zalingei, 6-9 months
- Nurse field co, Uganda, Arua, 1 year
- Medical, Burma, Mudon, 1 year
- Medical, Uganda, Patango, 6 months
- Gynaecologist, Liberia, Monrovia, 6 months
- HIV medical, Malawi, Chiradzulu, 1 year
- Medical, Darfur, Niertiti, 6 months
- Nurse, Chad, Adre, 6 months
- Laboratory technician, Northern Sudan, Bentiu, 6-9 months
- TB Nurse, Southern Sudan, Akuem, 6 months
- Wide-wife, Liberia, Lofa, 6 months
- Nurse, Uganda, Patango, 6 months
- Nut nurse, Niger, Tahoua, 6 months
- Chemist, Liberia, Monrovia, 6 months
- Nurse, Ivory Coast, Guiglo, 6 months
- Laboratory technician, Liberia, Monrovia, 6 months
- Nut nurse, Niger, Maradi, 6 months
- Field co, Ivory Coast, Abidjan, 1 year
- Field co, Darfur, El Genina, 1 year
- Field co, Southern Sudan, Khartoum, 1 year
- Logistician, Liberia, Lofa, 6 months
- Logistician/admin, Darfur, Zalingei, 9 months
- Logistician, Ethiopia, Galaha, 6 months
- Logistician, Ivory Coast, Guiglo, 6 months
- Administrator, Liberia, Monrovia, 1 year
- Administrator, Indonesia, Banda Aceh, 6 months
- Administrator, Colombia, Bogota, 1 year

TRAINING COURSES

→ NUTRITION/ IMMUNISATION

From June 13th to 25th, 2005 in Lacanau- Duration : 10 days. Session in French

→ TARGET GROUP

-Medics and paramedics with at least one field experience in nutrition and/or vaccination, who are interested in supervising nutritional and/or vaccination activities.

-Commitment of at least 12 months (flexible- one or several missions- for expatriates)

By the end of the course, the trainee will be able to:

EPIDEMIOLOGY:

-Describe and calculate epidemiological indicators

-Interpret and demonstrate results graphically

-Participate in carrying out a nutritional prevalence and vaccination coverage survey

• Nutrition

-Set up and coordinate nutritional programmes

• Vaccination

-Set up and coordinate vaccination programmes

Information and to apply contact your desk or Epicentre
Isabelle Beauquesne (01 40 21 29 27) or Danielle Michel (01 40 21 29 48)

→ LOGISTICAL SUPERVISORS (FORELOG)

Date: from June 13 - 25, 2005. Language: French.
Location: La Forestière, Lacanau

→ TARGET CROUP

The "Forelog" is designed for logisticians with at least 1 and a half years of field experience, who are/will be interested in becoming logistical supervisors. As technical and logistics supervisors, they will be members of the capital coordination team. Candidates must have basic technical knowledge of the different logistic domains of an MSF mission (validated basic logistics training.)

→ GENERAL OBJECTIVE

At the end of the training course, trainees will be capable, as part of a coordination team, to evaluate, define, organize, and follow missions' logistics programmes in their country, as well as supervise teams placed under their responsibility. The goal of this training course is not to provide pre-packaged answers, but for trainees to confront hazy, varied, and complex situations with critical analysis and problem-solving techniques.

Contact : Richard Jabot (05 53 63 38 08)

→ MEDICAL WEEK

Duration: 6 days. N° of participants:25. Language: English/French (simultaneous translation)
2005 Session: 04/07- 09/07

→ TARGET GROUP

Doctors of nurses, national or international staff, with varying experience.

→ GENERAL OBJECTIVE

The opportunity for care givers in the field to exchange ideas with the medical department at headquarters on the practical aspects of providing care to patients, in order to propose possible improvements on all levels of how we work. It is therefore more a week of reflection than a training course. The emphasis will be on group work in order to allow each participant to express his/her point of view, as well as to create a group dynamic. **For more information and to apply contact your desk or Epicentre Isabelle Beauquesne (01 40 21 29 27) or Danielle Michel (01 40 21 29 48)**

messages

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