Civilians Under Fire

Humanitarian Practices in the Congo Republic 1998-2000

Edited by
Marc Le Pape and
Pierre Salignon

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The Médecins Sans Frontières Charter

Médecins Sans Frontières/Doctors Without Borders (MSF) offers assistance to populations in distress, victims of natural or man-made disasters, and victims of armed conflict, without discrimination and irrespective of race, religion, creed, or political affiliation.

MSF observes strict neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance, and demands full and unhindered freedom in the exercise of its functions.

MSF volunteers undertake to observe their professional code of ethics and to maintain complete independence from all political, economic, and religious powers.

Volunteers are aware of the risks and dangers of the missions they undertake and have no right to compensation for themselves or their beneficiaries other than that which MSF is able to afford them.

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For François Jean

Preface

What is an effective humanitarian aid operation? The apparent simplicity of this question belies both its complexity and its vital importance for people affected by conflict and crisis. This collection of articles, which looks introspectively and self-critically at the operations of Médecins Sans Frontières/Doctors Without Borders (MSF) during an acute phase of the civil war that devastated the Congo Republic (otherwise known as Congo-Brazzaville) in 1998 and 1999, provides important guideposts to use in addressing this critical issue. In doing so, it debunks the prevailing approach that seeks to improve the impact and quality of aid operations by setting technical standards (as the Sphere Project aims to do) and by enforcing aid-worker "codes of conduct." It also sheds light on some of the important ethical, medical, and practical considerations that arise in making the decision to provide assistance to a category of victim that is generally neglected by humanitarian organizations: victims of rape.

The Congo Republic: A War Against Civilians

The armed conflict that ravaged the Congo Republic, a small country just north of its much larger namesake, the Democratic Republic of Congo, displayed many of the features of civil wars in the 1990s. Civilians, more than soldiers or guerrilla fighters, bore the overwhelming brunt of the death and suffering. The acts of violence against them – ranging from forced displacement to summary executions, rape, looting, denial of food, and use as "human shields"–seemed beyond limits. Yet this was not a case of anarchy. The war against civilians was organized by the

combatants to serve their aims. As a direct consequence of this violence, MSF teams were faced with a medical and nutritional emergency of staggering proportions that unfolded in a virtual vacuum. The media paid scant notice to the catastrophe, and few other aid organizations were present to assist.

In December 1998, opponents of President Denis Sassou-Nguesso, a strongman who had ruled the Congo Republic from 1979 to 1992 and who had returned to power in 1997 following an armed insurgency, revived their attempt to oust him from power. Official government forces and their *Cobra* militias, mainly from the north of the country, battled opponents Bernard Kolelas and Pascal Lissouba, whose *Cocorye* and *Ninja* militias were drawn mainly from the south of the country. As this struggle for power was playing itself out along geographical and ethnic lines, pitting "northerners" against "southerners, " control over the civilian population became a central objective of each of the warring sides. As a result, civilians were targeted and subjected to violence and abuse just because of their ethno-regional background. The southern districts of the capital city, Brazzaville, as well as southern cities such as Mindouli, were emptied, as tens of thousands of civilians who were labeled as being associated with the rebellion fled the repression of government-backed militias and tried to find refuge either in the Democratic Republic of Congo or in the forests of the Pool region, south of Brazzaville. There they were subjected to violence and looting by the *Ninja,* the very militia that claimed to represent them but in fact imposed a reign of terror. As a result of this brutality and deprivation, malnutrition and exposure to disease took a severe toll on the people hiding in the forests.

By May 2000, the government had regained control of

the southern parts of Brazzaville and had started to encourage people to return. This opportunity was quickly translated into a massive movement of desperate people, exhausted but eager to rebuild their shattered lives. Yet, even once they managed to escape from militiamen seeking to keep them in the forests, their hardships were far from over. They had to run a gauntlet of government forces and militia along a road into Brazzaville that was supposed to have been a "humanitarian corridor" but that, instead, they dubbed the "corridor of death." Upon their arrival in Brazzaville, they were screened at a makeshift transit center in an open-air sports facility before returning to their homes – in a city where economic opportunities and basic public services such as education and health care were at a bare minimum. By late 1999, as the government takeover progressed and a cease-fire agreement was concluded, humanitarian organizations were able to gain access to cities in the Pool region. There, too, people had escaped the misery of hiding in the forests only to return to an uncertain life in the towns, under the shadow of violent militia groups.

Quantifying the War's Impact on Civilians

Some of the impact of the violence, displacement, and deprivation endured by the civilian population is illustrated in medical data collected during MSF's operations and through epidemiological surveys, particularly retrospective mortality surveys, conducted by Epicentre. The data presented by Dominique Legros and Pierre Salignon give an indication of the magnitude of the problem: for instance, between 30 and 40 percent of the children under five years of age screened in the Brazzaville sports center during August and September 1999 suffered from acute general malnutrition, with severe malnutrition above 20

percent. Although these particular children were fortunate enough to be admitted to a therapeutic feeding center, Legros and Salignon's article strikingly reveals that aid agencies were not present at the location and time of greatest need. For many months, during the peak of the emergency, the forests of the Pool were completely off limits to humanitarian organizations due to violence and insecurity. A staggering 7 percent of the entire population of Mindouli (and 13 percent of the children under five) died of malnutrition and violence after having fled into the forests. This translates into overall mortality rates of 5 deaths per 10,000 people per day–2.5 times the emergency threshold – and 10 deaths per 10,000 people per day–5 times the emergency threshold – for children, every single day for more than six months. These dramatic figures raise a remarkably troubling question: despite all the efforts of humanitarian organizations to gain access to victims in the heart of conflicts, aren't similar situations occurring now in many other places such as Liberia, the Democratic Republic of Congo, or even Afghanistan?

An important contribution of epidemiological surveillance data is to provide perspective on the quality and effectiveness of an emergency intervention. In that respect, the nutritional interventions by MSF in Brazzaville and Mindouli were indeed effective in decreasing the very high mortality rates encountered by the medical teams. As Legros and Salignon point out, mortality rates plummeted after the bulk of the population returned to Mindouli thanks to the activities of the four aid organizations in town. Epidemiological data also suggest that, despite relatively high mortality rates of four percent in Brazzaville, MSF's intensive feeding centers were effective in restoring the vast majority of the children to proper nutritional status.

Deconstructing MSF's Decision-Making Process

There are clear limits to relying on epidemiological data or other technical measures either to define needs or assess the effectiveness of a humanitarian intervention. Jean-Hervé Bradol's essay and Marc Le Pape's reconstruction of the decisions made by MSF teams provide valuable insights into these limitations. Their introspective and self-critical look into what was, in many respects, an impressive aid operation also reveals how operational choices are imperfect and conditioned by a range of factors. Le Pape first underlines the importance of information: For many months, at the beginning of the war, the MSF team based in neighboring Kinshasa simply did not make sense of what was happening in the Congo Republic and therefore could not adapt its intervention to the rapidly evolving situation. That lack of understanding led to delays in reaching Brazzaville and a failure to anticipate the massive return of the population in May 1999. Bradol goes further in showing how aid workers, consciously or not, select information based on their own judgment of what constitutes need and on their organization's capacity to handle it. Well-established images of victims constitute a prism through which the messy reality of people's suffering is viewed. As Bradol argues, such a filtering process explains how pragmatic choices, such as tackling severe malnutrition in children, may have obscured other equally pressing problems, such as the massive number of rape victims requiring medical attention.

While an aid organization's intentions are thus based on limited and selective information, Marc Le Pape's account further highlights the fact that, once a decision to act has been made, effectiveness in the delivery of aid depends not only on adherence to technical standards and protocols, but also on overcoming many obstacles to reaching and helping people. Le Pape shows, for instance, how the MSF

teams struggled with the uncomfortable reality that humanitarian assistance could, in fact, facilitate violence against civilians. In just one example, after aid operations encouraged people to come out of the forests and return to Brazzaville via so-called "humanitarian corridors, " the travelers were routinely assaulted along this route. Another critical discussion underscored by Le Pape's account concerns the real-time need to balance, on one hand, the desire to increase staff and services to boost the scope and quality of aid programs, with the human resources, logistical, and security barriers to such an expansion.

Along with many other issues, these two key points – namely how aid operations can affect the safety of a population and how to assess the appropriate level of risk-taking to meet humanitarian needs – are essentially absent from much of the current international discussion of the quality, effectiveness, and accountability of aid. In recent years, those discussions within the aid community have focused largely on technical standards such as the Sphere Project guidelines and aid-worker "codes of conduct." The merit of Le Pape's blow-by-blow account of MSF's decision-making process in the Congo Republic is thus to emphasize the great importance of human, social, and political elements in the making of a successful aid operation.

The Rape Crisis: Why Didn't MSF Do More?

One of the main points conveyed in this collection of essays is that MSF could have, and should have, acted more quickly and assertively to address the specific medical needs of a particular group of victims: the large number of women who were raped during this episode of the Congo Republic's civil war. Survivors of sexual violence have

generally been neglected in standard models of humanitarian aid delivery, and Jean-Hervé Bradol's essay provides important insights as to why that may have been. He argues that MSF reproduced forms of prejudice against women in general and against survivors of sexual violence in particular, giving rise to discriminatory practices. Deeply rooted images put a premium on the innocence of victims, making children, who are by definition blameless, the ideal recipients of care. In contrast, women who have been sexually assaulted raise a number of unsettling issues for practitioners revolving around violence, physical and psychological trauma, sexuality, and gender roles. Bradol also points out that rape has generally been approached from a human rights rather than a medical perspective, and that women who have been raped have accordingly been viewed more as victims requiring protection from violence than as patients needing complete medical care.

While Bradol uncovers many of the underlying reasons behind what he denounces as a medical neglect of rape victims in the Congo Republic, the MSF teams did in fact rapidly view the large number of women who had been sexually assaulted–1,190 between May and December 1999–prior to arriving at the screening center in Brazzaville as a major humanitarian problem. In practice, the debate revolved around the level of medical care that MSF would provide. While treatment of sexually transmitted diseases and medication to prevent unwanted pregnancies were supplied to the Congolese doctors at Makelekele Hospital, the hospital to which rape victims were referred, MSF teams did not introduce post-exposure HIV prophylaxis with dual antiretroviral medication during the height of the crisis. It was only in March 2000 that a comprehensive medical program for rape victims, which continues to this day, was introduced.

In describing MSF's medical approach to survivors of rape, Joanne Liu and Pierre Salignon's paper not only provides data on the program's positive impact, but also illuminates some of the ethical dilemmas and difficulties associated with providing care to these patients in a country such as the Congo Republic, where AIDS treatment is not available to the general public. Moreover, delivering post-exposure prophylaxis is a valuable preventive measure but is far from infallible. Do medical caregivers have a responsibility to do more? What can and should doctors do regarding unwanted pregnancies arising from rape in a country where abortions are illegal? What is the responsibility of the medical caregiver vis a vis the perpetrator of the attack, who should be pursued by law-enforcement authorities yet may require medical treatment himself?

These questions, and many others, have gained much prominence recently. In January 2002, the report "Sexual Violence and Exploitation: the Experience of Refugee Children in Liberia, Guinea and Sierra Leone, " by consultants for the Save the Children Fund on behalf of the United Nations High Commissioner for Refugees (UNHCR), shone an international spotlight on the issue of sexual violence perpetrated against refugee women and children in West Africa. What was particularly shocking about the report were allegations that staff from humanitarian organizations were themselves sexually abusing young women that their aid programs were supposed to help. The report led to a flurry of activity to improve prevention and strengthen accountability, in particular through the adoption of codes of conduct directed at aid-agency employees. Yet the grave vulnerability of women in conflicts and refugee camps

throughout the world, as the case of the Congo Republic vividly illustrates, remains a pressing issue. Not only is adequate protection, which can entail a range of measures to deter aggression, punish perpetrators, and enhance physical safety, urgently needed, there also should be a stronger focus on delivering appropriate medical care for women victims of sexual abuse. Building on the Congo Republic experience, MSF has introduced comprehensive medical programs for survivors of rape in Guinea and Sierra Leone, with very encouraging results.

Meanwhile, in the Congo Republic, although the conflict has subsided, rape remains a critical problem. In early 2003, in collaboration with the Congolese Ministry of Public Health, MSF launched a nationwide awareness-raising campaign called “Tika Viol, je dis non” (No more violence, I say no) to combat the social and political apathy resulting in an ongoing failure to address the widespread phenomenon of sexual violence in the country. That campaign, along with the experiences highlighted in this booklet, make clear that actually relieving the suffering of victims of violence is a complex, difficult, and uncertain endeavor that depends heavily on both the thoughtfulness and tenacity of people who are committed not to accept what is unacceptable. And that’s what humanitarian action is all about.

Nicolas de Torrenté, Executive Director, MSF-USA
June 2003

Chapter One

How Images of Adversity Affect the Quality of Aid

Jean-Hervé Bradol, M.D.

Misery only catches people's attention when it is well-presented; that is, well-prepared by the imagination.

– Louis-Ferdinand Celine, *Journey to the End of the Night*

How can we improve the aid we provide to victims of armed conflict? To answer that question, we must first take a good look at our own personal images of disaster and consider how those images lead us to focus on certain kinds of victims while neglecting others. It is our hope that by doing so we can help ensure that humanitarian aid is not denied to certain categories of people to whom we are blinded, whether by our prejudices, by the temptation to rely on an all-too-convenient image of the "ideal victim, " or by our obsession with standardizing humanitarian aid under the pretext of efficiency.

Amid the Turmoil of the Emergency Mission

Let us begin by describing the circumstances under which humanitarian missions usually take place. They are characterized by a significant daily mortality level, by danger, and by constant pressure to provide aid in an urgent manner. If effective aid is not provided, every new day ends with a large number of avoidable deaths. So desperate are people's living conditions and so brutal is the violence inflicted upon them that their very survival is the central focus of aid operations – the daily death toll being the most important indicator of the success or failure of

that aid.

The food shortages that afflicted southern Sudan[1] in the summer of 1998 are but one example of such dramatic circumstances. Some 17,000 civilians, displaced by the fighting and associated violence, had assembled in the village of Ajiep in the state of Bahr el Ghazal. The kiss of their traditional food resources and the ineffective distribution of international aid had resulted in a famine situation. Humanitarian aid was being controlled – and misappropriated – by the Sudan People's Liberation Army (SPLA), which was in rebellion against the country's ruling military Islamic dictatorship. Population displacement, acute food shortages, and epidemics had brought a horrifying death toll, which aid had been powerless to reduce. Financial sponsors and United Nations organizations, encouraged by the United States government, had entrusted the civilian wing of the SPLA, the Sudan Relief and Rehabilitation Association (SRRA), with the distribution of food. In the late 1980s, this aid system had led to the creation of a specific institution known as Operation Lifeline Sudan (OLS). Over the years, the SRRA had seen its power grow within OLS, until it eventually came to be regarded by the United Nations and donor states as having the same status as an international humanitarian organization. Because of this special treatment, which the aid system rarely accords a protagonist in an armed conflict, it was easy for the rebels to divert a large proportion of food aid for their own use. It mattered little that this system also starved the displaced, because the main objective, from Washington's viewpoint, was to support armed opposition to the Sudanese regime, regarded as a "rogue" administration and an enemy of the US. In July 1998, mortality rates in southern Sudan were

more than 20 times higher than the widely recognized emergency threshold of one death per 10,000 people per day. Eighty percent of children under age five were suffering from acute malnutrition (half were severely malnourished) and were likely to die in the short term.

Now let us turn to the Congo Republic, which is also known as Congo-Brazzaville. In the year after the tragic events in Sudan, our teams found themselves in a similar situation, needing to act as quickly as possible to limit the extent of the disaster. In situations like this one, the *logistical* demands of deploying aid are uppermost in the minds of aid workers. Although the realities of people's circumstances are reduced to fit within the framework of an emergency plan, the actual complexity of their lives can surface at unexpected moments, sometimes in the form of fragments of individual accounts so horrifying that the relief worker is moved to stop what he or she is doing and listen:

> *My name is Albert. They tried to rape my sister. She was only 17 years old. I tried to help her, but one of the soldiers fired. She fell. They killed her and forced me to get into a truck and go back to Brazzaville.*

Because of the relationships we establish as we provide medical care or distribute food or equipment, we hear individual accounts such as this one, expressing both the horror of the acts and the cruelty of the perpetrators. But there is little time to listen to such accounts, because of the sheer volume of tasks to be carried out amid the turmoil of the emergency operation. The relationship we establish is a special exchange between two individuals – one residing in his or her own country and one foreign; one in desperate circumstances and the other an aid worker. It represents the starting point for the construction of an image of the

tragedy and its participants. The quality of the human relationship, on which the humanitarian relationship is based, is enhanced by an awareness of these individual accounts. The aim of their narrators is to make the aid worker understand that the degrading situation he or she observes is the result of a sequence of events, and that the suffering and the helplessness are the result of human violence or negligence. With words that evoke the past and proclaim their right to a future, these storytellers try to find a way to escape from their humiliating circumstances, to rediscover their own humanity, and to appeal to that of the aid worker. To attach oneself to the value of each life, however remote it may be from our own, to refuse to allow those who appeal to our humanity to die with no effort made to save them, is an arbitrary and drastic choice, and one that begins with this dialogue. The medical act also begins with the narration of the patient's history, which cannot be reduced to the history of the illness. This exchange cannot be reduced to a simple onesided issuing of instructions aimed to dispense care, as if we were veterinarians caring for sick animals.

To be able to listen, we must at least be curious enough to seek out those whom violence and discrimination tend to isolate beyond our field of vision. We must refuse to avert our gaze from an image of adversity that can often be extreme, and we must approach the individual while keeping our own prejudices well hidden. Our reluctance to engage in such an open-minded approach is sometimes based on the conviction that certain "more marginal victims, "–seen purely in terms of their material needs – will not be able to benefit from "effective" aid, delivered in the form of a standard product. Under this quasi-industrial approach, the initial contact is experienced as a false promise delivered by the visiting aid worker. And while we

cannot promise aid to everybody in distress, we simply must not refuse to listen to the story of an individual's misfortune; nor can we refuse to establish a relationship under the pretext that the necessary aid would be beyond the scope of a standardized approach. By trying to provide quality for as many people as possible, this "mechanization" of aid often produces a system marked by systematic acts of discrimination and injustice. Our safeguard, or reference point, is to remember that the aid is intended for human beings. Getting to know these human beings is not something superfluous; it is essential.

To make these encounters possible, humanitarianism must step outside the world of aid agencies, where the stereotyped interpretation of events, the scientific management of labor, the passionate debates with colleagues, and the fascination with the mechanics of action (i.e., computers, vehicles, and so on) use up too much of our energy. As aid workers, we must heed the emotions aroused by individual accounts, yet also transcend them. We must try to incorporate the diversity and complexity of the human consequences of these crises into a descriptive and analytical approach that focuses on action. To do so, we must learn to reconcile information and viewpoints that come from various sources and sometimes represent contradictory interests. Then, once we have constructed an image of the disaster, we must plan and implement a relief operation.

Propaganda, Deceit, and Aid

The narration of dramatic events often marks the beginning of relief operations. That is why it is so important to question the spontaneity and authenticity of eyewitness accounts and to ask whether they constitute

"historical truth"? There are two points to be made here. First, humanitarian workers do not have the required skills to establish historical facts. Second, it is unrealistic to imagine that a participant in certain events can establish the "truth" about them even as they are taking place. Since they cannot produce historical facts, humanitarian workers must focus on constructing an image of the event and of the individuals affected. Our responsibility thus becomes clear. The image we construct must be as impartial as possible, in accordance with the principle of the impartial distribution of humanitarian aid. We must therefore be very careful about authenticity and separate out those stories that have been dictated or distorted.

Recent history has produced a surprising number of examples in which the record has been distorted, on a mass basis, by ruling powers. If a story sounds stereotyped, if the teller offers very few circumstantial details, and if different individuals tend to repeat the same story verbatim, then clearly we are being manipulated. Such stories tend to be based not on individual interests but on the interests of the wider group. They are designed to gain an advantage, whether material or symbolic, either for a government or its opposition. Aid agencies' local staff and civilian or military "liaison officers" provided by the national authorities can play a key role in deception – especially when they serve as interpreters. They are in a position to distort people's stories and create the illusion that questioning many individuals will help us establish what really happened.

The mass flight of people from eastern Rwanda to Tanzania[2] in May 1994 provides an example of an organized effort to hoodwink humanitarian agencies. As Médecins Sans Frontières/Doctors Without Borders (MSF) was setting up its camps, we thought, and hoped, that these

refugees were victims escaping genocide. That was not the case. In fact, the refugees' leaders had taken them out of their villages in an orderly manner. Under the command of the "super Hutu killer" Gatete, mayor of his town and the man who had organized the genocide there, they had taken part in the extermination of their Tutsi neighbors before leaving their hillside homes. They had brought so many belongings with them, they could not possibly have left in haste. They claimed that they were fleeing the Rwandan Patriotic Front (RPF), which had been accused of massacring civilians. Their stereotyped accounts essentially echoed the rhetoric of their leaders, which had been relayed to them over the radio station Radio des Milles Collines. Pressed to describe the abuses they were supposed to have suffered, they told stories already reported by others. It was hard to find a direct witness to the violence. The attempted manipulation was clear; yet, we could not entirely exclude the possibility that the RPF had committed violence against civilians. In fact, quite apart from their fear of violence in general, these fugitives were influenced by more specific factors:

- fear of having to answer to specific crimes committed during the genocide;
- blind obedience to the propaganda of the extremists responsible for the genocide;
- fear of being killed for refusing to obey the military and civil authorities who were responsible for the genocide and who had organized the exodus;
- massacres perpetrated by the RPF;
- economics, pure confusion, their desire to remain with their families, and so on.

By stating that they had fled to Tanzania because of just one of these factors (massacres by the RPF), the authors and

interpreters of these stories were engaging in a manipulation that was not without consequences.

The perpetrators of the genocide were represented as leaders of a group of civilians fleeing the violence of the war. The United Nations High Commissioner for Refugees (UNHCR) therefore entrusted some of the camp policing tasks to these representatives of the former Rwandan regime.

Stories motivated by the quest for personal (often material) gain are another example of the rehearsed narrative. These stories are designed to lead us astray and are generally limited to the scale of an individual or a family. Their sole aim is to gain any advantage that the listener, inspired by the story, might bring to the teller and his allies. To gain some advantage, the teller of the tale tries to alter his own role or distort the meaning of the event. This type of behavior, which is encountered more often in the context of a food shortage, needs to be detected by the staff of humanitarian organizations staff during their day-to-day activities. If we were not able to distinguish among all the various stories and demands, the aid process could be brought to a halt. Our resources might otherwise be diverted for the benefit of small groups of privileged individuals. We need to realize, though, that these deceivers are sometimes very skillful and are quite capable of leading us astray.

The Necessary and Dangerous Classification of Victims

After determining the accuracy of personal stories, how can we assess how representative they are? By using a quantitative approach, we can estimate the degree to which a first impression, based on stories gathered at random, might be reaffirmed. We can design a standardized questionnaire to take account of the event and the

participants in all their various aspects. We can also create a representative sample, and we can monitor the effectiveness of data-collection procedures (relevance and precision of questions, level of interviewer training, and translation quality). The latter step enables us to estimate the frequency with which the events in question occurred and determine their relative importance. A survey can be a vital tool, provided that the data-collection process is not limited to extracting information for the questionnaire. It must also focus on the individual's story. By using the statistical method, we can determine how representative such stories are. But the transition from the qualitative to the quantitative requires the definition and use of categories (people, events, and risk factors).

The classification of victims is essential to the process of gathering information – a process that is used to plan and organize relief operations. The system of categorizing severely malnourished children is instructive, because it illustrates both the best and worst of such classification systems. Malnourished children are those who have lost a large part of their body weight in a short period of time. They often suffer from infection and, because of lack of food, are in a state of psychic and physical distress. In industrialized countries, these children would be treated in intensive-care units. In desperate circumstances such as those afflicting the southern districts of the Congo Republic's capital, Brazzaville, in 1999, treatment is simplified both because of lack of resources (i.e., lack of qualified medical personnel, adequate facilities, transportation, and storage capacity) and because of danger. In Brazzaville, local health workers were affected by the violence inflicted on the population as a whole, and international staff members were threatened. It is hard to provide such specialized care, even at a bare-bones level,

under such conditions, and thus it was hard to achieve our goals of weight recovery within a few weeks and prevention of lethal metabolic complications or infections.

In our desperate struggle to revive severely malnourished children, we need to estimate the number of patients who will be admitted to the therapeutic feeding centers, and thus the number of beds needed. Two other statistics are vital to defining the scope of our operation: We need to calculate the number of children to be covered by aid (comparing the number of children already benefiting from aid versus those who require care) and to monitor the evolution of the acute food shortage (stagnation, progression, or regression) within a specific population group. To ensure quality services, the importance of establishing a category for "children suffering from acute malnutrition" and of counting how many children belong in this category becomes obvious as soon as the first isolated clinical cases appear among patients receiving hospital-based care. The alert required to trigger the distribution of food (which often comes too late) depends largely on our having this data. How many starving people are there? Where are they? We are not just seeking to apply fancy scientific numbers to a social situation (whether a food shortage or famine) that might just as easily be identified by interviewing those concerned. Instead, we are refining our understanding to ascertain the extent and nature of the needs. The goal is also to make informed choices about aid having fully assessed the various options. The initial assessment of options provides the ethical foundation for the aid operation and is key to assessing and taking responsibility for the consequences of our decisions. We must always be aware that these categories of victim – the starving child, for example – resonate with the popular

imagination and answer the needs of the media. René Backmann and Rony Brauman have described this phenomenon:

> *Victim of cruel nature, of an absurd war (other people's wars are always absurd), of pitiless armed bands, or a bloodthirsty dictator – but a pure, nonparticipating victim.*[3]

For relief organizations, which are often coordinated by Westerners, the child is also the icon of "innocence, the victim of man's folly." Clearly it is convenient to use this "ideal victim, " particularly as window dressing for fundraising efforts. Yet, other categories of people affected by violence may, as a result, be pushed into the background when aid is being provided. In the case of the people of Brazzaville and Pool, for example, the image of starving children dominated that of rape victims. The image of the men who were summarily executed was also relegated to little more than a detail. The transition from the story of a family that is unable to feed its children to the image of a society in crisis, as described by epidemiological surveys, needs to be assessed very carefully.

The significance of a particular group within the general population can be determined through statistical analysis. But statistical analysis cannot answer the question raised by another form of struggle for recognition: that which, in the minds of aid workers, places each victim and his category in opposition to all the others. What order of priority should we assign to various individuals and groups, to distribute among them a quantity of aid that is most likely insufficient to meet the needs of the population as a whole? Estimating the respective numerical weight of each category does contribute to the decision, but statistics alone cannot provide the whole answer. The example of our operation in the Congo Republic shows how dominant,

"victim-oriented" representations can mask other, less visible suffering, thereby affecting individuals who are less "ideal victims" and yet are at equal risk of dying. In the chapter "Emergency Operations in Brazzaville: Médecins Sans Frontières and Violence Against Civilians, " Marc Le Pape, a sociologist with France's National Center for Scientific Research (CNRS) describes the internal debate at MSF in the face of these dilemmas. This classification process, which is the responsibility of the aid worker, must be subjected to critical analysis to ensure that the stereotyped representation of misfortune and the unfortunate does not cause an unfair distribution of resources.

Violence Against Women: The Power of Words and the Power of Numbers

The Congolese rape victims are an unfortunate example of a category of victims who did not receive an adequate level of care. The raped woman rarely represents the "ideal victim." Even if we recognize the psychological consequences of rape, we often underestimate the dangers it represents for physical health. And yet, the fact that rape is often associated with murder, the potential for transmission of the AIDS virus, and the risk of suicide underscores that rape is potentially deadly. Nonetheless, these women are still denied the role of "ideal victim" that opens the door to quality care. Some women were treated at special centers set up at the Makelekele and Talangai Hospitals in Brazzaville with the help of the International Rescue Committee (IRC). After being registered and interviewed, they received medical attention, generally limited to a shot of antibiotics. Although MSF teams also spent many months providing direct medical care to survivors of rape, initially, our involvement was limited to

providing antibiotics to the doctors who were caring for these women at Makelekele and Talangai Hospitals. In general, psychological care, pregnancy termination, and antiretroviral drugs (ARVs) to reduce the risk of HIV transmission were either available on a very sporadic basis or not at all.

Looking back, we can see why humanitarian agencies decided to switch their attention to the rape victims, after initially having been concerned mainly with the starving children. One initial factor that alerted the agencies to the unmet need was the Congolese health authorities' refusal, for many months, to authorize prophylactic prescription of ARVs following a rape. Their refusal sparked an outcry, but the reaction was not sufficient to improve the quality of health care for rape survivors. It was the increasing numbers of these women seeking help that ultimately made people realize that health care had to be improved.

Between May and December 1999, 1,190 women (including young girls and adolescents) came for treatment at Brazzaville's Makelekele and Talangai Hospitals, saying that they had been raped.[4] Most of the rapes had occurred on the road from Kinkala to Brazzaville, which was known as the "humanitarian corridor" by protagonists of the civil war and the "corridor of death" by the survivors. Even when peace brought a sharp fall in the number of rapes, the numbers did not diminish completely. In March 2000, 22 rape victims, aged between 3 and 40, were treated at Makelekele Hospital. Twenty-one of those rapes were committed by armed men and 13 were gang rapes. Between March and December 2000, 109 women were treated after having been raped. Thirty-one of those women presented less than 72 hours after the rape and were treated with anti-HIV drugs; fifty percent of the treatments were completed.

Twelve babies were born as a result of rape, and 56 women received psychological counseling.

In this case, the numbers were a major factor in the creation of a specific health care service. But it is unusual to register rape cases on a systematic basis. In most conflicts, rape victims are registered as having "gynecological illnesses, " "sexually transmitted diseases, " or "miscellaneous traumas." This is a well-known example of negligence on the part of the medical profession amid humanitarian emergencies. Trapped by their prejudices, physicians are loath to single out a specific group of patients, whose visibility might lead to tensions with political, military, traditional, or religious leaders or with the medical institution itself. They therefore practice discretion, or even silence. As a result of this more or less conscious effort to avoid tension, health services designed to meet the demands of certain patients are not established. Joanne Liu and Pierre Salignon's article, "Health Services for Rape Victims, " shows what can be achieved when we break with this curious form of medical negligence.

Health Experts and Political Experts: A Strange Acquiescence

The tendency of physicians to avoid conflict with authority explains the lack of epidemiological data during war – especially when political violence is the major cause of disease or mortality. In these situations, although pathology caused by political violence decimates families and becomes the focus of politicians' lies, it does not loom large in the reports of public-health experts, who appear to enjoy little independence from the political authorities. The very limited room for maneuver afforded these experts by political leaders dates back to the very origins of public health, as Didier Fassin notes:

Of course, the nature of the relationship between politics and the

body and the structure of public-health institutions varies considerably depending on the historical context, but the creation of a public health care system is part of the process of constructing a state.[5]

The reluctance of health experts to take on political authority is a constant feature of public-health systems. Maintaining public security is one of the essential functions of government. During a period of crisis, the forces responsible for protecting the public often divert from that role in three significant ways: by bearing direct responsibility for crimes, by becoming incapable of stopping crimes from happening, and by being unable to offer reparations to victims. That is why, for politicians, the production and monitoring of health statistics is a major part of the propaganda that goes along with armed struggle. We must realize that it is tempting for medical epidemiologists to limit themselves to consensual categories, such as malnutrition and epidemics, and that it is hard to make medical events stand out when they result from the systematic use of political violence: whether an individual dies from a machete or gunshot wound is not usually recorded in medical epidemiology reports.

The civil war in Rwanda provides an example of this tendency to manipulate events. In September 1996, rebel forces from the Democratic Republic of Congo (DRC), led by Laurent Kabila, and the Rwandan army of Paul Kagame, attacked Rwandan refugee camps in the North and South Kivu regions in eastern DRC. The camps had housed members of the former Rwandan army and militia who were responsible for the genocide, along with hundreds of thousands of civilians living under their grip of terror. During the attacks on the Kivu camps, civilians – including the elderly, women, and children–-were hunted down by death squads and ruthlessly murdered. The Rwandan

refugees, decimated by cholera and dysentery, initially enjoyed a positive image. They symbolized the "ideal Rwandan victim" for whom international aid agencies had been mobilized (while overlooking the victims of the genocide). Scarcely two years later, the refugees underwent a reversal of their public image, once more under the impact of international propaganda. Most observers thereafter associated the refugees with those who had carried out the genocide, as shown in an article by journalist Colette Braeckman:

> *Note, however, that the fugitives were more the remnants of an army in retreat (armed men together with civilians) than genuine refugees, in the strict sense of the term.*[6]

This process of redefinition gave way to massacres to which few people wished to testify. Some regional powers (Uganda) and international powers (the US and Britain) backed the DRC rebellion and the new Rwandan government. The United Nations High Commissioner for Refugees (UNHCR) declared that it was not known how many refugees had been massacred:

> *Thousands of Rwandans died as they fled – exactly how many will never be known.*[7]

Are we talking about thousands, tens of thousands, or hundreds of thousands? Apart from a retrospective mortality survey conducted by epidemiologist Pierre Nabeth, [8] the health statistics bear no trace of the events. Of a group of 3,121 residents of the Kivu camps who fled to the Congo Republic between October 1996 and May 1997, 615 (20 percent) were killed, according to execution witnesses; 1,857 (60 percent) became separated from their families; and 530 (17 percent) reached the Congo Republic alive. The total mortality rate during that eight-month period was 15.5 per 10,000 people per day. Forty-one percent of those

executed were women. It would not be scientifically sound to extrapolate from this partial data, but by piecing together the data that we do have, we can make a fairly accurate guess. At the very beginning of the crisis, the DRC-based nongovernmental organization Equipe d'Urgence de la Biodiversite (Biodiversity Emergency Team or EUB) reported burying 6,0 people in the Goma region alone.[9] Coming mainly from the camps, these dead accounted for one percent of the total camp population. We could provide a list of data about the various groups of Rwandan refugees that were hunted down by soldiers in various places and times. Those data do not reflect the simple liquidation of "the remnants of an army in retreat" but rather of a crime against humanity involving – at a conservative estimate – some tens of thousands of massacred people.

In such cases, it is in the government's interest to deny that such events occurred. The physician must therefore remain independent to guarantee that medical data are collected in the patient's interest, not in that of the state or political or military groups who use violence, misappropriate aid, and issue extremist propaganda. It is in the patient's interest to see his or her situation recognized. That is why we must record the key elements of patients' histories in our consultation and admission files. If certain pathologies occur often enough, we may be justified in including specific new categories in morbidity and mortality records, and even in establishing separate records. If circumstances suggest that it would be useful to the patient, a certificate stating the facts observable at a physical examination can be drawn up, along with the patient's history. The patient is held responsible for the facts related. Together, these files can be used to demonstrate that the causes of morbidity and mortality

have been detected in a significant number of people. In doing so, we must always ensure that information about patients' identity is not later used against them. In at least one instance, MSF's patient lists and medical files were, in fact, used by murderers to identify their future victims. In mid-july 1995, at the fall of Srebrenica, a Muslim enclave of eastern Bosnia under the protection of United Nations peacekeeping troops, a hospital admissions list was discovered in the possession of the Bosnian Serb officer in charge of selecting those who would be targeted for execution.

Collective recognition of the facts is key to mobilizing social and political efforts to halt violence and ensure that victims receive medical care. Generally speaking, the impact of political violence on civilians is not denied. Instead, it is either underplayed or overplayed to suit the purposes of those concerned. Nobody doubts that these crimes are committed against noncombatants during armed conflicts. But the frequency of such events is unknown, and dates and places are not exact. This scenario leads to all kinds of distortion, ranging from negation to exaggeration.

The Civil War in the Congo Republic: A Major Health Care Disaster

In the case of the civil war in the Congo Republic, violence against civilians was declared to be minor by the victors, who themselves had been scarcely less violent than their opponents. To recognize the extent of the abuse, the new regime would have had to admit that its own political position was achieved partly through the actions of armed bands who killed, raped, and starved thousands of Congolese. The following is an extract from an interview given by President Denis Sassou Nguessou to journalist

Stephen Smith and published in the French newspaper *Liberation* on June 13, 1999. Nguessou had returned to power in 1997 after five months of civil war. Renewed fighting had broken out since December 1998, eight months before the interview took place.

> *Libération:* Didn't you also lose control of your own militiamen?
>
> *President Sassou Nguessou:* No, absolutely not. Otherwise, how do you explain the fact that between October 1997 and last August, order was beginning to be restored and the process of reconstruction had begun? After my victory, nobody went off and sacked Brazzaville's southern districts. The whole country was at peace. So tell me where these abuses were committed. Nowhere. It was only after the attacks backed by the exiled former leaders that the violence started up again.

Nor was the opposition slow to commit acts of violence against civilians. President Sassou Nguessou's words might easily be found in the mouths of his main opponents. They rely on the substitution of the word *violence* for the word *abuse,* when it becomes impossible to deny facts that are all too obvious:

- We have not lost control of our own militiamen, so there was no abuse, anywhere;
- There was an attack by our adversaries, thus there has been violence.

At first the facts are denied or minimized. When that is no longer possible, the process of redefining the facts begins. The violence becomes a reaction to that of one's adversaries and thus is implicitly legitimate. This absolves its perpetrators of all responsibility. The available statistics belie the words of the victor of the civil war in the Congo Republic and offer confirmation (in the form of dates,

places, and details about how often incidents occurred) that responsibility for the violence cannot be laid solely at the opposition's door. According to the results of a retrospective mortality survey conducted in Mindouli, a town with a population of 10,0 near Pool, in southwest Brazzaville, 736 people (7 percent) died between November 1999 and January 2000. During that period, the mortality rate stayed above 5 people per 10,000 per day. Between August and September 1999, the prevalence of severe acute malnutrition (weight/ height ratio below 70 percent of normal) among children under five seen on their return to Brazzaville varied between 30 and 40 percent. We should also remember that between May and December 1999, 1,190 women, adolescents, and young girls sought assistance at the rape treatment center at Brazzaville's Makelekele Hospital. Many of those rapes occurred as the displaced returned to Brazzaville. At the time, the roads they used were under the control of militiamen allied with the Congolese president.

The sheer number of cases played a key role in winning access to health care for Brazzaville's rape victims. In terms of public security, people may be concerned about an incident whether it occurs 10 times, 100 times, or more than 1,000 times over a given period of time. But whether the event is perceived to be the responsibility of the broader society depends both on how often the event is determined to have occurred and on that society's perception of how serious it is. Moreover, we cannot ignore that these issues are being debated in a society in which referring to scientific methods adds weight to the arguments being advanced. But this is a minor point in light of the demanding characteristics of statistical methodology. It is much more difficult to make the figures say what you want when you respect certain elementary

rules, which can be verified by external observers. Are the categories relevant? How high is the quality of data collection? Has a representative population sample been used to determine the distribution of the event? Has there been an analysis as to whether or not a certain frequency difference is statistically significant? Figures are important, but only if explanations are given as to how they are obtained, so that the reader can review them in a critical manner.

Victims, Killers, and Aid Workers

Data collection that provides an image of the crimes committed during a conflict, medical concerns aside, is an essential part of ensuring quality patient care. However, those data can also be used for other purposes. Consider the problems that arise when one disseminates the information and, more specifically, the problem of its use for propaganda purposes. Consider, also, the impact of abuse of data on the actions of humanitarian workers. When it is the humanitarian workers themselves who are engaged in propaganda (as we discussed above) the most immediate consequence is that the aid is distributed on an unequal basis, because a complex crisis has been reduced to the single, almost blinding figure of the pure and innocent victim.

When publication of this information conflicts with the interests of one of the warring parties, it can be reflected in a hostile attitude toward staff of humanitarian organizations. From the threat of hostility to the hostile act itself, the range of retaliatory actions is broad: bureaucratic harassment, restriction of access, expulsion, attacks against buildings or staff. These actions are feared by aid workers not only because they introduce personal or institutional risks, but because they can also halt the provision of vital

aid. In circumstances where the use of violence by parties to a conflict is criminal, the dilemma is often automatically perceived as "presence in silence" versus "public communication with the risk that aid will be suspended." Describing the choice in this way is scarcely appropriate. Although it explains humanitarian workers' discretion toward crimes committed against civilians during the Congo Republic's civil war, it is not enough to explain the scant attention paid by the media. The above dichotomy also contains another, more awkward dilemma for the aid worker. Silence (often so intense that it borders on complicity) is not the only price exacted by the executioners for tolerating the presence of foreign witnesses to their crimes. The desire of the perpetrators of collective crimes to involve as many people as possible, under threat, to ensure silence through a sense of complicity, also concerns humanitarian workers.

Here again, an example from the Congo Republic is very instructive. It is the story of the so-called "humanitarian corridors"–known as "corridors of death" by the survivors. These words describe the roads, the periods of time, and the conditions of violence under which tens of thousands of civilians were displaced during the conflict. The displacements, which were marked by murder and rape, were carried out using trucks paid for through the European Union's emergency humanitarian aid program and procured through the aid division of a church. The most serious crimes did not stop with the "humanitarian corridors." At the end of the journey, if one somehow managed to survive that passage of terror, the life of a prisoner followed: a life prey to the abuses of militiamen, either from one's own side or from the enemy's. The mere association, in the propaganda of the killers, of the word

humanitarian with the "corridors of death" means that one had to distance oneself from them publicly. The killers' determination to associate humanitarianism with the concealment and facilitation of their crimes offered a practical solution to the dilemma of whether to remain present while saying nothing or to speak up and leave. At the same time, it is important not to endow one's presence at the victims' side with a kind of sacred status. Otherwise, that presence itself begins to appear more important than the refusal to associate oneself with a crime or the dissimulation of a crime. If one wants to reveal dangers that are partly hidden from potential victims through the use of the "humanitarian" label, one must speak out publicly about the crimes and those who commit them. This is what is required, in times when the use of terror dominates every aspect of people's lives, if we want to make sure that the role of the aid worker does not degenerate into that of the killer's assistant.

The story of the massacre of Rwandan refugees during the joint offensive of the Rwandan Patriotic Army (RPA) and the Alliance of Democratic Forces for the Liberation of Congo-Zaire (Laurent Kabila's ADFL) is the most striking example of a group of killers' capacity to manipulate aid agencies to its own ends. In early 1997, several months after the offensive in eastern DRC, MSF decided to stop our active search for refugees along the roadsides. The liaison officers provided by the forces of Paul Kagame and Laurent Kabila had been traveling with aid agencies, using them to locate groups of refugees who were hidden in the forest. These officers lured refugees to the road between Bukavu and Shabunda, tricking them into believing that if they left their hiding places they would receive aid and be repatriated to Rwanda. When they emerged from their

hideouts, the refugees were massacred by soldiers who had been informed of the refugees' whereabouts by the liaison officers. Humanitarian aid thus served as a lure, allowing the killers to massacre whole groups of refugees. These facts were presented in an MSF report[10] issued to the press.[11]

Humanitarian aid is neither feasible nor respected in all circumstances. There are some occasions when abstention represents the best possible humanitarian choice. Such occasions are rare, but they do occur. To refuse to take them into account is to surrender to an arrogance that can blur the distinction between humanitarian aid and complicity in a crime.

Medical Information and Propaganda in Favor of Military Intervention

Denial or, more often, underestimation of events is not the only reaction of authorities to the evidence of abuse. Exaggeration is also a frequently used device. It can be to the advantage of a warring party to use the repellent image of its enemy's violence for propaganda purposes. The victims then become the focus of intense publicity, which is not necessarily combined with delivery of quality health care. This phenomenon is magnified by aid agencies' and journalists' love of large numbers. When abuses committed by the opposing camp become fuel for propaganda, however, they lose their credibility and give rise to the production of fanciful estimated data. The number of victims of the federal army and the Yugoslav police during the war in Kosovo, as stated in NATO leaders' propaganda, illustrates this partisan manipulation. An article by journalist Elisabeth Lévy, [12] published one year after the start of the war in Kosovo in 1999, shows how central the number of victims was to NATO propaganda. At certain

moments, the propaganda intensified. The hundreds of thousands of civilians who could no longer be reached by NATO were transformed into potential victims of genocide. In mid-November 1999, a report by the International Criminal Court (ICC) mentioned the exhumation of 2,018 bodies and referred to individual families' reports of 4,266 disappeared persons. Later, the number of civilians massacred by Belgrade's forces, a figure that served as justification for NATO intervention, was reduced to a level far below that which was circulated at the time when it was essential to find reasons for the West's military intervention.

A few days after the intervention began, MSF was invited by *Libération*[13] to provide our opinion of the NATO air strikes and their consequences for the people of Kosovo:

> *"We have, no specific view about air strikes. Our information base is very weak, everybody is going on guesswork, and we do not want to reason on the basis of information that is in the public domain. As in all conflicts, the manipulation of information has played a major part. We hope to be able to express an opinion when we have established solid contact with the people concerned. That is how we work. When we receive disturbing information, we always ask how systematic it is. Are they isolated acts? Are they taking place all over the country? It takes several days of data collection to understand what is going on. Because the parties to a conflict can be extremely manipulative, we need to be careful. Because we are a medical agency, we have the privilege of being able to access thousands or tens of thousands of people. When we do not have this access, we are extremely wary."*

The reservations and intentions expressed in this interview would eventually be translated into action. A survey[14] conducted by MSF teams and Epicentre in Rozaje, Montenegro, and Kukes, Albania, among 406 Kosovar

refugee families confirmed the theory that Milosevic's forces had actively expelled hundreds of thousands of Kosovars (as opposed to their having fled war *and* NATO air strikes) and gave an indication of the number of dead from among these families. As to the reasons for their flight and the estimate of the number of dead, the answers were not as obvious at the time as they are under retrospective analysis. "Is a 'Genocide' Under Way in Kosovo? " asked the newspaper *La Croix* in a front-page story on March 29, 1999. Yet, according to MSF's study, seventy-nine percent of the families interviewed said they had fled because of threats and violence specifically designed to drive them from the country. Of the 3,047 people in the sample (involving 406 households), 13 had died, seven of them violently. It was stated that, due to the circumstances of the survey, it was not possible to evaluate the number of rapes. MSF's study responded dearly to the questions of why people fled and how many had died. It confirmed the reality of the expulsion process and underlined the fact that no evidence of genocide or large-scale massacres could be discerned from interviews with the refugees of Montenegro and Albania.

Despite the results of the survey, which contradicted the most radical aspects of NATO propaganda, its publication in the press[15] still found an echo in Western leaders' campaign to manipulate public opinion. Seeing the published results without an attendant denunciation of the deceptive presentation of the war as "humanitarian, " the public was led to understand that MSF's epidemiological survey confirmed the reality of the abuses that served as justification for military intervention by Western forces. The mere quality of the data is no guarantee that the traps of manipulation will be avoided. Understanding the goals pursued by the main political and military players is also

necessary. To release data without a precise political analysis in this context is to run the risk of unwittingly serving the objectives of those who back military intervention.

An interview[16] given to a French monthly by Admiral Pierre Lacoste, former head of the French military intelligence service, illustrates this point clearly:

> *"Take the case of Médecins Sans Frontières: having managed to secure world media attention for the famine in Somalia (and why not?), this NGO automatically triggered an international military operation, in which the United States, moreover, brought discredit upon themselves. Now that's what I call an effective international power: one that can even trigger military action."*

The attempt to secure world media attention, as described by Admiral Lacoste, was based largely on a survey[17] conducted in April 1992 in the regions of Merca and Qorioley, 100 kilometers south of Mogadishu. The population of this region was estimated to be 103,000 (both residents and displaced). Among a sample of 690 households, corresponding to 4,169 people, 497 deaths (or 12 percent of the population) had occurred in the year before the survey. In addition, the upper-arm measurements of 68 percent of the children, taken during the researchers' visits, showed signs of acute malnutrition. The aim of the survey was not, of course, to provoke a military intervention, but to trigger a massive distribution of food. The use of a dramatic statistic – in the case of the 1992 famine in Somalia, that 80 percent of food aid had been misappropriated by "Somali warlords"–served as a factor in US propaganda claiming that troops would be needed to protect the distribution of food. It is the symbolic power of numbers that actually makes them dangerous.

Statistics on the fate of civilians during the war in the Congo Republic show the massive level of violence perpetrated against civilians. They are presented by Pierre Salignon and Dominique Legros in the chapter "Violence Against Civilians: The Impact on Health Care." The violence spared no one. Men were executed, women were raped, and children were starved. Specific data on the fate of the elderly was not provided. Such was the extent of the violence that we can say the perpetrators are, at the least, war criminals, if not criminals against humanity. The survey data do not enable us to distinguish the degree of responsibility of politi cal and military elites relative to that of the men who carried out their orders. It tells us nothing of the complicity of outsiders, whether regional (soldiers from Angola, Rwanda, the DRC, and Chad) or international (France, oil companies, and private mercenaries). These data are not the first step of a judicial proceeding. They were not collected with the aim of providing evidence to any court, nor do they profess to have the necessary characteristics to constitute a legal document.

The data do, however, allow us to establish certain facts, which should be complemented by a description of the intentions of those who committed acts of violence and a determination of the social group to which they belonged. That information is both indispensable and hard for foreigners to access. It is difficult for humanitarian agencies, which have access primarily to the world of aid, to form opinions based on individual accounts and rumors of the most bizarre kind. The contributions of social-science researchers and journalists are extremely valuable when addressing questions such as: Who is perpetrating the violence? and Why?

In the case of the civil war in the Congo Republic, field

studies do not confirm an intention to exterminate an ethnic group: indeed, civilians were as much the victims of militiamen from their own side as they were of militiamen from the opposite side. To eliminate and terrorize the enemy, to execute the spies and the masterminds, and to punish those who broke the rules – these were the main motives of the crimes. Does stating this loudly and clearly constitute an infringement of the principle of the neutrality of humanitarian workers during a conflict? The Geneva Conventions give humanitarian personnel the right to use weapons to defend themselves if soldiers threaten their lives despite the fact that they are strictly respecting the framework of humanitarian action and are dearly identified. If the letter of the Geneva Conventions authorizes the use of a weapon under such circumstances, it is hard to imagine how the act of publicly denouncing the murder and the systematic rape of people protected by international conventions would be a violation. Once again, however, humanitarian medicine is not about dispensing justice. Taking a public position on these types of crimes fulfils the primary objective of dissociating ourselves from the crimes, ensuring that neither the label nor the logistical resources of humanitarian aid serve the purposes of the killers, and ensuring that aid for survivors includes security and high-quality relief services. Justice pursues other goals. It relies on the law to mobilize the forces of law and order against the perpetrators of these crimes, put an end to their activities, judge them fairly, punish them if they are found guilty, and provide reparations for the victims. This is well beyond the ambitions of humanitarian action, and well beyond the mandate of humanitarian workers, who are neither writers of history nor dispensers of justice.

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CHAPTER TWO

Violence Against Civilians: The Impact on Health Care

Pierre Salignon and Dominique Legros, M.D.[1]

After a year of calm, fighting resumed in Brazzaville, Congo Republic, in December 1998, causing one-third of the capital's estimated population of more than 800,000[2] to take flight. The majority of the displaced sought refuge in the forests of the neighboring Pool region. They fled from one village to another, joined by residents of the villages as they went. Then, caught up in the fighting, they found themselves at the mercy of militias, with no chance of help from outside and without food or security.[3]

In May 1999, the displaced people began returning to Brazzaville, a process that would continue until February 2000. During this period, 250,0 survivors made their way to the capital's sports center, which had been turned into a transit center for displaced persons to be registered. It is worth noting that 20 percent of these people came from the Pool region, having fled their homes to seek help in the Congolese capital.

In October 1999, the United Nations Office for the Coordination of Humanitarian Aid (UNOCHA) estimated that 800,000 people throughout Congo had been affected by the war. Thousands of civilians had died.

In May 1999, as the first survivors began to emerge from the forest, Médecins Sans Frontières/Doctors Without Borders (MSF) extended its activities to the southern parts of the capital, which were once again controlled by government forces. The Makelekele Hospital was reopened

gradually, providing medical and nutritional services; four therapeutic feeding centers (TFCs) were set up to address the emergency; and a continuous presence by MSF at the screening site in the sports center ensured that the sick were identified and referred to the hospital for treatment. In February 2000, MSF teams began investigating the extent of the tragedy through their work in the northern districts of the capital.

In October 1999, 11 months after the start of the war, aid agencies were finally able to reach the south of the country. MSF reached Kinkala in November 1999; Mindouli in February 2000; and then Sibiti, in the Lékoumou region, in April 2000.

This essay is intended to evaluate the health consequences of the war that devastated Congo Republic between 1998 and 2000. It retraces the route taken by those who fled the capital in December 1998–people who were dogged by violence and deprivation and who were joined along the way by inhabitants of the neighboring Pool region who also became caught up in the fighting. It then offers quantitative and qualitative data gathered in the course of MSF's activities in the Congo Republic. The results of surveys carried out by MSF and Epicentre are presented, as is epidemiological data gathered between May 1999 and February 2000 from the following sources, with support from MSF:

a) a survey conducted in Brazzaville in October 1999, based on sampling of mothers of children with acute malnutrition who were treated at a TFC on their return from the Pool region. The data were collected using a standardized questionnaire that focused on the family's composition prior to its departure, the route it took, its reasons for returning, and the number and causes of the

deaths it sustained.

b) a thorough and retrospective mortality survey covering the period from November 1999 to April 2000, which was carried out in the town of Mindouli in May 2000. This survey was used to estimate the mortality rates for the population as a whole (gross mortality rate) and for children under the age of five over the same period.

c) data on victims of sexual violence admitted by the emergency unit of Makelekele Hospital between May and December 1999.

d) nutritional data gathered at the TFCs opened by MSF in Brazzaville, Kinkala, and Mindouli (admissions, discharges, deaths, abandonment of treatment, recoveries).[4]

e) systematic screening of nutritional status among children under age five, based on a ratio of height to weight. This survey was conducted at Brazzaville's sports center between August and September 1999.

The Tragic Journey of the Forcibly Displaced

A survey of mothers of malnourished children, carried out in October 1999 at a TFC in Brazzaville, enabled MSF to reconstruct the route taken by 191 displaced families, comprising 1,033 people.

Among these families, 150 (78 percent) had left Brazzaville in December 1998, the month when fighting resumed in the capital. Forty-one families (22 percent) from the Pool region had taken refuge in Brazzaville because of fighting and worsening conditions near their homes. The average period spent away from home was eight months, during which time the families remained isolated and without outside help.

In all, 89 families (46 percent) returned to Brazzaville because of health problems (malnutrition and disease)

caused by their flight into the forest and hardships imposed by the militias. Sixty families (31 percent) went to the capital after having received "reassuring" information, despite the rumor that Brazzaville had been destroyed.

One hundred nine families (57 percent) reported having been held "against their wishes" by *Ninja* militiamen. Some families said that they had been held hostage by militias and used as human shields against attacks by government troops. One hundred twenty-four families (65 percent) said that they had been attacked by *Ninja* militiamen in the Pool region while fleeing and again by government militiamen on their return journey.

In all, 92 families (48 percent) reported having experienced the death of at least one member since December 1998, for a total of 139 deaths, or 13.5 percent of the total sample. Among the dead, 48 (34 percent) were children under five. The main cause of death reported was malnutrition (55.4 percent). Violence accounted for 12.9 percent of the deaths and affected mainly adults, especially men (*Cf.* Table 1).

TABLE 1

Causes of Death

Survey of 191 displaced families, Brazzaville, October 1999 (n = 139)

Causes of Death	N	Percentage
Malnutrition	77	55.4
Disease	20	14.4
Violence	18	12.9
Other	24	17.3
Total	139	100.0

Mortality in the Town of Mindouli

From April 24 to May 3, 2000, MSF carried out a retrospective mortality survey on the population of Mindouli, located in the southern Pool region. The stronghold of the Ninja militias and locus of intense fighting, this town did not become accessible to aid agencies until February 2000.

Covering the period of November 1999 to April 2000 (a period in which the population had sought refuge in the forests), this survey provides an estimate of the monthly gross mortality rates among the general population and among children under five years of age, together with the main causes of death. It also identifies the dates and locations of migration.

Six teams, each composed of two Congolese, asked the heads of families that were in Mindouli at the time of the survey to answer a questionnaire seeking the following information: number of people living under the same roof for at least two weeks, date of escape from Mindouli, date of return, main place to which they had migrated, and number of deaths in the home since November 1999. For each death, the age, month, and probable cause were recorded.

A total of 10,026 people were accounted for in Mindouli during this survey, compared with an estimated pre-war population of 12,000. There was a clear shortage of men (44.9 percent of the total population), especially young adults, and of children under five (13.1 percent of the total population), creating suspicion that some had died during the months of war and flight or were still fleeing or hiding in the forest when the survey was done (Cf. Fig.l).

All of the families in Mindouli in May 2000 had fled the town between October 1998 and November 1999. In all,

1,980 of the 10,026 people who were there in May 2000 (19.7 percent) had left in October 1998 when the first confrontations between Ninja militiamen and Congolese armed forces took place; 482 (4.8 percent) had left between October 1998 and June 1999 while the region was controlled by the Ninja militiamen; and the majority, or 7,413 people (73.9 percent) had left the town on July 18, 1999, in response to the advance by government forces and helicopter bombardments. Only 151 people (1.5 percent) had left after that date.

The Democratic Republic of Congo, because of its proximity, was the main destination, taking in 63.5 percent of the migrants; the others remained in the Congo Republic.

The majority of those present in Mindouli in May 2000–some 8,396 people (83.5 percent)–had returned gradually between January and March 2000, mainly in February, following the reopening of the hospital by MSF, the opening of a TFC, and the systematic distribution of food to all children under five. The average length of their absence from Mindouli was seven months.

Heads of families declared that 744 deaths had occurred during the six months that had elapsed from November 1, 1999 to late April 2000. These 744 deaths represented 6.9 percent of the original population on November 1, 1999. The gross mortality rate, averaged over six months, was 3.9 deaths per 10,000 people per day.

FIGURE 1

Distribution, by Age and Sex, of the Residents of Mindouli
in May 2000

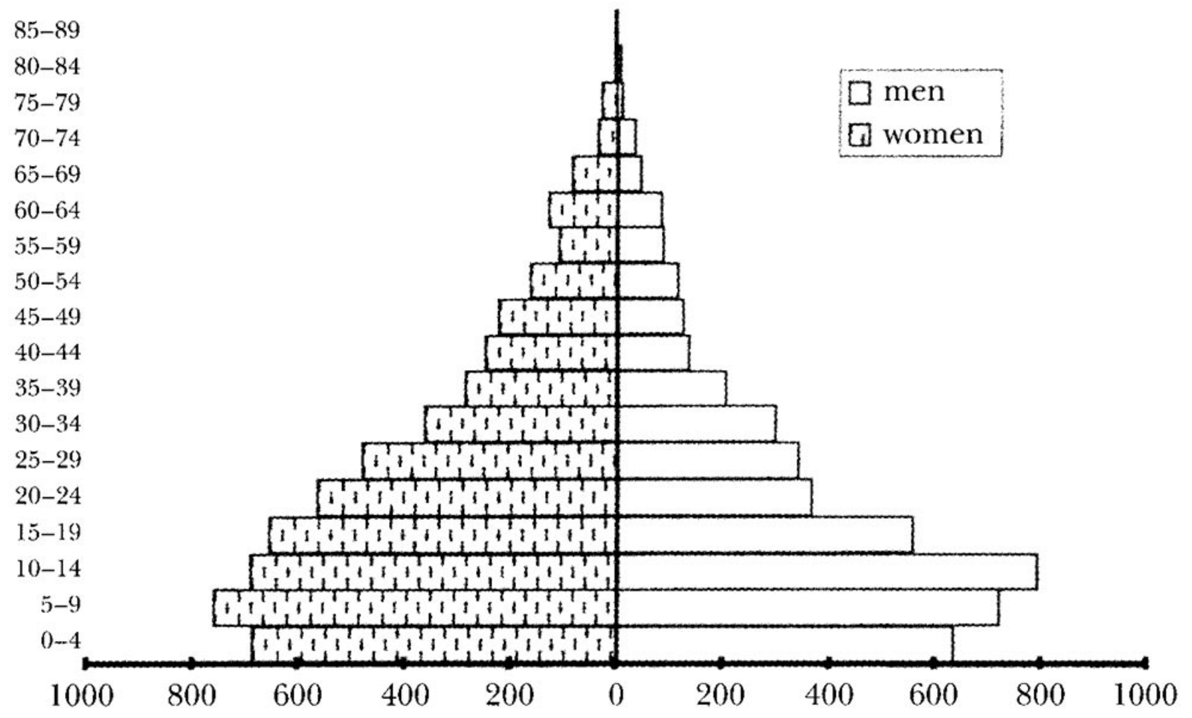
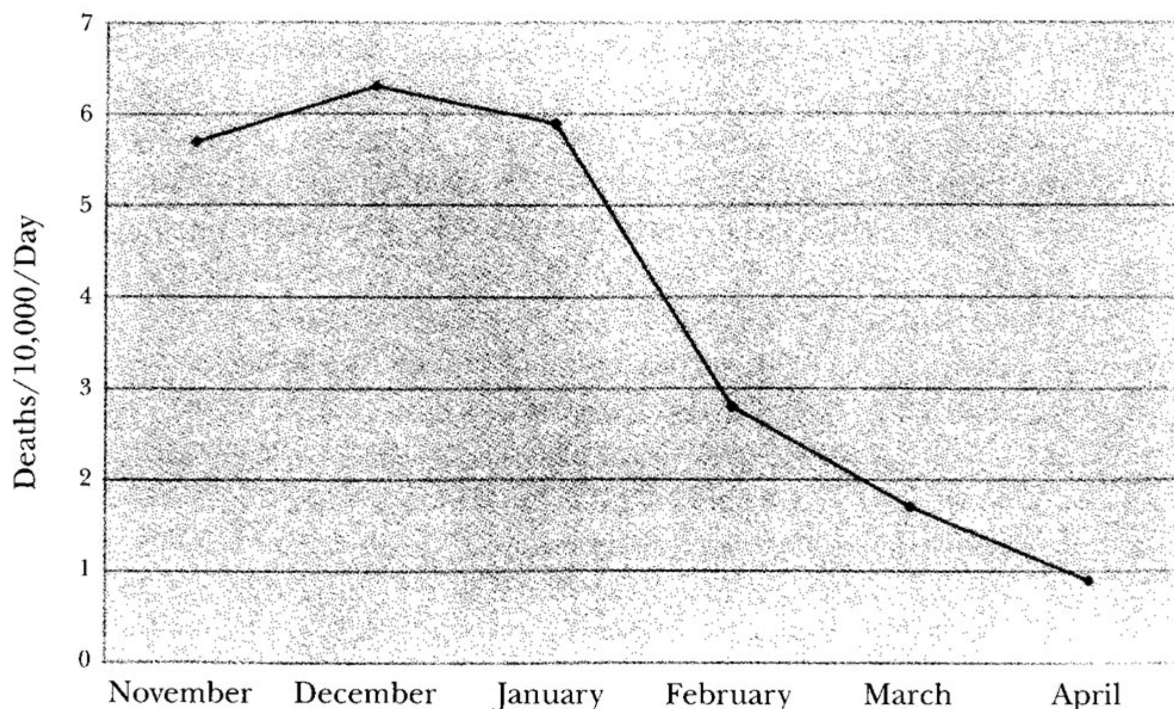


FIGURE 2

Gross Mortality Rate per Month

November 1999 to April 2000, Mindouli



The gross mortality rate exceeded 5 deaths per 10,000 people per day until January 2000, after which the rates continued to fall until normal rates returned (‹1 death per 10,000 people per day) in April 2000 (Cf. Fig. 2).

Among the 744 deaths, 429 (57.7 percent) were related to malnutrition and 17 (2.3 percent) to violence. The cause of 218 of the deaths (29.3 percent) could not be determined accurately (cf. Table 2). In all, 608 deaths (81.7 percent) occurred during migration, and 136 (18.3 percent) occurred after the return to Mindouli. The gross mortality rates were 5.7 per 10,000 people per day during migration and 1.6 per 10,000 people per day after the return. A significantly greater proportion of deaths related to malnutrition occurred during migration, confirming the extreme destitution experienced by the displaced persons during their flight into the forests.

TABLE 2

Causes of Death

November 1999 to April 2000, Mindouli

		Total	During	Migration		Mindouli	P*
	n	(%)	n	(%)	n	(%)	
Malnutrition	429	57.7	363	59.7	66	48.5	0.02
Fever	49	6.6	39	6.4	10	7.4	0.69
Diarrhea	31	4.1	22	3.6	9	6.6	0.11
Violence	17	2.3	16	2.6	1	0.7	0.31
Other	218	29.3	168	27.7	50	36.8	0.03
Total	744		608		136		

** Comparison of the proportions of deaths, by cause, during the migratory period and after the return to Mindouli*

Among children under five years of age, 195 deaths were reported to have occurred during the six months prior to the survey, a figure equal to 13.0 percent of the children who had been present in November 1999, yielding an average mortality rate of 7.6 deaths per 10,000 people per day. The mortality rates for children under age five exceeded 10 deaths per 10,000 per day between November 1999 and January 2000–or five times the “threshold of concern, ” which is 2 deaths per 10,000 people per day for this age group (Cf. Fig. 3).

Among the 195 child deaths, malnutrition accounted for 106 (54.4 percent), fever for 34 (17.4 percent), diarrhea for 13 (6.7 percent), and other unexplained causes for 42 (21.5 percent).

The mortality rates were 3.6 times higher during the period of flight than in Mindouli after its inhabitants’ return (respectively 5.7 per 10,000 people per day and 1.6 per 10,000 per day).

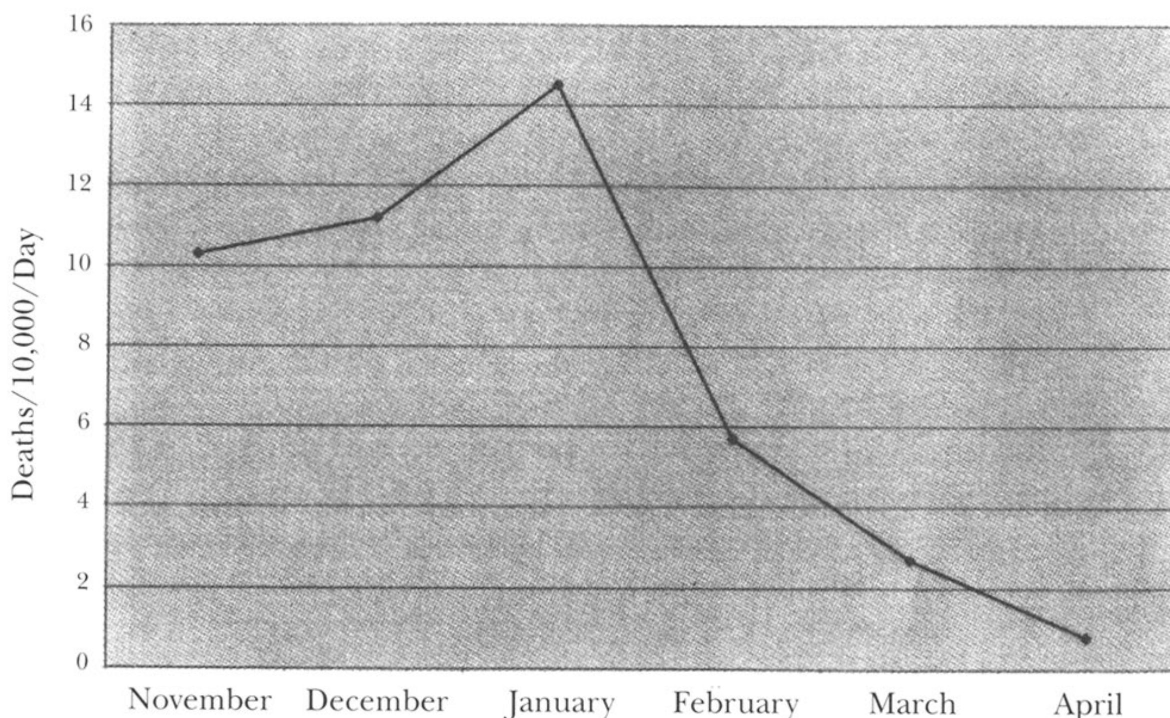
Likewise, between November 1999 and January 2000, prior to the return of the majority of inhabitants, the

estimated mortality rates were much higher than the acceptable threshold of 1 death per 10,000 people per day for the general population.

FIGURE 3

Mortality Rates for Children under Five

November 1999 to April 2000, Mindouli



These figures do not represent the entire migratory period and cannot be extrapolated to the entire displaced population of the Congo Republic. Nevertheless, they reflect the harsh conditions experienced by the population of Mindouli following the military events in July 1999, and also, for some, beginning in October 1998, after the initial confrontations in the region. The high proportion of deaths caused by malnutrition is especially revealing in this regard.

The improvement in mortality rates after the displaced had returned clearly reflects the presence of four

nongovernmental organizations in Mindouli: MSF, Action Against Hunger, Oxfam, and Caritas. It is likely that the situation remained critical for a long time in other areas to the west and north of the Pool region beyond the reach of international aid.

Large-Scale Sexual Violence

Between May 3 and December 31, 1999, 1,190 women and girls sought emergency treatment at the Makelekele Hospital in Brazzaville, stating that they had been raped. Most of the reported rapes had been committed along the road linking Kinkala and Brazzaville, which the survivors called “the corridor of death.” The corridor had been opened by government troops at the beginning of May 1999 to “encourage” displaced people to return home. Far from helping them return to safety, the road became the site of extreme violence (summary executions of numerous men, humiliation, robbery, and large-scale rape).

The number of rape cases reported to the Makelekele Hospital, beginning in May 1999 as people started to return, increased rapidly, from 97 in May, to 172 in June, to 272 in July, and to 189 in August. During July and August, displaced people returned in large numbers (more than 15,000 per week in July) to Brazzaville. After that, the monthly total of reported rapes, although still high, stabilized at around 120, then fell to 68 by December 1999, the official date of the cessation of hostilities. Most of the rapes that occurred during 1999 were committed by armed men. The victims, with rare exceptions all female, came from every age group; children and the elderly were not spared. Often it was a case of mass rape committed by government militiamen who stopped the trucks carrying displaced people back to Brazzaville and made the women and girls alight before selecting their victims.

The statistics on those who sought emergency treatment at Makelekele Hospital at the beginning of 2000 show a reduction in the number of women who had been raped.

In January and February 2000, with the peace process at a delicate stage, 68 rapes were recorded. Fifty of the victims were between 16 and 30 years of age; nine were younger than 15. In March, three months after the peace accords, 22 female rape victims arrived at the Makelekele Hospital. Their ages ranged from 3 to 40 years; nine were under 15. All but one of the rapes had been committed by armed men. In 13 cases, at least two men had been involved. In one case, eight men were accused.

Although the number of reported rapes diminished after 1999, sexual violence remained common. The war was succeeded by a period of brutality, amid a society already in disorder and devastated by several years of conflict. The sense of impunity remained strong, and social violence went virtually unpunished.

In March 2000, several months after the start of the negotiations with the Congolese minister of health, MSF was authorized to launch a treatment program, which included the use of antiretroviral drugs to prevent HIV, for female victims of rape.[5]

A Nutritional and Medical Emergency

Between August and September 1999, the prevalence[6] of acute general malnutrition among children up to age five seen at the Brazzaville sports center varied from 30 to 40 percent. The prevalence of acute severe malnutrition was greater than 20 percent, with kwashiorkor[7] accounting for 75 percent of such cases.

A total of 8,061 children were admitted to MSF's four TFCs in Brazzaville between May 1999 and February 2000,

and 286 died – a death rate of 3.6 percent. Between the end of July and October 1999, the number of children in the care of the medical teams never fell below 1,000. (To improve the outlook for children also suffering from malaria, the treatment protocols were changed to enable medical staff to prescribe the medicines arthemeter and Ceftriaxone.) A similar situation was observed at Kinkala, in the Pool region, between the opening of the mission in November 1999 and February 2000. There, the total number who received treatment at the TFC was 2,461, of whom 80 died – a death rate of 3.3 percent.

Conclusion

This summary confirms the dramatic health consequences sustained by the civilian population of the Congo Republic as a result of the war.

It has not been possible to make an accurate count of those who died or disappeared between December 1998 and January 2000. Governmental sources estimate that the conflict caused the deaths of between 10,000 and 15,000 people.[8]

The statistics presented here were culled from surveys carried out at health centers supported by MSF among people in serious difficulty. Although the figures cannot be extrapolated to the entire displaced population of the Congo Republic, they tend to indicate that the actual number of deaths was higher than the official estimates.

As in Kosovo, [9] East Timor, [10] and Sierra Leone, [11] the conflict in the Congo Republic was characterized by repeated acts of violence against civilians.

Forced to flee, the civilian victims found themselves caught up in the fighting, and were sometimes used as human shields. There are many accounts of the killings.

Men were the victims of summary executions carried out by Ninja militias in the Pool region and by Cobra militiamen in the "corridor of death." They were killed in groups, accused of being "infiltrators" or "enemies from within." Rapes were also committed on a large scale, and sometimes systematically. At the beginning of 2000, the United Nations was even speaking in terms of tens of thousands of rapes committed in 1999 throughout the Congo Republic. The number of rapes reported to the emergency service at the Makelekele Hospital can only be an indication of the sexual violence that occurred countrywide during the conflict, given that female rape victims often hesitate to come forward.

Deprived of food and security, the displaced managed to survive under appalling conditions. Malnutrition was the main cause of the deaths reported to have occurred during their migration. After the return to Brazzaville, [12] one-third of the children examined at the sports center were found to have acute severe malnutrition. In all, more than 10,000 cases of acute severe malnutrition were treated at the feeding centers run by MSF alone. This figure does not take into account the medical and nutritional services provided by organizations such as Action Against Hunger, Caritas, the International Committee of the Red Cross, and the International Rescue Committee, which also worked in the Congo Republic in 1999.

It must be said that the conflict that devastated the Congo Republic between December 1998 and January 2000 came and went in a climate of almost total indifference. It is in this context that the importance of systematic data gathering must be mentioned. This tool was vital for adjusting emergency medical and nutritional programs, as well as for retracing the tragic route taken by the displaced,

alerting the national and international authorities to the violence being committed against civilians, and attempting to confront such acts. This strategy enabled MSF to witness the appalling consequences of the fighting on the civilian population during a conflict that took place behind closed doors. Without these interventions, this tragedy would probably have passed unnoticed.

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1. Other contributors: Thierry Allafort, Jean-Clément Cabrol, M.D., Joanne Liu. M.D., and Fabrice Weissnian of Médecins Sans Frontières; and Vincent Brown. M.D., of Epicentre. This essay would not have been possible without the contribution of MSF volunteers in the field.

2. International Human Rights Federation (FIDH), *Congo-Brazzainlle. L'arbitaire de l'Etat,* June 1999.

3. *Congo-Brazzaville: Chronique d'une guerre a huis clos*, MSF, October 1999.

4. The indicators of severe acute malnutrition are weight/height indices lower than 70 percent of the median and/or the presence of bilateral edemas in children under five years of age. General acute malnutrition indicates a weight/height index lower than 80 percent of the median and/or the presence of edemas.

5. B. Bingoly-Liworo, M. Yila-Boumpoto, B. Libali, J. N'goulou, C. Mafoukila, K.G. Nkouika Dinghani, Violence sexuelles en situation de conjlit au Congo: cas de Brazzaville, Juillet-Novembre 1999. Ministry of Health, Solidarity and Humanitarian Action of The Congo Republic, in collaboration with the United Nations Population Fund (UNFP) and the United Nations Children's Fund (UNICEF). Brazzaville, November 1999.

6. Here, the prevalence of children up to age five presenting symptoms of malnutrition as compared with the number of children up to age five in the general population.

7. A serious form of malnutrition, caused by protein-calorie deficiency; symptoms include edemas (large belly, swollen feet), skin lesions, and loss of hair color.

8. *V. Brown, Besoins urgenls en santé, République de Congo, National Health Development Programme 2000-02,* consultation exercise for the World Bank, Epicentre, April 26-Mav 6, 2000; *Congo-Brazzaville, la vérite deux ans après la guerre du.5 June 1997*, The Congo Republic, Information and Broadcasting Directorate, Ministry of Communication, Brazzaville, October 1999.

9. P. B. Spiegel, P. Salama, "War and Mortality in Kosovo, 1998-99: An Epidemiological Testimony, " Lancet, vol. 355, June 24, 2000, pp. 2204-2209.

10. R. Ourdan, "Kosovo-Timor: Compter les morts, " Le Monde, September 2, 2000, pp. 2-16.

11. S. Swiss, P. J. Jennings, G.V. Aryee, G. H. Brown, R. M. Jappah-Sumakai, M. S. Kamara, R. D. Schaack, R. S. Turav-Kanneh, “Violence against women during the Liberian civil conflict, ” JAMA, 1998, Feb 25.

12. P. Salignon, “Congo-Brazzaville: récits de fuite, ” L’autre, Revue transculturelle, May 1, 2000, 145.

CHAPTER THERE

Health Services for Rape Victims

Joanne Liu, M.D., and Pierre Salignon

The war that raged through the Congo Republic between December 1998 and 2000 was notable for the widespread sexual violence committed against the civilian population. In 1999, more than 1,000 victims of sexual attacks who sought the emergency services of Makelekele Hospital, then being run with support from Médecins Sans Frontières/Doctors Without Borders (MSF), reported having been raped by armed men.

At the same time, the Congolese medical staff and their MSF colleagues were confronted with an unprecedented food crisis that called for massive logistical and medical resources. Nevertheless, they admitted the rape victims to the hospital and tried to provide them with urgent medical care. As the months went by, this assistance, which could be provided only on a limited basis during the active fighting, was accelerated. By agreement with the Congolese Ministry of Health, MSF gradually extended its collaboration with the national medical program for victims of sexual violence, which had been launched at the start of 2000.

Providing the Victims with a Full Treatment Program

Since March 2000, anyone who has suffered sexual violence in Brazzaville has been able to receive free comprehensive medical treatment at Makelekele Hospital. Three other facilities are capable of treating such patients, but the treatment is not always free: the Talangai Hospital, the Plateau des Quinze-ans Clinic, and the Blanche-Gomez Hospital. In practice, however, Makelekele Hospital, in the

south of the city, is currently the only one offering a full treatment program for the victims of sexual violence.

Patients who report to Makelekele Hospital are admitted by the Congolese general practitioner in charge of the emergency unit, and clinical examinations are performed. Preventive treatment against sexually transmitted diseases (including trichomoniasis, gonorrhea, and syphilis) is administered systematically. Psychological counseling is offered during the first consultation, and a medical certificate is issued to victims for use in legal proceedings.

Patients who arrive within 72 hours of an attack are offered the "morning-after pill" to prevent unwanted pregnancies, as well as double-therapy treatment to prevent HIV. Those who wish may have an HIV test (using the Elisa method).

In accordance with the protocol for antiretroviral (ARV) treatment introduced by MSF, blood formula and hepatic function are monitored, with ARVs administered over seven-day periods. The anti-HIV prophylaxis is deemed to be completed after 28 days of daily double therapy. If a patient fails to turn up for a weekly appointment, a social worker goes to her home to assess the situation and encourage her to continue her treatment. The risk of stigmatizing the victims has made this work difficult.

Those who are initially willing to be screened for HIV receive additional screenings after three and six months. If a patient tests positive, she is referred to an outpatient clinic (known as the Centre de Traitement Ambulatoire, or CTA) in Brazzaville, where she is offered palliative treatment, including treatment for opportunist infections, in exchange for a fixed financial contribution. Most people registered at the CTA cannot afford to take advantage of ARV treatment, although such treatments (for example,

Combivir®) are available in certain private pharmacies in Brazzaville.

Women who become pregnant as a result of rape are prevented by law from having abortions. Not only is termination forbidden, the conditions under which it may be carried out for medical reasons are unclear.

Nevertheless, various medical centers in Brazzaville offer abortions at a high price. Victims of rape who give birth, as well as their children, receive free medical care at Makelekele Hospital throughout their pregnancies and for several months thereafter.

More than One Hundred Victims Reported in 2000

From March 1, 2000, to December 31, 2000, Makelekele Hospital admitted 109 victims of sexual violence. All but one percent were female, and 52 (47 percent) were under the age of 18. Overall, the patients' ages ranged from 3 to 36.

Just over half of the attacks were committed by the military. In 94 cases (86 percent), the method was vaginal; 65 victims were raped by more than one attacker. In 10 cases, there were more than 5 attackers.

Among the 109 patients, 31 presented themselves within 72 hours of the rape and were able to benefit from anti-HIV prophylaxis. Among these patients, 14 completed their treatment and 14 abandoned it for various reasons. The remaining three tested positive for HIV at the initial screening and were referred to the CTA.

Some of the patients did not return for further treatment upon learning that they had tested negative for HIV. Others explained that it was too expensive for them to travel regularly to Makelekele Hospital for treatment. Many feared being recognized by neighbors and friends. By

contrast, no one gave up the treatment because of the side effects of the ARVs. By the end of December 2000, none of those who had completed the treatment had been found to be seropositive.

Only 56 of the 109 victims were evaluated by a Congolese psychologist working at Makelekele Hospital. This low number is partly attributable to the scarcity of psychologists (about a dozen) in the Congo Republic and the meager resources at their disposal. In February 2001, MSF brought in a psychologist from abroad to improve this aspect of the treatment.

Of the 109 victims who approached Makelekele Hospital for treatment, 12 gave birth in 2000. It was not possible to determine which of these births resulted directly from a rape. One-third of the victims who came to Makelekele Hospital agreed to use the "morning-after pill" to avert an unwanted pregnancy.

Lastly, one woman initiated legal proceedings against her attackers, using the medical certificate issued to her by the hospital as documentary evidence to support her claim. Many victims have been unwilling to take their attackers to court, because in general the latter are members of the armed forces or militias.

A Lesson for the Future

Although MSF teams frequently encounter sexual violence, especially in the context of armed conflict, it is rare that medical treatment is given during the critical period. Humanitarian organizations tend to channel their assistance toward other population groups, which seem to them to be more vulnerable (for example children or the injured). And yet the consequences for rape victims are terrible, even though they often go unnoticed: assault on their integrity, mental and physical injury, infection with

HIV, unwanted pregnancies and births, destruction of the family unit, and social exclusion.

The mission in the Congo Republic represents MSF's first experience of setting up a specific program to assist the victims of sexual violence. Its objective was to provide comprehensive, high-quality care in three areas of activity: medical, social, and legal. Although this effort came late – after the war was over – it has brought help to numerous women in Brazzaville, in particular by restoring their capacity for choice.

During 2000, MSF gave its backing to several pregnancy terminations, for medical reasons and in response to the special and legitimate requests of two patients. Unfortunately, in a country where terminations are illegal, even for rape victims, many women have had to endure their pregnancies. In practice, terminations are carried out, but they are expensive and all too often performed under minimal conditions of hygiene and safety.

Following the recent acknowledgment of rape as "a crime against humanity" and "a war crime" by the International Criminal Tribunal, discussions held with the Congolese authorities resulted in exceptional arrangements allowing rape victims to be given pregnancy terminations if they so wish. But other issues remain unresolved: the potential for victims to give up their babies at birth, the treatment of children born to rape victims and then abandoned, aftercare for women who have been raped, and so on. The medical, social, and legal aspects must all be improved.

For MSF, launching this program has meant living with a particularly intolerable contradiction: introducing prophylactic treatment for HIV for a small population in a country where access to ARVs is virtually nonexistent, despite the fact that eight percent of the entire population

is HIVpositive. This certainly explains the hesitancy of the Congolese medical authorities to allow ARVs to be included in MSF's emergency program for victims of sexual violence in 1999. Authorization was not given until 2000.

The effectiveness of ARVs as a preventive treatment for patients exposed to HIV through a sexual assault has not been proven scientifically. However, studies have demonstrated these drugs' usefulness in preventing infection following exposure to blood.[1]

In deciding not to wait for conditions to stabilize fully before starting to treat the victims of sexual violence, we adopted a pragmatic approach. This approach prevented patients from being infected with HIV or another sexually transmitted disease, and without doubt spared them unwanted pregnancies.

In the context of the fighting that tore apart the Congo Republic in 1998 and 1999, it is worth emphasizing the value of the program now in place. It demonstrates the potential, both in peace and in war, to provide a medical service adapted to women who have been subjected to sexual violence – victims who are too often forgotten.

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Chapter Four

Emergency Operations in Brazzaville: Médecins Sans Frontières and Violence Against Civilians

Marc Le Pape

This chapter is not intended to be a play-by-play account of Médecins Sans Frontières/Doctors Without Borders (MSF)'s operations in the Congo Republic during the war that broke out in December 1998. Instead, it looks at specific periods of time, situations, and issues selected to convey the spirit of the relief operations that were launched to address the disastrous circumstances facing people who began to return to Brazzaville in May 1999.

The southern districts of Brazzaville had been deserted from December 1998 until their reopening by the government in early May 1999, when the residents began to return. The process of return would last several months. We might have chosen to discuss other periods, interviewed other people, or considered other aspects of MSF aid programs.

However, we wanted to give a sense of the problems faced by that particular mission, the dilemmas that had to be resolved, and the positions MSF took both toward the war's outcome and toward the perpetrators of the violence.

In attempting to recreate this postwar period, we had to be careful to distinguish between what actually happened and our retrospective analysis. In recreating our actions and decisions several months after the events, we had to ask ourselves why MSF did or did not take certain actions. For

several months during this intervention – at least until December 1999 in Brazzaville – MSF staff lived in a world of violence and uncertainty, amid a massive influx of exhausted, severely malnourished civilians, both adults and children. Many of them – men and women alike – had suffered terrible abuse, humiliation, and physical violence after having been forced to flee in December 1998.

To maintain an awareness of the context in which MSF teams were working (the uncertainty, insecurity, horrific acts of brutality committed against civilians, and massive medical and nutritional needs) and the feelings of the MSF staff in Brazzaville and Paris who were involved in these crises, interviewees were asked to take themselves back to the concrete situations they faced; to describe their experiences and how they reacted at the time; and to discuss the guidelines they had followed and what their priorities were.[1]

The Médecins Sans Frontières Operation Begins: January-April 1999

January-February: "We didn't know what was happening."

In response to the violence that broke out in the Congo Republic in December 1998, the MSF team working in Kinshasa, the capital of the neighboring Democratic Republic of Congo, conducted an initial exploratory mission from January 9 to 15, 1999. Pierre Salignon, the MSF program director[2] visited the country in early February. He recalls his encounter with the war as follows:

> "Most of all, I remember that it took us awhile to get to Brazzaville. We already knew something about the situation because our team had traveled there from Kinshasa in January. They'd reported that the southern districts of the city had been emptied and that there was

no access. We'd been told about bodies being recovered, and we'd been told approximately how many people were on the move.

Our team had managed to get into the city's northern districts. In February, we postponed our trip twice because it seemed the situation was extremely tense and violent. In southern Brazzaville, we saw the riverbanks on fire and heard the explosions and the shots. Shells would fall every now and then into the river. The MSF team was very worried about the idea of going there.

"We went to Brazzaville for a day, February 8, on a United Nations plane. We could have gone by boat. From the airport, we took a little taxi into the city to meet with representatives of the United Nations, the Ministry of Health, and the International Committee of the Red Cross (ICRC).

"It felt like being in a sort of village that was ravaged by all kinds of fighting. The city was divided in two. There were very few people in the streets, and the town center would empty out by midday if not before. There were soldiers at the roadblocks, rather like those in Liberia or Sierra Leone.

"The ICRC was looking after those who had been displaced from the south of the city to the north. There were 70,000 displaced persons–30,000 at sites run by ICRC staff, who were very shocked by what they were hearing and imagining. They themselves had been victims of violence and looting. For security reasons, there was no permanent United Nations presence.

"I'll always remember one evening at the MSF headquarters in Kinshasa, when we went down to the riverbank. On the other side of the river, to the south, we saw some very large explosions. Around Nganga Lingolo, in the southern part of Brazzaville, houses were burning.

> From Kinshasa, it was impressive. I think that stopped us in our tracks a little. We felt a bit lost. We didn't know what was going on."

From January onward, our information and observations indicated that there had been a great deal of violence in Brazzaville since December 18, 1998. This situation was confirmed by our first exploratory mission team, whose report states:

> "In Brazzaville, the southern districts of Makelekele and Bacongo, where the violence is taking place, have been emptied of their inhabitants and are still out of bounds for nongovernmental organizations. It's a no-man's land, ruled by armed forces who continue to plunder anything that may still bring money. South of the city, in the regions of Pool, Bouenza, Lekoumou, and Niari, nothing is known of the plight of displaced persons living in the forests. A photograph of a woman and her baby suffering from serious acute malnutrition is on the front of all the newspapers. The woman died... "

The woman in question had been wandering in the forest to the south of Brazzaville. Her fate suggests the dire living conditions that faced the other displaced persons who fled the city. At the time, it was not possible to verify the situation through direct observation.

In early February, Pierre Salignon, the program director, received new information, which added little to our knowledge:

> "According to humanitarian sources, the inhabitants of Pool are living in an appalling 'humanitarian' situation, forced to hide in the forests. As for the civilians now living in the south of the country, we have little verifiable information, because we cannot gain access to the region. All indications suggest that their situation is disastrous. More than 100,000 displaced persons disappeared into

the forest, fleeing fighting and acts of violence against civilians by the various militia groups. The south of the country is cut off from the rest of the world. The authorities say there is a 'conflict' situation there, accompanied by the usual litany of abuses. Another point: Makelekele Hospital in the south of the city is no longer functioning. Nor are the other health centers in the southern districts. Health workers have fled the city along with the rest of the population. It is hard to say whether the hospital has been ransacked, but all indications are that it has been. Brazzaville's southern districts have effectively become a kind of no-man's land.

Because of the risks and uncertainties, the program director and team proceeded cautiously. Plans were developed to slowly set up a Brazzaville team, "if conditions allowed." It would happen during the second half of March.

March-April: Setting up the Brazzaville Operation

Marie-Jo Michelet, a nurse, began working in Brazzaville on March 24, 1999.

"We wanted to set up our operations again in Brazzaville, but we weren't too sure how to do it. There was one nurse and one logistician who both worked in Brazzaville four days a week and spent the rest of the time in Kinshasa. The nurse had to leave suddenly, and I was asked to stand in for her until she got back. When I arrived, I said I thought it was pointless going back and forth between Brazzaville and Kinshasa, and that, if we were going to work in Brazzaville, we needed to be there 24 hours a day. I also felt that it was dangerous to cross the river. There was often shooting, on both the Kinshasa and Brazzaville sides. There was no follow-up, anyway, and we weren't there just to sit in meetings. So the logistician and I decided to stay.

"At the time, there were camps for the displaced in the north of the city, where the ICRC was already working. There were some cases of cholera. The idea was to see whether we could do something for these people and about the cholera outbreak. We opened a small cholera treatment center at the university hospital center.

"I spent a lot of time at the health centers in the northern districts and at the camps for the displaced. That was a little strange. MSF never wants people to stay too long in the camps. It was hard for the ICRC, too. The authorities kept saying the people were coming back, the people were coming back, but they didn't come back. At the same time, people starting trickling back from the Pool, through Kinshasa, heading for the northern areas of the city.

"In fact, we never got much involved in the northern districts, except for the cholera intervention. There was no epidemic in the end, but we did set up a center at the university hospital center, and we trained staff to deal with the disease. We were there. At the same time, I went to the camps every week, and I tried to see the new arrivals, to talk with them and try to get a sense of what they'd been through."

In April, information about the violence was still sparse. Thierry Allafort was in Kinshasa from late 1999 onward. He followed the situation in Brazzaville, which he had visited several times in March.

"We received information about what was happening in the Pool region from Congolese who found refuge in the neighboring Democratic Republic of Congo. Before that, we had received very little information in Kinshasa. The people had begun to leave the Congo Republic in December. However, we didn't get to the 'unofficial' camps where they were staying until April, with the increased

flow of refugees and the government's April 24 military offensives against Mbandza Ndounga. Even though there was no medical emergency, we should have done it long before – gone to speak with people. We would have gotten some more information that way. Refugees reported that people were starving to death in the Congo Republic. We heard people talk about an 'epidemic of swollen feet.' (A form of acute severe malnutrition, known as kwashiorkor, is characterized by edema in the lower limbs). We knew that Ninja militias had confiscated radios from displaced persons to stop them from hearing about what was happening. We knew they'd been told anything and everything about Brazzaville, that the city was being torn apart by war. Nobody was prepared for what was about to happen."

This last remark is both a statement and a retrospective judgment. Certainly, nobody had been prepared for a sudden, massive population influx from the Pool, and nobody had anticipated the level of violence that would be inflicted upon those who had been displaced. Just how terrible the violence was would not be understood until the displaced returned to Brazzaville in early May 1999. By "nobody, " Thierry Allafort meant MSF and the other humanitarian agencies present: the ICRC, the Catholic group Caritas, UN agencies, local Congolese nongovernmental agencies, and so forth. He also says that MSF could have acted faster to help the refugees who had reached the Democratic Republic of Congo – that this involvement would have enabled the organization to bring in medical aid and that, by listening to their stories, MSF also could have better understood the nature and extent of the violence inflicted upon the people of the Congo Republic. Thus, MSF could have been better prepared for the problems it would face when those who had fled Brazzaville returned. The period between January and

April 1999 was marked by a dogged search for information, a lack of overall understanding of the facts, and concerns about the security situation in Brazzaville. During that period, the team did not anticipate a massive influx of displaced persons returning to Brazzaville.

Setting Up Operations at Makelekele Hospital

MSF had worked in the Congo Republic during 1997 and in early 1998, until it suspended its activities in April of that year. Several of its programs were based at Brazzaville's Makelekele Hospital, which, because it is located in the south of the city, was inaccessible in January 1999. "Bacongo and Makelekele are very dangerous areas, to which no NGO or agency dares to venture, " states the MSF program director's mission report of January 6-15, 1999. An initial visit to the hospital took place on March 25, 1999.

Marie-Jo Michelet:

"By March, we thought it was time to start providing services at Makelekele, but my big concern was that the people hadn't yet returned. The hospital was empty, and civilians had deserted that part of the city. Setting up a treatment center at the hospital also meant playing into the hands of the authorities: we would attract people to Makelekele, and the militias were still busy with their looting. Nonetheless, we decided to go ahead and set up a treatment center. If the people came back, MSF would be ready to provide emergency and pediatric care, and we'd be able to help set up a basic hospital.

"Up until then, though, civilians hadn't been allowed to return (although they were allowed to make two visits per week). Then we began to see people leaving the camps in the northern part of the city, and many also started moving out of the other areas of the city, where they had been living with families or in rented houses. They

returned to Bacongo and Makelekele and went home to see what was left of their homes, or to pick some fruit from their gardens. They probably also did a bit of stealing here and there. We saw lines of people heading out for Bacongo and returning at about one o'clock in the afternoon. Then the looting started up again, quite openly and publicly. Everything that could be looted in the southern districts was looted.

"We paid our first visit to the hospital on March 25 to see the director. I made a very rapid assessment. The hospital had been badly looted, but it wasn't too badly damaged. It hadn't been attacked like the hospitals in Somalia, for example.

"The next day, I paid a second visit, to see the director and two physicians who had fled to the northern part of the city. There was the surgeon, who had had a terrible time; the physician in charge of infectious diseases; and also a young woman, 'Doctor M, ' with whom I worked a lot. She was a physician's assistant. I visited all the buildings. We found one where there were two corpses, probably tuberculosis victims or old people who'd been forced to hide under their beds and then starved to death. Everybody had fled and just left the bodies there. The mayor had said: 'We'll move the corpses; we'll clean up, ' but nobody had. For three weeks, it had been nothing but corpses. What could we do? We had to find the families of the victims. That was our first encounter with Makelekele Hospital."

By the third visit, on March 31, the bodies still had not been moved. There were plans to reopen a part of the hospital by setting up three consultation rooms in a building that was still in good condition but "needed a good cleaning." The MSF team's sitrep[3] of March 22-27, 1999, addressed the team's position on opening the hospital:

> "We want to try to reopen Makelekele, but not while the security situation remains unstable. We've said 'no' to support from the French embassy. Our position is: make donations to Makelekele public hospital if you want to, but not to us. We do plan to provide support for the reorganization of the outpatient, emergency, and pediatric services, but we can't begin until we can be really sure the people will return."

Then in April, MSF carried out a logistical survey at the hospital, with the intention of opening up a medical unit if necessary. When discussing this period, team leaders note that they not only had to deal with constant security problems, but also had to seek authorizations and manage relationships with the Congolese Ministry of Health and other political authorities, as well as with the other aid agencies working in Brazzaville (mainly the ICRG, Caritas, and UN agencies). Given the political context, they also had to resist pressure from the French embassy, which, in early March, had offered to help fund their work at the hospital. According to the MSF head of mission in Brazzaville at the time, "We had problems with the French embassy, which wanted to exploit the services of a French NGO, " so that it could say that there was an NGO providing medical care at the hospital, with French funding. "We never requested a single cent or a single carton of milk, although the ambassador was quite adamant that we should accept his offer."

Our desire to remain independent of the embassy should, of course, be seen in its proper context. The security of our operations, and thus their very existence, depended – in the Congo Republic as elsewhere – on the principle of the genuine, manifest neutrality of humanitarian agencies with respect to politically involved parties (as was obviously a concern with the French embassy).

On May 1, 1999, MSF opened two outpatient units (emergency and pediatric), a pharmacy, and a unit for dressings and injections. A large quantity of essential medicines was discovered at the central pharmacy (part of a donation made by MSF in 1998). With the agreement of the hospital director, MSF opted to provide consultations and medicines free of charge for at least a month. That policy was changed in September 1999 when MSF started a "fee-for-service" system, after which only destitute and displaced persons received free health care. MSF supplied most of the medicines.

Emergencies Among the Returnees

On May 1, 1999, the Congolese president announced that residents of the city's southern districts could return home. During the first week of May, 10,000 people returned to the capital, and the flow of returnees continued to be significant throughout the month. In June, their numbers fell and then steadily increased again through July, reaching a peak the week of July 19-26, during which 15,780 returnees from the Pool and 18,980 from Kinshasa were registered.

Sitrep Brazzaville; May 3-9, 1999:

"Most returnees are in a very poor state of nutrition and health.

Four people died on arrival. According to the various eyewitness accounts, the returnees have been living in a state of total destitution for several months. In many cases, they have been living in the forest without food or medicine. At Kinkala, more and more people have apparently left the forests for the city, and are in an extremely poor state.

"Two women were raped upon their arrival on the

outskirts of Brazzaville. Due to the influx of severely malnourished children, [4] we opened a treatment center on May 6. All the new arrivals are from the Pool region."

[At the beginning of May, there were four MSF international staff members in Brazzaville, including two nurses. In mid-May, the team was reinforced by a female physician and a male nurse.]

Sitrep Brazzaville; July 20, 1999:

"Since July 17, between 1,000 and 2,000 people have been arriving straight from the Pool every day. The minister in charge and the mayor of Makelekele are organizing convoys to go and get them.

"The people are still in critical condition and more than 100 severely malnourished people are admitted every day. Our feeding centers are all overwhelmed, and we're going to expand them significantly.

"The convoys are arriving by day and night."

At first, nothing was done to provide medical care for the returnees. The authorities, wanting to prevent new resettlement camps from being set up inside Brazzaville, had not arranged for any such care. Returnees from the Pool had to be registered by the authorities at the Bacongo sports center. Once they had been registered by the army, they had to disperse immediately. If they had nowhere to stay, they were to find somewhere to stay in the deserted houses of the city's southern districts. They were forbidden to remain at the sports center. That situation would gradually change following intervention by Congolese NGOs and then by MSF. It was not until the first week of June that MOPAX, the Catholic association of Congolese women, was able to move into the sports center to provide hot porridge to the returnees. A Congolese medical NGO, the Legion d'Hippocrate, was working with the MSF team,

referring urgent cases and severely malnourished children to the hospital.

The First Weeks with the Returnees, May 1999

From an interview with Medical Coordinator Marie-Jo Michelet, who arrived in Brazzaville in March:

> “In early May, the authorities announced: ’People must leave the camps in the northern districts and return to Bacongo and Makelekele. The situation is calm, and people now have permission to return. They must return… And people did have to return. Most districts had lost electricity. But some of the people who’d been forced to leave the camps had nowhere to go. Their homes were on the other side of the Ndjoué Bridge, which they weren’t allowed to cross. That’s how the sports center got started. And the authorities wouldn’t allow assistance of any kind to be brought there. The official line was: ’Go to the sports center, and the Ndjoue Bridge will be opened very quickly.’ In fact, I was there for a month and a half, and access to the other side of the bridge was never granted. Whole families lived at the sports center. They were told: ’No more camps, go and live in the abandoned houses! ’ (which had been completely plundered). It was incredible. This went on for the first two weeks after the displaced began to return. We decided to reopen the outpatient unit at Makelekele Hospital to treat civilians.
>
> “At first, we had to make do with about 15 staff, a few midwives, 3 Congolese doctors (including the surgeon), a few nurses, and a Congolese nun with experience in emergency care. We did what we did in Somalia and Angola: we created a small urgent-care hospital, but our patients and staff alike were terrified after about four o’clock in the afternoon by the insecurity and the militias. Nobody wanted to stay there at night.

“Very soon, after three days, people began to arrive. Some came on foot, others in small Caritas trucks. They only stayed at the sports center during the day, then they had to leave. They were sick when they arrived at the hospital. Many were suffering from malnutrition, and some of the adult cases were the worst I’d seen since Somalia in 1992.

“At that time, I was one of four volunteers working there. The logistician and I were due to leave, and our replacements had arrived. But it was pretty clear that I wasn’t going to be leaving. There was an urgent need to save the lives of the severely malnourished children and adults. We opened a therapeutic feeding center (TFC), and, on the third day, 125 dying children were admitted. They came in little trucks as far as the Ndjoué Bridge and finished their journey on foot to the sports center, where they were registered by the police. During the first two weeks, 17,000 people came from the Pool, and 500 were admitted to the TFC. At first, I broadened the criteria for admissions to include 10- to 12-year-olds, but then I had to tighten them again.

“We had no night staff. I remember teaching the fathers of the children dying of cerebral malaria how to change their quinine drips during the night. It was still very dangerous; there were militia troops everywhere, and we couldn’t stay at night. A female doctor arrived from France. We were seeing 400 patients a day, and it was just unmanageable. More and more people were coming back to work at the hospital, but only until three or four o’clock in the afternoon. We provided transportation for medical staff. In the afternoon, the militiamen would resume their work. I used to go to the sports center regularly. After two weeks, a Congolese women’s organization arrived, and we gave them special food to distribute. It wasn’t just children. Adults were dying of hunger. The priests helped us open soup kitchens in three parishes. (There weren’t

enough Médecins Sans Frontières volunteers, and it was very dangerous. That's why we worked with Caritas). The patients arriving at the hospital were sent to the soup kitchens, where they were given two meals of porridge a day. It was all quite simple, just like in Somalia: two meals a day, and a very quick examination.

"In the mornings, we went to the hospital as early as possible. We ran around like mad, trying to see every patient. We hired volunteers and paid them. It was quite incredible: the trucks arriving; the patients getting out, nearly dead from starvation; the rape victims; the wounded... We were working like maniacs. People got off the trucks, and we didn't even have time to register their kids because they died in our arms. It was like that for almost two weeks."

In July, the flow of returnees again rose significantly. MSF decided to set up a permanent unit at the sports center.

Establishing and Protecting a Safety Perimeter

Patrick Hourtané, a nurse who arrived in Brazzaville on June 24 and left at the end of September:

"All through July, there were some days when there were incredible numbers of returnees arriving. I think the record was 7,300 in one day, on July 31. It was absolutely insane, I remember...

"It was quite something to see. The trucks usually left at about seven o'clock in the morning. With the time it took to drive, get through the roadblocks, register, get the people in, set off again, and get back through the roadblocks again, they didn't arrive back until nine o'clock. That morning, a few trucks had already arrived back. The mayor had gone out two days before, bringing back between 2,0 and 3,000 people. But that day, July 31, he had 7,000 people following him on foot. It was really

an amazing sight. I went out to the main road and saw a massive column of people. The local people had formed a sort of guard of honor along the side of the road, and were watching them. You could see a great mass of people coming, a sort of human tide. They besieged the center, like a massive river of people, bursting against the banks of our barriers. We worked until nine o'clock in the evening and set up emergency lighting. That was the first time we'd worked so late. Until then, there had been registration by the police; everybody was registered: last name, first name, and address. But that day, the authorities realized they'd never manage it. The mayor stepped in and told them to forget it. The president passed an act of leniency allowing everybody to pass without suspicion. In the end, the police just let it go.

"In July, there were 2,000 to 3,000 people arriving at the sports center every day. It was incredible. Inside the center, we'd marked an outer perimeter so that we'd have a safe working area. Some of the people who were there didn't seem to have an obvious function – mainly some of the policemen and the soldiers. The Makelekele police were there to inspect the returnees and register them. We didn't have too many problems with that. Eventually we learned to identify the police, even if they weren't in uniform. Then there were the militiamen who used the trucks to go back and forth. Those guys really weren't messing around. But some people – we really didn't have much of an idea who they were – were perhaps security police or special forces. They rarely wore uniforms, they were very often armed, and they camped right in the middle of the sports center. I went regularly to the security desk to ask, very diplomatically, that they stay outside the safety perimeter. Right up until the day things deteriorated.

"One day, a few of the mothers in the truck had

apparently reported recognizing some Ninja fighters, as they call them. So armed men blocked the exit to the sports center, and their leader walked past each of the men, one by one, placing his hand on their shoulders. Whenever one of the mothers said the word écran ('screen'), he ordered the man in question to step out. That day they arrested about a dozen men, mostly about 20 years old. At the time, the hunt for men aged 15 to 20 was pretty intense. We often saw men who'd been shot in the foot, the hand, or the thigh, purely because they were men, they were young, and had no money or anything else to give. They were regarded as Ninja, and one bullet simply meant one fighter less. That happened a lot.

"So 12 young men were arrested. The Makelekele chief of police arrived and asked to see them. Then three of them tried to escape. I guess they just got scared. There were shots. First in the air, but then low. Picture the scene: 600 or 700 people, including children, were just arriving, and the people who'd come in the earlier trucks were waiting to leave the sports center. The exits had been blocked. They started shooting in all directions. I called our head of mission, who came immediately. We decided to leave. We said we were stopping, that we weren't going to work under such conditions, that we weren't going to let people accuse MSF of taking part in arrests, of having been witness to them and not taken a stand. As long as that sort of thing went on at the sports center, with unidentified individuals making arrests where we were working, we wouldn't continue. It was five o'clock in the evening. We told the people to come back the next day and we'd see what we could do.

"When we returned at eight o'clock the next morning, the place was deserted. Not a soul. Previously, the police had always been there. We decided that we could start working again under these conditions. The incident had happened

on July 28. I carried on working at the sports center until it was time for me to leave at the end of September."

These two accounts, describing the periods when the return of displaced persons and refugees was at its height (during May, and again from mid-July to early August 1999), show the degree to which the medical community was ill-equipped to deal with the scale of the returns and sheer physical destitution of the people. The field reports of the period offer similar descriptions. There is no doubt as to the seriousness of the medical and nutritional problems the medical workers confronted, or the difficulties involved in providing care. The MSF team chose to prioritize emergencies and to take care of the most severely malnourished children. The team also helped run soup kitchens in five Catholic parishes that managed food distributions together with Caritas. MSF set the admission and discharge criteria and provided logistical support as well as technical assistance with the food distribution.

These two accounts convey a picture of caregivers who gave everything of themselves, who knew where their medical priorities lay, and who faced the constant pressure of both political danger and the threat of violence by armed men of various factions. They reveal caregivers who were constantly collaborating, interacting, and negotiating with other aid agencies (international NGOs and UN agencies), and who had to cope with dilapidated hospital facilities while providing training to make sure that medical systems were up and running in time for the return of people who had suffered from violence. Together with the other groups, they helped establish general medical and emergency facilities – both setting them up and protecting them from perpetrators of violence, abuse, and threatening behavior. The complexity of this challenge was demonstrated by the team's reaction to the July 28 incident

at the sports center. With shooting and arbitrary arrests occurring at the very site where they were trying to provide care for people returning from the Pool, how could they preserve the sanctity of the medical facility? How could they establish limits? How would they react to the events of that day? They decided to leave, promising to return the next day to evaluate the effects of their action. In fact, the authorities themselves never moved to protect the displaced people or safeguard humanitarian work and never took steps to put an end to violent interference by armed militiamen.

The Difficult Question of Rape Victims

In present-day conflict situations, it is rarely the case that rape "can be pushed into the background by the overwhelming nature of other forms of violence." And yet, there remains the risk that rape could still be regarded as "a sort of inevitable consequence of all wars."[5] In Brazzaville, the rapes started happening as soon as the first returnees arrived. Their occurrence was both known and recorded. When Makelekele Hospital opened, a Congolese doctor, who had run a medical program for rape victims before the war, restarted the program with material assistance from the NGO International Rescue Committee (IRC). Between May 1999 and the end of May 2000, 1,316 rape cases were reported to the hospital.[6] These rapes were all committed during the women's return journey, and 90 percent were committed by armed men.[7]

The MSF team rapidly assisted the hospital unit by donating the "morning-after pill" and drugs to treat sexually transmitted diseases. In July 1999, the doctor in charge of emergency operations at MSF's Paris headquarters issued a proposal for addressing the risk of HIV infection.[8] Under that proposal, a preventive dose of

AZT would be offered to any victim of sexual violence who filed a report within 72 hours of being raped. (After 72 hours, the drug becomes less effective.) The proposal was submitted to the Congolese Ministry of Health, which denied the request.

In October 1999, MSF publicly denounced the violation of human rights in the Congo Republic, including "rape on a massive scale." In November, MSF decided to revisit the HIV-prevention initiative with the Congolese authorities and to propose treatment with antiretroviral drugs. In January, the Ministry of Health consented. The antiretroviral program started in March 2000.

The Duty to Speak Out and the Duty to Heal

In May 1999, the MSF team decided to give priority to treating infant malnutrition. At the time, neither the field team nor the team in Paris had envisioned a specific medical commitment to rape victims, aside from the existing program at Makelekele Hospital. The MSF headquarters in Paris was focusing on one question in particular: was rape being "committed on a systematic basis" as a weapon of war and terror? The question recalled their experiences in Rwanda and Bosnia. No member of the field staff ever answered that question positively, but they did continue to stress the seriousness and frequency of the rapes.

Different people have differing views of their medical work and their incumbent obligation to collect data and gather eyewitness accounts. On one occasion, for example, several rape victims were answering questions asked by other Congolese women in the middle of the crowd in the sports center. Two MSF nurses expressed surprise that the women should be talking almost publicly about their ordeal, and one stopped the questioning because it was

being conducted in a place with no guarantee of confidentiality. One nurse wanted the questioning to be continued later, at the special hospital unit, by Congolese psychologists. It turned out that the questioning actually had not been part of a formal survey; the women were just collecting a few facts and figures. As accounts by field staff and senior officials at MSF in Paris show, the organization's encounter with multiple forms of massive, simultaneous violence did not, in fact, cause rape to be pushed into the background; nor was it defined in a purely legalistic way, as a violation of human rights. However, even as late as October 1999, public statements by MSF on the war in the Congo Republic made no special mention of the risk of HIV infection to women who had been raped and did not identify the problem as a medical emergency.

May 1999: "Very, very quickly, we realized that rape was a serious problem."

Marie-Jo Michelet:

"I'll always remember the day that we admitted a group of women who'd been raped by militiamen. The women had been taken to another place and raped again. Six came to [Makelekele] Hospital [on May 21]. The others had also been raped but didn't come.

"Very, very quickly, we realized that rape was a serious problem. Dr. M. came immediately. As soon as the hospital reopened, she started seeing people. She continued to work, together with a midwife.

"We heard people say: 'Militiamen with AIDS have been sent to infect us and eradicate us.' How much did paranoia have to do with it? At first, of course, some women never came. Some arrived in a state of acute stress, and others said nothing. We referred them all to Dr. Isabelle, a Congolese nun, who gave them medical care. They'd been

walking for a long time, and they were suffering from ulcers and old, infected wounds. Some had been wounded by the militias. At first, we really didn't pay much attention. Since 1997, the IRC had funded a program to help women who had been raped. At the hospital, a female Congolese doctor saw the women, offered them antibiotics, and gave them the 'morning-after pill'. They told them they would provide follow-up care, and took down certain details.

"What those women had to go through was horrifying. They arrived with their children. There were 15 deaths that day. Everything was a mess: they'd been raped, and they had their severely malnourished children with them, dying.

"It's true, I never considered what Médecins Sans Frontières might do about AIDS. We had too much to do. There were so many people to deal with. I left Brazzaville in early June [1999]."

Thierry Allafort:

"During May and June, there was a sign at the Makelekele Hospital that read: 'All women and girls who have been raped are requested to report upon arrival.' The IRC-supported program continued year after year, regardless. The doctors didn't have enough medicines to treat sexually transmitted diseases and administer the 'morning-after pill', so we kept them supplied.

"At the sports center, the 'MOPAX mothers' spoke to the women and asked them whether they had been raped. I often took part in these interviews, which would be held on a bench, located a little to the side. It was all like a normal conversation. The MOPAX mothers would speak quite openly. I'm pretty sure they even made announcements with a megaphone: 'If you've been raped, come and tell us.' I personally had to accompany a 17-

year-old girl to the hospital. We had quite a long conversation in the car. She told me about how she had arrived at Makana, at a roadblock. They put all the women on one side and the men on the other. They took her away and forced her into a bedroom. She tried to escape and they shot at her. They missed, but then caught her. Four soldiers raped her.

"In August 1999, we tried to set up an AZT treatment program to stop rape victims from contracting HIV. But we ran into problems with the government because we didn't want to force a test on women, either before or after their treatment. There was no way we could have given them proper treatment in Brazzaville. We didn't see how we could impose the test on women, tell them they were HIV positive, and then... do nothing."

Here, Patrick Hourtané describes the situation at the sports center in July, as women from MOPAX walked along the lines of returnees seeking to identify women who had been raped:

"They went along the lines and asked the question, directly and dis-creedy (if it's possible to ask such questions discreetly). They would just approach the women and ask the question. They essentially did the hard work, asking 'Who was raped, and when? ' and noting down the details. The people returning from the Pool were sorted out by age as the nutritional survey was conducted. After they'd been sorted into men and women, they'd be sorted by age. Then, as they lined up to get their soap, biscuits, or porridge, a 'MOPAX mother' would approach the young women and ask them if they had been raped. The information they gave was entered on a checklist, for example: '11 rapes, such and such a person, of such and such an age, on such and such a date, ' sometimes together with the name of the place and the

details about what had happened. I told them it wasn't worth doing that, because we weren't going to use it and because we'd be conducting an interview anyway, in an office, with a doctor and a psychologist, in a more intimate setting. The women from MOPAX weren't shocked at asking such questions. It was I who found it strange to have those sorts of details being collected under such circumstances. I doubt women in France would respond positively to those questions under such circumstances.

"There were 10, 15, 20 rape victims every day. That's a hell of a lot. After they'd declared that they'd been raped, they didn't go back immediately to where they were living. I'd take them to the hospital, so they could be seen quickly – the same day, if possible, unless it really wasn't possible for some reason. Most of the time, they came with me straight away. I took them to the doctor myself, so they wouldn't have to hang around in the corridors for ages. At that point there wasn't much in the way of highly structured care being provided by Médecins Sans Frontières. I just looked after them. That was my responsibility. I thought that was the humane thing to do, given what they'd been through."

The two expatriate nurses who worked at the sports center between July and November were surprised at how rape victims described their experiences. More readily than other victims of brutality and abuse, when they spoke, they stated directly what had happened to them.

"Why Didn't We Provide AZT Earlier? "

Pierre Salignon, Program Director, Paris:

"The rapes were reported from the start – as soon as the first returnees began to arrive. I remember Thierry saying on the phone, 'It's a nightmare.' There was the physical

condition of the people, and there was the violence. The MSF team described the rapes, the young girls who needed treatment, the summary executions in the corridor, the men separated from the women, the gang rapes... ”

“Before the war, there’d been the IRC. Their support to the hospital started up again very quickly. Our view was: IRC was already there, and we’d give the hospital staff what they needed to work – the ’morning-after pill’ and drugs to prevent STDs. The question of AZT was not addressed at all, at that point. I remember the doctor in charge of emergencies in Paris saying to me in July, ’Look at the HIV prevalence rates in the Congo. Why didn’t we provide AZT earlier? Why aren’t we doing it there? ’

“I think the question of AZT, of providing care for women, and especially of the risk of transmitting HIV came up during July, not before. Before that, we’d been focusing on nutrition, and on the violence – violence that we didn’t understand.

“When I visited Brazzaville, in December 1999, I remember asking the MSF team about assistance to the victims of rape and the IRC program. All they gave me was a list of the pathologies treated at the hospital. The categories included ’rapes’ on the same level as ’respiratory infections’. I think that really shows how we were willing to let IRC deal with the problem, we were quite happy somebody else was doing it.”

Jean-Hervé Bradol, M.D., Operations Director, Paris:

“When he came back from the Congo Republic, in December 1999, Pierre told me he’d tried to find out what was being provided for women who’d been victims of sexual violence. His conclusion was ’almost nothing.’ Médecins Sans Frontières was providing the staff of the IRC-supported hospital with additional drugs. At best, the

women were being given antibiotic injections to prevent certain venereal diseases. But as for what sort of services were being provided – in terms of recording their stories or providing medical care, psychological counseling, or abortion – we really had no idea. Abortion is officially banned in the Congo Republic. Certainly clandestine abortions are performed, as they are everywhere else in the world. But were they available to these women? We did not have that information.

"The team was faced with a situation that was not easy. In that sort of situation, there's never an answer for every question. You can't design perfect health care systems.

"So, apart from antibiotics, there was nothing, except the 'morning-after pill' for those who had reported less than 48 hours after the rape. It was all a little vague. Pierre concluded that, if the problem of rape weren't given special attention, one of the consequences would be that there could be no really effective medical care for women. He also said that people were generally aware of the rape issue. The government had even launched an awareness campaign about it. That was the paradoxical part of the situation. With very few resources, they were running an information campaign about rape, but nothing was being done for the victims. People were clearly aware of it, but the medical care being provided was really minimal."

"You haven't set up anything for women? "

Pierre Salignon, Program Director, Paris:

"We were very aware of the rape issue, but something got lost in the implementation... because the authorities refused and we couldn't go any further. My feeling is that we could have set up a medical program from the start. We were completely overwhelmed, and we did the best we could.

"There are always good and bad reasons for saying that we acted too soon, or too late, to deal with whatever the problem is. There are many factors over which we have no control, such as security. There's nothing we can do. We need to be aware of these factors, but of course that's not always enough. The rape issue should have been addressed very quickly. We know the date when the violence reached its peak, and that's also when women were generally arriving within 72 hours of being raped. We certainly could have done something then for those who needed it most. Now we do have the program, and it serves a real purpose, both for the women we're helping now and also for the future, for other situations. But we should have offered the program from the beginning and launched it in May or June."

Jean-Hervé Bradol, M.D, Operations Director, Paris:

"From May [1999] onward, rape was a permanent feature of the stories told by the families returning to Brazzaville. From the beginning of our operation, we realized that rape was a frequent element in their stories.

"But what was most striking to us in May was the food situation. So our priority then was taking care of severely malnourished children. Because of the number of children involved and the dangerous situation, we were constantly busy trying to launch that operation. We were aware of the rape situation at that time, but there were two big constraints: the huge amount of work that needed to be done and the very limited number of staff members available, even for food aid.

"Aside from the issue of feasibility, the second point was that, although we were obviously extremely distressed that so many women had been raped, men were disappearing and being tortured, and children were dying of hunger. People were inclined to wonder why a single

category of victim should be singled out – meaning that rape victims were no more of a priority than any other category of victim.

“Four, five months later, after we’d established the feeding program and the military and political context had become more favorable, we discussed the rape issue at a meeting in November [1999].

Several people said, ’We can’t work on this problem, precisely because it is a neglected issue. The very fact that this category of victim is never the object of a specific program makes things difficult.’ We’d heard the same argument a few years earlier about people with mental illnesses. But we cannot deprive these patients of the care due to them under the pretext that we do not have experience in caring for them.

“There was real resistance to the issue of rape. To those who asked, ’Why should we single out a specific category of victim? ’ others replied, ’When we single out children under five, that doesn’t cause the least problem. We’re always identifying special categories. So why, with this particular category, is it suddenly so unacceptable? ’

“There were also some very genuine arguments: lack of feasibility, the Ministry of Health’s opposition to our program... Those arguments could be substantiated, but there was also a whole slew of arguments that could not. In my view, they had more to do with ideology, which was not being expressed directly.

“I think all issues having to do with the situation of women make us uncomfortable. When you have a rape victim, what good does it do, in Africa, to talk about psychological support? A rape victim comes to us and tells us she needs an abortion. What should we do? We know very well that we’re going to be getting into difficult areas, which are going to force us to address women’s place in

society.

“Doesn’t a specialized and centralized unit like the one at Makelekele stigmatize rape victims still further? Sometimes it can be in the best interests of the women to maintain a certain amount of discretion. If, as doctors, we set up special units, aren’t we helping, in a way to stigmatize the victims? I don’t happen to think stigmatization is a problem in the Congo Republic. In general, though, you have to get involved in every aspect of the situation, and that’s what we’re sometimes not very comfortable with. At Médecins Sans Frontières, we’re comfortable doing what we usually do. When it comes to caring for women, we don’t usually do anything special. That’s really where the problem lies.

“The truth is, anybody taking on this issue is going to encounter not a nice easy road, but rather one paved with difficult, unsettling questions. And in many societies, there is pressure for such acts of violence to become less visible. We find comfort in the habit of not doing anything special and pretending not really to have noticed the violence. But doing nothing is never an option.

“The rapes raised another fundamental question for us: should we categorize different types of violence according to how serious they are? To some extent, that’s what some people were doing at that November meeting. They weren’t doing it in a malicious way, of course, but when they were told about the rape victims, they replied, ’Why don’t we also get involved with the issue of men who are brutally executed? ’ Some talked about the rape victims while others talked about those who had disappeared. They said things like,

’How can you place women who have been raped above men who have disappeared? ’ That question came up immediately. But we need to think carefully: if we can’t

categorize different forms of violence, then we can't specialize in one form of violence or another, and we can't therefore exclude any form of violence from our medical activities. In medicine, you can, in a serious situation, quite easily ask the nurse to see to the headaches and the diarrhea in adults as quickly as possible because there's a meningitis epidemic under way and you need to free up some beds for meningitis patients. But exclusion from care is something that doctors and medical organizations do not find easy to accept. With victims of violence, it's even more difficult.

"It reminds me of a question that an ECHO[9] consultant asked me in 1993 about the Burundian refugee camps in Rwanda. She said to me, 'You haven't set up anything for women? ' Her question annoyed me because of the problems we were having in the camps. Basically, though, she was right. Her question was justified. In refugee camps, women on their own are very much at risk of being raped. For example, we can always make it known that there are contraceptives available. A woman who has been raped does not necessarily have to be pregnant, too. We often don't even think about what we can do. We don't consider that women constitute a special category. Adult women are seen as socio-economically vulnerable when they lose their husbands, and as unjustified or unwarranted victims of violence. But they are rarely regarded as a special target of violence. We regard the child as the pure, totally innocent victim of violence. Men are the preferred target of the executioners and torturers. It's easy to see how men of fighting age can be targets. But women are seen as victims by default.

"I think there's a whole underlying set of arguments that is never brought into play during our operations, and that doesn't make caring for women any easier."

As soon as the displaced persons and refugees began to return, MSF decided to focus on the problem of malnutrition. The team was not very big, and the workload was enormous. Furthermore, the IRC-supported unit for rape victims was up and running. The fact that it did not deal with the risk of HIV infection was not, as far as we are aware, noted in the reports sent back by the Brazzaville team.

Before July, the problem of women and AIDS was not expressed as a subject of medical concern requiring a specific program (which the Congolese public health system could not possibly have provided). Interviews with those involved in the operations suggest two possible reactions to these events.

If we look at the events from a critical, abstract perspective, we may find it hard to understand how an organization like MSF – with all its experience of conflict, civil war, the brutality of armed militias, and refugee camps – had not already considered, in both general and medical terms, what should be done to address the apparent acceptance and widespread use of mass rape in modern warfare. Given the burgeoning AIDS epidemic, how can we explain this failure to prepare? What is the underlying reason?

And yet, from a practical perspective, MSF teams always have to evaluate the situations and conditions under which preventive antiretroviral (ARV) treatment for rape victims will be provided. They have to define protocols, draw up criteria for deciding which women qualify for preventive ARV treatment, determine how to respond to requests for abortion, and decide how to preempt any attempted abuse of the program. They need to find medical staff to implement the program; the population must be fairly

stable (that is, living under peaceful circumstances); and, if they are going to provide medical follow-up, they need to have the necessary resources.

How can a medical humanitarian organization both conduct an emergency operation and answer all these requirements?

Military Escorts and Aid to Civilians

From early May onward, military and civilian trucks transporting soldiers left Brazzaville every day to look for displaced people returning from the Pool. The trucks went as far as Nganga Lingolo, 18 kilometers from Brazzaville.

For aid agencies, departing from Brazzaville – for Nganga Lingolo and Kinkala in November, and later for other, more remote villages – required more than merely solving the problems of logistics and security. The decision of whether to accept military escorts on aid convoys was a choice with serious political repercussions given the context.

Caritas organized some of the trucks that traveled back and forth regularly between Brazzaville and Kinkala during September. During this time, abuse, rape, and violence were still being perpetrated by groups of armed men who set up roadblocks and then proceeded to do as they pleased, often committing horrific abuses. (Some militia leaders forbade rape on their territory, on pain of execution.[10]) Caritas allowed the trucks to carry military escorts for protection. On their return, however, the escorts did not prevent the trucks (which were supposed to be reserved for displaced persons) from taking on armed militiamen, many of whom carried the spoils of their plunder. That was the price Caritas paid to transport displaced persons to Brazzaville, even though, as a result, its

security was precarious for a long time. On several occasions, in fact, the soldiers' presence triggered shooting between armed groups, and civilians suffered the consequences (some died). Clearly, under conditions like these, humanitarian convoys cannot be regarded as neutral, and it was hard for the Congolese people who had fled Brazzaville in December to regard these soldiers as their protectors. The soldiers were seen as dangerous and as allies of the very people who had forced them to flee.

MSF began to be active outside Brazzaville without an escort in early September, when it established a medical triage unit at Nganga Lingolo. Like the ICRC and Action Against Hunger, it contested the presence of soldiers, refusing to transport them, and ultimately agreeing to work in Kinkala only when it seemed possible to move around without escorts. These organizations did not want to risk attracting additional violence to the people whom they wanted to help. Military escorts lead to violence and help foster insecurity and abuse.

Nganga Lingolo. Vincent Villiers, a nurse:

"When I arrived, in early September 1999, it was the second or third day of our operation in Nganga Lingolo. I used to go there every day. At that time, there were always as many as 200 or 300 people waiting for the Caritas trucks. We had two or three minibuses, each with 10 or 15 seats. We took 'emergency' cases, which we defined as follows: Among adults, priority was given to those who'd been shot, those who couldn't stand, or the elderly, who were truly exhausted. Among children, priority was given to those who were severely malnourished. There were a lot of people; they were piled into trucks. And the children who were weak, dehydrated, and malnourished found it hard to travel for an hour, so we took them.

"Sometimes we made two or three roundtrips, in the morning and in the afternoon. At that time, in September, security wasn't very good. To get to Nganga Lingolo, we had to cross three or four roadblocks controlled by soldiers, Cobra militiamen, or the police. We had to get back to Brazzaville by five o'clock in the evening, because later on there was no security."

Patrick Hourtané:

"When we began going to Nganga Lingolo, we went with the Caritas trucks. The soldiers used to force people to get into the trucks, even when Caritas had stated that they were full. Some people died in the trucks. Sometimes at the sports center, you couldn't even lower the sides. There was always a chance people would fall, and we had to monitor them closely and open the sides very carefully.

"We used two minibuses and a Toyota Land Cruiser to evacuate children and emergency cases – anyone we wanted to evacuate directly to the feeding centers or the hospital without going via the sports center. In the evenings, when I knew there'd be no more trucks coming back up, I'd pack our vehicles with kids, the sick, and the elderly – the people who seemed most vulnerable.

"We would arrive at Nganga Lingolo at about nine or ten o'clock in the morning. I wanted to be there as people were getting into the trucks, to see whether I could assess the condition of the people who'd spent the night there. That way I could say to Caritas, 'Come back later, try to come back to Nganga Lingolo later, some people are arriving late.' The security regulations were strict, and I couldn't stay past five-thirty in the evening. My idea was to go there in the morning to count how many people were staying the night, and then find out what had happened after we'd left.

"At Nganga Lingolo, I bent the security regulations a little.

It was my decision entirely, since it was still dangerous to be there. One day, I left on foot with a Congolese companion (I'd insisted on always having the same person at my side for two-and-a-half months) and another person. We walked as far as the church where the old health center was located. That was beyond the roadblock on the Linzolo road. As we walked, we kept on meeting people making their way back. A young woman told me there was an old lady sitting on the side of the road who couldn't walk. We asked whether she was far away. After walking for about a kilometer, we found her. She really couldn't walk. Gradually, we began to be more visible. We began to move around just a little, without really going very far. We went out looking for several people like that, even going into the forest one time. We followed a track that went about 500 meters into the forest. The directions were very precise, and we found the person we'd been told about: another woman who just couldn't walk any farther. The people who came back would tell us about others who were too exhausted to carry on. That woman, who was between 65 and 75 years old, was truly exhausted. She was barefoot, and all she had on was a loincloth. She was holding a small plastic cup. When the directions were precise, and it wasn't too far, we went."

During November and December 1999, MSF still faced violence and roadblocks controlled by armed factions on the Kinkala road. A significant number of rapes continued to be committed as people returned to Brazzaville, and they continued to be reported by the victims upon their arrival at the sports center. There were some weeks when the number of rapes was higher than in July: 22 rapes were reported between December 6 and 12, and 30 between December 13 and 19.

Young men also continued to be favorite targets. The following is an account by an 18-year-old man. He arrived

at a roadblock together with a group of men of his age. The men at the roadblock shot at him, hitting him in the groin, but he did not die. The militiamen then told him that they were going to kill the three or four other young men in his group, and that it was his fault. They did kill the others, leaving him. Later, at the hospital, he told the doctor that his friends had been killed because he had not died.

By November, despite the roadblocks and the risks, it was possible to travel without an escort as far as Kinkala. MSF opened a feeding center there for severely malnourished children. In January, the MSF team organized the reopening of the hospital. In mid-November, Kinkala still had scarcely emerged from the war. There was shooting every evening, there were soldiers everywhere, and people were beginning to return from the forests. As before, in Brazzaville and then in Nganga Lingolo, there was the problem of setting up and expanding medical facilities that would be safe from violence. No soldiers were allowed in the therapeutic feeding center; patients had to surrender weapons at the hospital door; and there was no preferential treatment – everyone had to wait his turn (a policy that was not without repercussions).

By late December 1999, armed groups continued to be seen at the sports center and on the Kinkala-Brazzaville road.

In modern warfare, there is nothing new about the type of violence that was committed against civilians in the Congo Republic – neither the executions, nor the rapes, nor the other atrocities. (Rape, for example, was widespread as a weapon of war in the former Yugoslavia and in Rwanda and was recently recognized under international law as a crime against humanity and a war crime.) There also is nothing exceptional about an entire human group, defined by its

origins or by other criteria, being treated as an enemy. The role of warring armies and militias in spreading HIV is also well known. And yet, the fact remains that decisions about medical aid amid war and collective brutality are based on judgments about what is feasible, given uncertain predictions, and on practical and political assessments made under emergency conditions, in light of tradition and operational know-how.

As for the actions of MSF, criticism has focused essentially on two points. First, there was the failure to anticipate the sudden flow of displaced persons and refugees from May 1999 onward, despite the fact that MSF was very used to conflict situations involving sudden, large-scale population movements and forced migrations.

The second criticism concerns MSF's position regarding rape. The organization did not immediately consider designing a medical program that took into account the risks of HIV infection, despite the fact that it had encountered large-scale and sometimes systematic rape during the wars in Bosnia and Rwanda.

* * *

These accounts of MSF's decision-making and implementation process reveal the motives, feelings, and perceptions that underlay the actions that were taken. In particular, they show the importance of the role played by medical expertise in the choices that were made. The first response to suffering is to give priority to those areas in which the aid organization has expertise and in which it is accustomed to operating. And yet, such a response can sometimes be inadequate. It took a great deal of persuasion within MSF before a program of quality medical assistance was set up for women who had been assaulted and raped by militiamen and soldiers.

However, the quality of MSF's operations depends both on medical assessment and political judgment. What is needed is to gain an understanding of the situation that will guarantee not so much the quality of the choices that are made, but that field and headquarters staff have the necessary intellectual tools to make informed choices. For there is always the risk that we will allow ourselves to be swayed by stereotyped interpretations or received ideas, pay too much attention to the emotions and opinions of the victims, and merely reproduce "politically correct" responses as a result of imperfect knowledge, a desire to empathize, or fear. The events in the Congo Republic give us insight into the solutions being found by MSF to counter those risks and to improve the aid that it provides.

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2. Based at Médecins Sans Frontières headquarters in Paris, each program director is responsible for the organization's operations in several countries.

3. Sitrep is short for situation report.

4. Among children under five, acute severe malnutrition is diagnosed when the child's weight/height ratio is below 70 percent of the median and/or there are bilateral edemas.

5. *S. Audouin-Rouzeau, L'enfant de l'ennemi, 1914-1918. Viol, avortement, infanticide pendant la Grande Guerre*, Aubier, 1995, pp. 39 and 44. From the beginning of World War I, rapes were denounced in French and British reports of "atrocities" committed by enemy forces. The French reports included precise and detailed eyewitness accounts of the nature and circumstances of the rapes, and had "considerable repercussions."

6. *Programme Viols – Congo Brazzaville,* Médecins Sans Frontières, Brazzaville, May 29, 2000.

7. This figure applies only to the period December 1999 to May 2000 and is based on data collected at Makelekele Hospital for 191 rape cases. In 71 percent of cases, there was more than one rapist, and in 15 percent of cases, five or more rapists. See also *Programme Viols – Congo Brazzaville*, op. cit.

8. Letter of July 28, 1999, from Dr. Jean-Clement Cabrol to the Brazzaville team on the problem of rape and MSF's response.

9. European Community Humanitarian Office

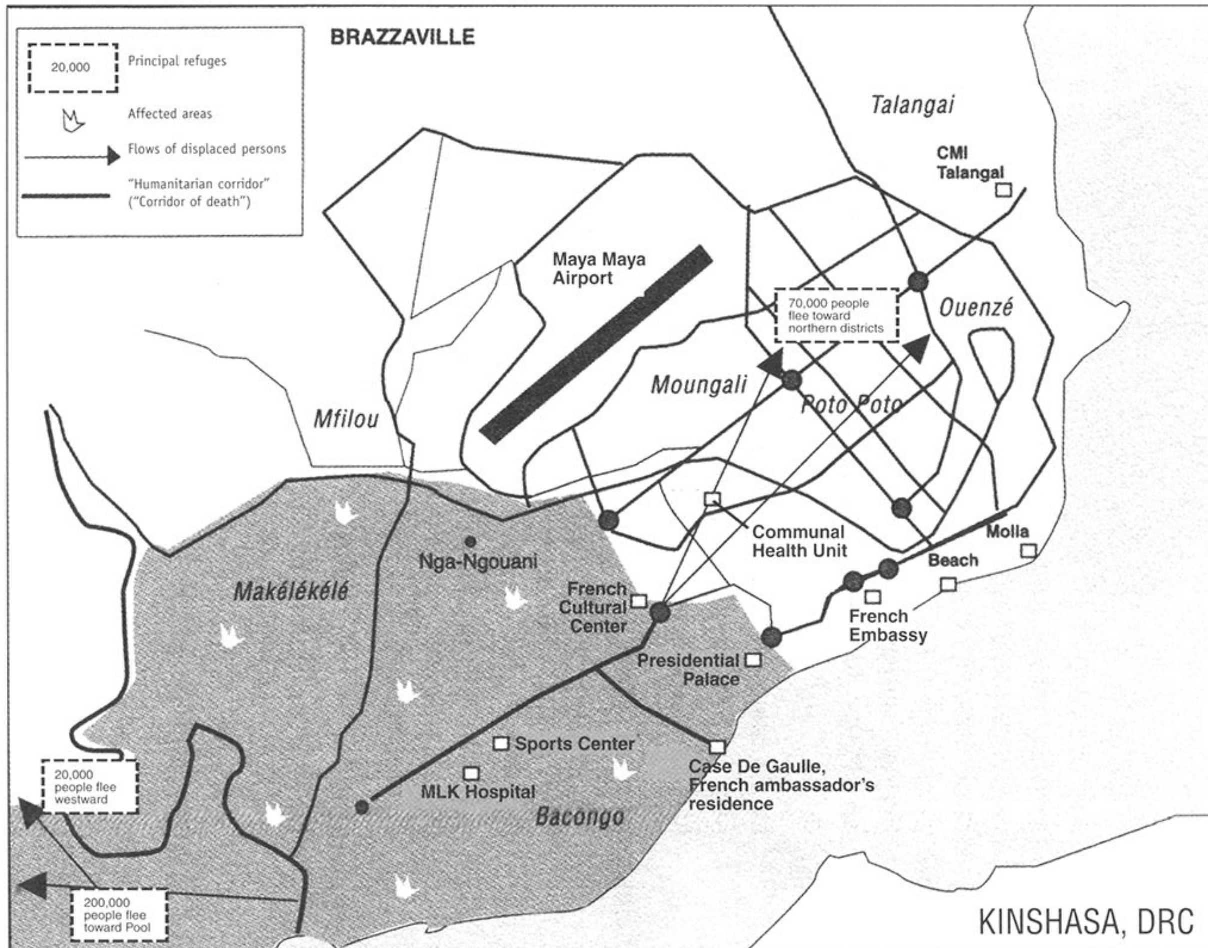
10. Ac cording to an eyewitness account by Yves Lallinec, head of mission in Brazzaville from November 1999 to March 2000, “Before January 2000, all the people you met at the barricades were armed, between ages 15 and 25. drunk on palm wine to varying degrees, and all very high on dope.”

Congo Republic

January-June 1999
Fighting and Population Displacements

Brazzaville

December 1998-January 1999
Fighting and Population Displacements



Key Dates/Chronology 1998-1999

1998

March	First confrontations in the Bouenza region occur between the Cocoye, the opposition militia, and government forces.
August	*August 28* Armed clashes begin in the Pool region, near Brazzaville, between the army and *Ninja* militias opposed to President Sassou-Nguesso.
September-October	*October 21* Armed assailants attack the Mouyondzi police barracks in the Bouenza region, killing three policemen.
November	Fighting between government troops and *Cocoye* militias spreads into Niboland. The government and the opposition create a process for dialogue on the situation in the Pool region. *November 14* Six clergymen who were members of the mediation committee are killed in Mindouli.
December	Clashes break out near the capital. *December* 16 Fighting erupts in Brazzaville's southern districts. *December 18-20* Following *Ninja* attacks in southern Brazzaville, the Congolese army bombs the area and sends in troops. The population flees, heading to the city's northern districts, toward the Democratic Republic of Congo and toward the Pool region. The government establishes a "humanitarian corridor" to enable people to reach reception areas in the northern districts. *December 21* The government decides to close off the southern districts. Residents are prohibited from returning to their neighborhoods, which are systematically looted. In Niboland, government forces bomb the town of Nkayi in Bouenza. People flee additional areas, including Dolisie, the country's third-largest town, in the Niari region.82

1999

January-May	Fighting continues between government forces and opposition militias in the Niboland and Pool regions.

April	The government uses combat helicopters to shell positions held by opposition militias.
May	*May 1* Government forces officially take control of Mbandza Ndounga commune, where the Ninja headquarters are located. Government forces announce the reopening of Brazzaville's southern districts (Makelekele and Bacongo). *May 2* Displaced persons begin to arrive from the southern part of the country. *May 4* Government forces capture Kinkala and the pace of returns picks up. The authorities set up a "humanitarian corridor" to direct the repatriation of displaced persons from Pool. First week of May: 10,000 people return to the capital. *May 9 Ninjas* attack the Bilolo military training center, 25 kilometers (15 miles) from Brazzaville. In retaliation, government forces conduct "screening operations" at the Brazzaville river port where refugees are arriving from Kinshasa. Young men suspected of belonging to the Ninjas are systematically separated from the other refugees. *May 12-14* Fighting breaks out at the Brazzaville airport, displacing large numbers of people and resulting in many civilian deaths and injuries.
June	*June 3* A convoy of people returning home is attacked outside Kinkala. Sixty-three people die. The flow of returnees drops.
July	*July 1* The Panafrican Music Festival opens. Brazzaville's residents consider this an important sign that peace has returned. *July 5* The flow of returnees begins to grow, with a marked jump in arrivals (15,780) from July 19 to 26.
August	*August 2* Brazzaville's southern districts open between the Djoué bridge and Nganga Lingolo. *August 14* The president gives an Independence Day speech, reaching out to his opponents. He proposes an amnesty to all opposition members who agree to direct negotiations with the government and to fighters who lay down their weapons.
November	*November 13-16* Representatives of the government's high command meet rebel leaders at Pointe-Noire. They sign a cease-fire agreement, which includes an amnesty for rebels who lay down their weapons and calls for reintegrating senior and junior officers, as well as privates, into government forces by December 15, 1999.

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