Next steps ahead...

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Conclusion and recommendations
1. Some basic assumptions

MSF is an international private humanitarian movement which is composed of national organisations. MSF has deliberately grown into an international movement because its leadership was and is convinced that a coherent and decisive international organisation is in a better position to serve populations in danger than purely national entities. The state of the world is such that purely national organisations will either become subcontractors of governments or marginalized action groups without real influence. But we are also convinced that a strong and dynamic international movement can only be a reality if it is composed of lively human size parts with strong commitment and strong roots in the civil societies, the national sections. MSF has grown from a small French NGO in the seventies to become the largest medical relief organisation world-wide at the end of the nineties. Some of us may not like this image of a huge potent organisation, but at times we are also proud of it and are able to use our influence in a positive way, being able to better assist people who live in a crisis situation. We thus need to acknowledge that the current size of MSF (in 1996: about 2500 expat departures, 15'000 national staff, budget of 250 million US$, present in 80 countries) gives us, more than ever, the moral and ethical obligation to be efficient, avoid wastage and duplication, and to define clearly who the prime beneficiaries of our aid should be.

It seems that we are at a turning point in the history of MSF, where a more profound reform is essential and unavoidable. The reform of MSF should improve coherence, ensure a more efficient use of financial, material and human resources, and avoid unproductive competition. It should improve the quality of our interventions by sharing experiences in a more coherent and organised way, and by accepting some “neutral” authority to judge the quality of the work. In addition, if we are recognised as a strong organisation speaking with one voice, our influence and strength in témoignage will increase.

Maintaining our independence will become more difficult in the coming years as globally resources are shrinking and as governments attach more and more strings to the money they give to non-governmental organisations trying to influence health and social policies in the beneficiary countries. Being a truly multinational organisation with a diverse cultural and societal base and a large number of private and institutional donors will allow us better to maintain our financial and political independence.

One could thus summarise the main objectives for a greater “internationalisation” as follows:

- to be coherent with our name “sans frontières”
- to do more and better, i.e. to be of better service to populations in need using resources more efficiently
- to preserve our independence.

The major challenge will be to find the right balance between unified rules of functioning and technical guidelines on the one hand, and enough delegation and trust to people working in the field or at headquarters to develop new initiatives: “Encourage peripheral initiatives on the basis of common rules”. Decentralisation of field operations will thus be a main element of the reform.

One can identify some principles that should be kept in mind in the design of the reform:

- the freedom of individual initiative must be preserved to the greatest extent possible, but must be applied within a given framework;
the principle of delegation and appropriation (so that each part of MSF feels concerned, involved and represented when another part leads an action) must be accepted and applied more consistently;
• coherence must be guaranteed, where necessary; but diversity should be encouraged whenever possible.

Translating these principles into operational terms means favouring coherence in emergencies and conflicts, when it is essential to act in a very co-ordinated manner and to speak with only one voice. This is the precondition for our credibility and for the effectiveness of our action, while competition is prejudicial to them. On the other hand, in “precarious” situations (structural, long-term or chronic), a diversity of initiatives, as long as quality is guaranteed, is the condition for remaining dynamic. It allows individuals to maximise their potential within MSF, and thus better serves the populations in danger.

With these principles in mind, we will now elaborate further on how the core of MSF, operations, should be restructured. Trying to implement the Chantilly projects has proven that “micro-projects” are not sufficient to harmonise our current functioning and are doomed for failure in the absence of a profound change in operations. This change needs to take place at two distinct levels: the content of operations and the structure and functioning of operations. We will address these two aspects separately first by describing the framework for a common operational policy and then by proposing a common operational structure that is accessible to all MSF sections.

2. Defining operational priorities and strategies

Until now, MSF has never had a common operational policy. In the past, operations, although based on common principles, have developed quite independently in each “section”. This means that certain types of interventions have been favoured due to national influences, personalities, opportunities, and other external factors, such as availability of funds, the media, historical ties to certain countries/regions and so forth. None of the sections has ever had a clearly defined operational policy. And probably this almost total space of freedom for developing new ideas and projects has been one of the main reasons of MSF’s development and dynamism. However, there are some good reasons why at this stage we should define a common operational policy.

• Given the stark growth of MSF activities, the great number of actors who implement them, and a pressing need to do better with the resources at our disposal, we have to recognise that we need a common framework for our operations if only to better match the means and competencies we develop with the activities we carry out. It is no longer credible that MSF cannot define the reasons for intervening in certain countries/regions, and for the type and size of operations carried out.

• The reasons for intervening in certain countries seem relatively clear in emergency or post-conflict situations, but even there the type and size of operations are often not agreed upon (cf. Liberia, Burundi, Angola).

• The reasons for starting longer term projects and the choice of projects and strategies are currently not explicit and not coherent at the global operational level. In addition, developing a wide range of projects is an obstacle to the development of know-how in selected areas, as
this requires a minimal “critical” volume of related activities and a group of people sufficiently competent to deal with them.

- MSF interventions in emergency situations (including refugee camps) have been relatively well structured in the past years based on our experience; however, there is no definition of the “other type of interventions, no “guidelines” and very little analysis of past experiences (i.e. AIDS projects, urban health projects, projects based on community health workers, influencing health policy at the national/regional level).
- Finally as we do not decide on certain priority areas for intervention beyond emergency medical relief, we are not able to communicate in a coherent and sustained manner in these other issues, either in the form of thematic campaigns (i.e. as we want to do with access to drugs in 1998) or with strong message during external events (i.e. communicating on our AIDS projects at the occasion of World AIDS Day).

There seems to be an apparent contradiction between coherence and diversity. However, there is a difference between diversity (perceived as positive) and disparity and inefficiency. The framework for an operational policy defined below tries to encourage coherence based on common principles, while also preserving space for diversity. In doing so one of the reference points is the identification of the areas in which MSF potentially, or already, has an added value. In addition, common sense pushes us towards doing well what we already know how to do, and towards consolidating what we have already achieved before opening into new areas.

We will first discuss how our basic principles should influence our common operational policy. Then we will examine who the beneficiary populations are under different circumstances and look at the different categories of MSF activities. Finally, we will propose two “new” strategies for identifying emergency and long-term interventions.

The principles that guide the operational policy

The basic principles of MSF, that were explicitly defined in our identity text in 1995, should influence the choice of our activities as a humanitarian and medical organisation. We will examine how six of these principles could be applied when we decide where and how to intervene.

“Medical action first”
This is the first heading of our identity, implying that MSF gives priority to “medical” actions and that activities in other sectors (water, shelter, food, etc.) do not have to be developed a priori. However, depending on the needs, other activities, that are not strictly speaking medical, can be developed. In emergency situations this is mostly the case, as there are urgent needs for safe water supply, sanitation, and food. But we are much less clear about the definition of “medical” actions and related activities in non-emergency settings. It could be interpreted as any activity that contributes to the overall improvement of health.

⇒ Does “medical action” mean the provision of care only?
⇒ Should it include supervision of health programmes?
⇒ What about health promotion activities or more generally public health programmes?
⇒ Does “medical” action cover improvements in the distribution and quality of water?
⇒ Making medicines more widely available?
⇒ Training future doctors?
⇒ Fighting against malnutrition by involvement in food production, etc.?
⇒ Improving health by educating people?

Given the wide range of activities that have developed within MSF in the past years we should define more clearly where we draw the line and what we consider priority “medical” activities.

**Témoignage**

Témoignage is mainly understood as a tool for influencing the causes that produce the situations which put populations at danger. Our action is thus not limited to direct assistance, but also includes reflection on and analysis of the causes of the problem and a willingness to act (e.g. by communicating). Such advocacy includes using the media, but also approaching competent authorities, lobbying, mobilising communities, etc. It may and should also be directed at the societies within which populations in danger are to be found (e.g. towards Russian society when trying to help the homeless in Moscow). If we accept this principle, témoignage activities should be an explicit component of all our interventions, clearly defining our objectives and the means to reach them.

**The proximity with the beneficiaries**

Seeking proximity to the “beneficiaries” is another basic MSF principle. This proximity is relatively easy to define in emergencies, where it is expressed in the doctor/patient relationship. But even in emergencies it is not always an MSF volunteer who is directly involved. “Proximity” can mean very different things ranging from direct care by a volunteer to the support role of a technical assistant in an institution or a ministry. If we want to respect this principle and use it in the choice of our programmes, we first need a better definition of what is meant by proximity, particularly in non-emergency contexts.

⇒ Does it mean the direct contact between the caregiver and the patient? (In this interpretation, for example, the exclusive provision of training programmes has little place, *idem* for laboratories.)
⇒ Should it be the proximity of the expat MSF volunteer to the beneficiary population or that of local personnel, including those who are not working for MSF (e.g. in a support programme for ministry of health personnel, etc.)?
⇒ Or does it simply mean being there, having contact with the population in the widest possible sense by avoiding the superb isolation of a 4-wheel drive?
⇒ And what does proximity mean in a programme exclusively focused on the construction of a hospital, or improvement of water quality or distribution of medicines?
⇒ Does the principle of proximity allow us to work entirely through other organisations?

**The effectiveness and quality of our action**

We are responsible for our actions meaning that the sole intention to provide assistance is not enough, but that our aid must also be efficient and of quality. We must be accountable for the impact of our actions to our beneficiaries, our donors or ourselves. It is for this reason that we try to intervene in situations that are likely to be changed by our action: saving lives, relieving suffering. For example, we focus rather on infectious illness than on cancers that are difficult to
treat. To improve the effectiveness of our interventions we have developed guidelines for refugee camps, for fighting cholera, etc. However, given the broad range of activities in many different areas, we are in no position today to ascertain technical expertise, good quality and efficiency in all areas of work. How could this be improved?

The notion of efficiency (benefiting the greatest number possible with the resources invested), also implies that we carefully choose our strategies: for example, we have always distanced ourselves from any action that will save only a few individuals, such as providing recourse to heart surgery for sick patients by transferring them to industrialised countries. This is an obvious example that will not elicit much debate. However, there may be other examples which are more in the grey zone.

**Independence**

Independence means that we decide ourselves when to start and when to end a programme, and that we fix our own objectives and strategies, as well as the standards of quality to be maintained. This independence covers politics, financing, the media, etc. However, although we are independent, we must take into account the wishes of our private and institutional donors and the society in which we are rooted. Should we therefore work only in contexts that are of interest to that society (working only where donors indicate)? We may then be independent in the choice of a certain programme but not in deciding in which countries we intervene.

By becoming international we have a certain guarantee of independence because all the various influences are mixed together. This does not reduce the importance given to Bosnia because Europe and the rest of the western world are implicated there, but Belgium’s interest in Congo, Rwanda or Burundi is counterbalanced by that of Italy for Somalia or Albania, or of the US and Hong Kong for North Korea, etc.

**Impartiality and Proportionality**

Impartiality, in the sense of non-discrimination in the local situations in which we work, remains an essential criteria in selecting target populations. We will work on both sides of a war, if possible etc. Outside of natural disasters and conflict situations it is more the discrimination against populations that governs the selection of projects and target populations, such as marginalised and excluded populations, minorities, etc. The notion of “forgotten populations” also falls into this category because they suffer discrimination through the lack of information about them. This is therefore more a question of a positive discrimination in the choice of people to be helped.

Impartiality could also be considered, along with the principle of proportionality, as a guide to deciding in which countries to intervene. Following this logic, less aid should be provided in Poland than in India. However, it is illusory to hope to be able to conform strictly to this logic, for there are a number of external factors (“inter-dependence”) that push us towards intervening in very different countries. On the other hand, our work in a variety of contexts allows us to learn and to widen our experience to the overall advantage of our activities.

We should examine our current activities in the field and test them against these principles. Are they useful in deciding about the relevance of our projects? Would we have to close certain programmes if we were to apply them strictly? Are there other principles that should be taken into consideration?
Who should be the beneficiaries and what are our objectives?

How many people will benefit from our aid, how we identify their needs, which types of services we propose and what the ultimate goal of our action is obviously depends greatly on the context in which we operate. There can be no rigid rules in defining beneficiary populations, but it could be helpful to reflect a little more on how we choose them.

In emergency situations, save the lives of as many people as possible!

In emergency situations (or where there is great instability), no matter the cause, the largest number of people must be saved. The objective is clear: to save lives and reduce the number of acutely sick people. The quantitative criteria takes precedence and we try to mobilise the maximum number of resources to achieve this objective. There is no other choice for a doctor: triages are aimed at saving the most people possible given the means available. Providing access for minimal care to the largest number is the objective for MSF, and is limited only by the resources available. Once the acute emergency is over and lives are no longer immediately at stake, we must watch out for the negative effects induced by aid (the breakdown of the social fabric and traditional health care system, the way in which aid is employed, etc.). This can lead to a reduction or reorientation of our assistance.

How to choose those who need our help most in more stable situations?

In more chronic situations, the obligation to assist the largest number possible can be interpreted differently. It is the cause of these populations and the specific problem of their situation, that counts more than the number of people involved. Helping all people concerned often exceeds our capacities. The assisted population is thus selected for its representativity. The objective of our action therefore concentrates more on the qualitative impact, either in pointing out and defending the cause of a population, or in the innovative aspects of a response first set up as a pilot project, but with a view to replication.

⇒ But in such situations, should there be a minimum number of potential beneficiaries for an action to be initiated (particularly when a certain degree of cost is involved)?

How do we define “vulnerable populations”?

It is our goal to help vulnerable populations, that is, those who are weakened, in danger, or disadvantaged compared with the rest of the population of a country. But in Cambodia or Chad, for example, we do not necessarily work for the most vulnerable population groups, but some “vulnerable” groups, although many others in the country may be equally vulnerable.

⇒ Should we accept such opportunistic choices?

⇒ Or should epidemiological criteria (morbidity-mortality rates) be the decisive criteria for opening a mission?

⇒ Should help be given to the most disadvantaged among AIDS victims, thus providing palliative care, or should we concentrate on certain, less extreme aspects of this illness where we can provide more “added value”?

In all situations, where we are not confronted with the urgency of immediately saving lives, we should take a fresh look at who our beneficiary populations are, how they were identified and
chosen, and what this choice means in comparison with the rest of the country or other countries in the region.

**How to categorise MSF activities**

The range of MSF’s activity is very wide and thus difficult to classify. However, it would be useful to have a common understanding of how we categorise our interventions to communicate among ourselves, to communicate to the outside world, to equip ourselves with the competence required to deal with them, to build up specific expertise in certain priority areas, to get an overview on the relative weight of certain types of interventions in our overall operational activities etc. As could be expected the classification of emergencies is relatively straightforward. It is for everything outside of emergencies that we need to be more specific.

We can categorise our programmes in line with a number of criteria: the environment (conflicts, unstable countries, etc.), the populations targeted (minorities, street children, the excluded, oppressed groups, etc.;), the overall health problem (epidemics, lack of access to health care, etc.;), the type of programmes, etc. The classification proposed here divides the world into emergencies and non-emergencies. For the latter, two main criteria are proposed: specific population groups and specific diseases.

**Emergencies: conflicts - natural disasters - acute epidemics**

1) *Conflicts and their consequences*

MSF must be present in such contexts in principle, and to avoid being present or to withdraw for security reasons counts as a failure *a priori*. The objective in severe conflict situations is usually to reduce the level of mortality as much as possible (as soon as possible and for the largest number).

To increase security, our presence must focus mainly on medical activities so that we are visibly present as caregivers and, at the same time, can be seen to have an impact on the situation. Here, even more than in other situations, our presence and witnessing/advocacy can be an element of protection for civilians.

We may increasingly work at the heart of conflicts, which renders the task more complicated and dangerous. This means that we must develop our ability to negotiate locally and deal assertively with the authorities, and our “proximity” is therefore a condition for successful action.

Our main focus of intervention are refugees and displaced persons, whether as a consequence or war or of natural disaster. The MSF approach for these situations is clearly laid out. However, chronic conflict situations fall also into this category, even if they are associated with zones that sometimes approach stable situations (Sudan, Burundi, etc.). Here, it is usually a question of “re-launching” health centres and hospitals, even if this means re-building them, ensuring adequate water supplies, organising health care for the most vulnerable, taking on nutritional problems, integrating and retraining local personnel, etc.; in summary, concentrating on the basic needs.

2) *Natural catastrophes and other disasters*

As regards natural disasters, it seems that these can be dealt with most efficiently once the worst is past. Interventions in earthquakes, floods, etc. are mainly directed towards their consequences.
Famines and other food-related crises form a separate chapter within this category (no matter whether the origin is natural or linked with conflict).

3) **Epidemics** (severe and non-endemic)

Epidemic diseases falling into this category are, for example, cholera, meningitis, shigellosis, measles, yellow fever, plague. Our interventions include preventive and curative activities, specific vertical activities, monitoring system for these diseases. Early diagnosis of an epidemic outbreak is essential for an efficient response.

**Beyond emergencies:**

Two criteria will be used for classifying such interventions:

- **populations:** the general population (of a “neglected” zone or urban area, whether a megalopolis or an average-sized town, etc.); a significant “vulnerable” population group, such as women of child-bearing age or children; or a more restricted group, such as the elderly, handicapped or the destitute and homeless, minorities or victims of authoritarian regimes, street-children and orphans, the “oppressed”, excluded and marginalised, addicts, asylum seekers, prisoners, etc.

- **health problems:** the lack of general care (whether in the public or private sector, with an eye to developing basic health care, working at the first level or in hospitals, etc.); and focusing on areas such as TB, AIDS, STD, trypanosomiasis, mental health, etc. For each of these health problems, we must specify what MSF can contribute and its principal added value factor. For example, should we get involved more systematically in the fight against leishmaniasis, dracunculiasis, onchocerciasis, shistosomiasis? Should we deal with mental health problems? How much should we target diseases preventable by vaccination?

Each intervention should take place at the point where these two categories coincide: TB among prisoners, limited access to health care within a limited geographical area (setting up a programme to reinforce the health system in a district, or a “rehabilitation”), AIDS prevention for the general population, health care for street children etc.

How do our existing programmes fit into these categories? How has the choice of the specific population group and the specific health problem been made? How can we establish priorities within this huge range of activities, meaning that we want to develop technical expertise, have a critical mass of projects in those areas and allocate a considerable part of our resources?

**How to integrate our emergency and non-emergency response in the field**

In the past, MSF has focused its activities and also its technical expertise on emergency interventions. We often went into countries during and because of an emergency, and then perhaps stayed on for some time. This is increasingly difficult to accept for most countries (emergency intervention brigade), is becoming less and less efficient (there is a need to know the country and to have pre-established emergency networks) and allows for hardly any preparation for disasters. We should thus develop a new approach combining emergency interventions and longer term programmes in a more meaningful way.
We recently initiated “disaster preparation” projects, but without clearly defining what is meant by this. Despite the lack of precision, there is an understanding that the best preparation for an emergency in a country remains the fact of working there before the emergency arises. This makes it easier to understand how things work, to establish a variety of networks, and thus be able to react very quickly. That is why emergency action and longer-term activities, far from being in contradiction to one another, are complementary. Formulated in this way, this is a different approach from many that have already been put into practice and from what is contained in the Amsterdam documents, for example.

The objective for MSF should thus be to work in a larger number of countries than today with a long-term vision for our presence. This would not preclude individual projects from being limited in time scale, but they should be part of a country policy that would be defined and adapted regularly. Actions in all countries would include preparation for emergencies adapted in line with each situation. Emergencies would be superimposed on existing activities as they occurred and would be dealt with according to their scale with the support of the international team or with the resources available locally under the leadership of the international head of mission.

In addition, in countries where MSF is no longer present, relations with ex-volunteers or former local staff should be systematically maintained. We could thus create a real sentinel network, that can be helpful in identifying needs as they arise and can be the source for initiating new activities.

3. Sharing a common operationality

More coherence in the field

In the past, decision-making power on field operations has mainly been with headquarters, with the exception of some cases where very experienced country co-ordinators are in place. This was based on the idea that headquarters staff are more competent than field staff and that there is a need to confront ideas between headquarters and the field even on relatively minor issues. However, experience has shown that this way of functioning can have negative effects: inappropriate decisions are taken by headquarters staff as they do not have sufficient information, work is duplicated, and increasingly disputes between different headquarters lead to difficulties for field staff from various sections when trying to collaborate. Recently, there seems to be a tendency to modify this headquarters/field relationship. In one section, it has even been completely changed, considering headquarters only as a resource and support system.

In the future, heads of mission should have clearly defined decision-making powers. As was already decided in Chantilly, but never fully implemented, in each country of intervention, a single head of mission should be nominated to represent the whole of MSF. There may be some exceptions to this in countries where there is no real centre of responsibility as for example during civil wars, or in countries which are divided into fiefdoms as currently Somalia or Afghanistan.

The terms of reference of the head of mission (HoM), in addition to his/her responsibilities as program co-ordinator, should be:
to be responsible for the definition and implementation of the MSF policy (the policy paper) in a given country with regard to medical assistance as well as advocacy;
• to be the sole external MSF representative towards local authorities;
• to be responsible for the MSF reaction in case of an emergency in the country.

The way in which activities would be organised around this head of mission may vary. In some countries, only one operational centre (OC) would be present and thus the head of mission would be directly responsible for and overseeing all MSF activities in the country. If more than one OC is present, there could be several co-ordinators, responsible each for a set of activities, but under the overall co-ordination of the HoM as described above. A more integrated, Cambodian-type model (one HoM, but modules carried out by several OCs) would also be possible.

The current pilot experience in the Great Lakes region may provide another example of how this could function. As there is no uniform model, the best way of organising operations in a given country should be decided based on an analysis of the country situation, the needs of the populations and the possibility of various OCs to respond.

The head of mission would answer formally to the group of directors of operations for all activities related to his/her status of international head of mission. With regard to the activities he/she implements for a specific OC, he/she responds to the director of operations of that centre like any other co-ordinators present in the country.

This proposal naturally presumes that the head of mission is a highly skilled, experienced and competent person. MSF works currently in a little more than 80 countries, each section having in most cases its own country co-ordinator. Hopefully, in the future 80 qualified heads of mission could be identified among the current pool of about 200 country co-ordinators.

A single emergency response

There is general agreement that we need one unique approach in emergency situations. As described previously the ET experience has been only partially successful, due to the fact that often the sectional logic prevails over the common interest, whether at headquarters or in the field. A truly international emergency team should thus be autonomous and independent of the administrative structure of the operational centres.

The following elements are being taken into consideration in redesigning the emergency team:
• A small committed team that is international, is supported by the different OCs and has its own administrative system. Some of the members of the team could be “decentralised” to the field (i.e. the current emergency preparedness post in Central America).
• The director of the emergency team is responsible for its functioning (see terms of reference below) and would be appointed by and be accountable to the general directors of the OCs.
• Funding of the emergency activities is done through a joint venture in which all sections have to participate according to pre-established rules.
• The emergency team relies on the technical support (medical advice, logistics, human resources) of the operational centres as needed.
The members of the emergency team are in direct and regular contact with the field (see terms of reference below).

Without exception, it is this team that plans and decides on the messages to be sent out during emergencies for which it has taken responsibility. A minimal communications service is attached to the team for this task.

The terms of reference of such a team should include:

* to develop a world-wide system of emergency response integrated into existing MSF programs; the emergency team technically supports the international head of mission to develop the country-specific emergency preparedness and ensures regular follow-up;
* to continuously evaluate the situation in those countries where MSF is not present;
* to intervene during emergencies either by supporting the country teams or by directly organising the emergency response, depending on the scale of the emergency and the capacity of the country teams. The emergency team would thus intervene directly in a country in which MSF is not present, or at the “request” of an international head of mission in other countries.

The rules regulating the relationship between the emergency team and the operational centres, the rules for attribution of financial resources as well as the control mechanism of this independent emergency structure need to be further elaborated.

The operational centres

One of the main dilemmas in designing a new operational structure for MSF is that historically operational support structures have developed more or less extensively in seven sections, whereas others have been prevented from doing so, and that in the future a formula should be found that allows all sections to have access to operations without indefinitely multiplying operational structures. It has already been argued that a loose federation of 15 or more operational centres would have many more disadvantages than advantages (see 3.1.). However, it remains to be clarified if a single operational centre would be better than a certain limited number of OCs.

A single operational centre would have the advantages of decreasing incoherence and unproductive competition and duplication. No central regulating mechanism would be needed, and the supervisory structure would be relatively simple (one international board). However, such a centre would be huge (currently about 500 staff work overall in MSF headquarters; one could expect about 300-350 people to work in a unique OC), hierarchisation and bureaucratisation would increase, the “human scale” of MSF would be lost, and it may be difficult to maintain diversity and individual initiative.

A limited number of operational centres would allow for smaller headquarters. For example, one could decide that the “ideal” size of an OC is around 60-70 staff at headquarters, allowing for a critical mass of professionally qualified people in all technical areas, but still permitting easy exchange of ideas within headquarters, between the field and headquarters and with the sections.
In addition, a small number of OCs (between four and six) would facilitate their regulation (who intervenes where? to do what?), avoiding the much stronger central regulation that would be required for fifteen or so sections and that would be quite unrealistic given an MSF culture that is deeply uneasy about strong constraints. Having more than one operational centre may also be helpful to maintain some intellectual stimulation, healthy competition and diversity (but not incoherence!) in our activities.

There could also be some advantages of having more than one OC active in a given country even if the presence of only one might appear simpler and more logical.

- This could increase our ability to respond to a greater number of needs for various reasons: additional resources (human, technical expertise, financial) would be brought in by a second or third OC; there is a “mechanical” limitation to administer missions that become too big; and, stimulating the spirit of individual initiative will diversify and increase activities. In fact, many examples show that people from different sections have different foci of interest (i.e. specialisation) and therefore together develop projects that a single OC would not have developed. More and different types of activities would therefore be carried out and more people would be covered thus benefitting populations in danger.

- Capital-based offices and teams would be smaller and would therefore be able to better follow activities, supposing that the overall volume remains the same. Other OCs would have the right to look into activities of the others and exchanges between OCs would take place directly in the country, potentially contributing to the quality of our work.

However, these arguments are only valid as long as there are no harmful effects from the presence of several OCs in a country. These potentially include unproductive competition, each OC claiming a right to “its” victims, incoherence of activities if they are too dispersed, and excessive expenditure by local administrative units compared to the volume of activities carried out.

If the idea of a limited number of operational centres is accepted, these centres need to be truly shared by all sections, maybe implying their “denationalisation”. There is currently a debate within the boards of the sections to further discuss this issue.

The number of OCs present in the field in any one country should be limited. There is no ideal number because it depends on the situation and the size of the country of intervention, as well as the volume and type of activities MSF deploys. Currently in most instances one can consider that too many OCs are present and that their number should be reduced. Consequently, in the future each OC would work in fewer countries than today, but would cover a wider range of activities.

The decision as to the operational model to be adopted for a specific country, the nomination of the international head of mission and the number of OCs present in that country would be taken by the group of Directors of operations. In case of disagreement, the Director of the International Office would have the casting vote as the only neutral member of the group of General Directors.

### 3.4. Organising support to operations

Each of the operational centres will have in addition to some administrative structure a series of technical departments that support operations in the field such as human resources management,
training, medical/public health expertise and research, logistics, and humanitarian expertise and research. Fund-raising (private and institutional), communication and public relation, and recruitment would mainly be the responsibility of the sections (see below 3.6.). All these support activities to operations need to be co-ordinated or streamlined. We will briefly discuss within which framework this will happen.

How to ensure the quality of our actions

It will become ever more important to critically examine the quality of our interventions and to improve it if necessary. In several instances in the past year, serious problems with the quality of our interventions have been noticed, mainly in highly visible situations such as emergency relief operations or vaccination campaigns. At present, there is no systematic evaluation of either emergency or mid-term projects within MSF. Firstly, it should be in our own interest to ensure that our interventions are as effective as possible and that they have the greatest impact possible for the people we try to assist. Secondly, donor countries and recipient countries alike are becoming ever more critical and demanding, for good or bad reasons. But we cannot ignore this trend. We thus need to control the quality of our actions in a more systematic way.

Each OC is primarily responsible for the quality of its activities and for maintaining coherence in its operations with those of other OCs. This function needs to be clearly identified in each OC, and most probably lies with the medical departments. Joint or crossed field visits and evaluations between OCs should be encouraged to further knowledge and understanding of each others programmes.

However, there needs to be some overall guarantee for coherence and continued or improved quality of all MSF programmes. For this purpose a small evaluation unit will be created independently of the OCs which will be responsible for the “external” evaluation of MSF activities (emergency as well as longer term), but also for capitalising on common experience, analysing strengths and weaknesses, improving the quality of actions and putting forward proposals (innovations, development) for the common operational policy. The advantages of such a unit are to have a global overview of all MSF activities, and to be able to take a “semi-external” standpoint without being disconnected or having a different agenda from MSF. This unit will rely on a network of experienced and qualified professionals from within and outside MSF, be probably situated in the International Office, and work in direct collaboration with research and training units.

Questions about the future of human resources

One of the basic principles of MSF is to be an organisation of volunteers who show their individual commitment (to the organisation or to the populations we serve? or to our principles?) and are not primarily motivated by financial interests. This has up to now mainly been applied to the expatriates who leave to a foreign country to work in the field. There is a growing dichotomy between expatriates and nationals who are employed locally, but may show the same type of commitment than those coming from afar. At the same time the external environment has changed greatly. Firstly, there are now many more qualified professionals available in countries where field operations take place, and in some instances national professional staff has filled what
would previously have been expatriate posts. Secondly, the greater complexity and specificity of many interventions, in particular in mid- and long term programmes, and the demand from “recipient countries” for highly qualified expatriate MSF personnel only (meaning a clear added-value to what is locally available), has lead MSF to request higher professional qualifications and experience than in the past. This raises several issues:

- Only expatriate volunteers have the right to become members of MSF, to participate to some extent in decision-making and to question our policies and strategies. Local staff, although often as committed as expatriate staff are “second class” citizens.
- The need for experienced and specialised professionals leads to a tension between wanting to send “first missions” to the field to renew the pool of experienced people in the organisation and inject some “fresh blood” and being able to ensure the quality of our actions and the credibility of MSF as an organisation with “know-how”.
- Finally, MSF wants one the one hand to retain experienced people within the organisation, but on the other hand claims that there are no “career opportunities” in the organisation. In addition, experienced people are/will be provided with incentives to remain in the field or return to the field from headquarters. This potentially creates a two-tiered system of “volunteers” and “ international MSF employees.

Based on the recognition of these and other issues, MSF must develop a coherent and forward-looking human resource policy and strategy which will be shared by all OCs, including the emergency team. This policy needs to include (1) a clear decision on where and how new volunteers (= the next generation of experienced MSF) will be trained without being detrimental to the quality of the programmes and without damaging MSF’s credibility; (2) a recognition that national/local staff is as “valid” as expatriate staff and has similar rights and duties; and possibilities for national staff to join MSF, i.e. by becoming a member, by taking an expatriate status etc.; (3) a unified approach for encouraging a long term commitment of qualified staff; (4) and, a unique definition of financial retribution and secondary benefits according to defined professional categories valid for all MSF field staff regardless of their nationality.

The responsibilities with regard to human resources in each section would be recruitment and selection of candidates, personal follow-up of the MSF career path of expatriates, and providing help in exiting MSF. The responsibilities of an OC would be (1) the appropriate placement of inexperienced volunteers and (2) the general follow-up of a pool of experienced co-ordinators to guarantee the quality of MSF programmes, taking into account the strengths and specificities of each person. There should be no differences in human resources management between the OCs. A common database would facilitate identification of the most qualified person for a given position. Professional criteria should clearly outweigh other interests (i.e. national “quota”, linking human resource to financial attribution etc.).

### Technical support to operations

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1 One means to achieve this could be to identify “training missions” (missions-école) where inexperienced volunteers could learn on the job, being coached and considered as trainees.
Regarding **medical/public health expertise and research**, the direct support to field activities needs to be in close relationship with operations and should thus be located within each OC. Medical services could specialise in certain areas and be available to all OCs. In addition, certain more global activities such as building on previous experience, collaborating with external partners/other institutions, and defining an operational research strategy should be co-ordinated centrally. The current international medical director should have greater authority and be responsible for defining MSF’s medical policies, strategies and research agenda in collaboration with the medical units of the OCs.

With regard to **humanitarian expertise and research**, the currently existing humanitarian departments, research centres or foundations need to be co-ordinated. The terms of reference of the humanitarian departments should be streamlined clearly defining their responsibilities including direct support to operations (as for example done currently by the context unit in Amsterdam), research on certain topics relevant to MSF, and participation in internal and external training activities. Depending on the profile of the person co-ordinating training (see below), his/her responsibilities could include the co-ordination of humanitarian research activities.

MSF will have a unified **training** strategy for all staff. Internal training can be carried out in a variety of locations allowing all sections to participate, but with a strong central co-ordinating mechanism. Internal training should be flexible and adapted to individual needs with the possibility of distance learning, including the use of computer networks/internet, and be decentralised to the field wherever useful and appropriate.

Regarding external training, MSF should become a recognised training partner, and all MSF staff should have access to a database on external courses for all different job levels and profiles. One MSF scholarship project would attribute training grants within the whole of MSF according to established rules.

Each OC and certain sections could have training units which could specialise in certain areas of training and would be under the overall direction of a co-ordinator for training, including also some aspects of research, who will be based in the International Office (currently being selected).

There will be **one common purchasing centre** in MSF funded jointly by all sections. The director of this center has been recently selected and the fusion of the existing purchasing centers is underway. This should ensure an improved quality of purchases and a better cost-effectiveness and remove unproductive internal competition and financial rivalries. Common standards will be defined through joint operational research projects. All purchases carried out by MSF will be regrouped, ensuring at the same time their quality control.

Each OC would have a **logistics** unit to provide on-going support to operations in the field. Joint logistic policies and strategies would be developed on a yearly basis and adhered to. One person would be responsible for co-ordinating the logistic units; this could be one of the heads of the logistic units of the OCs, or a separate international co-ordinator.

**Communication** has a very important national component, but at the same time needs international co-ordination. If operations were better integrated and co-ordinated, external communications would certainly be facilitated. The co-ordination of communications is
particularly important for advocacy campaigns on selected topics, during emergency interventions, in case of denunciation campaigns and to constitute an institutional memory on témoignage efforts. The communication units of all sections should thus work under the co-ordination of an international communications director.

Conclusion and recommendations

*There is no time to be wasted!* Once we have reached an agreement on the main tenants of the reform, its implementation must be rapid. Much frustration has been building up at almost all levels within the organisation over the past two years, and too much energy has been wasted on trying to harmonise our work without changing the heart, operations. There is a major risk that the “new sections” will become increasingly impatient if they are not fully recognised as equal partners and given access to operations. This would lead to the development of more operational centres and an increase of “nationalistic” attitudes within MSF as described earlier. On the other hand, those most plagued by the current situation, namely co-ordination teams in the capitals of the countries where we work, and mid-level management in the headquarters of the operational centres will react to a highly unsatisfactory situation either by leaving the organisation, or by adopting negative, counterproductive attitudes in their work. People committed to MSF need to have a good a sense of the objectives and ultimate goal of the functional and structural changes that are going to happen, they need to feel involved in this change process at their own level, and they need to feel that this is not a painful process lasting forever, but that after a difficult transition period we will have gained strength, coherence and a structure that allows to develop our common and our individual potential fully.

The transition will be difficult. We should not pretend otherwise. It will be painful to abandon old schemes and habits, to accept loss of influence and power at the individual or group level, and to think in broad terms about MSF and *the populations it wants to help* in the first instance. But we should try to go through this process rapidly and gracefully, while at the same time not jeopardising the day-to-day work.