A short history of the “internationalisation” of MSF

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References
Introduction

In the past two and a half years, many changes have occurred within MSF based on the acknowledgement that there is only one direction into which to go, often called the internationalisation of MSF. Many of us have participated in this process at various levels within the organisation, with its share of hopes and frustrations, with its moments of great trust and also deception, and with a sense that this may be a necessary, but very difficult and painful way to go.

It is encouraging though that a very large majority of volunteers still favours the construction of a harmonious international movement and does not wish to return to thinking in terms of national sections. This was illustrated by a motion passed by most of the General Assemblies in 1997, calling on the international council to present to their next meeting in 1998 a model for a reformed international structure based on criteria of operational effectiveness, democratic control by its members, and juridical and financial viability, applicable at the level of each section.

During the past two years a multitude of proposals have been made, many decisions have been taken, many projects started, and numerous “international” meetings took place at all levels. Given this flurry of activities, there are only few people within MSF who are still able to put all these bits and pieces together. The main purpose of this paper is thus to give a brief historical overview of the evolution of MSF and a review of the achievements and failures to date. This should be used as background to the discussion on future changes needed (see document “Next steps ahead”).

1. Brief history of the structural evolution of MSF

1.1. Some landmarks in the strive towards a more unified organisation

1971: founding of MSF in France.

Between 1980 and 1986: creation of the Belgian, Swiss, Dutch, Luxembourg and Spanish section as independent national entities, each leading mainly its own operations with some avenues for collaboration.

1988: first “official” international meeting of the presidents of the six sections in Paris.

June 1989; first big international meeting of the six sections in Toulouse leading to regular meetings and exchanges at the political (about four times a year) as well as the various technical levels. The idea of creating “MSF Europe” is discussed.

between 1990 and 1995: twelve delegate offices (DO) are being set up in the USA, Canada, Italy, Japan, UK, Denmark, Germany, Sweden, Hong Kong, Australia, Austria and Norway initially
with the main purpose of increasing and diversifying financial and human resources; in addition MSF is set up in Greece, being neither a full section nor a DO.

1990-91: MSF International, located in Brussels, is created. Its board is the International Council (IC), composed by the presidents and general directors of the six initial sections until January 1997. The role of the IC and its president are defined for the first time, and elections for an international presidency are instituted (rotation on a six monthly basis until February 1995; since then 12-15 months). The international office is set up as the executive arm of the IC, directed by the international secretary, with mainly an external role until 1995. Two liaison offices are created in New York and Geneva.

1991: a joint code of conduct for operations is adopted.

February 1992: second big international meeting in Melun leading to the “Melun declaration” which reinforces the wish to promote international collaboration within MSF, especially with respect to operations.

April 1992: the IC declares a moratorium on the creation of new operational sections; states that it is within the sole competence of the IC to open a new section or a new delegate office; and defines the role and functioning of DOs.

1992/3: MSF’s financial code is adopted defining, in particular, rules for financial independence; the so called “European policy of MSF in regard to witnessing” is developed.

1994: big international crisis between the six sections born out of mis-(non)communication, mistrust, and perceived divergence of ideas about the “essence” of MSF (including among others the associative dimension of MSF, the importance to guarantee our independence, the role of témoignage, technical assistance versus emergency relief); first meeting between the IC and representatives of the DOs; three-day retreat of the IC in Royaumont to come to the conclusion that we need an “active pause” to reconsider the pros and cons of international co-operation.

April 1995: enlarged IC (IC + board members of sections) meeting to define and agree upon the associative dimension of MSF and establish certain ground rules to be followed by everybody. (N.B. at that time the DOs were not yet granted the possibility of developing their own national association)

September 1995: enlarged IC meeting (IC + DOs representatives) to debate the pros and cons of internationalisation, agree upon the need to move forward towards a real union and prepare the international meeting at Chantilly.

It became obvious that change was needed at various levels. The following issues were identified as needing urgent attention.

- The shared values and guiding principles of MSF needed to be clarified. The only common text was the charter which is only a statement of intent, but is too vague to be the basis for our “corporate identity”.
• The two-tiered structure with sections who retain the decision-making power and DOs who are second-class citizens was felt to be a transitory solution which needed to be addressed with the vision of a future MSF where all entities are considered to be equal. This included a revision of the structure of the IC and granting the associative dimension of MSF to the DOs.
• The operationality of MSF needed to be redefined, including some access of all MSF entities to operations, and an internationalisation or denationalisation of operational centres.

As a first, but very important step, a common text on our identity and shared fundamental values was proposed, debated and agreed upon at the international meeting in Chantilly\(^1\) (October 1995). This text has been revisited at the second Chantilly meeting, has consequently been accepted by the national boards and the IC, and has become part of our “credo”, as naturally as if it had always existed. It has the immense value of clearly outlining where we stand as a medical relief organisation, what our specificities and our lines of action are. In some sense it is surprising that it took MSF more than 20 years to feel the need for such a text and to be able to agree on it.

1.2. **Major changes occurred in 1996 and 1997**

In addition to the debate on the identity text, several concrete proposals were made to further international collaboration and coherence in five sectors: operations, human resources, humanitarian and medical/technical support and research, and communication. The most exciting proposal put forward at the first Chantilly meeting, was to establish an international emergency task force within MSF (see below).

For the first time, international mini-general assemblies were organised in the field in March-April 1996 allowing for a debate on the identity text and other decisions taken during the Chantilly meeting and to propose concrete actions at the operational level to improve collaboration and internationalisation.

To move further in the process of reform, a second international meeting was organised in Chantilly (May 1996) bringing together all the heads of missions (country co-ordinators) of MSF (about 200 people) with representatives from the headquarters of the sections and DOs. This second meeting was “action-oriented”, endorsing and proposing a whole array of “international projects” with the overall aim to further a common identity and to move towards a unified organisation from within. As we will see later, some of the “Chantilly projects” came underway rather quickly, others dwindled along.

Thus the two Chantilly meetings were about a common identity and about international projects, but did not address fundamental changes in the MSF structure and our ways of functioning, perhaps with the exception of the emergency team.

Finally, during the International Council meeting in Brussels in January 1997 a first step was taken towards a functional and structural change within MSF. The 19 sections were recognised as

\(^1\) The first meeting in Chantilly brought together about 150 people, including members of the boards and staff from the various departments of headquarters of what was then called the sections. The delegate offices were each represented by one person, mainly the director of the office. There was no representation from the field.
equal members of the international council. The role and mandate of the IC and the other international decision-making bodies (restricted committee, group of executive directors) were redefined, and several commissions were set up to look into the issues at stake (definition of operationality and proposals for a shared operationality within MSF; further clarification of the different jurisdictions, also between IC and national boards; the expansion policy of MSF; and, how to function with 19 section in a coherent and satisfying manner).

2. Where do we stand at the end of 1997?

2.1. A common set of shared values and principles: the identity text

The identity text (annex 1) is divided in two parts: part one describes the principles that underpin our action, and part two defines practical rules for operationalising some of these principles. Regarding the principles, it was clarified that MSF acts mainly to provide medical aid to people in danger, but that témoignage/witnessing is an integral component of our action. This was extremely important, as our policy of témoignage had been discussed for years in many of the IC meetings, but is not mentioned in the Charter. However, a so called “European policy of MSF in regard to witnessing” had been adopted by the IC in 1993.

Other important elements of the principles are the definition of independence, our renewed commitment to accountability and transparency, and our adherence to other principles such as medical ethics, human rights, impartiality and a spirit of neutrality (all mentioned in the charter). In addition, we affirm that MSF is an organisation of volunteers who actively participate in the associative life of MSF. This should enable us to resist compromise, routine and institutionalisation, and maintain spontaneity and a spirit of innovation within the organisation.

The practical rules include how the not-for-profit principle should be applied; that 50% of funds must be private and 80% of resources must be dedicated to operations; and the issue of financial control and transparency.

It is obvious that some of the issues addressed by the identity text need further clarification and a more detailed description if they are to be applied consistently throughout MSF.

A major issue has been the MSF policy on témoignage, which was recently rewritten and accepted by the IC (September 1997: annex 2). But beyond a policy, there have been repeated requests for some sort of “guideline” (a more detailed, explanatory text) on témoignage which would make it easier to act in a similar way in the various field sites and in headquarters.

Another issue that has been addressed in more detail but without a definite statement yet is that of a relative standardisation of membership and associative rules. The identity text implies that being an association is one of the fundaments of MSF. The text upon which we currently rely are the recommendations adopted at the Paris meeting on the associative dimension of MSF in 1995 (annex 3). But it remains to be clarified what that truly means in terms of participation in decision-making (do members mainly elect the board members? can they participate in strategic decisions? and if so, how?), of who is entitled to be a member (i.e. voting rights of salaried staff),
and how an MSF association is defined quantitatively (minimum number of members, size of board, etc.) and qualitatively (involvement in strategic decision making within MSF nationally and internationally, livelihood of the national base of the association, active participation of members).

It had been requested at Chantilly that the notion of “independence” be clarified and explained, that an international fund be created to guarantee MSF’s independence and that the IC take an active role in ensuring that MSF maintains its independence, in particular at the financial level. None of this has been implemented.

2.2. An organisation composed of 19 national sections

Since January 1997, MSF is made up of 19 national sections all represented in the IC (resolutions of the extended IC meeting, Brussels, January 1997: annex 4). All sections have to become associations with national membership, election of a national board and a national president. Given the fact that many of the sections that were previously delegate offices had been denied this right, a two-year transition period was agreed upon to allow every section to fulfil this requirement. In line with this decision, ex-delegate offices were also granted the right, during this transitional period, to be represented on the IC by the executive director rather than the president.

Hitherto all MSF sections should equally participate in the debate and ultimately decision on MSF reform through their representation in the IC. It is the sole competence of the IC to define a blueprint for a new MSF structure including any decision about the creation of new sections or other entities, the definition of operationality and the number of operational centres.

During the IC meeting in January 1997, the role of the new IC composed of 19 members was redefined to orient it clearly towards global strategic decisions, give it the responsibility to develop a long-term vision for MSF and to safeguard the identity of MSF. In addition, it was decided that all sections have to participate in MSF’s operations and that the “operational centres” need to be denationalised. However, it was not clarified what this exactly means and how it would be implemented.

A smaller subset of the IC, called the restricted committee (RC), was given responsibility to follow more closely the execution of international projects and to serve as an international arbiter in case of serious conflict. In addition, for the first time, legislative and executive powers were clearly separated by formally creating the group of the executive directors, currently composed by the five directors of the operational centres (Belgium, France, Netherlands, Spain, Switzerland). They are responsible for international co-ordination and are the executive arm of the IC. They also are the first point of arbitration in case of disagreement on operational issues.

For historical reasons there are currently five operational centres, located in Amsterdam, Barcelona, Brussels, Geneva and Paris. The Luxembourg section recently signed a partnership agreement with the operational centre in Brussels, thus becoming part of that centre. The Greek

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2 In the text of this document we will refer to these five sections as “operational centres” (OCs) for anything that happened after January 1997 and when talking about the future. This does, however, not imply that they have been granted this status indefinitely. The differences between national sections and OCs will be further clarified later in the document (see 3.3 and 3.5.).
section is currently reviewing its association with the operational centre in Barcelona, and may propose a transfer to another centre.

In the current situation, each operational centre is directly linked to a national section and its board. This implies that other sections can only participate very indirectly, through the IC, in the debate and decisions taken in any operational centre.

Also for historical reasons (all ex-delegate offices were intentionally created and financially supported by four sections), most of the new sections are still financially dependent on one of the operational centres. As a corollary their private funds are mainly given to that centre, with little or no control over the attribution of these funds.

Based on the resolutions passed at the IC meeting in January, certain issues need to be clarified further. These include:

- to define the role and responsibilities of a section;
- to define the term “operationality” and determine how all sections can actively participate in MSF operations;
- to define the role and responsibilities of an operational centre and its link to all sections;
- to clarify the relationship between national boards and the international council, including delegation of authority on specified matters;
- to clarify the financial dependence between ex-DOs and ex-mother sections: for example, financial support should be time-limited, and to a certain extent decisions about attribution of private funds should be the prerogative of each section and should depend on the project and not the operational centre.

### 2.3. A first attempt to unify operations: the ET experience

It was decided during the first Chantilly meeting that an emergency task force should be created to manage emergency situations more efficiently on the operational as well as the “témoignage” level. This task force, now commonly called Emergency Team (ET), saw the light of the day very quickly and was fully operational in February 1996. The basic functional idea was to have a relatively small group of experienced and committed people who would be given full responsibility for all decisions regarding objectives, strategies and means to launch an emergency programme. ET would intervene during the initial phase of an emergency (6-8 weeks) and then transfer responsibility to one or more operational centres. One operational centre would be chosen by this group to technically back-up the emergency intervention. It was also suggested that there should be a common emergency fund.

ET operated efficiently and to the satisfaction of most sections during the first months of its existence. The massive intervention during the meningitis outbreak in Nigeria was certainly its biggest success. However, at the end of 1996 the Kivu crisis highlighted the limits of ET functioning. Trust between the operational centres broke down and national approaches became predominant, thus leading to non-respect of ET decisions and demotivation within the ET group.

An evaluation of the first year of ET functioning was carried out in the Spring of 1997 and summarises the achievements and difficulties as follows.

1. Most actors (volunteers in the field, ET members, sections) have truly felt part of an international movement.
2. ET has allowed all sections, and in particular the three major operational centres, to confront their differences and problems instead of bypassing them or covering them up. The constant collective work through ET has permitted to maintain contact even during major internal crisis.

3. ET had a very positive impact in Nigeria, and without ET this scale of intervention could not have been achieved.

However:

* Although everybody apparently adhered to the ET idea, the “sectional” logic prevailed frequently, leading to a non-respect of pre-established rules.

* One main problem appeared to be financial rules and attribution of funds to different operational centres. Back-up sections were chosen more to equilibrate the accounting than for efficiency reasons, which lead to some counterproductive decisions.

* ET in its current set-up is a heavy machine, with time-consuming rules and regulations, which are only warranted in big emergencies. But no other international mechanisms to co-ordinate emergency interventions exist.

* Information flow is not well regulated, reports, technical and medical data are not available in all sections, and the information is not user-friendly (too much in quantity, but not concise and easily understandable/useful).

* Differences of opinion are only being solved by time-consuming search of consensus. Too many people are involved in decision-making and there is no accepted authority that can arbiter in case of conflict.

Based on the experience of ET, the operational end executive directors reaffirmed in April 1997 that MSF needs to operate in emergencies as one MSF, with one voice and with the participation of all sections. Based on the evaluation of ET and our conviction that we need a common response to emergencies, some of the ET core members were asked to define a new framework before the end of 1997.

In addition, it was decided to create a joint venture, initially between the operational centres (could be extended to all sections in the future), to resolve the financial problems that have bogged down ET. This implies that a separate legal entity is being created, that members of the joint venture sign a yearly contract and that they will share a given and agreed upon proportion of any financial shortfall. A binding agreement would be signed by all parties that only the joint venture system can be used to implement activities in international emergencies.

2.4. Striving towards greater coherence: the Chantilly projects

Beyond the creation of the emergency team, many other international projects and recommendations for greater coherence emerged from the two Chantilly meetings. It has been the duty of the executive directors and the international secretary to follow the evolution of these projects closely and to report to the IC about achievements as well as difficulties and failure to implement. This has at least had the merit that the projects were not just forgotten or put indefinitely on a back burner. The last update on the international projects was done in September 1997 (annex 5). Without going into the detail of each project, some general comments may be useful.
Collaboration in the field

To increase the cohesion between sections, improve coherence of our action and be able to speak with a single voice, it was proposed to increase interchange of ideas and develop a shared view on our presence in a given country by:

- writing one policy paper for each country in which MSF works involving all sections present,
- producing a common situation report (sitrep) at intervals depending on the time frame of our work,
- looking for economies of scale, for example, by combining country offices of different sections,
- and, electing one single country representative among the heads of mission when another section arrives in the country (it was not clarified what should happen in countries where more than one section is already present).

In addition, it was proposed to develop a common policy with regard to local/national personnel.

None of these recommendations has been fully implemented to date, some started well, but then lost momentum (i.e. international sitreps), most have only been tried out in a handful of countries (policy paper, common offices and/or single representative, common policy for local personnel). Major problems which have hampered implementation are the lack of clear guidance and feedback from the operational centres; the difficulty to define common approaches in the field when country co-ordinators have to respond to different desks in the headquarters who frequently have different agendas; and that these issues were not given high priority by people responsible in headquarters. However, at least international sitreps do exist and are available to all sections.

In addition, the executive directors have decided that in March 1998 they will present for the first time a common operational project to the IC. The project will be based on “national” projects developed in each of the countries were MSF works, as a joint effort of all heads of mission present. This would allow for a global analysis of MSF’s operational strategies, which could then lead to a discussion about future choices. It would thus be a major step forward towards a more coherent and shared operationality.

Regrouping human resources

The basic idea behind the projects proposed is that if we want a coherent and unified MSF working together well, people need to get to know each other, need to perceive themselves as working for MSF and not this or that section, need common training opportunities, and should have similar working conditions regardless of the operational centre. In addition, mobility between the sections at headquarters and field level, and between headquarters and the field should be increased.

Some advances were made such as the publication of an international “dream list”\(^3\), continued work on sharing of human resource data bases or on one common data base, continuous attempts to unify contract conditions and a time limit on headquarters positions. However, with the exception of Barcelona and Geneva, the headquarters of the operational

\(^3\) This is a list of all vacancies available within MSF for field positions of a certain level of responsibility. The list is posted regularly on e-mail to be accessible to MSF sections and individuals.
centres remain very mono-national, there has been little movement from headquarters to the field (below 5%), and the exchange of heads of mission between sections is not supported.

Common training opportunities have been improved by “internationalising” some of the internal training courses. An analysis of existing internal and external training courses, and concrete proposals for an international MSF training strategy were made in August 1997. The selection of an international training co-ordinator is pending.

It should also be noted that the distribution of human resources within MSF remains very skewed. MSF is currently constituted of 19 sections who all contribute human resources, although at varying levels depending on the national situation and the length of existence of the section. However, certain nationalities remain very predominant. The 1996 MSF statistics show that 826 out of 2418 departures are of French nationality; 425 are Belgian and 273 Dutch. About 60% of all departures are thus composed by three nationalities. This implies that although people of more than 40 different nationalities have worked with MSF in 1996, MSF is not yet a truly multinational organisation, and that cultural identities of certain groups prevail.

Regrouping the technical departments

Collaboration between the medical departments and co-ordination of external contacts have been greatly improved since the nomination of an international medical co-ordinator in June 1996. However, harmonisation is limited due to the differences in operational concepts and procedures.

The functional integration of the two existing purchasing centres (Transfer and MSF Logistique) is underway. Only Amsterdam will not fully participate in this common system.

There is a willingness to harmonise financial tools at the field level, but progress is slow. This is, however, essential for smoother co-operation between operational centres in the field. Financial procedures at headquarters level will remain different.

Integration of the departments for humanitarian affairs remains very limited, mainly due to different working concepts and priorities. At least an updated list of publications will be regularly produced by the international office.

Improving internal and external communications

In some ways internal communication has been improved by overall access of the MSF network to electronic mail. However, information is often too much in quantity, but lacks quality, and remains difficult to use for those who are not directly involved.

A major tool to improve internal communication was supposed to be a common internal newsletter (the first and only one produced up to date was Inter-action in November 1995). This should allow for exchange of information and ideas without thinking in terms of sections/operational centres, without excluding the possibility of a more nationally oriented insert. Instead some issues of the “national” newsletters inserted an international part. The IC reaffirmed in September 1997 that this project should receive high priority if we want to foster a common identity.

External communication has been partly improved by the initiation of a common MSF data bank and the creation of a team of international field press officers, mainly to work in emergency situations. Workshops on media training are being integrated into the training programmes for co-ordinators (which are not yet internationalised). Another Chantilly proposal
that still remains to be executed is the production of an explanatory document on témoignage/witnessing for co-ordinators.

Although some progress has been made in the past two years, a recent survey on MSF communication identified seven major problems:

- difficulty to obtain quality information from the field,
- insufficient information provided by each operational centre to other sections,
- lack of technical support for communicating,
- lack of a unified, clear line of responsibility in emergencies,
- lack of a shared international strategy for communicating on medical issues,
- lack of a shared institutional memory on projects as well as previous témoignage efforts,
- confused image projected by MSF to the outside world (medical organisation or human rights organisation?).

These problems lead to a confusion that may endanger the security of teams in the field and that decreases our credibility. In addition, much energy, time and money is wasted.

Some solutions were proposed that point to the need for a common communication strategy:

- standardise reporting and dissemination of information from the field and between headquarters,
- improve communications support to the field
- develop guidelines and strategies on when to speak out, on what and how,
- standardise media/témoignage training across sections, departments and the field
- recruit a medically trained journalist

No concrete decisions have yet been taken to address the problems identified by the survey.

### 2.5. Lessons learned in the past two years

In summary, one could thus say that over the past two years there has been increased interchange between sections at the technical level trying to harmonise and/or unify procedures and improve links and exchange mechanisms. This process has involved to some extent all sections when it comes to human resources, communication/advocacy, and institutional fund-raising. In addition, operational centres have been concerned by harmonising administrative procedures, training, medical aspects and logistics (including supply centres). Overall, much progress has been made, and trying to work together becomes more the norm than the exception.

But the efforts made to implement the Chantilly projects have also revealed some basic problems which have greatly hampered their progress.

1. Although we are very capable of reacting quickly in emergency situations, we, as an organisation, are slow in implementing change within MSF. This often seems to relate to such issues as the difficulty of abandoning a section-oriented view of the MSF world, lack of authority within sections and in the international structure, and resistance to change because people don’t know where the MSF ship is steering.

2. One major constraint in implementing the Chantilly projects has been that the responsibility for their success has been laid mainly on the shoulders of mid-level management in MSF (i.e. the desks in operations, people responsible for communication or training). However, these are probably the people who expect the lowest benefit from
these projects, and are at the same time bogged down in the internal hierarchy of each section/operational centre.

3. In addition, most of the Chantilly projects are hindered by the fact that there is no clear concept on how the “heart” of MSF, operations, will function in a truly multinational movement. It is, for example, impossible to come up with a unified, international training project or medical support structure, if five operational centres abide by different rules, have differing strategies and fight for territory among themselves.

Beyond these problems there are some further stumbling blocks which were mentioned by a number of the participants in the Delphi survey on the internationalisation of MSF

- There is competition between the five operational centres for financial resources (mainly private), qualified human resources (mainly coordinators), and presence in the field (plantage de drapeaux). This makes it difficult to work towards a common goal (helping populations in need) by sharing resources in the most efficient way, rather than trying to assert the independence and power of a given operational centre.

  as one Delphi participant says: “I cannot accept that for reasons of power, the necessities of structures and quotas become more important than the operational priorities. To give an example, I cannot accept that, just to be part of it, a section sends an entire team to Rwanda of whom none speaks French. The same in Liberia, where another section sends francophones who don’t speak a word of English. These examples and many others impede the implementation of our charter.”

In addition, one can often notice a lack of respect for differences of opinion or of doing things with “nationalistic” views and judgements reappearing quickly.

- Many fear that unifying and globalising MSF could bring about an overwhelming and stifling bureaucratisation leading to paralysis. Already, decision-making processes are slow due to the multitude of actors, and once decisions are taken they are not respected.

  “It seems evident that we need to join our forces to share our experiences and learn from them how to confront the problems that henceforth can only be managed at the global level. But what scares me, is the weight of a big structure that ignores the individuals... something which is already a bit the case in the national sections now.”

- In addition, the big size of MSF overall and its image as an international organisation could provoke a decrease or loss of national identity and national visibility.

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4 A questionnaire with four open-ended questions (priorities for action, challenges ahead, difficulties in the internationalisation process, and expectations towards MSF as an international organisation) was sent to six different groups of MSF volunteers (“old” field volunteers, “young” field volunteers, “old” headquarters staff-OC, “young” headquarters staff-OC, ex-field staff, headquarters staff of non-operational sections) at the end of 1996. Out of 297 people contacted, 104 responded, some at great lengths. A summary of the survey results is available at the international office.
Based on the lessons learned in trying to implement some elements of reform within MSF in the past two years, and taking into consideration the potential problems of tomorrow, we should now decide about the next steps to be taken to overcome the current constraints, and to build together a stronger, more coherent MSF able to face the new medical and humanitarian challenges in a rapidly changing world.

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i Evaluation of the Emergency Team (ET). Cathrin Schultz and coll. June 97
ii Towards a common training strategy for MSF. Doris Schopper, Paul van’t Hout. August 1997.