CHAIRPERSON: Good evening, everyone, and welcome to MSF South Africa General Assembly 2009. We have a diverse group of people joining us for the General Assembly from many different countries and I'm going to try and list them and please shout out when I list your country so we know how many people from each country are here. And I may miss some, so when I do, remind me that I've missed you and call yourself out.

So we'll start with MSF Malawi, do we have people from MSF Malawi here?

MALAWI: Yes.

CHAIRPERSON: Welcome, MSF Malawi. MSF Mozambique, anyone from Mozambique?
MOZAMBIQUE: (Affirmative response).

CHAIRPERSON: MSF Swaziland?

SWAZILAND: (Affirmative response).

CHAIRPERSON: Do we have anyone from MSF Lesotho?

LESOTHO: (Affirmative response).

CHAIRPERSON: And what about, I'll save the noisiest for last. What about MSF UK?

UK: (Affirmative response).

CHAIRPERSON: MSF USA?

USA: (Affirmative response).

CHAIRPERSON: MSF Brussels, ACB?

BRUSSELS: (Affirmative response).

CHAIRPERSON: MSF Hong Kong?

HONG KONG: (Affirmative response).

CHAIRPERSON: MSF Denmark?

DENMARK: (Affirmative response).

CHAIRPERSON: And MSF South Africa?

SOUTH AFRICA: (Affirmative response).
CHAIRPERSON: Have I missed anyone?

RESPONSE: Zimbabwe.

CHAIRPERSON: Oh, my God, MSF Zimbabwe.

ZIMBABWE: (Affirmative response).

CHAIRPERSON: Have I missed anyone else? MSF Sweden?

SWEDEN: (Affirmative response).

Well, if I missed anyone else out I'm very sorry but thank you very much for your energy in helping us open the General Assembly. We will go through the various items on the Agenda, starting with an introduction from Sharon.

Introduction

MS EKAMBARAM: Okay, well, I'd like to welcome you to our third General Assembly, hello. And we have a very productive day of discussions tomorrow and we're hoping to get as much input from all participants in this meeting and to hear of your experiences but also challenges to this new branch office of what we could do to make your work in the field better and more effective. So, welcome.
Amandla!
Awetu!
Thank you.

CHAIRPERSON: We're going to start off with a couple of housekeeping rules and I think Melanie is going to tell us how to behave. Are you here, Melanie? Melanie? Not here, okay. So we'll do that later.

Adoption of Agenda

CHAIRPERSON: And instead we'll move onto the Adoption of the Agenda. Now I think
there are a couple of items to add before we ask whether you're okay with the Agenda and Sharon will add those points.

**MS EKAMBARAM:** The points I want to add are towards the end of today's proceedings and that is related to the election process. All of you would have got, well, members of the General Assembly of South Africa would have got green voting cards. Please look after those, you're going to be voting for the new MSF SA Board tomorrow. And Veronica and Rebecca, who are the election counters - I've forgotten the phrase - but they'll be speaking to you about the procedure and what we can do to improve our transparency and the way in which we go about voting for our members and various other things that we should have been doing, to ensure that we get as much feedback from the field in terms of what the members' needs are. That would come after the reading of the Treasurer's Report.

And then we will present to this assembly people that have been nominated or are standing for election, so that you know who you're going to be voting for. We need you to think about this and tomorrow, if you see on your Agenda, after lunch the process of elections for the new South African Board will begin.

So those are the only changes that I want to add to the Agenda for today. Tomorrow remains the same.

**CHAIRPERSON:** And so just to run very quickly through tomorrow, you have it all in your packs. But we start at eight o'clock with Registration and then the first session is to discuss the issue of Diminishing Space for Humanitarian Action and we'll have a presentation and then some group discussions. We'll then break for coffee. We'll report back at 10.45 with resolutions and motions for this General Assembly. We'll then go into a Plenary Session on the issue of MSF Hand-Over of HIV Projects, which will involve a panel discussion and then an open discussion with everyone in the room. We'll break for lunch and we'll start the election process and have a year in review 2008/2009 with a MSF South Africa perspective. This will be presented by the General Director.

Then we'll go onto a discussion of Operational Strategies in Complex Environments, using Somalia as a case study. Then the results of the elections, composition of the new
Board and Party! Party! Party!

Can I propose this Agenda for adoption or hear any changes that anyone wants to suggest? If there are no changes, then I'll consider this adopted. Thank you very much.

So, we are swapping two items round here and we're going onto now hear a little bit about the Outcomes of the Field Associative Debates and I'm not sure whether people have been warned about this or not. But what we would like to do in this session is to invite representatives from the various Missions we have in the room to tell us a little bit about how their FAD went and to tell us what the main outcomes are. So you don't all have to do it but anyone who wants to let us know how their Field Associative Debates went, please do put your hand up and we'll get a microphone to you and you can give us a brief summary of what was discussed and what the main highlights were.

So is there a volunteer to do that? No, I don't want to pick on anyone. I don't want to pick on Swaziland. Alright, I'll pick on Swaziland, will you be willing to do it? Oh, Hermann, can you introduce yourself when you speak because this is for the recording purposes.
OUTCOMES ON THE 2009 FADs
AND VOTE OF THE MOTIONS

MR PÉGUILLAN: Aymeric, I'm the Head of Mission of Swaziland and this is Hermann, that everybody knows here. We had two days of philosophic debates a few weeks ago and we looked into the international topic, which was, if I remember correctly, closure and hand-over of projects. So obviously for the Swazi Project, which is a very young project, it's a bit early but still we're thinking about it and trying to inspire ourselves from Lesotho and other projects in the region.

I think generally speaking, what came out quite strongly from the teams was that cooperation, collaboration with the Ministry of Health at all levels, that a lot of people do see as the main partner to hand over to, was essential. And that a lot of the planning, a lot of the strategic decisions should be taken with the Ministry of Health in the countries where we work. So there was a very strong call for a reinforced, a need for a reinforced perception that MSF should be seen as a willing partner and as willing to engage with that main actor, both at national and at local level.

What else can I remember, Hermann?

CHAIRPERSON: Did you pass any motions?

MR PÉGUILLAN: We passed only one motion, which actually is not a new motion, which is a motion that was already voted, I think two years ago internationally, which is the motion that basically describes the fact that for any position held by an expatriate there should be a significant effort being made for that expatriate position to be replaced as soon as possible by a national staff. And I think very strongly also it came out that the national staff is extremely willing to be involved in a supervisory position. And I think as well that there is a big commitment to be more involved quite quickly in the life of the association. I mean, we had a very good mobilisation for our second field certificates, I can say that probably 85% of the teams were there. So we are about 90 or 100 at the moment. So it was really a good mobilisation.
There is a lot of concern as well, I think, from the team side about the future, they know that MSF is not here to stay forever. They know that we are, you know, as much as this is a longer term project than maybe a classic emergency project, this is still something that raises concern as far as the evolution of people in the organisation and what happens when MSF goes. So I think there is also a sentiment that MSF should be involved in preparing actively for the building of some kind of structure at national level and I think when we speak of hand-overs tomorrow of the HIV Project that raises the question of what role for MSF in building those patient associations and building, you know, maybe local NGOs as well in this context.

Hermann, I don't know if you want to -

**CHAIRPERSON:** Thanks very much for reporting at such notice. We have a volunteer at the back.

**PATRICIA:** Hello, everybody, my name is Patricia, I'm a Zimbabwean in Lesotho. Those who were there yesterday know what that means, okay. Yesterday we had lively discussions on the projects that are taking place in South Africa, we had Lesotho, Musina, Jo'burg, and it was quite lovely. And Khayelitsha, sorry, sorry, guys. We had a lively debate on the closure of projects. We talked about the exit strategies being implemented from the start. We didn't want to have exit strategies like at the end of the project, two months before we close the project, so that whoever is left to take over will know what happens.

And then this was especially discussed on the chronic emergencies like in HIV care.

And we also discussed on national staff issues and it was agreed that the national staff also need to be involved in management issues. For example, somebody gave an example that if I come from Zimbabwe and I'm an expat and I go to Lesotho, since I'm a Sotho, and I go and talk to the Lesotho Government, it's easier for somebody who is Sotho to talk to the Sothos, who is a national star, than for me, a Zimbabwean or an Australian like me, to talk about Lesotho, okay.

And we debated also on the medical responsibilities of MSF being in highly mobile
teams, for example, in Musina, and it was a high debate issue.

Thank you very much.

**CHAIRPERSON:** Thank you very much. Do we have any other volunteers from - yes?

**PHILLIP:** Ja, I'm Phillip, from Zimbabwe. We had a debate and it was quite sensitive, discussing about hand-over / take-over of local projects. It's like it was something people were not prepared for but we had to go through it and discuss it. Ideally people said there is need for preparation on our patients so that they know that there will be one day a hand-over / take-over or a closure to a project, so that it will not come as a surprise to them.

Also the staff, both national and expats, should be also prepared and also our associates, those who we will be working with, they should know if ever there will be something like that.

It was also pointed out that there should be a suitable partner so that whenever this hand-over / take-over is to be done, then it should be done to a suitable partner. If no suitable partner, then there's no hand-over or there is no closure of projects.

It was also suggested that there should be a hand-over, maybe a closure policy for MSF, and these policies should be implemented at the beginning of the project. There was a call for integration, to integrate with the locals so that on hand-over / take-over it will be easy.

Also there was a motion which was passed in our discussion that MSF South Africa should become a delegate office so that we will be able to report closer, rather than to go where we say for MSF Belgium, to go to Brussels.

Thank you.

**CHAIRPERSON:** Thank you very much. So we don't all have to report back but it somehow seems a shame if we didn't hear anything from Mozambique. Anyone willing?
No? Perhaps if any - because we also have the hand-over debate tomorrow, so we don't need to hear about everyone's discussions on hand-over. But if there are any other motions that were passed that would be interesting to hear about, then maybe if anyone wants to tell us about them, one's about delegate status for South Africa.

CECILE: I'm Cecile, I'm working in Maputo in Mozambique with MSF Belgium. So our General Assembly was actually with MSF Belgium and MSF Suisse, all the projects from Mozambique, we were gathered on different topics. I participated in one so I can report from my experience, I would say. So I know there were two motions, one was on the hand-over too, so the same kind of remarks that it's difficult to define what is a suitable partner, when to hand-over and what are the problems; there was a nice debate.

And I think the other one was more general but I don't remember. I remember it was an old motion that we put back, so there was no debate on it and it was approved. Maybe you can comment.

MOZAMBIQUE: I'm ... from Mozambique. So the second option was relating to the condition to be members and we were asked to avoid any discrimination in that condition to be members.

CHAIRPERSON: Any other motions anyone would like to tell us about? If not, I'm going to move on from this session of the reporting back from the FAD and ask Melanie to tell us how to behave. So I think we should start by giving Melanie a big round of applause for having organised this General Assembly.

MS WILSON: Okay, hello, I'm Melanie. I wanted to introduce the staff to you so that if you have certain queries what we've done is we've broken them down and if you want certain things, to know certain things. But they're all on the third floor having their supper so I won't be able to do that now. I think we'll try and fit it in, in the morning, just for during the day so that you know where you need to be and that type of thing.

In your registration pack you'll find a pamphlet from a jazz café called Nsako. I just want to take mine and then show you, I hope it's there, it should be, ja, this one here. Okay,
everybody's most welcome to go to this jazz café this evening. There is an entrance fee of R60 for your own account but what we can do, is we can organise transport for you there and back. Okay, he's having a Zimbabwean guitar player there called Louis Mhlanga, I'm sure everybody knows him, he's very good, he'll be live at this jazz bar tonight. So anybody interested, there will be some transport leaving the hotel at 9.30 and returning again at 12.30, no later.

Is there anybody interested, can I - anybody? If you're interested in going just raise your hand and then I can do the transport, you know. So we're basically looking at about ten people, one more, okay. Okay, so the transport will be there at 9.30 and he'll drop you guys and then he'll pick you up again at 12.30, alright. Everybody okay with that? Okay, right. That's that.

And then I just wanted to talk about for a couple of minutes, about this alphabet you've got in your registration pack, that just basically indicates the group, the discussion groups you'll be joining tomorrow and you will see on your programme. Please, everything, all the floors are clearly marked and all the floors are mentioned in your program, so please read your programme constantly.

(HOUSEKEEPING ANNOUNCEMENTS)

**CHAIRPERSON:** If anyone has any admin questions, Melanie will be here for the next few hours and you can ask her.

**MS WILSON:** One more thing; you've collected your T-shirts at registration, please can everybody wear that for the photo session tomorrow.

**CHAIRPERSON:** Thanks very much, Melanie. So we now move straight onto the next item of the Agenda, which is the admission of new members and I will pass over to Elma to take on this slot.
ADMISSION OF NEW MEMBERS

DR DE VRIES: We are welcoming all of you who are here as new members. We will have the list of names tomorrow, so then we'll put the names up and you will all see who the new members are, so I'm sorry we don't have that list now.

What is next? Oh, okay. Then the next is the presentation of candidates for the Board and we'll call the Election Committee just now to explain how things are going to work.

The way the Board is put together is there are three to four members from OCB, nominated by OCB, and I think they must each say something about themselves just now and OCB nominates them. But then the ones we can vote for tomorrow are the ones that are elected by the General Assembly. And there are some people who have put their names forward, you've got a green card, you can look at the names on there. But it is also possible to now say I want to stand for election for the Board, so if there's anyone who suddenly realised that's what they want to do, it is still possible. So if we go through this list, we'll say some or we'll get the people to say something about themselves as well. But let's start with the OCB members. Jerome Obbereit, do you want to introduce yourself.

MR OBBEREIT: Hi, my name is Jerome Obbereit, I'm the Director of Operations in Brussels, and I've been involved with the South African initiative, initially then an entity in our branch office and we're sure much more in the future, since the beginning. In fact, since I first came as an operational co-ordinator to visit the programmes here and saw at the time the huge potential that the nation, the country had to offer MSF much further than just within South Africa.

So I have now been appointed by the OCB Board as one of the OCB representatives on the Board. And I'll be here, you'll hear plenty of me for the next two days because Sharon's managed to put me on a number of panels, so you'll get bored of my voice for sure.

DR DE VRIES: Fabienne de Leval, do you want to say something?
MS DE LEVAL: Hi, my name's Fabienne de Leval, I'm the Deputy General Director in MSF Brussels and the same as Jerome, I've been involved also in South Africa. But first as HR, I was more involved with HR, so I was in contact with (Penuel?) to begin with and then with Mmule now and more recently then with Sharon. So I've also been appointed by the OCB Board to be part of the South Africa Board. Thank you very much.

DR DE VRIES: Thank you. And then Dick van der Tak.

MR VAN DER TAK: Hi, everybody, good evening. My name is Dick van der Tak and I'd first of all like to thank everybody for welcoming me here, I come from a bit far. What to say to you? I've worked with MSF since 1994, I worked in the field for six years, then I went to Amsterdam Headquarters, I come from Holland, I'm Dutch, for two years and since 2003 I am the Director of MSF Hong Kong.

Like Jerome and Fabienne, it's maybe good to explain to you what I hope to contribute to MSF South Africa because I think always in terms of MSF Hong Kong, we're a little bit like a big brother of MSF South Africa. And what I mean with that is, that we are also a section or we are already a section, I should say, who are not in Europe and we try to bring a flavour from a non-European society, a non-western society inside MSF. That's not always easy but we hope in Hong Kong at least that we are increasingly successful in changing MSF from within and that the experience we have can also help South Africa to move forward in this battle.

I think I will see you guys at least once a year for the General Assembly but at least, I will come also at least twice a year to South Africa. This time because after this General Assembly the big meetings in Europe start, Head of Mission weeks and General Assembly members of Belgium and OCB gathering. But next time I very much hope to visit one of the projects in the region in South Africa, so I hope also to see you in the field. Thanks very much and looking forward to work with you. Cheers.

DR DE VRIES: Thank you. These OCB representatives are new. We had other OCB members of the Board and maybe they would like to take the opportunity to say
goodbye. Moses Massaquoi, do you want to say a word?

**DR MASSAQUOI:** Hi, I'm Moses Massaquoi, I'm currently the MSF Co-ordinator in Malawi and I've been serving on the MSF South African Board for the past two years. At this time I did tender in my resignation out of a heavy heart that after 18 years working for MSF I have to leave this time and merely because of family reasons. But I should say that it was a pleasure to work with fellow Board members. I will always remember all the discussions and deliberations and sometimes very difficult decisions had to be made. I would like to say here that I'm leaving MSF but as they have, MSF got deep down into my heart and I think by God's will I'll be back.

I hope the new incoming Board members will be able to take on the work as we've started and make sure that MSF South Africa becomes second to none in all of MSF. Thank you very much.

**DR DE VRIES:** And Søren Brix Christensen?

**MR CHRISTENSEN:** I'm Søren Brix, I'm the Chairman of MSF Denmark. I started off in South Africa in 2002, working in Khayelitsha. Remember, at that time there was a big discussion if we should go from 200 patients to 400 patients and it's so good to have been here, follow the people, the projects and the whole thing through the years and see how big it is. And how we really turned, not only the approach around in South Africa over the years but also bringing it to Europe to our other NGOs.

Just on the plane down here I had a big discussion with some of the then Church Aid and they're still in this prevention contra-treatment scheme. So we had a big discussion for a couple of hours. So that was really good.

But also I see, I know you're a bit frustrated here, you're only a branch office, you want to be more and I'm just saying be patient, you will be there. I'm confident with Moses that this the jewel of MSF, there's so much medical and so much power, civil power here that you really see it from the very start, you really feel this MSF spirit and I'm very confident that you will get there. You also just have to realise you're in a very complex maze of MSF where different people have different blocks and mean different things, so
you have to find your way but I'm sure you'll get there. Thank you.

**DR DE VRIES:** Thank you. Our other international member was Stefano Vajitho from Italy, he gave apologies, he can't be here but it was also wonderful to have him on the Board. And thank you very much to all the Board members who have served with us, we're very grateful for all your inputs.

For the new people, well, for these elections, the way the Articles of Association are written, the South African Board members have to be elected every year. So we've got some names here and the first one, Paul Tyler, is our Treasurer. Now we need somebody who knows about money on the Board, that is crucial. So Paul was actually co-opted onto the Board and we're happy to continue co-opting him, so you don't have to vote for him, he is going to be on the Board as our Treasurer because it is critical for a section 21 company to make sure we look after the finances very carefully.

Then the other people I'm going to call forward to say something about themselves. Andrew Bull?

**MR BULL:** Hi, I'm Andrew, I'm based at the University of Cape Town, my association with MSF goes back to the Khayelitsha Mission. I became involved in 2002, similar to Søren, I was inducted during some of those early days of the Khayelitsha Project. And it was a real privilege for me to be invited to be one of the South African members of the MSF Board for the last two years and also a real learning experience.

And my reason for agreeing to be nominated again is because I would like there to be some continuity. It's really been a building phase, as has been mentioned, in a very complex organisation, for those of us whose only experience of MSF was through the South African Mission. And it's been a time of growth and of learning about the movement and it's also been a time where we've spent a lot of time getting the basics in place in terms of the South African office. And I think it's important that the South African Board members are, even if not elected, at least available to provide that continuity. So I'm somebody who will take no offence if not elected to the next Board, I will stay associated with MSF irrespective. But I want it to be very clear that we are available to provide that continuity, if required.
DR DE VRIES: Thank you, Andrew. Prinitha Pillay is not here, she's in the field in Sierra Leone but she has written a letter of why she wants to be on the Board and Rachel will read that for us.

MS COHEN: Hello, everyone. I'm not quite as little or cute or medical as Prinitha but I just want everyone to hear what she wrote and it starts like this:

"To the General Assembly.
Since January 2006 I have been working with MSF, initially in an HIV/AIDS care and treatment programme in Lesotho as the medical focal point. I was recruited in South Africa by Dr Eric Goemaere and joined the Lesotho team as a regional South African staff. I expatriated and have to date undertaken field missions in India, South Sudan, North Sudan and then returned to Lesotho and South Africa Mission and am currently the Field Co-ordinator in Sierra Leone. I joined MSF to have the opportunity to contribute my clinical and analytical skills, as well as my passion and commitment to patients in other contexts in which MSF works but I have gained a lot too.

The principles and values of MSF tie very closely to those that inspired me to become a doctor. Those speak to alleviation of human suffering, protecting life and health and to restore and ensure deference for human beings and their basic human rights. I believe my personal background, professional experience and political history have enabled me to cultivate an astute sense of social responsibility and maturity. I have good exposure to all levels of medicine and have field experience in a wide range of settings.

My MSF experience is allowing me to develop a sound base of clinical knowledge, a vast array of practical surgical skills, as well as some insight into the many humanitarian dilemmas we face. In addition to wanting to contribute to other MSF projects in the field, I also feel I have something unique to contribute to MSF as an international organisation.

(Tape 2a)
I am a strong supporter of the establishment of an MSF section in South Africa. I
see clearly the value that MSF is bringing to medical and humanitarian challenges on the continent but I am also convinced that MSF will benefit deeply from greater ties with the medical, scientific and public health community, political analysts, media, intellectuals and activists in South Africa.

I intend to bring not only my experience as a South African doctor but also my experience as an MSF field worker to the enormous challenge of shaping a vibrant, relevant MSF entity rooted in South African society but intricately woven into the international MSF movement to meet the new challenges that medical humanitarian action faces. I'm willing to serve on the Board to help steer this enormous challenge.

Serendipitously, I was party to the initial drive to create MSF South Africa, when in December 2006 I accompanied the current DG, Sharon Ekambaram, to Brussels. I am so proud to see how much the office has accomplished over the two years, five months it's up and running. When I accompanied Sharon to the first MSFB Board to present the idea, I must admit I had no idea that what would actually actualise is the exact new flavour some visionaries back at La Manche had in mind.

When in Sierra Leone I received a Zimbabwe report, Beyond Cholera, witnessed the programme unit's immense strides it has made in evaluating the five MSF sections in Darfur from 2004 to 2008 and advocating to various key high level interlocutors, as well as hearing worthy praise about South African expatriates in the field. I am proud to be a part of this family. I confident that my commitment to patients, my context acumen, my curiosity, personal integrity, confidence, motivation and team spirit will allow me to be a valuable member of the MSF South Africa Board.

Yours faithfully,
Dr Prinitha Pillay."

DR DE VRIES: Wow, that's a hard act to follow. Hermann Reuter?

DR REUTER: I didn't know I had to write something. I'm Hermann Themba, I'm a
medical doctor, South African. When Eric first came to South Africa I think was the first national staff member of MSF in South Africa and I worked with MSF in South Africa for seven years, Khayelitsha and Lusikisiki, and I did a couple of visits to MSF Lesotho, not just personal ones, professional ones, and I've also visited some other MSF programmes in Malawi and Mozambique and Ethiopia.

I think my strengths are field experience, analytical kind of strategic planning for programmes, the programme design, and I've always played a strong role in advocacy, which I learnt way back in the political movement in South Africa but also in the Treatment Action Campaign, which I'm a founding member of. So MSF South Africa, I had many discussions with Eric Slobert who did the exploratory mission for MSF South Africa so I was kind of part of the process from the beginning. And as Prinitha, I think it's great what was achieved in the first two years.

I think for MSF South Africa the role, obviously to have an African section, I think it's very important, and to work towards establishing that in its full capacity. Also I think in MSF things have become a bit top heavy, head office is becoming too strong, too bureaucratic and I think having a small, new organisation can help and guard against that. Also I think that the témoignage, the speaking out that MSF does, I think it would be great to have service users speak on their own and not have MSF speak on their behalf and I think South Africa could add to that.

Ja, I think that's about it. So I'm making myself available as a candidate on the Board.

**DR DE VRIES:** Okay, I see my name is next on the list. You can give it to Wim so long. I've been the President of the Board for the past two years and it hasn't been an easy task. It was a new Board, we had to learn how to work together but I think we've come a long way. Ja, well, the things Prinitha has said, I think it's the things we all feel in our hearts, why we got involved with MSF is because we want to help, we want to be there for people who are vulnerable and who need help and that's why I'm involved with MSF. And also, as Andrew has said, in the interests of continuity I have agreed to be available again to serve on the Board, if I would be elected.

We've got two more people who were nominated to be on the Board. The one is Wim
Fransen, he can speak now, and then after him will be Ziad, who can also speak for himself.

**MR FRANSEN:** Hi, good evening. My name is Wim Fransen, I'm actually the Head of Mission for MSF OCB in Zimbabwe. In fact, I've been working in the humanitarian sector since 1992 and the last five years I've been working with MSF as the Head of Mission, first in Chad, in Indonesia and now in Zimbabwe. I have most of the time worked in African countries so when I came to Zimbabwe last year just before the elections I had a lot of contacts here with the office and since then I think we have building more and more contacts with them. And I think it's important to have a voice from the field to create a stronger MSF South Africa, not only in South Africa but I think also in the movement.

A lot of things have been said and I think we are all joining, with the same reasons for joining the MSF South Africa Board, which is good. So anyhow anybody you elect I think it will be very positive because they have all the same ideas. But I think it's very important that MSF South Africa becomes much more stronger within the movement. I think it is today the international offices who have the voting right in the international council, are almost all, except for Hong Kong, based in European countries. And it is not for nothing that this motion was passed in Zimbabwe for having more say and having really a presence from an African country in this international organisation. We can call ourselves an international organisation by really being international and being present on all these different continents and especially Africa, where the majority of our activities are.

So I really would like to contribute from my African experience from Zimbabwe to the Board and so I put myself also as a candidate. Thank you.

**MR EL-KHATIB:** Hi, everyone, my name is Ziad Khatib and originally I'm born in Lebanon and grew up in Lebanon, then I moved to Sweden. And the reason I am here in South Africa, I am here for my BSc studies in medical sciences. But I'm a previous expat with MSF, I've worked in South Sudan as a flying lab technician and when I went back to Sweden, it was a decision either I go to the Mission again or I start with my BSc and then after that I can join MSF again.
So I came here and the first time I knew about MSF South Africa was when Nathan was based at the NICD, National Institute for Communicable Disease here in Johannesburg and the project is at Chris Hani Baragwanath Hospital in Soweto. So Nathan was visiting the NICD to see how MSF South Africa and NICD can have a collaboration and that's how I started to know about the MSF South Africa office. And I had that contact, how we can have a liaison role on issues of lab support. So that's why I wanted to keep the contact with MSF because as Moses put it very nicely, that it stayed in my heart so I felt I can't give up easily to serve in South Africa on the MSF Board.

And for the last year I was serving as a co-opted Board member, which means I don't have voting power and I think in the last year I felt that I want to try again as a Board member and I was happy to hear today actually that I was nominated for this. So here I am, thanks.

**DR DE VRIES:** Voting is tomorrow, lunch time. So the explanation about the voting, is the Election Committee here?

**CHAIRPERSON:** Is that right, that Rebecca's going to explain the process or is that a surprise? Okay, so just remember that your - so maybe we do that tomorrow. Yes? And just remember that Ziad's also on the green form and it's not too late for others who are interested to try and get - oh, it is too late.

**MR VAN DER TAK:** I think it is the first time for MSF South Africa that there are real elections for Board members, but correct me if I'm wrong. And I think it would be very nice if the members have an opportunity to ask some questions to the candidates. So I don't know if that's planned in the programme but if not, I wonder if it's possible to open the opportunity for members who have questions to the potential Board members, if they can raise those questions.

**CHAIRPERSON:** Yes, I think that we think that's a great idea. Do we want to do that now or rather tomorrow morning? Now, okay. Tomorrow, tomorrow? We'll do it tomorrow, we'll find time for it in Agenda tomorrow, that's the decision. So we're going close this session with a good remark that actually I think we're in the luxury of having
more excellent candidates than we have places for, which is certainly not the luxury that every MSF Board has. But I think we’ve got some really, really strong candidates and whoever is eventually chosen we will end up with a very strong Board, I’m sure.

So thank you very much for your attention for that session and we will find time for some Q&A tomorrow morning. And now we’ll move onto the final part of the Agenda, which is the Moral Report from the President, which is in your packs.
Alright. I don't like making long speeches so this is hopefully not too long.

Exactly a year ago to the month we held our first General Assembly here when the xenophobic violence broke out in Alexandra and spread to other informal settlements in Gauteng. And I remember how the staff of the office here went to Alexandra that Saturday night, while everybody else was having a party they were in Alexandra. This operational intervention by MSF with an entity in the same location demonstrated in many ways the added value of MSF South Africa within this specific context.

The operational intervention has not solved the problem of the plight of Zimbabweans fleeing to South Africa but the operational presence informed the response by civil society in South Africa. This was only possible because of the fact that the MSF office is seen as a legitimate part of civil society in this region and for MSF South Africa this marked a decisive change from MSF being profiled as part of the AIDS lobby group because of the work in Khayelitsha, to a more informed understanding of MSF as an international medical humanitarian organisation.

Having been a part of this entity and as the Board of MSF South Africa we have struggled to merge the best traditions of what is South Africa with the clearly defined specifics of what is MSF. It continues to be a challenge that must be engaged with if the objective of setting up an office of MSF in the Southern most tip of Africa is to bring any added value to the movement. It makes the job that Nelson Mandela had in creating a rainbow nation look like a Sunday picnic.

MSF in South Africa can play a key role in Africa in terms of legitimacy and representivity. This can only be fully realised when the international movement and OCB in particular builds mechanisms that include MSF South Africa as a legitimate component of the movement and assists in building the capacity of the office to play this role.
Since the last gathering of this association, MSF South Africa has been formally recognised as a branch office by the IC. A steering committee has been established to facilitate strategic direction for both MSF South Africa and MSF in Brazil. We need to establish clear milestones in terms of the initial objectives to bring added value to the entire MSF movement. This is the challenge that is presented to the new leadership appointed to run OCB.

Another significant development since the last gathering was the review that was conducted and commissioned by OCB. Adrio did interviews with lots of people trying to document where MSF South Africa came from and how we understand where we want to go to. While this document was controversial in some respects, some valuable comments were made in the form of recommendations, which again cannot be implemented or taken on board unless OCB as a group leads this process - and I think Sharon will talk more about the review tomorrow.

Recruitment of medical staff from this region to support MSF operations has proven to be incredibly difficult and much more difficult than originally thought. If we look at some of the pictures that MSF has used before in promotional material, those pictures could easily have been taken somewhere in the South African public health sector rather than on what is traditionally seen as the MSF field and many medical staff in South Africa and Southern Africa already feel they serve vulnerable populations. And this will be the challenge to see that we can look at convincing medical people to work for MSF and not just to work for their own people in their own country.

My final comment will be on the building of the association. The last period has not seen any significant activity of the association outside of the GA held in May last year and the fact that there is no fulltime person employed to build and nurture the growth of the movement has been a factor. The Board has met three times in 2008 and had a second sitting during the day today in 2009.

The sum total of the Board sittings to date has been to ensure that the governance issues are in compliance with the legal requirements of a section 21 or not for profit organisation. This itself has been a massive job both for the Board and for the office but
there has also been brilliant input and discussion on operational issues within MSF at the various meetings of the Board.

The Board has also received activity reports from the Director and has engaged with the development of plans and commented on the budgeting activity and I would like to thank once again all the Board members who gave of their time and energy to do this hard work in the past two years. And a heartfelt thank you to Andrew, Moses, Stefano, Søren, Eric, Paul, Rachel, Prinitha, as well as Ziad and Ronel. And a big thank you to Sharon, Zoya and the office staff for all your support to the Board in the past year.

We need to debate on how to build this association so that we can benefit from the vibrant civil society in South Africa that's so often referred to.

In conclusion, I want to challenge the association to use this General Assembly, maybe we need to think about appointing a volunteer who will work with the Board and the office to look at building the association. I will further go and challenge the House to encourage those amongst us who have years of having worked with MSF and there are lots of those around, to bring concrete ideas on how to build an association that will encourage critical debate. We have to create an association that will tap into the best traditions of advocacy and lobbying in South Africa, combined with a movement which remains at the cutting edge of medical humanitarian operations.

Thank you.

Questions and Vote

CHAIRPERSON: As is standard procedure, we do have to vote for the passing of the report. But before we do that, does anyone have any questions or comments that they would like to make? Remember to tell us who you are.

VIVIAN: Hi, Vivian ... from OCB. I've only just had a few minutes to look at this, so my one question would be. Why is the information on page 29, the summary financials, why isn't that part of the audited financial statements? The last page, maybe Paul or the President can take this question.
CHAIRPERSON: Can I perhaps, we have the presentation of the financial report next, so maybe we think about that and answer it then. Is that okay? Does anyone else have any questions or comments? If not, can I ask you to raise your hand if you are in favour of passing the report of the President. Apparently you have to use your voting card because we worked hard to put them together.

Elma, your report is passed, thank you very much.

CHAIRPERSON: And now we move onto the Treasurer's Report and I understand that because Paul is not here, that Andrew will be presenting this. So if I may ask Andrew to come to the front. These also are in the packs of all members.
I'm reading a statement on behalf of Paul Tyler, the Treasurer but I'm not going to be in a position necessarily to respond to the questions that might follow.

"With regard to the General Assembly I would like the following short statement to be presented on my behalf.

I have been very glad to act in the role of Treasurer of the Board of MSF South Africa. It has been a privilege to work with my fellow Board members and with the staff of the organisation who give so much to the work of the organisation. They are skilled and passionate about what they do and so have given the organisation a great start on which we must now build. I'm sorry that I cannot be with you today due to prior commitments but trust that it will be a productive and memorable day.

We are very fortunate to have the financial support of the OCB, to which further generous funding has been added from certain companies and members of the general public, especially at the time of the xenophobic crisis.

The audited financial statements for the year ended 31st of December 2008 have been approved by the Board and are unqualified, apart from the standard qualification that non-profit organisations receive, regarding the fact that it is not possible to implement controls over grants and donations until they have been recorded in the accounting records.

The auditors have provided a management letter, which helps the organisation to improve its internal controls and this shows that great improvements have been made in 2008, for which much credit must go to Zoya and Zanele and to Helen Hamilton, who gives her time and expertise freely and generously. We are also grateful to the auditors, RSM Betty and Dickson, for their efficient work.
The audited statements confirm that the organisation is in a healthy financial position, holding just under R1 million in reserves due to under-spending against budget. The Board is committed to ensuring that the financial sustainability of the organisation is strengthened over time so as to ensure that the excellent work that has only just begun can strengthen and continue for as long as there is a need.

With best wishes,
Paul."

Questions and Vote

CHAIRPERSON: We're actually waiting for Zoya to come up, our Financial Manager, to come up and give us some support on any questions you may have for this report. But if in the meantime anyone does have any questions, you're welcome to raise them now. If not, then we just have the question that was raised after the President's Report and I suggest that Zoya answers that question directly to the person who raised it when she arrives and that we move on. But before we do that, we have to vote for the passing of the Financial Report. So can I once again see a show of yellow cards for who will pass the voting of the Financial Report.

Thank you very much, you may put your hands down now. And can people raise their hands if they want to oppose the report. Okay, then in that case I consider the report having been passed.

MS EKAMBARAM: Before we close, there are two items on the Agenda. One, Mpume wants to address the House but before she does, I need to take you through your pack. Number one, you have condoms, so whatever you do, you do it safely. Only two? Well, you can get more.

Audited financial statements, which we're sorry we gave you late but they are in your pack, the Moral Report.
Then a very important little document which we're very proud of, Welcome to South Africa. This has important information about logistics, who to contact, some points around tourism, a bit about the office, a little map, the Charter, which you all know, I presume. But most importantly, there are points around security and as far as possible we have tried to speak to everyone as you came into the organisation. Jonathan did a greet and introduction, Jonathan, over the back, thank you very much.

And so if you could read that but just to be aware that there are risks of being mugged and crime but at the same time we tell you about tourism and enjoying our country. And then you have a contact list, which is quite small but you could decipher telephone numbers of all staff so that if there are any problems you can call us, day or night, I'll hesitate to say. But if there are any issues, please feel free but this is really for you to keep and to read.

Then we have, we're very proud to produce an edition of Mamela which was put together by our new comms team, which we will speak to you about tomorrow and we'd like you to read that. And in it there's our fundraising initiative, we'd like you to fill out forms if you want to contribute towards our fundraising initiative in South Africa.

An article by Dr Eric Goemaere, some of you may know him, on what makes the humanitarian crisis forgotten. It was a speech that he delivered when we launched the Diploma in Humanitarian Affairs Programme that we're organising, you'll hear about tomorrow.

And, what else is there? Very importantly, an evaluation form and we'd like you to fill this out and please return to us but I'm sure Rebecca may be able to tell you more about this. But it's just to get a sense of how we've done and where we can improve and if you could make sure that you fill it out anonymously or you could sign your name and be as honest as possible and send it back to us. When you know who the staff are, you can give it to anyone of us.

Thank you very much.

CHAIRPERSON: So, as Sharon said, we understand that Sis Mpume has something
to say. While we're waiting, we have one quick point, which is don't forget your yellow cards tomorrow because if you leave them at home you won't be able to vote, and the green ones. Okay, Mpume.

**MPUME:** Hello, good evening, everybody. I'm sure with Rachel and Sharon, if my name is not somewhere in the programme I should be dragged to be in the programme. Okay, last year, we were here last year having our General Assembly and it was the time of xenophobia and we couldn't just keep quiet and hold a meeting while people were marching. So we went out and we joined the march and I just want to say thank you to the spirit of MSF because at least this year we are here again.

And from the Khayelitsha group we have just tried even to be song writers within no time and we would love everybody to join us in a song that really will unite us all and say never give up:

"You must *never* give up, *never* give up,  
*oh, never, never* give up,  
*oh, never, never, never, never, never, never, never, never, never* give up,  
*you must never* give up,  
*oh, never give up, oh, never, never give up,  
never, oh, never, never, never, never, never, never, never give up.  
*In times of sorrow, in times of sorrow you never, never give up,  
Never, oh, never, never, never, never, never, never, never, never give up.*

*In times of xenophobia, in times of xeno you never, never give up,  
Never, oh, never, never, never, never, never, never, never, never, never give up.*  
… *(mother tongue)*

*Viva, MSF, Viva.*"

**RESPONSE:** Viva!

**MPUME:** Viva, MSF, viva!

**RESPONSE:** Viva!

**MPUME:** Amandla!

**RESPONSE:** Awetu!
CHAIRPERSON:  Thanks, everyone, for your attention and we'll see you at eight o'clock tomorrow morning.

END OF SESSION
SATURDAY 23 MAY 2009

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CHAIRPERSON: NATHAN FORD
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(Tape 3a)

CHAIRPERSON: Good morning, everyone. Okay, not everyone is here but we're going to have to make a start because we have a very busy day and we have some extra items on the Agenda to try and fit in as well.

So what we're going to do this morning is we're going to run through the Agenda as it's written, so we have a session on Diminishing Space for Humanitarian Action and then some group discussions and then we have a second session on hand-overs and some group discussions. But we're going to hope to gain a bit of time this morning so that at 12.30 before the break, Rebecca will come up and present the electoral process and then the candidates for the Board will come up and we'll have a question and answer session for them, just before lunch. So then you can reflect on what you've heard and make your choices and then come back and vote after lunch. I hope that's okay with everybody.

Yesterday there were three of us up here and someone mentioned that we didn't introduce ourselves, so sorry about that. Elma introduced herself, I think. The other person was Sharon who's the Director of MSF South Africa and I'm Nathan, the Head of the Medical Unit for MSF South Africa and I will continue by going straight into this morning session by presenting Jerome Obbereit, who's the Director of Operations in Brussels.

Over to you, Jerome.
Okay, well, good morning, everyone. This morning the first session is talking about the Diminishing Space for Humanitarian Action. Now, for MSF OCB or MSF in general it's been a very difficult year over the last particular six months and I just want to start with a particular thought towards the two colleagues that we lost in Pakistan, which actually exemplifies I think the difficulty that we have in working in areas. Riaz Ahmad and Nasar Ali were two very committed MSF. On the 1st of February they left Mingora in what at the time was probably one of the most under-reported humanitarian crises in the Swat Valley of Pakistan, where tens of thousands of people had been displaced. Thousands of people had been referred through the ambulance service for life saving conditions and they were gunned down on their way to picking up some wounded.

So I'd just like to have a few thoughts for both these very young, 24 and 27 year old, MSF’ers that were extremely committed and doing actually what is one of the founding kind of humanitarian actions, ambulance service in a war zone.

Now, unfortunately it doesn't stop in Pakistan and Asia has seen a fair amount of diminished space and not conflict areas but China - and Dick is here and he might want to say a few words later, has also seen the withdrawal of MSF OCB. And I think some big questioning for the remaining section, MSF France, in terms of what operational space there is and in fact the MDR Project which MSF OCB had built and discussed with the local authorities in Inner Mongolia for the past two years finally led to nothing and a decision to actually withdraw from China. And the RDTB is probably the most under or the most acute and under-served disease in and biggest killer in China. And it was really a very strong blow to MSF to actually find that there was absolutely no space to develop anything, despite the very strong openness that we had from the local authorities and the clear needs on the ground expressed by the medical services, we in the end got completely blocked at national level.

Also further in Asia is Indonesia and Wim is here as well and I think, Wim, maybe if you
have comments later on also the very reduced space that we had. In the end, we left Indonesia and the only area of action that was accepted by the authorities was actually to work on epidemics. Beyond epidemics, anything linked or anything closely touching violence, political upheaval and all this was clearly a no-go for MSF. Now in an area like Indonesia, which had a good response capacity for epidemics, also national catastrophes, really the added value of MSF was questioned and in the end - although far from being a zone or an area where we felt that there was no more role for MSF in the future, in the end we decided that the space was not enough and certainly the role that was given to MSF was too limited.

In Europe we also find that, we've had huge challenges in Russia. Although the needs in Russia have been diminishing, we've also seen that the Georgian crisis didn't materialise for us with an inability and a complete blockage to go across the border and actually go into the conflict zones of Georgia. And we find that also the asylum seekers' projects are extremely difficult and in places like Italy we've had to leave Lampedusa due to the again restrictions from the authorities. In Malta we found strong difficulties in actually being able to act and respond to needs in front of us in a coherent manner.

But obviously the area where we've had the most difficulties over the past year have been Africa. If I go through the list of areas where MSF has had to really curtail its operations, it goes from the well covered, the Darfur situation with the expulsion of a high number of NGOs, including two MSF sections. But the expulsion already came on the back already of very limited and reduced space due to administrative conflicts, security issues and finally the expulsion.

Ethiopia has also been an area where we've found the increasing blockages over the past year and MSF Geneva decided in the end to actually leave Ethiopia due to the inability to develop coherent operations in the Ogaden Region. The Ogaden Region is the ethnic Somali area of Ethiopia, which is a very large chunk of the country where MSF in general has had strong problems in actually expanding operations and being able to assess freely around the Ogaden Region and there have been strong discussions between the various OCs. And in the end Geneva said enough is enough and we do not find the operational space for the Ogaden Region, therefore we don't think it's legitimate for us to develop other activities in Ethiopia where we're not able to
go where we feel the needs are the most acute.

This had led to a number of debates and I think it's not a finished debate now, it's something that still goes on and has been expanded really towards more than just the Ogaden Region. We saw last year the huge nutrition needs in the Oromia Region and there was a big deployment of OCB and OC Paris to actually respond to the nutritional crisis.

This year we are finding indicators that are coming through which are extremely worrying but again MSF has been completely blocked this year by the authorities to actually undertake assessments. So this again questions the operational space, the capacity to actually go where we feel the needs are, as opposed to where the authorities actually accept us to go. There's also the question that when there are acute needs that we can access, quite often there are a lot of other agencies which are able to access those needs. So the pertinence of MSF is something that we really have to question.

We also know that in the Ogaden Region ICRC has been completely blocked and actually unable and formally denied the access to the Ogaden of Ethiopia.

Now Somalia is again another area where conflict activities have been very difficult, here not due to any administrative blockages but just due to the high insecurity. Since the tragic loss of our colleagues last year from MSF Holland we have decided not to put permanent international staff on the ground. So the projects are being run by our national colleagues with punctual visits from international staff, which as we saw just a month ago led, the insecurity led to the kidnapping of two of our colleagues and fortunately the good resolution. So again, Somalia shows that the high insecurity, the conflict leads to our inability to maintain a permanent presence on the ground by international staff.

This leads to a lot of questions in terms of what kind of pressure is being put on the national staff, how far they can actually run coherent programmes, also knowing that since the early 90s there's no infrastructure, there's no education, there are no medical schools running. So most of the medical staff that Somalis, the majority of them are actually informal medical staff, trained on the job by MSF and there are only just a few
very precious staff that have had formal training.

Now again in Africa the reduced space has also been seen in other activities and not just conflict. I’ve mentioned Ethiopia with the nutrition but Niger was also a big example, where the, let's say actions of MSF France, which really brought new operational strategies to answer to malnutrition, acute malnutrition and actually highlighted the problem of what was going on in Niger very strongly over the past year, led in the end to a very tense relationship with the government and finally their expulsion.

In Burkina this year we've been wanting to go into vaccinate, one of the biggest measles outbreaks that we've seen in the country and again full blockages by the authorities who want to control everything, who want to see MSF as a donor but not an actor on the ground, who doesn't want to actually have the - not only the independent action showing they can't respond completely to the situation but also the témoignage that will go along with it. They also want to control all the resources going into the country.

We've seen also the problems of being able to do decentralisation in Mozambique, which has been a challenge. We've seen also some of the issues, there are migrants in South Africa, the issue of being able to find the space to provide the assistance as we want to towards the Zimbabwean migrants has been an issue around not only finding them but also accepting that there was a cholera outbreak. This took time, we found the space eventually but again it was a challenge.

So this is just to say that the difficulties have been high, I think particularly high over the past 12 months and there are a lot of questions that need to be asked. But then the question comes to, is it radically different to the past years? I think we have to remember that in the 80s we decided to leave Ethiopia because of the manipulation and the inability actually to answer towards the needs as we wanted to.

Then in North Sudan in ’89 MSF OCB and Paris and Amsterdam decided to suspend all operations. This was again due to high insecurity. There was a plane that was shot down going from the north to the south and culminating with a lot of blockages that just didn't allow a coherent response to the acute needs that we found in Southern Sudan. So this was what led to actually a different operational strategy of going towards Kenya
and doing cross border operations from Kenya. This was not just MSF, this was a
general issue and this led to the UN operation of Operation Lifeline Sudan, which was
the biggest cross border operation that was developed in I think the history of
humanitarian aid.

So not new, also in Somalia the tragic loss of Ricardo, one of the doctors in '97 in
Baidoa, led to the withdrawal of the French section. And I think we have to remember
that over the past years we've had complete failures of developing operations in Korea,
North Korea, in Eritrea and although China has culminated in what we're seeing today, I
think China has always been a very difficult area for MSF to actually find coherent
action.

So the question is, what could be making the space smaller, if it is indeed smaller and
what has changed in the environment to actually lead to this culmination of
complications over the past year? Well, clearly, we're in a much more globalised
environment, where today there's a lot of scrutiny being placed on any action that takes
place anywhere around the world. 10/15 years ago you could probably go to a forgotten
corner of the world, it would take quite a long time before the visibility of that crisis came
forward. Today the media environment has completely changed and the weight of MSF
presence is scrutinised, is followed and the smallest of let's say emergencies or crises is
actually getting a lot of visibility. We saw this with the Mt Elgon Project last year, which
was actually a small crisis but the capacity of MSF to actually highlight it, bring it to the
forefront, was actually very high.

There's also the globalised judicial environment with the ICC and the fact that, as we've
seen in Sudan today, the reach of the ICC is going further and further. This is a clear
let's say fear that a lot of the conflicts that countries have, that information will get out, it
will go to the ICC. That MSF may be sharing, although it's very clear that MSF has no
link with the ICC and has made it clear to the ICC and to all governments.

Unfortunately, this is happening also within an environment where there's increasingly
mixed mandates of organisations. Organisations that are blurring the line between the
very pure humanitarian action, which is first and foremost about providing assistance to
populations in need and about witnessing what we see and not about collecting
information to provide to human rights agencies and so on and so forth.

In my personal experience of NGOs in Darfur in 2004, they were going in with a humanitarian mandate but were clearly stating that we're here to collect information, we're here to provide information about the crisis, it's the best way we can solve things. Now it's not a surprise that five years down the road that the Sudanese Government then actually clamps down on NGOs and actually says, well, you know, there's a lot of responsibility behind the indictment of our President and so on and so forth. So the mixed mandates of organisations is clearly not helping us.

Now we also have to be very careful within MSF with this increased, well, with the ICC and so on, we have to be very careful about the temoignage. I think we have to remember that a few years back we would have been quite happy to actually share information with certain actors, human actors, actors linked to courts and so on, which today we cannot do. So it's not just about the environment changing but it's also about MSF having to adapt to this changing environment and there's a lot of issues that we still have to be careful about, in particular in our temoignage and our report writing.

In 2005 with a very strong report that was written MSF Holland on rape in Darfur and one of the conclusions was a call for the end of impunity. Now how far does that go in actually calling for international justice? There's a thin line between the two and I think MSF has to be very careful in its temoignage within this evolving environment.

Now also sometimes we may be our own enemy in terms of blocking ourselves out of certain situations due to our standards, our approach, our technical standards and quite often we refuse to actually act when we are not able to deploy what we feel is the correct response. And I think there we have to also be quite careful because we can actually do things illegally, sometimes we can actually bring a change through action, through example and I think South Africa in 2001 really showed this with the start of treatment on ARVs. It came in through the backdoor, it was a very clear action in terms of breaking the rules and not compromising on technical standards. On the other hand, we didn't wait for the green light or legislation to allow us to do this.

So are we today less apt and less ready to act illegally in certain countries? Of course,
this is a very difficult choice and this is a choice that is not only the organisation's choice but it's also the individual choice of the people who are going to take this illegal action within a country to ensure that proper treatment gets to the victims that we're trying to reach. And this act of defiance is really something that we need to maintain in MSF as we grow and ensure that the kind of legitimacy of MSF, the kind of scrutiny of MSF still allows us to be nimble enough, intelligent enough and flexible enough to actually confront what we feel is the right thing for our patients.

Clearly, what's also changed is the integrated approach of humanitarian response where we see now the kind of big state building solution, along with humanitarian solution, along with peace building solution being under one umbrella and being under one often political leadership of the Security Council of the United Nations. Now this has led again to a blurring of lines, in an environment where we see that humanitarian aid is increasingly be used as a force multiplier for some of the main belligerents in a conflict, such as Afghanistan, such as Sudan, where we are being dragged in and being seen as part of the bringing the better world, bringing the better solution.

And again we have to completely detach ourselves from this and be independent from this integrated approach, which is not easy. And I think we have to also be careful that being independent and not integrated doesn't mean breaking away from all contacts or all discussion. On the contrary, as soon as we break away from common co-ordination mechanisms, as soon as we break away from the forms of integrated approach that have been developed by the UN and so on, we need to reinforce our bilateral contacts with the various actors. Breaking away from talking to the Americans or to the NATO troops and forces in Afghanistan would be the same as breaking away from having a relationship with the Talibans or other insurgents in the region. We need to talk to them but we need to talk on a bilateral basis and make it clear to them that we engage with them as we would engage with any belligerents within a conflict.

Now also what we're finding is, quite surprisingly over the past year I've found that in a certain context, be it Darfur or be it the Gaza situation in Palestine, the lack of formalised and recognised mandates of MSF internationally because our mandate is what we define it to be and it's not any set in stone international mandate that's recognised by any state, leads to a - the fact that we're just a NGO and nothing more.
Unlike ICRC in the UN that have a formal mandate, that have a right to actually be in countries that have a very clear relationship with governments, we don't.

I have found that this fear of being expelled, this fear of actually speaking out or actually moving into areas because of the consequences that that could bring on other projects is something that has made MSF very timid sometimes to actually take a voice or act. Now I found also that ICRC and the UN surprisingly have been more vocal than MSF in certain of these key crises. And I think that's again something that we have to look at, to recognise and again potentially the fear of reduced operational space in Zimbabwe was one of the key reasons why MSF didn't speak out more strongly over the past years. But when we did speak out, when we did bring out the report of Beyond Cholera, in fact there were not repercussions and I think that's also something that we have to learn about and again have the guts to actually sometimes confront what we're seeing and put it out there publicly and live the consequences but obviously in a manner that has to be judged properly.

So what can we do about all this and how can we redirect ourselves to adapt to this growing environment? I think you have in your folder the paper that Eric wrote for I think the inauguration of the training course that was done jointly with the Liverpool Humanitarian Action, that was done jointly with the Liverpool School, where he talks clearly, in a very clear manner about independence, impartiality and neutrality. Now these are key elements that we really have to reinforce and our core values have to be reinforced and I think the independence side is the one that's the most difficult to actually put forward.

We are very much seen as a Western organisation, we have our country names after Medecins Sans Frontieres, Belgium, France, Holland, that doesn't help, it really - I mean, in places like Somalia where we've been present since the beginning of the conflict, I remember going back there a few years ago, where we've really been ramming down the throats of all our colleagues, our counterparts, local authorities, who we are, what we do. The fact that we're independent, after having a meeting with some local authorities and elders, they said, oh, when you go back to your country please thank your governments for the help they're providing.
So it's again this, we can't realise how we are seen as this big machine with this big logo, with these flags. I mean, also the flag planting is very much of a nation state approach to going to places and that independence has to be fought for and thought through constantly, in particular within conflict settings and in particular for more political actors.

But this means also, outside conflict settings I think it's very important that the association of our logo doesn't systematically go with others, we have to very careful about this and I think this is also something that we have to be careful about within stable settings. Because things are being seen, it's going on our website, so you know, the association of logo is something that doesn't help the fight to actually promote our independence in areas where it really makes a difference in terms of our ability to access populations.

Now there's another issue I think that's been raised here and discussed is staffing and how do we, I think yesterday it was the Swaziland Programme saying that as soon as we can replace international staff we should do so by a national staff. But again here we have to be careful about what we mean by staffing. Quite clearly some of the successes that we've had in a country like Somalia, which I'll talk about later this afternoon, has been about ensuring that national staff are put in key positions of responsibility and decision making.

Now it doesn't mean that then underneath them there are only national staff, it means that they may be actually managing and they were managing clearly international staff. So again it's how do we build the programmes, how do we build the roles, the complementarity between what is international and what is national staff, that is something that we've really got to work on. But the ability to actually discuss with people, to understand the environment in which we are working, to accept that in an environment like Darfur or like Pakistan or Afghanistan, the perception of how we do things is going to be a lot of what allows us to gain operational space or not. It means that we have to really involve our staff in key decision making positions, in key positions of responsibility.

The medical identity is also something that we've had to maintain. We can see that
that's the most acute need and it's the one issue that is understood and accepted by all sides of the conflict. Quite clearly, again, in the kind of asymmetrical warfare that we're seeing, the opposition groups to the government or the insurgents are often not very visible. What we can bring them is, as humanitarian agencies, is very difficult. Quite often if you provide camps, well then it plays in the favour of the government where people are treated properly and so on.

The one thing they do understand and the communities as well, which often have links with the insurgents, is the need for health and is the need for basic healthcare. Not just for the fighters and obviously that's an important part of it but also for the vulnerable populations, for mothers, for children and so on. So as MSF we are in a very privileged position of being very focused with our operational mandate and I think this focus has to remain in particular within conflict settings.

And also in parallel to this medical identity to ensure that we remain a humanitarian actor, not just in conflict settings but overall and that we do not become embedded with, as a technical actor, the technical implementer with technical assistance programmes for governments. That's not our role, we have to be ready to confront, to break the law, as I've mentioned before, in the interests of the populations that we've trying to serve. But we are not an organisation that does technical assistance, we are there not to replace, not to substitute for governments, we are there to actually push them towards their responsibility, to fill the gap and to drag them to fill their responsibilities, in particular within stable settings.

Communication is also an area where we've been in many respects failing to be impartial in what we do. When we look at where our communication is going today and you look at the MSF website, we talk about the classic big emergencies of the Congo, we talk about the HIV programmes, we talk about Niger but we've failed over the past years to actually highlight the crisis of Pakistan, to highlight what's going on in Darfur, to have the MSF voice come out on what we've seen in Gaza. And this is due to the fear that communication will actually reduce our operational space, due to the fear of how this communication will be taken.

But I think there we really have to look ourselves and when going to Pakistan people
say, well, when I look at your website there's not much about us, about what we're seeing. And I think this is again something that we have to not just communicate about what's easy and safe to communicate about but bring into proportion what's difficult and a challenge to communicate about. And again this will open a broader understanding about what we are about, what we do and that we're not just in the countries where it's easy and safe to work, we are actually fighting to actually assist and promote the situation of the population in actually much more extreme situations.

Also the networking is an issue where we've, I think a few years back I was talking, when we had a Mission Week, saying we have a lot to learn from some of the HIV programmes on how we network that we could apply for the conflict settings. It's obviously easy to say because quite often within the stable HIV settings you will have a much more, you also have let's say a social fabric that will allow you to use civil society to push things forward like we did in South Africa or like we're trying to do in the other settings. It's much more difficult to do so in conflict areas where the social fabric has broken down.

However, I do see that MSF has to move beyond the networking with the usual suspects, the UN, the international NGOs, and really ensure that we have much more grassroots networks with academics, with civil society actors and so on, which are much more difficult to reach, which are often underground as well within a conflict area or oppressive states. But again, this is an area where MSF has usually, the way we work, the way we have a high rotation in conflict settings doesn't really allow for this. So one of the decisions that we took for Afghanistan is that the Head of Mission there would commit for at least two years, to again ensure that we can build these kind of networks, this kind of understanding. Here as well the national staff will be key to allow us to actually build this kind of network.

So yes, I mean, in stable settings clearly I think the ability to open operational space, to allow us to act, to defy governments when they've actually said, no, you cannot use this or, no, it will not work, has been about this link and this mobilisation of civil society behind the fight that we've tried to take on. I think on this side South Africa has been an example and it's certainly something that we still look at and try to learn from to adapt to other humanitarian situations.
Now I just want to conclude by saying that a lot of our ability to go beyond and enable our operational space to be broadened will be by creating a formal Without Borders association, a formal Without Borders movement and I think this is very much what was behind the thoughts of investing in and creating MSF South Africa. And I'd just like to open now the floor and have a discussion on what the thoughts are that this association could bring in terms of perception, independence in terms of opening the space that humanitarian action can have beyond the stable settings but in particular within some of the conflict areas that we find ourselves in today. Thank you.

Discussion

CHAIRPERSON: Thanks very much, Jerome. So following his invitation, if anyone has any questions or comments or ideas, the floor is yours. At the front, please, thanks, and don't forget to introduce yourself.

GEORGE: My name is George. I'd like to ask on the humanitarian assistance diploma that is being introduced, what qualifies a national staff member to be one of the students in this programme?

CHAIRPERSON: I think that's rather a question for Bridget and it's a bit, maybe a bit out of this debate but Bridget, could you answer very, very quickly and then if you want more information, you can talk perhaps afterwards, in the break.

BRIDGET: Ja, it is a bit out of the discussion, I hope it's okay. Just to say a few words about the diploma in humanitarian assistance, it's an intensive six-week training programme for humanitarian workers in emergency relief and development and it's taking place in South Africa in July and August. The criteria is, you need a university degree and/or significant field experience, so it's a fairly high level training programme. But if you have a lot of field experience you don't necessarily have to have a university degree and you need to apply as soon as possible.

CHAIRPERSON: Perhaps, Bridget, you can be available in the lunch break if anyone has any questions about the course.
BRIDGET: Ja, sure.

MR OBBEREIT: What I'll do is I'll answer the question. Actually I was going to throw that question to Hermann, so maybe I'll do that as you've got the microphone, I'll put a question to you. As a Board member of MSF South Africa and I think we're investing a lot, we're putting a lot of energy into it, what do you think MSF South Africa can bring or the role of MSF South Africa can be in the future to actually open and fight for this humanitarian space?

DR REUTER: Ja, I'm Hermann, working in Swaziland at the moment for MSF. Jerome, thank you for your input. I think that this diminished space that you were talking about, I always see MSF with two kind of branches. The one is looking at the emergency activities and the other one is looking at infectious diseases, TB/HIV long-term projects. And I think you were more referring to that first aspect of MSF work. And I think the diminished space might actually be a result of MSF's success in - you know, I don't, I mean, you looked at the diminished or the space that was there in the 80s and that there is now.

But I think the crises in the 80s were more acute than they are now and I think like government actors were less prepared in the 80s to deal with them. Like speaking about Ethiopia, when there was famine in Ethiopia in the 70s and in the 80s, the government didn't know how to respond, nobody responded and there were no NGOs responding. If there's a hint of a famine in Ethiopia now, then you've got ten players who are interested to respond. And I think the government now has got much more capacity to respond and perhaps their need at the moment is finance and not expats who come and sort out the problem. I'm speaking a bit provocatively but I just want to make a point. Often local players now are better equipped, better educated and can actually address these problems and I think in Asia this might be very much the issue.

Another issue, like I said, in many countries now in Africa HIV and the infectious diseases that go along with it are perhaps bigger killers, so to say, than the humanitarian crises. And, you know, I sense sometimes that MSF is saying, oh, we have done enough in HIV, we've shown that it can be done, now we can move out, we
don't have a responsibility anymore. And I think MSF seriously has to think how do we, you know, we were used to short-term interventions but HIV is going to stay with us for the next 50 years. So what remains MSF’s goal in this increasing or continuing crisis of HIV?

Then I think there are new emergencies and crises that MSF doesn't deal with. In many countries in Africa road deaths, road traffic accidents make up a high, high proportion of deaths amongst young people and I don't think MSF has got a single programme that looks at this and perhaps you should investigate this. You know, can we build up model programmes how governments or how communities can respond to road traffic accidents on a medical basis and on a preventative basis.

So I'm just throwing out ideas. I'm not answering your question about MSF South Africa’s role but perhaps that role is to take away, you know, I mean, at the moment MSF South Africa is seen as a counter to other MSF sections who have also linked to a country nation state. And perhaps you need to get away from this vision of an MSF office representing a country but perhaps it's MSF representing humanitarian needs in a globalised world and we need to take away all those nationalistic feelings about which office one belongs to.

MR OBBEREIT: Ja, okay. Well, I completely agree with your last comment, Hermann. To go back to, if I step back one by one, I think the road traffic accidents, MSF has never been an organisation that actually responded purely on indicators. If we did purely go on indicators of let's say mortality, yes, we would be actually running traffic schools and we would actually be running alcohol prevention programmes in Russia. But that's not what we've defined as our core role, it's not what we've defined as our added value as a medical organisation or as a humanitarian organisation. I don't think that MSF has an added value in research capacity that it's built over the years and the mandate that we've given ourselves in conflicts or in the mandate that we've developed within epidemics, within acute medical situations, our medical know-how and so on would have a huge added value for road traffic accidents or for alcoholism.

Now in terms of diminished space and greater capacity of government to react, yes, a given, Ethiopia has a lot more capacity today. But I think in the '80s there were NGOs
that were trying to actually respond to the needs of the famine and actually as MSF did in those days, we highlighted the fact that the famine was being created by the government. That the displacements were creating a lot of the famine and the deaths that we were seeing in the '80s.

(Tape 4a)
Now this is obviously something that the Ethiopian Government remembers. But also it's not just about having the ability to respond but it's also about government choosing who they will respond towards and I think today if you look at Ethiopia there's been a clear choice by the Ethiopian Government not to invest, not to respond or not to allow agencies to respond in the Ogaden Region. Now this is something that is unacceptable to an organisation like MSF where our impartiality should be leading us to the populations with the greatest need, with the greatest neglect.

So while I can accept that a government like Ethiopia has more capacity, I think their choices are actually something that we have to fight against and the forgotten crisis of the Ogaden is something that MSF has a key role and a key role that unfortunately cannot be fulfilled at this stage due to the complete restrictions that are being imposed on us.

In terms of where we find the successes, China is again a reduced space, it's again, I think, something similar to what we see in Ethiopia but for different reasons. The Chinese Government initially chose not to deal with HIV, have chosen not to deal with MDR the way they should be dealing with it, the way they could be dealing with it. And as MSF, an organisation with the know-how, again, of how to tackle MDR, how to tackle HIV, I think it is our role to actually confront this. And I think, not being able to confront this is again a failure of the Aid system to be able to go where we should be able to go.

CHAIRPERSON: I just want to say something quickly about road traffic accidents. It’s an interesting one to pick because the WHO defines it as a form of violence and it does so because there’s a direct link between a society of inequality and structural disorganisation and mortality from road traffic accidents. MSF does have a project where it responds largely to road traffic accidents in Nigeria, where we have a trauma programme in Port Harcourt where we are trying to be there to respond to victims of violence but most of the people who come into the A&E ward are victims of road traffic
accidents.

I think this is going to be a topic that is raised during the coordination days in Brussels, that often when we want to be in conflict areas and we want to set up trauma responses in those areas, the burden of disease we’re dealing with is not gunshot wounds and other violent events but things like caesarean sections and other needs. So that’s also a question of when we get into the settings we want to be in, what diseases and morbidities do we respond to and what ones do we think are not our business.

Sharon?

**MS EKAMBARAM:** It’s Sharon from MSF South Africa. Hermann, your point around national states having the capacity to respond, I think aside from the point that Jerome made about biased provision of services, if you look at South Africa, for example, and dealing with the Zimbabwean migrants, when we were challenging the UNHCR, its response was, we respect the sovereignty of the state. And I think that’s the other side of the challenge that MSF has in going into these countries where there is no approach to vulnerability irrespective of which side of the fence you’re on.

I think that goes back to the first point, which I agree on, that the nature of the conflict has changed. The humanitarian law that provided a framework, the international humanitarian law that provided a framework during clear conflict situations, war situations in the Cold War, that space has been taken away, the right of MSF to intervene. And I think that’s what makes - in the days of communism and imperialism, MSF as a western organisation, being neutral, gave it its credibility. You don’t have that situation anymore.

And I think we need to be - in South Africa, for example, we use the Constitution as our legal framework in terms of our intervention. A very good example was the raid on the church and how MSF worked with legal actors in the country. But I think that expats coming in, international staff coming in have been formatted to almost sectarianism about how to work with other role players, while keeping your independence, while ensuring that you don’t sign every petition, while respecting your key focus.
I think that’s an area that we do need to work on, whether it’s training, whether it’s what our PPDs are offering in terms of the networking that you spoke about. But also, I don’t think that we’re using the power as an international movement and that’s the point about the national structures. The fight against HIV was a very good example against the pharmaceutical industry. It was an international campaign that MSF played a critical role in, kept its independence but we mobilised internationally against the pharmaceutical companies.

We can do the same with mobile populations. We have examples in Europe, we have examples in the East, it’s an increasing problem in Africa and I don’t see MSF integrating its work with where it’s working in different parts of the world. And we’re still working in very isolated five OCs and it’s becoming more and more with borders instead of without borders.

**MR FRANSEN:** Yes, Wim from Zimbabwe. First I wanted to add one or highlight maybe a few points on what you said. I think one of the other points that made this crisis a bit more complicated is the multiplication of the number of NGOs and I think that has really increased a lot in the last 20 years. Knowing that I won’t put a percentage on it but probably more than, I don’t know, 90-ish% is completely donor driven, is completely, 100% depending on donors.

And there you have an indirect link with the donors and the push of the donors and the donor manipulation because they have indeed, like you also highlighted, their own agenda. But they also push that through to the other NGOs, which makes all these fancy logos of all these 1 000 different NGOs difficult to make the difference between MSF and the other NGO and I think that is definitely something which is also important in this crisis today.

And then I can’t answer for the MSF South Africa Board but I can give one idea in this particular context of what I would be expecting, being in Zimbabwe. I think it is an African view on Africa. You mentioned it yourself, we have to go back to the grassroots levels and not only the UN and the international organisations or NGOs. And I think, having that link with an African view from Africa, you see already also how the Zimbabwean Government reacts in the whole context. They will not listen to the UK or to
anybody else.

But with SADC and with Mbeki, there are links, there are - okay, not a lot but there is some respect and there have been some negotiations that lead to some improvements. Okay, they’re all limited, let’s be very careful with the improvements but I think that is really important. And that is what you said about grassroots; that is something that we have here and that we don’t have in Europe. And it’s the same probably for other contexts like Afghanistan and Pakistan, where I think it’s important to have that grassroots level, that other contact, that view of the Islamic world, of the other Islamic countries. It’s the same for Africa here. Thank you.

CHAIRPERSON: Eric.

DR GOEMAERE: Yes, I’m Eric, a dissident from MSF South Africa. That’s why I have a different T-shirt, I’m the left branch. Thanks, Jerome, for a very interesting presentation. There was a lot of food for thought. It gave me almost a headache. It’s difficult to swallow but it’s extremely interesting. And apart from being really interesting, the fact that you extended - I thought you would speak about Somalia, Darfur but you went up to Mozambique, reduce humanitarian space, which inevitably raised the question, hey guys from Mozambique here, yesterday we were cheering there. What did you do? Oh, are you vocal about this? That’s the question to the floor and it brings me to what I want to say here.

I think one of the key words beyond what you said there is the question of legitimacy. Who are we, thinks the Government of South Africa or thinks the Government of Ethiopia, to be that little pain in the butt. You know, that little thing that stings, that comes and says, zzzzz, you’re not doing the thing properly. Right? And we have no mandate, as you said. We have no mandate, so who are we to do that thing? And we have discovered a modus operandi, as we call it here in South Africa, to recuperate on the legitimacy, which is to network and to build a coalition with citizens who claim the Constitution to say, no, it’s a right, as you said, Sharon.

There’s a question to you; do you think, seriously, this kind of network can apply and how do you transform it for conflict areas, the other part, as Hermann said, of what MSF
is doing? That’s a question to you. And a bit of a piece of publicity here. The publicity is for Paula who is sitting over there. Why so? Because, while it’s very interesting; when you spoke about Mbeki and SADC, and while Jonathan was in Addis exploring the AU and the organogram, and I think he got almost lost there with people hardly interested; well, some politely speaking to him but nothing else - exploring the top-down approach, Paula at the same time was launching an email to say Manto has been appointed as the representative for Mother and Child Health, Manto Tshabalala.

So are we going to now go and speak to Manto Tshabalala because she’s appointed there? So Paula presents - and she will lead one of the groups later on - the grassroots approach, the bottom-up approach, the top-down approach. And I think that’s exactly what we’d like to explore with MSF Southern Africa, not South Africa, is how much this bottom-up approach will change a little bit our relation to the member states in Africa.

You remember - that’s for the one who followed everything - a guy, former MSF, whom you might have heard of, Bernard Kouchner. Have you heard that name? He’s one of the founders and we are a bit on difficult terms with him because he’s a minister but not only because he’s a minister but because he wrote one day: "The right of Interference: In the name of humanitarian aid we have the right to interfere in the nation state’s affairs."

Actually this kind of right does not exist. The only ones who used it ever were the Americans in Iraq, under this famous right. So how much is the top-down and the bottom-up approach? We are not for the right of intervention but how much does the civil society exist and how much did we do, each of us in our own countries, to fight this reduction of humanitarian space? Thank you.

MR OBBEREIT: Okay, maybe I’ll try and answer a few questions or reply to some of the comments. I think it’s absolutely right, as you say, that the use of the South African Constitution has provided a framework and that South Africa’s probably quite exceptional for that because there is an exceptional constitution that allows for this to happen. So your question, Eric, is how can we apply this to more extreme environments?
I think we do apply it in various ways. I mean, we can see again that in the Mt Elgon example of Kenya, it was basically through putting pressure through civil society, through the media - the Kenyan media, not the international media - that there was a level of recognition of the problem, that it became an issue for the government, that it couldn’t just be this forgotten crisis, even within Kenya, to be dealt with.

So it’s again the traditional public speaking out, temoignage, which traditionally in MSF has been done internationally, that sometimes actually works a lot better when you tackle things nationally because often the crisis in which we work, even conflict settings, have now emerging governments, have got emerging constitutions and so on that hold out a lot better, they’re a lot more able. Therefore you have to be able to challenge them through the civil society and often, if it’s not through the networks that you’ve done here, it can just be through direct temoignage within the country that this can work.

Now if you go to more extreme environments, because again this might work in Pakistan, it could potentially work to a certain extent in a place like Afghanistan but obviously when you go to a place like Somalia, which has no government, which has no, let’s say, national civil society fabric, it becomes a lot more complicated. But I think in those environments, again what we have to do and carry on work on doing is working at the lower level. That means that you work through operational communication with the local community.

I mean, if we can ensure our security in a place like Galgaduud in Somalia or the Bakool Region, it is through actually communicating, making the Committee understand what we bring to them, what their rights are if they fight towards the ... elders in terms of health care and so on, we saw a good example, and I’ll probably talk about it this afternoon, on Somalia, on how the community really mobilised behind MSF for the kidnapping and how they were actually the resolution to freeing Jorgen and Kees.

I think there are some parallels there because there was a lot of work that was done by the Somalia coordination, by the Somalia team to do operational communication, to go and talk to women’s groups, to go and talk to village elders, to go and talk to religious elders about who MSF is, what we do, how we work, what we bring and so on. Of course, there was the other side of it, which is the colder side, that we bring a huge
amount of resources and salaries and so on into the region. But I think those two - I mean, the reaction of the Somali community behind MSF would not have worked if it had just been a kind of financial transaction and technical health transaction that we'd had with them.

Now the last point - I'm sure I'm not answering everything but on what Wim raised in terms of the NGO, unfortunately humanitarian aid and NGO is a concept that's seen in most countries as actually being contractors for governments, contractors, implementers for big donor countries that have other vested interests. And we maybe need to think about the use of humanitarian NGO for MSF, to detach ourselves. Do we have another label? What we've chosen to do in the Pakistan region is actually not call ourselves an NGO because NGOs usually have a connotation with Americans and with Christians. So we've decided to call ourselves in that region an independent medical organisation and that's how we present ourselves, that's how we discuss with people and so on. But unfortunately that's a reality that we have to face increasingly in a lot of areas.

**CHAIRPERSON:** Thanks, Jerome. There were a couple of people who had their hands up but I'm quite worried about the time and the need to get into the groups. So if you really want to speak, please go ahead, otherwise I'd quite like to move into the groups.

**DENMARK:** I'm from Denmark. I'm just wondering, this humanitarian space that is limited, are we not also limiting it for ourselves because I've seen over the years we've been slower in being vocal, we've been more afraid, more people have to go to press conferences, it takes them more time, reports are withdrawn hours before they are going to be released. We've seen we're not allowed to say anything. In a way it seems more top heavy than ever. It seems that we should go back to what we were; we were not afraid, we were more in the front of our shoes but now we are a bit on our heels. So it seems that we are limiting ourselves.

We've seen just in Sri Lanka, people are not allowed to say anything, they're not allowed to do fund raising but it seems we've also created an organisation now where it's easier to get forgiveness than to get permission. I think that's a dangerous road and I maybe would like you to answer how can we get away from this very heavy way of getting permission. It's so slow that we're actually losing the momentum that we once
MR OBBEREIT: I think it’s a very topical issue and it’s actually one of the main subjects that we’ll be discussing during our Mission Week, this issue of speaking out; who decides, where does it go and so on. I think there are a number of issues there. It’s not just headquarters, I think a lot of the fields which are in conflict settings themselves need to be pushed to speak out because they actually have the - they’re too close and they’re not really seeing the broader impact that it would have.

For example, not communicating on Gaza has an impact on our operations in Pakistan. Therefore there’s one section in Gaza but the voice that we carry there cannot be - it’s such an emblematic context it cannot be purely seen as the responsibility of the one section. Now in terms of processes, I mean, we can see in South Africa it’s quite easy. One section, we’ve been able to talk and actually come out quite quickly with messages. And I don’t think that here headquarters - tell me if I’m wrong, it’s a bit easy from where I’m sitting - has been a blockage in actually pushing for the voice or the message of what we’ve brought out in South Africa.

On the other hand, across the border, three sections. Three sections in Zimbabwe, nine months to come out with a report and I’m sure if there’d only been one section there, potentially it would have been a quicker and a harder voice. So those are questions that we have to ask ourselves and ask ourselves what are the mechanisms in between. I think one of the main problems that we have is that we give too much importance to ourselves. We find today that if MSF speaks out, we might be condemning people to God knows what - I might be a bit exaggerating there - but at the core of the next conflict because of how our voice is being heard.

And again, what word in all this is being lost in our broader messages, yet we put so much importance in our own voice and I think that’s then actually leading to too much self-criticism. We’ve got to be able to go back to a much more spontaneous, field-driven voice. Now I know what it’s like. For Somalia there’s so much discussion on what can we say, what can we not say that when you end up in front of the press, you just want to talk about Somalia - this is what we see, this is what we do - and then you have the don’ts. Don’t mention this, don’t do this.
Now we give this to our poor field coordinator who comes out of the field and is suddenly in front of Al Jazeera, CNN and BBC. They could just be talking about what they’ve seen but somehow we’ve briefed them to actually freeze themselves in their kind of public communication. So I do think there’s a lot to work on, I do think there’s - it might be because there are a number of sections, because of the fact that there are fewer conflicts, it’s very different to the ’80s. So the convergence or the movement towards a much more coherent approach is potentially also a convergence towards a complete clash in terms of how do we approach these situations. And this is something that we really need to look at.

COMMENT: Thanks, Jerome. I’m a member of MSF South Africa and MSF Sweden. Speaking about communication, I agree with Wim, there are many organisations today but what makes MSF unique is the temoignage and the communication, I see them as the same. In the last few weeks or the last two months, how much the media was talking about the swine flu, that was really ridiculous compared to how many people are dying from TB, for example. Are we lacking here some innovation in MSF on how we can spread out the message? Is it that we need to learn more from journalism how to really reach people more? Thank you.

MR OBBEREIT: Borrie, do you want to answer that, from an outside perspective?

MR LA GRANGE: Ja, like Jonathan said, I’ve been here for a week. Just the last half an hour listening to what Jerome has said, what Eric has said, it’s an interesting sort of head space. Until two weeks ago I was still a journalist and I was phoning up Rachel, asking for comment about this, that and whatnot. South Africa’s in a very sort of unique position on the continent and also in terms of the politics that we live and how we relate to one another.

I had a question, though, about how do we pick who we want to work with if we want to network with national or local actors because in our decisions in delivering services and picking the people that we want to work with, don’t we then also exclude others and what criteria do we use? So it becomes more complex, in my mind. And in terms of what Ziad said about maybe learning from journalists, ja, sometimes I think we do need to
check too many boxes. I’ve only been here for a week so I might be talking out of turn but can’t it be simpler, really?

It’s an awesome movement. The defining elements of this is that you want to help people and that no matter which section you work for, which country you come from, essentially you want to fix people and you want to facilitate that. So maybe at least in our office we can try and sort of cut down the red tape. I don’t know whether I’m setting myself up for a pitfall later but I think a good point is that it is probably easier to ask for forgiveness than permission, so let’s butt our heads.

CHAIRPERSON: Thanks very much. Jonathan’s desperate to ask or comment on something and this really will be the last comment and then we’re going to the groups. Jonathan.

MR WHITTALL: Thank you. I just wanted to follow up on one of the points around communications and the fact that sometimes when we’re not speaking out. You used the example of Gaza and the implications for Pakistan. I think there’s also the example of Darfur; that has implications for - well, it’s interesting to see how, when we do speak out, the way we speak out and the implications that that has as well.

In the example of Darfur, I found it interesting that MSF was expelled because we were seen as a proxy of a western organisation or western governments essentially. We were seen as linked with the French Government, seen as linked with the Dutch Government and yet the way we spoke out was to - the first OpEd we produced was in the New York Times. When we spoke on Al Jazeera, we used the Director of the French - we had a French person speaking on Al Jazeera.

When we engaged and decided to engage with the African Union, with the Arab League, we sent letters to both organisations through the ambassadors in Geneva and in New York. So I mean, these are just some examples of how we’re identifying the problems and we know what the problems are internally, and yet we continue to make the same mistakes and we become our own worst enemy and perpetuate this image. I think that’s linked into the role that MSF South Africa can play, hopefully, moving forward.
CHAIRPERSON: Thanks for that comment. We’re going straight into the groups now. The groups are on the eighth floor.

MALAWI: I have a question.

CHAIRPERSON: Okay, and this is the last one.

MALAWI: I’m Lois from Malawi. Mine is a general question. I wanted to ask whether MSF activities have been affected - that is, worldwide - due to the global economic crisis, that is, in terms of donors.

MR OBBEREIT: I can’t really answer in detail your question because my colleague, the Financial Director of OCB would be better placed. But I think globally there has been some impact but the impact hasn’t been a huge impact. So there’s been some reduction in some of the incomes that some of the big sections have seen but we cannot say that MSF today is in a crisis situation itself. I mean, we still have a fairly healthy financial base but we are aware that we’re going into troubled waters.

I think that’s where it’s important, to ensure what we’ve talked about, the identity, the perception of MSF, moving beyond the borders that we’ve created ourselves between each section and all this is also about being more rational and efficient with our resources. And that’s something that we really have to move towards, every percentage saved at MSF today or in the OCB is a million Euros, so we’re not talking about a little money. I think that’s very important for all of us in the operations and in the field to see how we can share and minimise duplication between sections. That’s very clear.

CHAIRPERSON: Can we go to the groups now? Okay, so the way it works is you will have a letter but it should be a number - so A is 1, B is 2, C is 3 - and on the programme you see there are three groups; Group 1, Rachel Cohen, Group 2, Paula, and Group 3, Jonathan. All the group discussions are on the eighth floor. Don’t be shy about using the stairs; it’s only nine floors down.

Can I ask the leaders of the groups, we have to be back in this room at quarter past eleven, so whatever you do with the discussion and the tea break and getting up and
down in the lifts, we need to be seated at quarter past eleven. So thanks for doing your best to keep us to time.

DELEGATES MOVE INTO GROUP DISCUSSIONS
FEEDBACK FROM GROUP DISCUSSIONS

CHAIRPERSON: We are now looking to have feedback from the three groups, so is someone from Group 1 nominated to provide feedback? If so, could they take the microphone.

GROUP ONE:
ROLE OF MSF SA: REPRESENTIVITY AND LEGITIMACY

GEORGE: It’s still morning. I wanted to say good afternoon. But anyway, we are in Group A and we were responding to the representivity and the legitimacy. We started by trying to put down how MSF is perceived in its different operations in the world. Mostly, if we take, for instance, MSF Africa or MSF South Africa - we would want to call it MSF Africa as it is going to be, the first and maybe the main branch in Africa.

So we have put down that MSF sometimes, where it gets into conflict with the government, it is because it is being perceived as a western organisation which is trying to impose the wishes of the western countries.

We have also realised that MSF is being taken as a French organisation and that becomes again a question of those countries which were being colonised by the French. So they take it as an organisation which is representing the French and would like also to push for the French to take over again. That’s what some people say. Sometimes they take it as an organisation that exposes the dirt the government will be doing, so it is perceived as an exposing organisation.

Sometimes it is also perceived as an organisation that comes with donations, as a donor organisation. And in, for instance, Malawi, it has been said that it is an organisation that substitutes the government. And some, and how we all like it to be perceived, as being a life-saver. As I can put it, I can say that it has become broader than being doctors without borders but has become life-savers without borders in that it is not only looking at the medical part of it but has been involved in a lot of humanitarian assistance since its inception. So being a life-saver - because of its ability to stretch its arm beyond its
founding mandate, this has brought us to being perceived as a life-saver.

Then in some areas it is not perceived at all and there are several reasons for it not to be perceived at all. This is what we have come up with on how it is perceived. And also we noted that its legitimacy goes with how it is perceived.

Then we can also have some more contributions from the group to add onto what we were talking about.

**MS EKAMBARAM:** Just one point I want to make is, the most powerful point made by Aymeric is that MSF, because of the French, it's seen as western imperialist in nature, South Africa is more and more playing a similar role in the region and on the continent and so that mix, we need to be very cautious about how we position this organisation in South Africa and its profile, not to feed into the same agenda.

**MR OBBEREIT:** I think, just to enforce this point, it’s also important to note that there’s an Africa initiative which is also ongoing out of Nairobi. I’m not too sure how strong the links are between the MSF South Africa association and the Africa initiative in Nairobi, which is made up of actually, I think, over 100 people from the region and mainly Africans who have had strong field experience with MSF in all the different sections. So I think it’s also important, if you want to broaden that kind of debate of the legitimacy of the role of MSF South Africa, to make sure you don’t forget that group.

**MS COHEN:** There was just one interesting point, building on what Jonathan said at the end of the discussion this morning, that in response to the expulsions from Sudan, we took a quite, I would say, western, European approach to our public communication with a white French doctor in Geneva doing a little video that was broadcast all over the web, explaining why MSF was extremely upset and we had nothing to do with the International Criminal Court and so forth and letters sent to Geneva and New York without engagement with, for example, the AU.

And there were some feelings in the group that it might have been something interesting to try to either provoke neighbouring countries with more influence over Sudan or MSF representatives or beneficiaries even to be speaking about what it meant for them that
MSF was expelled; that we recognise that that might put people at an unreasonable risk, especially in Sudan, in Darfur. But as a principle, to think more about when we think about representivity and legitimacy, not just to go to the standard MSF spokespeople who are very often western, white and based in Europe.

**GEORGE:** Anymore contributions from the group?

(Tape 5a)

**COMMENT:** I just wanted to expand on two points there. I think there’s a point of perception on the issue of MSF being taken as a donor and also like an organisation which has come, for example, to take over some of the activities which are supposed to be done by the government. This is happening in so many African countries. For example, I’ll give you an example in our country. Our project is like in two categories. You have got a team working in the hospital setup and we’ve got some working, for example, in the rural areas. We call them health centres.

The problem is normally not the people you are working with. These people understand you as like any other medical person. They will not differentiate whether you are from government or from an organisation because they will find that MSF staff are always there on a daily basis for them. But now sometimes the problem comes with the administrators and maybe fellow, maybe co-workers. Your presence to them, it means they can be easily roaming around. They know there’ll be somebody who’ll be working for them.

It’s the same with the supply of things, whatsoever. Government gives money to each and every hospital and whatsoever but the first thing, when there is a problem, there is a shortage, what do people go for first? They go for MSF. So in those scenarios it’s like people completely abandon their responsibilities, be they administrators or health workers. It’s like they think MSF, you are there to relieve them or to take care - they don’t take you as partners, as it should be.

And also, secondly, on the issue of people may be viewing us as people who have come to relay crucial information maybe to outside governments, this normally we discuss; it depends from government to government. In a stable government, MSF normally doesn’t have these problems but in certain governments whereby you have got
evil things or bad things happening, normally we are viewed as people who like to relay bad information about a particular government, even though each and every government has got its own things to hide. But there are certain things which need to be hidden. So when they see an MSF organisation, they feel you are there to take out the information.

And also we questioned the issue that as much as we need to be independent and neutral, there’s an issue, for example, where you are on the ground and here comes maybe a photograph or a video; this is an MSF flag there, so it’s like sometimes MSF will not send us as a witness. You’re out of the ground, you write a report to the desk, you include what was happening on the ground. Information will never be hidden forever. You find the organisation looking for that information and they think it’s MSF having that information.

But when they come to us or government comes to us for that information, we say, no, we cannot stand as witnesses. So we also felt this is also another challenge because whenever you are saying no, I cannot be a witness, I cannot supply this information, they think you are taking sides. So that’s why we also discussed that maybe up to that extent, we also need to review our art of communication and also the issue of independence and neutrality.

CAROLINE: I’m Caroline from MSF South Africa. In our group, Group A, we also found out that in as much as the problems that we encounter working with the government and the people, they differ from country to country. Because in some countries the government is very cooperative to work with the non-governmental organisations but in other countries, like in Zimbabwe, for instance, I worked there and the government was saying there’s no cholera and the next morning we had 8 dead, just one night.

So I was seeing this as something that varies from one country to another. Some governments are very cooperative to work with non-governmental organisations and other governments are so resistant. So we could not actually find what exactly it was but we think it varies from one country to another. Thank you.

CHAIRPERSON: Can we move on? Thank you very much. So Paula’s group, who is
going to be reporting from the second group? Ziad.

**GROUP TWO:**
**THINK TANKS AND CIVIL SOCIETY POTENTIAL IN SOUTHERN AFRICA**

**MR KHATIB:** The group was supposed to discuss think tanks and civil society potential in Southern Africa. I tried my best to make a summary and at the end, if anyone of the group wants to add more, please do that.

We spoke about rich and poor NGO settings in Southern Africa. Each country has a different setting and a different number of organisations operating there. And the other point was the issue of channelling information vertically and horizontally, how to do it. So let’s go to the details.

When it comes to the issue of collaborating with other people on the ground, first the patients need to be involved and here there was the example of having patients advocating collaboration with MSF Denmark. This can be replicated, maybe, to learn from it when it comes to the effect of TB drugs on death levels. So patients need to be involved. Although maybe they’re not an organisation on their own but we are there to serve them.

And also as MSF we start taking initiatives and we start projects where other people don’t go. We do temoignage, and also we lobby for policy change. But also we cannot be everywhere and we don’t stay forever, so we have our own limitations. So how do we collaborate with other organisations without jeopardising our own independence? And here independence has been mentioned a lot, so I put like four underlines below ‘independence’, that that’s a very important point.

Another point was the collaboration with other organisations either to share information, to know what's happening in other settings, in other places, especially when there are acute situations - for example, in South Africa the xenophobic attacks - to know how to reach underground populations. And also when we cannot do temoignage, maybe we can share the information with other organisations, that they can lobby for this.

There was a point on creating demand, so maybe Sharon can explain more about it
because I put a question mark there.

There were two resolutions. The first one was that at every GA, to invite Access Campaign representatives because that’s one way of sharing information horizontally with other people.

And the second one, decentralised decision making, so no need to send information to headquarters first before acting on the ground, so to make it a down-top approach.

And here I want to invite the other group members, if they want to pitch in any information I have missed or I misunderstood. Paula?

**MS AKUGIZIBWE:** Thanks, Ziad. I just wanted to expand a bit on the independence thing because, like Ziad said, that was something that was discussed quite extensively, especially when we talk about - I mean, we started off by discussing why should MSF engage with civil society? What are the benefits that come out of this?

Advocacy obviously was listed as one of the major values that civil society can add to MSF’s work and whether it’s advocacy on access to medicines or advocacy when MSF has developed programmes that really work and then needs to leave, that exit strategy, where governments may not be willing or ready to come in and take over the work and as a result, people will be left in the lurch. So putting that pressure on governments and that needs to come from civil society, from the community. So in terms of the long-term impact and sustainability of MSF projects, it’s valuable to have that civil society voice on the ground.

In terms of translating good practice into broader public health practice, where you have MSF projects that are doing really good work based in countries that are doing a really bad job, how do you link those two together? How do you actually make it meaningful to the broader public health agenda? So I think we all agree that it’s really important to have that advocacy function but at the same time, MSF has certain limitations in terms of how much advocacy it can do because of this issue of independence and what does independence mean.
So we had some discussions about that and I think, from a civil society perspective, what I raised in the group is that it’s not - in a region like Southern Africa, where we know what the health systems are like here, we know how linked health systems are with politics and with governance issues, it’s not really a realistic approach to have projects that work in complete independence or isolation from the broader context. For implementing the project it’s not realistic and for the long-term sustainability of the project as well.

But it’s possible to maintain political independence and not compromise that, while at the same time making some clear-cut statements, using the information that MSF has access to that civil society often struggles to get access to. Like Sharon-Ann mentioned, we were at a meeting a couple of weeks ago with activists from around the region and a lot of them just unable to get information on coverage figures in the countries and budgets. That’s the kind of information that MSF would have access to that would be valuable for advocacy.

And also, as far as the access to the Access Campaign goes, which Ziad mentioned, in addition to the resolution that we should have people from the Access Campaign present at general assemblies, there’s also a recommendation that there needs to be these people present in each country project, who can then actively reach out to civil society and engage them to help push the advocacy forward.

I think one more important point to add is that of education and empowerment. In the region outside of South Africa, there are very few strong civil society groups, so in terms of reaching out to civil society, it might not always be an obvious thing. There might not always be a group that stands out as being active and strong but we need to find ways of identifying either like ARASA, for example, it’s an organisation that works with small groups in countries to help build up its advocacy movements.

So perhaps the same sort of energy that’s gone into developing a strategy for engagement with the African Union should also be invested into developing a strategy for how we can identify these groups and help to build that up because we’re not going to find ready-made civil society solutions. It’s something that MSF needs to do together with groups like ARASA, groups like TAC, other groups that are already building up
capacity in the region. Do you want to add something?

**MS LYNCH:** If I can just add - I’m Sharonann Lynch, I’m based in Cape Town, working with MSF South Africa in Lesotho. Eric made a good point, which was the need to find the balance between autonomy and independence and where that can blur into arrogance if we find ourselves in sort of an ivory tower where we’re not reaching out to others.

And the reason that the Access Campaign came up so much is because we’re talking about the way that the Campaign used to work, whereby country representatives were working in Uganda and Kenya and South Africa and Thailand, and certainly there were benefits. What Jonathan said before we broke, and I heard the first group allude to it as well, in terms of we’re working on issues that affect this region via Europe. And for me, it doesn’t make sense for MSF only to be talking to ministers of health in Geneva while in Geneva, without us reaching out to civil society groups that are being affected by contact DRTB, which is what we were advocating upon right then and there.

In terms of demand, I think it’s pretty clear but to generate demand through literacy efforts, working with civil society groups in-country and not just at the international level. Thanks.

**CHAIRPERSON:** There are two hands up but we’re going to have to move on shortly.

**DR REUTER:** I just wanted to add to Sharonann’s input. Hermann from Swaziland. The effectiveness of the Access Campaign; I mean, we discussed it. It used to be very effective and somehow it died away and that we need to have an internal kind of review as to why the Access Campaign lost its momentum.

But one of its issues was that the Access Campaign worked across the sections and information about access to HIV medication spread very quickly between Zimbabwe and Mozambique because it didn’t have to go to head office and come back and go up and down. And we said that as the Access Campaign should be revitalised to have that role, but also the office in South Africa should be tasked to fulfil this role to share information between the different projects in the region.
MS COHEN: I just had a question for the group and maybe for you, Paula, but anybody from the group. I think the ways in which MSF can and does and should engage more with civil society on access to HIV treatment and health systems and so forth is actually rather straightforward. So I’m interested to know if - and I agree with everything that’s been said, completely.

I was wondering if there was any discussion in your group about how, if there are any innovative ways of engaging with civil society or sort of non-state actors in more kind of classical or complex humanitarian emergencies, conflict settings, especially where MSF is facing enormous problems to access populations and to have the kind of humanitarian space that Jerome spoke to us about this morning. Because I think that’s a far more difficult question, actually, and I just wanted to know if there was some discussion about those types of contacts and not only the HIV and chronic disease ones.

MS AKUGIZIBWE: There was a bit of discussion but unfortunately not much resolution because I think - Eric raised Zimbabwe as an example. I think it’s an area where civil society, to be honest, is also quite weak and perhaps this is one of the things where we should be putting our heads together and figuring out how we move forward with that. You know, Zimbabwe has come up repeatedly in advocacy discussions for years now, not just with us but with other organisations, but no one really has a clear idea of how we go about changing the situation, using civil society groups on the ground.

But my response when that question was raised was that, ja, we need to discuss it more and perhaps the knowledge of MSF Missions on the ground in terms of the political situation, the groups that we could work with and reach out to could be very valuable in helping to figure out a way forward. But that in itself is another area where there needs to be that dialogue between MSF and civil society, where it could be valuable. But no clear answers, sorry.

MS EKAMBARAM: I think that’s one area for a resolution or a motion, to engage more with Access and explore how we could - because the South African office hasn’t been doing that and it’s very obvious that that’s one of the things that we should do. So, ja,
just to ask whether that’s something that we could possibly put forward as a motion.

**CHAIRPERSON:** I think the way Hermann put it was interesting, that when we talk about the Access Campaign, which is largely about medicines and diagnostics and vaccines, what we mean here is broader than that. It’s about networking with cross-sections, with a multi-disciplinary team of people who can help solve complicated problems.

We’re not only talking about medicines but we’re talking about things like the HR crisis but how to develop that mobility to make quick decisions, analyse things in a comprehensive and meaningful way and actually influence policy in real time, bringing people together around an issue. Which isn’t a resolution either but I just thought I’d make it clear that for me it’s broader than just medicines.

We have to move on to the third group. Thank you very much for a very rich feedback from Group 2.

**GROUP THREE:**
**GOVERNMENT INTERLOCUTORS: SADC, PAP AND AU**

**CECILE:** Hello, Cecile from Mozambique. Group 3, the discussion was about should we make a link with the African Union as we are already speaking with the European Union, the UN and all those big machines? Should we try to implement something and should MSF South Africa try to implement something?

So we agreed that, yes, we should, but the way we should do it is still really unclear, so we raised a few issues. The problem is actually how, so make a balance between the African Union and the impact that we can have on governments, and the independence that MSF has, and raising of the civil society awareness and motivation. So it’s difficult.

We should actually support the two possibilities and not focus on one or the other. I think they are both - we thought they are both important. We should also realise that making a link with the African Union is whether we go for the Secretary, so the big responsible of the big machine and we try to see what we can do, or whether we go for the individuals in that association and try to make personal links to see how it’s going
and try to make -

We also said that making a link with the African Union could have an impact on global policies but it doesn’t mean that we will have an impact on the countries. There’s a difference between the policies and the reality of the country, so we should keep also the two levels, meaning the contact within the country and the contact with the regional area because we think that maybe the African Union is the big machine but the local regional area, like ECOWAS or SADC, are maybe better actors to speak with because they are actually taking decisions and going back to the African Union to discuss them. That is our vision and proposal.

We also discussed the vision of the African Union. We can make a parallel with MSF’s vision, meaning that the philosophy is actually to make a Pan African link to try to help people and find solutions within the country and without borders, actually. So we make a link between these two visions and philosophy. Okay, does anyone want to add something from the group?

**DR DE VRIES:** Hi, I’m Elma from South Africa. Just to expand on the last point; in the African Union, apparently they spend a lot of the time discussing a united states of Africa with this whole Pan Africanist idea and we said but MSF is about being without borders. We want to treat and help refugees who have crossed borders, so maybe there’s some synergy in what the African Union thinks and what MSF’s approach is. But, thanks, I think you’ve summed up our discussion well. Does anyone else from the group want to add?

**CHAIRPERSON:** Any questions to the group?

**MS AKUGIZIBWE:** Just to comment on the United States of Africa because that does occupy a huge amount of the AU’s agenda time but it’s not really a proposal that is actually going to become reality, I don’t think. I don’t think anyone thinks that it is. At the individual country level, countries haven’t really bought into it but the Head of the African Union, it’s his pet project and he gives lots of people lots of money, so he gets, to a certain extent, to influence the agenda. That’s just my feeling, so I just have reservations about the suggestion that there could be some good synergy there.
But I also have some reservations about the African Union in general. From a civil society point of view, I guess the only engagement that I really see being valuable with the African Union is just trying to make them accountable because they waste millions and millions of Dollars but they don't actually - they're pretty defunct. It's like a regional sort of gathering of nationally defunct ministries getting together and not really achieving anything programmatically.

I'm just not sure what value one would get by investing in this - in building up this long-term relationship with an organisation that's widely regarded as corrupt and inefficient and hasn't really achieved anything tangible for the region. I feel like attention would be better invested in focusing at the country level and that will ultimately feed back up to the African Union level. Those are just my thoughts.

CHAIRPERSON: Jonathan has the answer.

MR WHITTALL: No, I definitely don't have the answer but to add onto that, in our group discussion there was an acknowledgement around the ineffectiveness of the African Union as an institution and the need to distinguish between the AU as a policy-making machine, which is not trickling down to a country level, not necessarily being effective, and also the realisation that the AU, number one, is playing a role in the context where MSF is operating. So they're contributing peacekeeping troops in Somalia, they're involved in Darfur. And there are people within the AU - that's number two, who we need to be talking with.

Now I'm not saying any comment on the amount of resources or things that MSF should invest in but I think the feeling amongst our group when we were discussing was that that distinction needs to be made, that we need to be able to influence and have access to certain people within the AU, without trying to influence on a policy level, which will require extensive resources, which I think we all agreed they could be better placed having a complementary approach between the bottom-up civil society engagement and the kind of top-down engagement with AU.

And not only AU, we discussed SADC, ECOWAS and other regional groupings. So to
try and find that balance. It’s not an easy thing and that’s where the discussion of the group came out, that we don’t know exactly how this would look like and what the investment of time and energy and all of those points would be. That’s just to add and then if there’s anyone else in the group who wants to add on some more?

**COMMENT:** Just something that’s coming to my mind. We said we wouldn’t raise it because it should be raised by the first group but we should also know how we should address them, if it’s going to be MSF South Africa, MSF Southern Africa, MSF Africa. That was also a question. It’s anyway better than MSF France or Belgium or OCB, but that was also raised, that how are we going to present to them and that we should be clear because the feeling was not clear.

**CHAIRPERSON:** On the issue of how to engage with defunct groups that waste a lot of money but don’t have any responsibility, we could probably learn from our engagement with the G8 over the last decade because we’ve been learning those lessons painfully over the last decade. Jerome?

**MR OBBEREIT:** Ja, I think when we address anyone, it shouldn’t be MSF Africa. That would just be extending borders further. It’s MSF full stop and I think that’s the way we should be engaging, whether it’s in Europe and so on. Also I think we have to break the kind of vision that we’ve hugely engaged with the European Union. We don’t have anyone engaging on a permanent basis with the European Union at the Brussels office level and it’s an ad hoc thing that happens.

We’ve talked about how to engage with them but it’s not like we’re doing something in Europe that we’re not doing at all on this side. So I think sometimes it’s a bit of a myth on how much we’re engaging with European based institutions, which is not that much in fact. But I completely agree with what Paula and Jonathan have said; these are dysfunctional entities and we need to be very careful not to invest too much and become lobbyists that actually have very little impact at the end of the day. So we have to really be careful how much we invest in those kind of entities.

**CHAIRPERSON:** Last comment at the back. Okay, second to last comment at the back.
COMMENT: Mine is not necessarily a comment but it’s a question. I don’t know under which group it would fall but it’s still in line with the sustainability. Normally I would like to dwell much on the course of after the hand-over of a project. I would like to know what measures does MSF put in place to make sure that the quality and the standard of the services which were being given to the patients or to whoever where MSF was allowed is actually still going on.

Because normally what happens is you will find MSF will leave you maybe with 20 vehicles, a pharmacy full of drugs, a lot of things but in two, three months, all those things go down. So I would like to know, because I’ve also heard a number of nations will be handing over and the like, what are the standard things MSF puts in place to make sure that there is a proper continuity and sustainability of the quality control and the standard, actually, which was being done while MSF as a project was allowed.

CHAIRPERSON: That question is not limited to HIV programmes but it’s particularly important for HIV programmes and I’m going to pass it on to the next session. We have a session on HIV and I’ll ask the panellists to address that issue, if that’s okay with you. Last point from Eric.

DR GOEMARE: It’s a question to Jerome. I think, as Paula said about civil society, it’s good to raise the question, why would we like to engage with them. So a question to you. I guess we have some plans of why we want to engage with the AU. It might be for a very different issue, typically for the peace-building force or peacekeeping forces versus the health agenda. It’s not at all the same kind of dialogue, neither the same kind of pertinence, I would say. So do you have an idea - I guess it has been discussed - of what were the main reasons to engage with the AU?

MR OBBEREIT: I’m stressing again, we’re not engaging much with the EU for the moment at the Brussels level. I think it’s to engage on all topics, whether it’s health, whether it’s actually conflict related, whether it’s investment. There’s also a big area where the EU is a big investor in post-conflict settings as opposed to - and also a big actor in acute emergencies like South Sudan. But overnight the kind of disbursement that they’re doing is completely different.
On the one hand, they’re going through NGOs, then overnight it starts going through purely state actors or the UN consolidated approach, which doesn’t reach often the beneficiary which is still in acute need. So the reason to engage with the EU is mainly because it’s one of the big donors. Oh, with the AU. I thought you said the EU.

Okay, well, I think much the same as what Jonathan has said. It’s about meeting the right people, broadening our understanding of what they have of the region. In fact, I think in the first phase it’s not so much thinking that we can influence policy but it’s actually engaging with people who have their own point of view, who are actually engaging with contacts like Somalia, like the broader health issues around HIV and so on. But I think for the moment, engagement with the AU would be mostly around conflict that we would be interested in or acute situations like Zimbabwe and so on.

But it’s also to get an exchange. I think a lot of the richness is what Jonathan was saying. It’s not just about, on the one hand, we’re going to influence their policies, which I don’t really believe in, but I do think we can engage with them and learn a lot about the way they’re thinking and find allies also that they’re working with in the corridors of the AU as well.

CHAIRPERSON: Go on, Rachel, a final point.

MS COHEN: I think the reason to engage with any state actors or intergovernmental institutions is ultimately to - I hope that the reason is to ultimately affect our capacity to deliver more effective, good quality aid to the people that we aim to assist. So my understanding is that’s, of course, the pretext, needless to say, of any engagement with state actors or those that hold political responsibility.

But I also understood from all the discussions we’ve been having over the past several years that one of the main rationales for engaging with the Arab League and the AU and so forth comes back to the first group’s discussion, which was about representivity, legitimacy, etc. And here I just want us to be very clear that we not make the mistake - I know it’s been said already - that by having just anyone, for example, sitting in Addis, engaging with the AU, that in itself doesn’t change how MSF will be perceived, it doesn’t
change our representivity, it doesn’t change the legitimacy we feel we have to speak about the conditions that we as an aid organisation or that our beneficiaries are experiencing.

So I think we need to not just talk about who do we engage with when we speak about expanding representivity and legitimacy of MSF towards these actors but who is the voice of MSF in front of those actors. So I think again it comes back to the first group and the questions around perceptions and changing perceptions, changing the voice, changing the way in which we engage, particularly in non-European, non-North American settings.

**CHAIRPERSON:** Thank you very much. I’m going to end this session with just one point because this was a 15-minute report back of motions and resolutions. We had a very good discussion but within all of that, any motions or resolutions that groups came up with I think have been a little bit lost. So if groups did come up with clear statements, could I charge the leaders of the groups to get them written down and pass them on to Sharon, please. Thank you very much.

A big round of applause for that session. Thank you very much.
HAND-OVER OF HIV PROJECTS
Jerome Obbereit / Hermann Reuter / Rachel Cohen

CHAIRPERSON: We now move onto the next session, which is HIV and if I could ask the panellists to come up. That’s Jerome, Hermann and Rachel. The title of this session is Hand-over of HIV Projects but it’s going to be much broader than that. It’s going to be discussing, rather, the continuing role for MSF in HIV care and to what extent we want to continue with our operations or expand them or define the limits of our work in HIV.

We will start with Jerome, who is going to tell us a little bit about OCB’s current thinking on HIV, ongoing projects, hand-over of projects and so on. So over to you, Jerome.

MR OBBEREIT: Okay. To begin with, I’d just like to give an overview of what HIV means inside the OCB, so there’s a clear understanding of how important it is within the OCB. Today HIV, in terms of patients in the OCB, represents approximately 50 000 patients that have been treated movement-wide and something like two thirds of those are within the OCB. It represents today 22% of our operational expenditure. That means that close to a quarter of every penny raised for MSF goes towards HIV programmes.

Now I also want to be clear that our point of view in the operations inside the OCB is that the commitment towards HIV is still there but that that commitment has to be taken very seriously in view of the size of the portfolio. We have to realise that it has to be controlled, it has to be with a clear aim and we cannot just open HIV programmes all over the place, they are very difficult to hand-over.

So we’ve gone also, in the early part of 2000, with our first HIV programmes, then in 2004 and 2005 there was a huge increase in HIV projects; that went up to 18 projects. We’ve now handed over a number of projects, of which I think Lusikisiki was the first one, and then we’ve had Rwanda, we’ve had Peru and a host of other projects that have been handed over, over the years. Today we’re left with 12 projects and two will be handed over by the end of this year, which is Burkina Faso and Cambodia.
So we are getting a level of experience in terms of handing over but what we are aiming
towards is actually making sure we develop a diversified portfolio that actually answers
a general objective of a continued fight in the HIV. Now this means that with the huge
and the massive needs in terms of HIV, we have to be very careful that any new project
is actually bringing something new to the fight and that we’re certainly not going for a
coverage.

It’s also clear that we had to reorganise our current portfolio to make sure that the
projects are complementary, they’re not copy and paste, they each bring something
which is key to the broader fight. And again I would like to go back to what Hermann and
other people have been saying in the past, that we are MSF as a whole and the best
way to be efficient in the fight against HIV is that each operational section is clear about
the reasons for each of their projects. Then we can sit between one another and have a
look at the complementarity that we have between sections and the added value that we
have with each one of our projects.

So while today we still have 12 projects in OCB, we are still the biggest section involved
in HIV, with the broadest financial volume and patients on treatment. I do think that we
can probably work down to a lower number but work into a much more kind of common
and cohesive approach with other sections.

Now to let HIV go beyond the current percentage of expenditure I think would be unwise
on a number of fronts, first and foremost towards what we portray and the trust we give
to our donors that are funding us. Most of our donors today are actually funding MSF as
an international medical organisation, mainly involved in conflict and mainly involved in
acute humanitarian needs.

(Tape 6a)
Now we’ve identified HIV as an acute humanitarian need but we would be, I think, to a
certain extent dishonest with what we portray MSF to be through our websites, through
the media when you look at fundraising across the world, if we were to commit 75% of
our resources towards HIV. Now I don’t believe we should go there. I think that 20%,
25% is a sufficient proportion at this stage but if we were to go further, I think we’d have
to relook completely at how we present MSF to the wider world. We’d have to be very
honest about who we are and how we’re changing, as an association, the fundamental
So today, yes, I am in favour of handing over projects, those that can be handed over. I’m in favour of ensuring that this is done in the proper way. There’s been a lot of investment that has gone on and I’d like to - I think we’ll hear from Elma about this - to continue to know what to build our HIV portfolio on and what the next challenges are but also to make sure that we capitalise on the hand-overs.

I think Lusikisiki is one of the first projects that was very strong on capitalising on the hand-over process. It was a very methodically built-up hand-over and some of the work that was done with Guillaume, I think, at the time are things that have been expanded towards Lesotho and it’s something that we have a responsibility also to share with other sections.

So I'll leave it at that at this point.

DR REUTER: Thank you. I’m asked to speak about the role that MSF still plays or continues to play in the HIV struggle. I haven’t fully discussed this with the organisers what they expect from this discussion so I’ll take my independence to share my own views. Looking at the terrain of HIV struggles, I think that MSF has moved on as the context changes. Or it has to move on. Nationally MSF tackled HIV as an emergency because that was MSF’s task, to deal with emergencies in populations that are vulnerable and in need.

Nationally the struggle with HIV was about policy issues, saying Africans have got a right to HIV care, saying drug companies should make cheaper versions available. It was the campaign for access to treatment, access to diagnostics. It was an issue of getting funding from international agencies for HIV programmes worldwide and that’s why MSF initiated some programmes in Thailand, in South Africa, Khayelitsha, to show it can be done and it should be done. And I think those struggles have been won and now we see big agencies pushing a lot of money into HIV programmes, you see successful HIV programmes in nearly every African country and we can say, okay, the emergency’s over. Our work is done, we can step back.
But we see that HIV continues to be the leading cause of death in most countries and consumes like 80% of the healthcare services in most African countries, so obviously MSF cannot step back. I’m not saying we cannot pull out and hand-over programmes, I’m saying the role of MSF should focus largely - and I might argue more than 22% - on HIV programmes. But the role has to change.

MSF, when I engage people at Head Office on this issue and say, ja, we need to see how MSF can continue to develop health services because basically HIV challenges the sustainability of health services, is there enough staff to continue giving medicines? Malawian colleagues said the lab services are run by MSF; we cannot pull out because the Ministry doesn’t manage the lab services. I know the same about drug supply systems in Swaziland; the Ministry’s not capable of supplying drugs consistently, so MSF has to be involved.

So basically the task now is to develop the whole health system to ensure that HIV service users stay on treatment. The old guard that has been with MSF forever thinks that MSF’s task is not development. Other NGOs, other agencies should be there for developing health services and I think we need to rethink that in the light of HIV.

So what specifically should be MSF’s role because I don’t think that we should stay in Lusikisiki forever or that MSF should stay in Lesotho, in the Scott Hospital region forever. I think the modus operandi of MSF to build up a project and to hand it over is correct but what should be the specific task with these projects? I mean, we want to show pilot model sites and one of the things that we need to show is how to best utilise the existing Ministry of Health staff to develop services, so that we don’t substitute too much with MSF staff and make a system work, relying on MSF staff but not showing how it can be done with existing staff.

It involves issues like task shifting, which is a terminology used often but not often implemented concretely in different countries. MSF needs to look at an increased role in training healthcare workers and developing the skills of healthcare workers around HIV/TB programmes. From a medical point of view, I think it involves a lot of things like shaping TB/HIV programmes as one unit and not as separate programmes and it is sad that MSF still treats these as two different programmes.
It is issues like promoting point of care testing in terms of CD4 counts, TB, to develop new tests that we can actually decentralise systems. And when I talk about decentralised systems, yes, I have to be honest about this. I’m now working in Swaziland and a lot of people in Swaziland - you know, I’m coming from the programme in Lusikisiki which was kind of put forward as a success in terms of decentralising HIV care, and I thought that message has been spread to outer sections.

And we talked about information sharing. When I come to Swaziland it seems like Swaziland has not learned the lessons of Lusikisiki and I think these things we need to take seriously in terms of what we mean when we talk about decentralised care. It’s care at the basic village level, that ARTs are available at village level and that we develop efficient systems to make them available at village level.

Yes, I think MSF often - you know, it’s again the old guard. In my topic even it says ‘vulnerable populations’ and many people think vulnerable populations, that is the prisons, that is the migrants, but in Africa everybody’s vulnerable to HIV. So we’re basically saying all women, all men, all youth are vulnerable to HIV and we’re basically saying, MSF. I don’t think we have to find a specific role to develop systems for the difficult to treat, although we might do that as well.

Coming to my last point, I want to address is the hand-over. There is a lot of nervousness in many programmes that hear about hand-over. I think hand-over goes down to the core that the role of MSF is limited to not taking over the health services. When I talk about developing health services, I don’t say we have to take them over. I think we have to show models, we have to demonstrate models.

When we handed over in Lusikisiki, it wasn’t an issue of our funds had run out so we couldn’t do any more, so now we needed somebody else to keep funding the programme. We had funds, we could have carried on but we said the Ministry can do it just as well. We negotiated agreements with the Ministry that on a quarterly basis MSF would go back and see that the services are maintained. Sharonann is just back from Lusikisiki and patients are still getting onto treatment at the same rate, the follow-up is the same, patients get CD4 counts, so the services continue.
I think, again, how this succeeded, perhaps there wasn’t enough communication about this, perhaps there wasn’t enough information sharing about how the programme was built up to succeed in handing over without compromising the care to service users. I don’t have time to go into the detail but there is a report on Lesotho, written by Guillaume. Guillaume is not spelt like G-i-o-m, Guillaume is like 20 letters. It’s very difficult.

But there is a report on Lesotho, on the hand-over strategy and I think everybody in this room should get hold of that report and see what it means. It talks about working with the Ministry of Health by responsibilising the Ministry of Health, finding a common exit kind of target and say, within six months we want to have achieved that you take over so many lab staff. Within six months we want 80% of the drug supply to be by the Ministry of Health, within a year we want 90% of the drug supply to be by the Ministry of Health. Work on a common strategy to find common ground with government and other NGOs.

Some issues like counsellors might not immediately be taken over by the Ministry of Health, so we do networking with other role players to take over those functions. But I think definitely MSF will need to play an active role within HIV programmes to develop proper decentralised care so that people in all communities can have access to them, and then to step back and let other role players carry on with these tasks while MSF takes on new projects in other areas, in other contexts and develops the health services as well.

Thank you.

**MS COHEN:** Hello everyone. By any objective measure, HIV in this part of the world and in high prevalent settings in general is by far, without any question, the leading cause of illness and death. In Lesotho and, I think, it’s probably true in Swaziland as well; certainly it’s starting to become the case in places like Zimbabwe and other neighbouring countries, we actually see the population shrinking every year as a result of HIV.

When I arrived in Lesotho at the end of 2005, the population was recorded as 2.2 million
and today the latest census reports 1.8 million. The death rate as a result of HIV is exceeding the birth rate in Lesotho. So by any measure, HIV is absolutely, without question, the greatest health and humanitarian emergency in some parts of the world.

After we have some debate about the role of MSF in HIV and our future commitment in our operational portfolio to HIV/AIDS, I’m going to share with you a statement that many of us who attended an MSF meeting in Maputo put together to try to help frame, to try to help put some logic into what Jerome has some anxiety about, and others have some anxiety about, which is a sort of unstrategic proliferation of MSF HIV/AIDS programmes that are no longer necessarily giving the kind of added value that we know MSF can provide to countries, to populations that are struggling with HIV, TB and other illnesses.

I think there is no question that in high prevalent settings, where we see the emergency threshold being far exceeded, that there is still a role for MSF. I think that there are also other settings in maybe more low prevalence areas where there are very neglected, marginalised populations and MSF may have a role to assist those patients.

I think there are also other areas where states are not functioning or are refusing to be engaged in HIV/AIDS treatment programmes where MSF probably has a role to play as well, to push and to play that role that we know MSF is very uniquely positioned to do, which is to be a catalytic actor, to try to push governments to take responsibility, to push for things that would not otherwise be available to people who need them, people with HIV.

And I think that there’s still a role for MSF to play in terms of innovation, being able to foresee the problems that we will be facing down the line; for example, with people who are failing on first line or who are failing on second line and who need treatment alternatives. But those things cost money. We all know we need a better first line regimen for people with HIV. We speak a lot about Tenofovir for first line, access to viral loads so that we know when patients are failing, access to second line and third line drugs, which put us back to where we were ten years ago in the whole debate about drug prices, patents and access to medicines.

Third line drugs in South Africa today are R3 500 per person per month and our patients
- Mpume can tell you - in Khayelitsha who are now failing on second line have no treatment options. We’re back where we started and we’re back where we started against the backdrop of a massive backlash against HIV and HIV/AIDS funding in the kind of global political arena.

There are many, many, many actors, so-called public health specialists, donors and others who are saying, listen guys, the emergency is over. We’ve thrown all this money into HIV, it’s not really helping. In fact, it might be taking away from primary healthcare, it might be harming health systems to have had such a verticalised approach, disease-specific approach to HIV. And those voices are getting louder and louder at a time when we’re in a major global economic crisis and funding is starting to come down, not only for HIV.

We have always spoken about the six million people who are in clinical need of antiretroviral therapy. At this stage, and now I’m speaking still about the old criteria of people who just have a CD4 count less than 200 or have a stage 4 AIDS-defining illness, 6 million people in need and we still have only 30% coverage globally. So is that success? Are we satisfied with that basically? Are we satisfied with the role that MSF has played in contributing toward that?

I totally agree with Jerome and Hermann that we need to hand-over programmes. We cannot get stuck forever in programmes substituting for ministries of health. It’s an essential principle of maintaining the kind of mobility and reactivity that we need to be able to respond to new needs and to be able to go to neglected areas that have not been reached yet by either non-governmental organisations, academic institutions or governments.

Eric always says this and we’ve raised it on the panel today; we were only able - we spoke about it at our field associative debate on Thursday - the only reason we were able to open the programme in Lesotho is because we responsibly handed over the programme in Lusikisiki.

So I absolutely agree that we need to have a more focused, more strategic way of opening and closing projects. We have to have a methodical, rigorous and responsible
way of handing over our programmes but it is essential, and we shouldn’t be afraid, to start confronting the challenges of handing over, even if it means that there’s a slight drop in quality when MSF leaves. We have to accept that that’s a possibility. We don’t like it but we have to accept that it may be a reality but it doesn’t mean we can stay forever.

I do think that we need to have better focused operations, more clearly defined criteria for why we are intervening in certain areas for HIV but I think - and this came up in the last discussion a bit about the Access Campaign - we have lost completely our political analysis of what is happening around HIV, globally and within the countries where we work. So we need to get back that capacity to analyse what is happening in terms of access to medicines and diagnostics, get back that capacity to analyse the global health financing architecture that’s being constructed by people who think AIDS received too much attention and was treated too exceptionally and no longer should receive funding.

We’ve also got to learn from our history in Khayelitsha, in Lusikisiki and in many other places that the key to success in our HIV programmes has been the kind of partnerships and networks that we’ve developed, and the fact that we don’t think of ourselves as the only ones who are acting in the fight against HIV. We are helping to empower people living with HIV, local partners, civil society organisations, activists to speak on their own behalf and, as Hermann said, not just speaking through MSF; us on their behalf, helping to figure out a way to restore what we say the purpose of testimony is, which is to restore to individuals a sense of dignity and autonomy so that they can speak for themselves. And as we think about our future commitment to HIV, I would like that we not forget that key principle which we learned so well from these last ten years of experience with HIV.

CHAIRPERSON: I’d be surprised if anyone has anything additional to add after the three very comprehensive presentations but the floor is open for questions or comments to all three panellists. I see Ziad has his hand up at the back there.

Discussion

MR KHATIB: Thank you. I introduced myself yesterday. What I’m doing now, I’m
getting on to treatment failure, actually, so about Jerome’s point of serving 50 000 patients, if you think about the extended families that will have a secondary effect when these patients are healthy. So I think it’s more than 150 000 patients that MSF is helping indirectly.

And also the issue of orphans when patients are on treatment. When patients have died, what happens to their kids? As we know, we’re operating in weak health system settings and now with the economic crisis, to hand-over, there would be a question mark about drug stockouts. We know in South Africa, in the Free State, the drug stockout is happening and we’re not operating there, so unfortunately we cannot do temoignage because we don’t see what’s happening to the patients.

Issues of treatment failure and the issue of diagnostic tools which Hermann has mentioned, from Malawi that MSF is also contributing to. And also when we talk about HIV drug resistance, it’s still low so there is not any alarm yet but when we hand-over and we talk about treatment failure, this is something we have to think seriously about with limited line regimens.

And also the other huge elephant, TB. Now MSF is going into drug resistant TB projects, is it really wise to drop down HIV and just follow TB because they are kind of twins in this setting.

And MSF can do a lot of innovation when it comes to diagnostic tools; like can we try to do something about having like a dipstick for viral load? Like a urine dipstick, have a viral dipstick. MSF has thought about it, question mark? Dry blood spots and viral loads, dry blood spots and drug resistance; we haven’t done anything about that. And also, as we have done lobbying for line regimen prices, now we will be hitting the wall soon with the second and third line regimen prices, which actually has been spoken about already.

So my question is, can we really afford to gamble with patients’ lives here by handing over to governments that are actually already struggling with other issues? Thank you.

MR OBBEREIT: Okay, first of all, I’d just like to make a couple of comments. We’re not dropping HIV. I think there’s this kind of a myth going around that MSF is dropping HIV
and now we’re going onto the MDR bandwagon and so on. Like I say, it’s the single most invested in, in terms of finance, human resources, operational research, publishing is HIV at MSF OCB today. The question is to maintain, exactly like Rachel said, a clear focus on what fights we are doing and making sure that every HIV programme is key to the overall fight, is key not just to our patients today but to the broader treatment campaign that we’re trying to lead.

So on this, I think, also the issue of the dipstick innovation has been - it’s actually quite an old story, that specific funds have been allocated to that. I think it was specifically MSF France that actually led some of those thoughts but maybe, and Nathan, you can say a few words on that. And in terms of abandoning patients because we hand them over to irresponsible governments, I don’t think that’s been the case so far. In fact, the responsibility of patients is not MSF’s responsibility, first and foremost. It is the governments’, who we’ve actually confronted, that we’ve put people on treatment, we’ve actually handed them over and like Hermann said very clearly, if there’s any hope for these people it will not be MSF. We are very finite in terms of resources, in terms of capacity. We are also finite in terms of time and how long is MSF going to exist. So if you want to give any hope to patients for the future, their best hope is clearly a hand-over to governments that will be able to take them over.

But I think so far, whether it’s in Rwanda, whether it’s in South Africa, whether it’s in Peru, the hand-overs have been done properly but then the question comes to how do you monitor those hand-overs? And I think, once we’ve handed over, the responsibility is no longer MSF’s. Our primary responsibility is for the projects where we remain and towards the populations which have not been reached yet by projects. Now it’s interesting to know what happens, to learn and to better answer the future projects, so I think that’s what we try and do in a way where we don’t create any kind of expectations from the populations.

Because if we go back to Lusikisiki now with a formal, full evaluation of MSF, how it’s all been done, and we see that it’s not going well, well then, our responsibility would be to react in there. And would Lusikisiki actually be the ones who should be getting our assistance after all the investments or should we be going to KwaZulu-Natal today? So I think there are a lot of questions that we have to ask about the hand-overs and how to
follow them.

But I do think that we are fortunate enough with Lusikisiki and the creation of HAACO and the ..., to be able to have an indirect role there and not raise expectations because it was clearly a role where we’re still phasing out. Fortunately today that’s coming to an end but I don’t think we can say that MSF abandons by handing over the responsibility to those who hold that responsibility first and foremost.

CHAIRPERSON: I’m going to ask a question, if that’s okay. It’s a bit of an abuse of power, I know, but something that Ziad said that made me think about an issue that you touched on this morning, Jerome. You were mentioning, in a different context, not to do with HIV, the fact that we want to guard against becoming technical assistants and substituting for Ministries of Health by just providing technical support and losing sight of what our role could be.

But you can, in what Ziad said, imagine a role in which MSF isn't routine daily patient care but rather there to take on specific technical challenges that are above and beyond the capacity of the health system. Could you foresee us playing that role?

MR OBBEREIT: Well, as long as the role is temporary, as long as the role is about filling a gap where there’s no capacity, that there needs to be a know-how developed. But also then it leads to the whole issue of not accepting to work within a system. And this may be a bounce on to what Hermann said at one point; to develop programmes that fit within the capacity of the country. I don’t believe we should be doing this.

We should be treating while we’re there, using the resources but actually fighting for more capacity to be built into those programmes because I think that’s the old development logic of playing around with standards, reducing things. But I think Hermann means that as well. We have to, in parallel, do the advocacy, do the fight, use civil society to make sure that the investment goes in. And much the same with the level of what you could call technical assistance but it’s not going in there like MSF has been contracted by the MOH to actually run the services for X number of years.

No, that’s not a role that we should play. We should be in there, filling this technical gap
but actually tasking and challenging those that have not provided the services to start providing that service. I think this is where we have to challenge the broader financial institutions to actually fund them. I mean, we have no problems in Darfur, when we see that there’s actually pipeline failure in terms of food for the refugees, to actually challenge WFB, to actually challenge the donors to actually fill up that pipeline. Now it’s very much the same, I think, to go back to basics with HIV care but it’s just a bit more complex of who these actors are.

CHAIRPERSON: Moses.

DR MASSAQUOI: Thank you very much. With all due respect, for the purpose of reinforcing what the two brilliant speakers presented about the facts against HIV and AIDS, I’d like to reiterate that this is a long struggle and we’ve been in it for quite some time but we are all learning along the way. No one is an expert, so I just hate to hear that MSF will be getting out of HIV/AIDS work. It’s a matter of reinforcing it. I know, Jerome, that you’ve just put it clearly that we’re now going out but it is somehow stress releasing for us to say this all the time when we meet.

I think our role has been as a catalyst, demystifier. We were in the frontier of simplification, we decentralised, we carried out innovations and I would like to draw the group’s attention to Malawi which was a special case. I think you all know Malawi has been very successful in terms of coverage, what you call universal access, but the way Malawi has succeeded in taking the bull by the horns approach, where in Malawi the two MSFs have reached 27% of the total cohort, which is around 160 000 patients ever started on ARVs. The two MSFs, France and Belgium, reached 43 200.

That’s just about 27%, so there are still 250 000, that’s the estimate, that need to get onto treatment. But the sad news is, for every one patient there are five new patients. What about prevention?

And then of course just to close my talk, hand-over is unavoidable. We should hand over programmes but I think we should still be innovative to open specialised, I would say - I like to use the word ‘vertical’, so I would say vertical, second line HIV projects because we don’t know anything about second line, we don’t know anything about third
And just to again come back to Malawi, just recently in the funding mechanism for global funding, Malawi is on the round system and because Malawi is one of the countries that performed very well, they qualify for a new mechanism called the Rolling Continuation Channel. That means Malawi will have ARVs from 2008 to 2016. This global funding channel was signed but the bureaucracy in the global fund and also the whole procurement system broke down and we just received in April that we are going to run out of ARVs.

Everyone was going helter skelter in Malawi because imagine if you have this huge cohort on first line, which is even not working very well and we are even thinking of changing it, and you cannot even get it for the patients. That is scary, so I don’t know whether MSF, in a huge programme like Malawi, will hand-over easily, knowing the fact that who will you hand-over to? Government? But in fact the government capacity is purely foreign aid, so how will you grapple with those kind of situations?

CHAIRPERSON: Thank you. The plan is, by the way, that we’re going to run on for another 10 or 15 minutes, then we’re going to break for lunch and then we’re going to do the Board members Q&A after lunch.

Sakkie?

SAKKIE: Ja, I’ve got an issue here that doesn’t sit very well in my mind. On Thursday we discussed the issue of Musina, where MSF is providing excellent service to the Zim migrants, but there is a problem somewhere which I think we need to discuss extensively and I would like an answer.

There is testing that is done on people who present to MSF. These people are staged, meaning a demand is being created that once you know your CD4 count is at a certain number, you know you are getting close to death. And people know, there’s education; people know that once your CD4 count is below 200, you are getting close to that stage. You have these people who are being staged with no treatment possibility in mind and they are just left in the lurch. My fear is that you have now people who are going to be
knocking at the doors of the health structures of South Africa and not get any answer.

These people are already burdened with the problems in Zimbabwe from where they fled. Now here you have MSF testing them and saying to them, basically, we are not going to be able to provide treatment for you. There are issues; the SA Government is antagonistic and you need to go and knock - I cannot see a situation where people are staged and then the answer for that hinges on advocacy. This to me is a problem. I think we need to find a solution for that and very quickly. Can anybody say anything about that one?

**MS COHEN:** I can say a few words but I think anyone that was part of our discussion, and especially the team from Musina that brought that debate topic to our field associative debate, please add in. Sakkie, you raise a very good ethical dilemma, I think, that we face. What we do in Musina is along the farms along the east and west borders of Zimbabwe, our medical teams, mobile teams are going there, they are testing patients. We have more than 35% of patients on average each month HIV-positive. On some farms, I’ve been told, it’s more like 50 or 60%.

We do diagnose them, we treat their opportunistic infections and we draw blood for their CD4 counts and then what we do is we refer them because the purpose of the project, as you know, is to facilitate access to the existing health system in South Africa that Zimbabweans have a right to access under the South African Constitution. So rather than substituting ourselves we try to refer them to existing ART sites in the country.

The problem is they work on farms sometimes 50 or 60 kms away from the ART centre in Musina. Many of them are undocumented so they have, at least historically, have not been safe to travel from the farms to there for fear of being arrested and deported. This may change now with the new legal permit but we don’t know. And sometimes when we do refer them, they can’t get time off from work in order to be able to go to the clinic, or when they arrive at the clinic, they are poorly treated, discriminated against, thrown out, charged exorbitant fees, etc.

All of those things are not legal and I think you actually answered your own question by saying the number one thing that we need to do is to advocate, much more strongly
than we have, to figure out a way to address the particular needs of this highly mobile migrant population. And for me, when we speak about different types of logics for intervention for MSF in HIV programmes, that might fit into a logic around high prevalence settings. It might also fit into a logic around specifically neglected or marginalised populations.

(Tape 7a)
Hermann mentioned prisoners, migrants, IV drug users. There are many who are on the margins of society who don’t access services, even if they’re available, for various reasons. So advocacy is definitely the key and if that does not work, then we need to think about a new way, maybe a new sub-project that would specifically cater to the needs of that population. But under the current kind of logic of the project in Musina, we’re trying to insist that Zimbabweans have the right to access ARVs and we need to help facilitate that and we have not gone far enough yet, I totally agree.

DR REUTER: Sorry, just before Musina themselves answer this question, I want to challenge Rachel. I agree that our primary role should be to ensure that Zimbabweans get access to South African health services but the lack of the Zimbabweans who work on farms around Musina, the lack of access to ART care is not the reason that they are Zimbabweans, the problem is that they are farm workers. And it is not just the Zimbabwean farm workers who are excluded from ART, it is also the South African farm workers who are excluded from ART.

And I think, although MSF set itself up as a programme in Musina to assist Zimbabweans, being there, we witness that farm workers don’t have access to treatment. I think our role is to engage with the health services in Musina to see how the ART programme that is existing in Musina at the moment can be extended to also reach out their services to farm workers.

CHAIRPERSON: So can I ask whether someone from the Musina project is willing to add. And Sharonann and Paula, I’ve noticed you.

MUSINA: Just to add, I think Hermann has indicated something that I wanted to say also. Maybe, like Rachel was saying, to solve the problem we need to go for advocacy. But I’m looking at a situation where we push the government to initiate something that
they don’t have in mind. How about going the direction of setting an example?

On a practical basis we start something, we create a model and we start the ARVs on the farms with the idea, right from the beginning of handing it over to the government with, as Hermann was saying, farm workers in mind. Maybe that can solve the problem. Okay, at what level are we going to do advocacy for the South African Government in particular that is so arrogant in that sense? I don’t know, maybe food for thought.

**CHAIRPERSON:** Thank you. So Sharonann.

**MS LYNCH:** Bon dia. I just had, last week, the unpleasant experience of having Graça Machel of all people disagree with me. Not very nice, is it? And what she disagreed with - well, let’s put it this way; she said that HIV is receiving so much funding and Maternal and Child Health is not receiving that sort of level, so therefore we should shift some of this funding from HIV to Maternal and Child Health. Obviously there are two things wrong with that sort of analysis. Actually three things.

One, because she disagreed with me. Two, because, I mean, a pregnant woman needs to receive ante-natal care that has HIV as a component, right? I mean, sometimes we’re talking about one and the same person, aren’t we? And secondly, it’s kind of strange only to talk about funding when we should be talking about beneficiaries and burden of care. So while HIV may be taking up 22% of OCB expenditures, do 50% of people on treatment right now represent 22% of the beneficiaries from OCB in total, for the people who have gone through an MSF cholera tent, for example?

So I think it’s also important for us to recognise that when we talk about money, part of the reason that HIV has been neglected is because of money, isn’t it? I mean, the reason that we don’t have ART in every clinic where there’s TB treatment is because of money. So I would hate to have, obviously, the funding issue scare us off because MSF has been part of the larger effort to get the costs down.

The second point I would like to make is in terms of hand-over, I think we need to look structurally at how MSF does work, starting at the headquarters level, in terms of the people that it sends to projects. That we have a philosophy around hand-over and
obviously learn from our lessons, so that we have someone - let’s say, rather than a coordinator, that a person have the title of Coach because all of our jobs, if we’re working in a hand-over context, is to replace ourselves.

And part of that discipline as well could be where somebody doesn’t come and say, hey, where’s the expat meeting, when there aren’t expat meetings, there are management meetings. So there’s a whole discipline that needs to be changed, I believe.

Thirdly, I’d just like to say that for me, I’ve had a fear that MSF would say to itself that we have nothing left to prove on HIV, because that’s part of the reason that MSF of course defines its added value; catalytic, something to prove, something to add value to the whole discourse around HIV and its management. That’s been my big fear for the last eight years. And I already see, because the Access Campaign is not the Access Campaign that it used to be, that the overall movement to get more people on treatment has suffered greatly because we don’t have as much of a voice as we used to.

And I don’t mean to be a jerk here but Moses mentioned that MSF was behind advising for the simplification of treatment of HIV/AIDS. Many people were saying we should use not D4D and first line, even though it’s affordable, because it’s a crappy drug, etc, etc, so to me, I almost have a feeling like I should be able to say we have an obligation to see this thing through. We don’t have all the lessons yet. We don’t know, still, how long people can survive on second line. We don’t have access to third line. We don’t know what long-term adherence really means.

So to me, there is still an obligation for MSF involvement, both in terms of the field and in terms of, most certainly, advocacy. And I know that no one is saying MSF should be involved less but let’s be very, very careful when we talk about our criteria for involvement on HIV in both cases. That’s something that should be a large, large debate and I hope will never be isolated to any headquarters of MSF anywhere. Thank you very much.

**CHAIRPERSON:** Paula?

**MS AKUGIZIBWE:** Thanks. I just wanted to share a couple of things also related to the
money issue, which I think would give some important context. The World Bank published this report a couple of weeks ago about the human crisis of the global economic downturn and they estimated, from the countries surveyed - and there are some concerns about how the estimates were reached - that 61% of people who are already on treatment, within the next 12 months are going to be threatened as in their access to treatment is going to be threatened because of the financial crisis.

So that’s just people who are already getting treatment, that doesn’t even touch the 70% gap to universal access. And already in the region we’ve heard about what’s happening in Malawi. In Botswana they’ve already gone on record to say they’re not going to be enrolling any new patients up to a certain year because they can’t afford it. At a workshop in Swaziland a couple of weeks ago, the national ART coordinator mentioned that they are starting to think about revising the universal access figures because they were overly ambitious.

So if we’re having all these people who are at threat of not being able to continue the first line treatment, therefore a threat of developing drug-resistant HIV and creating another hole much harder to manage the epidemic, I just think it’s something that we should bear in mind when talking about handing over.

And secondly, also related to resources, we’ve been speaking a lot about migrant and war populations. SADC has developed a policy on this that was pretty sound in principle that would give universal access to all migrants that are nationals of any SADC country, regardless of what country they’re in. When it got through to the ministers and senior health officials in Mozambique about a month ago, they just bounced it. They refused to even discuss it because they said, where’s the money going to come from?

So those are two things that I think provide the context, in this region at least, for HIV. If you’re handing over into a vacuum, then you’re just creating more damage further down the line, so we really can’t separate. We keep hearing advocacy coming up but I think it should be central to any discussions about handing over, which should have advocacy for resources as an integral part of that.

CHAIRPERSON: Andrew, and if possible to make this the last comment before we
hear back from the panel, unless someone has something very urgent to say.

ANDREW: I just wondered whether there was any move to create some kind of summation report or bring together the current sentiments because I think there’s quite a pervasive sentiment of a battle that’s not yet won or even a battle that’s turning into a losing battle. There’s a sense of despondency about the constraints on reaching universal access, the sense of trying to define MSF’s role when there are so many other players on the ground now who define their role very similarly to MSF in terms of the catalysing, doing technical development, innovating.

I was just thinking, maybe if we were to try and bring together all of our country experiences and the kind of state of being of the global response to HIV into a global report where we could try and make a splash about the fact that we’re in this particular time economically and we really have this - I mean, for me, the South African statistic is that 2 000 people die a day and 1 000 people die from HIV, and that in spite of the largest treatment programme in the world.

And I think if we go to every country we’ll be able to map the crisis, we’ll be able to map the crisis in the state response and in the kind of global and NGO response. And the process of developing such a report might also help us clarify what our particular role is. If we go through systematically country by country, theme by theme, we might be able to find where as a global organisation we should be placing the emphasis.

CHAIRPERSON: Thanks, Andrew. You’ve just set Rachel up for presenting the Maputo Statement that she mentioned earlier on, so she’s just going to show some principles for MSF engagement that came out of this regional meeting on HIV that took place a few weeks ago in Maputo, involving around 50 or 60 people from all the major HIV projects in the region, from all sections.
THE MAPUTO STATEMENT ON AIDS
Rachel Cohen / Hermann Reuter, Jerome Obbereit

MS COHEN: Every field participant in the room endorsed this statement and asked that it be sent through the MSF AIDS working group and through operational and medical departments in each section for debate and for discussion to help shape, potentially, a future vision for MSF on HIV. It’s just one statement, a kind of collective expression of what came out of our discussions in Maputo. It’s not meant to be the final word on anything at all.

There are a couple of introductory paragraphs that discuss roughly what we’ve been discussing today and then a proposal that MSF consider a renewed vision for MSF’s role in HIV and AIDS, taking into account or suggesting, proposing potentially four different operational logics for field projects as a way to better respond to needs in different contexts, to reduce duplication and to develop a more cohesive strategy between sections. So the first one there would be a logic saying:

"MSF should be intervening for HIV/AIDS to catalyse and ensure access. (And there it says) MSF has a unique capacity to kick-start programmes and rapidly launch new interventions in high prevalent settings, where the burden of disease is high and lack of access to treatment reaches emergency thresholds.

Suggesting that in such projects, MSF can play a role to assist with implementation rather than substitute for other actors, but acknowledging that we will also often need to fill gaps and try different approaches, resource light approaches, where feasible. And here we say:

"Whenever possible a rigorous and responsible hand-over to local health authorities and other actors should be programmed from the beginning."

That’s sort of one way of thinking of one operational logic, one justification for MSF intervention in HIV. The second logic was:
"Programmes targeting particularly neglected or marginalised populations, for example, migrants, prisoners. (MSF Holland suggested we also say neglected HIV-positive individuals in low prevalent settings), injecting drug users and people in conflict in other unstable environments. Such programmes could also be launched where local health systems have either collapsed or are unable to cope with the needs where there are no other actors present or where the actors are not sufficiently able to cope with the needs." (Zimbabwe would be a very good example of that.)

Then we had a third operational logic, overlapping a little bit with No. 1 but still slightly different; pilot programmes, demonstration programmes that prove feasibility. And here the suggestion was that such programmes could be existing programmes where we redefine the added value in a specific context of an MSF project by shifting from the role of routine service provider to service innovator in order to take on more complex issues; something Hermann, I think, alluded to.

‘Key interventions in such projects could, for example, include managing patients on second line, piloting new models for integrating Maternal/Child Health and state of the art PMTCT protocols and/or HIV and TB services, developing rationally resourced models of care for large cohorts, addressing long-term challenges such as adherence challenges in children and adolescents, and implementing new technologies, including preventive tools.

I heard somebody mention prevention. I’m pretty sure it was Moses; what on earth does MSF do about prevention? Not much at the moment.

"In order to achieve this shift in operational strategy within existing programmes, it may be necessary in some projects to hand-over routine initiation of stable adults on first line ART to local actors."

And then the final type of project or logic for intervention would be dedicated sites for innovation and here the suggestion was that:
"These would include a limited number of programmes in a range of contexts that have the capacity for rigorous operational research, including perspective studies, but that also respond to continuing patient needs. (So in other words, operations but also operational research.) Such sites could develop and validate innovative strategies to confront long-term challenges of keeping adults and children alive, including field testing new drugs and diagnostics, managing complex co-infections, long-term side effects and addressing long-term adherence challenges, for example.

These sites would provide a window into the future challenges that other programmes will face within and outside of MSF and as much as possible, they should be supported inter-sectionally (meaning to rationalise our resources, they should, as much as possible, try to be international sites of innovation for MSF) These should establish strong links with key academic and research institutions outside of MSF to ensure rigor and also to multiply MSF’s impact."

So these were just four ways of thinking about MSF engagement operationally. There are other things said about our engagement on advocacy and sort of the backlash on the economic recession and why it’s important that we still consider HIV very much an emergency but we thought this was an interesting way to frame the potential kind of logic for how MSF could frame its future investment and commitment to HIV.

CHAIRPERSON: Thank you very much, Rachel, and I will invite the other two panellists to make some concluding remarks, if they wish.

DR REUTER: Thanks. I think this was a great discussion and my final comment is that we cannot separate the struggle for HIV care from the struggle for more human resources, for more staff that deals with HIV care in our health system. Although one of our tasks would be to assist to simplify HIV care systems and to task shift, nevertheless I think the biggest obstacle to universal access is not hidden in the most vulnerable population. It’s often in the high density HIV areas where we just don’t have enough healthcare workers to do the work, where we don’t have enough lab staff, where we don’t have enough druggists, assistant pharmacists, people who ensure drug supply, where we don’t have enough nursing staff to actually initiate people onto ART and do
the necessary counselling and checking for side-effects.

So I think MSF should become much more vocal on addressing the issues that would ensure more numbers of healthcare workers. And I think the global crisis will put increased pressure on African governments to reduce public spending on public service staff and healthcare workers will be affected by that. With increasing levels of migration, healthcare workers will be blocked from working in other countries. Like Namibia has just passed a law that foreigners may not work in the country unless there’s an explicit kind of procedure and it was addressed to prevent other African people from coming to work in Namibia but it also impacts on healthcare workers. And Namibia has got a great need for healthcare workers but you can’t get a job there anymore because you fall under the same labour laws.

I think these things will increase, so there will be an increased demand for training for healthcare workers and for making positions open within the Ministry of Health, of recruiting more low level healthcare workers, midlevel healthcare workers, and I think MSF should lead the struggle in this terrain.

It will also come to funding. I mean, funding for HIV programmes is not just the ART, it is also the funding for those healthcare workers who provide it and I think that should be included much more centrally in our HIV programmes.

**MR OBBEREIT:** Okay, I think, to add onto this, it’s another key issue that we have to work on, where some projects have been actually leading by example with the capitalisation and actually sharing the experience of MSF. Quite often we still find our projects are running but to actually make the government we want to hand-over to understand how they’re running is not easy and we often don’t know ourselves how we manage to make our projects run, to tell you the truth.

And I think on this side it comes down to modelling. I don’t think we should believe that MSF has the model. That would be the biggest mistake, that we have the model, here we come, we implement it and that’s it. Here, take the model up. We have to learn how modelling happens and how to actually be able to show where we’ve got to, what we’ve learned to governments without having to hand-over six files of papers that are
indigestible, unreadable and so on.

And here I think that’s a particular challenge that no project yet has done, to be able to actually map the services, the tasks that have been shifted downwards, by what cadre they are being filled and so on and so forth in a very readable, simple way and actually in a way that can be changed over time as the model evolves. Because I do believe that MSF has a clear role in the model but is participating to its evolution and not in pruning its finality.

Then I hear a lot about the financial crisis and so on. It’s a bad excuse most of the time. When we look at where we’re going, we’re talking about a few percentage points recession, maybe, and that’s where people are starting to panic and so on. I mean, basically if you’re not in growth, you’re stable, you’re in a crisis. If you lose a few percentage points, you’re in a recession. We shouldn’t accept this. I mean, we know that funding is going to other areas and it might not be going to Health, it might not be going to where we’re going.

I remember two years ago the food crisis. It was a huge thing. Who was caught in the shops in the food crisis? The FAO and WFP. Why? Because for them to actually call a crisis on food was a good way to replenish their coffers and actually make this crisis out there to their own interest in terms of where they were going. Who’s calling the crisis today? It’s clearly the financial sector. Of course, they’re the ones that are actually intricately linked to how much money is available but I do think there’s still an over-paranoia and a lame excuse not to actually put the resources where they should be put. So I think we have to be very careful on this.

CHAIRPERSON: Thanks very much. And of course, not treating HIV has a tremendous cost as well. Thank you to our panellists, thank you to all of you for your attention. We’re going to break for lunch now and hopefully be back as close as possible to 2 o’clock. Thanks very much.

LUNCH BREAK
CHAIRPERSON: We’re going to start again, everyone, so if you can take your seats. Welcome back to the serious business of the General Assembly.

What are we doing? We’re not presenting candidates for the Board with Q&A because we’ve already voted. It was Wim and Dick who wanted that to happen but they said they did prefer drumming over democracy, so we’re very happy having sacrificed that for the drumming.

We’re not going to do Somalia, which is a bit of a pity but it’s quite a specific case study on the general point of increased insecure environments and the challenge to MSF’s operations was covered this morning. So I think, again, drumming displaced Somalia but that’s okay. So it’s the Year in Review and then the results of the elections. So we’re going to go straight into the Year in Review session, starting with Bridget who’s going to talk about something.

Diploma in Humanitarian Assistance

MS STEFFEN: Hello. I’m just going to say literally a few words about the diploma in Humanitarian Assistance because there’ve been quite a lot of questions about it and I just thought it would be good to give a bit of an overview. Basically this has been a dream for many years. Liverpool School of Tropical Medicine has been running this diploma in Liverpool for five years and several of us MSF staff have actually taken the course and recognise the huge importance of an initiative like this for humanitarian workers on the ground, for decision-makers in government, for people within the whole sort of humanitarian system.

So MSF is really putting a lot behind this course so that it can be established in South Africa, for the continent, with a focus on humanitarian issues across the region. It’s a six-week intensive course. It’s from July 20th until August the 28th. It’s going to be running yearly and Wits University will eventually take it over. The idea is then, the long-term dream is for this to then be propagated across Africa, through African universities and eventually take over the world.

So this is just the beginning of a much bigger thing. But this year it is fairly expensive
because there’s still a long way to go in terms of getting funding for the scholarship fund, so bear with Liverpool and Wits and everyone on that. So therefore this year it is currently a total of R35 000 per person; fees, accommodation, food and everything. It’s going to come down a lot next year but for those of you who are able to put forward staff or to put pressure up the echelons to allow staff members to come on the course, it’s extremely enriching.

The applicants that we’ve had so far are from across Africa. We’ve got 80 applicants and about 70 of them are from Africa, so it will be an extremely enriching environment to share experiences across the continent and also to look at humanitarian assistance from perhaps a less western perspective and to really explore a humanitarianism that comes from the continent, for the continent.

And talking about humanitarian space this morning, for places like Somalia, I think it could really be a part of expanding that humanitarian space in terms of really building the capacity of staff on the ground to act on humanitarian crises on their doorstep, rather than having a huge influx of people coming in from elsewhere that are then - yes, I think it could be a really important initiative for the longer term as well. So please do support it in whatever way you can and ask me if you have any questions and go on the website, which is on the posters, to apply or to find out more.

Thank you very much.

**MS EKAMBARAM:** Bridget has to leave, so if you have questions, you can ask her at the party this evening.
It’s a bit of an anti-climax to start reporting on the work that we’ve done since the last General Assembly so we’ll try to make it a bit exciting. What we’ve decided is I’m going to give you a very quick presentation from the review that was done, because I think that was significant, during the period since the last General Assembly, which took place in November and some of the recommendations that were made.

I think it was quite an intense process. It was short but intense and discussions were had with various members of the Board and people in the office. So that’s going to be useful in future planning for the office and for where we’re going to and I’m starting with just a working vision for MSF South Africa. I think this General Assembly has engaged with a lot of the issues that we need to take into account in the coming period.

Our vision is:

"To establish a section that has a direct impact on MSF’s social mission, based on its medical action, to ensure access to quality care for vulnerable populations. (So that’s specifically in relation to the various programmes that we have set up) And to develop and use MSF influence to increase the humanitarian space."

Jonathan will speak more about that, which falls under the work of the Programme Unit. And then the final one is linked to the association and speaks to the need to build a vibrant association but also to actively recruit some strong African MSF actors to integrate in MSF analysis. I think today’s discussions were a start in that process in bringing our operational experience, specific work that we do to engage with some of the difficulties that MSF’s experiencing.

A picture of South Africa for those of you who don’t know where it is on the map, the southern tip of Africa. This is our organogram. Medical Unit made up of four people. The Head of the Programme Unit, we have an admin team and a communications team.
which has only just come together after a period of departures and replacements. You’ll be meeting various team heads in the different presentations. And then the Recruitment Unit.

In terms of governance, I’m just going to report on this because Zoya’s unable to be here. It’s her father’s 70th birthday, so she had to go. I think one of the big achievements has been to have a clean audit report, financial report, really proper running systems for human resource policy within the office and ensuring that staff files are maintained and proper inductions and performance appraisals and the general smooth functioning of the office. I think working with Operations, sharing the same space does ensure that we pay particular attention to that in terms of the various arrivals, departures and activities. Organising Board meetings is a big part of what we have to do, and General Assemblies.

This is a bit of background to the review of MSF South Africa. I’ve mentioned that it was done in combination with OCB and after both South Africa and Brazil were granted branch status, which was reported earlier on, something that took place in June last year, shortly after the General Assembly. This was through interviews and discussions and the goal was to understand how both the offices evolved, where we came from, what influenced specific focuses that Brazil and South Africa had and how can we go forward with a clear understanding, within the movement and in the two entities, and go forward on a similar plate.

There were some recommendations made and while they were not made to be enforced, there were suggestions that came out of various discussions about perceptions and strengths and weaknesses.

So the motivation for setting up MSF South Africa. I think this is important for us to be constantly reminded of. I also think that these points need to be remembered in the context of a vision for OCB and for the movement and where we’re going to. The new entities, Brazil and South Africa, were set up in order to inform or to assist in meeting or developing that Mission. So our work that we do has to - it’s almost in the making as we demonstrate added value of where to lay emphasis in what work we do.
So it’s to build a section rooted in African society and I think again the discussions today about various different initiatives in Africa and how does what we’re doing here today, this association, bring in the essence of what different regions are and different flavours in this part of the world and the dangers of just focusing and becoming a South African entity. I think that is something that I’ve been wary of from the beginning, that as South Africans we can be very inward looking.

It’s been a big challenge not to just run with campaigns and activities relevant just to South Africa and I think that that’s something that needs to be monitored and ensure that we don’t very easily fall into the trap of doing HIV/AIDS or the regular things that there’s a huge demand to be involved in, and to bring in new issues from the continent which we struggle with. I think over time, building on what are medical humanitarian values, what is this concept, will create the space and the platform to have the debates and to get some resonance in civil society in South Africa and the region.

And I think the final point is to attract people to work for the organisation and to be self-financing. So you’ll hear about these initiatives that we’re taking and successes that we’ve had with reports from the other units. Okay, so just a bit of where the momentum came. We’re circulating a document that came out of La Manche and I think for those who haven’t seen it, to read it, of the spirit within which South Africa and Brazil definitely were initially set up. The entities to:

"Develop a meaningful associative life and improve legitimacy in governance."

And I think that’s what we’ve been debating in the various groups in our discussions this morning.

Okay, so this point, being a branch status, was there a price to pay? I think this is something that Adrio, the person who did the review - this was an interesting thing that he engaged with. I think we do need to debate about this, that the criteria for granting MSF South Africa branch status was unclear, this decision. There were no specific criteria. It almost went back to the resources-driven argument about financial, HR, which the initial motivation for setting up South Africa, and to a lesser extent Brazil, was not for resources, it was for the added value of the African voice, which I think we’re all
beginning to debate with and try and clarify what is this thing that we just bandy about.

But more what you will see with reports, of critical value is the proximity, the geographic location proximity to the kinds of diseases and the expertise that exists in this part of the world, whether it’s through academics or through the knowledge of doctors and institutions, about the diseases that MSF is working with in the rest of Africa and how can we bring that value to the operations and improve quality.

The other point which is worrying is that there’s very little mention of the associative life and I think it’s why we need to clarify what are we bringing to this associative life. What is the analytical thinking, who do we bring to it, the criteria for building an association in this part of the world. What are the different experiences and expertise? And to bring people like Paula and others who have long experience in working in Southern Africa, not just in South Africa, and how can we define ways of working and using that to strengthen the work that we’re doing. So I think that will be a challenge going forward, specifically in building the association.

(Tape 8a)
So again the question of the Board. The Board comprises qualified South Africans. This was a comment that Adrio made, that we’ve moved things forward and developed a vibrant forum around the MSF’s operations and we’ve had our GA with about a hundred members but the weak link is between OCB. But I think since then there’ve been a whole lot of developments with the Steering Committee, with direct contact with the various heads of units in Brussels. So this was at a point in December and we’re now in May and so just to report on the importance of this document in informing the integration, if you like, of MSF into the OCB movement.

Recommendations on the Board. I want to point this out for this General Assembly because I think the fact that we are now electing a Board, we need to ensure that we hold the Board accountable. Up to now, the Board has been appointed, the South African representatives, and that was by virtue of having to set up the organisation. There was a process which Marta Dada was very crucially involved in of trying to pick out people that we’ve worked with, who have an understanding of MSF and what they could bring; and as you’ve heard, have played an incredible role in bringing together some kind of structure.
I think now that we’re electing members onto the Board, we need to hold that Board accountable for specific deliverables and so I think the link between the Board and building the association has to be the challenge that we go forward with. There’s more OCB representation on the Board and we want to ensure that the experience of the international is brought to our Board meetings and to the General Assembly and I think today again reflected a start of that process, for us to feel that we are part of an international movement and not just a little national entity on the southern tip of Africa.

These are points that came out of the Review, which I think go to the broader challenge of a strategic vision for OCB and where it’s going to. Some of the challenges that we spoke about today, about humanitarian space, representivity, legitimacy and how do we define that, I think that’s something that in setting up this office, I’ve grappled with. My mandate, if you like, was to demonstrate to the movement added value, that the two entities, Brazil and South Africa, were not set up to have more sections. That there was a moratorium placed on sections and the two sections or the two entities, branches now, were set up to show what change they could bring to the movement, other than just finances and new recruits for the field.

But that is still vague. I think you'll see in the various reports that yes, we have gone quite far ahead, whether it’s the Medical Unit, the Programme Unit, fundraising, communications, certainly, and struggling a bit with HR but I think that if we are going to have a two or three-year vision, it has to be within a proper framework with reference and how do we build that.

Okay, I think that was it, so I will hand-over to - who shall I pick? Mmule, do you want to start?

Field Recruitment and HR

MS RASEROKA: Hi, I’m Mmule, I’m looking after field recruitment and HR for the office, for the branch - sorry, overstepping my mark - branch office of MSF South Africa. I just wanted to give a summary of what has happened to date in terms of recruitment. Recruitment started off in South Africa in 2007, November, when five people were
recruited. In 2008 15 people were recruited and in 2009 to date, nine people have been recruited and that’s not including the assessment centre that happened on Wednesday, so that could increase.

Currently there are 28 people in the pool and I need to make a point that not all of these 28 are actually waiting for Missions. Some of our expats - the Mozambicans will know the guy on the right, Dr Danson. Contacts where we have currently got MSF SA expats are Liberia, Sierra Leone, Mozambique, Swaziland and Zimbabwe. Currently we’ve also got expats preparing to go to Pakistan, Sudan, in (Kagoor?), Darfur and in Port Sudan. We’ve had expats who have been in the DRC in the Kivus, Pakistan, Brazil and Ethiopia.

The reason I’m showing you where we have been is just to show you the diversity of the types of Missions that MSF South Africa expats have been going to. They’re not just going to HIV/AIDS Missions, as people tend to assume. They’re actually going across the board to trauma and emergency Missions and HIV/AIDS and TB Missions. That just shows you the diversity of the types of people that we recruit.

Then some of the tools that we’ve tried to encourage people to participate in and get involved with MSF in is by introducing MSF SA on Facebook and trying to encourage people to get involved through this. It’s growing slowly but the idea is that through you, members of the association, through your friends joining and becoming part of this, you can actually encourage people to learn about MSF SA, first of all, then secondly, we’ve seen people starting to apply through that and trying to find out more about how to work for us, how to participate.

This has particularly been interesting with university students and with doctors, friends of friends. Word of mouth is a very strong tool and the good candidates that we’ve been getting through the Assessment Centre and through recruitment have all been through word of mouth. So you guys are our ambassadors and you guys are the ones that have been promoting MSF to qualified people. You already have the experience working as international staff in MSF and you know the type of people that we need to make this movement stronger. So I’m asking you to keep marketing us. You are our marketers. So that’s the end of my presentation. Five slides as stipulated.
CHAIRPERSON: We’ll save questions for after all presentations, so over to Jonathan.

Programmes Unit

MR WHITTALL: Hi everyone. My name’s Jonathan and I’m the Head of the Programmes Unit. I’m the only one. As you saw on the organogram, we have quite a big unit with me and me - me, myself and I - so I’ll be very quick to go through the main achievements since the last General Assembly.

It’s actually quite strange to be at this General Assembly because last year, as we said in the beginning, it was the time of the xenophobic violence and that’s when I was very new in MSF then and when I started getting involved more with the Mission particularly. So the xenophobic response continued after the last General Assembly and the Programmes Unit continued to play a role in supporting the Mission in responding to the xenophobic violence. We’ve also played, in the last year, a role in context analysis for the South African Mission on the political developments in South Africa.

Zimbabwe. I shouldn’t be doing this presentation, I should be asking others to give feedback but we’ve played a role in Zimbabwe in facilitating a debate around the risks to speaking out in Zimbabwe. Jerome mentioned it in his presentation; there’ve been concerns in the Mission about the potential operational risks of speaking out. The Programmes Unit has played a role in engaging in that debate. We’ve supported as well the Zimbabwean Mission in context analysis, which culminated in February this year with the issuing of the report, Beyond Cholera, which the Programmes Unit was involved in drafting over quite a long period of time.

I think one of the successes is that we built on our experience in South Africa, expanded into supporting the Zimbabwean Mission and at the beginning of this year we provided support to the Darfur Mission in doing a review of MSF in Darfur over the last five years. So looking at five sections over five years. It was quite a mammoth task but it was successful and we produced a review of the operations in Darfur during that period.

And also recently, I almost forgot, in the last few months, as many of you know, working
in the region, we’ve had severe flooding in parts of Southern Africa and the Programmes Unit played a role in working with the Emergency Unit in Brussels to conduct an explo in Namibia for the floods.

Networking, I’m glad Bridget got a chance to give a bit of feedback on the diploma on Humanitarian Assistance because it’s true that that course has expanded on network exponentially, not only with government but with think tanks, with civil society groups, etc.

We’ve played a role in building links with regional UN bodies, those regional structures of the UN working in South Africa, as well as think tanks that are providing us with analysis that we can feed to operations in the region and beyond.

We’ve also been involved in some training with Wits University and others, which of course will then go into the diploma in Humanitarian Assistance and will hopefully expand. And I’ve put that it’s important I think that over the last year we’ve increased our role in becoming more and more a reference point for humanitarian issues in South Africa, which is one of the main reasons for establishing the Programmes Unit.

Both of these things, Operational Support and Networking have laid the foundation for our role in advocacy, so we completed last year a mapping exercise of the different players in South Africa who we can engage with. We’ve also just engaged with national interlocutors, so the South African Government, the ANC, others on the dossiers of Zimbabwe, Darfur, DRC. And recently, as I mentioned earlier, I’ve just come back from Ethiopia where we’re looking at building up a strategy for engagement with the African Union, in collaboration with the international office, which hopefully is also contributing to internationalising MSF South Africa as an entity.

And, of course, there are the UN agencies. South Africa is a pit stop for many UN people from New York, Geneva, who are going to Zimbabwe and other parts of the region and we’ve been able to grab them while they’ve been here.

I’m not going to say much on this because I’ll hand-over and introduce you to Borrie but in the last few months particularly, we’ve played a role in covering for the gaps in the
Communications Units, so in this year alone - it’s quite a staggering figure - MSF has appeared in South African national media, on average, 22 days of each month.

We’ve had a successful press conference on Zimbabwe, the launch of the reports and we launched the Sexual Violence Report in South Africa as well, which we doubled up with, with Darfur, which was a huge success.

The new website was launched and increasingly, I think, we’re becoming a focal point as well amongst media, not only national media but also foreign correspondents based in South Africa, which is a huge resource to tap into and a brilliant audience for MSF’s messages. Let me hand-over to Borrie.

**Communications Unit**

**MR LA GRANGE:** Hi, I’m Borrie. I started on the 11th, which makes Monday two weeks. This is Baikong Mamid. She’s the Communications Officer. Would you like to introduce yourself please.

**MS MAMID:** Hi everybody. Again I am Baikong Mamid, the new Communications Officer for MSF SA. Well, actually, to introduce myself but very briefly, I came from Philippines, I’ve worked in Mindanao and I’ve also worked with the Burma Response, the cyclone response. This is my first encounter or job with MSF, so I’m really looking forward to working with more humanitarian issues in Africa. Thanks.

**MR LA GRANGE:** Just a bit of background about myself, I used to be a journalist and I used to phone knowledgeable people like Rachel and ask silly questions sometimes, so this is my first encounter with no NGO experience and I hope to learn a heck of a lot in a very short period of time, which is probably likely.

If I can perhaps start out with over the last 14 days, I’ve just tried to get the Communications Unit working and up and running and getting to know one another, really, and getting to know the organisation. So our objectives are quite clear; it’s building the image and experience and understanding of MSF as an international movement and the work that we do among the South African public, first off, and then
also within the region, focusing on donors and potential beneficiaries because South Africa is kind of unique in that respect.

What we would like to do is to create unique content as a value add and also share that within the movement internationally and also regionally. We would like to liaise a lot closer with the projects in the region and in South Africa, and particularly give a space for the authentic voices of our patients and although it's not in this slide, but also the doctors that we recruit. So in essence our supportive role for recruitment is also quite clear, or we’d like to make that more clear.

First off, it’ll be a bit of a diary that I’m going to run you guys through. We haven’t been inducted officially in terms of the Brussels experience, which we’ll do at the start of June. It’s pretty much official, it’s just that it’s the Jo’burg experience, so we’ll be going off to Brussels and hopefully learning a lot more about that sort of aspect of the movement. Our activities would include launching the Why I’m Here Campaign, which will, as you can pretty much read from the slide, aim to increase the South African public’s awareness and respect and also recognition of vulnerable migrant populations, given the backdrop of the xenophobic attacks last year.

Coupled with that, just way at the bottom is something that I had a brief interaction with Sharonann about Why I’m There in terms of the South African doctors recruits, just to further the explanation of why you as a South African doctor or nurse would like to get involved with MSF and do work elsewhere.

The other main pillar of what we would have to do and complete perhaps before next year this time would be a baseline study on the awareness by South Africans of MSF as an international movement but also in terms of our activities.

We’ve got two research proposals from two different and quite large research companies and we’re trying to get a third. From the indications that we’ve received from them is that we’re likely to have results within either seven weeks or four months, depending on which one we pick. That’ll pretty much guide our roadmap in terms of what we’ll do further.
The other stuff’s pretty self-explanatory. The key issue here is if we’re able to generate our own content, it would legitimise us in the eyes of the people that we treat and also the doctors that we’re trying to recruit.

Our support services for the short-term or at least for the next two months would include two conferences, one in Johannesburg about sexual violence in which Rebecca Singer - I’m new, so forgive me if I make a huge mistake - I was told that she was from MSF Spain and she will deliver an oral presentation on the Adherence of Post-Exposure Prophylaxis for HIV among Victims of Sexual Violence in Monrovia, Liberia. So our main purpose would be to set up an exhibition stand at the conference where we would interact with other conference goers and also it would give us an opportunity to speak to other general interest but also specialised interest groups.

The second conference we’re referring to will be the AIDS Conference in Cape Town. We’re also meeting with the Access Campaign guys in Geneva when we have completed our Brussels experience. And then further would be to have a really tight working relationship with the recruitment aspect, which Mmule spoke about. We’ve got four recruits and the idea would be to generate content from their experiences as well i.e. blogs or audio content for the website. So part of that would include broadening our website and the content that it can provide.

That’s basically a bit of a summation of what we’ve been doing the last 14 days. It’s very much developing concepts for the quarterly magazine that we want to bring out; Baikong’s looking at that. And it would sort of create a space between communications and fundraising, beneficial to both.

And then Zethu’s busy with some groundwork for the Swaziland website that we’d like to do as well, so we would very much like to come and visit Hermann.

Then the last one would be that we had an offer from a PR company on behalf of Mr Conrad Rautenbach. He’s a rally driver but his dad’s a bit of a nefarious character. We’ve decided in principle to turn it down because it would be damaging to our reputation if we were to have a relationship with this chap, so we also do a bit of risk analysis sometimes. So that’s it. Sorry if it was longer than five slides and if I stammered
a bit too much but this is the first presentation that I’ve done since I think the last six years.

Thanks for your time.

**Fundraising**

**MR DE LOS SANTOS:** Hi, I’m Guillermo and I’m responsible for fundraising. I’m under the Communications Unit that I hope this time is stable. We have had so many changes that also affect fundraising work, so welcome and good luck. I would like to invite my colleague and friend James to more or less give us an introduction of how MSF in UK does fundraising. He did the first study for MSF South Africa in terms of fundraising, so it would be good for him to explain it. I hope you won’t be too long.

**MR KLIFFEN:** Good afternoon. I have more than five slides but I intend to go through them as fast as I can. My name is James and I’m really, really, really pleased to be here. I’ve had the responsibility or the privilege of helping to start fundraising for MSF in two countries. One is the United Kingdom, where I’m from, and another is Ireland and I had the opportunity also to play a small part in starting fundraising here in South Africa. And out of the three, I think that history will show that it is the third one that will be by far and away the most significant. So I’m actually very nervous to speak to you because I think it’s tremendously exciting just being here.

We use a lot of jargon. What I wanted to explain to you is just a few words about where our money comes from because the way that we raise money and where our money comes from is a bit different, in fact, very different to similar organisations. In MSF we use a lot of jargon, a lot of jargon. We’re MSF, we’re an NGO. Everything has three or four letters and people assume that we know what these letters and things mean. Before I worked for MSF, for six years I worked for the Red Cross, which is also an humanitarian organisation.

And working for MSF my new Director, Jean-Michel, came in and he announced that he was going to get somebody from the Red Cross to come to our MSF office and explain what the word humanitarian meant. And I thought, well, I worked for the Red Cross for
six years, I don’t need to hear this. And I was very embarrassed by the time the morning was over to discover that for six years I’d worked for the Red Cross and I had no idea what the word humanitarian meant.

In fact, part of my job is I go around and I talk to schools and I talk to companies and I talk to groups of people about our work and the first question I always ask them is, what does the word humanitarian mean to you? And usually what I hear is a very loud silence and people are very nervous to answer this question. I think you would do better than them. The funny thing is that when people do come up with an answer, they almost always get it right. In fact, the only time I've had a wrong answer is a doctor who said an humanitarian is someone who eats humans. But anyway, he was being funny.

I think, if you can look at where our money comes from and why it matters, you have to go back about 150, 160 years to this man, a very odd-looking guy, from Switzerland called Henri Dunant, who was a businessman 150 years ago. He had some business problems that he wanted to sort out with somebody called Napoleon III and by the time he caught up with Napoleon III, Napoleon III’s armies had just fought a battle in the northern part of Italy. And what this guy found was 38 000, roughly, men who were wounded or dying at the end of a battle and nothing really being done to help those soldiers.

Because from the point of view of the defeated armies, they just left, they weren’t interested in their own wounded. And from the point of view of the army that had won, they weren’t interested in the defeated wounded and actually they weren’t interested in their own because men were cheap. So Henri was disgusted by this and he asked people to help the wounded, mostly women and girls, and treat the wounded in the local town.

And at the end he wrote a book about his experiences, where he really came up with the idea that there would be an organisation that would go into the battle during the middle of the fighting between the two armies, and afterwards as well, that would help people without taking sides; without taking sides between these two armies, good or bad, we’re not interested in your argument. That’s the idea. And treating people according to their needs, for no other reason. So the “without taking sides” bit is neutral and "treating
people according to their needs" is impartial and that’s what MSF is. We’re an humanitarian organisation, we don’t take sides and we try to help people according to their needs. (This is the battle.)

Okay, this is a quote from Colin Powell who was in charge of the US armed forces in 2001, just after the September 11th attacks, in which he was speaking to the heads of US Aid organisations which the US Government was funding. So he was speaking to aid organisations that the American Government was funding, telling them that:

"I have made it clear to my staff there (and he goes on to say) that you NGOs are such a force multiplier for us, such an important part of our combat team, you’re part of our military."

So in 2001 we have this situation where he’s telling these aid organisations, you are actually on our side in this conflict and you are part of our military. Now how does that fit with our whole humanitarian thing? It doesn’t fit very well, does it, at all.

If you want to be neutral, this is a problem if your money’s coming from these guys. And to take the example of Somalia, working in Somalia - and I know a lot of people from Somalia have come here - if you’re taking funding from the American Government with that kind of statement behind you, you have a lot of problems because the American Government is very much involved in the conflict in Somalia. So if you want to work in a country like Somalia, you’ve got to be really careful to make sure that you’re not going to be linked to that funding.

Now Jerome made a point earlier on; it’s not good enough just to not take the money, you have to also let people know that you’re not taking money from the American Government because when we’ve talked to people in Somalia, our MSF OCA team in Mogadishu, they found that even though we don’t take money from the American Government, people thought that we do. But nonetheless, it would be really stupid to take money from the American Government in a situation like that because then you’re going to become part of the conflict. And the thing is that when you’re going into the middle of the battle, if you’re part of the conflict, then you are going to get hurt and then you won’t be able to help people.
And just to take the point a bit further, these two photographs were taken in Afghanistan in 2004. One of them is obviously an MSF vehicle, a Land Cruiser, and this is another white, four-wheel drive vehicle. Both of them are doing medical work. So we're helping people in clinics and the one on the top left hand side is also reconstructing clinics. Well, we're MSF, so who are these people on the top left hand side? They're soldiers. They're part of what are called provincial reconstruction teams.

These provincial reconstruction teams are funded by the part of the US and the British Governments that fund aid organisations, so when we're working in a country like Afghanistan, this becomes a really big problem for us because the military are trying to look like us and then we become targeted. So again a big problem for us if we're taking money from those governments because of that confusion. So that's about neutrality. Let's talk about impartiality.

I guess some of you know where this is. Yeah, it's Cape Town. I was here in 2006. I went for a walk in the Botanical Gardens and found this sign saying: "Don't eat the plants, they're toxic" and next to that, this sutherlandia. I'd heard of sutherlandia's somewhere and obviously there's a story in South Africa, in Mozambique, in Swaziland, in Malawi, in Zimbabwe, about HIV and HIV treatment and getting access to this treatment. And I'm not picking on the American Government, it's just that these are the quotes that are available.

In 2001, it's a long time ago but many of you were around at that time. The person who was in charge of the US Government Aid Agency, USAID, the funds aid organisation, the donor said this: "You shouldn't give people ARVs because they won't know when to take them." Now let's be clear about this. This wasn't just the policy of the American Government, it was the policy of every government. No government in the world, in 2001, would fund a single ARV.

So how do you prove this guy wrong? How do you pay for the ARVs? How do you get to show that actually if you take them in the morning and you take them in the evening, then it works? The answer is you need some funding that allows you to do that. It's not going to come from donors, it's going to come from governments. So where's that
money going to come from that gives you that freedom to prove these guys wrong?

I just want to talk about one last thing to do with money and this business of impartiality. Sometimes there’s a big crisis that takes place or rather there’s a crisis that takes place which is big in the media. This is a photograph taken after the Tsunami disaster in Indonesia and on the top right hand side you have the number of aid organisations that were working in this part of Indonesia, Aceh, that were just doing medical work. There are a lot of them. I think there were something like over a thousand aid organisations in total that worked in the Tsunami.

Now it’s a huge disaster, it was on television, all the aid organisations went there. And I’m not going to go into the details but what happens in these big media emergencies is that aid organisations tend to follow the money for economic reasons. And sometimes you get a crisis that nobody notices and suddenly it’s on television and then all the aid organisations go there and the television cameras leave and then they leave. For example, a lot of focus on Zimbabwe because of cholera but not so much focus before on HIV/AIDS or TB.

So if you’re going to be impartial, if you’re going to help people according to need, you’ve got to find a way of having money which doesn’t follow the TV cameras. So the money we need has to be independent of all this government interest and other interests. We need money that we can spend freely wherever it’s needed. And actually we need it to be secure. We have a big recession right now taking place around the world. What’s happening with our funding? There was a question about that this morning. The answer, by the way, is we’re doing okay.

So, okay, we do get this type of money that we need and who does it come from? Here are some photographs of the people who give this money. It’s not very representative of the profile of people who support us around the world or in this country but I particularly like Zara here, who decided that instead of people giving her presents, she wanted people to give money to help MSF’s work. So basically we get money from people, people like the Girl Guides who I’m collecting a cheque from, who gave money to support HIV work in South Africa.
So we get money from people and the great thing about people who give money is that
they do it without any agenda. They just want to help their fellow human beings. So
that’s basically where our funding comes from.

And just to close by saying something about the type of funding we get. I had the
privilege of visiting Malawi last year and this is a support group of people who are HIV-
positive. I love this photograph. It’s the best photograph I’ve ever taken in my life. It was
a happy accident. I briefly said this is my job; I raise the money and this is where the
money comes from. A woman in the group said that she wanted to congratulate the
people in my country who are funding that work in Malawi, who are individuals, not Bill
Gates, just people, for their exceptional intelligence and sensitivity. Yeah, I agree. She
then went on to say but you must tell them that the most important thing is that they
carry on giving because with ARVs, with HIV treatment, we need that funding to
continue. That’s how we do it.

What we do is we print pieces of paper, things like letters that we send out or we put
inside newspapers and we give information about our work and we ask people to make
a monthly donation. And that’s where a lot of our funding comes from. So people give a
little bit every month, not a huge amount for them, and in that way we have hundreds of
thousands of people around the world who support us with a little bit for them, and that’s
where our funding comes from. And the great advantage of that is that it doesn’t
change, it’s secure.

So we know that our programmes are secure and we can fund them and that’s where it
comes from. We do have a small amount of money that comes from governments but
we don’t rely on it. And in any given country we don’t have to take money from
governments if it causes a problem. But maybe, also, the final thing I want to say is that
it’s actually this work that makes that fundraising possible because the only reason why
people give money is because they learn about the work that you do and want to
support it.

So in my job, in Guillermo’s job we need that information, we need those photographs,
we need that testimony to mobilise the people who help our work. So that’s just a bit of a
background on how we raise money and why you don’t need to worry about your
programmes being shut down because of the global recession and why Guillermo and I and all the people around the world who raise funds need your help.

Thank you.

(Tape 9a)

MR DE LOS SANTOS: We haven’t started, as James said, in private fundraising. What I want to be clear is the kind of fundraising we are doing, we don’t approach, in South Africa at least, governments through MSF South Africa. We go and ask individuals, as James said, through an appeal, websites, SMS’s, if they would like to donate and our approach has been to link doctors and nurses from South Africa to their work wherever they are in the world and also to connect with their experience in South Africa in the past.

So we also try and earmark as much as possible so we can use this kind of funding whenever we need it and whatever. And earmark is we don’t specifically allocate this funding to a specific project. Everyone can allocate the funding, for instance, to pay for emergencies that are coming up tomorrow and we don’t know today where they are happening.

Also it’s very important, something that James said, that this kind of fundraising also helps us with our independence. We can go where others cannot go and that helps us to go to areas, as I said, that are maybe banned by some kind of government funding.

The other thing is we have a very strict corporate code following our ethical principles. That is a very good checklist that helps us to, like for instance, not accept funding from sectors that we think may harm MSF work, like pharmaceutical groups and alcohol, for instance.

And how do we do it? We do it through donations, through web pages, direct debit orders, we issue tax certificates for donors, we do donations by SMS. We have a system in place and we have a fundraising account. And who is everybody? Who are our donors? We want donors who can donate even R5 per month. That will be R60 per year and in three years it will be R180 and that gives us kind of additional support to all our activities.
Just one example I wanted to give in this testing is last year, during the xenophobia, we’d just started with a fundraising team and we received a big gift from First National Bank. The first amount, €100 000, was from the bank and the others were employees who raise funds on our behalf.

This is some information that was in The Star about the gift we received. It’s going to be next year, one year. This is Sharon with the Head of the Red Cross and the Head of The Salvation Army with the CEO of the bank.

We also will start to test other additional fundraising techniques where we have very good recruiters like the one in front. Just a map of South Africa, market competition, the big international NGOs and that was a good question about them versus local NGOs or CBOs. Some are already established in the country, some are coming. And please remember that every contact you have can be a public donor. Thank you.

**Medical Unit**

**MR FORD:** Hello, I’m Nathan. I’m the Head of the South African Medical Unit. I thought it would have been quite quick and clever and easy to just present what we’ve been doing in the last year with some numbers but after James and his pictures of little children, I think this is going to be a very boring presentation. Nevertheless, what have we done?

In terms of operational support, we’ve spent collectively almost eight months in field programmes through lab support in Lesotho, Malawi, South Africa and Zimbabwe Missions, surgical support to Haiti and DRC, operational research support to Lesotho, Malawi, Mozambique and Thailand and decentralised HIV training in Zimbabwe. And I think that’s a very impressive figure that shows that the Medical Unit is not a unit of doctors sitting behind computers in an office in South Africa but is intended to be a very mobile team of people who are out there in the field, supporting our medical work in the regions and beyond.

In terms of training, we have, in the last year, trained 32 medical doctors and clinical
officers from the region, with the clinical HIV/TB training that we run in Cape Town. That’s been an international training for the last two years, so that includes not just OCB staff but staff from other MSF sections as well. In addition to that, we recruited a number of individuals onto an MDRTB training that was being run by the South African Mission and we provided a specific training in ultrasound for a radiologist in Zimbabwe. So in addition to the general HIV training, we’ve also been trying to accommodate more particular needs to projects in the region.

We ran one decentralised training in Zimbabwe, so Musaeed, the clinical trainer, went to Zimbabwe for a week. He was asked, I think, to train five doctors and when he arrived there were 16 in the room but he coped quite well.

We have been involved in the development of academic courses, one that’s been running for a couple of years now but was run twice last year, the Decentralised Models of HIV Care with Wits University. It’s a Masters in Public Health module and the Medical Unit is also involved in the health content of the diploma in Humanitarian Assistance. We also organised one regional workshop in monitoring and evaluation last year in Johannesburg, where over 20 people from the region attended.

Lab support; one of the primary objectives was to support the enrolment of MSF Missions into a quality assurance programme run by the National Health Laboratory Service in Johannesburg and that took off very quickly. Within two months of our lab advisor, Emmanuel, arriving, he’d enrolled eight Missions from three different sections into the programme and that’s running routinely now very well. He’s also been busy providing Missions in the region with diagnostic support for viral load genotyping drug sensitivity testing for TB and we’re supporting the diagnosis of cholera, so providing reagents to the Missions affected.

This is in addition to all the field support visits that he’s undertaken. He’s in Zimbabwe at the moment. In fact, it’s a sign of how mobile the Medical Unit is that none of them are here today because Emmanuel’s in Zimbabwe, Kat has just come back from a Mission in DRC. I think had 48 hours rest and has then gone to the US to make a presentation on surgery in an annual conference before finally having some holiday. And Musaeed is doing a training course in Paris to support the clinical training.
Epidemiology and Operational Research Support. We are supporting a number of countries in the region and in the last year have put out 22 research articles, which are supporting operational research in Missions in Haiti, Malawi, Mozambique, Lesotho, South Africa and Thailand. We’ve supported the production of three country reports on their HIV programmes in Lesotho, Malawi, South Africa and have recently been involved in supporting an epidemiological survey, a retrospective mortality survey in DRC.

So those are the activities for the last year, a brief snapshot in numbers and that’s it.

**CHAIRPERSON:** So now, from Sharon’s presentation to all the individual presentations, I think we have 15 or 20 minutes. The floor is open for questions.

**Discussion**

**DR DE VRIES:** This question is to the fund raiser. We all got this My School form in our packs. Can you just explain how this works for South Africans who don’t know. Or do you want me to explain?

**MR DE LOS SANTOS:** My School card is a programme that helps different NGOs to raise funds and you can use it at, I think, Woolworths supermarkets. If you fill in the application form, you can fax it or submit the form online and every time you purchase groceries, you are donating an amount to MSF. That is how it works. You also can nominate a beneficiary and you can have more than one beneficiary; only within the borders of South Africa.

**DR DE VRIES:** Just to explain, it’s an automatic donation, so if you buy R200 worth of clothes at Woolies, they give 0.5% of that to whoever you nominate, just by swiping your card. So it’s not that you actively make a donation by giving extra money, it is Woolies giving some of the money that you pay for the clothes towards the thing that you want to fund.

**MR DE LOS SANTOS:** Ja, that is actually the concept. Thank you.
COMMENT: Thank you all. I have a question about the fundraising presentation again. Is there any information about people of today, they feel they want to donate money for an environment cause rather than an humanitarian aid cause, with all the publicity about global warming? Thanks.

MR DE LOS SANTOS: Currently we are doing now a survey about different kinds of causes, so I don’t have a number to give to you but actually Greenpeace is doing a lot of campaigns, and WWF, regarding the environmental climate change. It hasn’t affected us or we don’t cross each other.

CHAIRPERSON: Sharonann.

MS LYNCH: I actually don’t have a question, I just want to say thanks for the work that has been done in terms of what everybody’s presented but I will continue to rail on and on about if the Access Campaign was stronger, etc, etc. And I just am so pleased that we can have assistance to projects to document experience, to document outcomes, especially where our job is supposed to be to replace ourselves, isn’t it, for the hand-over context. And Nathan helped incredibly for Lesotho and I know he’s helping with Malawi but to see that - and it’s not so much about numbers but for 22 articles to have been published, in that way, it helps with the MSF voice.

CHAIRPERSON: It wasn’t only me.

MS LYNCH: It wasn’t only you but I just want to say thanks.

CHAIRPERSON: Sakkie.

SAKKIE: I’ve got a question which, if it is answered positively, might put a lot of anxiety about the national staff and opportunities for expatriation kind of thing. Is there a plan that has been built into the recruitment policy of this office to identify possible candidates across all departments, not only focus on medical but people who can be identified for expatriate positions?

CHAIRPERSON: From within the South African Mission? Did you hear that question,
Mmule? Regional Missions. So actually it doesn’t need to just be South Africa, it could be in the region. The question was, is there a plan for the South African HR Department to be able to support the identification of national staff candidates who might be suitable or eligible for expatriate positions, not just medical?

**MS RASEROKA:** For national or regional staff, the way it goes is, it comes from recommendations from within the Mission, the expatriates who are already there. That recommendation is then passed on to the OC that you’re working with and from there it comes back to me or to the HR Department. It’s not only limited to medical or nurses, it’s also logistics, admin and fin but primarily it comes from you expressing an interest to become an expat and expressing it to Co-ordination, who then helps facilitate the process. Does that answer your question?

**SAKKIE:** I just want to know, the people who now have been distributed to other Missions, are they all doctors or do you have different profiles?

**CHAIRPERSON:** Sorry, one sec, Wim is also going to add.

**MR FRANSEN:** I don’t know if there is another rule with South Africa but I know that in the previous years, when I was in Indonesia or Chad, the national staff can just apply and you don’t need an approval of a head of Mission or a medical co-ordinator or a logistical co-ordinator. Of course, it can help if they support you but it is really not a rule and that was done just to protect you, that if you have - because today I’m the Head of the Mission, you have maybe a good relationship or a bad relationship and then the next one is good or bad. So one day you’re okay, the other day you’re not.

Everybody knows that it’s not always easy to adapt to the new bosses that come, and I know I’m one of them, but it is for everybody the same. It is not always easy to adapt to each other. It’s a new country, it’s a new boss, new rules and he wants this like that and some ideas are good and some ideas are maybe less good. So in order to protect you, you can normally apply yourself and you don’t need to pass by a co-ordination. You can of course ask them to help you about how to go about it, what is the process and this and that.
But according to me, except if there is another rule for South Africa, until I heard this, I’ve never heard of that and it was always directly possible. And I think it’s important because it preserves your possibility, your freedom, your democratic freedom, I would say, to apply yourself. And then you can be refused, accepted. That’s another issue. And then you still have an employer which is then your national Mission that you have to discuss with on how you will hand-over or when you will go and this and that. So that’s normally the rule within MSF, but maybe there is a small change here.

**MS RASEROKA:** The actual application does not come to me, it actually has to go to the OC because of all the reference checks that have to take place. And that’s the difficulty because the natural tendency is to apply to me. I’m on the continent, I’m in South Africa and it’s easier to apply to me directly but I have to then take your document to the OC for all those reference checks. That’s what I’ve been told.

**CHAIRPERSON:** Fabienne?

**MS DE LEVAL:** To clarify, you can send your CV directly to Mmule but it’s true that the idea is to get references from the people who have been working with you. It’s more in the sense that it’s something that can be useful and it should be supportive of your request to become an expatriate. So the reason behind it is to try and get people who know you to give reference checks, be it Wim in Zimbabwe or Rachel in South Africa, it usually supports your proposal to become an expatriate. Then the reference checks go via Brussels but the actual recruitment can happen here in South Africa.

**CHAIRPERSON:** Last comment from Dick.

**MR VAN DER TAK:** Maybe to add to that on a slightly different track, I think actually there is great added value of the recruitment in South Africa. A little bit too black and white, maybe, and simplified but I think before, when a national staff member wanted to go for expatriation, he or she had indeed to get a recommendation from the Head of Mission, then it went to Brussels or to Paris or to Geneva, etc, etc. Then it’s a little bit what Wim said; sometimes you have a good feedback, sometimes you don’t have a good relationship.
And I think in particular what is important is that when anyone wants to work in an expat status with MSF, national staff or people from outside, they have an objective assessment of their skills, etc, etc. Part of that of course is that recommendations will be asked for. They will be asked for from the Head of Mission but also from another employer. And I think with South Africa, simply because you are proximate, you have great added value actually to help and to promote national staff who want to go for expatriation and to help them further in the movement. And I think, if that’s not the case, we should go for that.

CHAIRPERSON: Thanks, Dick.

GEORGE: I just want another questioned answered. Does the period that you have been in MSF play a role? Does it play any part in the recruitment? The period that you have been in MSF, how long should it be? The minimum.

MS RASEROKA: It’s two years professional experience and it doesn’t have to be in MSF. But if you want your MSF experience to be counted, it’s one year.

CHAIRPERSON: Eric?

DR GOEMAERE: Okay, I don’t qualify, so I’ll go for another subject. But no, it was part of the subject. I think it’s rewarding to see the attendance at this General Assembly and I want to thank all the colleagues who took the bus yesterday, early morning, to attend this from the region. MSF South Africa was set up - we just spoke about one example - to give operational support and certainly not in priority in South Africa but as you know, in the region and in the surrounding countries.

So two things here. One, I’d like to hear a little bit from the delegations that came from the surrounding countries. After you heard the summary of MSF South Africa’s activities, what would you suggest for next year? What could be something that you would suggest to be a priority in terms of activities that would support you?

And the second thing is not a question, it’s a suggestion that actually came from Jerome. I think that it’s time to change the name of this entity. It’s not MSF South Africa
because it’s the same way we don’t like to call MSF Brussels MSF Belgium. It’s an old acronym. We are a regional entity, so it’s MSF Johannesburg, I think, in the future but that will require a Board decision.

But I’d like to come back to the first question. Is it possible to have a bit from the delegation that came here, even in French, if you want, or in Portuguese - we will translate - a suggestion about what you expect next year from MSF Jo’burg?

**SWAZILAND:** Yes, from Swaziland, I think we’ve already started talking about contexts with the Medical Unit. I think very clearly we’re very interested in tapping into these resources for training, for support, for operational research and I don’t see any obstacle really at HQ level and we’ve been very transparent about this with HQ.

I think on communication, we’ve started already working on a couple of occasions. There was a bit of turmoil recently but I think we’re going to go back very soon on this.

I think, Jonathan, we’re also very much interested in collaborating more closely, including, and we discussed with Bridget earlier about the possibility of having some people from the team in Swaziland going to the Wits Law facility, doing the diploma. So I think that’s clearly important.

I think, more generally, on communication it would be very good if we could have some sort of a gathering where we would like to discuss how we want to position ourselves on some key issues in the region. Last week I was in Geneva and in talking to different people, there is an argument at MSF at the moment that MSF should refocus its public communication on itself and on what problems it faces in doing its work and that we should move away, to some extent, from trying to be the voice of other people. And on that note, I’d like to hear, maybe after people have answered your question, maybe from Sharon and Borrie - I know you’re very new - but also the people who have run for the Board.

I think it’s very important that generally speaking we are quite in agreement in terms of what we want to be talking about in the region. But I think, to come back to your question, having a gathering where we would really try to decide - because there is a lot
of coherence in this region, or there should be, and there are a lot of things that bring us together. I think it would be very interesting to do that at some point.

**CHAIRPERSON:** So more of the same but the new point of emphasis is on this idea of MSF South Africa being a facilitator for regional dynamic on common issues.

**SWAZILAND:** Because let’s be honest, I mean, some of us have an interest in this office or in this structure but your communication has not been great towards us.

**CHAIRPERSON:** We’ll do better.

**SWAZILAND:** No, honestly, we don’t have that much information, unless we come here, about what exactly is happening, so I think we can really strengthen that.

**MR KASSA:** I’m Alain from MSF Mozambique. I don’t like to speak on behalf of my staff because we came here with 19 people, 16 are Mozambican. Of course, it’s good that we have an office in Johannesburg because it’s very close to our place. We can even go by foot next year. And even more, we’ll try to hire two buses next year.

But for MSF South Africa or MSF Johannesburg, I think it was last year when we had floods in Mozambique, we were recommended by MSF South Africa as to why we were not doing a lot of lobbying, why was there no camera on the Zambezi River with the MSF logo.

Of course, for myself this is not a problem. I was just coming from MSF South Africa, MSF Australia, MSF France, I don’t care but for Mozambican's perspective it was endurance. It was, why South Africa, now they start to tell us what we have to do? I was thinking that, of course, like Eric said, be very careful of what your neighbours are thinking about endurance. South Africa could become one of the members of the Security Council of the United Nations and it will change a lot of things for us.

It’s already changed a lot of things because South Africa, for us, is seen more or less as a neo-colonialist, like the Brazilians are doing. So for us, the new branch or new office is very welcome because we are very proud to have an office in Africa but you should be
very careful of what are the perceptions of my colleagues. Because it’s MSF also but MSF South Africa and South Africa is just a big neighbour and we are sometimes afraid of it.

**CHAIRPERSON:** Moses?

**DR MASSAQUIO:** Thank you very much. I think for Malawi, we’ve got a very good relationship with MSF Johannesburg - okay, MSF in Johannesburg. Okay, let’s see how that will go in the future. But I think we are constantly being reminded, that as ... said, the ... is doing a lot of work. We have a special need. That is, for example, our nurses are a lower cadre because we don’t have the same kind of level of training that South Africa might have and most of the training aids that go into some of our cadres, they do need it. And we’ve kept asking for training for nurses. This is my territory, so I’m asking this. I would like to see some more, Eric, if it’s possible, if this can be arranged.

Another thing I would like to bring to this gathering is that a regional workshop, which is something we’ve started before, should maybe start again, where we can - because the General Assembly is good but it’s difficult to know all of what is happening in the region because we only have probably a few hours to share and then it gets dominated by MSF South Africa or the South African Mission. So if we could have some regional gathering, where challenges can be shared together and see how we can address them.

**CHAIRPERSON:** So, sorry we haven’t done the nurse training yet but you’re right to bring Eric in as well because the Khayelitsha Programme has a very good nurse training that they’ve been running for a long time now. So if we were to look at mobilising a nurse training to come to Malawi and other countries to do that, it would be depending very much on the training that the Mission has developed over the years. So I also need Eric’s support for that.

And again, a second call for MSF South Africa to be a regional dynamo for Missions exchange. Does anyone else have any points? Sharonann.

**MS LYNCH:** The period of appreciation is over. No, I’m just kidding. Considering that if there was more time, there actually would be more requests from the projects to MSF in
Johannesburg. There would be. The Programme Unit, Communications, SAMU, etc. My question is, it seems that the projects have more flexibility in terms of HR and getting head count because there’s a freeze now on this office and other offices. Is it possible to pool resources - a little bit from Mozambique, a little bit from Malawi, a little bit from South Africa - so that we can have one solid, dedicated nurse trainer for the region, for example? Can we explore creative options like this? I can keep on talking.

CHAIRPERSON: Yes, I hope so. I would agree that with the SAMU Report showing that we have eight months worth of people in the field, it’s a bit ridiculous to me that the staff of SAMU are counted as among people who sit in a headquarter office because we are effectively short of three quarters of one FTE for the period of the year while they’re mobile. And a position which would be highly mobile and much more in the field than in the office, I would hope that we could think imaginatively about under what category they are placed in this current freeze environment.

The vote count is ready, so we can hear about the election results but we still have a little bit more time if anyone wants to say anything more. Yes, Elma. This will be the last comment or question.

DR DE VRIES: It’s a question to the floor. I said yesterday in the Moral Report that we need to build the associative life and we’re not going to do that very well if we see each other just once a year. So what ideas have you got on how we can build this associative life? There’s been the suggestion of regional meetings around specific topics but are there other ideas on how we can build association? Thanks.

COMMENT: Well, there’s another key way in which associations meet, normally, throughout the year. It’s when there’s a Board meeting. So during Board meetings all associative members are invited to come and participate. There should be an open session to the Board and a closed session. So I think that’s something that maybe needs to be looked into.

There are normally, I think, Elma, three Board meetings a year, to see how far these Board meetings can actually be more accessible or more people can come to those Board meetings and maybe have more of an open session that actually interests people.
who are ready to do operational presentations of other projects during those Board meetings.

**CHAIRPERSON:** I think, rather than brainstorm, we should just take the comment as noted and note that we need to think of ways of keeping the dialogue going throughout the year. So we will work on it.

Thank you very much, everyone. I'm going to pass over to Sharon for the last word to conclude the meeting before we then go on to the election results. Sharon.
SUMMARY
Ms Sharon Ekambaram

Okay, I just want to quickly start with thanking the office staff, all of them. It was a real team effort to get these two days together. And to thank everyone who has come, participating and being involved right up to the very last minute in keeping the engagement and discussion. I think it’s been a very successful General Assembly.

If I have to just summarise what I think are the key things that came out that we do need to work on, I think Andrew made a very good suggestion around mapping the crisis in the various projects that we’re working in and seeing how that can inform where the gaps are and what can inform our strategic input as MSF with the HIV/AIDS crisis.

The Maputo Declaration was very important and endorsed in terms of the presentation.

Then there was a suggestion around the Access Campaign, the need for decentralisation of information, bottom-up approach and across sections. I think that was a very useful suggestion.

Aymeric’s suggestion on a regional discussion on how to position ourselves on key issues, which I think would be very useful.

And I think something that Hermann raised of MSF in Johannesburg disseminating information more to the field and to relevant key stakeholders.

(Tape 10a)
So I’d like to thank you all and looking forward to a very successful General Assembly next year as well. Thank you very much for your support.
COMPOSITION OF THE NEW BOARD

MS CEDERHOLM: Alright, as a representative of the Election Committee, I’m proud to present the 2009 South African Board. It’s:

- Prinitha Pillay
- Hermann Reuter
- Wim Fransen, and
- Elma de Vries.

MS EKAMBARAM: Can we just please give a big round of applause to Rebecca and Veronica for having been with us, for their very hard work and ensuring transparency in this process. Thank you.

Next Year’s Nominating Committee

MS CEDERHOLM: Alright, for next year’s Nominating Committee, the way it’s going to work this year, because we don’t have any real guidelines or processes for how to do it, we will collect nominations from the floor and then the Board will contact those people and find out if they’re interested and if need be, appoint. So are there any nominations for the Nominating Committee?

Okay, can the new Board members please stand up. Or the entire Board, everybody who’s on the Board.

Okay, so to explain again, what the Election Committee does is that they meet over the course of a year, either via email or telephone, and they look at the Board’s composition, they talk to the Board and find out what’s needed and then they solicit and look for members who they know or who they know of, that they think would be good members and ask them to run.

They also collect nominations from the general membership and make sure that there is a slate to be presented to the General Assembly next year. They don’t pick the Board
members. All they do is facilitate the process but we also need to write guidelines on how it works.

**CHAIRPERSON:** A question, yes?

**QUESTION:** Who is eligible to be on the Election Committee? Or rather who is not eligible?

**MS CEDERHOLM:** Well, members are eligible.

**COMMENT:** So office staff as well?

**CHAIRPERSON:** No, not office staff but other members. Moses?

**DR MASSAQUOI:** The results of the election was based on count, yes? Would it be possible to know in figures how - sometimes it’s good to know figures rather than just saying -

**MS CEDERHOLM:** It’s unusual to announce the number of votes that people got because it’s an election of your peers. I mean, that’s not really up to me to decide. I have to defer that question to the Board.

**CHAIRPERSON:** So the answer is no, unless anyone has anything else to add.

**COMMENT:** In fact, it varies from association to association. I know that in Belgium the voices per candidate are actually announced with the candidate when they’re put forward. I don’t know what it’s like in other associations. I think also in Paris, which are the two associations that I’ve been a member of. I don’t know if anyone else has another experience. Oh, Geneva as well.

**CHAIRPERSON:** I hope someone’s making a note of the things we need to clarify.

**MR KASSA:** It does not seem very transparent they way you are organising the votes. Sorry, I just want to explain myself. I think that a couple of people are sharing my...
opinion that we should have, minimum, how many people have voted, and for who. That’s the minimum, I think.

**CHAIRPERSON:** The rules around this we’ll get for next year. We’re going to vote on whether we’re going to see the vote count. So can everyone who wants to have the breakdown of the numbers put their hands up with the yellow card or just put their hands up. 22. Okay, thank you. Can everyone who doesn’t want to know the vote count put their hands up. 12. And can everyone who abstains, put their hand up. So the vote is in favour of having a breakdown of the votes.

**Breakdown of the Votes**

**MS CEDERHOLM:** Prinitha got 65 votes, Hermann got 61 votes, Wim got 44 votes, Elma got 41 votes, Andrew got 40 votes and Ziad got 27 votes. And believe me, we counted and recounted and recounted because they were so close. And actually Mmule was standing with us, checking us the last three counts because we were not sure that, you know, we didn’t want to throw it off by one vote.

**CHAIRPERSON:** So that’s it. Thank you very much for a very long but very interesting meeting. We have a party on the sixth floor which starts now. Hang on, we do have one comment.

**How to Become a Member**

**ZIMBABWE:** It’s a question about membership. Nothing has been said about membership, how to become a member, how to continue being a member. I don’t know how it is exactly.

**CHAIRPERSON:** Sorry about that but I don’t know the answer. Who can answer this question? Mmule will answer this question. How do you become a member?

**MS RASEROKA:** The easiest way to be a member is for you to - for those of you who are not members, you need to have worked for six months in the field and one year in the office, so those of you who attended this year and are not members, next year you’ll
be eligible. You need to pay a subscription, which is R100. It can be done through one person, so in the case of Lesotho, Tseleng was kind enough to organise it and in the case of Mozambique, Alain Kassa was kind enough to organise it. It can be done that way but paid before the actual General Assembly for next year. It’s as simple as that.

**QUESTION:** I’m from Zimbabwe. We pay to whom? Because when I go back I will advocate for members and then how will they do it?

**CHAIRPERSON:** So the question is, does it go through the Head of Mission of the country or is there another process? Is that right?

**MS RASEROKA:** I think that’s better placed at asking Wim at this point in time.

**CHAIRPERSON:** Is it in general workable that it can be co-ordinated within country or do people need to pay online to a South African bank account?

**MR FRANSEN:** In Brussels it works that national staff can pay for MSF B membership by withholding from their salary and there is a specific account number which refers and which is then checked in the Brussels account. I imagine we can do the same thing but that needs to be discussed with Finance and meanwhile we can do it cash through me or something like that.

**CHAIRPERSON:** So I’m going to suggest that we clarify this and we will communicate the process to the Heads of Mission in the region and they will make a notice in-country, so that anyone who wants to become a member will be very clear of the different ways of going about it. And that will be done within the next four weeks. Okay? So can we go and party now?

Thanks very much everyone.

**MEETING CLOSED**