

Läkare utan Gränser/ Médecins sans Frontières (MSF)



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This is a capacity study of Läkare utan Gränser/MSF-Sweden.

However, Läkare utan Gränser/MSF-Sweden is a partner section of the international MSF movement and the operational activities are carried out by other sections of the movement. The report therefore not only refers to Läkare utan Gränser/MSF-Sweden but to MSF as a whole.

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1. Preface

In the Terms of Reference this study was called “a modified capacity study”. What was called for was not really an assessment of the capacity of Médecins sans Frontières (MSF) in the ordinary sense, i.e. its capacity to formulate, implement, and follow-up its numerous projects. Instead it was the capacity of MSF to project developmental concerns into its humanitarian operations.

Very early on we realised that we were treading contested ground and that we had been placed at the cutting edge of two different (and to some extent conflicting) perspectives. During the course of study the “capacity issue” was therefore slowly broadened to include not only the way by which MSF incorporated developmental issues in its practice.

Equally (and possibly more) important was the capacity of the interaction between the two parties – MSF and Sida – to be based on a clear understanding of the driving forces and key concepts of each. This is the reason why we have moved beyond the issues and questions raised in the TOR and included a mock evaluation of MSF (section 10.2) using standard evaluation criteria rather than developmental ones, as well as also a section on the interaction between MSF and Sida (section 9).

Having said that we wish to stress that we do not claim to have understood MSF in their totality. As is pointed out in section 5 MSF are not easily put into one single mould and their range of operations is extremely wide, both as regards context/countries and in terms issues. It may also be that we have misinterpreted some facts and misunderstood others. Even so we believe that the issues we have dealt with do illustrate some of the bearing principles and practices of MSF.

2. Background

Sida has assisted the humanitarian medical relief operations of MSF since the late 1980's. Until the establishment of MSF/Sweden as registered Swedish NGO the support was routed directly to the Operational Centre in Brussels (OCB). As of 1993 MSF's interaction with Sida, including project-by-project agreements and corresponding financial transfers, was taken over by MSF/S.

During 1999–2002 a total of 39 MSF projects were supported by Sida in 16 countries, at total volume of MSEK 78. In sheer volume and spread the Sida assistance to MSF puts it in the same bracket as that of the so-called 'frame agreements' that Sida has with 13 other Swedish NGOs, an arrangement that simplifies the collaboration and avoids the cumbersome project-by-project application and approval routines.

However, the relation between Sida and MSF differs from that to any other NGO on a number of grounds. First and foremost, MSF have as a very basic principle that they will not comply with any other policy or strategy than their own – direct humanitarian action in support of people in distress, neutral not only with respect to local/national political forces or government agendas but also independent from the developmental or other agendas of donors, multilateral agencies or other NGOs. It can do so not only because it is enshrined in MSF's official 'mission'. It is also backed up by two core principles: (a) not to accept more than 50% of their total financial requirements from institutional donors – thereby providing an independence that few if any other NGO can afford; and (b) never to take on any project formulated by a non-MSF actor or institution. As a consequence, MSF will not, and cannot, comply with Sida policies except when these are identical with their own. Nor will they, or can they, consider possible Sida proposals for modifications of their own project proposals. The effect of this is that all institutional donors, and Sida among them, provide budget support rather than project support, as any project approved internally in MSF will be taken up with institutional donor support if possible or otherwise from funds donated by private individuals.

In addition, Sida's support to and contractual agreements with MSF is through MSF/Sweden, which is one of 18 Partner Sections or 'local chapters' of the international MSF movement. As such it is at one step removed from any involvement in the implementation of MSF projects

in the field, including those assisted by Sida. Full operational and managerial control of these projects is sub-contracted from MSF/Sweden to one of the five MSF Operational Centres.

Taken together these two rather unique features – the declared ‘irrelevance’ of Sida’s own policies and strategies in the field of humanitarian health assistance, and the formal project agreements being with a supportive rather than executive unit of the organisation – makes for a considerable degree of mutual non-transparency. What is the context and processes that guide the implementation of projects in MSF? What is ‘development’ to mean in the rough and tumble of MSF’s humanitarian practice? What are the criteria by which Sida assesses the alignment of proposed projects with its own policies and strategies?

Against this background Sida and MSF/Sweden agreed that a ‘modified capacity study’ should be undertaken in order to (a) outline the determinants of the policy-to-practice of MSF operations, and (b) review some issues central to Sida’s policy in respect to humanitarian health assistance.

3. The Assignment

The Terms of Reference (Annex 1) define the ‘modified’ capacity study of MSF as one which is anchored in three core issues¹:

- To what extent and how does MSF activities relate themselves to local health structures (i.e. local health service providers whether public or private)
- To what extent and how does MSF relate itself to other external supportive agencies or fora (i.e. coordinating bodies, UN agencies, NGOs)
- To what extent and how does MSF incorporate efforts to promote sustainability and long-term results of their activities

Apart from reviewing the interface between MSF policies and practice in the light of the issues above, another important aspect was to provide Sida with an insight into how MSF works as an organisation.

The study was to be based on (a) field visits to three countries or contexts in which MSF operates, (b) perusals of relevant documents and reports, and (c) interviews with individual staff members at MSF/S, Sida (SEKA/HUM), and OCB².

The countries selected for field visits were Sierra Leone, (South) Sudan, and Sri Lanka as these were deemed to represent varying stages of conflict dynamics. Within each country as many MSF projects as possible within the given budget and timeframe should be visited, regardless of whether they had received Sida assistance or not.

The study was carried out between April and June 2003 by a team from Gothenburg Development Group³ within its framework agreement with Sida. The team comprised the following members

- Gordon Tamm⁴ – teamleader, participated in launching of all country studies and throughout the South Sudan field visits
- Åsa Königson⁵ – Sierra Leone

¹ The ToR has a more “leading” way of putting these issues than what is done here. See below section 9

² Attempts were made to include visits also to MSF/H and MSF/F but time and budget constraints made this impossible

³ Gothenburg Development Group is a consortium of two consulting companies based in Gothenburg, Sweden: Swedegroup international consultants AB and Swedish Development Advisers AB

⁴ Senior partner at Swedegroup

⁵ Consultant at Swedish Development Advisers

- Malin Nystrand⁶ – South Sudan
- Chandra Vithanage⁷ – Sri Lanka
- Sebastian Tamm⁸ – Sierra Leone & Sri Lanka

⁶ Consultant at Swedish Development Advisors

⁷ Senior Consultant at CCC Consulting Services of Colombo, a joint undertaking between Swedegroup international consultants and Ceylon Chamber of Commerce

⁸ Junior consultant at Swedegroup

4. Approach and Method

The assignment was divided into four distinct phases.

- (i) Inception period during which documents and information on the various MSF projects in the selected countries were collected and reviewed. This included interviews with staff at OCB. The data was used to further specify the approach, issues to be dealt with, and timeplan in an Inception Report, which was discussed with staff from SEKA/HUM and MSF/S (See Annex 4)
- (ii) Field visits were carried out in a staggered manner involving different members of the team. The Teamleader participated in the start-up of each country study (and throughout the visit to South Sudan) to ensure that contextual factors were given due recognition in each case, while at the same time the study should pursue the common overall themes. The field visits invariably started with discussions with the different Heads of Missions (in all cases more than one, implying that more than one Operational Centre was running projects in all the countries visited⁹. Apart from an overall view and background of each Mission it also provided the necessary opportunity to select projects to be visited. The criteria for this selection were primarily travel time, accessibility/risk, and variation over OC:s.

Project visits ranged in time from an exceptional low of 4 hours¹⁰ to 3 days. Discussions with both expatriate and local staff were very informal and were adjusted to the often busy schedules of the MSF staff. A checklist was used to guide the interviews but more often than not the discussions drifted over a very wide range of issues and concerns. For each country visit a fixed time-frame of 10 days was allotted, within which as many project visits as possible (and feasible) were carried out. Needless to say, the logistical and security constraints of the contexts in which MSF operate meant that the actual field visits reflected 'the art of the possible' and plans were frequently derailed. By and large, however, they were carried out as intended (although not always as planned).

- (iii) Preparation of 'country cases'. Immediately after the conclusions of the field visits the three 'country cases' were drafted, highlighting

⁹ In Sierra Leone/Freetown the Teamleader was given the opportunity to participate in a regional meeting of MSF HOM:s (and some MedCo:s) to review the dynamics of the ongoing conflict in the region and the implications for MSF operations.

¹⁰ A project in eastern S Sudan (Lankien) which was possible by deviating and delaying the 'regular' MSF flight

variations over countries/contexts, over OC:s, over projects, and over activities. Given the often hectic workload and uncertain conditions under which the projects operated, the different ‘country cases’ had of necessity to reflect these uncertainties as well as the informal nature of discussions and interviews. Consequently, although they differ as to their form and scope of issues raised, they all embody information on the three overriding issues of the ToR (see Annex 5.1–3).

- (iv) Feedback presentations and discussions of main findings, incl. follow up of outstanding issues, with Sida (SEKA/HUM), MSF/S, and OCB. This was done separately with each in order to provide a more focussed as well as open discussion on issues relevant for each stakeholder.
- (v) Drafting of final report, incl. a presentation and discussion with MSF and SEKA/HUM jointly

This is not a study of how MSF’s handles Sida-assisted projects, even if Sida’s support was the triggering factor. In fact, only 4 out of a total of 11 visited projects were Sida assisted projects. The focus was instead on getting as large a variation as possible in terms of types of projects and contexts, as well as in terms of the OC:s that ‘owned’ them.

Informal discussions (even if guided by a checklist) and often cursory site visits turned out to be the primary form of collecting information. It therefore goes without saying that many conclusions and reflections are based on very soft data and relate primarily to specific situations and contexts. It should therefore be stressed that the study can in no way be said to cover MSF as a whole, nor is it necessarily representative in terms of the issues it raises or the inferences drawn. Even so we believe that it does capture much of the strengths, the underpinnings, and the uncertainties of the practice of MSF. More importantly, as the starting point and rationale for the study was the interaction between MSF and one of its more important institutional donors, the information as well as the analysis was consciously biased towards the light they could throw in that interaction rather than on the dynamics of MSF as such.

The “sample” – field visits

As pointed out above the study involved visits to three countries that were partly chosen for their different positions along a peace – conflict scale:

- Sierra Leone: a post-conflict situation in the middle of a very unstable region
- South Sudan: unstable with sporadic conflict in a situation of severe deprivation and underdevelopment
- Sri Lanka: an irreversible peace process with pockets of tension

In total 11 projects were covered, distributed over all the three major Operational Centres:

Country	Projects covered	Sida supported
Sierra Leone	3 (Holland, Belgium)	2
Sudan	3(+1*) (Holland, Belgium, France)	0
Sri Lanka	3(+1*) (Holland, France)	2
Total	11	4

*Closed projects

5.MSF

– Action and Voice

MSF Mission Statement

MSF works in situations of crisis, and carries out its actions to relieve human suffering from unmet medical needs, and to create a place for humanity. MSF works to provoke a social and political response that meets the essential needs, and respects and protects the dignity of people in danger. MSF strives to innovate and incite change through its medical action, its *temoignage*, and its active reflection on the situation of populations in danger. Committed to its Charter and shared principles, MSF is an independent movement of citizen associations that interact openly with their societies. In a spirit of volunteerism, proximate and in solidarity with assisted peoples, MSF's members adhere to humanitarian principles and respect for medical ethics.

In a certain sense Médecins sans Frontières do not need any presentation. With their longstanding and well-publicised track record of humanitarian medical support to people hit by wars and natural disasters, and with a Nobel Peace Prize to boot, it has one of the strongest 'brand-names' among all NGOs active in development or humanitarian work.

But behind this lies a very complicated system, even if carried by a small set of firmly entrenched values and guiding principles. What makes this system tick and what makes it an extraordinary effective tool for translating the rather lofty values and principles into practice is the insistence of MSF on two straightforward directives:

- Direct *action* to give immediate medical assistance to people in distress
- Unbiased *voice* for those whose rights have been violated by the powers that be

We will in this section look at the framework within which these directives are played out.

5.1. Key Values

The general documents that contain the common values of the MSF movement are

- the Charter of MSF, and
- Guiding Principles of the MSF movement.

The main points in these documents are:

- *Medical activities* first, with *témoignage*, i.e. witness against human rights violations, and other types of interventions, such as provision of water, etc as essential complements
- *Focus groups* are
 - populations in distress,
 - victims of natural or man-made disasters,
 - victims of armed conflict
- The role of MSF is based on *neutrality and impartiality* in the name of
 - universal medical ethics and
 - the right to humanitarian assistance
- The organisation is based on *voluntarism*, i.e. action based on the commitment by individuals, and run as an *association*, i.e. the volunteers' active participation in the organisation.

These are the key principles on which all the MSF organisations and activities are based.

5.2. Operational policies and strategies

There are no unifying operational policies and strategies for MSF as a whole, other than the two value-base documents mentioned above. All policies and strategies are developed separately for and by each MSF section. There is no common framework for the policies and strategies. Some sections have an annual plan, while others have a three-year plan or policy and others again have both.

The actual priorities put forward in the annual plans of the OC:s are rather similar. For 2002 and 2003 there is a common focus on:

- Improvement of quality rather than growth
- Specific focus on malaria, HIV/AIDS and tuberculosis

The medium term policy documents contain strategic discussions on the changing external and internal environment and MSF's role, while the annual plans are focused on operational priorities.¹¹

With respect to OBC the operational 'strategy' or list of priorities for 2003 can briefly be summarised as follows:

(a) Overall priorities:

- improvement in quality of medical assistance
- increased emphasis on effective curative measures to specific diseases (malaria, AIDS)
- strengthening conflict response programmes

(b) Target situations:

Four activity axes:

1. Victims in conflict
 - Refugees and displaced persons
 - Nutritional emergencies
 - Epidemics in areas of conflict

¹¹ The same approach of developing medium-term strategies and rolling annual plans

- Access to basic health care in areas of conflict – remains one of the most important areas – not only in acute situations, but in particular in complex emergencies, chronic conflicts and recent post-conflict situations
- 2. Emergencies in stable contexts
 - Natural catastrophes – emergency preparedness
- 3. Access to care in stable countries
 - TB, Malaria, Trypanosomiasis and other neglected diseases – MSF should continue to be a key actor
 - Populations in poor rural areas – isolated populations excluded from health care – issue for témoignage
 - Populations in excluded urban environments – focus on excluded populations, i.e. ‘street people’, develop expertise for other excluded urban groups
 - Migrants and asylum seekers in developed countries – issues of access to care and respect for basic rights – national MSF staff
- 4. AIDS
 - Increased MSF investments
 - Countries with high prevalence but low capacity of response
 - Promote quality of treatment
 - Support actors for change – networking with other partners

(c) Transversal (or cross-cutting) priorities

- Mental health
- MSF concentrates on exogenously determined mental health, i.e. war, exclusion, persecution, poverty, violence etc – promote systematic inclusion of mental health care in projects for victims
- Water, hygiene and sanitation
- integrated in health care programs to increase quality and impact of these medical programs – WHS activities should stem from a medical need
- Women’s health
- Ensure access for women – inclusion of reproductive health care in primary health care (not MCH) – emphasis on Sexual and Gender Based Violence (SGBV)
- Access campaign

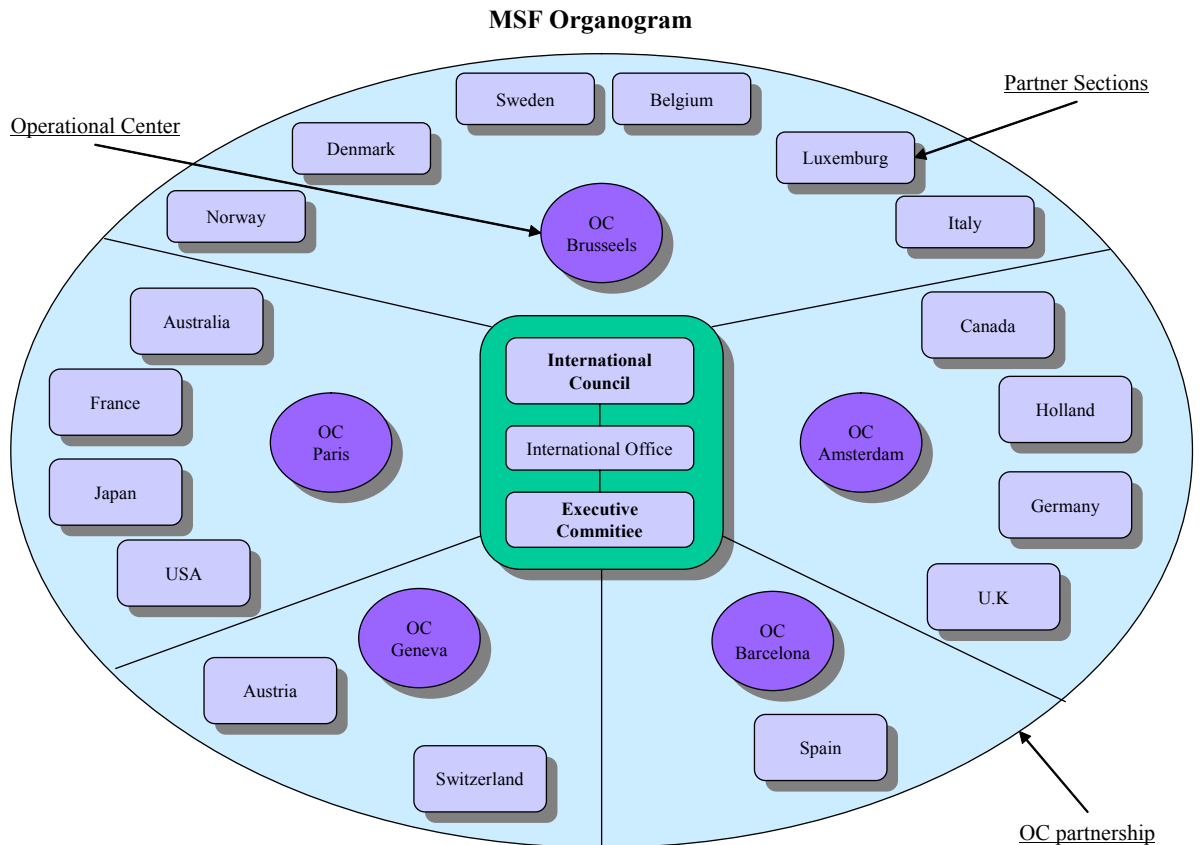
For each of these priorities are given a number of ‘strategic considerations’ that are intended to guide the development, management and implementation of specific projects. In general they all emphasise the need for MSF to be ‘self-sufficient’ in terms of technical know-how, in understanding the socio-political and epidemiological context, in supply and logistics etc.

In content and focus the priorities do not look very different from that of any of the major institutional donors engaged in humanitarian health assistance except in two ways. Firstly, the depth and extent of ambition in the medical/curative field, secondly, the very marked emphasis on direct action and a corresponding absence of such themes as HRD, institutional development etc.

5.3. Organisation

MSF present a mixture of organisational principles that makes them difficult to pin down in any single format. This is not only so for outsiders, but even longstanding insiders give different interpretations of the structural logic (or lack of it).

The various components of the MSF system are depicted in the following organogram.



In global terms the MSF system is made up of 18 national partner associations (Partner Sections) that are member-based NGOs registered in their different countries and each with their own specific Memorandum of Association. These sections are in turn associated to form the global MSF with an International Council and Executive Committee.

In terms of coordinated fund-raising and recruitment the 18 national MSF associations are grouped into 5 partner groups, each with a largely autonomous Operational Centre (OC) that has its own Board. Although there are links and personal connections between the various components, each is to a great extent independent from the other – the relations between them gain meaning and concreteness from the specific issue or activity at stake.

5.3.1. MSF – the Movement

At an overall level and in most official documents MSF prefers to call itself a *movement*, echoing its roots in the radical humanitarianism and activist ideology of the 1970's. In the spirit of that tradition it has an innate resistance to develop formal centres of authority, of hierarchy, and

of bureaucratic structures. As such it is one of the very few activities NGOs that has not only grown exponentially over the years, in terms of global reach as well as scope, but in so doing also managed to retain the element of rebellious ‘anarchy’ on which it was founded. Indeed, its success in maintaining an independence from the political and economic powers can in no small measure be attributed to its internal refusal to ‘become one of them’, i.e. the bureaucratically organised and slow-moving government agencies, multi-lateral institutions, or even developmental NGOs.

The movement aspect touches, however, only part of the MSF, and is most clearly seen at the two ends of the MSF spectrum:

- (a) The International Council (and along with it the Executive Committee) – an elected body that is both a gate-keeper and a safe-keeper of the MSF values. The IC has little directive powers and does not lay down any operational policy or strategy¹², but acts as a clearing house for broader issues as well as the global voice of humanitarian concern and ‘temoignage’ in various global fora or UN contexts. In all these roles it corresponds well to being the hub of a movement rather than a ‘board’ of an international organisation.
- (b) The (non-operational) Partner Sections of which MSF/Sweden is one. These are member-based national ‘chapters’ of the MSF movement, with similarly little direct operational responsibility or mandate. As such they give voice to MSF concerns in national public fora and mass-media, as well as act as a channel through which interested professionals (through recruitment) and the general public (through donations and/or volunteer work) can join or support the MSF movement.

At the heart of the MSF movement lies the ability of MSF to inspire support for its cause and the values it stands for. As such it is the mechanism for *recruitment* whereby professionals volunteer their services – for field projects or for the national associations. It is also the vehicle for *fund-raising* from the general public. More than mobilising resources both these efforts serve to maintain an active public focus on and solidarity with people caught in the clutches of civil war, struck by natural disasters, or generally without recourse to minimal medical services.

5.3.2. MSF – the Organisation

Beyond that of being an activist movement MSF is also an implementing system, an organisation that has charged itself with providing effective and quality medical services to specific trouble spots. In this respect it ceases to be a movement carried by a value system and loosely connected nodes, and relations between and mandates of the various components of the MSF are accorded certain structural features.

At the centre of the MSF Organisation stand the five Operational Centres. They are the ones that are charged with organising, supervising, and coordinating all field interventions, and are at the receiving end of the fund-raising and recruitment efforts of the national partner sections and in which they are only indirectly involved.

¹² It does, however, initiate or endorse MSF common stand on such issues as the Access to drugs campaign, or approve launching of the associated entities in the name of MSF (e.g. Drugs for Neglected Diseases Initiative – DNDI – which is planned to be constituted as a non-profit organisation in July 2003)

The OC:s all have the professional and technical functions required by an executive headquarter of an implementing organisation – logistics, technical departments (the content and nature of which vary over OC:s depending on specialisation), financial and administrative departments, operational management etc. They also each have separate management lines into the field with each OC having their own country representative or Head of Mission (HoM) – in one country there may be up to five MSF Missions each reporting to their own OC and each comprising a cluster of projects.

It is this line – from a field project through the country Mission to the Operational Centre – that forms the organisational backbone of the MSF system. In reality there are five parallel organisations emanating out of the OC structures with no strategic management that binds them together or links them to the MSF Movement.

5.4. Mandates, roles, and relations in the MSF system

5.4.1. Operational Centre

The operational centres (OC:s) are the hubs of the executive management structures of the organisation. The five OC:s are separate organisations with separate management structures. All five are, however, organised as matrix structures. The following outline is based on MSF-OCB, but the other OC:s would have similar structures..

At the centre of the organisational chart is the Operations department, signifying MSF's focus on action and activities. The Operations department is divided in to cells¹³, each with operational responsibility for activities in specific countries. Each operation cell consists of an operations director, an operational coordinator, and

- a medical officer,
- a logistics officer,
- a financial officer and
- a referent field administrator.

The positions within the operational cells are matched by and coordinate with the other departments of the OC;

- Medical department
- Logistics department
- Finance department
- Human resource department

The Operations department also includes press officers, which coordinate with the Communications department.

The Operations department as well as the other departments report directly to the General Direction, which is the executive management of the OCB. The General Direction reports to the Board of Directors that report to the Annual General Meeting of MSF-Brussels, i.e. the members.

The operations department is the decision-making unit for activities in the field. Launching a new project, closing down a project and all

¹³ Seven in the case of OCB

major strategic changes in an ongoing project are decisions taken by the operations director of the cell concerned. The other departments have a more supportive and specialist role.

Some specific characteristics of the OCB

- Operational cell with the Luxembourg section
One of the operational cells within the Operations department is 'delegated' to or situated at the Luxembourg MSF section, which is a partner section. The staff within this operation cell coordinates with the support department at the OCB, in the same way as the other cells. The Luxembourg office has their own Finance, Human Resources, and Communications positions as well as Executive director and Board of Directors, but no Medical and Logistics positions.
- It is the largest of all the OC:s with more than 250 projects operating in 42 countries (2002). In terms of expatriate postings (volunteers) it has, however, relatively fewer than the OC in Paris – 550 over 250 projects against 500 over 82 projects.
- WHS
OCB is the only OC that has a Water and Sanitation unit. This unit does not really fit into the organisational structure, but is located in the Medical department. Three of the five persons in the WHS unit of the Medical department are also organisationally placed as WHS advisors under the Operations department.
- OCB and MSF-B
The Belgian MSF office has felt a need to separate its OC responsibilities from the Belgian specific responsibilities. Therefore, attempts have been made to separate these functions, especially in relation to the partner sections, allegedly in order to increase the partner sections' responsibility for the OCB. The corresponding positions for OCB and MSF-B are held by the same person in all but one case, making the distinction somewhat academic.

5.4.2. Country Missions

Although the MSF country missions are largely identical in terms of their set-up, management and main orientation, their roles and more importantly their priorities and mandates differ – over OC:s as well as over countries. Generally speaking, a country mission is the supervisory and coordination unit that is responsible for (a) monitoring the dynamics of a conflict/distress and to ensure a preparedness both for security issues and for additional humanitarian interventions (b) provide quality assurance, logistical and technical support to field projects, and (c) liaise with the home office OC on technical as well as organisational issues. Within those parameters the Head of Mission (HoM), and along with him/her the Mission Management Team have a large scope to put their imprint on MSF operations. For some OC:s this is further accentuated by a greater emphasis on decentralisation (MSF/H) whereas in others the tradition as also the management provisions are more centralised (MSF/F). Whatever be the case, the different missions can and do influence the MSF practice in a very real way, and also give MSF a face in the national

environment. More than that, the personality of the HoM is probably the most decisive factor in giving that face a substance (cf section 7.1. below)

The country Missions are also the ones that interpret the contextual dynamics in which the MSF operations find themselves. Although major decisions are taken only with a go ahead form, or at the instance of, the respective OC:s, it is the HoM:s that set (or can set) the agenda for the tone and extent of MSFs practice on such critical issues as coordination and collaboration with others (e.g. with the UN bodies, with coordination platforms, with donors, with local government structures). Similarly s/he, in consort particularly with the Medical Coordinator of the Mission Management Team, can encourage, endorse, or discourage changes in the ongoing practice of the projects – thereby influencing the medium and even long-term role and relevance of concrete MSF intervention in much deeper way than can the more short-term staff at the project level or the distant OC. However, this depends largely on personalities more than anything else due to the reluctance of MSF to formally locate strategic management at any specific level. We have consequently seen examples of strong field (or project) coordinators setting the agenda more than the HoM or the OC, as well the OC ‘imposing’ its will on both HoMs and project level management.

Between the different country missions within the same country we did not come across any structures or ‘rules’ of how this was to be done: in fact the various country missions appear more as ‘embassies’ of their respective OC’s than as a team representing the same organisation. In that vein, one of the critical areas for the HoM and generally the country missions is to act as spokespersons for the MSF in various fora. This includes that of using the tool of *témoignage* (although this is done in close consultation with the respective OC) as well as lobbying and running consultations with government representations etc. In essence this means that it is the HoM:s that makes know the position of MSF in the local political and institutional environment. With no formal structures or routines of internal coordination between the various MSF country missions even within one country, this can (and often does) cause some confusion – externally as well as internally – as to what MSF (rather than some unit within MSF) stands for.

The lack of formal platforms and mechanisms of coordination between parallel lines of operational management – from projects through Missions to individual OC:s – is a problem of which MSF is aware and it spills over also on the Partner Sections who are otherwise outside these management lines. This is well illustrated by the Mid-term Policy document of MSF Sweden (2003–2005):

“Mutual trust and interdependence of the MSF-sections – we all know of intersectional quarrels. Lack of coordination in formulating *témoignage* messages in the press releases, disagreement addressing the root causes of conflict or not, the best way of conducting operations in a certain extent, only to mention a few. The fact is that we are interdependent, have to answer to what other sections do or say when people see us as one. On top of that we can be stronger of joining forces in all our home societies. We have to solve that in order to become stronger in our role to provoke change, while at the same time keeping our reactivity.

Common co-ordination team in the capitals – as it is now we usually have several co-ordination teams in the capitals. This is costly some believe a waste of resources. In the Government of Burundi in 2002 this ended up in an intersectional conflict on the strategies used before we could find a common one.”¹⁴

5.4.3. Partner Section – MSF Sweden

The national Partner Sections function as local ‘chapters’ of the international MSF movement, although they have their own Boards and slightly different rules as to membership qualifications (associates). With respect to OCB the relation between the Operational Centre and the partner sections is somewhat fluid and vague, based on a the partner sections acting as ‘owners’ of the OC with representation on the Board, but with a ‘gentleman’s agreement’ of non-interference in any managerial or operational matter.

The main responsibilities of a Partner Section such as that of Sweden are:

- To assist OCB (and through OCB, the international MSF movement) in
 - Recruitment
 - Fundraising (private & institutional)
 - ‘Temoignage’
 - Influence donor policies and priorities in line with MSF values
- To participate in ‘guiding’ the OCB through membership of the OCB Board and through exchange of views and experience with OCB management
- Publicity and information in Sweden about (medical) plight of populations in conflict and disaster situations around the world

The Partner Sections are all member-based, with the members (or “associates”) being individuals who have served as MSF volunteers at home or abroad for a specified length of time and who pay their membership fees.

Although these national associations are critical for the survival of the MSF movement as whole, their role is very limited in terms of the MSF organization, i.e. in terms of taking part in the actual implementation of projects. The closest they come to strategic issues in connection with field activities is probably in the dialogue they have with the institutional donors. In the case of MSF Sweden it is often called upon to answer questions from Sida regarding specific projects, questions that are generated not only out of the project proposals at hand but also from the continuous contacts and dialogue between individuals at MSF and Sida.

¹⁴ Medium Term Policy 2003–2005 Focus And Identity Of MSF-Sweden, “The capacity to question”.

6. Country Cases

6.1. Sierra Leone

Even though Sierra Leone is a rich country considering the natural resources such as oil, diamonds, gold, the country is considered to be one of the poorest in the world. The natural resources was an important factor in the civil war of Sierra Leone. The war began in 1991, by the Revolutionary United Front (RUF) that had gathered strength from Guinea in order to overthrow the current government in Sierra Leone. Finally, a peace treaty was signed between the Government of Sierra Leone and the RUF in 1999. However, the treaty did not mean a complete end of the war. The situation was stated as “relative peace”. Now, after the war, Sierra Leone is facing the difficulties with an entirely collapsed infrastructure including health structure. Ministry of Health is slowly managing to recover themselves. Especially in the more remote areas of the country the problems such as lack of qualified medical staff and medicine are still widely spread. In addition the war situation forced large numbers of people to abandon their homes. In order to help them several IDP camps were initiated in the South eastern parts of Sierra Leone. Later on, when the situation became less intense in Sierra Leone, the conflict arouse in Liberia. The camps former used for IDP now we became a refugee camp of Liberian refugees.

Sierra Leone has since the war struggled with rebuilding of the infrastructure with insufficient funds at hand. Even so there were noticeable differences between Freetown and the rest of the cities and more remote areas the team visited.

Presently, three different MSF sections are operating in Sierra Leone. All of these three have their country office in Freetown. The humanitarian/medical areas and issues that MSF has committed themselves with in this region is:

- emergency surgery on victims of the war,
- outbreaks of epidemics,
- primary health care
- training of Ministry of Health (MOH) staff
- treatment of mental health problems and
- treatment of ghost limb syndrome.

We got to visit the country office with respective HoM for MSF-B as well as MSF-H. Apart from that the team visited three projects:

- Bo (MSF-B)
 - District hospital and
 - 4 of the refugee camps where MSF-B is an important actor.
- Kabala (MSF-B)
 - The Fabala clinic one of the remotely located clinics within the project.
- Makeni (MSF-H)
 - The Makeni District Hospital and
 - Kagbere clinic, one of the remotely located clinics within the project

Presently there tend to be different views on the need for MSF to stay.

6.2. Southern Sudan

Sudan's civil war has been going on for two decades. The main divide is between the Arab-Muslim population in the North and the black Christian and animist population of the South. The North has long held political power, while the country's natural resources are found mainly in the South. Several peace initiatives have so far proved unsuccessful. The combatants are the Government of Sudan (North) (GOS) and two liberation movements of the South; SPLM and SDPA, who currently are in a process of merging to one. At present there is a cease fire between the GOS and the SPLM, but local warlords and clan fighting make sure to maintain the insecurity of Southern Sudan.

Southern Sudan is very underdeveloped: social services and physical infrastructure is virtually non-existent; no schools, no health system, destroyed water distribution systems, non-existence of roads, etc. Furthermore, the country is prone to environmental crisis, such as drought and floods, affecting food security and access. All transport has to be made by air.

Four MSF sections are working in Southern Sudan, spread out from West to East and from South to North. Activities include:

- primary health and hospitals;
- TB, Malaria, Kala Azar, sleeping sickness programs;
- nutrition programs and
- water programs.

Three MSF sites were visited; two in the Eastern part, which is rather insecure due to clan fighting and warlordism and one in the Western part, where SPLM is in control of the rural areas. One of the projects was focused on primary health care, two projects included large vertical programs and one project included a large PHCC, which was in effect a hospital.

Southern Sudan's 'double' problem of long-term conflict and grave underdevelopment poses specific challenges to MSF as well as other actors in the area. The line between emergency activities and development activities is difficult to draw and the risk of becoming a service provider and be captured by local political actors is obvious. Several of

MSF's projects in Southern Sudan have been going on for around 10 years and the role of MSF as an emergency actor is difficult to maintain.

6.3. Sri Lanka

More than twenty years ago (1979) the civil war between the Tamils in the north and the Sinhalese started. The Tamils (brought by the British during the colonisation) has ever since felt like second class citizens and wanted to claim their rights. In 1983 militant groups was formed and claimed an independent state "Tamil Eelam". The conflict between the two parties got even more tense. In 1990 The Liberation Tigers of Eelam (LTTE) was the only Tamil militant group fighting against the Government, mainly by guerrilla warfare i.e. assassinations of politicians etc. The war went on with periods of stalling peace negotiations and fluctuations in the intensity of the crises. In December of 2001 a cease-fire agreement has been formalised monitored by the Sri Lankan Monitoring Mission (SLMM). This agreement still holds and the situation can be illustrated as "No war no peace" scenario. During 2002 there was still some tension and rioting exists between the LTTE and the Muslim community in the East.

Regions in the northern parts of Sri Lanka are devastated after having been the war zone for many years. The heavy LTTE recruitment of Tamils is also an important factor contributing to the difficulties in the development of the LTTE controlled areas. In Sri Lanka there has never been a total collapse of the national health system but it is glaringly absent in the more remote areas in the northern parts of the country.

Presently, two MSF sections (MSF-F and MSF-H) are located in the area. The geographical focus is the war affected areas i.e. northern and eastern parts of the country. The activities include surgery, obstetrics and gynaecology services, Paediatric care, Primary health care, malaria control, pain management, psycho-social care, waste management, training of MoH staff and volunteers.

A part from the respective country office we got to visit two operating programmes, the psycho social programmes in Vavuniya and the operation of surgical/maternity ward in Point Pedro Base Hospital. We also visited the Mallavi Hospital, from where MSF has recently phased out.

Both of the HoM feel that the time has come to phase out MSF's presence in Sri Lanka, given that the situation doesn't become more tense again. MSF-H has a more cautious approach to a total phase out, while MSF-F will have left Sri Lanka at the end of July if the security situation does not change.

7. Operational issues – what guides MSF operations?

7.1. Role And Relevance

At OC level we have not found any instruments or procedures that are designed to help the operational units in the field to answer such questions as: how long should we continue what we are doing here in face of the continuously pressing needs and new emergencies elsewhere? When do MSF's specific advantages become irrelevant and possibly liabilities in the context in which they are played out?

This should be contrasted with the very strong set of guidelines and procedures that guide actual implementation and ongoing activities. In a sense this should not come as a surprise. As MSF has taken upon itself to provide medical assistance to people in acute distress the focus is clearly more on how to efficiently provide that assistance as well as one can. Consequently the role and relevance of what one is doing is given in the very reason for doing it. The problem comes not at the conceptual level or coordinating level (OC), or even at the level of management support and positioning MSF in relation to other actors (Mission), but in the field. The most frequent issues raised in our discussions with field staff – local as well as national – were those of role and relevance. This was particularly so in project settings where MSF had been present for a long time – which comprised the bulk of the project sites visited.¹⁵

If the vertical lines do not carry any clear strategic management beyond that of the often very experienced know-how of individual staff at the OC and HoM level, the horizontal processes are even weaker – the relations between OC:s, between HoM:s or between projects (see above section 5.4). It is quite common that the different MSF mission in one and the same country have different understandings and make different 'readings' of the dynamics and trends within the country/context in which they operate (See Annex 5 for the 'country cases'): what is relevant for one mission in terms of priorities, length of presence, and need to coordinate/interact/relay with others differs, and sometimes markedly so. The only case where we found a more systematic attempt at a joint definition of the context, and consequently a shared (if not joint) response to changes in the socio-political environment, was in West Africa. This was partly due again to individual factors, but more to the absolute

¹⁵ MSF requires that an emergency intervention that moves into a longer term presence should be defined and formulated as a new project. However, from what we saw this meant primarily shifting the justification from the acute situation towards the need for 'presence', for providing a service because no one else did, or for serving a refugee camp until it closed, etc.

need to share information about a conflict that is in reality a complex web of interconnected power struggles that spills over from country to country (see Annex 5.1).

Again, this is not something that MSF is unaware of – the conflict between the need for having a common internal strategic management process with the perceived need to maintain the activist movement nature and avoid becoming a hierarchical organisation ‘like those that have lost sight of the humanitarian imperatives’ has been and continuous to be a standing source of apprehension within MSF. In the late 1990’s attempts were made to resolve this and explore ways by which a strategic guidance could be put in place for the entire MSF. This was in the end rather less than successful and left behind a document that is more informative about what it does not say than for what it does not¹⁶ (see Annex 4).

In the partner sections there seems to a greater willingness or capacity to undertake both strategic analysis and strategic planning¹⁷. Again, this is perhaps not surprising as the partner sections have a more confined space of mandate and operation than the OC with the world as their field.

7.2. Strategic Alliances

A basic principle, and almost existential criteria, for MSF is the one of independence – and its mirroring demand of being self-reliant as far as possible. This is what permeates the entire logic of MSF operations, and is particularly strongly argued at the level of country missions – i.e. at the level where positioning MSF in relation to other actors is done. There is no doubt that there is a very strong logic, and quite possibly a real need, for having at least one ‘free agent’ in situations where almost everyone else is tied up in relating to each other as much as to impacting on the situation on the ground – someone that keeps an undiluted focus on the human beings rather than on the sidelines of the institutional environment and the medium/long-term trends. However, the very strong allegiance to the concept and practice of independent action works less well, and is in our view sometimes distortive, when it comes to the ground level activities themselves. Disengagement often requires some form of strategic alliance, a notion of relay-ship or handing over. The lack of support or guidance for such a process makes it difficult for field staff – and missions generally – to do much more than letting the context itself take care of such decisions¹⁸.

At another level we also believe that the very insistence on independence makes MSF overly reluctant, and sometimes perhaps blind, to engage in constructive if informal agreement with relevant others. The only organisation with which MSF seems to have a standing interaction with that has weathered both time and contexts is that with the ICRC. This is probably so because the two organisations are similar in scope and mission at the same time as they are different enough to complement each other.

A notable lacunae is to our mind the reluctance or willingness to engage in a ‘strategic relay’ with institutional donors. This is particularly

¹⁶ See Annex 4 for the outcome of these workshops – The Chantilly Statement

¹⁷ Our experiences from partner sections are only gathered from MSF-Sweden.

¹⁸ See Annex 5.2. and 5.3

so with respect to the so-called like-minded group and even more so as regards the Nordic donor agencies. The latter are noted for the strong involvement in, and financial support to, UN agencies and especially so with ‘softer’ ones that are the most relevant for humanitarian actions. UNICEF, UNHCR, WFP, etc. It would seem natural that the MSF makes more systematic attempts to channel their lobby efforts as well as concerns through the partnership of the institutional donors that support them. The effectiveness of work hand in hand with donors in that way, even if only at the country or mission level, was illustrated in Sri Lanka¹⁹.

7.3. Entry

Entry (or start-up) is of all the challenges faced by MSF operations the most simple as well as the most complex. It is simple because the triggering mechanisms are fairly well defined: inadequate or collapsed health services in situations of conflict or disasters (all countries visited by the team), build-up towards or actual epidemic outbreaks (parts of Sudan, refugee camps), or marginalized situations with extreme under-development (parts of Sudan). It is complex because it requires building up specific and tailor-made solutions for effective supply and support lines to frequently very inaccessible locations.

In designing a specific intervention MSF lays particular stress on ‘substitution’, by which is meant taking on activities that would otherwise not be undertaken and which have a direct bearing on the emergency at hand. Examples of such substitutions range from providing surgical services to victims of conflicts, special feeding programmes for children with acute undernourishment, treatment of TB patients, and treatment of specific diseases such as Kala Azar²⁰. The logic of this is that as the emergency situation passes and conditions go back to normal, the MSF assistance can be withdrawn without having created an unsustainable increase in the normal health service. This is also the logic of aligning the services with existing health structures without any specific effort to increase their long-term capacity beyond that of providing hands-on demonstration and training. In fact, one might very well argue that a major consideration in MSF’s entry strategy is how to avoid interventions that emphasizes sustainability as an integral part – leaving those to others that deal with long-term institution-building: local politicians and public office bearers in the first place, but also institutional donors and development NGOs.

On the face of it such an approach can be seen as both justified and rational, even if factors such as local insatiable needs, duration of MSF presence, and the rapid turnover of expatriate volunteers make it difficult to maintain (see below and section 8.2). But there is an added value of emphasising ‘substitution’ in humanitarian medical relief work. The location and reach of health care institutions in conflict areas are determined by the logic of the conflict itself. This may very well mean that they are sub-optimal in long term perspective or may even become distortive liabilities if they were to be sustained and maintained beyond their temporary humanitarian need²¹.

¹⁹ See Annex 5.3

²⁰ See ‘Sri Lanka’ and ‘S Sudan’ in Annex 4

²¹ See for example Malawi in Sri Lanka, Annex 4.3

7.4. Continued presence: what makes MSF stay on?

In many locations MSF has been present for a very long time, and often long after the crisis that caused its entry has subsided. The project configuration may have changed, some activities may have discontinued and new ones have been added. As a result the project may be more recent, but the location in which it is played out is often the same. The objectives may similarly change from direct emergency support to war victims to more medium term objectives such as “...to provide accessible primary and secondary health care services...”.

Type of on-going projects

The on-going projects vary in type, scope and duration. The type of on-going projects can be classified as follows:

Program or project	Examples of objectives for on-going projects	Location	Examples
Vertical programs Conakry	“Reduction of HIV/AIDS”	Often country or	Guinea
	“Revision of the Malaria protocol in a country”	region/district wide	Sierra Leone
	“Containment and reduction in the number of TBC cases”		Sudan
Medium to long-term location based programs	“Provision of accessible primary health care in x village or refugee camp”	County, district or city/village	Kabala clinic program, Sierra Leone
	“Provision of quality emergency health care”		Bo Hospital, Sierra Leone
Monitoring projects	“To monitor the health situation in x district”	County or district	Kabala clinic program, Sierra Leone

MSF often establishes a base where a disaster has occurred, thus providing the justification for their presence in an areas. When the situation changes, the local health care facilities and the competence are often found lacking, therefore providing a reason for MSF to stay in order to help re-construct the health infrastructure, in many cases both in terms of the physical structures as well as medical competence.

The scope of the on-going programs varies, from very narrow or specific, such as that of focusing on one community or habitation or on one type of disease. Other such projects have more indefinite objectives that provide little guidance as to when the objective has been achieved i.e. “Provision of accessible primary health care in community x”.

Changes in the scope of on-going projects

The scope of the on-going projects often changes, as the health situation in the area either worsens or improves, or even as new volunteers come and go. Such changes include

- widening or shrinking the geographical area of coverage (increasing the number of local clinics receiving support),

- limiting or increasing the type of medical and health assistance available (e.g. cutting down or closing general consultations and out-patient treatments)
- limiting or increasing the type of other assistance offered (Watsan support, building of hospitals and clinics etc.).

The changes can occur either during the project period, and therefore only require some re-allocation of existing personnel resources, or could be substantial and therefore require additional funding and the approval of either the Head of Mission, the Operational Centre or both. Changes in the scope of an on-going project are often initiated at the project level, where the staff sees the need first.

With the frequent change in expatriate staff at project level, the imprecise objectives of the projects are often interpreted in various ways, and can therefore result in an excessive increase in the MSF activities in an area. Supplementary activities (such as Watsan, nutrition, infrastructure building and hospital management) are often taken on. There can be two reasons for this, firstly, there may be no other organizations able to carry out these activities, and for the fulfilment of the over all objective such activities are needed. The second reason could be that the expatriates need to be involved in an activity and therefore begin a “pet-project”.

Changes in the scope of country-wide projects are more rare. The country-wide vertical programs are normally disease or area specific and have specific staff assigned to it. Such programs are also often relatively isolated i.e. they do not change as the health situation in an area changes. Decisions to initiate such projects are often taken at Country and at OC level.

Interaction with other actors

The impression of the Consulting team is that the interaction with other actors (NGOs, the UN, the local authorities) is the largest at project level, mainly for practical reasons. Out in the districts cars, petrol, electricity, food, drugs and water can be in short supply and different organizations rely on each other out of practical reasons. MSF teams are often dependant upon security reports from the UN, upon logistical support from other NGOs (Action contra la fame in Sierra Leone), and upon building of infrastructure (typically UNESCO's watsan projects) for them to be able to operate hospitals and clinics.

The level of interaction depends partly on the number of other organizations in the area, and partly on the “seniority” level of MSF. If MSF is the first organization to enter a disaster area, and remain, organizations arriving later often depend on MSF's structure, network and information in order to operate. In such a situation, MSF would not to the same extent be dependant on other organizations and the level of interaction is therefore less.

In some cases, at project level, MSF is required by the local authorities to cooperate with other NGOs or local authorities e.g. management of health issues in refugee camps under the responsibility of the local government.

Cooperation by necessity

Interaction within MSF i.e. between projects operated by different OC:s, is often limited, partly due to the geographical location, but also as each project is self-sufficient and only dependant on support from their OC and HoM. Exchange of information relevant to the security situation is shared, but experiences at project level are not.

At country level, the interaction with other organizations is reduced, partly in order to remain independent, but also as the HoMs are often less dependant on other NGOs for assistance. MSF establishes a self-sufficient operation in each country, relying on their own cars, satellite links, shipments etc. for logistics. The main outside assistance needed at country level is information about the security situation, contacts with the national health authorities and the local government.

At OC level, the organization is fiercely independent, with a declared policy of aggressive co-existence and consistent lobbying rather than collaboration particularly as regards UN organizations.

“We have to be there, since no one else is”

The lack of access to health care of a group of vulnerable people is one of the often used rationales for expanding an on-going project geographically. In many MSF projects, the staff undertakes “screening” missions to remote areas to assess the need for health care facilities. However, if the MSF does establish themselves, in many cases there is a strong possibility that this would delay the arrival of the national health authorities as they are a strong or in many cases stronger substitute for this. In one case, an MSF project coordinator had decided against expanding the clinic program, on account of the substitution effect.

In some cases, the quality of the health care is deemed to be too low, therefore justifying the presence of MSF. However, pulling out of a hospital can become difficult, if the quality threshold is too high. What often happens is that a foreign donor or NGO is sought to take over, or that the MSF reduces its operations to a few wards, typically the Paediatrics and Maternity wards.

Also at a country level, MSF in some cases, substitutes the national health authority. In a country where the MSF have several on-going, well established projects, a good information network, good information about security issues and an efficient logistics network, the MSF is often among the first to know about health occurrences (epidemics, incoming refugees, localized fighting among war-lords, health situations in refugee camps etc.). In many cases the national authorities depend on MSF for information e.g. in Freetown, Sierra Leone, MSF were asked to investigate a rumour about a local typhoid epidemic in the northwestern province of Kabala.

Institution building

In some cases, MSF projects have been operating in regions for more than a decade, with the scope of the on-going projects constantly changing as the disasters follow and health needs arise. In some cases the MSF projects tend to increase over time, with more expatriates and more local staff needed until MSF turns into an institution, with a long history and a purpose of its own, see the example of the Bo project in Sierra Leone.

Dismantling such an organizations becomes difficult and unthinkable for the local staff. Expatriate staff, on short-term assignments is unlikely to take such a decision. “If the MSF pulled out, we would all be out of a job!”

At country level, the practicality of having a strong, large project as a base can be important, especially in an insecure and dangerous region (see the Sierra Leone, Liberia and Guinea Conakry). Staff from a large project can quickly be re-allocated to support emergencies in other countries, regions or medical emergencies in the same region.

7.5. Exit

One of the most difficult decisions to take in any organization is to cease with an activity. This applies also to MSF, who has a long track-record in many countries that are in a post-conflict situation.

In all three countries visited, MSF were in post-conflict regions (in the case of the western part of S Sudan true at least to some extent).

Other than in Sri Lanka, preparations for an exit from the country were minimal. Sierra Leone is a post-conflict country, where there is currently a fragile peace. Sudan is still a conflict area, but where the fighting between rebels and government forces has abated but where there is still much tribal fighting. Sri Lanka is a country in peace where the peace accord has been signed and displaced persons are returning to their home regions.

There are a large number of MSF activities in each of these countries, where MSF have operated

	Country	Length of Missions	Potential MSF exit
MSF in Sierra Leone	Post-conflict	13 years	At the country level MSF staff are considering a gradual exit, but new projects are continuously identified at project level
MSF in Sri Lanka	Post-conflict	17 years	Officially declared for MSF/F, kept pending by MSF/H
MSF in Sudan	Conflict	23 years	Not considered for the foreseeable future

The two countries we have visited where exit strategies are relevant for MSF is in Sri Lanka and Sierra Leone. Sierra Leone is in a pre exit-phase, while Sri Lanka is in the execution of the exit phase. Lets start with the case of the pre-exit case.

The difficulties for MSF does not seem to lie in the exit phase itself but in the grey area between feeling less humanitarian need from the population to actually deciding that it is not within MSF mandate to stay. In any case, there is a lack of a defined exit strategy, even an exit strategy composed while being present in a country for a period of time. In the absence of a strategy MSF is discussing through the line of the organisation whether it is time or not to pull out. A time consuming procedure where the outcome depends on the interpretation of the MSF mandate. In the same time the field units apprehension of the need for MSF to stay or not differs between each other and, in some cases, between HoM.

The discussion doesn't state whether to withdraw or not but when to withdraw. The absence of a strategically defined exit strategy makes it troublesome for MSF to be consequent and to withdraw when the need is higher in another location.

When the decision is made and MSF states that one or more of the above mentioned exit criteria's is fulfilled, MSF enters into the execution of the exit-phase, as in the case of Sri Lanka. The overall strategy is again effected by factors as personality, differences among the OC:s. MSF-H²² has defined a guideline of how to exit, which is as follows:²³

- All MSF interventions should be flexible and react to changing circumstances – but exit criteria should be articulated whenever possible and linked to specific intervention objectives. (The most appropriate being we close the project, as the needs are addressed and finished.)
- If exit involves hand-over to a local organisation, we have to be realistic about their capacities and our expectations – and our ability to develop their capacity.
- Sustainability of our projects after we leave is not an exit criteria (it can be a means to an end).
- MSF will take direct responsibility for the resources we use and our action all the way down to the individual/patient/survivor. (Therefore, less than 10% of our operational budget will be spent via other related or operational organisations).²⁴

The first issue can be illustrated by three different cases. In the case of Malawi, Sri Lanka where MSF-H in the recent past withdraw from a hospital due to the decrease of medical need in the area.

In Puthukkudiyiruppu (PTK), MSF was standing by until a screening of the more remote areas in the region was conducted. This in order to be sure of the decrease in need of medical support MSF provides.²⁵ Or in the case of Akob0, S.Sudan, where MSF-B had to pull out due to exhaustion from constant raids of looting the hospital²⁶.

The second and third issue can be illustrated by the ongoing project in Vavunyia, Sri Lanka, where MSF has decided to pull out and handing over the activities to a local NGO.²⁷

The fourth and last issue can be illustrated by the logistical and administrative activities of the preparation of MSF's exit of Point Pedro Base Hospital as well as in Puthukkudiyiruppu (PTK), Sri Lanka. The field coordinators emphasized the importance of trying to push in the local staff into other institutions and organisations when MSF leaves.²⁸

²² It appears that MSF-H is in the forefront of developing exit-strategies.

²³ Medium Term Policy MSF-Holland 01/2003–12/2005 "Fighting to Care", p.16

²⁴ Medium Term Policy MSF-Holland 01/2003–12/2005 "Fighting to Care", p.16

²⁵ Appendix Sri Lanka

²⁶ Appendix South Sudan

²⁷ Appendix Sri Lanka

²⁸ Appendix Sri Lanka

8. System Issues

8.1. Evaluation And Monitoring

Internal evaluations of projects are of the following types²⁹:

- Annual evaluation of each project as part of annual planning
- End of project evaluation six months before end of project cycle in order to determine whether the project would be closed down or extended
- 'Ad hoc' evaluations of specific issues, motivated by specific problems
- Specific technical evaluations, made by the medical or logistics department

The three first types of evaluations are made by the operations department. Each country is visited at least once a year by staff from the operations cell.

External evaluations almost exclusively have a medical focus and the main concern is the medical quality of the activities.

8.2. Recruitment and staffing

We do not know how many volunteers have been sent out totally by MSF since its start in the early 1970's, but it is probably in the range of 5.000 plus. In 2002 OCB sent out 450 persons to 254 projects in 42 countries/missions, figures reflecting a continued and accelerated increase over previous years.

MSF/S has since its start as a full partner section in 1993 recruited a total of 162 persons from Sweden (excl volunteers working for MSF/S) of which 44 during 2002 alone. Since 1993 these volunteers have been in a total of 45 countries, with a majority of them attached to projects run by OCB (although all 5 OC:s are represented)

There are to our mind two aspects of recruitment that deserves attention.

First, and as mentioned above, a continuous and effective recruitment of volunteers is a sine qua non of MSF and it is also the one factor that more than any other determines both the quality, scope, and volume of MSF interventions. As noted earlier, MSF has during recent years expanded rapidly in number of projects and volunteers and, as illustrated

²⁹ The evaluation practices referred to are based on information on OCB.

by MSF/S, recruitment by partner sections has been similarly stepped up. Although the overall expansion has caused a growing number of non-filled posts in the field, the issue is not one of numbers but of quality as well as of possibly perpetuating activities that have lost their relevance or priority due to changing circumstances.

Secondly, as noted in the plans of virtually all OC:s there are relatively less persons that are willing to go on a second (or recurrent) missions, and the proportion of first-timers is therefore growing across the board³⁰. This was also very noticeable during our field trip where a majority of the expats met with at the project level were first-timers. During our discussions with them it was noted that the briefings given to them before departure was inadequate to prepare them for their role in the particular environment where they landed³¹. By the time they were 'mature' enough to reflect on the relevance of their role and to prioritise among their activities it was time to go home. As a consequence the ability of the various project units to adapt to changes or change their orientation based on experience gained is curtailed.

The accelerated expansion of MSF operations has by itself brought in its wake an increase in the number of first-timers, an aspect that on its own puts the project management concept of MSF to test³². But we also believe that it has strained, and possibly down-graded, the capacity of MSF to properly brief those going on their first mission. Professional preparation is one thing, and also seemingly well provided for³³. But more important is to enable a person to understand the concrete role and context s/he is asked to serve in: what was the 'testament' of the previous incumbent in that very project? What to prioritise as a midwife when MCH is not really systematically promoted or supported in the project she is going to? How to reconcile a doctor's or nurse's expectation of doing hands-on curative work with the fact that in that particular project s/he will have to spend as much if not more time wrestling with an inert (and possibly corrupt) hospital management? Learning it the hard way may be all right if you have time, but with an average span of 5 months stay on a mission that is exactly what you don't have as an MSF volunteer.

Once a project is launched the net effect of this is to our mind two-fold.

On one hand there will be a tendency in each project to continue doing what the previous 'generation' was doing, with little questioning or reflection as to the continued relevance or justification of any specific activity. This does not mean that things are not done well, but it does mean that there is little pressure from within a project to change and adapt, to question and reprioritise and thereby to develop (including discontinuing). We were a bit taken aback by the very frequent invocation

³⁰ It appears that the respective OC:s try to give first-timers either easier postings, or postings where there is more of a surrounding 'critical/supportive' mass, including 'veterans'.

³¹ This was in parts echoed by the second-timers' experience of debriefings on their return home. For the few veterans and the most medically qualified (surgeons and GP:s) briefing and debriefing appeared naturally enough as less important.

³² The various MSF OC:s as well as MSF/S all raise the problem of the increasing proportion of first-timers, but sees this primarily in terms of how to increase the number of repeat missions (e.g. by individual career plans). However, although this may indeed motivate some volunteers to return for more missions, we believe that an increased proportion of first-timers is an inevitable consequence of the expansion as such. This is particularly so as MSF repeat missions literally demand that the persons are single (which often means young) and there is clearly a limit of how much 'loyalty' that can be expected from individuals with growing private demands and obligations.

³³ MSF/S volunteers are required to attend to special courses in tropical health at Uppsala (with Liverpool as an option).

of generalised justifications for doing this or being there: “as long as there is one refugee left in the camp, MSF will remain”, “as long as the people here have no other health service provider, we have an obligation to continue doing what we are doing”, etc.

On the other hand the only way a committed volunteer can make a difference (rather than fill the shoes of his/her predecessor) is to add something – making projects expand by small increments over time. And the logic of the whole situation is that the longer the duration of the MSF project, the more it will expand in various directions, an expansion that is further justified by the obvious need for more and better health services.

8.3. Capacity Development & HRD

The Capacity Development and Human Resource Development in MSF is a rather large part of MSF operation on the field level. We generalize three categories of volunteers/workers within MSF: medically trained, para-medical and non-medical staff.

Generally within the movement of MSF all the OC:s identify the need for more effort in the HR departments.

MSF-France, has identified the following trends regarding human resources:

- There has been a greater internationalisation of the staff in the field teams
- The teams remain very medical
- A decrease in first missions (FM)
- Less doctors wanting to take on increased responsibility within MSF.

The objective of the HR department is to improve the quality of the field teams. To reach this objective MSF-F has stated the following two strategies:

- Continuing to recruit volunteers and
- To retain existing volunteers.

Concerning the strategies of the local staff MSF-F has started to develop an overall policy for national staff.³⁴

MSF-Switzerland has recently reorganised the HR department in order to increase the focus on field staff. Their main concern is the increased difficulties in the recruitment process which in turn has led to that MSF-CH has the highest average age of field staff within the movement. At the same time MSF-CH has become very dependant on the other OC:s in the recruitment process.

A recruitment/detainment action plan has been created in order to reach the long term objectives of MSF-CH. A scheme of internal training has also been implemented and the need for improved tools of training the field staff is identified.³⁵

MSF-Holland. As the other OC:s, Holland struggles with the decreasing and low levels of FM. They state as their primary responsibility to increase this level concerning all different categories of staff and to

³⁴ Annual Plan 2003, MSF-France

³⁵ Annual Plan 2003, MSF-Switzerland

retain the volunteers currently involved in MSF. There is a special need for specialised medical staff. In order to attract these people MSF-H stresses the importance of having these people in the organisation in order to retain the cultural values that lies in the name of MSF. For MSF-H this becomes specially important since this part of the movement are the once that has taken the relatively largest step towards supplementary fields such as, PH, MCH and Watsan.³⁶

MSF-Brussels has also recognized the decrease in FM on the field. At the same time MSF OCB has moved towards a more people intensive project approach. This MSF OCB identifies as a positive move. It is regarded as positive even though this implies an actual shortage of staff in relation to posts on the field to be filled. Furthermore, in turn this increase in people intensive projects has led to a need for increase in substitution³⁷. This shall not be regarded as a system reinforcement effect for the region as such, rather a capacity reinforcement of MSF's ability to work efficiently in that specific project. It is important to stress the difference since MSF in general do not want to see themselves acting as trainers of the local health structure. That objective of training would, from a developmental point of view, be regarded as a sustainable enhancing operation. Instead MSF stress the need for training of local staff to assist the process that MSF is undertaking in that specific project. Still MSF do regularly train the local staff in order to get a more smooth running operation. There is still an unwillingness of training medical staff.³⁸ The reason for this unwillingness is that it is regarded as useless and makes it even more confusing for the local staff themselves as well as for the next MD that arrives to the scene. The staff on the field stressed the differences of the culture of the medical Expatriates. Still this does not imply that when MSF decides to end a field operation that local staff is simply left behind. A large amount of effort is being put into the process of getting the staff that has been employed by MSF into other organisations and institutions.³⁹

Generally regarding the entire movement of MSF, the key issue that affects the capacity development as well as human resource development is the shortage of new recruits in MSF. Different OC:s stresses different need of professionalities depending on where on the scale of purely action oriented actor on the one side and a more developmental actor on the other, the different OC:s want to image themselves.

8.4. Strategic competence – are MSF able and willing to change?

The strategic competence of an action oriented humanitarian organisation like MSF can be broken down into two dimensions. First, the ability to translate its overall mission and objectives into a set of *priorities* at any given point of time and in any given context. Second, the ability to continuously assess the *relevance* of its activities – not so much in relation to its own objectives (which would only imply a self-justification) but to

³⁶ Medium Term Policy MSF-Holland 01/2003–12/2005 "Fighting To Care".

³⁷ Normally, from a developmental point of view, substitution is regarded as a negative effect that brings along problems such as crowding out of local actors. After a discussion with OCB we found that substitution in this case referred to as a positive and "desirable" effect of increasing and reinforcing the quality of the field units.

³⁸ Naturally, in a context when the option is limited this is not an issue.

³⁹ Prospects 2003 Operations department.

the humanitarian and social context in which it operates. The capacity to set priorities broadly reflects the first part of MSF's proud slogan "first in, last out" – how do we decide on going into context x or issue y? The second part can be seen in the light of its ability to assess its relevance

With respect to the first dimension there is no doubt that MSF have developed a competence, along with a system to back it up, that is second to none. This is particularly so when it comes to the system that guides MSF's entering a crisis area and in preparing for pro-active responses once they have established themselves on the ground. The backbone of this competence can be summarised as:

- a very good intelligence and decision-making system with reference to crisis dynamics. This appears as a judicious mix of very experienced individuals who undertake early reconnaissance missions or acts as Heads of Mission in the field, non-bureaucratic and very quick senior management decisions⁴⁰, and constant surveillance and monitoring of the major actors during a conflict.
- Clear and seemingly unambiguous key values and operational policies that guide decisions (cf sections 5.1. and 5.2. above). It should be noted that the operational policies differ over OC:s. There are, to our knowledge, no unifying operational policies for the MSF movement as a whole. Strategy is therefore a question of which OC one chooses to look at. Even if the differences may be small they are substantive enough to be of interest to an outside donor, particularly as regards the different strategic traditions on such standard developmental issues as 'community development', 'preventive health care', 'MCH', and local capacity development.
- Constant access to and control over critical supply lines – recruitment, logistics and procurement, fund-raising (by virtue of the policy of more than 50% own funding) – that operate in a decentralised manner and independent of any given crisis. In fact, the MSF movement can in principle operate as an operational universe of its own. This leaves strategic choices largely free of the constraints normally bogging other organisations such as 'do we have the people? do we have the resources? do we have the facilities?'
- The close to total independence of other actors as a consequence of its strict interpretation of neutrality and impartiality. This is partly also a consequence of not having to rely on others for critical operational issues (see the point above). But it is also reflecting the fact that MSF (along with IRC) are typically the first humanitarian organisation on the ground in a crisis situation. During the initial stages of entering an area the independence is therefore less of a strategic choice than a practical fact, particularly as local health structures have typically collapsed as part of the crisis itself.

The simplicity and straight-forwardness of MSF's guiding values, backed by the continuous working of critical supply lines, makes MSF's strategic competence largely that of a quick response unit: is it a humanitarian crisis (i.e. have the local life-supporting systems broken down or become

⁴⁰ This is to a large extent the advantage of having very loose and non-specific management lines.

abnormally inadequate)? is the scale of the crisis significant enough to warrant our intervention? do we know enough about the nature and dynamics of the crisis and its main actors? what are the risks involved for an intervention? In this sense we have no doubt that MSF have evolved, and continuous to evolve, a very impressive and indeed leading capacity in its field.

If MSF therefore has both the operational and strategic capacity to be “the first in” – into a crisis context as well as into an issue – the “last out” notion is more problematic, all the more so since it appears to be reflect the real situation in all the situations visited by us.

The reasons why MSF are reluctant to let go of a project are complex.

One reason often put to us during our discussions with MSF field staff is the need to maintain a continued ‘vigilance and watchdog’ presence beyond the point of an acute crisis. This was particularly so in the case of Sierra Leone and Sri Lanka where it was argued that as long as there was a risk of conflicts flaring up again MSF must retain a preparedness even if the emergency had passed. This argument was most consistently put forward by the OCB mission management in Sierra Leone that also actively considered phasing out of concrete projects (particularly those where the collaboration with local health structures were problematic) while retaining a country presence that could act as a base from which to reactivate specific interventions should the need arise. This appears to us to be a very appropriate response and fully consistent with MSF’s strengths (and limitations).

In other cases it was argued that “as long as there is one refugee or internally displaced person around, MSF will remain”. A variation of this was that “as long as there is no viable local health provider, we will remain”. This was a prominent view with the country mission of OC Amsterdam in Sierra Leone and in Sri Lanka, as well as generally throughout the MSF projects.

Although this should of course not be taken literally it does strongly suggest a difficulty or even unwillingness of MSF to take strategic stock of the relevance of its presence, the role and responsibility that a continued presence implies, and the danger of MSF emerging as an important local actor in spite of its professed policy of non-interference and neutrality. In fact, even in the still very unsettled conditions of S Sudan there were clear signs that MSF had taken on the role of a local service provider – i.e. a resourceful local institution that was a significant local actor with considerable influence and clout. Although the MSF staff itself avoided meddling in local politics the very resources, length of stay, and reluctance to place itself under larger coordinating structures tended to turn the MSF projects into centres of influence (if not power) in spite of itself. We have already referred to the un-intended consequence of MSF projects out-competing significantly less resourced local institutions or peer NGOs by the sheer quality, scale, and subsidisation of its health services. One may also assume that other actors, including the conflict parties and local decision-makers recognise an MSF project as a relevant body in laying out their own strategies and policies.

To us the conclusion is that MSF must force itself to overcome its reluctance to face issues of local institutional development in one of

several possible ways. One option is the brutal one of simply physically dismantling a project after a given period of time, e.g. 2 years. Another is to make it mandatory that after an 'emergency presence' of 1 or 2 years the project must develop and incorporate a concrete strategy of 'relaying' or handing over specific functions and activities to others, or else a scaling down/capacity development/handing over strategy as part of any further presence. Whatever be the case, we strongly feel that the management traditions and reluctance of MSF to see itself as an actor influencing local development must be dealt with – not by policies alone but by introducing and exploring tangible statutory executive guidelines. And in this we believe that institutional donors such as such Sida can play both a pushing and facilitating role.

9. The MSF

– Sida interaction

During the years 1999–2002 MSF Sweden submitted a total of 39 proposals to Sida, out of which 23 were for new⁴¹ and 16 for ongoing projects. At the time of the study 3 additional proposals were submitted in 2003.

MSF proposals submitted to Sida 1999–2003

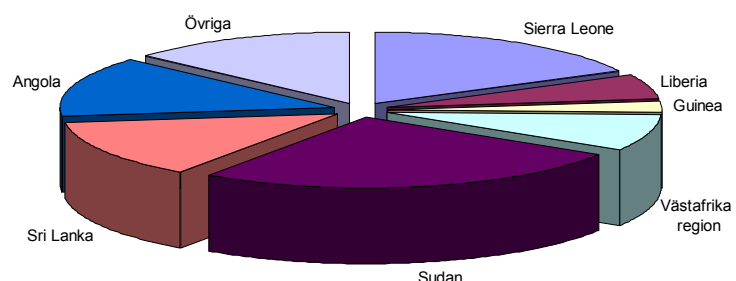
	1999	2000	2001	2002	Tot 99–02	2003
Proposals submitted	11	11	7	10	39	2
Of which turned down by Sida	3	1	0	3	7	1
Total approved MSEK	20,8	18,4	16,5	22,3	78,0	10,9

The proposals are normally preceded by informal contacts between MSF and Sida in order to avoid applications that are beyond Sida's policy or ability to even consider. The approval rate is therefore fairly high.

In addition MSF has also received indirect Sida assistance through Forum Syd (one project in Russia) and emergency allocations from Swedish Embassies abroad.

The geographical distribution mirrors that of MSF's total commitments with an absolute dominance of Africa (Angola, West Africa, Sudan).

Sida anslag per land totalt 99-02



A review of the Sida process suggest the following⁴²:

- The criteria for assessing (and turning down) proposals appear inconsistent or non-systematic. Although they are specific in each case, the

⁴¹ These projects may have been new for Sida, but are normally continuation of projects in the MSF context.

⁴² For details see Annex 7

reason for turning down one proposal may in another case be a supportive argument for approving. A main reason for the inconsistent processing by Sida appears to be the very high turnover of staff at SEKA/HUM.

- There appears to be an inbuilt contradiction in Sida's view of MSF (as it emerges from the internal assessments of applications). On one hand Sida deplores MSF's lack of attention to developmental issues (institution-building, sustainability, etc). But when aspects of these do appear in MSF proposals, MSF's lack of track record in this very area is then invoked as a negative factor
- Apart from Sida already giving support to some other organization in the area, the most common reason for turning down projects appear to be direct or indirect questioning of MSF's role and working modalities rather than an assessment of the project as such. However, the most common reason for approving is again MSF's role and working modalities.
- Of the more substantive issues raised and for which clarifications are sought from MSF the most frequent are those relating to sustainability and coordination with others, i.e. on the very issues where the MSF stand is already very well known
- Apart from visits by Sida staff to the area, the most common references are the Embassies and other organizations active in the area. The former tend to result in positive assessments in support of the proposal, whereas the latter tend to be negative.
- Although the proposals from MSF are normally very clear and operational, there is a somewhat surprising lack of discussion of issues known to be central to Sida – particularly as regards sustainability and coordination. This in turn generates almost routinely questions from Sida
- In one particular case – West Africa – the dialogue with between Sida and MSF/Sweden has generated a regional (although still embryonic) strategy within MSF/S and through it to MSF at large.

Against the background of the findings in this study and in view of the obvious need to further develop the interaction between Sida and MSF/S we suggest the following

Framework agreements

The current individual project-by-project interaction makes it virtually impossible to introduce a strategic content or partnership notion into the collaboration between Sida and MSF. In fact, we strongly believe that it has only been in the context of the West Africa regional support that something like a platform has been established on which to base a discussion and mutual understanding of the role and priorities of MSF and Sida. Furthermore, this is also one of the areas in which MSF/Sweden can interact with OCB (or the other OC:s) as an active and involved partner in MSF operations.

However, while we strongly support the further development of a 'West African frame agreement' it should be stressed that the specifics of

that region as well as Sida's own work on a regional strategy makes it somewhat unique.

Even so we think alternatives to the cumbersome and often strategically and contextually blind project approach should be explored. One such way could be to take one of the country contexts where civil war and local conflicts seem at least in the medium term as there to stay – Angola, Congo, Sudan. The problem here of course is that there is not only one MSF present in each of these contexts but several (in Angola all five OC:s, in Congo four, and in South Sudan four), each with their own specific interpretation of the context dynamics as well as of the priorities of MSF. However, without imposing a common strategy for all the OC:s it appears to us that it would be possible to lay the various mission plans along each other and initiate a discussion with Sida (or some other institutional donor) on the possibility of moving towards a 'basket' and possibly in the end to a 'programme' approach. In any case we believe that Sida should ask for, and MSF should routinely supply, copies of the various mission plans in connection with any specific project application. We do not see how Sida can otherwise be able to put a proposal in any context other than the general one of MSF (and all the positive as well as negative assumptions that go with that)

MSF and development issues

Although the project proposals are often very clear as to the activity parts, they are either very vague or even dismissive of the development context in which they are to be implemented.. As noted above this routinely generates questions on 'sustainability' on 'coordination', on 'capacity development' etc. from Sida. Apart from the fact that the proposals do reflect the 'minimalist' and even independent stand of MSF when it comes to development issues and development actors, they also reflect the fact that MSF does not have within its system of volunteers or staff anyone with experience from and knowledge of the 'development industry'

The point we wish to make is not that MSF should join the development mainstream. But unless MSF can explain, to itself as well as to the outside, the bearing (or otherwise) that concrete activities/projects have on standard development issues we believe that it will always be looked upon with a certain suspicion by others. Furthermore, we also believe that the weaknesses we observed in the field with respect to what we referred to as supplementary or expanded activities (Watsan, PHC, MCH, etc)⁴³ reflect a lack of practical development expertise within the ranks of MSF.

Without suggesting that MSF should swell its staff with 'development experts' we believe that it should systematically avail itself of such expertise, e.g. by recruiting such people as volunteers (even on a pro bono basis). The purpose would not be to turn MSF interventions (or project them as such) but to vet them and particularly the proposals that go to institutional donors for their development content.

⁴³ These are all activities where the distinction between relief/emergency operations and development work becomes blurred and very quickly untenable.

Sida's processing of MSF proposals

As noted above the high turnover of staff at SEKA/HUM as well as the very MSF system itself has not been conducive to developing a common approach or criteria for processing the proposals. Apart from the fact that it makes it difficult to carry on a constructive dialogue between the two parties – on matters of policy and strategy of humanitarian assistance, on quality issues and relevance etc – it also makes it very difficult for MSF to know what Sida ‘wants’ and what projects they should therefore be approached with.

A more systematic set of criteria for and method of processing MSF proposals are to our mind absolutely necessary if the MSF-Sida interaction is to move forward. This should also include guidelines for what references that are relevant.

10. Summary

10.1. Summary according to ToR

In the Terms of Reference three specific questions were posed by Sida⁴⁴:

1. How well does MSF identify and promote the local health structure?
2. How does MSF collaborate/coordinate with other actors?
3. How well developed are the (MSF) strategies and implementation mechanisms to secure sustainability and long-lasting results?

10.1.1. Local Health Structures

Our view is that MSF's capacity of *identifying* local health structures generally is good. When a local hospital or clinic exists MSF works with existing staff and existing facilities if possible. MSF knows about other NGOs working with health care and to some extent divide the work between them, thematically or geographically.

Promotion of local health structures is more problematic, due to MSF's focus on their role as emergency actor. They explicitly do not work with institution building, but limit their local capacity building to on-the-job training of individuals, i.e. local staff.⁴

MSF's effect on local health structures is potentially even negative, due to the 'cuckoo' effect, i.e. their tendency of blocking entry of others due to their ability to provide high quality health care at no cost. The exception is the cases where an existing local health structure is temporarily non-functioning due to a conflict or natural disaster, but becoming operational again when the situation has stabilised. The majority of MSF operations are however, situated in contexts of chronic conflicts, conflicts in combination with underdevelopment or contexts where the reasons for lacking health care are structural rather than temporarily (permanent lack of access to health care). One could imagine MSF acting as a spearhead in these contexts, with other organisations coming in with the developmental approach, but such strategic alliances are not common⁴⁵. MSF's main orientation is to lobby for political responsibility and public health care, but since the global tendency is one of governments rolling back from welfare provision, the question of who to hand over to and who to create alliances with remains unclear.

⁴⁴ As mentioned in section 3

⁴⁵ MSF-H has allegedly had cooperation with a health NGO with more developmental approach, but we do not know the details of this cooperation.

10.1.2. Coordination

Sida's question regarding MSF's cooperation with others reflects the common view of MSF as difficult to cooperate with and overly arrogant and self-sufficient.

Our findings indicate that MSF's cooperation with other actors is better the closer to the field level you come. At the local/field/contextual level cooperation with other actors, local counterparts as well as other NGOs is good. At the national level cooperation is 'arrogant' and highly selective and at OC level almost non-existent. The image of MSF as independent, neutral and impartial is nourished more the higher up in the organisation the interaction takes place. As donors interact with MSF only at the highest level, the view of MSF's overly independence is exaggerated, although not incorrect.

10.1.3. Sustainability/Lasting Results

This question about sustainability also reflects a preconceived notion of MSF; their reluctance to take in the donor's insistence on consideration of sustainability issues even in the case of humanitarian aid.

MSF's view of humanitarian aid is that it is not supposed to be sustainable and that they do not work with development work. Since they have delimited themselves from the development side of aid their ability to exit and phase out and let others take over becomes more important.

The question thus becomes whether MSF's has mechanisms of exiting and phasing out.

At activity level, i.e. different programs within a project/location, instruments and procedures for closing down are in place. Such decisions are made based on assessment of priorities, cost and work-load.

At project/site-level exit is more difficult and normally due to external factors, such as unacceptable level of insecurity, obvious lack of demand for MSF's services. Our impression is that exits at project level are due to external non-health factors rather than own strategic decision.

At country level exit is difficult due to individual attachment of senior MSF staff. A tentative conclusion is that variations are more due to personalities than strategic choices.

10.2. "As if Evaluation"

This is a capacity study of MSF, not an evaluation, but if standard evaluation criteria were used the assessment of MSF would be:

- Efficiency – Very good
- Effectiveness – Good
- Relevance – Problematic
- Sustainability – as organisation: Yes; as field operations: No, and should not be

The fifth standard evaluation criteria: impact, is disregarded in this assessment, partly because that is the main difference between an evaluation and a capacity study, and partly because it is obvious in the case of MSF that the activities have an impact.

10.2.1. Efficiency

MSF is a very efficient organisation, both in terms of cost-efficiency and action.

Their recruitment system is good as discussed in section 8.

Their operational costs are low, due to low cost of international staff, modesty in living standards and efficiency in planning and logistics. MSF's independence and low degree of coordination and collaboration with other actors makes it possible for them to act fast and efficient.

In fact, the good performance in terms of efficiency is closely connected to the organisation's identity, since voluntarism and action orientation are part of MSF's core values.

10.2.2. Effectiveness

Effectiveness has to do with consistency between goals and actions.

Our impression is that MSF has good operational control. The management lines are rather clear and monitoring of activities is maintained continuously. The emphasis on medical activities enables a concentrated focus in activities. Supplementary activities, however, such as WATSAN, are however handled rather amateurish and somewhat lost in the organisational structures, reflecting the fact that these are not core activities for MSF.

10.2.3. Relevance

The relevance of MSF's activities is rather problematic.

Their strength is in emergency situations, where their emphasis on independence and action is relevant and unique and allows them to act in crisis situations where not many other organisations can work.

In 'chronic' situations of underdevelopment and naturally occurring distress situations, the relevance of MSF's approach is more problematic. In these situations there is a clear risk of MSF becoming a service provider that blocks the entry of other actors, due to their ability to provide high quality health care at no cost; an ability not many other actors have.

10.2.4. Sustainability

MSF is highly sustainable as an organisation due to its:

- Brand name
- Fifty percent rule as regards own funding
- Efficient recruitment system
- Networking within the movement

As field operations MSF is not sustainable and should not be. The role they have defined for themselves is not a developmental role, but a provider of short-term relief. The line between relief and development work is, however, not clear and MSF often end up in the grey zone, where their lack of strategic capacity and lack of understanding of development issues becomes obvious and their role blurred.

Three of the MSF operational centers have projects in the country; MSF Belgium, MSF Holland and MSF France. The three centers operate relatively similar type of projects in different districts i.e. hospital management and support to MOH clinics or refugee camps.

Halving poverty by 2015 is one of the greatest challenges of our time, requiring cooperation and sustainability. The partner countries are responsible for their own development. Sida provides resources and develops knowledge and expertise, making the world a richer place.



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