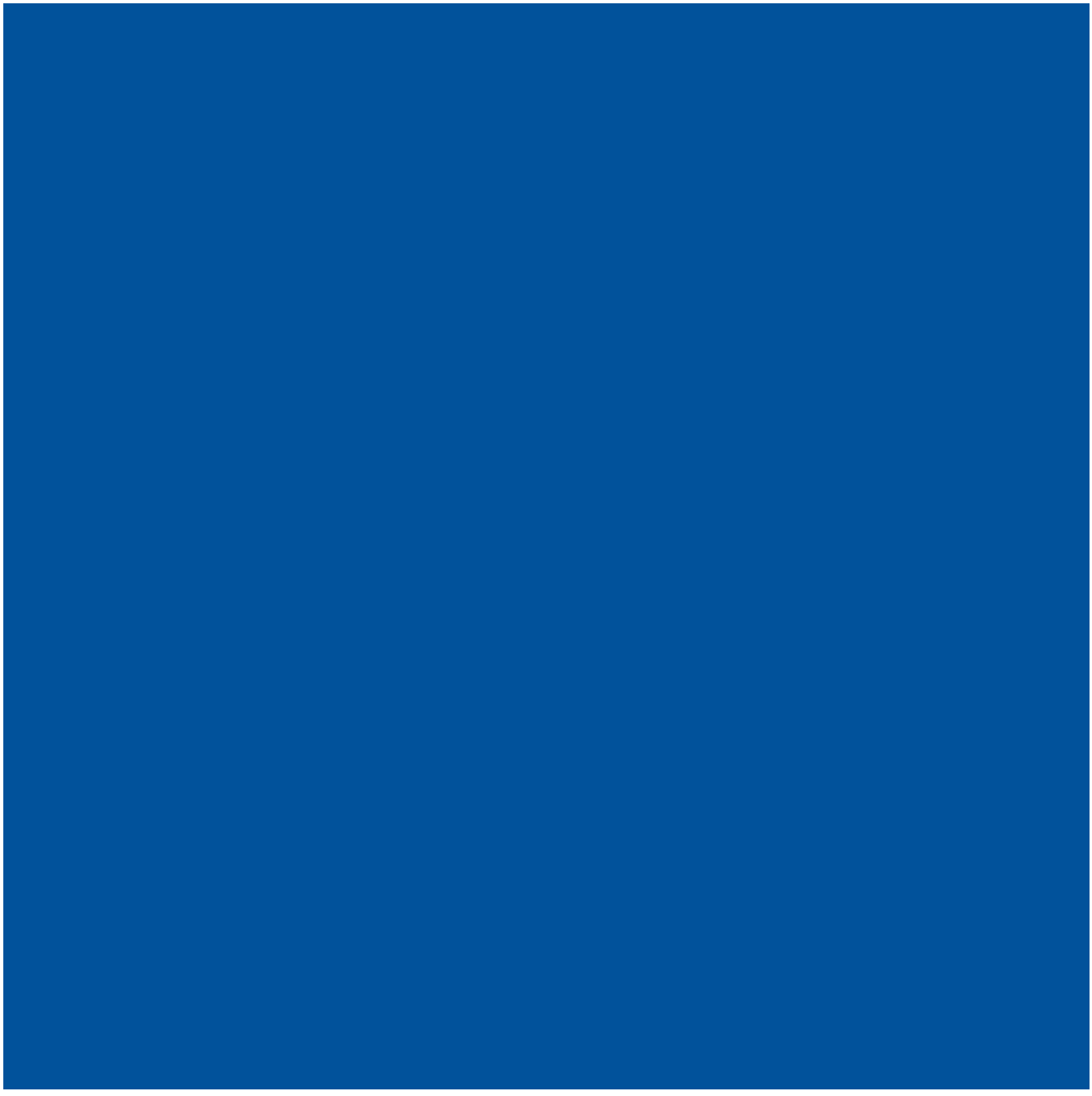
Sida

MAY 2004 • DIVISION FOR HUMANITARIAN ASSISTANCE
AND CONFLICT MANAGEMENT

Appendices to Capacity Study

Läkare utan Gränser/ Médécins sans Frontières (MSF)



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Appendix I – Terms of Reference

SEKA/HUM 2003-01-13
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Diarienummer:

Uppdragsbeskrivning för kapacitetsstudie av Läkare utan Gränser

Beskrivning av Sida

Styrelsen för internationellt utvecklingssamarbete, Sida, svarar för det bilaterala svenska utvecklingssamarbetet. Sida handhar även huvuddelen av samarbetet med länder i Afrika, Asien, Latinamerika samt Central- och Österuropa. Sida har omkring 650 medarbetare – inklusive expertis (varav ca 100 i fält) inom ekonomi, teknik, jordbruk, hälsovård, utbildning och miljövård. De övergripande målen för svenskt bistånd är att bidra till minskad fattigdom, ökad demokratisering och uthållig utveckling i Sidas samarbetsländer.

För mer information se gärna Sidas hemsida, www.sida.se

Sidas humanitära enhet handlägger det humanitära biståndet. Verksamhetens mål är att undsätta och skydda människoliv i enlighet med internationell humanitär rätt samt bidra till att lindra följderna av humanitära katastrofer i samband med krig och naturkatastrofer.

Grundläggande för det humanitära biståndet är Sidas policydokument; ”Utvecklingsfrämjande humanitärt bistånd”, ”Policy for Sida’s support for Mine operations” ”Riktlinjer för humanitärt bistånd inom utbildningssektorn”, ”Ett humanitärt bistånd med barnrättsperspektiv”.

Hälsoinsatser i humanitära situationer utgör mer än 30% av Sidas humanitära bistånd. Ett policydokument från juni 2001, ”Guidelines for humanitarian assistance in the health sector” presenterar riktlinjer för utformningen av och prioriteringar för humanitära hälsoinsatser.

Riktlinjerna fastslår vikten av att mobilisera och stärka nationella/lokala resurser och att koordinera insatser med lokala hälsomyndigheter och andra nationella och internationella aktörer inom sektorn. Detta för att göra insatsen så effektiv som möjligt, inte urholka lokala strukturer och att skapa förutsättningar för en framgångsrik transition från den

humanitära fasen till en mer långsiktig utveckling av nationella strukturer.

Beskrivning av MSF/Läkare Utan Gränser

Läkare Utan Gränser Sverige är den svenska sektionen av det internationella nätverket Médecins Sans Frontières (MSF). Ursprungligen startades rörelsen av ett antal unga franska läkare och journalister i Paris 1971. De ansåg att det behövdes en oberoende medicinsk hjälporganisation som öppet talar om övergrepp och maktmissbruk, och där arbetet styrs av de nödställda människornas behov utan politiska hänsyn.

Nätverket består idag av 18 sektioner i lika många länder. Fem av dessa sektioner – Belgien, Frankrike, Holland, Schweiz och Spanien är huvudsektioner med full verksamhet, vilket innebär att den operativa verksamheten utgår från dessa kontor. Läkare Utan Gränser i Sverige är en så kallad partnersektion, som tillsammans med Danmark, Norge, Italien, Hongkong och Luxemburg är kopplade till huvudsektionen i Belgien med kontor i Bryssel. Partnerskapet med MSF Belgien innebär att insamlade medel allokeras i Bryssel och många svenska volontärer i fält arbetar för den belgiska sektionen. Ett mindre antal svenska volontärer arbetar även i fält för de övriga operativa sektionerna. Varje år reser omkring 3000 volontärer ut och samarbetar med omkring 13.000 lokalanställda för MSF i över 80 länder. Tillsammans genomför dessa människor varje år över 5,5 miljoner konsultationer och 180.000 operationer, samt vaccinerar flera miljoner barn och vuxna mot sjukdomar som mässling och hjärnhinneinflammation. I flyktingläger runt om i världen har nutritionscenter upprättats där 85.000 barn får näring och vård varje månad. Förutom de rent medicinska insatserna förser teknisk personal årligen hundratusentals flyktingar med rent vatten och latriner. MSF är en internationellt erkänd organisation och en anledning till detta, enligt Läkare Utan Gränser själva, är att deras läkare och sjuksköterskor ofta är först på plats och sist kvar i svåra konfliktområden. ”Professionella, effektiva och ofta massiva insatser som utan dröjsmål når nödlidande människor har blivit något av ett kännetecken för MSF”.

Den årliga budgeten för MSF är drygt tre miljarder svenska kronor. En princip är att minst hälften av verksamheten skall finansieras genom privata gåvor. MSF finansieras idag till 75% genom privata gåvor och till 25% genom bidrag från regeringar och deras biståndsorgan (t.ex. Sida) samt internationella samfund (t.ex. EU och FN). Maximalt 15 procent av de insamlade medlen går till administration.

Läkare Utan Gränser i Sverige

Den ideella föreningen Läkare Utan Gränser i Sverige bildades 1993 och samlar in pengar, rekryterar volontärer och bedriver opinionsbildningsarbete. Under 2001 samlades i Sverige in totalt 90 336 849 kronor. Största delen av insamlade medel kommer från privatpersoner medan en mindre del, ca 25 miljoner kronor under 2001, utgörs av medel från Sida. Under 2001 användes dessa medel till projekt i Angola, Brasilien, Kenya, Kongo, Mexico, Sierra Leone, Sri Lanka, Sudan, Turkmenistan/Uzbekistan och Zambia.

Opinionsarbetet som Läkare utan Gränser bedriver i Sverige består i att informera politiker, medier, sakkunniga och allmänhet om livsvillkoren

för människor som lever i de länder där MSF arbetar. Den svenska sektionen rekryterar varje år ett 50-tal volontärer, framför allt medicinsk personal men också ekonomer, administratörer och logistiker.

Att den största delen av organisationens medel kommer från privatpersoner är enligt Läkare Utan Gränser en förutsättning för att de humanitära behoven skall tillåtas styra arbetet och att man bibehåller en oberoende ställning gentemot institutionella finansiärer med politiska kopplingar. Principerna utgör en viktig grund för organisationens arbete:

”Till våra grundprinciper hör att vi inte tar politiska hänsyn utan bara ser till de nödlidandes behov och att vi i svåra humanitära situationer vittnar offentligt om maktmissbruk och brott mot de mänskliga rättigheterna. Genom dessa principer skiljer sig MSF från många andra humanitära organisationer.

Vi låter oss inte hindras av nationsgränser och regeringars politiska överväganden. När vi anser att de humanitära behoven är akuta gör vi allt vi kan för att nå dem som lider nöd, även om det innebär att korsa en gräns utan myndigheters tillstånd. Genom att tala öppet om övergrepp mot civila som MSF-personal själva har bevittnat sätter vi press på det internationella samfundet, enskilda regeringar och stridande parter att stoppa kränkningar av de mänskliga rättigheterna och den humanitära rätten”.[46]

Syfte och mål

Sidas humanitära enhet genomför kapacitetsstudier i syfte att klarlägga behov av förändringar eller förstärkningar av en organisations kompetens och kapacitet att genomföra humanitärt bistånd.

Denna studie är en modifierad form av kapacitetsstudie. Syftet i det här fallet är att granska och analysera Läkare utan Gränsers kapacitet att beakta ett antal aspekter av humanitära insatser inom hälsosektorn, vilka av Sida bedöms som särskilt centrala. Målet för studien är att den skall ge underlag för Sidas bedömning av organisationens kompetens och kapacitet som kanal för humanitärt bistånd inom hälsosektorn, enligt gällande anvisningar och riktlinjer.

Uppdraget

Det finns ett antal aspekter på humanitära insatser inom hälsosektorn, definierade i Sidas riktlinjer, som betraktas som speciellt centrala vid bedömning av insatser. Mot bakgrund av dessa skall följande frågor speciellt beaktas:

- Hur väl identifierar och främjar MSF lokala hälsostrukturer i sin verksamhet?
- Hur fungerar MSFs samarbete/koordinering med övriga aktörer (lokala myndigheter, internationella organisationer, NGOs, givare)? Påverkar organisationens tolkning och tillämpning av de humanitära principerna om opartiskhet och neutralitet möjligheten för effektiv samordning av den operativa verksamheten?
- Hur väl utvecklad är organisationens strategier och implementeringsmekanismer för att säkra hållbarhet och bestående resultat vid övergången från humanitära insatser till utvecklingsinsatser?

[46] Ur Läkare utan Gränsers informationsmaterial om MSF.

Kapacitetsstudien skall omfatta MSFs organisation i Sverige, dess relation till de operativa sektionerna, samt ett urval av fältverksamheten. I uppdraget ingår därför två fältbesök, i Sudan och/eller Angola och/eller Västafrika, där flera av de operativa sektionerna av MSF är verksamma. Vilka två platser som skall besökas bestäms i samråd mellan konsulten, Läkare utan Gränser och Sida.

Studien skall inhämta och sammanställa information avseende:

- bakgrund och syftet med bildandet av Läkare utan Gränser
- organisatorisk uppbyggnad och relation till andra MSF-sektioner, inklusive de operativa huvudsektionerna.
- styrelsens roll/mandat
- visioner, mål, verksamhetsplan och policies
- vissa aspekter av verksamhetsimplenteringen:
- samarbete med andra organisationer i fält, organisationens nätverk
- medverkan i relevanta samordningsfora
- främjandet av lokala hälsostrukturer
- beaktandet av insatsers hållbarhet på längre sikt
- andra finansiärer

Metod

Uppdraget skall genomföras genom:

1. Studier av tillgänglig dokumentation vid Läkare utan Gränsers kansli i Stockholm
2. Intervjuer med Läkare utan Gränsers styrelse samt kanslipersonal i Stockholm
3. Fokusgruppdiskussion med ansvariga personer för de operativa sektionerna
4. Två fältbesök för studie av den operativa verksamheten
5. Studier av SEKA/HUMs anvisningar för bidrag till enskilda organisationer, Sidas riktlinjer för humanitära insatser inom hälsosektorn.
6. Intervjuer med Sida-handläggare i Stockholm.

Den verksamhet som Sida genom Läkare utan Gränser stödjer bedrivs genom någon av de stora fem operativa huvudsektionerna, ibland flera. MSF Belgien är Läkare utan Gränsers partnersektion och därmed utgår en merpart av Läkare utan Gränsers resurser till just denna sektion. Det förslås därför att fältbesöken genomförs på två platser där flera sektioner är verksamma, varav en är Belgien-sektionen.

Att i övrigt definiera metoden för genomförandet överlämnas till konsulten.

Tidplan

För att ge möjlighet att kommentera eventuella sakfel och missförstånd skall ett preliminärt utkast till slutrapport vara Sida tillhanda senast: *2 maj 2003.*

Slutrapport skall presenteras till Sida senast:
20 maj 2003.

Rapportering

Uppdraget skall redovisas i en skriftlig rapport och överlämnas till Sida både i form av papperskopior och en diskett (innehållande endast en fil) i Word 6 alt.7 format, för att underlätta korrigering och tryckning.

Slutrapporten skall skrivas på svenska (max 70 sidor exklusive bilagor) och bifogas med en genomgripande sammanfattning på engelska (max 35 sidor exklusive bilagor).

Konsulten skall – som en del av uppdraget – göra en presentation av slutresultatet för berörd personal på Sida samt berörd personal inom Läkare utan Gränser och dess styrelse. Presentationen skall ske på Sida i Stockholm.

Konsulten skall vidare på begäran av Sida eller Läkare utan Gränser stå till förfogande för diskussion om analys och slutsatser.

Appendix II – List of References

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MSF-Sverige/Läkare utan Gränser, 2002, Läkares utan Gränsers grundprinciper

MSF-Sweden, August 2002, Medium Term Policy "The capacity to question" 2003–2005

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MSF-Switzerland, Annual Plan 2003

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RAX Consulting AB, 1993, Capacity Study Of Mediceins Sans Frontiers

Sida, 15–May-03, Hårddragen rapport drar felaktig slutsats om Sidas humanitära bistånd

The Save the Children Fund (UK) South Sudan Programme, June 1998, Postscript to the Southern Sudan Vulnerability Study on the 1998 crisis.

Appendix III – Inception Report

MSF – modifierad kapacitetsstudie

Angreppssätt och frågor som kommer att behandlas

1. Huvudtematan

ToR anger tre breda frågor som ledstjärnor för studien

- ”Hur väl identifierar och främjar MSF lokala hälsostrukturer?” Detta kan brytas ned på:
  - Vilken betydelse ges åt, och hur hanteras, lokal förankring/ deltagande?
  - Hur kartlägger man den lokala situationen och lokala institutioner och vilken betydelse ges detta i en insats planläggning, mobilisering och igångsättning?
- ”Hur fungerar MSFs samarbete/koordinering med övriga aktörer?”
  - I vilken grad och hur styrs detta av MSF (e.g. värdepremisser, policy, eller managementstruktur)?
  - Vilka faktorer i ’the peer environment’ styr detta?
  - Hur och i så fall varför förändras samarbete/koordinering under genomförandet?
- ”Hur väl utvecklad är [MSFs] strategier och implementeringsmekanismer för att säkra hållbarhet och bestående resultat”?
  - Vilken innebörd lägger MSF vid begreppet ’sustainability’ – som strategisk begrepp, som praktisk utmaning, som kontextuellt bestämt?
  - Vad styr och hur sker utfasning av insatser?

2. Angreppssätt

Ovanstående frågor kommer att belysas över tre variabler eller sammanhang

- MSFs organisationsmiljö.
  Även om MSF är till sin policy och värdebas en uppenbarligen enhetlig organisation är den också mkt komplex med sitt International Council som nav, 5 Operational Centers som sinsemellan oberoende management-enheter, och 18 National Partner Associations med ansvar för lobbying, fund-raising, och rekrytering. MSF

Sverige ligger som partner till OC Bryssel men har full frihet att agera tillsammans med ngt annat OC, likaväl som OCB kan gå utanför sin partnerkrets för att mobilisera resurser för verksamheten.

  - Givet att varje OC har sin egen tradition och egna styrsystem (hur projekt tas fram och följs upp, egna management linjer från OC ut till projekten, i viss mån egna prioriteringar och förhållningssätt till omgivningen, etc), vilken betydelse har detta för evt variationer i fältpraktiken? Vilken 'managerial discretion' har olika nivåer (OC/DO, HMO/MD, lokal projektledning och personal)? För Sidas del aktualiseras detta av att projektstödet till MSF Sverige fördelas 1999 2002 över huvudsakligen 4 OC (Bryssel: 31%, Paris: 15%, Amsterdam: 46%, Geneve: 8%)
  - Vilka förändringar över tid (inkl pågående processer) har skett i MSFs styrsystem, prioriteringar, arbetsmetoder etc? Vilken roll spelar de årliga och andra utvärderingar som görs av varje OC av 'sina' projekt i 'sina' länder och 'sina' områden? Var och hur drivs förändringar fram av organisationens sätt att fungera?
  - Vad innebär det faktum att MSF Sverige är ansvarig part gentemot Sida samtidigt som det är det OC som projektet faller under som har det fulla genomförande-ansvaret (via "utkontraktering" från MSF Sverige). Vilka möjliga tillvägagångsätt kan finnas som evt förenklar och fördjupar MSF Sveriges roll som ansvarig part gentemot Sida, resp deras inflytande på MSFs praktik i stort?

- Den konkreta miljön i vilken insatsen görs
  Det är uppenbart att en stor del av de tre huvudfrågorna ovan måste ses i ljuset av den konkreta miljö i vilken verksamheten utspelas. Syftet med fältbesöken är dock inte att försöka göra ngt representativt urval av MSFs verksamhet utan att söka efter *variationer* och evt mönster i dessa. De faktorer vi kommer att titta särkilt på är
  - Existensen av lokala hälsostrukturer, om än enbart som tom infrastruktur (ex.vis om de är lierade med ngn konfliktpart, hur förhåller sig MSF?)
  - Antalet/tyngden av andra aktörer på plats
  - Professionellt kontra organisatoriskt samarbete (ex.vis 'remisser' i förhållande till samplanering av verksamhet/insatsområden)
  - Längden av närvaro i ett område (ex.vis svårigheten att balansera självständighet/oberoende i förhållande till andras 'agendor' gentemot att därvid också bli en lokal aktör)
  - Betydelsen och vikten av témoinage för graden av förankring, koordinering, och hållbar utfasning
- Sidas policy och strategi miljö
  MSF är som aktör ganska problematisk/unik som samarbetspartner i den svenska biståndsmiljön (finansieringsmodellen, oberoendet, avtalspart/genomförandepart, "take it or leave it" karaktären i ansökningsförfarandet, etc). Den 'niche' som MSF valt att göra till sin är sannolikt också viktig för Sidas humanitära strategi och dess trovärdighet, samtidigt som den passar ganska illa in i gängse begrepp och prioriteringar (samverkan, lokal förankring, bärkraft, åtskillnad mellan emergency/relief/development)

Även om ToR inte anger det ser vi det som nödvändigt att försöka belysa inte bara MSFs kapacitet att handha för Sida centrala begrepp och frågeställningar, utan också relevansen och kapaciteten i Sidas handhavande av den niche som MSF står för (idiosynkrasier och variationer i bedömningar, relevansen av nuvarande form och struktur för projektansökan, kriterier för bedömning och uppföljningsfrågor etc).

I den meningen är en viktig målsättning för studien att bidra till att anpassa de instrument och kriterier som bestämmer dialogen och beslutsfattandet mellan MSF och Sida till den verklighet som just MSF opererar inom.

De frågor som kommer att tas upp bestäms i första rummet av erfarenheterna från fält-besöken

3. Fältbesöken

Tre länder kommer att besökas, vilka med viss försiktighet kan ses som tre principiellt skilda sammanhang:

- Sierra Leone (”konsoliderings-miljö”): i möjligaste mån kommer samtliga Sida-stödda verksamheter att besökas (dock kan andra projekt också komma att behandlas beroende på tid och omständigheter). Bryssel, Paris, och Amsterdams HoM kommer att kontaktas för diskussioner
- S Sudan (flytande och osäker miljö): enbart projekt i rebell-kontrollerade områden besöks. Liksom i Sierra L kommer försök att göras att diskutera med olika OC företrädare samt med amb i Nairobi
- Sri Lanka (”utfasningsmiljö”): både Sida-stödda och andra projekt kommer att besökas. Särskilt tonvikt på utfasningsprocessen (MSF avslutar SL-närvaron per 1 juli i år)

Beroende på situationen i Liberia (dålig f n) kommer kanske ett kort besök att göras från Sierra Leone, avgörs i diskussoner med MSF i Freetown.

Efter fältbesöken kommer också Bryssel samt Amsterdam och/eller Paris att besökas, speciellt med avseende på management-praxis och planerings/uppföljningssystem.

4. Metod

Teamet håller på att utarbeta en gemensam checklista för fältbesöken. Denna kommer att vara intern under studiens gång men kommer att biläggas rapporten.

Det är uppenbart att vilka projekt som kommer att besökas måste avgöras på plats i samråd med MSFs personal. Med tanke på att studien inte rör hantering av Sida medel i sig utan MSFs förhållande – i policy och i praktiken – till ett antal kärnfrågor som i sig är tämligen donorneutrala kommer vi att i första hand titta på verksamheter av olikartad natur (service/PHC, vertikala projekt, situations-specifika projekt etc) oansett vilken OC det ligger under och oansett vilken institutionell donor som ligger bakom.

5. Tidsplan

Fältbesöken kommer förhoppningsvis att ske som följer (med starka reservationer då dessa ännu ej bekräftats av MSF):

22/4–1/5 Sierra Leone

28/4–7/5 S Sudan

12/5–21/5 Sri Lanka

Besök vid OCB/F/A i slutet av maj enligt överenskommelse med MSF

3/6 Genomgång med SEKA/HUM samt MSF Sverige

10/6 Inlämning och presentation av slutrapport

6. Rapporten

Bortsett från de beskrivande delarna (som vi ser som viktiga för att klarlägga praxis i MSF stödet) kommer rapporten att diskutera slutsatser och ge rekommendationer för de tre ovan angivna 'miljöerna':

- MSF (Sverige och Sverige-OC)
- Kontexten (faktorer som bör beaktas av både MSF och Sida i upplägg/projektanslag)
- Sidas policy och strategi hantering avseende HUM och MSF

Appendix IV – Country Cases

A. Sierra Leone

The following section includes impressions and reflections on the operations on MSF operations in Sierra Leone, as described to the team by the staff in the field. It is based on a 10 day visit in May, 2003 to the project coordination headquarters of MSF-B and MSF-H and three projects in different districts. During this time, the team discussed MSF, the projects and the situation in Sierra Leone with local and expatriate MSF staff as well as with other local actors, patients and chiefs. The following description reflects the impressions of the consulting team as well as the ideas and considerations of MSF staff.

History

Medecins Sans Frontiers (MSF) have been active in Sierra Leone periodically over a period 18 years. They first arrived in response to a Cholera outbreak in 1985 and stayed only a short while. Then in 1990, MSF arrived in scale and were involved in various activities:

- 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

Current Operations

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.

	MSF Belgium		MSF Holland		MSF France
Location	Bo, Bo and Pujehun District		Makeni, Bombali District		Not visited by the consulting team
Activity	1. Operation of the Maternity and Pediatric wards in Bo Hospital 2. Provide primary health services to refugee population through clinics located in the vicinity of five refugee camps 3. Treatment of severely malnourished children in refugee camps 4. Provision of secondary health care in a referral center located in Gondama 5. Detection and medical treatment of Sexually and Gender Based Violence (SGBV) among refugees.	Expatriate staff: 10 Local staff: ~150 Staff with incentives: ~90	1. Operation of the Maternity and Pediatric wards in Makeni hospital 2. Provide primary health services to the local population through five clinics	Expatriate staff: 5 Local staff: 26 MOH staff with incentives staff: 30	
Location	Koidu, Kono District		Kambia, Kambia district		
Activity	1. Provision of primary and secondary health care through the Koidu district hospital	Expatriate staff: 5 Local staff: 50 MOH staff with incentives staff:	1. Provision of primary and secondary health care through the Kambia hospital		
Location	Kabala, Koinadugu District				
Activity	1. Provide primary health care through Kabala hospital 2. Provide primary health care through 10 outlying primary health units	Expatriate staff: 3.5 Local staff: 100 MOH staff with incentives staff: 40–50			

The three OC seem to be operating relatively independently from each other on a project by project basis, but work together to assess the security situation. During the consultants' visit a two day meeting between all the HoMs of Liberia, Sierra Leone and Guinea was held, where the war situation in each country was thoroughly reviewed.

The three OCs in Sierra Leone currently cooperate on one cross-country project; a study of the efficacy of the currently available and alternative anti-malaria drugs.

During the Consultants' field visit the following projects were visited:

Bo District (MSF Belgium)	Bo District Hospital Gerihun refugee camp Jimmi Bagbo refugee camp Bandajuma refugee camp Gondama referral center
Makeni (MSF Holland)	Makeni District Hospital Kagbere clinic
Kabala (MSF Belgium)	Fabala clinic

In Bo, MSF is operating the following sub-projects:

Bo District Hospital

Management and support to the maternity and pediatric wards and Temporary Feeding Clinic (TFC) in Bo District hospital. MSF provide the hospital with the minimum required equipment, drugs and medical supplies free of charge. In the hospital the MSF are operating with the following staff:

- One expatriate doctor
- One expatriate nutrition nurse
- 17 local staff employed

Supplementary Feeding Clinics (SFC) in 5 refugee camps (Bo project)

Mobile team visiting each camp each week to weigh, measure and if needed refer malnourished children to the nearest clinic. In four camps of five, MSF is providing supplementary food (BP5) to severely malnourished children after examination. In one of the camps, WFP provides MSF with food for malnourished children. The MSF have organized the refugee camp rotation with the following staff:

- One expatriate nurse
- Eight local employees in the mobile SFC team
- 3 staff in the screening team
- 90 volunteers (Liberian refugees). In each camp MSF have organized the volunteers into the following teams
  - SFC team: 5 persons per camp responsible for visiting severely malnourished children each week
  - Home visitors team: 10 people per camp responsible for visiting all refugee households during the week, providing education on hygiene, disease, malnourishment etc.

Gondama referral center

MSF have recently build a new referral center for refugees. MSF have built the facilities, infrastructure, provided the equipment and will be supplying the center with drugs and medical equipment. All services provided by MSF will be free of charge. The center has the following facilities:

- Maternity ward (13 beds)
- Male and female wards (12 beds each)
- Isolation ward (4 beds)
- Reception and diagnosis, dispensary

The referral center had not, at the time of the Consultants' visit been inaugurated, but MSF were planning to have a staff consisting of:

- One expatriate doctor
- One expatriate nurse
- Approximately 25 local employees (nurses, watchmen, cooks etc.)

Support to five MOH clinics	MSF are providing five clinics located close to each of the refugee camps with medical supplies and drugs free of charge. The clinics are operated by the MOH, but with support from MSF. MSF provide medical equipment and drugs and also have MOH staff at each clinic receiving an incentive from MSF. MSF have • One expatriate nurse supervising the clinics • 48 staff on incentives
Water and Sanitation	MSF staff, both expatriate and local staff, are involved in the following activities: • Improvement of sanitation in three of the five camps (mainly digging of holes for toilets) • Provision of clean water in Jembe camp and Zimmi way station • Provision of clean water at Gondama referral center • Building of protected sheds for SFC in each camp • Hygiene promotion programs The MSF staff involved in water and sanitation projects are: • Two expatriate water and sanitation staff • 9 local staff including one construction supervisor • Liberian volunteers involved in construction
Bo project office	The administrative, logistic and domestic staff for the Bo project are: • One expatriate project coordinator/medical coordinator • One expatriate log/admin staff • 65 staff (watchmen, drivers, administrative staff, cleaners, assistants, stores administrator etc.)

The Bo project gave the impression of being large and slightly unwieldy. MFS is the single largest employer in the town, with a total staff of about 250 including domestic staff and administration personnel. Project coordination is an important, but at times difficult job as new projects are initiated with expatriates arriving, other activities are reduced in scope or delayed, and more than 250 staff need to be managed. The MFS team in Bo gave the impression of coping well, but it would have been expected that such a large project would require a that more and stricter routines and procedures be established. One of the more difficult tasks for the project coordinator was to reduce staff, as MFS were turning over the management of the hospital to the local health authorities.

MSF would seem to be well entrenched in Bo, with fixed routines for managing the sub-activities, an important role to play in the management of refugee camps and the hospital. It would appear as it MFS has become an institution. They have a long history of activities in the region, they are asked to participate financially and with staff in local coordination activities (also those that are not health related) and would seem to have certain influence in local decision-making partly due to their seniority among the many NGOs operating in the area (there are

more than 25 NGOs working in Bo and surrounding areas).

The Bo project seemed to be operating on a day-to-day basis, i.e. slightly without direction. The long or medium term strategy for the project was unclear and not discussed among the staff. There did not seem to be any effort to either focus on quality or quantity, or any consideration of when or why an exit would be possible

In Bombali district, MSF Holland are managing the following sub-projects:

Makeni District Hospital	Management and support to the Pediatrics and Maternity wards and emergency surgery when needed. All MSF services and medicines are free of charge. MFS also provide the hospital with medical equipment and drugs and have rehabilitated the water and sanitation facilities. MSF have the following staff operating in the hospital: • One expatriate doctor • One expatriate midwife • 3 full time nurses employed by MSF • 5 medical staff on incentives
Five clinics in Bombali District	MSF supports five outlying clinics in the district. They provide medical equipment and medicines, free of charge, and have also refurbished the clinic and provided clean water by digging wells and toilets. For the five clinics MSF have: • One expatriate nurse on rotation • 25 MOH staff on incentives (5 people at each clinic)
Makeni project office	The administration, logistics and domestic tasks are carried out by: • One expatriate project coordinator/medical coordinator • One expatriate log/admin staff • 23 local staff (drivers, watchmen, construction workers, administrative personnel, cleaners etc.)
Malaria study	The cross OC and nation wide Malaria study is being currently being finalized by an Expatriate doctor and one expatriate nurse. They are currently based in one of the wings of the Makeni District Hospital.

The Bombali project was managed by staff sent out by the Dutch OC. It was a small team with a high degree of expatriate staff relative to local staff. This was a consequence of their strategy, which was clearly articulated as: proximity and quality. The project and country leadership had decided to focus on fewer sub-activities but where the expatriates would instead have a higher degree of influence over the activities. MFS had for example, limited the number of clinics it supported to five, choosing not to expand into new regions as that would mean that one nurse could only visit a clinic every two weeks instead of every week.

The Makeni MFS team worked closely with some of the other NGOs in the area, among them Acción contra la Fame (ACF) in particular. MSF and ACF would carry out clinic visits together, with an ACF nutrition specialist accompanying the MSF team to each clinic. MSF also had good relationships with the UN and the local government, necessitated by the need for security information.

MSF in Makeni appeared to have good relationships with the local chiefs in the villages. As the only NGO and support organization in some of the regions, they would receive requests for support in a number of areas and demand for their services was large (more than 70 patients were seen per day in one of the clinics). However, at the hospital in Makeni, the MSF team had what can be described as a truce with the local DMO, mainly due to the fact that the hospital would charge for services provided by them (but not by the MSF).

In Koinadugu district MSF Belgium is operating the following subprojects:

Kabala District Hospital	Management of the entire hospital, all wards and carries out emergency surgery. The DMO is responsible for cold surgery only. MSF have rehabilitated the hospital and provide medical equipment and medicines free of charge. In the hospital MSF have • One expatriate nurse • 50 locally employed staff
10 clinics in Koinadugu district	MSF supports 10 clinics in outlying areas with medical supplies and drugs free of charge. MSF staff also provide basic on-the-job training and collect statistics about the health and economic situation of the population in the area. The MSF have also helped refurbish the clinics, provided safe drinking water by either digging wells or building rain water tanks and provided the furniture for the clinics. MSF have • One expatriate nurse on clinic rotation • 40–50 MOH staff on incentives (4–5 at each clinic)
Kabala project office	The logistical, administrative and domestic tasks are carried out by: • One expatriate project coordinator/medical coordinator • One part-time expatriate log/admin staff (shared with Kono district) • Approximately 50 locally employed staff (drivers, watchmen, radio operators, cleaners etc.)

Koinadugu is a district which was a rebel strong-hold during the war. The town of Kabala was never taken by the rebels, but the destruction in the nearby villages and among families meant that a majority of the people in the district fled to other areas and to Guinea during the war. Few of them have, however, been recognized as displaced persons or refugees as they were said to have been hiding in the country side.

The infrastructure (roads, building, water and sanitation) are very poor. The MSF staff also suggested that the national government puts less emphasis on building up the infrastructure in the district than in other districts, because of it being an ex-rebel area. MSF are currently one of very few NGOs in the area, although there is a large UN compound in Kabala.

The operations in Koinadugu district did not appear to be as well supported as in other districts. In many cases MSF had tried to start Village Development Committees, partly to help the villages help themselves, but also as a means to start a democratic process. These had, however, met with mixed results. In one village, the village chief did not see the need for MSF's clinic support program (and the reconstruction of a new clinic) as there was a clinic in the next village and few people attended the one currently supported by MSF.

The MSF team, who are based in Kabala, would seem to have a quantity goal. The staff argued that as long as there were people who needed free health care in the area, MSF should stay. Also the fact that MSF is one of very few NGOs in the area, justifies their activities. MFS currently have a relatively large organization with many local staff, cover 10 clinics and are considering expanding to clinic project to 15.

Staffing

MSF Operations in Sierra Leone rely on

- expatriate staff,
- locally employed staff,
- staff employed by the MOH but where MSF pays an incentive, and
- volunteers who in some cases receive some compensation for their time.

Expatriate Staff

The typical MSF field office in Sierra Leone is staffed as follows

Position/title	Responsibly
One Field or project coordinator	The main responsibility is to ensure the safety of the expatriate and local staff. His/her duties lie in regularly updating the team and the mission coordination on the stability of the peace in the area and the safety situation of the staff. (S)he is also the task manager and overall leader of the field mission and maintains contacts with the MOH representatives, other NGOs, the UN and the local and regional political leadership. The field coordinators are often medically trained in order to be able to also take on the role of medical coordinator. The field coordinator/medical coordinator would typically be on a one year contract.
One logistics/ administrative person	His/her responsibilities lie in managing the project funds, administrating the project, hiring a recruiting staff, logistics and transportation. The log/ admin staff also manage various other projects such as water and sanitation, overseeing of construction or rehabilitation projects etc. The log/

	admin expatriates are not medically trained and often are on a 6 month to one year contract.
One medical doctor	The medical doctors are often based at a hospital or larger clinic where they attend to patients and perform surgery. Medical personnel are often required to stay for a minimum of six months. Often the Western European or North American medical staff need to familiarize themselves with local diseases and ailments, which can take a few weeks.
One or two nurses	The nurses work either at a hospital or on a clinic rotation. The tasks of the hospital nurse include treatment of patients, on-the-job training of local staff, establishment/improvement of routines regarding hygiene etc. The nurses on clinic rotation, are required to visit the clinics MSF support to provide training, assistance, collect health statistics and help diagnose difficult cases. The nurses are also on a minimum of six month contracts.

The impression of the MSF expatriate staff are that they are highly qualified in western medicine, committed to the cause, independent and keen to make an impact. The training of an expatriate from a western country can, however, take considerable time. One example is a European nurses, she spent two to three months learning on the job about tropical diseases, malaria symptoms and malnutrition in children from another other MFS expatriate (from an Africa country). This she claimed was a long time, considering that she had a six month contract.

All the expatriates are keen to make an impact. They often initiate 'pet projects' that they can implement in addition to the other tasks they carry out. Such projects can be e.g. the replacement of metal water collection tanks (which tend to corrode) with cement tanks, or the implementation of a survey of health care beneficiaries to assess the effectiveness of the clinics in one area. The 'pet projects' that the team have seen would all seem to be relatively short and thus carried out by the initiator during his or her contract period.

Locally Employed Staff

The ratio of local staff to expatriate staff in Sierra Leone varies between projects although several of the projects are relatively similar.

	Bo (MSF Belgium)	**Makeni (MSF Holland)**	**Kabala (MSF Belgium)**
Management of hospital	Maternity and Pediatrics	Maternity and Pediatrics	Entire Hospital
Clinics/refugee camps	5 refugee camps	5 clinics	10 clinics
Expatriates	10	5	3.5
Locally employed staff	150	26	100
MOH staff with incentives	90	30	40–50
Ratio expats/local staff	15:1	5:1	10:1

MSF work and employ a large number of local staff and in the cases where they operate refugee camps, also have volunteers receiving some compensation. Locally employed staff work under one year contracts and MSF are subject to national laws regulating holiday entitlements, bonuses, benefits, working conditions etc.

MSF salary scales for local employees, have been harmonized between the three MFS OC operating in Sierra Leone, and range from Leones 182,600 for domestic staff to 1 million per month for a chief medical surgeon at a district hospital:

Salary level		Monthly salary paid by MSF (in Leones)	Monthly salary paid by MOH
1	Domestic staff and watchmen	182,600	45,000
2	Chief watchman	197,400	50,000
3	Drivers and chefs	220,300	60,000
4	Qualified medical staff and supervisors	254,500	80,000
5		303,500	90,000
6		376,200	
7	Doctors	455,100	
8		569,700	
9		738,400	
10	(chief doctor at district hospital)	1,004,100	

Salaries paid by MSF are very high compared to MOH salaries, in general three to four times an MOH salary.

MSF also has a tradition in Sierra Leone of make payments to MOH employees, so called incentives. This is to o provide an incentive for MOH staff to work and live in remote areas and to work on MSF projects.

Incentives paid out by MSF match the salaries paid by the MOH, thus doubling the income per month.

MSF also relies on volunteers, often from the village or refugee camp, to carry out construction work, sanitation work or home visits. They are not under any contract with MSF, and receive between Leones 500 and 2000 per working day depending on the skill required. Home visitors, often with a medical background, are paid Leones 2,000 per day while construction workers receive Leones 500–1000. This is usually paid directly to the volunteers.

The local staff were mainly composed of security personnel, administrative staff, drivers and domestic staff. A majority of the local staff suggested that to work for MSF was a relatively prestigious job. It is well paid compared to government jobs and it would appear as if the local staff are giving a great deal of responsibility and freedom, and that they are not governed by strict rules and regulations (other than for security reasons).

Sequencing of an MSF Project in Sierra Leone

Identification — In many cases the local MSF field office are made aware of a need or a specific situation. Outlying clinics may identify new areas where medical

	services may be needed. The MSF team also visit distant areas in order to "scan" the need for medical services.
Exploration	A team consisting often of one medically trained expatriate and medically trained local staff visit the areas under consideration to assess the need. Issues taken into consideration are: • Health needs in the region (similar to other locations where MSF are operating clinic or more urgent) • The existence of operational medical facilities • Availability of local medical staff • Accessibility of the population to the nearest MOH or MSF clinic • The quality of any medical service that is provided (the existence of drug peddlers or "quacks") • Existence of other NGOs providing health assistance (WFP, ACF, World Vision etc.) • Existence of infrastructure and equipment The team also contacts the village/district leaders at each proposed site.
Preparation of proposal	A proposal is prepared according to a standard template. The proposal includes a brief note and justification of all the points mentioned above. The field log/admin person also estimates a budget for the project which is annexed.The proposal is sent to the Mission coordinator and to the operations coordination in Europe.
Consideration of proposal	The mission coordinator and operations coordination consider the proposal and if it is in line with the annual plan for the project. The financing of the project is managed differently in the Belgium OC and the Dutch OC. In the case of the Belgian OC, the OC is responsible for finding financing or and contacting donors. For the projects managed by the Dutch mission, the mission coordinator in Sierra Leone can contact donors directly to fund projects, or chose to fund the projects with MSF private funds.
Approval/ dismissal or proposal	The project is often dismissed not for financial reasons, but more often due to the project match with the annual plan. As the stated medium term plan for MSF Belgiums' involvement in Sierra Leone is to gradually reduce MSF presence, increased presence would contradict that plan.

Summary according to ToR Questions

• *MSF's Role in Identification and Promotion of Local Health Structures*

In Sierra Leone the role of MSF varies between the different contexts of the different projects. When the team visited Sierra Leone the MoH was

on a strike. The reson being that salaries were too low. MSF used in all cases they felt necessary a "tip-of" system to maintain the MoH staff in the Hospitals and clinics. In the case of less specialized medical staff MSF either "tipped off" MoH staff or trained locally.

In Bo MSF(-B) has the role of being the largest NGO in the area. This implies that MSF has to collaborate with the existing health structure as well as other NGOs in the area. A large proportion of the programme was focused to improve the health situation of the refugees living in the in the camps. A problem arise when some of the clinics turned out to have a majority of local citizens rather than refugees. Partly because the health situation in these local villages was worsened but also due to that the MSF treatment was almost free and the presence of MSF assured quality. However, MSF is in this case due to their role forced to both identify and promote the local health structures.

In both of the other projects visited in the northern parts of the country. MSF is overall operating in a more direct manner in hospitals and clinics. In this situation MSF is thriving to be able to leave the hospital i.e. the MSF mandate forces MSF to leave. This implies that there is an continuous screening and monitoring process going on of the local health structure, wich in many clinics seemed to be glaringly absent. In all the clinics we visited there was almost a total lack of local health structure. MSF is trying to put pressure on MOH to take action. The problem is that the MOH consider this as unnecessary since MSF is present.

- MSF's Cooperation/co-ordination with Other Actors involved in Humanitarian Aid

As stated above, MSF in Bo has the role of the largest NGO in the area. In this case it also means that MSF is conducting several operations in the supplementary area such as Watsan and PFC (primary feeding centers) within the projects. In some cases MSF felt the need of conducting these supplementary activities in order to assure themselves of the quality, even though that there in many cases existed other NGOs with core-activities perhaps more suitable to carry out these activities. In the northern projects visited (Makeni and Kabala). There were generally less presence of other Humanitarian Aid organizations. Still the once that were in place did not have any "business" collaboration with MSF. In Makeni there was some collaboration within the logistical/transportation with another NGO (ACF). In the case of Kabala there were none, due to the fact that the only other main actor was the UN.

Generally, on all levels of the country mission, the ability of any UN organ was questioned.

- MSF's Strategies to Assure Sustainability and Lasting Results

Since MSF generally do not have any long term perspective of its operations. At the same time it is hard for a humanitarian organization not to be regarded as an institution after being present in a country for more than 18 years. MSF has due to their needs ongoing been conducting training of staff, building, rebuilding and improving clinics and hospitals. In that case MSF will be leaving a somewhat lasting result at the time of phasing out. Generally, in this case MSF has successfully avoided creating sustainable activities.

B. Southern Sudan

History/background

The country is divided into two MSF missions: North Sudan, which is run from Kharthom, and South Sudan, which is run from Kenya. This study only concerns the South Sudan mission.

MSF has many and large operations in Southern Sudan. Four OC are involved: MSF-F, MSF-B, MSF-H and MSF-CH. For MSF-CH, Sudan is the largest mission.

The security and political situations are difficult. The internal war has been going on for 20 years. The government of Khartoum is fighting against different rebel groups in the South. Currently some towns in the South are controlled by the government, but the major parts of the country are controlled by the two rebel groups SPLM/A and SPDF, who recently merged to one. At present, SPLM are more or less in control of the rural areas of the Western parts, while the Eastern and Central parts are more turbulent with different warlords and clan fighting. MSF's local counterparts thus consist of GOS (Government of Sudan) based in Karthoum, SPLM/A and its humanitarian wing SRRA and SPDF and its humanitarian wing RASS, who recently merged into SRRC. Furthermore, local chiefs are the main local counterpart in areas where neither the rebel groups nor the government has control.

MSF-B and MSF-H work in the Eastern part, while MSF-F, MSF-CH and MSF-B work in the Western part.

MSF has worked in Sudan since 1985. In 1989 two MSF volunteers were killed when a plan was shot down by the GOS and in early 1990 two MSF staff were kidnapped by SPLM, whereby MSF-F and MSF-B suspended their activities in Sudan. MSF-B came back in 1992 while MSF-F and MSF-CH did not return until 1996. MSF-F acted under the name of UDA instead of MSF.

The different MSF sections have taken different strands in relation to cooperation within Operation Lifeline Sudan (OLS). OLS is a political and organisational agreement between GOS, SPLM/A and the UN to ensure delivery of humanitarian aid in Sudan. The agreement was initiated in 1989 and was supposed to ensure access to people in need and security for humanitarian workers. Most NGOs active in Sudan signed a Letter of Understanding in order to operate under the OLS umbrella. The OLS cooperation has been problematic and tainted by the political game between the actors. OLS has sometimes been seen as facilitating access and security for humanitarian efforts, while at other points in time as restricting access and not being able to provide security.

MSF's relationship to OLS is complex and the different sections have taken different strands in-between them and over time. Initially MSF operated under the OLS umbrella, but when they came back in 1992 and 1996 respectively, after having withdrawn in 1990, MSF-F and MSF-CH operated outside OLS, while MSF-B and MSF-H operated under the OLS umbrella. However, both MSF-B and MSF-H had activities in the Nuba mountains outside the OLS, thus violating the agreement, which restricted access to this area. In 2000 both MSF-B and MSF-H left the OLS cooperation and currently all MSF sections operate outside OLS. There has been a lot of debate within MSF with regard to the relationship to OLS, but it is maintained that the diversity in the MSF

movement in this case might have helped them to both eat and keep the cake in the sense that they have been able to influence and benefit from OLS from within and at the same time criticise and act independently from outside. Currently the cost of being part of the cooperation in terms of restricted access and political 'tainting' is regarded as higher than the supposed benefits in terms of security and information. The fact that MSF operates outside OLS makes it possible for them to operate in areas where no other organisation can go.

Current operations

	MSF Belgium	MSF Holland	MSF-F	MSF-CH
Location	Tangyang (East)	Laniken (West)	Akuem (West)	Kajo Keji (South)
Activity	1. Primary health care3 PHU, Planning 4th PHU and perhaps 5th PHU and PHC 2. Nutrition survey Had TFC last year, failure	3. Kala Azar 4. TB 5. Nutrition – TFC 6. Lab 7. Drilling (contract out)	1. PHCC 2. TB 3. MCH 4. Nutrition – TFC and 2 SFC 5. Lab	Large hospital Sleeping sikness program
Location	Mapel (West)	Western Upper Nile (Central/East)	Ibba – Maridi, Kotobi (South)	Marial (West)
Activity	1. PHCC 2. 4 PHU 3. TB program to be started	2. PHCC + outreach 3. Kala Azar	a. Sleeping sickness b. Basic health care	Large hospital
Location	Akobo (closed down 2001) (East)	Nuba (North)		
Activity	3. PHCC	1. Basic care 2. TB will start		

Bentiu (B/F) – run from N Sudan – Nutrition, PHCC, Kala Azar, TB
Wau (H) – run from N Sudan (Karthoum) – pedriatic ward of civilan hospital

Visited projects/sites
Tangyang (MSF-B)

The location:
Tangyang is located in Bieh state in Jonglei in Eastern South Sudan, between Waat and Akobo. The area is supposed to be controlled by RASS, but their actual influence is minimal; local chiefs constitute the main counterpart power structure. Clan fighting is common and violent. Tangyang is a small village and the main reason MSF has chosen this location as centre for their operations is that the two larger towns in the area, Waat and Akobo, are too insecure (see below for information on the former MSF operations in Akobo). Furthermore, Tangyang has an airstrip that is decent enough to be used even during the rainy season.

Activities:
MSF started operations in Tangyang in January 2002. Previous to that they had had some SFC outreach activities in the area from the PHCC in Akobo.

Currently 3 PHUs are operating, one in each of the villages of Tangyang, Jidit and Boung. A fourth PHU was to be opened in May

2003 in Walgak. The plan for 2003 is to prepare for a PHCC and possibly a fifth PHU. Malaria, gastro related sicknesses and skin diseases are the most common diseases.

A water drilling program is running and the drilling team of MSF-B is currently situated in Jidit. The plan is to install 10 water pumps in the area during 2003. Up to April 6 has been installed. All villages with PHUs have access to water as well as a number of other strategically selected villages.

Nutrition and emergency surveillance is included in the program. A food availability survey and a nutrition survey have been made since Sept 2002. In 2002 a TFC was set up since the nutrition survey indicated a 20–25% prevalence of malnutrition. The program did not have enough patients, however, and was regarded as a failure. One possible reason was that the population expected food supply but got medical treatment. If the nutrition survey indicates a need this year, MSF is considering integrating SFCs into the PHUs instead of putting up a TFC.

A recent survey also indicated a high level of Kala Azar prevalence. A program might be considered.

Staff:
Expatriate staff consists of three persons: one field coordinator, one nurse and one log admin. Each PHU has 5 local staff including a community health worker, a dresser and a drug distributor. Some of the community health workers have been trained by ICRC.

Cooperation:
No other organisation is operating in the area, due to the difficult security situation. Furthermore, the area is red lighted by OLS. The local counterpart is officially RASS, but their presence and control is weak. The actual counterpart is the local chiefs and communities. Coordination with the local communities is crucial for security reasons and is maintained. MSF cannot afford to create tensions in this volatile area.

Referral centres are MSF-H in Lankien and the War hospital in Lokichokio. Lankien is two days walk from Tangyang, which is not too far away, but problematic due to clan issues. The War hospital in Lokichokio is supposed to cater primarily for war victims and the patients needs to be taken by flight; hence access is restricted.

Comments:
This is a recently opened project in an area where no one else is operating. It is 'virgin land', the needs are immense and the relevance of the activities cannot be questioned at this stage.

The MSF staff in Tangyang had a clear feeling that what they did was important and meaningful.

The cooperation with the local counterpart necessitated large discretion and continuous dialogue with the local communities, due to the 'decentralized' law and order situation, i.e. no government structure, a lot of weapon around, clan fighting. Two incidents at the time of our visit illustrates the situation:

- MSF label on gun: When MSF staff was travelling between two of the PHUs they were stopped and threatened by a young man with a gun. Nothing happened, the driver managed to calm down the man, but the gun had a MSF sticker on it. The MSF field co immediately talked to the village leaders about the incident, demanding they control their youth and demanding all MSF stickers back (they must have been stolen). They received the stickers and apologies form the village leaders and the father of the young man. In an insecure area like this, it is of course fundamental that MSF is not seen as being an actor in the local fights. The incident was reported to the HOM.
- The location of the water pumps to be installed required intensive coordination and many meetings with the local communities. It is important that the local communities perceive the choice of location as based on relevant facts and not on favourism of some communities. Several meetings were held with each community around each water pump in order to explain the reason for choosing one location over another. In one case a local man, who was powerful because he was feared for spiritual reasons, opposed the location of the water pump in a neighbouring village and demanded it be placed in his village. The MSF field co held many meetings with the local community and explained the physical and practical motives of the chosen location. Members of the local community came and talked to the MSF staff after the meeting and said MSF was right regarding the location, but that they feared the old man. MSF field co decided that they had to solve the issue themselves, and that MSF would not install any pump in the area until they had agreed among themselves to have it installed in the place that MSF had decided. Eventually the village leaders from the different villages came and told MSF that they had agreed and convinced the old man and now the pump is installed.

In order to try avoiding to be capture in the local power struggles MSF attempts at spreading its presence between the villages in which they operate, not making Tangyang the centre and MSF 'owned' by the Tangyang community. Compounds were MSF staff can live have been built in all three villages where they have PHUs: Tangyang, Jidit and Boung. Currently, the drilling team stayed in Jidit, while the medical personnel stayed in Tangyang.

Discussions with the drilling team revealed that they felt somewhat left out in the MSF organisation. The fact that their activities were not core MSF activities were felt in a weak organisational support structure…..

Lankien (MSF-H)

The location:
Laniken is located in the Jonglei state in Eastern South Sudan, north of the town of Waat. The area is rather insecure, due to clan fighting. No government structure or public services are available.

Activities:
MSF has operated in Lankien for approximately 10 years.

The current program includes:

- Kala azar
- TB
- TFC
- Water drilling
- Lab

The Kala azar program is an OP program for 17–30 days that has approximately 100 patients. Those that live too far away or are seriously ill can stay in the special care ward. The drug used is PSF, which is imported from India.

The TB program has approximately 100 patients, and has run for about 5 years. The treatment is very controlled. The patients stay at the compound for 4 months and their intake of the tablets is monitored strictly. They are given a weakly ration of food, which they cook for themselves. After the 4 months they are allowed to leave, but required to come back for regular follow-up for 3 more months. The patient as well as their village chief is required to sign an agreement committing themselves to fulfilling the treatment. Approximately 20 patients are admitted per month. The patients are screened by CMA (see below) and referred to MSF. Approximately 80 percent of the TB patients are women. The MSF staff guesses that this is due to clan issues and security reasons and perhaps that men are less willing to stay at the MSF centre for 4 months.

The TFC has approximately 100 patients as well. Average period of treatment is 39 days. The majority of the patients are children, who stay at the centre with one carer.

Water drilling is contracted out. 7 pumps are planned to be installed this year.

Staff:
There are 7 expatriates: 2 doctors (one for TB and one for Kala azar), 3 nurses (2 for TFC and 1 for special care, i.e. Kala Azar), one logistician and one lab tech. The Kala azar program is run by a local South Sudanese man who has worked with MSF for a long time and who is very knowledgeable and committed to the Kala azar treatment.

Cooperation:
A Christian NGO called Christian Mission Aid (CMA) works with primary health care in the region and MSF cooperates with them on a regular basis. CMA has many PHUs in the region, but according to MSF the quality of the care is not very good. Cooperation is good anyhow. CMA uses MSF as referral centre and MSF does not work with primary health care, since CMA does so.

Comments:
In Lankien, MSF works only with vertical programs, while CMA works with primary health care. It is worth noting that MSF cooperates well with CMA, their activities complementing each other, in spite of MSF complaints about the quality of CMAs work.

The TB program in Lankien is very strict, almost military, and unlike the program in Akuem (see below).

Akuem (MSF-F)

The location:
Akuem is located in Aweil county in the state of Bahr El Ghazal, the Western part of Southern Sudan. Aweil is the nearest town. The area is controlled by SPLM. The railway runs through Aweil and south towards Wau, and the area around the railway is insecure and raided regularly. This area was severely affected by the famine in 1998.

The project was taken over by MSF-F from the sister organisation MDM (Médecins du Monde) in 1999, who had been operating it since the beginning of the 90s. Their program was more or less the same as the current, except that MDM were working more with community visits.

Activities:
The MSF compound in Akuem is large and currently includes the following activities:

- PHCC
- TB
- TFC

Furthermore, a small PHU is run in another village and nutrition programs are run in four other locations. Two SFCs have been set up recently, with a 3rd one coming soon as well as a 2nd TFC.

The PHCC is large and could almost be categorized as a hospital. It includes CPs, IPs, laboratory, TFC, TB, MCH. It has 300 inpatients and 5000 OPs per month (the number of OPs has doubled since last year). The PHCC has a large uptake area.

The TB program was started in July 2002 and has 100 patients on treatment as well as 45–50 in-house patients. The TB regime and treatment here is less strict than the one in Lankien. Hospitalization is not mandatory, the period of in-house treatment only 2 months and the follow-up is voluntarily. A certain prevalence of resurgent cases could be noted.

The TFC in Akuem is located inside the 'hospital' and has ~250 patients, the majority of which are children. This program was started in March 2001 and is run throughout the year. Admissions in April this year was 340, to be compared with last year in April admissi

The nutrition program is currently being expanded significantly, due to the coming hunger gap and indications of food scarcity. A new TFC is set up in Madhul, which will start up with 150 patients. Two SFCs had just been started up and a 3rd one is coming.

Staff:
The number of expatriates in Akuem was 7, but due to the current nutritional activities there were 16. Approximately 100–150 local Sudanese staff are employed. The expats included 2 doctors, 3 nurses (of which one midwife), field co, log admin.

Cooperation:

SPLM is in the process of forming some kind of proto-government and has divisions corresponding to ministries, including a division for health. MSF's activities are strictly controlled by SPLM. The MSF volunteers are not allowed to leave the MSF compound and health centre without being accompanied by a SRRC[47] representative. MSF has signed a MOU with SRRC, and a new MOU is coming up. Discussions about cooperation with the health governance structures is being are expected and MSF are concerned about the risk of being dragged into the political game even more.

Several other NGOs are active in the area: Tearfund, IRC, Save the Children, IAS, Oxfam, Amort, etc. Only Tearfund and IRC are working with health care, the others work with agriculture, WatSan, primary education, etc. Furthermore, Unicef and WFP are active in the area.

MSF cooperate with the NGOs that complement their activities, such as IAS water drilling and have divided the work geographically with the ones working in the health sector. Tearfund and IRC are working in the Eastern parts of the Aweil county while MSF works in the Western part. Communication on activities and exchange of services is common among all organisations.

Tearfund is just starting up a nutrition program including SFCs and community based TFCs. The concept of community based TFC was questioned by MSF staff, but the view seemed to be that 'let them try'. In spite of Tearfund's initiative, MSF is setting up both TFC and SFCs in the same area. No prior coordination was made, but Tearfund did not disagree with MSF's initiative: 'There is enough work for all of us'.

IRC is running 4 PHUs and a PHCC. The PHCC has staff employed and trained by IRC, while the community health workers at the PHUs are employed by the community. The PHUs are supervised by the staff at the PHCC. MSF staff was critical about the quality of care at the IRC clinics, and pointed out cases of incorrect diagnoses. IRC said their current priority was improvement of quality and further training of existing staff, rather than expansion of the program.

Nutrition:

MSF-F has a regional food security expert, a position that does not exist within the other MSF sections. This food security expert has monitored the food availability situation in the Akuem area for one and a half year.

WFP made an Annual Needs Assessment in September last year, which resulted in them categorizing the Akuem area as having a 'moderate' food availability problem. According to MSF's nutrition and food availability survey the food security situation was grave, hence intensive lobbying was made for WFP to change their assessment and food supply plans. The MSF lobbying activities paid off and resulted in the food supply rationing being increased from 50 percent to 75 percent and the food deliveries starting one month earlier than originally planed. By the end of April[48], however, the WFP pipeline did not have food to deliver, for reasons other than planning[49]. The risk for an upcoming difficult

[47] The humanitarian wing of SPLM.

[48] At the time of our visit.

[49] Speculations had it that either supply or funds had dried (not harvesting season in the US), or recourses had been redirected, for example to Iraq.

nutrition situation is therefore regarded as high; hence MSF's increased nutrition activities.

Comments:
The Akuem operation is huge and has been going on for a long time. Questions about the relevance of the project and in particular questions about MSF's role in the area were raised by several of the volunteers.

MSF's role in relation to SPLM is problematic. It is clear that SPLM tries to capture MSF and other actors in the area in order to legitimise their attempts at forming a proto-government structure. MSF staff cannot go outside their compound without an SRRC representative accompanying them and they cannot employ a single person without agreement by both SRRC and the local chiefs.

The division of work between MSF and other NGOs in the health sector is problematic as well. MSF is regarding itself and seen as having a much higher quality care and it is provided free of charge. The other health care initiatives are community based and has a more developmental direction, and their lower quality, cost-based care cannot at all compete with MSF. Currently the number of OPs in MSF's PHCC is growing almost out of hands and people are coming from far away to seek assistance with MSF. The geographical division with the other NGOs did not seem to help. MSF volunteers were themselves questioning how to handle this and whether it would be relevant to close down the operations for a while or limit it to vertical programs. It was however maintained that MSF presence in the area was important for surveillance of the nutrition situation and endemic diseases. And the needs are unquestionable huge, no local structure exists.

MSF has taken a very active role in surveying, action and lobbing as regards the nutrition situation. It is understandable due to the catastrophic lack of timely action in the famine of 1998 when the Akuem area was severely hit, and in view of WFP's perceived lack of ability to meet the needs. But it is not at the core of MSF activities, and other organisations are working on the issue as well.

In discussions with the midwife who was responsible for the MCH at the PHCC it became clear that she felt somewhat left by herself in her work. MCH is not at the core of MSF activities and it was perceived as the organisational structure did not give enough support to and did not have enough understanding of this type of work.

Information on projects not visited but covered indirectly:

Akobo (MSF-B)

MSF's have had a large project in Akobo, in the Eastern part, close to the Ethiopian border. This site and project was closed down in April 2002 after having run since 1993 (?). The activities in Akobo included a large PHCC, TB….. programs. The reason for closing down the program was that the insecurity became too difficult to handle. The MSF staff had to be evacuated several times, and each time the compound and the clinic were looted. The local counterpart could not be trusted after nine years of operations. In the beginning of 2002 the staff was evacuated the last

time. In April the same year a visit was made and the looting evident, and it was decided not to go back again. Since then operations in the area was concentrated to Tangyang.

Issues

- Cooperation with others

In spite of MSF's identity as being independent and focus on action, the cooperation with other organisations seems to be good on the field level and on a practical level. MSF complains about the quality of health care activities of other actors, but still maintain a good working relationship.

- Baseline of underdevelopment

Southern Sudan is not only a conflict area, it is also an area which is very underdeveloped. There are no local structures for any public services and physical infrastructure is almost non-existent. Hence, development and relief activities cannot easily be separated. Anything that is provided by MSF is more than what ever has been there, hence essentially it is development work. And there are no local structures to take over, if and when the conflict situation calms down. This poses certain questions as regards the length of projects and the relationship to other actors: basically as regards the role of MSF's humanitarian activities in relation to development activities. So far, these questions are basically avoided with reference to the ongoing conflict situation, but in areas such as Akuem, where a proto-government is being formed and other actors are working, the role of MSF is not entirely clear.

- Different TB regimes in Lankien and Akuem

The large difference in the TB regimes and treatments between Laniken and Akuem is surprising in a medial organisation such as MSF.
We cannot assess the medical merit of one or the other, but just note that the practice differs.

- Organizational issues – HOM in Loki and Nairobi

The MSF operations in Southern Sudan are run from Kenya, due to the difficult security and infrastructure situation in Southern Sudan. Lokichokio on the Kenyan border to Sudan functions as a gate to Southern Sudan for most international actors in the area. All MSF-OCs have compounds in Loki, where support structures are located and from where staff is sent out to the field.

MSF-F and MSF-B have located their management team in Loki, while the management of MSF-H and MSF-CH are located in Nairobi. The benefit of being in Loki is supposed to be the closeness to the field, while the benefits of the Nairobi location is the proximity to other international actors and organisations. The management teams from the different sections interact and meet regularly and claim to benefit from each others choice of location Hence, as in the case of OLS, the diversity within the MSF movement is seen as a strength.

Summary according to ToR questions

- *MSF's Role in Identification and Promotion of Local Health Structures*

In the case of Southern Sudan, no local health structures exist, at least not in the areas visited. MSF does not promote a local health structure since there is no recognized government as counterpart. In the Eastern

part there is no political structure except for local village chiefs. In the Western part SPLM is in control, but according to MSF's policy of neutrality, they have difficulties in cooperating with one part in a conflict. Hence, they are reluctant to work with capacity building with this organisation, since it still is a rebel army without official recognition as government.

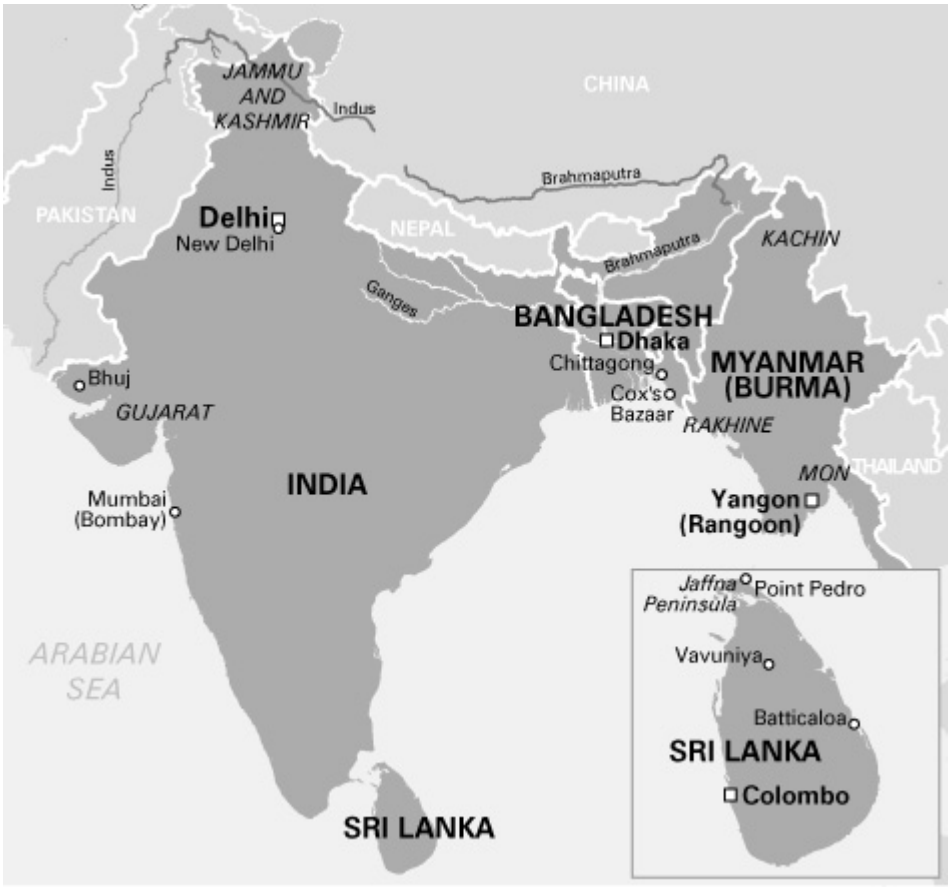
- MSF's Cooperation/co-ordination with Other Actors

In the field and in practical and operational terms MSF's cooperation with other NGOs and local communities is good.
MSF has chosen to act outside the OLS cooperation, although some MSF-sections were part of OLS until 2000. MSF has given priority to access to areas in need, which is restricted within the OLS cooperation. Furthermore, MSF has perceived OLS as tainted by political considerations and chosen to be independent. One effect is that MSF can work in areas where other organisations working under the OLS umbrella cannot work.

- MSF's Strategies to Assure Sustainability and Lasting Results

MSF does not have a developmental and long-term view of its activities. They do not build local capacity in institutional terms, only in terms of on-the-job-training for individuals. Their focus is on addressing needs. In the Southern Sudanese setting of combined conflict and underdevelopment problem, the risk of becoming a service provider is obvious. Several of MSFs 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.

C. Sri Lanka



History

Medecins Sans Frontiers (MSF) has been operating in Sri Lanka continuously for a period of 17 years and it is one of longest serving missions in MSF history. MSF's mission in Sri Lanka started in 1987 with MSF-F and was joined by MSF-H. MSF-F has had projects in the Base Hospital of Point Pedro, Jaffna Teaching Hospital, Madhu area in Mannar District, Vavuniya Base Hospital and Batticaloa. With the joining of MSF-H, they have agreed on clear demarcation of areas with MSF-F operating in Government controlled areas and MSF-H operating in LTTE controlled areas. MSF-H has had projects in Vavuniya Base Hospital, Mallawi Peripheral Hospital, Mannar Base Hospital and Puthukudiyruppu Peripheral Hospital.

MSF works under a MOU signed with the Government of Sri Lanka in 1986, which has been amended in 1991. MSF-H has been officially registered as an International NGO by the GoSL. MSF has been involved in following activities during its 17 years of presence in Sri Lanka.

- Emergency surgery on victims of the war,
- Surgical and mobile clinics
- Obstetrics and Gynaecology services
- Paediatric care
- Primary health care
- Malaria control
- Training of Ministry of Health (MOH) staff and health volunteers
- Hospital waste management
- Pain Management Programme for burn patients
- Addressing psycho-social problems of war refugees

Understanding The MSF Presence, Meeting With Respective HoM

Currently, the overall situation of the conflict of Sri Lanka can be described as " No war no peace" situation. Nobody really knows what is going to happened. But there is a general urge for the population to come to an agreement.

The overall strategy for MSF in Sri Lanka is to exit the country. It is not any longer a question if, but rather when to pull out. In the case of MSF-H the overall apprehension of the situation of the staff in Sri Lanka is that it is time to leave. At the same time OC-Holland states that it is to recent the intensity of the conflict decreased to the present level and therefore MSF-H should stay in order to monitor the situation and have the opportunity to a quick reinforcement in the case of new out brake of the war. At the moment the situation can be described as "*We intend to phase out but we will see how it goes next year*". In the case of MSF-F the phasing out seem more definite. The problem of phasing out was stated by both of the HoM as the fear that MSF will not be able to be present and be the voice of people in situations of violations of human rights. If the peace talk stagnates totally and the conflict burst out again, there is no doubt in that MSF will reinforce/re-enter the areas of conflict. Thus, one can conclude that there is a different way of looking at the present context and/or that the reasons of presence and the exit

criteria's stated in the MSFs "Country Profile and Policy of Sri Lanka" – document is interpreted differently.

At present MSF-F and MSF-H in Sri Lanka maintain a very close relationship and have regular interactions with each other, at least on the HoM level. This has not always been the case. The reason for the present interaction seem to partly depend upon the individuals themselves as well as the relatively calm situation in Sri Lanka.

Current Operations

At the time of the visit in Sri Lanka MSF had 4 projects in operation. MSF-H has two projects i.e. Psycho-Social Program in Vavuniya and the medical support project in Puthukkudiyruppu (PTK). MSF-F has presently two projects i.e. surgical program in Point Pedro base hospital as well as a surgical and mobile clinic programme in Batticaloa. However, it has already been decided to phase out all MSF-F operations in Sri Lanka by end July, 2003 and MSF-H most probably in end 2003 or early 2004. recently MSF has phased out two programs i.e. a obstetric/gynecology program in Mallavi (MSF-H) as well a pediatric and midwifery assistance program in Jaffna (MSF-F).

We were able to visit Vavuniya, Point Pedro, the recently out phased program in Mallavi and the HoM office of MFS-H as well as MFS-F. In addition we got to have a meeting with the project coordinator (PC) of the PTK program.

Some information of the currently running programs are outlined below:

	MSF France		MSF Holland	
Location	Base Hospital, Point Pedro Jaffna District		Vavuniya	
Activity	6. Operation of the Maternity and Surgical wards and conducting surgical and maternity clinics in Point Pedro Hospital 7. Improvement of hospital waste management	Expatriate staff: 4 Local staff: 20 (Should phase out in beginning of June)	8. Implementation of psycho social programme 9. Provide primary health services to the local population through health volunteers	Expatriate staff: 4 Local staff: 38 Health Volunteers with incentives staff: 21
Location	Batticaloa District		Puthukkudiyruppu Hospital, Mullativu District	
Activity	4. Operation of Surgical ward in Batticaloa Hospital 5. Implementation of a Pain Management Program for burn patients 6. Operation of 4 mobile clinics	Expatriate staff: 4 Local staff: 25 (Should phase out in end of June)	4. Provision of primary and secondary health care through the Kambia hospital	Expatriate staff: 3 Local staff: 6 Health Volunteers with incentives staff: 21

Vavuniya Psycho Social Programme

Psycho-Social Programme, Vavuniya District	Main objective of MSF's psycho-social programme in Vavuniya is to increase the positive coping strategies of the population, within the Vavuniya district, who are suffering stress and trauma due to the ongoing effects of the conflict. The activities carried out include; trauma counseling, operation of community (counseling) centers, outreach services by community health promoters, training of counselors and community health promoters, community health awareness/education MSF has been operating with following staff • One Project Coordinator • One Clinical Psychologist • One Logistics and Admin Coordinator • 38 Local staff including 21 counselors • 40 Community Health Promoters on an incentive payment

Vavuniya was during the previously more intense conflict situation a important strategic location due to its geographical location. It is the most northern city before the conflict affected areas. MSF has in the recent passed been operating in Vavuniya with medical programmes. For a period of time The MSF office in Vavuniya was a important logistical outpost to support the field units operating in conflict areas. A quite interesting fact is that even though both MSF-H and MSF-F [50] had a need for a logistical base. There seem to be little coordination/collaboration between the two. For instance MSF-H has in one of their compound a maintenance shop. This unit was not used by MSF-F which went to the local maintenance shop and had their cars etc. fixed.

The psycho-social programme in Vavuniya happens to be the one turned down by SIDA (MSF managed to get funding from other sources). This program was started in 2000 and will be handed over next year. The problem of the "handing over" started when MSF realized that there was no suitable organization to hand over to. As a result of this MSF decided to build up a local independent NGO. The objective is that this NGO shall be running when MSF leaves. MFS has in this case taken the role of being the trainer of trainers. It is an exception for MSF to have the exit phase integrated in the start-up phase. Furthermore, this programme has no medical intervention strictly psychological issues are treated. The two main issues are counseling and working as community health promoters. The MSF Project Office in Vavuniya has been a very active member of the Psycho Social Forum, where 15 organizations involved in psycho social programmes are represented. MSF has taken the initiative to establish this forum and this forum has now become a sub group of NGO Consortium. The aim of this forum is to avoid duplication of work, establishment of best practices and access and share the services of other organizations wherever possible.

All in all, this is a project that contributes with potential sustainable and long lasting results. Thus, this project seem to go beside the general

[50] MSF-F had an operating unit in Vavuniya up to 1997 and then re-opened again in 1999 and finally closed again in 2002.

objective of the MSF movement. But, it shall also be considered that the current presence of MSF in Vavuniya also implies a strategic importance.

The Obstetrical/Gynecological Programme In PTK Hospital.

Puthukudiyruppu Hospital	In Puthukudiyruppu, MSF is involved in maternity care programmes, curative services in obstetrics and gynecology, training of community health volunteers, hospital waste management, provision of supplementary medical supplies and supervision of community ANC ClinicsThey are largely dependent on MOH staff for all supporting services. In Puthukudiyruppu, MSF has • a Project Coordinator • one Medical Doctor • one surgeon • one anesthetist • one Logistics and Admin Coordinator • 13 Local staff • 34 Volunteers

We did not get to visit the programme in PTK due to security reasons going into LTTE area. But, we got an opportunity to discus the programme with the Project Coordinator (PC)

The presence of MSF in PTK started in 1998 with a malaria programme. At the time it was a strategically important location as the conflict risked to put the Wanni[51] in half.

This project is in the last stages of phasing out. At the time of the visit it was stated that the exit should have been completed in April. The main event before definitely going ahead with the procedure was to screen the more remote areas of the region in order to assure themselves that the medical need was not to large, forcing MSF to stay. In any case, MSF has no plans on just swiftly leave the scene. They have implemented a strategy to assure themselves that they are giving the local staff the opportunity to work elsewhere. MSF has given the local staff a five month notice of them leaving. Since then, MSF have been giving the staff a free of charge education, in order to improve their skills further. Concerning the local medical staff that has been working and taught by MSF they try to push them into working for MOH. The deal that MSF is using towards MOH is: *OK, our staff may not have a formal degree, but they have more than enough skilled to start at the lowest level of the MOH "skill-scale"*. The MOH attitude towards this argument seem to be rather skeptical. The situation become even more complex since there are not very many of the MOH staff who wants to work in these remote areas.

The PC of this project just up to recently coordinated the programme in Mallavi Hospital. The programme was closed in March this year.

Visit to Mallavi Peripheral Hospital

Mallavi Hospital as a former location of one of MSF-Hs programme which was recently closed.

[51] The district where PTK is located.

It quickly became obvious to us, the reason for the MSF phase out in this location. During the more intense stages of the conflict. The area around and in Mallavi was filled with IDPs in need of medical care. Now, with the situation being a bit less intense. The Mallavi was almost empty. The only signs of MSFs presence was the wards built by MSF and a incinerator given by MSF as part of the waste management programme. As a matter of fact otherwise the hospital was almost empty.

Jaffna Coordination Office And Manthikai Base Hospital, Point Pedro

In Jaffna Peninsula, MSF is operating the following sub-projects:

Manthikai Base Hospital, Point Pedro	Main objective of MSF's presence in Manthikai Hospital was to • provide gyneco-obstetric and surgical assistance to the population of Tenmarachchi and Vadamarachchi divisions of Jaffna Penisula and • monitor the situation of supplies of drugs, medical equipments and materials and repair and maintenance of medical equipments and complement when the need arises • assist for improvement of waste management by building an incinerator and by training the hospital staff on waste management techniques. In Point Pedro, MSF has been operating with the following staff: • One Field Coordinator • One Surgeon • One Anesthetist • One Gynaecologist • Operation Theatre Nurse • 12 Local Staff (translators, logistics personnel, drivers, cooks etc) • MSF use MOH staff to carry out all medical services

MSf has a long in history in this area and has more or less been present the outburst of the civil war. For a period of time, MSF withdraw their operations in Point Pedro due to the changing situation of the conflict. In 2000 MSF-F re-enters into point Pedro.

MSF is still located in Jaffna, but there is no intervention of expatriates in the hospital (Jaffna Teaching Hospital, JTH). MSf only has an office left in Jaffna where the Field Coordinator is the only expatriate staying and wrapping up the out phasing of MSF-F presence in the area. On a part time basis the Field Coordinator is present on Point Pedro, doing administrative and logistic work for the team as well as wrapping up there as well. If the phasing out of the project goes as planned. MSF will have it las day of operating on 6th of June.

After a discussion with the field staff we realized that there was not any longer within MSF-Fs mandate to stay. The conflict has decreased and there exists medical staff within the MOH to fill the places of MSF. The problem only is that the location does not seem to be very lucrative.

The distance between Jaffna and point Pedro is approximately a 45 min. drive. An interesting event that has occurred is: The doctors working in JTH has setup small counseling offices in Point Pedro in order to attract patients to come to JTH instead of Point Pedro Hospital i.e. JTH is competing about the patients with the hospital in Point Pedro. Since this event started the staff has noticed a decrease in patients treated in Point Pedro hospital. This event underlines the increased supply of medical services in the area.

A difficulty that MSF faces when Phasing out, in this case, is that MOH are reluctant to replace the the unattended posts in the Hosptial once MSF leaves. MSF has an ongoing discussion with MOH in order to find replacement staff knowing that there is human resources available such actions. Other actions undertaken by MSF, except from the medical work in the hospital is to pressure The Hospital itself to search for resources. After a meeting with the present Adminstrative Officer (AO) of Hospital we understood the the difficulties and the bureaucracy in actually manage to get what you applied for from MOH. At the same time we could sense a somewhat "bristande hadlings förmåga", maybe due to the fact that since MSF has been there their has always been means provided by MSF. Other logistical issues undertaken is to find alternative work places for the local MSF staff as well as selling, donating inventories.

Staffing

MSF Operations in Sri Lanka are carried out with the help of

- expatriate staff, mainly medical personnel and administrative staff such as Head of Missions, Project Coordinators and Logistics and Administrative Coordinators
- locally employed staff,
- volunteers trained by MSF or volunteers already working with MOH, who in some cases receive some incentives for their services
- staff employed by the MOH

Expatriate Staff

MSF operations in Sri Lanka is structured in the following manner.

A main office or headquarters is established in the Capital of Sri Lanka, Colombo. This office is managed by a Head of Mission supported by a Medical Coordinator, Logistics and Admin Coordinator, Finance Controller and a supporting staff recruited locally.

All field projects are handled by offices located in those areas and one office may handle one or several projects depending on the circumstances. A typical field office is structured in the following manner.

Position/title	Responsibly
One Field or project coordinator	The main responsibility is to ensure the safety of the expatriate and local staff. His/her duties lie in regularly updating the team and the mission coordination on the stability of the peace in the area and the safety situation of the staff. (S)he is also the task manager and overall leader of the

	field mission and maintains contacts with the MoH representatives, other NGOs, the UN and the local and regional political leadership. The field coordinators are often medically trained in order to be able to also take on the role of medical coordinator. The field coordinator/medical coordinator would typically be on a one year contract.
One logistics/ administrative person	His/her responsibilities lie in managing the project funds, administrating the project, hiring and recruiting staff, logistics and transportation. The log/admin staff also manage various other projects such as supplementary activities such as water and sanitation, overseeing of construction or rehabilitation projects etc. The log/admin expatriates are not medically trained and often are on a 6 month to one year contract.
One medical doctor	The medical doctors are often based at a hospital or a larger clinic where they attend to patients and perform surgery. Medical personnel are often required to stay for a minimum of six months. Often the Western European or North American medical staff need to familiarize themselves with local diseases and ailments, which can take a few weeks.
One or two nurses	The nurses work either at a hospital or on a clinic rotation. The tasks of the hospital nurse include treatment of patients, on-the-job training of local staff, establishment/improvement of routines regarding hygiene etc. The nurses on clinic rotation, are required to visit the clinics MSF support to provide training, assistance, collect health statistics and help diagnose difficult cases. The nurses are also on a minimum of six month contracts.

Locally Employed Staff

The ratio of local staff to expatriate staff in Sri Lanka varies between projects although several of the projects are relatively similar.

	Manthikai Base Hospital (MSF France)	Jaffna Teaching Hospital (MSF France)	Psycho-Social Programme (MSF Belgium)	Puthukudiyiruppu Peripheral Hospital
Management of hospital	Maternity and Surgical Wards	Pediatrics Wards		
Clinics/refugee camps			10 clinics	
Expatriates	3 ½	½	3	6
Locally employed staff	12	0	38	13
Health Volunteers			40	34
MoH staff with incentives				
Ratio expats/local staff				

As a policy, MSF tries to employ expatriate staff to fill positions such as doctors, anesthetists and in some cases nurses with a view to maintain impartiality and minimize resistance from various parties and all such postings in Sri Lanka have been held by expatriates. They are mostly on short term contracts varying from 3–9 months and sometimes extending up to on year. However, there have been instances, where such professionals have had very short contracts of one month due to shortage of personnel.

MSF recruits a considerable number of local staff such as administrative assistants, translators, drivers, watchers, cooks etc to ensure smooth operation of its field operations. Locally employed staff work under one-year contracts and MSF are subject to national laws regulating holiday entitlements, bonuses, benefits, working conditions etc. MSF have been paying somewhat higher salaries than the public sector salary scales.

MSF have been using volunteers trained either by themselves or by the Ministry of Health to implement their projects in Sri Lanka. In some cases, MSF have paid a nominal incentive for some of these volunteers but most of them have been working without any form of incentives.

MSF have been using the staff of Ministry of Health as far as possible and substitutions have been made only in instances where the Ministry has been unable to provide necessary staff due to ongoing conflicts and security considerations.

The View Of Sida As A Partner/Funder

At a OC level it was stated that MSF uses SIDA and other funders as a channel/partner to put pressure on the Government in respective country. In addition the goods and smooth relation with the Swedish embassy was mentioned. From a project level we did not really see this strategical view of SIDA as a partner, but rather a point of view from a more frustrated point of view. It was mentioned in one pf our discussions that donors generally seem to have unreasonably difficult demands of information wanted to be included in the monthly field reports.

Answering The Questions Stated In The ToR

- *MSF's Role In Identification And Promotion Of Local Health Structures*

MSF have been operating in Sri Lanka under a Memorandum of Understanding signed with the Ministry of Health. All their operations have been based in areas affected by the armed conflict in the North & East. The projects initiated by MSF has mostly been aimed at substitution of medical professionals in places/instances where the Ministry of Health has not been able to deploy people due to ongoing conflicts and security considerations. MSF has always made attempts to utilize the existing health structures as much as possible and strengthen them further so that the MOH could continue such services without any interruption, even after the MSF phase out their operations. MSF has maintained a very close rapport with health administrators such as Deputy Project Directors of Health Services (DPDHS), District Medical Officers (DMO) etc.

In addition to deploying medical professionals, such as doctors, surgeons, anesthetists, paediatricians to substitute for MOH staff, MSF has also involved in;

– training of supporting staff such as OT Nurses, health volunteers, minor staff involved in hospital waste management
– improvement of hospital management skills of relevant staff in areas such as better stock management and replenishment of drug supplies, repair and maintenance of hospital equipments etc.
– introducing new systems for hospital waste management
– providing essential drugs, medical materials and medical equipments
– helping the hospitals and MOH staff to establish linkages with humanitarian aid agencies and other relevant organizations

While the emergency medical and humanitarian support provided by MSF has resolved many of the immediate health and medical problems of the war affected areas, the MSF's involvement in areas mentioned above, have significantly contributed to strengthen the local health structures. Local health officials associated with MSF projects confirmed this and the consultants were also able to observe the positive impact of MSF's role in strengthening local health structures.

- **MSF's Cooperation/Co-Ordination With Other Actors Involved In Humanitarian Aid**

MSF has maintained very close co-operation with almost all humanitarian agencies operating in Sri Lanka both at national level and regional level. They have been participating in monthly meeting of International NGO's. INGO Meetings at regional level has been a forum for sharing information on projects implemented by different organizations and inter organizational coordination for effective implementation of respective projects. MSF has used this forum for mustering the support of other humanitarian agencies to expedite matters coming under their purview. For example obtaining the support of UNHCR to provide essential facilities for refugee camps in Vavuniya.

MSF Project Office in Vavuniya has been a very active member of the Psycho Social Forum, where 15 organizations involved in psycho social programmes are represented. MSF has taken the initiative to establish this forum and this forum has now become a sub group of NGO Consortium. The aim of this forum is to avoid duplication of work, establishment of best practices and access and share the services of other organizations wherever possible.

There is another forum called Consortium of Humanitarian Agencies (CHA), however MSF-France has disassociated themselves from CHA because they have reservations on CHA's conduct.

In addition to formal meetings, expatriate staff of MSF have close informal interactions with expatriate staff of other humanitarian agencies and it has helped to share valuable information and experiences on their day to day activities.

MSF also maintain very close contacts with Government Agents and other Senior Government Officials in the respective Districts and MSF has actively involved in lobbying for providing necessary facilities and improvement of service levels, particularly for people living in refugee camps.

While maintaining close cooperation with other actors involved in humanitarian aid and related activities, MSF has always maintained its

independence and identity as a emergency humanitarian aid and medical support organization.

• *MSF's Strategies to Assure Sustainability and Lasting Results*

Although it is unusual for an emergency humanitarian aid organization like MSF to operate in Sri Lanka continuously for 17 years, MSF has regularly reviewed the need for its presence in Sri Lanka. Although, MSF has substituted medical professionals in instances where MOH is unable to deploy required personnel due to various reasons, it has never attempted or intended to become an interim organization.

As a part of MSF's strategy to assure sustainability of its activities once MSF phase out its projects, it has focused special attention on number of areas such as training of MOH staff, improvement of management skills of hospital staff and establishment of links with relevant organizations in order to improve the capability of local health structures to effectively manage their day to day activities. At the same time, keeping in line with MSF policy of phasing out when there is no emergency need, they have taken steps to inform relevant authorities well in advance so that MOH could arrange replacements on time. When there is no adequate progress, MSF has also put pressure on MOH by giving deadlines, which has, in most cases, compelled them to arrange replacements. MSF strictly maintains that it cannot act as interim organization, therefore, they make every attempt to get required personnel and facilities through the MOH and relevant authorities once they pull out.

However, in the case of Psycho-Social Programme in Vavuniya District, MSF-H is trying to form a new NGO with the help of existing staff to continue the programme. This is a novel approach as far as MSF is concerned and it is a challenging task to establish a NGO and make it a self-sustainable organization without heavy reliance on donor funding. MSF-H has already discussed the matter with staff of psycho social programme and they are prepared to take up this challenge. They have already arranged management training for the Assistant Project Manager, who is going to manage the programme after MSF pulls out of the programme. However, as there are nearly 15 other organizations involved in psycho social programmes, one could argue whether there is a need for a new NGO to continue this programme. MSF is of the view that most of the other Programmes has no adequate capacity to undertake qualitative psycho social programmes, hence continuation of MSF programme is essential.

People met during the visit

The consultants had meetings with following persons:

Mr. Jan van't Land
Head of Mission
MSF-Holland
(MSF France)

Ms Maureen
Field Coordinator
Psycho-social Programme
Vavuniya

Ms Bree
Logistics & Admin Coordinator
Psycho-social Programme
Vavuniya

Mr Abdul Manaf
Assistant Project Manager
Psycho-social Programme
Vavuniya

Mr. Ewen Mspherson
Project Coordinator
Wanni (Puthukudiruppu Project)

Mrs E Elaparamoorthy
Officer in Charge
Mallawi Peripheral Hospital

Mr Yves Chartier
Head of Mission
MSF-France

Ms. Pascale
Medical Coordinator
MSF-France

Ms. Segolene
Project Coordinator
MSF-France
Jaffna

Dr. Sathurnugar
Director
Jaffna Teaching Hospital

Dr Pierre Marie
Surgeon
Point Pedro Hospital

Dr Piotr
Consultant Anasthetist
Point Pedro Hospital

Dr. Marico
Consultant Gynaecologist
Point Pedro Hospital

Mr.
Administrative Officer
Point Pedro Hospital

Appendix V – Chantilly Statements

Who are the Medecins Sans Frontieres

I The principles

Médecins Sans Frontières (MSF) was founded to contribute to the protection of life and the alleviation of suffering out of respect for human dignity.

MSF brings care to people in precarious situations and works towards helping them regain control over their future.

1. Medical action first

The actions of MSF are first and foremost medical. This primarily consists of providing curative and preventive care to people in danger, wherever they may be. In cases where this is not enough to ensure the survival of a population – as in some extreme emergencies – other means may be developed, including the provision of water, sanitation, food, shelter, etc.

This action is mainly carried out in crisis periods when a system is suddenly destabilised and the very survival of the population is threatened.

2. Témoignage (Witnessing) – An integral complement

Temoignage is done with the intention of improving the situation for populations in danger. It is expressed through:

- the presence of volunteers with people in danger as they provide medical care which implies being near and listening
- a duty to raise public awareness about these people
- the possibility to openly criticise or denounce breaches of international conventions. This is a last resort used when MSF volunteers witness mass violations of human rights, including forced displacement of populations, refoulement or forced return of refugees, genocide, crimes against humanity and war crimes.

In exceptional cases, it may be in the best interests of the victims for MSF volunteers to provide assistance without speaking out publicly or to denounce without providing assistance, for example when humanitarian aid is "manipulated".

3. Respect for medical ethics

MSF missions are carried out in respect of the rules of medical ethics, in particular, the duty to provide care without causing harm to either individuals or groups. Each person in danger will be assisted with humanity, impartiality and in respect of medical confidentiality.

In other respects, this ethical consideration provides that no one will be punished for carrying out medical activities in accordance with the professional code of ethics, regardless of the circumstances or the beneficiary of the action.

Finally, no person carrying out a medical activity can be forced to perform acts or operations in contradiction to the professional code of ethics or the rules of international law.

4. Defence of human rights

Médecins Sans Frontières ascribes to the principles of Human Rights and International Humanitarian Law. This includes the recognition of:

- the duty to respect the fundamental rights and freedoms of each individual, including the right to physical and mental integrity and the freedom of thought and movement, as outlined in the 1949 Universal Declaration of Human Rights;
- the right of victims to receive assistance, as well as the right of humanitarian organisations to provide assistance. The following conditions should also be assured: free evaluation of needs, free access to victims, control over the distribution of humanitarian aid and the respect for humanitarian immunity.

5. Concern for independence

The independence of MSF is characterised above all by an independence of spirit which is a condition for independent analysis and action, namely the freedom of choice in its operations, and the duration and means in carrying them out.

This independence is displayed at both the level of the organisation and of each volunteer.

– MSF strives for strict independence from all structures or powers, whether political, religious, economic or other. MSF refuses to serve or be used as an instrument of foreign policy by any government.

The concern for independence is also financial. MSF endeavours to ensure a maximum of private resources, to diversify its institutional donors, and, sometimes, to refuse financing that may affect its independence.

– From their side, MSF volunteers are expected to be discrete and will abstain from linking or implicating MSF politically, institutionally or otherwise through personal acts or opinions.

6. A founding principle: Impartiality

Impartiality is fundamental to the mission of MSF and is inextricably linked to the independence of action. Impartiality is defined by the principles of non-discrimination and proportionality:

- non-discrimination in regard to politics, race, religion, sex or any other similar criteria.
- proportionality of assistance as it relates to the degree of needs – those in the most serious and immediate danger will receive priority.

7. A spirit of neutrality
MSF does not take sides in armed conflicts and in this sense adheres to the principle of neutrality.

However, in extreme cases where volunteers are witness to mass violations of Human Rights, MSF may resort to denunciation as a last available means in helping the populations it assists. In these cases, simple assistance is rendered in vain when violations persist. For this reason, MSF will drop its strict observance of the principle of neutrality and will speak out to mobilise concern in an attempt to stop the exactions and improve the situation for these populations.

8. Accountablity & Transparency
Faced with populations in distress, MSF has an obligation to mobilise and develop its resources.

Aiming at maximum quality and effectiveness, MSF is committed to optimising its means and abilities, to directly controlling the distribution of its aid, and to regularly evaluating the effects.

In a clear and open manner, MSF assumes the responsibility to account for its actions to its beneficiaries as well as to its donors.

9. An organisation of volunteers
MSF is an organisation based on volunteerism. This notion principally implies:

- an individual commitment to people in precarious situations. The responsibility of the organisation is based on the responsibility taken by each volunteer;
- disinterest, attested to by the non-lucrative commitment of volunteers.

Volunteerism is a determining factor in maintaining a spirit of resistance against compromise, routine and institutionalisation.

10. Operating as an association
The commitment of each volunteer to the MSF movement goes beyond completing a mission; it also assumes an active participation in the associative life of the organisation and an adherence to the Charter and Principles of MSF.

Within the different representative structures of MSF, the effective participation of volunteers is based on an equal voice for each member, guaranteeing the associative character of the organisation.

MSF also endeavours to constantly integrate new volunteers to maintain spontaneity and a spirit of innovation.

Linked to the idea of volunteerism, the associative character of MSF permits an openness towards our societies and a capacity for questioning ourselves.

II. Practical Rules for Operating

1. Organisation and decision-making

MSF is made up of 19 national sections, with overall coherence ensured by an International Council.

The majority of members are volunteers who work or have worked for MSF. They constitute the General Assemblies of each section, and they elect a Board of Directors whose members are mainly doctors or medical professionals. Almost all are unsalaried.

The Board of Directors names the executive team. The Board guarantees respect for the MSF Principles, ensures that decisions taken at the General Assembly are executed, and controls the management of the organisation.

2. Non-profit

Each section is founded on the not-for-profit principle.

The principle of disinterest is part of the commitment of all MSF personnel. In their work for MSF, staff are not entitled to additional remuneration from the organisation, its satellites, suppliers, or any other individuals or legal entities with whom the organisation has relations, other than salaries or allowances. By choice, the proportion of salaried positions remains limited. Management staff salary levels are lower than those in comparable sectors of the employment market. All salaries are public.

The financial reserves of MSF are intended to ensure the smooth functioning of the organisation and to allow the organisation to rapidly react to emergencies and periodic shortfalls. In no case will they constitute a means for perpetuation. For this reason, the reserves, including property holdings, never exceed the annual operational expenses.

3. Management of Resources

At least half of the global resources of MSF must come from private funding.

MSF directly carries out its operations for populations in danger, so 80% of the resources of the organisation are exclusively dedicated to operations.

MSF retains continuous and direct control over the management and delivery of its aid.

Funds received by MSF are allocated as the organisation considers them most useful, in conformity with its principles. However, if a donor wishes his or her donation to be used in a specific mission, MSF will respect this request.

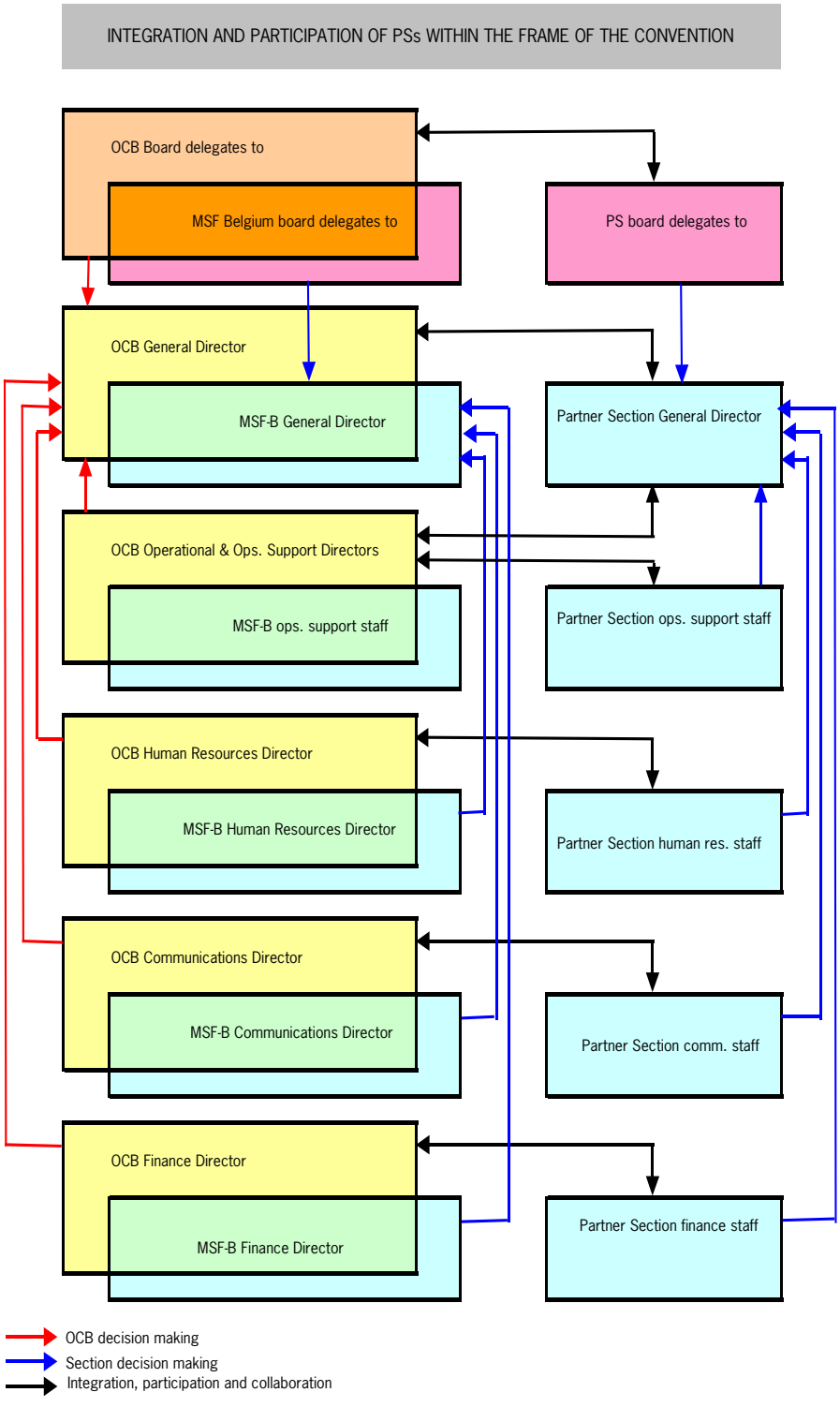
4. Financial Control and Transparency

The use of MSF funds is regularly controlled. In addition, each section makes public its audited financial reports.

Different categories of expenses are clearly identified in the accounts, clearly showing the disbursement of funds. It is therefore easy to distinguish the expenses for operations, administration, communications or fund-raising.

The accounts are then published and provided to all donors through different newsletters and communications support materials produced by MSF. The accounts are also available to anyone upon request.

Appendix VI – Interaction between OCB and Partner Sections



Appendix VII – Sida's assessment of MSF proposals

Summary of facts

	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*

Allocation per country MSEK	**Tot 99–02**	*2003*
Sierra Leone	**13,6**	
Liberia	**4,4**	
Guinea	**2,0**	
West Africa region	**6,5**	*10,9*
Totat West Africa	**26,5**	
Sudan	**20,0**	
Sri Lanka	**10,5**	
Angola	**10,5**	
Others	**10,5**	
Total	**78,0**	

Reflections as regards the assessments of proposals

Decisions are based on assessment of background, organisation and the relevance of project.
Common justifications for approval:

- Responds to a humanitarian need
- MSF has demonstrated capacity to implement similar projects
- No other organisaitons are working in the area

In the case of assessment of continued projects (17 of 41 assessments) there is a discussion on

- Long-term view

- Handing over to local authorities
- Coordination with other organizations

Sida has, both in the case of West Africa and Sudan, encouraged and initiated coordinated proposals and program thinking.

In West Africa, MSF is considered to have a good cooperation with authorities and to work with capacity building and with a long-term view. Sida has encouraged and initiated program thinking which has resulted in coordinated proposals containing several projects, as well as a regional proposal for 2003 containing five projects.

In some of the assessments it is specifically articulated that MSF's presence in a certain context is good for Sida's possibilities of following the development in that context. (Sudan, Chechnya).

Several assessments include discussions on MSF's cooperation or not-cooperation with coordinating bodies for NGOs (Sudan, Angola, Chechnya). Sida does not want to support organizations outside the coordinating bodies, but have in the cases of Sudan and Chechnya been indulgent towards MSF's independent view and role, while the same has been questioned and contributes to disapproval of a proposal concerning Angola.

Disapproval concerning Angola 2003 is based on the questioning of MSF's coordination with other NGOs and local authorities, as well as the too short-term perspective in the implementation of the project. References are made to the Embassy and Padrigu.

Contradiction: Sida encourages and asks for a long-term view and a developmental perspective while at the same time holds forth that the strength of MSF is in emergency and conflict situations.

References used

16 assessments refer to the opinion of the Embassy (or Sida's humanitarina coordinator) (recommendation or dissuasion).

9 assessments refer to field visits by Sida's staff

Other references that occur a small number of times are: other departments of Sida (AFRIKA, Sida-Öst), Padrigu (concerning conflict analysis of Angola), local authorities and other locally active NGOs (ICRC, UNICEF).

References are also made to conformity with the priorities in Sida's country strategies.

Disapprovals

8 of 41 assessments led to disapproval of the proposal.

All disapproved proposals concern new projects, not continued allocation to existing projects.

Justifications for dissaproval		
Sida supports other organisations in the area	5	2 times as justification in combination with questioning of MSF's role
Type of project	2	Tent not MSF's core activity; massimunisation not emergency activity
MSF's org	2	Angola – Embassy questions MSF's cooperation/ coordination; Somalia – MSF-S is regarded as a new org, in spite of the fact that support has been given earlier.(!)
Substitution (institutional)	1	Kenya nutrition

Sida's guidelines

In some cases it is noted in the assessment that the proposal does not correspond to Sida's guidelines, but that this is temporarily overlooked, while supplementations to the proposal are requested in other cases. The impression by the Consultants is that discussions about the format of the proposals have been held continuously and that the quality of the proposals and reporting has gradually improved and now are regarded as satisfactory.

The organisational structure of MSF

In most assessments the different MSF OC:s are regarded as different entities and assessed as different organizations in a network, while some assessments only refer to MSF as a whole.

In one assessment concerning Somalia in 2002 MSF-Spain is referred to as a new organization or Sida, which is not correct, since MSF-Spain was allocated resources in Mozambique in 2000.

In one assessment concerning Chechnya it is pointed out that it MSF's organization in the region is unclear and that the assessment only concerns the structure of the project.

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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