# STRATEGIC ORIENTATIONS 2020-2023

MEDECINS SANS FRONTIERES - OPERATIONAL CENTRE BRUSSELS

MEDECINS SANS FRONTIERES

# CONTENTS

# THE PATIENT COMES FIRST

## A manifesto for quality medical humanitarianism in proximity to the most vulnerable and neglected

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# INTRODUCTION

This four-year strategic orientation lays out an ambition for an evolved MSF-OCB that is ready to meet the medical humanitarian needs of vulnerable and excluded populations in a changing political and aid environment.

We will prioritise the response to medical humanitarian needs arising from vulnerability, neglect and exclusion from access to health care. Our priorities will be set in response to excess morbidity, mortality and suffering and where needs are unlikely to be met by other actors. Situations of conflict, natural disaster and epidemics will remain a central focus of the OCB portfolio, as vulnerability and exclusion are likely to increase in these periods of disruption. It is the convergence of populations' vulnerabilities, medical needs and contexts of distress that will be the main drivers of our medical humanitarianism.

The trends in the environment in which we work will be followed closely and will inform our future operational approaches. Wherever needs exist that MSF is unable to address due either to our failure to negotiate humanitarian access, or due to a lack of institutional capacity or expertise, OCB will seek to invest in these capacities, rather than abandon such contexts.

Proximity to patients and populations in need is an essential component to achieving our social mission. Our direct medical action, together with *témoignage* that is rooted in our operations, will remain at the core of our medical humanitarian identity.

It is our belief that impartially treating patients and speaking out about their exclusion is a radical act of patient solidarity in a context of increasingly hostile expressions of state self-interest and nationalism. Humanitarian *'sans frontierism'* and state sovereignty have possibly never before been more at odds. As MSF grows, there is a risk that we also assert our own national identities. However, we envisage an MSF that primarily remains connected to patients, that builds on local and regional expertise, while at the same time remains networked globally and defiant in our principles and identity as an international medical humanitarian organisation that acts based on need alone.

This expression of 'sans frontierism' in our current political environment requires us to forge new alliances with communities and social movements; ensure that we can negotiate and engage with a broad range of state and non-state actors; distance ourselves from a compromised aid system and the manipulation of people's suffering by states for political ends; push back against the structures of exclusion that are encountered by the

patients we treat and the criminalisation that we risk when we go against these forces. In such an environment, our solidarity with the most vulnerable and excluded is inherently political. This does not require us to abandon our principles, but it does require us to take conscious risks in our operations and public positioning.

To achieve our ambition and for us to be relevant to the reality of peoples' exclusion, we need to constantly adapt and evolve our models and ways of working. We envisage limited growth over the coming years, we will respect international agreements on growth and those agreed with the OCB board. This will not reduce our drive to respond to crises and we will remain ambitious. Any intended operational growth should be driven by a needs assessment and quality interventions, prioritizing response to excess morbidity, mortality and suffering in situations where needs are unlikely to be met by other actors. Any non-operational growth should be guided by an ambition to put field projects at the centre or increase quality and efficiency of our operations and resource management, whilst respecting the social mission ratio.

We will focus on placing the field project at the centre of our future reforms. Any changes we make should be exclusively driven by the ambition to increase the quality, impact and effectiveness of our operations. We believe that this change needs to be anchored in a bold move to give more power to project teams, optimise the support provided to these projects, remove unnecessary decision-making layers, and enhance a safe working environment with equitable access to knowledge and opportunities for a mobile global workforce.

These strategic orientations – which draw on a vast process of consultation with over 1,000 participants – provide a manifesto which aims to frame the coming four years and the ambitions to collectively achieve this, acting as an OC whilst belonging to a movement.

*Endorsed by the OCB group, October 2019*



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# WHAT WE WANT TO DO

## A diverse operational portfolio, reactive to emergencies, high in quality and speaking with a defiant voice

### 1. WE WANT TO ADAPT TO THE CHALLENGES POSED BY OUR EXTERNAL POLITICAL AND AID ENVIRONMENT, TO BETTER RESPOND TO CHANGING MEDICAL HUMANITARIAN NEEDS

Our external environment is characterised by an assertion of nationalist self-interest in a context of changing global power dynamics.[1] We are under attack for our work with excluded communities. States are able to limit and instrumentalise humanitarian action, often with the backing of emerging power alliances.

In such an environment, where proximity, independence and impartiality are under threat, we are also rejected by transnational armed opposition groups leading us into situations where we de facto become part of anti-terror coalitions, such as in Nigeria or Iraq, in order to access some of the populations most affected by conflicts.

Donor states that shape the aid system openly declare their foreign policy interests as fighting terrorism and containing migrants, refugees and epidemics. In countries in which we work, the myth of humanitarian organisations as independent actors continues to be eroded. Our words and actions are challenged by communities, states and armed groups and economic interests prevail.

This environment changes the equation of who can unlock our access to where needs are the greatest; it changes the range of actors we need to be able to engage with to build acceptance and influence change; and it alters how we advocate and how we mobilise

1 For a more detailed overview of medical humanitarian needs in a changing political and aid environment, see the publicly available outcome of the working groups on the political environment, aid environment and medical humanitarian needs: http://msf-analysis.org/medical-humanitarian-needs-changing-political-aid-environment/

popular support. In short, our leverage to carry out our social mission needs to be constantly revised.

In conflict environments, the assertion of national self-interest in a context of changing global power dynamics has created a space for the core tenants of International Humanitarian Law (IHL) to be reinterpreted. National counter-terrorism laws are often used to supersede IHL. The notion of the 'civilian' is eroded in wars with no limits, where political cover is given by an increasingly fractured global power landscape.

In contexts of migration and displacement, xenophobia and racism prevail. Borders are being reinforced, pushed back and closed. Migrants and refugees, often fleeing the consequences of war, inequalities, and economic collapse, are painted as a global security threat or as a threat to national self-interests.

Many of the patients we treat are being specifically targeted and criminalised, including migrants, sex workers, sexual minorities, and women seeking safe abortion. These communities are stigmatised, targeted with physical violence and oppressive legislation and are pushed underground.

In the global health arena, money for medical needs is being tied to arbitrary classifications of countries as lower, middle or high income. The World Bank continues to expand its role as does the private sector. User fees remain an obstacle to access health care for some of the most vulnerable. Epidemics are viewed through the lens of security or as a financial burden. Conservative agendas around sexual health are once again creating health risks.

Alongside this, the aid system around us continues its alignment with the state. The so-called 'nexus' (the UN move to merge development and humanitarian aid), 'aid localisation' and the 'new way of working' are all new ways of talking about an age-old approach to aid delivery, whereby development and humanitarian assistance activities of the traditional aid system are merged to build the capacity or 'resilience' of the state and its institutions. This approach is implemented for the sake of building the state and advancing a global neo-liberal post-Cold War era of free market cooperation. The resultant shortcomings of the aid system to respond to emergency needs is therefore not a failure of capacity that can be fixed but rather a deliberate political choice that should be challenged.

Within this environment, medical humanitarian needs are no less acute. The concept of a global 'epidemiological transition' claims that there has been an epidemiological change from high mortality among infants and children alongside episodic famine and epidemics, to one of degenerative and man-made diseases. However, what we see in our areas of operations is that while non-communicable diseases are emerging everywhere, acute and chronic infectious disease remain the primary burden of disease and cause of early mortality in most settings where MSF works, such as in sub Saharan Africa. Advances made in tackling HIV, TB and malaria risk being rolled back in the current environment where more than ever donors' response to global health needs are secondary to promoting national self-interest. We are increasingly concerned by the difficulty of patients to access testing and treatment in low prevalence contexts such as West and Central Africa, while we also see a growing problem of advanced disease in patients formerly put on treatment and a continued high incidence in our traditional areas of response to HIV. AIDS is back. But the outrage is disappearing.

In conflicts we continue to see shortfalls in the provision of healthcare across the spectrum of primary to secondary healthcare. This includes in preventive actions such as vaccinations as well as significant gaps at district level general hospitals. However, we also see gaps in the response across the trauma pathway from the point of injury (stabilisation) all the way up to the point of reconstruction and rehabilitation (post-op). Conflicts pose additional challenges in the ability to respond to infectious diseases.

Add to this the emergence of Anti-Microbial Resistance (AMR) and we face immense medical challenges. AMR poses major complications in war wounded and in the arena of infectious diseases. This creates an urgent need to improve our diagnostic and treatment capacity.

We are not only working in contexts with weak health systems that are in the process of being strengthened but also in contexts with sophisticated health systems that are being eroded. In addition to this, we encounter high quality health systems that are entirely inaccessible to excluded groups. This requires adapted approaches in our way of interacting with the medical communities around us.

In our response to the medical needs caused by violence we continue to witness high levels of sexual violence and continue to see the needs of victims of torture. We also encounter the realities of structural violence, whether it is through restrictions on safe abortion or the mental health consequences of targeted exclusion amongst migrants and refugees.

Climate change will result in increased medical needs that will disproportionately impact the global south. This will result in an exacerbation of existing vulnerabilities as it is likely to result in more displacement, natural disasters and conflict.

The realities of our political and aid environment, and the changing landscape of medical humanitarian needs, requires a constant evolution of our ways of working. We need to better equip ourselves to identify medical needs in contexts of exclusion, understand vulnerability and design relevant medical humanitarian responses that directly treat patients while exposing and advocating against the structures of exclusion that deny them access to healthcare. Vertical responses, integrated approaches, punctual interventions, scalable models of care, substitution and support to existing health capacities all have a place among our operational responses.

We need to better navigate on the one hand, the need for maintaining our independence, while on the other hand identifying allies among communities, civil society groups and social movements to reach the most vulnerable, speak out with outrage and advocate for change. This requires flexible operational models that are connected to communities and delivered in proximity to those who need it most. It is in this way that we will ensure our medical humanitarian impact is effective in a hostile environment.

Within this environment of exclusion, nationalism and criminalisation, a defence of impartial humanitarianism is essential; the direct act of saving lives in accordance with medical ethics is an act of defiance and patient solidarity.

## 2. WE WANT TO MAINTAIN A DIVERSE PORTFOLIO OF OPERATIONS THAT RESPONDS TO VULNERABILITY AND EXCLUSION

The OCB operational portfolio of the coming four years will be defined by responding to concrete medical needs among vulnerable and excluded populations in contexts that are known to exacerbate these needs and vulnerabilities.

We will aim to disrupt the status quo in the operational responses where we choose to play such a role. We will keep the patient at the centre of our activities as we save lives, alleviate suffering and ensure dignity of the most vulnerable.

Our portfolio will be made up of default and choice projects. Projects by default are those projects that respond to acute peaks in mortality and morbidity in situations where we know that vulnerability and needs are most acute: conflict, natural disasters and epidemics. This will represent the core of MSF's added value as an emergency oriented medical humanitarian actor.

Choice projects are those projects where we see an added value for MSF to disrupt the status quo, to demonstrate new ways of working, to tackle more chronic problems that require us to demonstrate something through evidence and will contain a strong advocacy component – rooted in our operational reality – or where we wish to develop expertise to better respond to evolving medical humanitarian needs.

A strong collaboration will be reinforced between the Operations, Medical and Analysis departments to constantly understand our environment and the


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medical humanitarian needs that exist. Our priority areas of operations will exist in the intersection between medical needs, the most vulnerable populations and the potential impact that we can have as MSF.

We will promote the principles of agility in our operational design and decision making while ensuring that our operations remain of a high medical quality. We will better connect with communities and embed our operations in their reality while maintaining a robust commitment to our principles and medical ethics. We will ensure that we are able to take risks, negotiate access with tact and navigate complex security landscapes. Our projects will always aim to be hands on and our voice will be rooted in patients' realities.

In conflict environments we will manage security by negotiating access and acceptance with all sides and in accordance with our principles, by ensuring quality and relevant operations, by being respectful and inclusive in our HR management, and by ensuring proximity to patients and in consultation with the population.

The evolving medical humanitarian needs that occur within our political and aid environment require us to make clear priorities. In the coming four years we will continue to respond to medical needs in conflict. Within these contexts, where we have a clear added value as an independent and risk-taking actor, we will respond to a full spectrum of medical needs.

We will emphasise the continuum of care in our projects from the Primary Health Care (PHC) level up to secondary care and will seek to ensure better links between these levels. We will not focus on system strengthening but rather in ensuring quality of care to patients. We will re-invest in PHC where security allows, and in more community-based case management where relevant – based on iCCM (integrated community case management), diagnosing and treating pneumonia, malaria and diarrhea. As such, we will ensure that we orientate our activities toward the main killer diseases.

We will maintain a strong commitment to tackling chronic infectious diseases while others retreat. We will focus on advanced disease among our HIV/AIDS patients, ensuring that our operations are coupled with anger at the reality of AIDS that continues to affect patients. We will continue to invest in our response to DRTB with shorter and more patient friendly treatments. We will look for opportunities to integrate TB, HIV and to a lesser extent HCV into our existing operations.

We will continue to maintain a capacity to respond to outbreaks of cholera, measles, typhoid, dengue, malaria and ebola, and we will build our capacity to detect and respond to (re)emerging outbreaks such as diphtheria and yellow fever. The management of these outbreaks will be holistic, including medical management, vaccination, laboratory confirmation, community engagement, social science, health promotion and environmental health activities. At the same time, we will seek to prevent the occurrence of epidemics by organizing multi-antigen preventive vaccination campaigns in humanitarian emergencies.

In migration contexts, we will continue to develop an adapted approach to migration and health, to ensure the best possible response to the medical humanitarian needs caused by restrictive migration policies. We will couple our action with strong advocacy and *témoignage.*

We will maintain a special interest in populations that are excluded and criminalised. This will include migrants, sex workers, prisoners, LGBTQ communities, and victims of torture. We will aim to integrate activities for these vulnerable populations into our existing work.

We will take a more holistic approach to child and maternal health. We will engage in more paediatric In-Patient Department's (IPD), avoid missed EPI opportunities, and develop approaches to reach adolescents in our projects.

In the area of women's health, we will continue to focus on family planning, safe abortion and Sexual and Gender Based Violence (SGBV) in addition to obstetric activities. We will re-engage on treating fistula and will have a renewed attention to Sexually Transmitted Infections (STI's), in the light of the growing antibiotic resistance. As such, we will consider gynaecological needs more broadly rather than a focus exclusively on obstetrics and maternal care.

In tackling the challenges posed by antibiotic resistance (ABR) we will prioritise Infection Prevention and Control (IPC) and antibiotic stewardship in all our health facilities and progressively integrate microbiology in the diagnostic package in part of our hospitals.

We will make a conscious move away from WASH into integrated environmental health approach where relevant for our projects.[2] We will prepare ourselves for changing patterns, scope or frequencies of emergencies, triggered by climate change. For neglected tropical diseases we will seek to integrate activities into our existing portfolio but will not foster a specific operational angle on this as such.

In our approach to non-communicable diseases we will treat diseases rather than risk factors. We will focus on severe hypertension and acute cardiac care, type 1 diabetes, asthma and epilepsy. We will improve the quality of our IPD and emergency care for patients with a Non-Communicable Disease (NCD). We will continue to focus on mental health and intend to offer more psychiatric care, with task shifting to lower level staff where needed. We will limit our cancer response to Burkitt, cervical cancer and Kaposi while continuing to reflect on what more we could do in this field.

If we consider the current geographical distribution of our portfolio, it is clear that gaps in our response remain in the Sahel region, which will be reinforced. We do not foresee needs reducing in Central Africa and the Middle East, which will require us to maintain our investment and respond to unmet or new needs that emerge in these regions. As the displacement crisis grows in Latin America, this region will require a renewed level of attention. At the same time, we will need to constantly monitor and be ready to respond to needs in the Horn of Africa where we currently have a limited operational presence. However, these geographic areas of focus will evolve over the coming four years based on a constant monitoring of medical needs and in complementarity to other OCs.

Our emergency response capacity will be reinforced, with a proportional increase in our emergency envelope foreseen to enable us to better respond to complex large-scale emergencies as well as smaller pockets of acute need.

Our direct medical action, together with témoignage rooted in our operations, will remain at the core of our identity. This will include, among other topics, thematic such as counter-terrorism, the global health security agenda, and the aid system. We will also advocate against inappropriate or substandard medical practices and policies which harm the patient.

The overall operational ambitions of OCB will be achieved by taking difficult choices of where to disinvest in the coming four years. In many of the areas where we have invested in the past, by building our expertise through vertical projects, we are now in a position to integrate these expertise into existing projects. We therefore envisage doing less vertical activities related to Hepatitis C and in Non-Communicable Diseases. We will also see a significant reduction in investment in construction projects.

The OCB Operational prospects document for 2020-2023 will outline in more detail our ambitions and priorities in the coming years.

## 3. WE WANT TO BE AGILE AND REACTIVE IN RESPONDING TO LARGE SCALE EMERGENCIES AND SMALLER, DISPERSED POCKETS OF ACUTE NEEDS CAUSED BY EXCLUSION

The Emergency Pool model is a tried and tested formula in MSF: a dedicated team of people, available immediately, with priority access to the organisations resources and the ability to deploy large scale operations at short notice. This capacity – which lies at the heart of our social mission – will be maintained and boosted.

However, the nature of the emergencies that MSF faces today are arguably changing. Natural disasters happen in places where governments have the capacity or willingness to control the response. Conflicts take place in contexts where we often don't have access to all parties to the conflict in order to negotiate our access. We are often surrounded by more aid actors. And the aid system is geared towards reinforcing the efforts of the state in epidemics, natural disasters and also in conflicts, further eroding the acceptance of independent humanitarianism. There is a trend against independent foreign aid workers and a desire to put national capacity at the centre of humanitarian responses. Needs are not decreasing, but the ability to deploy impartial medical humanitarian responses is constrained.

2 The WatSan unit proposed to reframe WatSan as part of Environmental Health which is a branch of public health. This reframing was implemented in May 2018 in OCB and should provide a solid base to finally guarantee the inclusion of environmental health – including the effect of climate change – within the programmatic medical discussion within OCB.

OCB will adapt to this landscape. We need to be able to maintain our medical focus, independent needs assessment, the logistical capacity and technical know-how for the large-scale emergencies for when they happen. At the same time, we will invest in building regional networks to better enable our ability to deploy this full emergency capacity. We will also incorporate a capacity to respond to smaller crises, geographically dispersed and often with characteristics that do not always fit our classic understanding of 'emergencies'.

### 4. WE WANT THE PATIENT AND THE POPULATION AT THE CENTRE OF OUR MEDICAL ACT, ENSURING PATIENT SAFETY AND PROVISION OF HIGH-QUALITY HEALTHCARE

Quality of care is determined by the structure in which care is delivered (i.e. context, facilities, staff, resources), the processes for the delivery of healthcare (i.e. patient-provider relationship, preventive and curative care) and the outcomes or the effects of healthcare on patients and populations (i.e. health status, behaviour, knowledge, quality of life). Quality of care is also about ensuring the highest standards of patient safety, respect and dignity.

For MSF, the first step to ensuring the implementation of our commitment to quality healthcare is proximity.[3] The relationship between the patient and healthcare providers remain at the centre of our medical humanitarianism and form the foundation from which we will strive to ensure a continued increase in the quality of services provided to patients.

In the coming four years, OCB will aim for a comprehensive and holistic approach, from preventive healthcare, to curative and palliative care. This means our engagement with the local healthcare ecosystem will be integral to our medical and operational capacities as well as the clinical capacities of the staff we deploy and employ in our projects.

The human factor is key to our ambition to provide quality healthcare in a safe environment. We will improve every step along the way: recruitment, onboarding, clinical supervision, mentoring as well as learning and career opportunities. Healthcare providers wanting to embrace a clinical career will be valued, supported and offered challenges.

At the heart of patient safety is our ability to become a learning organization: working as a multidisciplinary team, sharing good practices on the job, debating different approaches to clinical challenges, knowing our limits, identifying incidents and near-miss incidents, adapting the system, sharing our successes, our failures and our solutions with the movement, welcoming feedback and giving feedback in an empowering way. Nobody should work in isolation. Everyone is part of a community of practice.

Empowered field teams will be supported by best practices, tools and guidelines, by access to telemedicine services and by direct access to technical and medical advisers. Expert advice will be sought early in the design of a project to identify the best strategies and the best set-up. Scientific evidence can often guide these decisions. Whenever evidence is lacking, or new approaches are being implemented, the opportunity to conduct operational research will be considered.

However, the majority of MSF clinical activities take place in dynamic and challenging contexts. Minimal or essential requirements are not always within immediate reach. The field teams will need to balance the risk/benefits for the people between no intervention and an intervention with the available means at the time. Once an activity has started, we share the responsibility over time to go above and beyond the essential requirements.

### 5. WE WANT TO MAINTAIN AND EXPAND OUR ABILITY TO ADDRESS MEDICAL NEEDS EXACERBATED BY CONFLICT; TAKING AND MITIGATING RISKS, TO THE BEST OF OUR ABILITY IN PROJECTS WHERE WE HAVE THE HIGHEST ADDED VALUE

Situations of armed conflict and violence will continue to lead to significant medical and humanitarian needs and amplify pre-existing vulnerabilities and exclusions. Such environments require our ongoing investment to be able to respond to the medical needs of the most vulnerable.

OCB will continue to carry out medical activities that are either related to (1) direct victims of violence – which will include medical care for war-wounded, victims of torture (VoT), SGBV and displacement (2) indirect victims of violence – which will include excluded populations and populations with increased vulnerability linked to the deterioration or destruction of existing health systems (which can include primary or secondary health care, vaccination campaigns, mother and child health, or chronic diseases).

Our trauma responses, where they are relevant, will take into consideration the medical needs that exist in the full trauma patient pathway from the point of injury (stabilisation) to surgical treatment and rehabilitation and where possible up to the point of reconstructive surgery.

These ambitions are challenged on the one hand by the proliferation of non-state armed groups that reject humanitarian presence, often as part of the rejection of any western presence of which the traditional aid system, including MSF, is historically part of. In addition to the resistance from non-state groups, states no longer dependent on western donor money only, are re- asserting their sovereignty which includes restrictions on humanitarian aid reaching territories controlled by their opponents – who are increasingly classified as 'terrorists'.

Therefore, it is likely to take more time, effort and resources to be able to address the indisputable medical needs that exist in these environments. Working in such environments will require us to build our capacity at all levels of the organisation to be able to negotiate access and navigate complex environments. We will need to ensure that we constantly expand our networks at local, national and regional levels and maintain a sophisticated analysis of our environment. We will need to publicly position ourselves in defence of impartial medical humanitarianism to preserve our ability to reach the most vulnerable.

By keeping medical needs at the centre of our desire to work in such environments, we will invest in better navigating these complex security and aid landscapes in order to ensure that we reach the most vulnerable and excluded.

### 6. WE WANT TO REVITALISE AN MSF IDENTITY THAT CAN SPEAK OUT WITH OUTRAGE AND CREATE CONTROVERSY BY CHALLENGING THE STATUS QUO, RATHER THAN BECOMING PART OF THE ESTABLISHMENT AND JUST ANOTHER LOGO WITH A RED AND WHITE SYMBOL.

While the trends outlined above pose limitations on our independent humanitarian voice, we commit to speaking out to effect change or highlight unacceptable situations we witness in the field. We will speak out to challenge existing narratives, to increase our capacity to work in certain places, and to make sure we acquire the necessary resources to do so.

We are confronted with challenging compromises to access populations in danger and to deploy our operations. However, we often forget the power of public positioning as a form of operational leverage. The more aid is polarised and instrumentalised the more important it has become to clarify who we are. Every moment of silence can be considered as a form of co-option and a support to the status quo.

From Lesbos to Aleppo, individuals and governments have the capacity to mobilise globally in a very short space of time. In the SAR operations, our public image and reputation shifted from the angels of the sea to the co-conspirators of traffickers amongst many national audiences and in a short period of time.

Considering the changes we face in our external environment, the polarization of societies and the evolution of the aid system, we shouldn't shy away from taking a stand. Our patients are discre-

© Bruno De Cock/MSF - Burj el-Barajneh Camp, Lebanon

3 Proximity here is meant as the proximity between the health care provider and the patient. See also part 9 on our engagement with communities and patients

dited as is our practice of humanitarian medicine. We shouldn't try to please everybody externally or even internally. We need to be able to 'set the record straight' in defending our patients and accept that we will sometimes represent a minority position in our home and host societies. We will also not always be able to reach internal consensus on positions that are most likely to trigger debate or create controversy.

Although not the primary objective, these kinds of positions can have a positive impact on the public support we can generate from a polarized society as proven for instance in fundraising with the rise of so called 'rage giving'.

Public positioning does not necessarily have to be a form of advocacy. It is entirely legitimate for us to simply show outrage and emotions. However, our voice will remain rooted in our direct operational role and witnessing, and we will not take public positions that are disconnected from our direct medical action. This is an essential component to our medical humanitarian identity and legitimacy.

We will also be willing to admit our mistakes, or our dilemmas. Showing the courage of our convictions, being honest about what is happening and what we could do better is a strength of MSF and an essential component to building respect, support and accountability.



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# HOW WILL WE DO IT

## 7. WE WILL PUT FIELD PROJECTS AT THE CENTRE.

We will build on our diverse institutional makeup and become a truly international movement with decision making based closer to where our operations are and with expertise built and retained within operational hubs closer to the patients we treat.

In response to our external environment, we need to be more disruptive, more innovative and quicker at adapting our responses in a hostile political landscape.

This requires a change in our set up to ensure that we are agile in our decision making, flexible in our approaches and taking decisions as close to the patients as possible. Re-centring the project and the patients at the core of our organisational set up will be a critical step in being better equipped to respond to the contemporary challenges that we face.

Over the last two decades there have been evolutions in the contexts of our interventions, the technological environment, the size of the organization, the nature and specialisation of our operations and the emergence of new ways of working. These evolutions have exposed the limits of our current managerial model. Ad-hoc variations within cell-based models have been tried in this period for various reasons and with varying levels of success. However, the system itself has until now remained untouched.

Meanwhile, we are continually confirming our frustration with an overly heavy and centralised decision-making process. There is an increased perception of bureaucracy and high growth of HQs and support entities. The present managerial model needs to be questioned and the organisational system reviewed where possible.

In order to re-balance the organisation's centre of gravity out of Europe, changes are needed to bring the decision-making as close as possible to our patients and where our humanitarian action is taking place at the project level. This will change roles of field staff and reduce the number of support positions.

The Field Recentralisation (FrC) programme will aim to put decision-making as close as possible to the medical-humanitarian act and patients. This will be achieved by increasing the autonomy of the field teams and ensuring accessible knowledge and adapted support.

It will be built on the principle of subsidiarity in decision making and will place the project at the centre of decision making.

This process of placing the project at the centre of decision making will likely result in different operational models co-existing. Projects will determine the best way to achieve their objectives, making use of the knowledge of their environment and support available. This will result in a reduced dependency on traditional vertical line-management as it appears now in MSF.

To support project teams, there will be a sufficient medical-humanitarian technical capacity that is appropriately networked internally and externally for effective operational support within a given context. This will include global 'Communities of Practice' that are readily accessible to project members, including inter-project-sharing.

It is around these project needs that we will reinforce regional operational hubs that have a global perspective.

## 8. WE WILL BUILD REGIONAL OPERATIONAL HUBS THAT TAP INTO MEDICAL EXPERTISE, RESPOND TO EMERGENCIES AND SUPPORT FIELD TEAMS

We see the opportunity to develop 'Operational Hubs' closer to the patients we treat and rooted in partner sections and branch offices located in proximity to our operations. These hubs will be available for the movement and we will also make use of services provided by initiatives from other OCs where relevant. We will take an active approach of sharing competences and we will seek inter-OC collaboration to avoid unnecessary duplication.

In complement to these Operational Hubs, existing OCB partner sections will continue to provide transversal expertise that will be used to support projects. These transversal expertise include topics such as mentoring/coaching, operational research and evaluations.

The Operational Hubs within the OCB group will not represent new growth in OCB but rather a reprioritisation of where investments are made. As resources are transferred closer to the field, there will be a reduction in Brussels.

These operational hubs will contain one or all of the following components:

**Operational support**
An operational mentoring capacity could be placed in regional hubs with a varying degree of support provided to projects in their region, replacing or in complement to existing cells. This implies some structural changes at the Operations Department to avoid duplication of structures. This support may vary from region to region. In all contexts, this capacity will form part of the 'operational line'.

**Medical Centre of Expertise**
Based on the experience of developing SAMU in Southern Africa, we see the unique opportunity to build on this model in other regions. Beirut has already started to develop a medical unit focused on AMR, which will be developed further in the coming four-year period. BRAMU has developed expertise on social science support to medicine and will expand to include topics such as mental health.

These centres of expertise are located strategically in proximity to an operational volume that deals with the issue and in proximity to partners, and can tap into academic and civil society expertise on the subject. The expertise developed through these regional centres will be made available to operations globally. This perspective of 'regionally developed expertise made available globally' will be emphasised in order to ensure the continued *sans frontierism* of our medical humanitarian set-up.

**Emergency Response Teams**
Within an Operational Hub, a Regional Emergency Response team can be developed; responsible for scanning their environment, identifying situations of acute need where MSF could have a role in punctually responding, flagging emerging needs and future emergencies to feature in the thinking of regular operational priority setting. They will play a role as openers in specific contexts, paving the way for the deployment of additional Emergency Pool resources. They will be located closer to where emergencies take place, giving them the scope to conduct quick assessments, boost acceptance through experienced teams from the affected regions and better understand needs and the role that MSF could play.

We will invest in our capacity to tap into different networks and build partnerships – including academic, civil society, governments and armed groups – that can open doors for our teams to be able to better assess and respond to needs. In order to be better positioned to scan the epidemiological and political landscape we will preposition ourselves to respond quickly to alerts of small scale and acute pockets of need and have real impact. We will maintain a capacity to navigate local dynamics where emergencies might be more linked to exclusion than to large scale humanitarian needs.

To achieve this, the Emergency Pool will add to its existing set up regional Emergency Response Teams that bring a different set of skills and know-how than what might exist in our current centralised model. OCB is well placed to do this through the existing network of sections that are well placed in proximity to areas where the emergency needs of the future are located. Close collaboration with for instance MSF Honk Kong's Operational Support Unit will be envisaged. Resources from the Analysis Department, located in regional hubs, can support the Emergency Response teams with developing and maintaining networks.

This regional emergency capacity will be responsible for developing regional emergency preparedness plans – in collaboration with existing missions and in countries where we have no existing operational footprint. They will be involved in training and in potentially identifying regional stocks, as well as in identifying and training a 'red organogram' of staff that can be quickly detached. This will allow us to better make use of the expertise and experience of regional staff in responding to emergencies.

## 9. WE WILL BE CONNECTED TO SOCIAL MOVEMENTS AND TO COMMUNITIES IN WHICH WE WORK. WE WILL ENGAGE WITH THE COMMUNITIES, LISTEN AND INCORPORATE THEM IN OUR PROJECTS.

Our operations cannot be disconnected from the communities in which they are being implemented. This is essential for us to ensure appropriate medical humanitarian project design and implementation, to ensure acceptance, to build sensitivity to the political realities of vulnerability and to implement relevant advocacy initiatives that tackle exclusion.

To ensure adequate community engagement, we will systematically include the community during the project cycle. We need to recognise and make use of all staff's community links in a systematic way. In the coming period of these strategic orientations we want to make increased use of exploratory (rapid) anthropological assessment tools before or at the opening phase of a project, depending on the context. We need to develop standard processes, tools and documents – such as patient charters – in our projects. We will strive to engage in a collaborative approach to decision making between clinical teams and patients in order to improve the relevance of our responses and in recognition of the role of patient led advocacy toward all stakeholders.

Communities are not simply formed of apolitical populations bound by a geographic location. Increasingly, transnational communities are taking the form of social movements; some of whom share similar medical objectives to MSF, such as #totalshutdown for survivors of sexual and gender-based violence in South Africa or the Black Women's March fighting for women's rights – including access to healthcare – in Latin America. Activism is increasingly moving away from the NGOisation era that marked the 90s and early 2000s, into an era of amorphous and loosely organised networks that form "imagined communities", or social movements for change. MSF's ability to engage with these movements, beyond asymmetric power partnerships, will be a key step in the organisation's capacity to speak and act with relevance on a range of medical topics.

This is not about networking with the usual suspects of NGOs, nor is it about the implementation of a 'localisation' agenda that often gives governments' greater control over locally led aid responses. Connecting with communities for us will be about


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embedding our operations in the realities of communities' struggles. It will be about ensuring that we understand the communities we are working in. It will be about creating alliances with civil society and social movements around shared medical concerns. It will be about ensuring that we listen and learn how communities are addressing the challenges that they face and the language they use to explain power dynamics that are at the root of their exclusion. Connecting to the community is about increasing our relevance, the quality of our care, the leverage we can exert and the acceptance we can obtain.

This need for engagement is how we will also approach our public communication... With the speed of the news cycle and in the social media era we are living in, combined with the saturation of information and disinformation, we can no longer simply communicate at people. We need to engage, to enter into real conversations with diverse audiences and search for supporters worldwide. We need to stop acting in silos and put an end to the past dichotomy between our field and fundraising audiences. This will require an overhauling and reshaping of the current MSF communication mind-set and structure. Our challenges vary from one part of the world to another. In societies where MSF has a long-standing institutional presence, our brand-awareness remains relatively strong, but we face difficulties to connect with the younger generation and gain new supporters. Over the past years, MSF has rightly invested in new offices (Lebanon, Taiwan, Singapore, China, Russia, India etc.) but building public support, where that has been the objective, will take time and effort. At the field level, despite the progress made with the investment of field communications positions, we need to opt for a more natural and less over cautious engagement with public opinion.

## 10. WE WILL MAKE THE GLOBAL MOBILE AND DIVERSE WORKFORCE A REALITY, WHERE PEOPLE AND ORGANIZATIONAL NEEDS, VALUES AND CULTURE, DEVELOPMENT AND SENSE OF BELONGING ARE THE CORE FOCUS.

The organisational culture and model we want for tomorrow is one with less hierarchy, reduced bureaucracy and increased subsidiarity. We want a learning organisation with a coaching and mentoring approach as the keys to successful team management. This change of culture will be achieved by defining and implementing a model of regular and qualitative feedback, based on the competence model required for the operations and the organisation.

Subisdiarity and participatory leadership built on inclusion and responsibility-sharing will be the guiding principles of our management, which is grounded in the OCB management values of: Respect, Transparency, Accountability, Integrity, Trust and Empowerment. These values are to be integrated by all OCB staff at all levels and be a real framework of our daily interactions.

We will need polyvalent generalists with strong humanitarian motivation to develop tomorrow's leaders and specialists, of all profiles, to meet our operational ambitions.

Mobility, both geographic but also functional, remains a key element to maintain our 'sans frontierism' identity. This means we must take the traditional labels away and adopt a global HR approach based on organisational needs and people's competences. We will need a mobile workforce to ensure the right capacity, rapid deployment and adapted support to our projects, with skilled staff that have the relevant operations knowledge. However, the added value brought by mobile positions should not overlook the need for more stable positions at field level to enhance and maintain field knowledge, technical expertise, long-term perspectives and in some instances to overcome access constraints.

Diversity, specifically at managerial level, will be a top priority where we will invest to ensure better representation of our workforce at all levels. However, we will also seek to address any structural barriers that may exist to achieving our desired diversity.

In the years to come, recruitment will be essential to building the future workforce and it will be essential to have a singular competence framework with core values as a foundation. We will work on reinforcing recruitment skills at all levels, a coherent approach for all recruitment and a strong global recruitment network, including field, HQ and the OCB partner sections. We will invest in alternative recruitment formulas, including headhunting or on-the-job recruitments which will be complemented by a fast track induction process. To support those recruitment ambitions, we will strengthen and diversify our HR marketing and external communication.

We want our people to feel fully part of MSF. We want to retain staff through valuing them. We will reinvest in a solid induction path and process, giving all our staff the time to understand the essence of MSF and reinforce their sense of belonging, despite the size and complexity of the organisation.

As a learning organisation, we aim to give an equitable and inclusive access to all MSF staff to relevant, innovative, timely and streamlined development opportunities aligned to the needs and operational priorities in OCB. We want to develop a flexible and modular professional development path, consistent with job opportunities (and organisational needs) to enable everyone to acquire competencies corresponding to their professional expectations within the organisation. A talent development strategy will complement our ambition in staff development.

Collective learning and support will also play a key role in achieving our future ambitions. We want to support the development of a strong collective dynamic, where we draw on individuals' competencies, share knowledge and experiences, create interdependence and cooperation, and share values. This will contribute to reinforcing teams' professional autonomy and capacity to adapt operations.

In terms of reward, OCB wants to play an active role in designing staff reward policies that reflect our organisational and specific OCB needs, include people's changing individual needs and overarching MSF principles.

The entirety of our diverse workforce must be able to work in a safe and respectful working environment, free of abuse, where every individual is expected to respect and carry the organisational values. A stronger focus will be put on prevention of abuse. When it comes to the mechanisms that we have in place, the whistleblowing mechanism in the Garec will be strengthened. A field-based support structure will be designed and initiated. A headquarter based support structure within the HR department will be put in place to receive and centralise all cases related to non-ethical or purely management cases.

We will continue to consider staff wellbeing as an integral part of being a responsible employer. The organisational emergency culture, the contexts where we work, and the size of the organisation are risk factors in terms of the wellbeing of our people. To counterbalance these risks, an integrated strategy focusing on wellbeing remains one of our priorities with an increased focus on mental health.

We will continue to work in risky environments. We will never be a zero-risk organisation. Our duty of care includes what the organisation puts in place as prevention and mitigation measures before, during and after work-related risk exposure. HR and Operations will work towards an integrated risk analysis and risk management approach, where security, safety, health and legal risk will be thoroughly and transversally considered. The duty to inform people on risk is an essential part of the pre-risk exposure practice and will continue to be reinforced.

## 11. WE WILL BUILD A STRONGER CADRE OF HEALTHCARE STAFF THROUGH THE MSF ACADEMY FOR HEALTHCARE

As a key component of the ongoing Learning and Development activities of OCB, the Medical Academy for health care will be a priority.

Our healthcare staff are among MSF's most crucial resource, from community health workers and nursing staff, to surgeons and medical coordinators. All must master a complex set of competencies, requiring up-to-date skills. Yet, in many countries where we work, there is a dramatically low investment in developing healthcare workers. The activities of the MSF Academy for Healthcare, created in 2016 to confront these challenges, are chosen in view of operational priorities and aim to improve quality of care in the MSF projects. As of 2019, five projects have started: training in IPD nursing, an anaesthesia scholarship project for certified nurses, a training project for OPD consultation staff, Post Graduate Diploma in Infectious Diseases for medical doctors and a master's course in Medical Humanitarian Action for present and future medical coordinators

The Academy's pedagogical approach is based on three pillars: up-to-date practice in adult learning, work-based learning and competency-based programmes. The delivery approaches vary depending on the resources and constraints in the field, but a strong emphasis on accompanying the learners with clinical mentors remains at the heart of our strategy.

Over the next 4 years, other learning needs will be assessed; surgical skills and learning in the field of Antibiotic Resistance are already being considered.

Other possibilities include hospital management and clinical paediatrics.

For now, MSF employees are the main target participants for the Academy, many of whom will be able to contribute to quality of care in their country after MSF has departed. A possible next step may include the staff of Health Ministries. The MSF Academy is rapidly building up an interesting network with learning institutions and national or regional health authorities. Based on this an advocacy agenda could be developed on the topic of development of healthcare workers in countries or regions where this is most neglected.

The Academy started inside OCB, in collaboration with OCBA, but every project is open to serve the needs of all Operational Centres. The Academy also links with other initiatives in the movement that work on learning for healthcare staff and aims to become a strong platform to bring medical learning in MSF to a higher level.

## 12. WE WILL ENSURE SOLID AND FORWARD-LOOKING SUPPORT SYSTEMS THAT ARE RESPONSIVE TO OPERATIONAL NEEDS WITH AGILE PROCESSES

We will ensure that our support departments are geared to meeting the operational challenges that we will face in the coming period and are adjusted to our recentralisation ambitions. This will entail smart systems, adapted to the needs, and responsive to the demands of our operational environment and ways of working. Departments will be expected to not work in silo and to critically look at their processes and standard requirements which have sometimes hampered autonomous reactivity and decision making at the field level.

To optimally fulfil our social mission in today's reality there needs to be a structured, diverse and multidisciplinary project team that is not just a sum of effective individuals. The project teams must be understood as a collective intelligence organised around its core and governed by participatory management. This project team approach will be developed in collaboration with the operations and other departments.

Logistician needs to be autonomous, pragmatic, polyvalent and solution-oriented, understanding the complexity of our operations, and ensuring the quality of the environment of our patients and medical teams. The logistics solutions, structure & support mechanisms are constantly adapted to best suit operational needs, in partnership with all actors involved.

With regards to supply, risk, performance and stock management will be enhanced to allow informed decision-making in the field. In parallel, procurement coverage will be enlarged in all areas with a clear focus on field operations, to guarantee the best possible use of resources.

ICT should be seen as an operations enabler. If today ICT is still sometimes perceived as a supplier, tomorrow ICT should be seen as the strategic partner of operations, focusing on shaping and delivering new, sometimes innovative, digital solutions that are not overdone but fit for purpose and aligned to operational needs. Digitalisation is a priority and improvement of field connectivity, data protection, security and access management will be our key areas in terms of investment. ICT officers are present in most capitals, however we will need to bring more ICT competences to the project level, by investing in an ICT learning and development strategy. ICT regional functional support will be considered.

Financial guidance and reliable financial projections will be provided in a timely, qualitative and solution-oriented way to support operational decision making. To enable management and accountability of resources, MSF staff will be empowered on financial subjects. Processes will be reviewed and rationalised to make them as simple and adapted as possible to the evolving and changing operational needs.

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All support units will work towards a culture of capturing and sharing knowledge, enabling both individual learning as well as organisational learning. We have so far a pyramidal structure with vertical communication, support and decision-making lines. This tends to limit access to information and centralised knowledge and flows, leading to a perception that at any level of the organisation holding knowledge is a way of holding power. We commit to making knowledge accessible horizontally and transversally. Such a mindset requires a cultural shift and recognises the power of knowledge to optimize our work effectiveness, favouring equal access to the opportunities that knowledge can offer.

The experience of the community of practice developed by the Logistics community (Sherlog) will be one of the options to be encouraged. It will be extended to other departments in support to the project teams. These developments will happen in synergy between the Ops, Med, Log, Supply, ICT, Finance and others to avoid vertical disciplinary islands.

## 13. WE WILL ANALYSE AND ADVOCATE AGAINST THE STRUCTURES OF EXCLUSION THAT HAMPER THE MOST VULNERABLE FROM ACCESSING HEALTHCARE

OCB will continue to analyse, advocate, network and negotiate on a number of thematic topics related to our operations; including in the fields of forced migration, conflict and humanitarianism, and the politics of health.

As a priority, we will seek to develop a deeper documented analysis, and possible advocacy initiatives, on the systems that exclude certain groups from accessing health care. This takes many forms, including, but not limited to: the fact that the concept of a civilian continues to be eroded in counter-terrorism operations, resulting in patients being blocked from accessing health care; migrants that are being criminalised, contained in unacceptable conditions, pushed back to countries from which they are fleeing, or subject to violent obstacle courses to safety is impacting on their health and wellbeing; IV drug users, sex workers and men who have sex with men that are stigmatised and targeted in hostile crackdowns is pushing them underground and out of reach of health services, leading to specific vulnerabilities with regards to HIV/AIDS and other infectious diseases; women's reproductive rights that are undermined through gag laws and limitations on access to services such as safe abortion is leading to unacceptable assaults on dignity and patient maternal mortality. All of these are examples of the systems of exclusion faced by our patients across our areas of operations and which increasingly define medical humanitarian needs in our contemporary aid environment.

Compliance with the political restrictions on who is considered a 'worthy' recipient of medical assistance is enforced through funding restrictions, propaganda, auditing, criminalisation, prosecution, and even direct attacks on health workers. We are criminalised because our patients are criminalised.

The hostile environment created by both states and non-state armed groups has a clear impact on the delivery of impartial and independent healthcare, with very few organisations or individuals willing or able to challenge these restrictions on who deserves aid.

The criminalisation of patients, aid providers and humanitarian personnel strikes at the core of the humanitarian mission. Not only are humanitarians restricted by who they can reach – who is considered 'deserving' of aid based on political need, but the whole notion of humanitarianism is perceived negatively in the public eye and by governments unless it abandons impartiality and only gives aid to 'good' patients, and only helps people living in areas controlled by the 'good guys'.

The return of an increasingly strict application of the concept of sovereignty and the rise of nationalism creates an environment where the powerful jealously guard their freedom to wage war (often by proxy, further diluting their responsibilities), reinforce borders and deny care to society's undesirables.

We will develop strategies to challenge these structures of exclusion.

## 14. WE WILL INNOVATE IN OUR FUNDRAISING APPROACHES AND CONTINUE DIVERSIFYING OUR FUNDRAISING MARKETS.

The exceptional private income growth that we experienced, especially from 2014 to 2016, has reduced dramatically, to the point of becoming a negative growth trend in 2018. An up surge of nationalism and populism around the globe, that is to some extent directly attacking our principles and activities and that often doesn't support the concept of international humanitarian aid, has contributed to this downward trend. National affairs are dominating the news, giving less space for MSF in the media. Emergency situations with huge media visibility like the Tsunami, Haiti and Ebola in West Africa haven't happened over the past 3 years, while in those emergencies that have taken place, MSF has often chosen to stay silent or remain technical in its public positioning.

At the same time, other NGO's are looking to expand their private income sources and are competing with us in terms of raising funds in emergency contexts. While we may still have an added value in terms of our reputation and 'trustworthiness', we cannot take this for granted.

In some of our own markets we have almost reached the maximum audience for our cause. In these environments, recruiting new donors or simply keeping the existing donor base and market share requires significant investments with a lower Return on Investment (ROI). Having a strong public position and profile in new emergencies can shift this equation.

However, in general we need to shift our fundraising programs in such high saturation markets. This will mean a shift from a very acquisition-oriented strategy to a more development-oriented approach. We can do better with mid-level and major donors in most of our markets. The same is true for private foundations, which also need more tailor-made, precise and frequent project status reports. An important opportunity for our future income could well be in the form of legacies. It's a long-term investment with a very promising ROI, but unfortunately hard to predict.

However, we need to urgently find ways to better engage with the new generation of engaged youth and mobilise them around MSF actions, in particular in more critical societies and contexts. Today's youth are future staff, and future donors of MSF. This younger generation cares about things that relate to their lifestyle, relate to their interests and are often willing to give to small causes when they feel a connection and proximity to making a difference. We need to reinvent the way we communicate with them; we should not be afraid to refer to humanitarian activism. We have to meaningfully engage with our supporters in order to build their trust in MSF.

The changes in our environment require urgent and long-term investments in the geographical diversification of our fundraising. We are still very much dependent on the European and North America sections. Similarly to the investments done in the past four years in Singapore, Taiwan and Finland, we are ready as OCB to boost new investments in new markets. We need in coordination with the OCB group and the movement, to push for a global investment strategy which will encompass the need to optimise our resources and maintain our relevance in mature markets (dis-investments in some specific areas or activities should not be a taboo but should be encouraged at section level) whilst exploring opportunities in new markets for mid to long-term strategies.

During this period, we will build a conducive environment for fundraising to be developed, as a way to protect our financial independence. We will promote a culture in which our teams (and leadership) in the field and HQ recognises that they each have a responsibility for the success of fundraising efforts, allowing us to create a strong connection with supporters by bringing the voices of our field staff closer to their home society. Also, as an OC, we will contribute to the movement's fundraising efforts by creating adequate processes to maximize income coming from large private foundations and donors, which will imply improving our capacity to identify projects to be presented, building project proposals, reporting on use of funds, facilitating visits to the field, etc, all to meet the demanding requirements of such a donor profile, seen as an avenue of growth for the coming period.

## 15. WE WILL ENSURE THAT WE UPHOLD VALUES OF ACCOUNTABILITY/EFFICIENCY IN OUR OPERATIONS AND STRATEGIC RESOURCE MANAGEMENT

True public accountability is seen as not only communicating our achievements in the face of external challenges, but also being transparent on where we struggle to find the right approach due to internal imperfections and venturing into unknown territory.

However, public accountability can only be built on a foundation of solid internal accountability and transparency. An increasingly open conversation within MSF, about imperfections and mistakes, is a precondition for more openness towards people outside of MSF. We want to push for the OCB operational portfolio to adopt a culture of evaluations in order to encourage transparency in our decision making, but more importantly to give the field teams the opportunity to learn from their practices and to constantly improve the quality and pertinence of operational / medical interventions. Requesting an evaluation should not be perceived as a threat for the mission, individuals or even the policy evaluated. But it should be seen as a way to boost our sharing mentality and to learn from one another. The Swedish Evaluation Unit will be key in achieving this transformation.

In accordance with international agreements including the RSA4, we will work towards a movement with no budget deficit by the end of 2021. Our growth will be adapted to the reality of our financial situation and when growth is possible it will only be driven by its potential impact on people in need.

Efficiency and accountability are as well core principles of a healthy management of resources that aim to support operations in meeting its objectives and in ensuring the stability and continuity of our action. It is our duty to fully integrate these principles into our management to maximise our social mission and ensure that optimal services are delivered to patients. Therefore, the values of efficiency and accountability in our resource management will be embedded as a transversal objective of the coming period.

In order to achieve OCB's resource management vision, a change is required at both organisational and individual levels. Sharing competences and resources between OCs at both field and office level to avoid unnecessary duplication, will be part of our efficiency effort and resource management. Obviously, resources should not define our operational analysis, nor should resource management become a target in and of itself, but rather it should be a guarantor of MSF's capacity to respond to emergencies and sustain its existing projects with quality.

OCB has already launched several initiatives including a code of conduct on the management of resources which has been completed and the implementation phase is starting now. Amongst initiatives that are already ongoing, OCB will focus on having an integrated stock management approach and will act on roles and responsibilities to ensure the values of accountability and efficiency are crucial to the management of OCB resources.

## 16. WE WILL RESPOND TO CLIMATE CHANGE CHALLENGES

Dramatic changes to our environment require adaptations from MSF. The impact of climate change is and will disproportionately affect the health of vulnerable populations. To respond to these profound changes, WatSan in OCB is being reframed as part of environmental health which will provide a solid base to guarantee the inclusion of environmental health issues, including the effect of climate change, within our programmatic medical discussions and decisions.

Changes in outbreak patterns, extreme weather events, changes in the disease burden linked to the environment will need to be monitored as part of our emergency preparedness and responded to as part of our emergency response capacity. OCB operational, medical and analysis departments will work in close collaboration with MSF Hong Kong Operations Support Unit (OSU), BRAMU from MSF-Brazil and MSF Southern Africa to engage in reflec-

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tion, research and risk analysis to develop models of intervention, better understanding of emerging medical needs and appropriate public positioning and advocacy on the topic. It is important for these reflections to occur from the 'global south', where the impact of climate change will be felt the most and where mobilisation on the topic often includes reflections on the intersection of different struggles.

At the same time, OCB commits to be environmentally responsible by considering more sustainable solutions where possible. Procurement policies and services, hazardous waste management and energy related choices are amongst the activities that will require the most attention. Initiatives and accountability are encouraged at field and HQ level to translate ths commitment into concrete operational innovation and policies.

## 17. WE WILL THINK AS A MOVEMENT AND ACT AS AN OC

The movement faces significant future challenges. We have not been able to create sufficient space to respond to the second biggest ever Ebola epidemic in DRC. We are being investigated for supporting terrorism by Turkish authorities. We continue to be co-opted into counter-terrorism operations in contexts such as Nigeria. Our ability to successfully negotiate access with states and non-state actors continues to be challenging. Our difficulties to attract new supporters poses constraints to our future growth. We have had a significant deficit of strong public positioning on key medical humanitarian concerns. In the global health arena, actors are withdrawing from HIV and TB. While in epidemic responses, the World Bank and others are now pouring money into emergency responses that crowds our operating environment. Our focus as MSF has been on our internal functioning, which has dominated our collective thinking.

While this may have been needed, we need to put our operational challenges back at the centre of our intersectional collaboration. We should welcome each OCs new operational approaches and initiatives, we should reinforce our sharing of analysis and information and allow for minority positions to be expressed publicly.

Intersectional collaboration is not an end in itself, but it is a means to better serve our patients. In the right framework, MSF has the potential to overcome most challenges due to its global resources, skills and expertise. With 30+ entities and missions in over 70 countries, the movement has an incredible richness of differences that should be nurtured for the benefit of MSF's activities in the field.

Effective intersectional collaboration will require us to move away from a consensus driven decision-making model into a model where space for different approaches, priorities and sensitivities related to their immediate environment is maintained. We need to accept that there is often more than one approach possible and sometimes desirable. The important need to optimise resources should be carefully balanced with the essential need for new ideas, approaches or tools to emerge.

As an OC we will not block another OC from operationally intervening in a context in which we work, even if it is to address the same needs in a different way. We commit to an approach of "letting go and less ego".

When it comes to OCB participation in international projects, we value mutualisation and optimisation and we will cultivate this mindset. We have participated in a number of important international and intersectional projects that have delivered good results. However, we cannot absorb too many international or intersectional projects at the same time. In the future, OCB may choose not to opt-in or to opt out from initiatives without blocking others to progress and move forward.

The changes we hope to bring by placing the project at the centre of our decision making and the investment in regional operational hubs will require a continuous reflection on the governance and architecture of OCB. Commitment exists to improve our accountability towards the OCB board, where the diversity of our group is well represented, and toward the movement as a whole. The positive functioning of our group as a diverse collective of opinions and approaches is essential, as is the fruitful collaboration with all MSF entities.

## 18. WE WILL CONTINUE TO STRENGTHEN THE ASSOCIATIVE NATURE OF OUR ORGANISATION

To achieve the ambitions of these strategic orientations, we need a vibrant association that is able to debate and engage with our operational challenges. The healthy foundation of our movement is the associative nature which feeds our reflections and improves the quality of our choices. It is an essential part of our internal accountability. We encourage associative initiatives in the field for people to associate around our operations, contribute to better quality of the projects and be able to engage in local humanitarian initiatives. We also want to remain engaged with associative members in countries we leave, these connections have been very useful in helping to monitor humanitarian situations in these countries as well as in starting operations in case of increasing needs. A good example of that is our active member-group in Liberia.

'The highest governing body of the OCB group and its associations is the OCB Board which is given this mandate on a yearly basis at the OCB Gathering. The OCB board provides guidance and support for the Executive, while carrying the overall accountability and oversight for our operations. Within the OCB group, both the executive and associative collaboration and co-ownership of the operations will be further strengthened. Overall, OCB will continue to improve communication and links within the group between the partner sections (including the second partnership sections) to ensure a real co-ownership of the OCB operations.

Associatively, MSF Lebanon for instance will be further supported in its development of one informal associative dynamic in the Middle East with a direct link to the OCB board and the international movement. This includes the creation of an informal association that will be the counterpart of the executive in the Beirut office. The election of representatives of such an association will then play the role of a board that could also start attending and contributing to the OCB board and the IGA.

The OCB board has also created a field representation on the board in order to strengthen the link with our front-line workers and to ensure their involvement in the different associative debates that impact them.

Overall the OCB board will continue to speak and act in favour of a greater diversity across the movement in order to see new voices joining the MSF international association. This will start with the delegation of some IGA-reps position to non-represented regions at the IGA. For exampleIn particular an MSF-B IGA-rep position will be taken up by one representative of the Middle East region. In the coming period, the question of the IGA composition and its pertinence should be re-opened to ensure that our associative governing bodies are truly representative of our field realities.


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# CONCLUSION

## REACHING THE PATIENT – OVERCOMING OUR INTERNAL AND EXTERNAL BARRIERS TOGETHER

Within the contexts in which we work, we can see that limits are clearly being placed by states on who is considered to be an acceptable patient. Those that go beyond these limits, by treating the 'undesirables', are often criminalised and attacked. Non-state armed groups, communities and civil society are often rejecting our actions.

We will resist these trends by constantly seeking to save lives and alleviate suffering and in so doing, challenging the structures of exclusion that face the patients we treat. We will seek to better engage with those state and non-state actors who reject us.

This era of medical humanitarianism requires a fundamental shift in how we engage with patients, communities and our supporters. We cannot hide behind a misinterpretation of neutrality as an excuse not to engage with the polarised political environments of societies in which we fundraise and places of operations. We need to be willing to take bold positions that will sometimes complicate our relationships with governments or alienate certain individual donors. We need to navigate this environment and take risks both in our operational positioning and in our public voice.

It is time to shift our attention from a period of intense focus on ourselves toward using our collective resources to navigate our external environment in order to reach the most vulnerable and excluded.

Fulfilling these operational ambitions requires us to evolve pragmatically. We will make changes to our set-up and approach to bring our decision making closer to the patients. We will build support structures closer to where expertise exist that is based on first-hand experience. We will diversify our workforce to ensure we are adequately equipped with the range of perspectives needed to overcome the obstacles that we face.





# ACRONYMS

**ABR**: Anti-Biotic Resistance
**AIDS**: Acquired Immune Deficiency Syndrome
**AMR**: Antimicrobial Resistance
**BRAMU**: Brazil Medical Unit
**DRC**: Democratic Republic of Congo
**DRTB**: Drug Resistant Tuberculosis
**EPI**: Epidemiologist
**FrC**: Field Recentralisation
**Garec**: Group for Advice and Research into Ethics and Conduct
**HCV**: Hepatitis C Virus
**HIV**: Human Immunodeficiency Virus
**HQ**: Headquarters
**HR**: Human Resources
**iCCM**: Integrated Community Case Management
**ICT**: Information and Communication Technology
**IHL**: International Humanitarian Law
**IPC**: Infection Prevention Control
**IPD**: In-Patient Department
**LGBTQ**: Lesbian Gay Bisexual Transgender Queer
**NCD**: Non-Communicable Diseases
**NGO**: Non Governmental Organisation
**OCB**: Operational Centre Brussels
**OCBA**: Operational Centre Barcelona
**OPD**: Out-Patient Department
**OSU**: Operational Support Unit
**PHC**: Primary Health Care
**RSA4**: Resource Sharing Agreement 4
**ROI**: Return on Investment
**SAMU**: South African Medical Unit
**SGBV**: Sexual Gender Based Violence
**STI**: Sexually Transmitted Infection
**TB**: Tuberculosis
**VoT**: Victims of Torture
**WASH**: Water Sanitation and Hygiene
**WatSan**: Water and Sanitation

OPERATIONAL CENTRE BRUSSELS

# STRATEGIC ORIENTATIONS 2020-2023

**COLOPHON**

**Médecins Sans Frontières - OCB**
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MEDECINS SANS FRONTIERES