



25 Years of Medical Humanitarian Action

Leslie Shanks

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List of abbreviations:

ACT	Artemisinin combination treatment
AIDS	Acquired immune deficiency syndrome
AP	Annual Plan
ARV	Antiretroviral
ART	Antiretroviral therapy
CAME	Campaign for Access to Essential Medicines
CMT	Country management team
DD	Demand driven
DNDi	Drugs for Neglected Diseases initiative
DOTS	Directly observed treatment short course
DRC	Democratic Republic of the Congo
EPH	Emergency public health
ERB	Ethics review board
HA	Health advisor
HAT	Human African trypanosomiasis
HEP course	Health emergency preparation course
HIV	Human immunodeficiency virus
HoM	Head of mission
HQ	Headquarters
IDP	Internally displaced person
KA	Kala azar
KNCV	Koninklijk Nederlandsche Centrale Vereeniging
MAM	Moderate acute malnutrition
MedCo	Medical coordinator
MDR-TB	Multidrug-resistant tuberculosis
MH	Mental health
MoH	Ministry of Health
MSF-B	MSF-Belgium
MSF-H	MSF-Holland
MSF-OCA	MSF-Operational Centre Amsterdam
MT	Management Team
MTP	Medium term policy
NGO	Non-governmental organisation
OD	Operational director
PHD	Public Health Department
PMTCT	Prevention of mother-to-child transmission
PTSD	Post-traumatic stress disorder
QC	Quality control
RDT	Rapid diagnostic test
RH	Reproductive health
RHU	Refugee Health Unit
RUTF	Ready-to-use therapeutic food
SAM	Severe acute malnutrition
SFP	Supplementary feeding programme
STI	Sexually transmitted infection
TB	Tuberculosis
TFP	Therapeutic feeding programme
UNHCR	United Nations High Commissioner for Refugees
VCT	Voluntary counselling and testing
Watsan	Water and sanitation
WHO	World Health Organization
WHS	Water, hygiene and sanitation

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Goma, Kibumba camp, Rwandese refugees. Photo: © Henk Braam

On 6 April 1994, President Habyarimana of Rwanda and President Ntaryamira of Burundi were killed when their plane was shot down as they returned to Kigali from talks in Arusha. The genocide following the plane crash was masterminded by extremist politicians intent on manipulating tensions between Hutus and Tutsi in order to decimate the opposition. By June 1994, an estimated 500,000 to one million people had been massacred. On July 4 1994, as RPF took control of Kigali, defeated government officials used radio broadcasts to invoke hysteria about the likely retribution for the crimes committed and incited the population to flee, thus prompting the fastest refugee exodus in recent history. Among the refugee population were many of those responsible for the genocide. In less than a week more than 700,000 people crossed the border into Zaire, creating a humanitarian disaster on an unprecedented scale. Cholera and dysentery and dehydration due to lack of water quickly swept through the crowded camps and within one month an estimated 50,000 refugees died.

25 Years of Medical Humanitarian Action

MSF-Holland was 25 years old in 2009. The anniversary was a fitting time to look back on a quarter century of medical humanitarian action. A conference in September 2010 brought together experts to identify the lessons learned and the future challenges and adaptations needed by humanitarians to continue to operate in a changing environment.

MSF's international movement is debating governance models in order to manage the unprecedented growth of the organisation and to adapt to evolving external changes. Within MSF-H, out of which grew the MSF-Operational Centre Amsterdam (MSF-OCA), there is also a period of strategic planning. Some in MSF-OCA suggest that the organisation needs to re-invent itself. Others insist that the needs and reasons for it continue to exist as starkly as they did in 1984. At this key point in the organisation's history, it is instructive to look back at the years of medical humanitarian assistance, to review how the organisation has adapted medically to the external and internal challenges, and to learn from both the successes and failures. This paper does not aim to be a full history of the organisation nor review the geo-political context in which MSF-H works; rather it attempts to look through a medical lens at the past 25 years of medical action by MSF-H.

The beginning

Médecins Sans Frontières was started in 1971 by a group of French doctors and journalists frustrated by the inability of the International Committee of the Red Cross to respond effectively to the crisis in Biafra. It was the first independent non-governmental organisational focusing on bringing emergency medical aid. The success of the French doctors led to new MSFs starting in Belgium and Switzerland

in 1980. A group of Dutch doctors working with the Belgium and French sections came together and decided to start a Dutch section of MSF. The first office was in the basement of a house belonging to the mother of one of the founders. Initially the group recruited doctors to work with MSF-Belgium (MSF-B), sending their first doctor to Chad in 1984 to respond to the havoc wreaked by war, drought and famine. Soon the new section took on its own projects and missions.

Early days: 1984-88

The first MSF-H independent project was a response to cholera in Somalia, in the Gannad refugee camp, under the overall country direction of MSF-B. The Dutch team of three doctors, three nurses, a medical coordinator and logistician arrived with 15 tons of medical supplies. The camp consisted of makeshift shelters, had little drinking water and no latrines. The team set up a cholera treatment centre, installed a mere five latrines and got to work. It took two-and-a-half months, but the cholera was brought under control, at which point the team moved on to provide general medical services in the camp.¹

The first entirely independent mission was to Sudan in 1985 - a country where MSF continues to work 25 years later. The call was in response to a famine in north Darfur. MSF was charged with providing

supplementary feeding. There was little practical experience among the team in providing this, and the logistical challenges of reaching remote villages were great. Unfortunately the Dutch teams arrived just as the peak of the famine was over. Nevertheless the team enthusiastically distributed sugar, dried skimmed milk powder and oil to all villages where more than 10 percent of the children were malnourished. Soon it was recognised that the nutritional emergency was over, but the team had become aware of the abysmal state of the healthcare centres in the villages and proposed to rehabilitate them. This idea was hotly debated in Amsterdam, since it was outside the strict emergency mandate of the organisation, but it was eventually approved. At a board meeting in April 1986, it was officially agreed to add rehabilitation projects to MSF's emergency assistance role. Darfur was given the go-ahead for a rehabilitation project to train healthcare workers, equip health centres and provide medicines. The strict condition was that the project was to last only one-and-a-half years. The project ended up demanding significant technical support and expertise from Amsterdam, and was one of the main responsibilities of the first member of the Medical Department. Despite the strict timeframe given by the board, it was not closed until 1990.

Several of the earliest projects were responses to natural disasters under the

¹ Haan A, Lute E, Bender R. 10 years Emergency Aid Worldwide. Médecins Sans Frontières 1994; p. 17.

umbrella of MSF-B. In 1985, news of an earthquake in Mexico City prompted MSF-H to send out an immediate assessment team. Within 72 hours, a Hercules plane took off with a surgical team, medicines, tents and two vehicles. By the time the team landed, the immediate medical emergency was over and Mexican doctors had the situation under control. MSF intervened temporarily - working on water supply and giving support to health structures - but the mission did not get established much beyond an assessment mission.

Two months later, the Nevado del Ruiz volcano in Colombia erupted, leading to a mudslide that buried an entire village and made 20,000 people homeless. Two days later a charter plane left Europe with 22 tons of supplies. This time the team was able to start work immediately. A makeshift hospital with dispensary and operating theatre were set up in a building on a coffee plantation. MSF was the first emergency aid organisation on site, and was able to respond to major needs.

Still the evaluation of these responses to natural disasters was not wholly positive in Amsterdam.

In terms of publicity, these were highly successful missions. Logistics in Europe were also successful. Less successful: coordination with Belgium and the late arrival and inadequate preparation of the team. As a result, we hardly did anything. Lesson for later: set up a stand-by emergency team that is ready to leave in less than 12 hours.²

These minutes reflect a number of themes to be repeated and developed over time: the difficulty in responding to medical and surgical needs in natural disasters when MSF is not already on the ground, and the challenges of coordination with other MSF sections. Three other major natural disasters would be responded to in MSF-H's first five years: flooding in Sudan (1988), a hurricane in Nicaragua (1988), and an earthquake in Armenia (1988).

Armenia was the first mission in the Eastern Bloc and is remembered best in some quarters for its dialysis project. On request of an Armenian hospital, kidney dialysis machines and supplies along with nephrologists from Dutch hospitals were flown in to deal with the kidney failure secondary to crush syndrome. As one expat present remembers it, it was "disastrous". This was the first and last time the Dutch section would attempt to provide dialysis in an earthquake response.

Two events in the early days forced the organisation to examine the principle of neutrality and the responsibility of medical people faced with gross human rights abuses to speak out. In 1987, two MSF doctors working in Wau in southern Sudan in the midst of the war found themselves witness to a massacre of the Dinka by government forces. As one of the doctors wrote:

"Everything God and Amnesty International have forbidden is happening here with a vengeance. Every Dinka has become a legitimate target for attack."³

The security was so poor that one doctor escaped through the war zone and the other was evacuated by air to Khartoum. There was fierce debate in Amsterdam over what to do. There was no possibility of remaining silent about such massive abuses, and yet there was a serious risk that denouncing them would jeopardise other MSF projects in north Sudan. In the end, MSF gave eyewitness accounts to a journalist whose report, Sudan's Secret Slaughter, was published and MSF was able to continue operating while the world was alerted to the situation in south Sudan.

The second event was the poison gas attacks on Kurds by Saddam Hussein in 1988. MSF heard from several sources of a terrible attack in northern Iraq targeting the Kurdish population. The presidents of MSF-H and MSF-B investigated and found a horrific situation:

"It was a ghost town. There were dead people everywhere, civilians who had met sudden death in the middle of their daily activities... Their faces, lips, and nails were blue. We estimate the number of direct victims at anywhere between a thousand and five thousand."⁴

The judgment was that there had been a poison gas attack, using cyanide and mustard gas. Samples were taken to verify this at Ghent University. They confirmed the use of gas. A response was mounted for the survivors and a press conference was called. For the first time MSF-H publicly denounced a regime for the atrocities witnessed. Within the MSF-H office, this move provoked fierce debate about the compatibility of public denunciation with the principle of neutrality. Some resolved this dilemma pragmatically by concluding that neutrality is less a principle and more a means by which to achieve access to populations in need.

This discussion was also taking place internationally. The first version of the MSF charter stated that MSF should avoid being engaged in a government's internal policy and field volunteers should not publicly voice their opinions on what they had seen⁵. The French had already abandoned this principle in practice and fought for a change in the charter in the first formal international meeting of the six MSF sections held in Toulouse in 1989. The Dutch initially resisted, but eventually agreed to an amendment. The confidentiality clauses were deleted from the charter, and while there was no mention of an obligation to speak out, it was no longer prohibited. Ironically, 20 years after the charter was so decisively changed, MSF found itself agreeing to sign confidentiality clauses in its memoranda of understanding with governments such as Sri Lanka in order to continue its medical activities. Again there was heated debate, but this time the clauses were accepted.

The early projects consisted mainly of delivering basic healthcare, including vaccinations, surgery, malnutrition and

2 Ibid. p. 24

3 Ibid. p. 27

4 Ibid. p. 30

5 The second principle of the original charter reads: All doctors and nurses working for MSF shall maintain professional secrecy. They shall refrain from publicly expressing any opinion in respect to the situation in any of the areas where MSF is operating.

responding to outbreaks. The response then was less comprehensive than today's, and much less standardised. Doctors would sometimes see up to 200 patients a day, handing out large quantities of antimalarials for fevers, basic antibiotics for respiratory infections and paracetamol for aches and pains. Teams were very independent in determining what kind of programmes to offer and how to deliver them. This was seen positively, particularly in terms of project development, as the teams were free to innovate in order to meet the needs in front of them.⁶ The independence of the teams was based on several practical realities - the logistical difficulties of communicating with headquarters, and the lack of headquarters staff to back up the teams. In 1987, there were just two project managers, both physicians, who were responsible for supporting all of the field operations.

On the other hand, medically some teams were floundering:

*"In Uganda, we were suddenly faced with malnutrition and had to design a response to that all by ourselves. We were literally inventing the recipes for the supplementary feeding programme."*⁷

Projects like the rehabilitation of health centres in Darfur demanded more expert support. A medical working group consisting mainly of returned field volunteers acted as a kind of think tank and resource to the project teams. They drafted several papers for the project teams on topics such as immunisation and were able to respond to questions from field expats.



Turkey refugee camp.
Photo: © Jan Van Veen

Refugee camp 'Isikveren' for Kurdish refugees, fleeing Iraq after the Gulf war. Doctor Henk Hammer is working as a volunteer at the camp. In just a couple of days, thousands of tents appeared on the mountain sides near the Turkish-Iraqi border. About 55,000 Kurds were fleeing from Saddam Hussein's troops. For MSF this operation was one of its biggest since the creation of the movement.

⁶ Interview Barbara Lopes-Cardozo, Founding Member MSF-Holland

⁷ Interview Riekje Elema, Health advisor, 30 July 2010

An early MSF-Holland Intervention Biyoley Refugee Camp: 1986-87

Gannad refugee camp in North West Somalia (now Somaliland), was the site of the first MSF-H project in 1984. In October 1985, a further influx of refugees led to the decision to relocate the camp into three new sites. MSF-H was asked to work with the Somalia government's Refugee Health Unit (RHU) to implement medical activities in one of the new sites in Biyoley.

In coordination with the RHU, the MSF-H team planned and implemented medical and nutritional activities for the population of 27,000 refugees. Services included outpatient care, maternal child health, an overnight observation centre, a TB clinic, two intensive feeding centres and three supplementary feeding centres. Referral services were available in nearby cities for medical and surgical emergencies. A visiting eye team held weekly clinics and identified cases of cataract for surgery in a nearby city. An MSF-H administrator also requested funding to install playground equipment in the camp. His proposal included hand-drawn pictures of swing sets, slides and a wooden donkey mounted on a metal spring.

The tuberculosis programme was transferred over from Gannad Camp. In its first months, 150 patients were under daily observed treatment in the clinic. Defaulter tracing was done by community health workers. Standardised reporting on outcomes was not done, but few defaulters and deaths were recorded in the medical reports.

Nutritional deficiencies were a serious problem. The refugees were dependent on the food ration distributed by the World Food Programme. In the antenatal care programme, in one month there were 10 maternal deaths attributed to anaemia. A randomly selected group of 60 children revealed 90 percent to be anaemic with haemoglobin under ten grammes. MSF-H lobbied for the food ration to be improved to include minimal quantities of iron, and for routine supplementation with iron tablets be done for high-risk groups. In the feeding programmes, iron sulphate powder was added to the milk. A 'liver programme' for pregnant women was piloted, and results showed that women supplemented with fresh liver doubled their haemoglobin in a period of one month.

Cases of bleeding gums and painful swollen joints started to be seen in increasing numbers in the clinics. Scurvy, caused by a deficiency in vitamin C, had been a problem in the previous camp and was now present in the new location. A survey revealed over 40 percent of a thousand adults and children surveyed had symptoms of scurvy. Again, MSF lobbied for improvement to the food ration and for vitamin C distribution. Grapefruits were added to the general food distribution, with some limited improvement.

The basic laboratory was able to do malaria slides and stool examinations. A nine-year-old chronically ill boy was discovered to have eggs of *Schistosomiasis mansoni* in his stool sample. The disease had never been identified before in Somalia, yet several more cases were identified by the laboratory. The findings prompted an

examination of the river running through the camp for the intermediate host, a specific type of snail. MSF-H sent the specimens to the London School of Hygiene and Tropical Medicine, where they confirmed the snails to be the correct species for hosting *Schistosomiasis*. A total of 86 cases were subsequently identified and treated in the camp. The MoH alerted WHO to the finding to help stop the new disease spreading to other parts of the country.

The objective of starting the intervention in the new camp was to hand over all medical activities to the RHU. In April 1987 this was achieved, and MSF-H left the camp to take on support to secondary level medical services in the nearby centre of Sheik. It would be MSF's first surgical programme.

Source: Project progress reports, Survey Reports, Medical Reports.

The desire to professionalise MSF's medical response started to be discussed in earnest during the development of the first strategic planning document, *1987 and beyond*. It speaks of the need to evaluate the medical quality of projects in terms of effectiveness: namely vaccination percentage, access to medical services, medical consumption, mortality and morbidity numbers, etc.⁸ This move towards being more professional provoked a debate in the organisation from those who felt that it clashed with the volunteer spirit of the organisation. Up to that point, expatriates had been recruited through word of mouth, had no formal entry criteria to meet, and did not receive any preparation or training. Improving the quality of the staff was felt necessary for increasing professionalism, which would necessitate bringing in salaries that were in line with the Dutch labour market. The decision was made to move away from the 100 percent voluntary nature of the organisation and pay salaries to coordinators. And in 1988 the decision was taken to replace the voluntary medical working group with a medical department in order to ensure a higher quality of technical support.

Moving towards professionalism and standardisation

The new Medical Scientific Department consisted of a medical doctor, a temporary assistant and a librarian. The primary tasks as set out in the 1989 annual plan were to design and organise a new training scheme for volunteers going on their first mission, to provide substantive support to the north Darfur rehabilitation project, to advise other projects, and to manage professional contacts.⁹

The Health Emergency Preparation course, or HEP course as it came to be called, was delivered to all first-mission medical staff. It covered topics such as the use of oral rehydration solution, how to implement a disease surveillance system and how to respond to disease outbreaks. It also included sessions on how to change a tyre, supervise staff in a cross-cultural environment and cope with

conflict within the team. The inevitable scenarios presented under the topic of working as a team were the effects on team dynamics of a romantic liaison between the logistician and the driver, and what to do when a team member brings home prostitutes.

The course was the first of many developed by MSF-H, first by the Medical Scientific Department and later by the new training unit. Early courses were on nutrition, vaccination and management. As the medical programmes become more complex, the range of courses expanded. Many were intersectional, but MSF-H made an early investment in developing courses and technical trainings.

Kala azar

In 1988, the MSF team in Sudan found itself responding to an outbreak of an unknown disease. The first patients were seen in a camp for displaced southern Sudanese outside Khartoum. Symptoms were fever, extreme weight loss, anaemia and enlarged glands. The standard treatment MSF was providing was not working. One of the doctors realised that they were dealing with kala azar (visceral leishmaniasis). This was the beginning of MSF-H's commitment to controlling and treating kala azar. The patients in Khartoum had travelled miles from West Upper Nile region, where a devastating outbreak of this parasitic disease, transmitted by sand flies, was decimating the population. MSF-H was working in Ler, West Upper Nile, and soon realised that it too was seeing signs of this deadly disease.

"New patients are coming in daily: hobbling with a stick or carried by relatives on an improvised stretcher. Some had to walk for days, trudging through mud or wading through rivers. Severely malnourished, often reduced to mere skin and bones.. they are first given injection therapy, lasting 30 days or longer. Imagine daily getting a painful injection and having to swallow flagyl pills, which give you nausea and you understand that a discouragingly high percentage (20 percent) of the patients don't survive. On the other hand this leaves 80 percent who wouldn't have otherwise survived..."

Excerpt from a letter, Mieke Knoppers quoted in Haan, A. Lute, E, & Bender, R. (1994) Médecins Sans Frontières. 10 years Emergency Aid Worldwide, p. 86

The initial challenges of responding to kala azar in south Sudan were linked to security and logistics issues. The Khartoum government banned aid agencies in the south of the country, and MSF-H was one of the very few agencies working in true 'sans frontières' fashion. Access was by chartered plane, which flew into south Sudan illegally to transport personnel and drugs. When the outbreak first hit, the teams on the ground thought that it was typhoid and flew out blood samples for Widal testing. The plane with the samples did not make it back to Kenya. Months later the wreckage of the plane and the body of the pilot were found. When the outbreak was finally confirmed as kala azar, the teams responded by flying in the expensive drugs to treat the disease that otherwise had almost a 100 percent mortality rate.

Realising that kala azar was the main health threat to people living in the region of West Upper Nile, MSF scaled up its clandestine interventions. Teams travelled on foot to the remote villages, often setting up a clinic under a tree. Starting in 1991, workshops were organised with international experts to share experience and develop a research agenda. As MSF gained recognition externally with WHO/UNICEF for its work with kala azar, it was decided to risk a public statement. The Sudanese government did not retaliate and, from then on, the response to the epidemic in the south was done openly. Between 1989 and 1995, 19,000 patients were treated as part of the response to the outbreak in south Sudan¹⁰. Sadly, those treated represented only a fraction of those infected with the disease, as the population was not immune to kala azar. An MSF mortality survey suggested that since the start of the outbreak in 1984, an estimated 38-57 percent of the population had died. In absolute figures this represented approximately 100,000 people¹¹.

8 "1987 en verder..." Beleidsnota mei 1987. Artsen zonder Grenzen. p.9.

9 Annual Plan 1989

10 Seaman J, Mercer AJ, Sondorp E. The epidemic of visceral leishmaniasis in West Upper Nile, southern Sudan: course and impact from 1984 to 1994. *Int J Epidem* 1996; 25(4): 862-871.

11 Griekspoor A, Sondorp H, Vos T. Cost-Effectiveness Analysis of Humanitarian Relief Interventions: Visceral Leishmaniasis Treatment in the Sudan. *Health Policy & PI* 1999; 14(1): 70-6.

Evolution of the Medical Scientific Department

The Medical Scientific Department was created in 1988. The early team was made up of just one doctor, an assistant and a part-time librarian. Shortly after, a part-time training position was opened to develop the HEP course for new medical recruits.

The 'scientific' label had dropped off by 1991, leaving it as the Medical Department. Each individual medical scientific advisor, the precursor to the health advisor, had a topic area they supported, such as malaria, anthropology or surgery. The first specialist position was a nutritionist in 1991, followed by a mental health specialist in 1997. Gradually other specialists joined including an HIV advisor, lab specialists, epidemiologists, etc.

The first pharmacist started in a position called 'medical logistics' in 1994. His role was to ensure the quality of pharmaceutical, food and laboratory items supplied and used in the field. During the period of large-scale drug distribution programmes in the 1990s, the position was

supplemented with an additional pharmacist. The medical logistics position was later phased out and replaced by a full-time pharmacist.

Water and sanitation was considered a key pillar of the emergency public health (EPH) response. The first position was opened in 1989, and supported both watsan and construction while based in the Logistics Department. Relative to other specialist advisor positions, the number of watsan positions grew quickly. In 1998, the 3 person unit joined the Medical Department. The controversial move reflected recognition that watsan programming was a public health intervention and not merely a technical subject. It was not until 2008 that field responsibilities shifted to mirror the departmental logic, where the MedCo assumes responsibility for watsan programming from the LogCo.

The Humanitarian Affairs Department also merged with the Medical Department in 1998. The new department - composed of the Medical Department, Humanitarian Affairs Department and the Watsan Unit - was renamed the Public Health

Department (PHD).

The PHD grew to include positions based in other sections in response to the move towards sharing operations amongst the four sections making up the Amsterdam group. The ambition was to bring the delegate offices - which were responsible for recruitment, fundraising and communications - closer to the field operations. One means of doing this was to put medical expertise in the section. The Manson Unit in the UK was created to implement new treatments for emerging and re-emerging diseases. The first focus was on malaria and ACT. The Canadian office, over time, attempted to put medical advisors in Canada, notably an HIV advisor previously working in Amsterdam. Another model of sharing operations was to move one of the operational cells from Amsterdam to the partner sections. Berlin was the first section to do this, followed by Toronto. This led to health advisors being based in Germany and Canada. Currently the PHD with the Manson Unit has over 30 staff spread over four countries.

The neglected nature of the disease, the fact that it attacked a population affected by years of war and which was geographically isolated, the long painful and expensive treatment regimens and the difficulty diagnosing the disease all called for a major engagement by MSF. It would not work to wait for big pharma or Western experts to do this work - if MSF wanted to see the care of their patients improved, they would have to do it themselves. In the early days, any research was frowned upon and felt not to be MSF. The medical teams persisted, however, and now more than 40 publications have been written on kala azar, the majority in peer reviewed publications. This body of work includes major innovations on diagnostics that allow for screening large numbers of patients and avoiding invasive

parasitological tests, as well as support for decentralising services to the peripheral level. Vector control trials demonstrated the feasibility of mass distribution of insecticide-treated bed nets to control outbreaks of disease. A clinical trial addressed the safety and efficacy of the generic formulation of the antimonial drug used to treat kala azar in East Africa, allowing huge improvements to the affordability of treatment in East Africa. Improvements in treatment regimens trialled included the use of combination therapy to decrease mortality and shorten treatment courses. New drugs were successfully evaluated for use in severe and complicated kala azar. Finally a body of work advanced the knowledge and treatment protocols for patients co-infected with both kala azar and HIV.

MSF in the 1990s: emergency public health

The ABC discussions

The external environment changed radically in 1989 with the end of the Cold War. The nature of conflicts shifted to more internal civil wars, and humanitarian action became more complex to negotiate. The early 1990s saw unprecedented organisational growth linked to the increased demand for MSF-H to intervene in emergency situations in the post-Cold War environment. The demands placed on the organisation to respond and manage this increased portfolio of projects, and concerns about the quality of projects, led to what became known as the 'ABC discussions'.

The 'ABC discussions' were essentially a typology of projects. 'A' projects were acute crisis situations including disasters, acute conflict and refugee movements. The time-frame for A projects was a maximum of three months. 'B' projects were chronically unstable areas that could lead to a maximum 18-month intervention. 'C' projects were development. In May 1991, there was a decision to focus exclusively on A and B projects and scrap C projects altogether.

These longer term structural and rehabilitation projects were seen as demanding a different type of expertise, on a different timeline, that distracted the organisation's attention from high-priority emergency assistance and confused the public's image of MSF. To take over the abandoned C projects, it was decided to create a new organisation, HealthNet International, to handle MSF projects as they passed from the emergency into the transition phase.

The ABC discussions and decisions resulted in a strong focus for MSF in the coming years on emergency medical assistance. From the point of view of the other MSF sections, it was often seen as too rigid a focus. However it did give a clear direction to the organisation, and allowed the still fledgling Medical Department to give priority to emergency assistance over the more complex, longer term C projects.

Emergency public health

The strategy document *MSF Holland in the 1990s: Decisiveness, Involvement and Independence*, written in 1993, mentions for the first time the concept of emergency public health (EPH). It was the logical extension of the ABC discussions and the prior choice for the speciality of medical aid. In the strategic document, EPH is defined as one of three core competencies of MSF-H, together with logistical decisiveness and deployment of flexible, sufficient and committed staff. In

the years following the strategy document, the Medical Department worked on further developing the concept of EPH. A 1995 document¹² describes the core concept:

In contexts of socio-political instability or reduced health infrastructure delivery capacity, EPH activity offers a targeted health intervention focused on risk reduction in acutely vulnerable populations, with a view to bridging public health and health service capacity for that population. This concept includes access to a population or population access to health care, health services to a population, and advocacy for a population at risk.

The key difference with public health is the context. The focus is on the urgency, scale and priority of health needs by vulnerable groups. The intervention is aimed at ensuring that basic human needs (water, sanitation, shelter, food, curative and preventative medical care, and safety and security) are met. Effectiveness is to be evaluated by reduced morbidity and mortality instead of cost and other measures used to evaluate usual public health interventions.

"It is not different from public health; it derives from it. What is different is the context in which public health principles and practices are applied."¹³

"EPH is kind of paradoxical in that we use public health strategies designed for stable environments over the long term for unstable environments over the short term. Another dimension is that we use these public health strategies in combination with curative services. We need to do this maximise impact."¹⁴

The EPH concept was influential in the period from 1993 to 2002. The primary emphasis - on context and only secondly on health needs - is one that continues to distinguish MSF-H from other sections. The rationale is on giving priority to the higher degree of suffering which comes

from a deliberate attack on a population in the context of war or deliberate exclusion which overlaps with the health needs created.

"Epidemic or pandemic disease in the context of social instability or complex humanitarian disasters is an EPH priority. We need to think about diseases like diphtheria, TB, AIDS, malaria and others in terms of their context. If that context causes an increase in incidence or prevalence, then they become EPH priorities."¹⁵

The choice of a target population is identified by their specific vulnerabilities as shaped by the context:

"An emergency is not necessarily a random event, but its effects are targeted to the most vulnerable, or create vulnerable groups. We need to ensure that our EPH interventions recognise the causes of vulnerability as well as the effects."¹⁶

The public health focus ensured that prevention and curative care were part of the response, and effect was measured as impact on overall mortality and morbidity of the population rather than the impact on individual patients. Implicit in the EPH strategy in the mid-1990s was the limit placed on the level and standard of care to the individual:

"When the health level of a vulnerable group matches surrounding levels, that is when we stop adding more resources."¹⁷

This is not to suggest that the quality of intervention is not important in EPH, as specific tools and a focus on evaluation were considered part of the package. However, it does implicitly accept the double standard of quality of care between the rich and poor countries - a double standard that in less than ten years would be a rallying call to change how malaria was treated, and to introduce antiretroviral therapy (ART) when the norm in AIDS programmes was condom distribution and palliative care.

12 Orbinski J. Emergency Public Health: An internal Qualitative Survey. Summer 1995; p. 3.

13 Ibid. p9

14 Ibid. p9

15 Ibid. p11

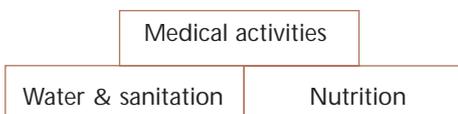
16 Ibid. p10

17 Ibid. p12

A new challenge for the Medical Department - due both to the changing geo-political balance as well as the ten-year-old organisation's potential for growth - was responding to large scale emergencies. The goal was to achieve quantity and, at the same time, high quality interventions all within a modest budget. Performing comprehensive assessments before interventions and having pre-packaged intervention models ready were critical to success for this new challenge.

A major achievement linked to this quest for high quality, high volume medical aid was the development of the medical kits for teams faced with a cholera outbreak. They could order from headquarters an off-the-shelf kit that included everything from chlorine to Ringer's lactate to rubber boots for the staff. In addition, manuals started to be written. One of the most important of these was the Refugee Health Manual. This pulled together the accumulated operational experience of MSF in one guideline, and famously defined the top ten priorities for refugee healthcare. It was published externally, and became widely used by both MSF and other humanitarian groups. It continues to be used widely today. The manual also represented the first real collaboration between the three large MSF sections. Where collaboration on an operational level was often difficult, the Medical Departments were able to work together positively and produce a truly joint project.

Non-medical props



From: "MSF in the 1990s: Decisiveness, involvement and independence". Policy Memorandum, MSF-Holland, 1993.

Nutrition and water & sanitation (watsan) are described as the pillars of medical activities in large scale disasters. Watsan was becoming increasingly important due to the inability of many traditional watsan NGOs to work in unstable contexts. The

1993 policy recommended a 'more prominent' position in MSF-H for these activities. Ten months later, MSF found itself responding to the world's largest refugee influx as the Rwandan genocide ended and refugees poured over the borders to Tanzania and Zaire. In the resulting cholera outbreak in Zaire, MSF responded with its biggest water trucking project in history, supplying two million litres of clean water a day to the camps¹⁸. In the same year, but a continent away, the watsan team installed 16 km of pipeline in order to ensure water supply to the Sharsahid camp in Jalabad, Afghanistan¹⁹. It was and remains the largest infrastructure project constructed by MSF-H.

Nutrition, though not seen as medical, had always been a large part of MSF-H's response. Initial activities were selective feeding programmes for the moderately and severely malnourished. Learning was very much by doing, and this accumulated experience was distilled into MSF's Nutritional Guidelines, published in 1994. They were used extensively in the field and were adopted by many organisations looking for practical advice. Gone were the days of each project inventing its own recipes for therapeutic milk.

Having developed protocols for the treatment of malnutrition, the organisation struggled with the dilemma of prevention. As with watsan, the organisations responsible for the large

scale general food distribution programmes - which were essential for keeping refugees and IDPs alive - were often not up to the job in unstable settings. This was having a significant negative impact on MSF's medical and nutritional programming. MSF-H did not feel that it had the expertise to perform these distributions itself, nor did it relish the idea of becoming a sub-contractor for the World Food Programme (WFP). For a time, the possibility of setting up a separate organisation for general food distribution was considered. MSF-France was already moving in this direction and had set up a new Food Aid Department. In the end, MSF-H decided against this route. Instead, a classification system for nutritional situational analysis was developed, which signalled when interventions were needed. This system was later taken up by the WFP and adapted for wider use. MSF-H concentrated on lobbying other actors for food aid using the classification system to signal alerts. Only when the lobby failed would MSF-H reluctantly consider doing general food distributions.

Mental health

In the late 1980s, the psychological impact of the experiences of field staff started to be recognised. In 1989 contact was made with the Dutch Institute for Psychotrauma to see what role MSF could play in supporting the mental health of staff and returned volunteers. A number of recommendations were made and,

"In Baghdad I was taken hostage with two other female team members. We were in Baghdad for a meeting and [our cab] somehow ended up in the Shiite district. We were suddenly set upon and pushed into the back seat. The attackers then got into the cab themselves, ordering the chauffeur to drive away. The chauffeur translated for us that they wanted to rape the women and kill us. We entered the desert and, after driving around for two hours, we entered Baghdad and were released. At the time, no psychological support was provided after an experience like this; there was no emotional debriefing. I was very confused by this incident. Months later I still couldn't talk about it. I also wasn't sure whether this kind of thing could be talked about at the office at all."

First time mission volunteer 1991. In: Haan, A. Lute, E, & Bender, R. (1994) Médecins sans Frontières. 10 years Emergency Aid Worldwide, p. 59.

18 Op Cit. de Haan. p103

19 MSF Operational Memory Project. Afghanistan and Pakistan. 1979-2005. p30.

despite resistance, the culture slowly started to change to make emotional support of staff less of a taboo. Information on stress reactions was included in trainings, while teams from the Dutch Institute for Psychotrauma started to provide direct support to teams who had undergone traumatic experiences. By 1992 a psychologist worked in the office to brief and de-brief expats²⁰ and, one year later, a peer support network was started.

The recognition of the emotional effects of trauma on MSF staff prompted an awareness of the mental health consequences of trauma for the populations helped by MSF. In 1990, MSF-H entered the Gaza Strip in order to establish a strategic presence in the Arab world and, during the exploratory mission, contact was made with a Palestinian psychiatrist, who needed support running a community-based mental health programme to help Palestinians cope with the mental trauma of the intifada. MSF sent several psychiatrists out to help support training and also supported an occupational therapy programme. The project was not a runaway success due to challenges working with the local partners, but it did meet many of its objectives. In HQ it received little attention and was eventually handed over in 1995.²¹

Nevertheless, on the basis of the Gaza programme and the experience of returning expatriates, one of the board members put forward mental health as a new programme area. The reasoning was that if expatriates could become so distressed by what they had seen and experienced, the refugees must be in much worse shape.

In 1993, an appeal came from the psychiatric department of the Kosovo Hospital in Sarajevo. The staff were overwhelmed with the caseload and requested help. A programme to provide psychotherapy by lay counsellors was

Objectives

The objectives of MSF mental health programmes are:

1. To give appropriate support/treatment to people suffering from PTSD;
2. To prevent PTSD and more severe psychopathology in the group that suffers from traumatic stress, through the support of the normal coping process;
3. To avoid unnecessary medicalisation of traumatic stress and PTSD-related problems by offering adequate information (psychoeducation), initiating self-help mechanisms in the community and support/treatment;
4. To promote the rights of, to create awareness of and to bear witness to those traumatised by violence.

Excerpt from the MSF-H Mental Health Policy 1998

developed. The overall objective was to provide support for those suffering war-related mental health trauma and to prevent severe psychopathology. Treatment was based on principles derived from brief trauma-focused therapy (Brom, Kleber & Defares, 1989; Foa, Hearst-Ikeda & Perry, 1995).

Counsellors came from a variety of professional backgrounds and were trained for three months by a team from Amsterdam. Through collaboration with Utrecht University, a database was created to track and monitor the clients of the programme. The efficacy of the interventions was monitored through application of standard psychological instruments²² at the start of intervention and on the final visit. The results were published in 2003. In terms of subjective general health status, 67 percent had either improvement or complete recovery, whereas in the domain of coping with traumatic experiences, only 38 percent either improved or recovered. Fewer than 10 percent experienced worsening of symptoms in both areas. These results are described by the authors of the paper as 'modest'. What is notable, however, is that the intervention model of the first mental health programme was so well monitored and documented. Given the newness of the programme, it was

important that, first of all, it was shown to be safe and not harmful, and secondly to show the efficacy of the intervention.

Fifteen years later, despite the explosion of popularity of mental health programming in emergency aid, there are few reports on outcomes of mental health interventions in the literature. Within MSF, the results of the Bosnian mission were influential in formulating the intervention approach for future mental health programmes. The ability to measure the results was also important in helping build scientific credibility for an area that for a long time was seen as soft.

The focus for MSF-H's future mental health programmes was determined to be trauma, in line with the strategic choice to focus operations in conflict and post-conflict areas. The initial policy paper, developed in 1998, defined the target population of mental health interventions as primarily the 20 percent of the population affected by post-traumatic stress disorder (PTSD) and secondarily the 80 percent of the population suffering from 'traumatic stress' and therefore at risk of developing the pathology²³. In time, the ambitions were scaled down to the more realistic objectives of relieving symptoms and improving day-to-day functioning.

20 (Summary) Medium-Term Policy Plan MSF Holland (January 1994)

21 Timmermans N. Internal Evaluation of MSF-Holland projects in the Gaza Strip, Occupied Palestinian Territories June 1990 - January 1995.

22 Mooren TTM, et al. The impact of a mental health programme in Bosnia-Herzegovina: Effects on coping and general health. *Journal of Clinical Psychology* 2003; 59: 1-13.

23 De Jong K. *Mental Health Policy* 1998.

The 1996 mid-term plan stated the ambition of MSF-H to become a leading expert in mental health care. Commitment was one thing, but actually opening projects was another. Uptake in operations of mental health programmes was not easy. In 1999, external evaluators assessed the barriers to implementation and recommended several options, including abandoning mental health and psychosocial programming altogether²⁴. The management team decided to go with the option of integrating mental health into regular MSF programmes. Mental health thus became part of a trio of 'non-medical' interventions associated with EPH, together with watsan and nutrition.

MSF sans médecins?

The focus on emergency public health, with curative care on the side, impacted on the profile of staff sent to the field. Most doctors and nurses recruited in the 1990s for MSF-H were told not to expect to lay hands on patients. Clinical care was to be done by national staff or Ministry of Health (MoH) partners. The expat's role was to put the intervention in place, and train and clinically supervise the national medical staff. The few 'lucky' ones who ended up doing clinical work were surgeons and those in the first-tier response to emergency outbreaks. The overall number of doctors and paramedical²⁵ staff in the organisation dipped from a high of 79 percent in 1985 to an average of 36 percent between 1992 and 1999 (see annex 5). This affected not just the composition of medical staff in projects, but also the number of medical and paramedical people in field coordinating positions. The 1994 PHD AP notes:

"In 1993 it became clear that the medical department-medical coordinator axis is becoming crucial in improving the quality of programmes, given the situation that more and more country and project managers do not have a medical background."²⁶

The decline in medical people in the organisation was not just in the field. Previously, operations - responsible for line managing all the field missions and taking the decisions on programmes -

were medical doctors. This started to shift in the mid-1990s, when it became less common for those making decisions to have a medical background. There is no evidence that this was an intentional shift, and the board at times emphasised the need for medical people in the positions of management. It is likely that the shift came about simply due to the proportional shift of medical to non-medical people in the field. A deliberate change was to remove the head of the Medical Department from the Management Team in 1993. It came as part of an organisational re-structuring that aimed to improve decisiveness and flexibility now that the focus following the ABC discussions was so strongly on emergency aid. With few medical operational managers and no formal medical voice in the management team, MSF-H earned notoriety as the section without medical people in decision-making positions.

Responding in Europe: Bosnia

The post-Cold War context alerted the organisation to the need to find ways to respond to crises in Eastern Europe. It would quickly be put to the test in Yugoslavia. MSF-H made a strategic decision to intervene in the region in 1991 before full-scale war in the region broke out. The first intervention was to work with the other sections to assist in evacuating wounded from Vukovar when it fell in 1991. The evacuation was dangerous, and three MSF expats were injured when a convoy hit a land mine. Immediately afterwards, the intervention moved to Bosnia. The pre-war assessment had predicted that the key needs would be drug supply rather than medical staff. In the early days of the war, MSF was the only major international NGO present in Sarajevo. On the day the siege started, MSF-H received its second shipment of drugs and supplies. These supplies proved critical to keeping the health system in Sarajevo partially functioning during the long months of siege.

Bosnia proved to be MSF-H's largest programme ever in terms of both expats and money. In 1992 and 1993, the mission accounted for 25 percent of the overall

operational budget, and 11 percent of expats. The main activity over the period of the mission from 1991 to 1997 continued to be drug distribution. Drugs, medical materials and logistical materials (including coal for psychiatric institutes) were supplied to hospitals and health centres on all sides of the various frontlines. Insulin supply programmes kept diabetics alive and, in a separate project, cyclophosphamide was procured for renal transplant patients who needed to continue on their immunosuppressant. The distribution programme started to be seen as being "out of control" and was criticised for being in contradiction to the medical identity of MSF, as it lacked proximity to the patients. To answer this, an evaluation was done in 1995 which concluded that the growth could be attributed to three aspects: needs, internal factors and availability of funds. In the early period, there was a clear justification in terms of needs. The strategy to meet these needs contributed to the growth of the project. There was a strong desire to reach the most isolated and vulnerable communities and, to ensure neutrality, to work on all sides of the conflict. The result was to target all of Bosnia that was accessible, and this resulted in providing support to health systems covering a population of 2,417,000. This wide geographic coverage provided access to a huge amount of information which was highly respected by other actors²⁷, and with that respect came a certain amount of influence.

In 1993, the medical officer in the Bosnian city of Tuzla recognised that a number of trauma patients had dysfunctional limbs due to a disruption of peripheral nerves. Although some could receive treatment in Tuzla itself, others were being evacuated out of the country for surgery. Meanwhile, there was pressure from HQs to 'do something medical', and the Medical Department was especially keen on the surgery idea. Externally, there was intense media hype around airlifts of individual patients for specialised care in outside countries. MSF opposed the airlifts of individual patients and felt that resources should instead be directed toward providing care in-country. Thus the specialist surgery programme was born.

24 A Study of the Operational Constraints and Opportunities for Mental Health Programmes within MSF-H. Queen Margaret University College, Edinburgh. March 1999.

25 Paramedical is used within MSF to refer to all non-physician health staff. It includes, among others, nurses, midwives, nutritionists, mental health workers, epidemiologists, laboratory technicians and pharmacists.

26 Annual Plan 1994, p. 36

27 Veeken H, Meijman B. An internal evaluation of the MSF distribution/ monitoring project in Bosnia (period Sept 1991- Sept 1994). January 1995.



Photo: © Sven Torfinn

Five teams of plastic surgeons and anaesthetic nurses performed 150 microsurgery operations in Tuzla in 1993-94. An orthopaedic team did a rotation but was not so successful. In Sarajevo, plastic surgery teams rotated throughout central Bosnia, and trauma surgeons worked on a rotating basis in war hospitals. The trauma surgery idea was quickly abandoned because the surgeons found their Bosnian colleagues were often not receptive to their assistance. It was also very complicated to prepare the visits due to the insecure areas they were working in.

The plastic surgery programme was successful in the sense that it provided highly specialised care to a group of patients with significant functional impairment. The numbers treated were small, but there was a morale-boosting impact for the population. However, in the office people remembered mostly the huge logistical effort to implement the programme, and the challenges of dealing with so many surgical

personalities. It was ten years before another specialist surgery intervention was attempted by MSF-H, this time for the facial mutilation perpetrated by the Lord's Resistance Army in Uganda. The Bosnian mission was the first response to a crisis in Europe. Most projects up to that point were in sub-Saharan Africa in settings with weak health systems. Bosnia required adaptation, not only in terms of a massively expanded drug list, but also in terms of attitude.

"Imagine yourself in the position of a Chinese healthcare team coming into YOUR hospital and demanding to treat YOUR patients. The chances are 99.9 percent that you would kindly tell them to bugger off and get the hell out!"²⁸

Despite the development of the Yugoslavian health system, there were gaps. Rational drug use was not understood, and prescribing habits were driven very much by demand. MSF did little to address the gap. Training was a

minor part of the distribution programme and even in the surgery programme, there was a hesitancy to impose knowledge or improved techniques on the Bosnian doctors. This is illustrated rather starkly in the awkwardly worded job profile for the expat trauma surgeons:

Follows up, as much as possible, the treatment protocols established by the surgical units of the hospitals, unless ethical considerations unable to do it. In such a circumstance, avoiding controversy by transferring the patient to local colleges is advised.²⁹

Even more fundamental than how to intervene in settings with functioning health systems, what Bosnia and other missions in Eastern Europe illustrated were the challenges to find relevant medical interventions in these settings. While the contexts fitted with the organisational priorities, often it was difficult to identify needs that MSF-H could address. The imbalance risked leading to projects that had little impact on the health needs of

28 Kiseljak quotes

29 War Surgeon/Surgical Support Programme to War Hospitals. Job Description.

the population, while, from an operational perspective, they were in places where MSF clearly needed to be present. This dilemma of a mismatch between context and medical needs continues to challenge MSF-OCA today.

Genocide, refugees and cholera

On 6 April 1994, the genocide in Rwanda exploded. MSF-H teams reduced dramatically in number as many members of the international staff were evacuated. A small team attempted to provide surgery in Kigali, together with the Red Cross, despite the impossible conditions. In the following months, MSF struggled to respond on the ground while publicly advocating for an international military intervention to stop the genocide.

In July, when the refugees starting pouring over the Gisenyi border into Goma, in what was then Zaire, at a reported rate of 15,000 per hour, it was like nothing that anyone had seen before. MSF-H was well positioned to respond, as a regular project was already present and emergency stocks were on the ground. However, the scale of the crisis was much larger than ever had been imagined. Within days, cholera struck. The major difficulty in reaching the refugee camps was that the roads were blocked with people and corpses clogging the roads. MSF-H chartered a helicopter to get the team and supplies up the 50-km-long stretch of road. Dumper trucks carted out dead bodies from the camps, while journalists stood amid the chaos and applied make-up ready for their on-camera spot. Staff and Ringer's Lactate poured into the country. All five MSF sections worked full out to contain the cholera, the dysentery, and eventually the meningitis that followed. Surgical services, inpatient care and nutritional centres were quickly set up. Mental health programmes were added when teams in the clinics reported high numbers of patients presenting with non-specific physical complaints.

Témoignage

The post-cold war landscape, and the increasing tolerance amongst the international community for human rights abuses, as exemplified in the former

Yugoslavia and Rwandan crisis, resulted in an increased emphasis within MSF on the dual role of medical staff as healer and as witness. In 1995, an intersectional meeting in Chantilly added témoignage and advocacy to the organisation's informal mandate. Despite the initial reluctance and internal debates about sacrificing neutrality, there was now a clear sense of duty and a priority within the Dutch section on witnessing and advocacy. In practice, this was done mostly through passing on information to other actors and direct lobbying with stakeholders, the so-called 'silent diplomacy' route. However, MSF was now increasingly speaking out in its own name.

The mid-term plan (MTP) of the late 1990s identified the integration of témoignage into MSF's activities as a shift of policy. The humanitarian affairs unit, which had started in 1992 with the hiring of one lawyer to address legal issues linked to International Humanitarian Law, was now an established unit working on humanitarian advocacy. It joined the Medical Department and Watsan Unit in 1998, prompting the name change to the Public Health Department. The merger of units acknowledged the connection between public health and advocacy, something that was not necessarily obvious to all in the organisation. The links between health and human rights were actively explored and used as a framework both for intervention criteria but also for targeting of some medical programmes. When MSF's role for humanitarian advocacy conflicted with the possibility for presence, there was always a difficult debate. How to weigh the ethical balance between responding to medical needs versus the moral obligation to denounce unacceptable violations of human rights? How to respond if there is suspicion that MSF's medical action is actively fuelling the conflict? How is the obligation towards immediate patient needs weighed against the obligation to do no harm? These debates flared around specific events, such as the famous decision to withdraw from the Zairian refugee camps after it became clear that humanitarian assistance was being actively diverted by the genocidaire leaders in the camps. MSF-H did not take this decision immediately,

and only did so after all advocacy avenues had been exhausted, nine months after the French section had pulled out. Crucially, the decision to withdraw was possible because the mortality rates were under control and there was no longer a major health emergency.

'Demand driven'

The growth of MSF-H in the mid-1990s led to the conclusion that headquarters had grown too large and the organisation was at risk of becoming bureaucratic and losing its focus on populations in danger³⁰. Many felt that the organisation had gone from a 'pioneering' or entrepreneurial organisation to a highly structured, bureaucratic one that had lost some of its reactivity. The proposed solution was to become a demand driven organisation.

Demand driven (DD) was a concept developed by management theorists in the mid-1990s for business. The principle was that businesses should entirely orient themselves around the client rather than around its own bureaucratic needs. To do this, the company needed to identify its primary processes or core business. The managers in charge of the primary process should be responsible for both resources and output³¹. MSF-H identified its primary processes as medical emergency aid, advocacy, the use of volunteers, and fundraising. All activities should be focused on these core processes.

A new organisational structure was devised to accommodate the new DD structure and implemented in 1997. Operational Directors (OD) would be in charge of the primary processes: both the resources (ie support departments) and operations. Together with the general director, they would form the management team. Decision-making was pushed down to the field, to the country manager, who replaced the programme managers or desks sitting in Amsterdam. The country management team (CMT) became responsible for all the operational decisions, keeping the decision-making close to the 'client'. They in turn delegated tasks to headquarters. The OD's main role was ensuring compliance with policy. The role of the MedCo was re-

30 Demand Driven MSF-Holland: A very brief overview. 1997

31 O'Malley S. Demand Driven Evaluation. 2000: p11.

defined to one of functional support, as the authority lay with the project coordinator/country manager line. This line management model effectively cut out the support departments from decision-making at HQ level, and at field level cut out the medical coordinators (and logistics coordinators) from line management. There were exceptions, however, to the DD model. Key aspects of security and advocacy remained the responsibility of the OD, and the emergency support desk and finances were not part of the DD system³².

The shift to field management was important to ensure flexibility and the ability to react to events. It put the decision-making as close as possible to the populations in need. However, it did have some negative consequences for medical programming and medical ambitions. Relegating the medical coordinator and health advisor (HA) to advisory roles relied on the goodwill (or good sense) of the country manager or the Operational Director to ensure that their advice was taken. Many MedCos and HAs complained of decisions being taken without proper medical input, particularly as they related to closing projects and changing strategy. A couple of examples of the demand driven system having a negative impact on medical quality and medical programming are the local purchase of pharmaceuticals policy, and the issue of female genital mutilation.

Local purchase of medical products was well known to be high risk, and an international policy existed stating that the quality control responsible (ie a pharmacist) must approve all local purchases. This kind of top-down approach did not sit well with the demand driven culture:

Since the change to a demand driven system, the policy seems to have become more a guideline. MT basically... agrees that a medical coordinator can approve the use of local pharmaceuticals. Advice: do not

*make too many policies, keep the field responsible and do check the drugs if necessary (there can never be a 100 percent guarantee)*³³.

The impossibility of a medical coordinator having the technical expertise to safely evaluate the quality of a manufacturer and supplier did not seem to matter. In the end, the head of the Public Health Department succeeded in convincing the MT to overturn the decision months later, but it is shocking that the MT would prioritise a management principle over quality of care to the patient, particularly on such a technical issue. It is especially shocking given that there was acceptance that another highly technical issue - namely financial control - was explicitly excluded from the demand driven model. Similar decisions were made weeks earlier for the document tabled on female genital mutilation, setting out MSF's opposition to it and the refusal to allow MSF materials or staff to be involved in the practice, and for a document on emergency preparedness. After discussion, the MT decided to make both documents guidelines rather than policy, with the reasoning being that fewer policies should be made by headquarters in the new demand driven structure³⁴.

A demand driven organisation needed a focus on accountability and reporting, as well as monitoring and evaluation. MSF as a 'learning organisation' became a fashionable catch phrase. As a direct consequence of the DD changes, the Monitoring and Evaluation Unit was created in 1997. MSF-H, from its earliest days, had emphasised the quality of the intervention and monitoring and evaluation of interventions. The very first MSF-H mission in Darfur had an external evaluation. Now, with an increased need for accountability in the decentralised decision-making structure, the evaluation function became formalised in headquarters. Over 11 years, the unit produced 52 evaluations. This was an area in which MSF-H led in terms of the other sections, even up to several years ago³⁵.

Ultimately the DD model was abandoned in its purest form, and adapted to a more hybrid system. Line management remains, however, as do many elements of the DD model, namely that many decisions remain decentralised to the field.

Tuberculosis

MSF-H's focus on emergency and short-term commitment posed a problem for TB treatment. In the 1990s, WHO did not recommend treatment of TB in unstable and emergency settings, yet teams were encountering patients with TB in the field, in feeding centres and hospitals, and had difficulty accepting that they could not treat them. The fear was that resistance would develop if patients could not be guaranteed to complete their treatment: the potential public health risk trumped the individual patient risk. But the pressure from the field teams was to treat, and eventually they just started to do it.

*"That idea was not yet accepted in the world of TB experts, which is very conservative overall. But for us it was clear that you can treat TB in refugee settings. We started treating TB in south Sudan: MSF-H was really a forerunner in that. There was criticism from other sections, as well as from other actors. At some point, the other sections followed, but that was when WHO was also already changing its position."*³⁶

One of MSF-H's first programmes to treat TB in unstable settings was in south Sudan³⁷. The regimen introduced was the Manyatta regimen, which had been used by the Ministry of Health in Kenya, and which MSF had experience of in Kakuma refugee camp. It was adapted to a semi-nomadic population, using a longer intensive phase under directly observed treatment, and was completed by several months of a continuation phase that could be done without supervision. Between 1993 and 1997, 2,500 patients were treated in West Upper Nile province by MSF³⁸.

32 Ibid.

33 Minutes Management Team Meeting. December 29, 1998.

34 Management Team Minutes. December 1, 1998.

35 Cabrol, Jean-Clement. Evaluation and MSF. November 2008: p1.

36 Interview Lucie Blok, former Head of Public Health Department

37 Keus K, Houston S, Melaku Y, Burling S. Treatment of a cohort of tuberculosis patients using the Manyatta regimen in a conflict zone in South Sudan. *Trans R Soc Trop Med Hyg*; 2003; 97: 614-8.

38 Ellman T. Evaluation of Tuberculosis Treatment in Lankien, South Sudan: The 2001 Pilot Cohort. August 2002. Annex 1.

The decision to start a TB programme should never be taken lightly. The decision does not only have to take medical aspects into account, but also important non-medical aspects.

Three questions always have to be answered first:

1. Does MSF have the commitment and the resources to continue a TB programme for a sufficiently long period (at least 12-15 months)?
2. Is the area or camp, where the TB programme will be implemented expected to remain stable for at least 12-15 months?
3. Is MSF able to assure a good quality programme, when it runs a TB programme, alone as the directly implementing agency or in a supporting role, working with counterparts?

MSF TB Policy 1995

It took a lot of pushing from the Medical Department and field teams in order to increase the organisation's commitment to treating TB. The longer-term nature of treatment went against the emergency focus of the organisation. Some felt it was too complex for MSF and that the expertise was lacking. The pressure from the medics continued, and slowly it achieved focus. A platform to discuss and advance TB was formed with KNCV in the mid-1990s. Annual plans of the department continually put TB as a priority. An intersectional policy for TB was agreed in 1995. While this was undoubtedly a step forward, given the general reluctance to treat TB, the policy was still remarkably conservative in defining who should be treated and in which settings. The irony was that in MSF-H's first projects in the 1980's TB was treated in refugee camps without any discussion, as a direct response to field needs. It was when HQ became involved that treatment stopped.

Evidence to counter the MSF policy was collected in south Sudan several years later in a more insecure context than the first south Sudan experience. It consisted of a pilot cohort of 163 patients who were admitted in Lankien during a time of active conflict. The programme arose after much debate in the team about treating TB - a debate that resulted in some expats

leaving MSF to start their own NGO to treat TB. In the pilot programme, the team focused on patient education and contingency planning, which included a 'runaway bag' of one month's drug supply in case MSF was forced to evacuate. The pilot experience showed that the default rate from the four-month intensive phase was less than 1 per cent. This experience was well documented and showed that it was possible to safely treat TB in conflict settings despite the constraints³⁹.

HIV

HIV care started to be intensively discussed in the movement in the 1990s and many projects started to think about incorporating AIDS prevention messages into their programmes.

"When I was working as the HoM/MedCo in Uganda, in the early 1990s, we were already coming across HIV-positive patients in our project. We organised a regional meeting with the other sections on HIV/AIDS in 1991 and decided that we could no longer ignore the problem. A letter was issued to all the sections that we had to respond to HIV/AIDS in some way. Following that, projects were started up, but only focusing on prevention and palliative care at that time. In Uganda, the MSF-H mission in Soroti started its first HIV project. Then, projects in Southeast Asia followed."⁴⁰

The idea of standalone vertical HIV projects was highly controversial in the management team. They were considered 'C projects', and thus at odds with MSF-H's emergency focus. Further, the idea of doing HIV treatment in developing countries was seen by outside actors as unfeasible. But it was not possible simply to ignore HIV, and gradually more programming and projects got acceptance. The 1996 annual plan mentions that three projects had been designated as HIV ones: Cuba, Myanmar and Cambodia. Cambodia had several projects for HIV, including one addressing STI/AIDS which started in 1995 "in close cooperation with brothel owners". These projects started to move from STI treatment to AIDS 'care', which essentially meant opportunistic infection treatment and palliation. The next hurdle was starting antiretroviral therapy (ART).

Access to Essential Medicines Campaign

The lack of access in the developing world to drugs, diagnostics and vaccines was identified internationally in the late 1990s as a major issue blocking the ambitions of the field teams to improve the medical assistance they were delivering. Sometimes it was a question of price, at other times it was a lack of research and development - into neglected diseases, for instance. A good example was the lack of good treatment for sleeping sickness (human African trypanosomiasis). In 1999, MSF's Campaign for Access to Essential Medicines Campaign (CAME) was launched by all MSF sections. In MSF-H, positions were created for campaigners who sat in the Public Health Department (PHD) and functioned as the liaison between the Access Campaign and the field teams. The early focus was on getting access to artemisinin combination therapy (ACT) for malaria and to antiretrovirals for HIV. Initially the field teams worked very closely with the Access Campaign, with more than half of field missions asking for support on access issues in 2002⁴¹. Later, as the key drivers that prompted the start of the Access Campaign were successfully addressed, requests for field support dropped and eventually the positions in the Dutch office stopped.

³⁹ Keus K, Houston S, Melaku Y, et al. Field research in humanitarian medical programmes: Treatment of a cohort of tuberculosis patients using the "Manyatta" regimen in a conflict zone in South Sudan. *Transactions of the Royal Society of Tropical Medicine and Hygiene* 2003; 97: 614-618.

⁴⁰ Interview Lucie Blok, former head of Public Health Department

⁴¹ PHD Annual Plan 2003, p1.

Natural Disasters: defining the limits

The questions raised by the first interventions in natural disasters continued. When responding to natural disasters in countries where MSF was not already present, the teams were consistently too late to have a significant medical impact in the initial phase. Overall, the medical assistance MSF could deliver was limited, and while epidemics were often feared in the aftermath of natural disasters, experience showed major disease outbreaks to be a rare event. In the late 1990s, evaluations of the responses were done, and separate policy papers outlining a limited role for MSF in natural disasters were defined. The guidance limited interventions in countries outside MSF project countries to extremely large-scale disasters where MSF-H could reasonably hope to arrive early enough to fill a gap in the response of other actors. In countries where MSF was already working, MSF would plan to respond as needed. Following this, a review was done of 21 natural disaster responses by MSF-H to check the reliability of the guidance. The analysis looked at a number of elements of the response and graded how many of the interventions met the criteria. The findings were that 80 percent of the interventions met criteria for a 'good enough' intervention including speed of response, control of epidemics and exit strategy⁴². It recommended retaining the policy for limited intervention outside MSF project countries, while at the same time it encouraged better preparedness in MSF missions in countries that were disaster prone. The management team (MT) used the results of this evaluation to confirm the guidance as policy. A recent review of seven natural disaster responses by MSF-Operational Centre Geneva came to similar conclusions as those reached by the MT, which turned out to be remarkably similar to the opinion of the board in the 1980s.

The 2000s: Shifting from populations to patients

The approach towards programming in the late 1990s was framed on the principles of emergency public health (EPH). Curative care for the individual patient was a component of the EPH approach, but the emphasis was on impact at the population health level. In 1998, as the organisation was again reviewing strategic direction, there was an explicit debate on this choice: should MSF-H focus on curative care or public health? The feedback from the debates with the field and the association was split. The Public Health Department decided to refuse the question:

Whether we choose a public health approach (combining curative and preventive healthcare, water, sanitation, food and shelter), or a more individual curative approach, or a combined approach, will depend on the found needs, priorities and best way of making a meaningful difference.⁴³

The resulting decision on medical intervention strategies in the mid-term plan for the new century was a significant broadening of medical programming:

We will not limit ourselves as to what kind of programmes we will do - we will do any medical programme that is an effective reaction to the needs created by humanitarian crisis (including TB or HIV projects, projects in institutions or in urban contexts).⁴⁴

The analysis was still through an EPH lens, and the language still talked about populations in danger, but the next mid-term plan (2003-2005) would announce boldly the ambition to refocus on people and their needs rather than on populations, diseases or health systems. This shift from public health towards curative care, and the introduction of the word "patients" to the MSF-H lexicon, was a major turning point. The influences were varied. The external environment, with the growing threat from infectious diseases and resistance, and the switch to new contexts - away from closed camps toward open settings, urban

environments and institutions - demanded a different response. Medical ethics were more visible in the organisation, with the focus on putting the patient at the centre of the individual doctor's response. Changes within the movement had an influence as well. The International Council, the highest associative body in the international MSF movement, was continually, and initially with few visible results, pushing the medical departments and operations to respond to the threats caused by resistant malaria and TB, and to start ART for HIV patients. The Access Campaign was moving forward and challenging MSF medical departments and operations to keep up.

The shift in focus came with a new emphasis on an integrated approach to the needs of people and an objective to further develop quality of care.⁴⁵

Integrated approach

The emergency public health model had evolved to one based on a model of an integrated package of health services. Here the integration was medical care together with nutrition, water and sanitation, and later psychosocial and mental health programming. The logical extension of this approach in the public health programmes was to shift it over to the new curative focus. This subsequent choice to focus on people and not on diseases had major implications for medical programming. MSF-France was developing vertical programmes as 'islands of excellence', where a surgical ward in a district hospital would be fitted out with the latest equipment, and expat specialist surgeons would rotate on a three-week schedule to provide high-level surgical care. Yet if you were unlucky enough to have a non-surgical problem, there was no MSF doctor to help you. This approach was unpalatable to many raised in the MSF-H tradition, with its history of utilitarian ethics and the new focus on people. The idea that the type of pathology determined access to treatment was simply not acceptable; the ambition instead was to respond to the major morbidities and mortalities where MSF worked. Vertical approaches were

42 Doherty P. An Evaluation of MSF-Holland Natural Disaster Response, 1999.

43 Lucie B. Health Trends in a Context of a World of Injustice and Humanitarian Crises. 1998: p9.

44 MSF-Holland Mid-Term Policy 2000-2002, p13.

45 2003 PHD Annual Plan

reserved for settings where the other major health needs were already met, where MSF needed to invest to learn a specific approach such as MDR-TB, and where a single pathology was the overwhelming need.

The integrated approach led to the inclusion of non-communicative chronic disease treatment in primary and secondary care programmes. Limits remain with oncology treatment, where the only exception where MSF-H offers treatment is with Kaposi's sarcoma in HIV programmes. This is an area that will need to be addressed in the future.

The treatment of psychiatric patients was introduced, with the same integration logic, into primary care services. It has proved difficult to achieve widespread access to care due to barriers on the part of individual healthcare workers. Some physicians and MedCos are not used to treating psychiatric illness, and have proved resistant to start, despite efforts to provide expert support and guidelines. Where physicians have adopted the simple treatment measures needed to treat acute psychosis, for example, the treatment has been transformative for patients and their families.

The choice of integrated health programmes as the default option has had consequences. Often it means that the standard of care does not achieve what is possible in a vertical programme. It puts a high burden on medical staff to be generalists, to work further outside their comfort zone and - in particular for medical coordinators, who are increasingly non-physicians - to manage highly complex and diverse medical programmes. Integration demands easily accessible tools and guidelines for the field. One of the lessons learned through the implementation of HIV integration is the value of expert implementers who can go in, assist the teams to start the new activity - whether it be reproductive health or HIV care - and then hand over a programme which is up and running. Integration has demanded simplification and new models of care delivery.

Quality of care

The term 'basic healthcare' carries an intrinsic risk of acceptance of sub-standard levels of care as the ultimate to be provided in crisis situations. We have not only accepted to work with ineffective protocols, such as prescribed by MoHs in different countries, we have also followed WHO doctrines and developmentalist rhetoric on sustainability as a pre-condition for interventions such as TB treatment and AIDS care. During the past few years we have, however, started to challenge these axioms... Still it is not realistic to expect to be able to provide the European standard of care in all situations. Anti-epileptic treatment without a fair chance of uninterrupted treatment would be mal-treatment, while starting TB treatment without proper follow-up would be unethical.⁴⁶

Quality is a persistent theme in MSF-H strategic documents dating back to the late 1980s. Initially it referred to the quality of interventions, and it took time for the concept of quality patient care to be introduced. The public health framework, with its notions of utility and equity, focused on providing immediate lifesaving care to as many people as possible. With the change in the external environment introducing the need for more complex medical intervention to address emerging pandemics such as HIV, drug-resistant malaria and TB, the dialogue on medical ethics and the creation of the Access Campaign, the emphasis shifted more strongly to the patient, and how to provide the best quality of care for him or her. Putting international medical staff back into a hands-on role with patients has also contributed to field pressure not to accept a double standard of care between resource-limited and resource-rich settings.

It would be a mistake to represent the choice between best care for the patient and greater good for more numbers of people so starkly. In reality, there is a continual tension between what the best quality of care is for the patient and what is best for the population or appropriate for the setting. Issues of sustainability,

where to set the standard, medical ethics, and resource choices all come into play. MSF is in a privileged position in that it has its own private funds, and therefore the choices and compromises are often less than other agencies are forced to make. Nevertheless, this tension between the population-based need and that of the individual patient is a healthy one, as it forces MSF to continually challenge the limits of its response.

A project to promote the understanding and practical use of medical ethics within the organisation to help with these deliberations on quality of care, resource allocation and operational choices was launched by the Public Health Department. A number of workshops were held and documents written to address the issues. Training on a medical, ethical framework for decision-making was introduced at all the coordinator courses. Intersectionally, MSF-H promoted the development of an ethical framework for the movement, which provides practical guidance on how to use medical ethics in field missions, including dilemmas linked to advocacy and closing projects.

Taking quality seriously required a way to measure what was happening in the programmes. Improving the medical reporting and internal monitoring of programmes was a long-term ambition, which became more acute when institutional funding and its requirements for external reporting decreased. The Public Health Department attempted to introduce standardised medical reporting in the late 1990s, and promoted the new format at co-days 2001. Implementation was obviously slow, because in 2002-4 one of the objectives of the department was again to establish a regular system of reporting. The slow progress was linked, in part at least, to the demand driven structure. While various types of reporting were mandatory, such as sitreps, all reporting to the support departments was at the discretion of the country manager as to timing and format. More progress was made when there was agreement from the management team to implement a set of standard health indicators for all programmes in 2005.

The indicators reflect measures of volume and outcomes for the main programme areas. Over time, they also included indicators to measure adherence to policy, such as confirming the diagnosis of malaria. The standard indicators, together with the use of standardised data tools for the main programme areas, allow regular monitoring of the quality of programmes from both the perspective of the country management team based in the capital and from headquarters level. MSF-H was ahead of the other sections in standardising data collection and reporting, which was in keeping with the section's reputation for being focused on process and standardised procedures. Quality of care has recently become an organisational risk management issue.

MSF has always been a target for court cases and lawsuits from opportunistic former employees and landlords, but recently there have been several examples of medical liability court cases. This development may be inevitable, as the population becomes more educated and aware in the countries where MSF-H works. It does, however, demand an organisational response and may well end up having a wider impact on where and how we intervene.

Diagnosics

In 2003, the Public Health Department hired its first laboratory advisor. The importance of having access to good diagnostics in the programmes, and ensuring reliability of the results, was recognised early but now needed expert input to move it forward. Over five years, MSF-H transformed the standard in its laboratories. New standardised operating procedures were written and translated into French and Russian. Manuals for malaria microscopy, TB microscopy, and numerous other support materials were developed specifically for field conditions. New diagnostic methods were trialled in the field, some to improve the quality of routine lab tests, others to add to what the lab could offer. A programme of annual workshops for lab technicians ensured that the new materials and knowledge in headquarters was translated to the field and, more importantly,

allowed the field to bring issues of concern from their missions. Quality control was reinforced. Where methodology did not exist for quality control, new ideas were experimented with - some were more successful than others.

The importance of quality control and proper lab standards was reinforced in 2005 when the problem of false positive HIV results was discovered. Staff in Zambia, in Ethiopia and in DRC all realised that some of the patients in their programmes had been falsely diagnosed with HIV on the basis of rapid diagnostic tests (RDTs). The enormity of the impact on the affected individuals and their families galvanised the department to respond. Procedures and protocols were tightened, and eventually mandatory confirmation testing was introduced for all projects in addition to the WHO recommended RDT algorithms⁴⁷.

Standardised reporting of the lab's performance on quality control allowed HQ to identify problems, and also provoked internal competition amongst labs.⁴⁸ The success of the laboratory programme in providing reliable results for clinicians, and in promoting new diagnostic tools, was due in large part to

the vision of the lab specialist who led the development of laboratory support. Many of the innovations developed subsequently by the lab group have been adopted outside MSF. An example is the methodology for quality control of malaria microscopy which has been adopted by WHO. Unfortunately, promoting the tools internally within the international MSF network has been much less successful.

MSF *sans médecins* continued

The move towards more medical programming from that of public health interventions was reflected in a subtle shift in the organisation's identity. The mid-term plans from 2002 onwards start to emphasise MSF-H as a medical/humanitarian organisation rather than the more generic 'humanitarian' focus of previous strategic documents. The renewed interest in medical assistance to individuals as opposed to emergency public health put the medical profile of the staff on the agenda - albeit eight years after the downward trend started. This move towards more medical programming and the consequent need for more medical people in the organisation came to be known as re-medicalisation. The MTP for 2002 states:

"While I worked for MSF, we worked very hard on regaining the medical focus of the organisation. I am not sure if that has fully succeeded. There was a time when it was felt that the medical issues were supporting other agendas. It was felt that this needed to change, and the lack of medical perspective in operational decision-making was a problem all over the movement. It seemed to be worse in MSF-H, though, as other sections did have more medical people in their management. In the field, too many of the MedCos were not doctors. Also, among the HAs there should be a balanced mix of doctors and nurses, but we always had very few doctors. One of the things done to increase attention to medical consequences of operational decisions, was that the Medical Director became part of the MT.

"The whole idea of separating the medical from the operational is nonsense. We are a medical organisation: the medics should be taking the lead, receiving advice regarding politics from the operational people. Now, it's the other way around: decision-making is all about politics, and the medical programming is only the second priority. To change this, the medical people should become more assertive."

Interview with Christa Hook, former MedCo, health advisor and past president of MSF-UK.

47 Klarkowski DB, Wazome JM, Lokuge KM, Shanks L, Mills CF, O'Brien DP. The Evaluation of a Rapid In Situ HIV Confirmation Test in a Programme with a High Failure Rate of the WHO HIV Two-Test Diagnostic Algorithm. *PLoS One* 2009; 4(2): e4351. doi:10.1371/journal.pone.0004351
48 Orozco D, Klarkowski D. Implementation of laboratory QC programme in resource limited settings. *PLoS Medicine* January 2010.

*We will also re-establish space for MDs, nurses, midwives etc in the frontlines and all the way up the organisation, to ensure we act according to our values and create the organisational culture and activities that attract and keeps the type of staff we so desperately need.*⁴⁹

The MTPs in both 2000 and 2003 defined targets for the re-medicalisation objective, such as one doctor in each project and a minimum of 50 percent of expat postings to be people with a medical or paramedical⁵⁰ background with 20 percent medical doctors. There were also targets for the number of doctors in head of mission positions and in the management team. These targets, while modest, are still proving elusive to attain. The average figures for doctors and total paramedical/medical postings for the period 2000-09 are 19 percent and 45 percent respectively. Few heads of mission and none of the current operational managers have a medical or paramedical profile. The analysis of why it is so difficult to attract and retain medical and paramedical staff varies. The external labour market changes for medical staff are mentioned in strategic documents from both the 1990s and the 2000s.

Other proposed internal factors are a lack of effective recruiting and retention strategies, the bureaucratisation of the MedCo role, which discourages interest from clinicians, a lack of field positions for medical profiles, and a lack of medical role models in management positions. The objective of re-medicalisation is still questioned within the organisation. Some individuals experience it as undermining their own contribution to MSF, or that of other non-medical people. On occasions, it has been argued that medical people are different to logisticians or finance administrators in not being capable of or interested in taking on management roles. Others reject the idea of quotas for medical people, while willingly accepting quotas for French-language speakers.

A positive change in the management structure in MSF-OCA took place in 2005 when, for the first time since 1992, the

medical director position was included on the management team. This change, however, was a long time in the making. It came with the re-structuring of the management team, which grew out of the changes in the organisation after implementation of the demand driven model and line management. The objectives or criteria to evaluate the proposed structures were not linked to medical leadership⁵¹, though the board did stipulate that one member of the new management team should have a medical background.

Resistance to change

Implementing new therapies and protocols in MSF-H field programmes to respond to resistance to commonly used anti-malarials, to introduce treatment for HIV patients and to diagnose and treat multidrug-resistant TB (MDR-TB) was not easy. Some consider MSF-H's slowness to implement these new treatments as a major organisational failure.

Artemisinin Combination Treatment

In 2000, the intersectional malaria working group concluded that the era of chloroquine was over, and that MSF

should work to implement Artemisinin Combination Treatment (ACT) and rapid diagnostic tests (RDTs) in most settings. In a policy paper written the following year, MSF-H stated that "MSF should play a more significant role in combating malaria and influencing policy on a global scale".⁵² It reiterated the need for the introduction of ACTs and RDTs and highlighted the necessity for monitoring drug resistance. Subsequently, the MSF-H annual plan for 2001 included the implementation of pilot projects and resistance studies for chloroquine and Fansidar. In October 2002, the new intersectional MSF malaria policy took it a step further, and advocated the introduction of ACTs for Falciparum malaria in all field sites.⁵³

The switch to new treatment often involved doing a drug-resistance survey to demonstrate the level of the problem and to convince the MoH of the need to switch. Alternatively, the surveys were used to determine the best combination of drugs to use. Introduction of the new drugs involved not only changing prescribing habits, but also introducing confirmation of malaria diagnosis through the use of RDTs. The new Manson Unit⁵⁴ in the MSF-UK office took on the task of helping the field make the change, and

Malaria drug-resistance in Myanmar

The Myanmar mission implemented a large malaria programme aiming at high coverage of the population. It used community based lay people to perform microscopy and deliver drugs. The initial evaluation showed that uptake was poor. One of the factors identified was that the treatment wasn't working. A drug effectiveness trial was done in 1995 and found high levels of resistance to chloroquine, but a good response to combination artemisinin and mefloquine. Negotiations with the MoH led to permission to treat children, pregnant women and adults with first line failure with ACT in 1996. Two years later the protocol was extended to all age groups. In 2002 the national protocol changed as a direct consequence of MSF's drug effectiveness study.

Frank Smithuis. The development and results of a large-scale malaria project in Rakhine State, Myanmar. p. 107-120.

49 Medium Term Policy MSF-Holland 01/2003 - 12/2005. p 23.

50 Paramedical is a term is used to refer to all non-physician medical postings. It includes nurses, lab technicians, mental health officers, epidemiologists, etc.

51 Terms of Reference for the Study and Analysis of the MT and HQ structure of MSF-Holland Amsterdam Group. Version Oct 28, 2005.

52 Veeken H. MSF and malaria into the 21st Century: a policy paper. April 2001.

53 Hook C. MSF Policy on Falciparum Malaria, 21 October 2002.

54 The Manson Unit is a medical unit based in the MSF-UK office that offers expertise to the movement in order to implement new policy change.

provided implementers who were able to do the surveys, negotiate - where necessary - with the MoH, and train the staff.

ACT implementation did successfully take place in all target countries by the beginning of 2005 - two years' later than originally targeted. The timeline is mapped in annex 6. An evaluation of ACT implementation by the Manson Unit done in 2005-06 analysed the reasons for the delay and concluded both internal and external factors were responsible. The field-driven model allowed the field to set their own implementation plans and this meant a lack of priority in some countries. Competing priorities also played a role - perhaps more so in areas where resistance data was not yet available and therefore the problem was less visible. The active resistance of some medical staff (national and expatriate) due to a 'lack of confidence in ACT' is surprising, especially now that ACT is so widely implemented, but underlines how difficult it can be to change medical practice.

Teams invested large amounts of time in lobbying MoHs for permission to use ACT. MoHs were reluctant to change national protocols due to the expense and, at the same time, were reluctant to allow exceptions for MSF-supported structures within the MoH systems. Advocacy at the

"The new policy was received enthusiastically in most missions. But, in some, field staff refused to implement it. This happened in Sierra Leone and in Nigeria, where MedCos considered it inappropriate to use these effective treatments and refused. And there was no structure to enforce the policy. HQ responded inadequately to the issue, which also relates to the problem of having a non-medical operational line. The operational managers were the only ones who could enforce decisions. But they didn't understand the issue enough to really acknowledge the need to act upon this. Finally, it was many months before we pulled out the management team from Nigeria because of disregarding the policy and, in so doing, negating one of the key purposes of the mission. During that time, it is highly likely that many children died because they received the wrong treatment."

Christa Hook

international level with donors, WHO and others was often needed to push this forward, and the role of the Access Campaign was critical.

Once MoH approval was obtained, actual implementation took place from one to eight months later. Reasons for this delay seem to be lack of planning (e.g. drugs not ordered, RDTs not yet implemented) or an inability to operate on parallel track, whereby permission is sought from the MoH at the same time as preparations are being made for implementation. Similar delays continue to be seen with implementation of second-line drug treatment for MDR TB.

Antiretroviral treatment

Since the early debates on AIDS programs, MSF-H has become engaged in a variety of AIDS programmes, including implementing a needle exchange programme in Russian prisons, treating STIs among Burmese sex trade workers, doing behaviour change on the beaches of Cuba, and helping people with AIDS die in Zambia. The Vancouver AIDS conference in 1996 introduced the world to combination antiretroviral (ARV) treatment, which dramatically changed the face of AIDS in the West. In 1998, the PHD Annual Plan stated that ARV treatment would not be started before its feasibility could be properly considered. This 'consideration' turned out to be a lengthy meditation:

MSF-H also needed a long time to put HIV on the agenda. The price for ARVs was considered too high to commit to treatment programmes. And there was also the fear that low adherence would lead to resistance. And what were the implications for MSF-H as an organisation? ARV is a lifelong commitment, and MSF is present only temporarily. At some point we felt we should just try it.⁵⁵



Photo: © Olga Overbeek

The Access Campaign worked on getting prices down, and the International Council passed resolutions to make encourage it to happen. By the end of 2001, ARV treatment started to be delivered in resource limited settings by MSF-France in Africa. It was another two years before MSF-H would start the first patient on drugs in its African and Asian HIV programmes. There were long debates with the board and the association as to the feasibility and wisdom of starting treatment for what was a lifelong disease. Implementing TB and HIV in unstable conflict settings required a change in thinking.

Progress was first made in Ukraine where ARVs were administered as part of a prevention of mother-to-child transmission (PMTCT) programme. It extended in 2002 to giving drugs to infected babies and finally to the parents. Next to start ARV treatment were projects in Zambia, Myanmar and the Democratic Republic of Congo (DRC) in 2003. Each of these projects received a commitment of three to five years in order to have sufficient time to develop the programme and execute a handover plan.

The experience of the vertical programmes was critical to learning in the organisation, and in many ways changed the nature of MSF. The staff who were recruited were often less of the humanitarian-focused tropical-doctor

Unfortunately treatment of TB and AIDS in unstable environment is by most health professionals still seen as impossible and so far we seem to be one of the few agencies even trying to find answers. We have developed some ideas over the past year, but have so far not been very successful in building confidence amongst field teams (or maybe even ourselves) on their feasibility. At least it has as yet not resulted in the start of programmes in conflict situations (with exception of one TB cohort in S Sudan). This is where further innovation is needed.

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type, tending instead to be more disease-focused. They were fully committed to providing a high standard of care to their patients, and were not at all troubled by utilitarian arguments of resource division. If it was possible, they believed, it should be done: cost was rarely part of the equation for these clinicians. This dynamic fed into the organisation, contributing to a change of focus that was more on individual patients and which was critical of medicine being delivered with a double standard, according to whether the patient lived in the developed or developing world. This stance was very much supported and promoted by the Access Campaign. These programmes also forced longer-term project planning on the organisation, which otherwise tended to work on one-year project cycles, and put a focus on handover strategies to assure continuation of treatment after MSF left.

The accepted agreement was that it was unthinkable to provide ARV treatment in conflict settings. And yet this was precisely where MSF was working. The first project in a conflict setting was Bukavu in DRC. ARV treatment commenced in October 2003, after much planning and investment, and MSF was the first provider of ARV treatment in eastern Congo. Scarcely seven months later, the city of Bukavu was under attack, and many of the population - including the expatriate team - evacuated across the border. Thanks to the efforts of the staff remaining, the clinics were still able to provide drugs, and key lessons in contingency planning were learned. This positive experience significantly helped to reassure doubters in the organisation that ARV treatment for conflict-affected populations was feasible and safe.

The integration of HIV care into regular MSF programmes was a particular challenge. The vertical programmes started with clear project commitments on the length of stay, but integrated ones were much less predictable. The message that a sudden stop of drugs was not going to cause resistance needed to be fully understood. Next was the acceptance that if a sudden exit was required, MSF-H could and would stop treatment. The minimum length of

treatment in order to provide at least a temporary restoration of the immune system, and hence quality of life, was judged to be six months. Projects that had the intention of being present for at least six months should then plan to offer ARV treatment. In reality, the commitment has always been longer, and no patients have yet had to stop due to lack of a handover partner. However, it was important for the acceptance of ARV treatment outside vertical programmes to have these understandings to avoid resistance from operations.

Integration of HIV was also difficult in that project teams were often overwhelmed with heavy demands running busy and complex programmes. There were often more visible and pressing priorities for the medical teams' attention. HIV prevalence in the hospital wards and in the TB and antenatal care programmes was hidden if testing was not being done. It took a concerted push from headquarters, led by strong HIV advisors, to make it happen.

Drug-resistant tuberculosis

The first drug-resistant TB programme was in Uzbekistan. MSF started by initiating a DOTS (directly observed treatment, short course) programme in three regions of Uzbekistan and Turkmenistan. It scaled up progressively between 1998 and 2003 to achieve coverage. The early finding that 10 percent of the smear positives did not convert with standard first-line treatment prompted a drug resistance survey in both countries. The findings were worrying: overall levels of multidrug-resistant TB (MDR-TB) in the MSF DOTS programme were 27 percent in Karakalpakstan, Uzbekistan, and 11 percent in Dashoguz, Turkmenistan. For five years this was the only MDR-TB programme in MSF-H. Measured against the small numbers of patients treated, and even fewer cured, this was a hugely expensive and complex programme that generated little enthusiasm for more investment. Non-medics, in particular, struggled with an expensive programme that, in 2008, started approximately 250 new patients, and over time achieved variable rates of successful treatment completion from 53 to 70 percent.

The common wisdom in the TB community at the time was that first an adequate DOTS programme must be in place, and then a DOTS-Plus programme. This ignored the fact that, in contexts of high drug resistance such as Central Asia, drug regimens recommended by WHO were actually driving resistance. The result was a long delay to start second-line drugs, fuelled by an ambition for coverage of DOTS for the population, a handover, and then a separate parallel programme to treat second-line patients with resistance. In retrospect, it is clear that this false separation between first and second-line TB programmes was the wrong choice, and now the project is reorienting to treat TB in all its forms by introducing rapid molecular testing for drug resistance at the first point of contact for the patient.

Shabunda, DRC, was the improbable location for the next MDR-TB treatment programme. This isolated village in the middle of the forests of eastern Congo had been the site of an MSF project responding to years of war in the region. MSF had a large and successful TB programme, with good support from the MoH, but several patients were not responding to category 2 treatment. The second-mission expat, whose first mission was in the MDR-TB programme in Uzbekistan, could not accept that the only recourse was to send these patients home to infect their communities and die. A proposal was made to test and treat these patients and send to headquarters. A key issue was having a viable handover strategy, as the context was now post-conflict, and it was not clear how long MSF would be staying. Approval was granted, but further delays came from the provincial Ministry of Health. Eventually the patients were started, with sputum monitoring samples travelling by chartered airline to Goma, then by courier to Europe. The project closed after the intensive phase finished but, as MSF was still in-country, the TB doctor continued to support the MoH to monitor the patients until the end of their treatment. All patients successfully completed their treatment, and the regular visits of the MSF doctor allowed the HIV patients on ARVs to continue their treatment and monitoring in the absence of a handover partner in Shabunda.

A policy change to integrate second-line diagnosis and treatment into all TB programmes was made in 2007/08. Implementation is slow, due to initial resistance within the Medical Department and in the field. Where agreement had been made to go ahead, the next phase of delays came from ministries of health on the level of memorandum of understandings (MoU) or drug importation. Some members of the MSF-H board and OCA council continue to be reluctant to make this change, finding it overly ambitious and 'impractical'. The complexity of the programme, the amount of resources for a small number of patients, and a lack of belief in the problem of drug resistance, are all cited as reasons to place priorities elsewhere. Progress is being made, with six projects now offering drug-resistant treatment, but the culture change required has been every bit as difficult as implementing ACT, psychiatry in primary care and HIV treatment.

The slowness to adopt new treatments in MSF-H can be attributed to a number of causes. The lack of medical people in decision-making positions, a relative lack of strong medical voices elsewhere in HQ and the field, and the complexity that comes with the integrated program model all contribute to various degrees. Lastly the MSF-H board and OCA Council has often been difficult to convince. This contrasts with other sections where the associative more often functions as a driver of change rather than the brakes.

New nutritional strategies: adopting the RUTF revolution

Therapeutic feeding programmes were based on inpatient care for severely acutely malnourished (SAM) children, and an outpatient supplementary programme for moderately acutely malnourished (MAM) children, which often also included pregnancy and lactating women. The programmes for SAM provided good quality care but were unable to respond to high numbers of patients. Nor did they lend themselves to high geographic coverage, especially in insecure settings. In 2000, strategies started to be tested for community or home-based treatment. A first trial from Ethiopia with Save the Children was reported the following year. MSF began to experiment with the new model, initially a hybrid between the Ambulatory Therapeutic Feeding Program (ATFP) model of today and the classic approach. Children underwent phase one as inpatients and then, when stable, were discharged to complete the second phase of treatment.

The development of ready-to-eat therapeutic food (RUTF), a high energy spread used to replace the F100 milk used in classic programmes, made the home-based model feasible on a large scale. Plumpy'Nut® samples were sent to south Sudan in the late 1990s, where it was tried out. Security problems forced the team to evacuate shortly afterwards but, in the limited pilot, it worked well. In

Table 1: MSF OCA Therapeutic Feeding Programmes 2005-09

	2005	2006	2007	2008	2009
Countries with TFP	14	18	17	17	18
Projects with TFP	30	36	43	38	45
Ambulatory programmes	17	24	34	36	42
Admissions in TFP	16,324	11,976	16,228	34,960	41,860
Admissions in SFP	42,902	11,939	13,807	4,914	1,391
% TFP programmes ATFC	56%	66%	79%	95%	93%
% Programmes with WHO references	0	0	37%	80%	86%

2003, a campaign began to promote the new strategy in the office and field. The programme in Marere, Somalia, was the first real success of the new model, and the results were used to promote the model within MSF as a whole. Marere implemented the new strategy in response to overcrowding at the feeding centre, and high defaulter rates because women were not able to stay full-time in the centre due to other responsibilities. In 2005, the official policy changed to make ambulatory feeding programmes the standard model of care. In some countries there was difficulty switching due to the MoH reluctance to adopt the new model. Once the switch was made, it was realised that defaulter rates were very high in some programmes. This needed to be systematically addressed with good strategies to educate the caretakers and improve defaulter tracing. Also in 2005, there was an evaluation of the supplementary feeding programmes in MSF, prompted by concerns about their impact. While the evaluation stopped short of saying that the impact was poor, it did conclude that supplementary programmes should not be a standard approach in nutritional problems in communities⁵⁶.

The decision on what to do with the poorly performing supplementary programmes was made easier when the WHO adopted new growth standards in 2006. Using these new standards and definitions for severe malnutrition meant effectively widening the inclusion criteria for children into the therapeutic feeding programmes. The new growth standards were adopted, along with a decision to phase out supplementary feeding programmes, with the rationale that most high-risk children were now included in the new criteria for SAM.

Medical advocacy

MSF-H realised that being a catalyst for change - the major theme in the 2000 MTP - could refer to more than changing the humanitarian agenda. The medics knew this already, and had been investing in changing medical practice in kala azar, in the treatment for sleeping sickness and in introducing ACT to Myanmar. But it did not get translated into any

organisational priority until the mid-2000s. The Access Campaign undoubtedly put medical advocacy high on the agenda, as did the medical policy changes that insisted on a choice of drugs for sexually transmitted infections which took into account the risk of antibiotic resistance. The model of catalyst for change became a compelling reason to invest in improvements in medical care in the missions as, despite a potentially heavy investment for a small number of patients, it could be viewed as a means to provoke a wider change in medical practice. This was the case with ARV treatment provision in HIV patients in the smaller integrated settings and also with MDR-TB integration.

While effective advocacy was done on a country level, MSF-H is not well known for medical advocacy on major themes in the same way as MSF-Belgium or MSF-France, for instance. The Humanitarian Affairs Department, despite being situated for a number of years in the Public Health Department, did not do medical advocacy and there were no other resources in headquarters assigned to do so, with the exception of the Access Campaign. The successful initiatives that did emerge on medical advocacy were due largely to the interest and commitment of individuals in the Public Health Department and in the field. There were some attempts to develop a platform to work on initiatives through a working group that engaged humanitarian affairs, operations, communications and the Public Health Department; however, the initiative seems never to have got off the ground. It is also likely that the choice for integrated programmes in conflict settings meant that some advocacy initiatives, such as promoting ARV treatment in conflict settings, required a strategy other than a high profile campaign.

Women's health

Reproductive healthcare has long been part of MSF-H's response. The first MSF mission in Darfur worked with midwives and provided them with safe delivery kits, including ergometrine tablets and surgical instruments to deal with the obstetrical consequences of female genital mutilation

(FGM) or infibulation⁵⁷. Despite the programmes, there was very little organisational focus on reproductive healthcare until the mid-2000s. However, a number of policy decisions were taken forward. Guidance on responding to FGM was given in 1999, reinforced with a formal policy statement in 2006 stating MSF-H's opposition to any form of FGM and refusal to take part in reinfibulation for women post-partum. Safe abortion care was introduced in response to the International Council resolution in 2002, though implementation continues to be challenging, particularly in countries where abortion is illegal.

Gender issues have received little organisational attention in MSF-H. Most other organisations in the sector adopted clear policies and tools to address gender in programming. Undoubtedly for some NGOs this was donor driven - a factor that MSF in the 2000s rarely needed to deal with, due to the predominance of private funds. While sexual violence was recognised as an issue in refugee settings early on in the field, there was recognition - but little formal response - of the need for the protection of women as vulnerable groups. An example is the evaluation of an environmental health programme in Darfur done in 1999. The evaluator notes that female-headed households were not identified as a specific vulnerable group amongst the displaced in terms of receiving extra priority in the latrine building programme. He confidently concludes, however, that as the coverage in these households was just less than that in the total population, the women managed to construct latrines as well as the rest of the population without special arrangements by MSF⁵⁸. The absence of understanding of the vulnerabilities of this population is striking. Currently there is no formal policy on how gender is taken into account in either watsan or other programmes. Specific advice and mention is present but there is not a systematic emphasis.

Sexual violence

MSF staff members have been faced with survivors of sexual violence throughout the years of operation. In the mid-1990s,

56 Evaluation of Supplementary Feeding Programs in Darfur, Somalia and Uganda. MSF-H. October 2005.

57 Soeters R. Famine Relief Northern Darfur. Evaluation of a supplementary Feeding Program for MSF-H. Second edition. Feb

58 Oudman M, PhD. Environmental Health for the Displaced in Greater Khartoum, Sudan. 1992-1998. Evaluation Report. January 1999. p11.

Fistula camps

In the remote village of Shabunda, in eastern DRC, the medical team identified women presenting with sexual violence who had genital fistula due to violent rape. Constantly leaking urine, the women were ostracised by their communities. Shocked by their situation, the team organised to evacuate the women by plane to a specialised hospital where they were able to have their fistulas repaired. The surgery was life changing for the women, as they were able to return to their villages without the persistent leakage and accompanying odour. The programme continued into 2002, with MSF facilitating and paying for the transport and surgery.

Sierra Leone is home to the world's worst maternal mortality figures. MSF-H was responding to the brutal war between the RUF and government forces. The destruction of health facilities impacted on the already poor access of women to emergency obstetric care. The field teams recognised the problem of obstetrical fistulas in 2004. Women were presenting with leaking urine due to the creation of an opening between the vagina and the bladder due to obstructed labour. A gynaecologist was recruited and, in early 2005, 86 patients were operated on to have their fistulas repaired. At the same time, training was done.



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The experience from Sierra Leone and reports from other countries highlighted the need for access to safe delivery and caesarean sections where needed. It was recognised by the reproductive health advisor that more needed to be done to put this in place if the fistulas were to be prevented. Once achievements had been made in getting the basics present, it was decided to train a group of surgeons to

repair the fistulas. The model of a surgical camp was set up. The surgeons would fly in, operate for several weeks, then leave the team with wards of women with catheters. The model was successfully tried out at the end of 2007 in Somalia and Katanga, DRC. Since then, annual camps have been held in a variety of countries.

the topic became very prominent with media attention on rapes perpetrated in the former Yugoslavia and those linked to the Rwandan genocide. In 1995, UNHCR published their first guidelines for prevention and response to sexual violence in refugee settings. MSF's response was ad hoc at best, and depended very much on the individual team members as to whether it was recognised and treated. This was despite the mental health programmes, which had clearly come across sexual violence linked to conflict, for example when working in the Great Lakes during the refugee crisis following the Rwandan

genocide⁵⁹. In the late 1990s, the Public Health Department attempted to put the issue on the agenda, but the issue did not get taken up by operations until the release of the UNHCR/Save the Children exposé on (s)exploitation in West Africa in 2002. The report and subsequent investigation exposed allegations of aid workers trading aid for sexual favours and included a mention of MSF. The international movement reacted immediately to the report, and each section reviewed the adequacy of its own measures to protect against exploitation of beneficiaries by MSF staff. Ironically, while the report was about

exploitation, it acted within MSF-H as a catalyst to push forward support for sexual violence care, where all the attention in Bosnia and Rwanda years earlier had not succeeded. The first action was to put in place a working group with members from the Public Health Department, humanitarian affairs and operations. A researcher was hired in 2003 to review the situation in several key countries, and to implement clear case management guidelines. Sexual violence has remained high on the agenda since then, but the question remains why it took so long to be recognised outside of the PHD.

59 Shanks L, Schull MJ. Rape in War: the humanitarian response. CMAJ 2000; 163(9): 1152-6

Environmental disasters

MSF-H has focused mainly on the standard list of responses to major disease outbreaks, natural disasters and conflict. There are, however, exceptions and unusual contexts where MSF-H has intervened over the years. Response to a handful of environment disasters is one of these.

In 1987, Guyana identified an outbreak of poisoning from thallium sulphate used as a rodenticide in the sugar plantations. The news prompted public panic, and the European Community requested MSF-H to intervene. A team arrived with testing equipment and was quickly able to establish that the levels were much lower than initially thought and the risk to the population was low. The intervention was short-lived, but it marked the first response to an environmental crisis.

In 1995, an exploratory mission to French Polynesia was launched by the Programmes Department to determine if a humanitarian response was needed to combat the health consequences of nuclear testing. No programme intervention was launched, but an advocacy campaign followed, with meetings with the French government encouraging them to take responsibility for the health effects, an article in *Le Monde* and a paper in the *Lancet*.

The Aral Sea desiccation in Uzbekistan has been described as one of the world's greatest environmental disasters. MSF-H launched a project in Karakalpakstan to investigate if there was a link between the disaster and public health issues in the region. There was also interest in investigating the consequences of the economic and health infrastructure decline after the collapse of the Soviet Union. This marked the start of an unusual project for MSF. The key objective was operational research. A consortium of experts from universities in the UK, Canada and the US worked together with a local research group. Various issues were looked at, including hypertension linked to the hypersalinity, anaemia and renal failure. In the end, no concrete link was found. The research did demonstrate major concerns with TB, and the project shifted to that of a vertical TB project.

In 2010, the emergency response team in Nigeria investigated reports of high

mortality in several villages in Zamfara state. The team was in the midst of responding to a meningitis and measles outbreak, as well as a suspected Lassa fever outbreak in a neighbouring state. The teams were initially puzzled by what they found. In one village at least 30 percent of the children under five had died over the last year. In the health centre, the story was of children presenting with convulsions and coma.

Many of them were testing positive for malaria, and the infants had bulging fontanelles, suggesting meningitis. However, there were also reports that the villages had recently seen an increase in artisanal gold mining activity. Blood samples were sent to a reference lab in Germany to determine if heavy metals were responsible. The results were startling: all eight children and both adults tested had levels at least ten times the alert level. One expert reviewing the report described it as the worst heavy metal poisoning in modern times. MSF's experience in responding to lead poisoning was non-existent. A network of experts was mobilised quickly and a response plan developed with their support.

The occasional nature of the response to environmental disasters has not led to the development of any institutional knowledge on the effects of pollution or environmental/ecological disasters. However, on each occasion MSF was able to mobilise the required expertise. The question remains as to whether these events merit a more systematic investment.

Engaging with health systems and the user fee debate

One of the most consistent strategic choices MSF-H has made since the ABC discussions is not to engage in health system building. It is recognised that engagement with health systems is necessary, but MSF-H has never seen its role as building health systems. This is due to the longer-term engagement and different skillset needed for this work. However, often one of the tools to ensure handover of programmes or continuation of an important medical policy choice, such as ACT, can be training and capacity building. HIV has pushed this border, as will other chronic diseases that require

strong handover plans.

A challenge of interacting with health systems is that of cost recovery or user fees in countries where MSF-H is intervening. In 2002, an international consultancy looked into MSF's interaction in the field with cost recovery and participation fees from patients. As described in the terms of reference:

In recent years, MSF has been requested, by authorities of certain countries, to implement or participate in cost recovery/participation (CR/P) programs in the hospitals or clinics in which we work. (By the term "cost recovery" in this study we mean the payment for medical services and/or drugs by patients.) There are increasing concerns about the impact of these programmes on beneficiaries, particularly because these initiatives are being implemented in unstable economic environments and war zones⁶⁰.

The study involved surveys in four key countries. The survey revealed the fact that MSF was definitely participating in user fees for patients in a number of countries. Often this was at the insistence of the MoH but, in other cases, it was because the teams believed that cost recovery was the best long-term solution for the population:

"The MSF team believed in the possibility that the healthcare could be self-sufficient after a certain period. Something that the present team does see now that it is not possible."⁶¹

However, in DRC, for example, all the project coordinators came to the same conclusion:

"We have realised that the current strategy of cost recovery, albeit subsidised, is not resulting in sufficient increase of utilisation of health structures. We think that it may still be too early for any form of cost recovery in North Kivu."⁶²

The results of the consultancy led to a policy change agreed by all sections at the general director level in January 2004:

As a humanitarian association dedicated to assisting people in times of crisis, and

60 TOR Coordinator, Cost Recovery Study, 2002.

61 Peter Rietveld, Project Coordinator, Lokutu, DRC, 04-09-10.

62 Danielle Pronk, Project Coordinator, North Kivu, DRC, 30-09-02.

*assisting the most vulnerable without discriminating, we can no longer accept to produce or even allow exclusion within our projects.*⁶³

This international decision did not produce any immediate changes within MSF-H. User fees were still operating throughout 2004 in certain countries until the new medical director pushed the issue with operations. This resulted in the management team putting out a position paper on the topic instructing the field firmly on the issue. In settings such as DRC, where there was strong pressure from the MoH, the change in policy was aided by surveys looking at the impact on health seeking behaviour of user fees, even the small symbolic fees that MSF had negotiated as an alternative to full cost recovery. By the end of 2006 user fees were phased out in all MSF-H countries. The exception - as was so often the case - was Myanmar where, under the radar of headquarters, the malaria programme with lay microscopists was still charging nominal fees to patients. It took a visit from the humanitarian affairs advisor in 2008 to expose the practice and get it changed.

Responding to insecure contexts

The explicit organisational choices for conflict as the intervention priority in MSF-H demanded that the medical responses were adapted. In reality, much of the response to conflict in the 1990s was in safe areas - responding to the population once they had fled the conflict area. The organisation had already invested in standardised approaches to refugee settings in camps, and to a certain extent these were the easy interventions. The department recognised the challenge in adapting responses to open settings from camps as the context changed. New contexts that demanded a response were urban violence, where MSF-H operationally had less experience in negotiating access with gang members etc. Programming challenges were also often difficult in order to identify needs for MSF-H to address. In Papua New Guinea, a new project was proposed to respond to astoundingly high levels of societal violence with a sexual violence

programme. The mission was debated fiercely, as many felt it did not fit into the intervention criteria. Eventually, however, it was accepted and, as the reports from shell-shocked expats and HQ visitors trickled back to the office, they quickly erased any concerns that the mission did not meet the intervention criteria.

However, adapting MSF-H's model of sexual violence care and mental health to a context of societal violence is proving difficult. The programme has struggled, as the old ways of working cannot simply be translated to this new context. The uptake of the sexual violence programme proved much lower than anticipated, and the programme has pragmatically widened its objective to include victims of domestic violence and not just survivors of sexual violence.

The 2007-2010 strategic plan announced a focus on direct victims of violence, specifically war wounded, those with mental trauma, and sexual violence. The distinction was made with the indirect medical effects of violence, such as those arising from displacement and disruption of healthcare. The difficulty with focusing on war wounded is that it demands operational presence during the height of the conflict if MSF is going to have a lifesaving response. Instead, MSF is often either forcibly kept out of the war zone, as occurred in the final months of the war in Sri Lanka in 2008, or leaves voluntarily due to unacceptably high security risks. The surgical response then becomes one of responding to those with injuries that are not immediately life-threatening and can make it to relative safety. The clear needs are for immediate resuscitation in the so called 'golden hour' of trauma response. The dilemma is similar to that of natural disasters, where the window for major impact with medical and surgical interventions is small. The challenge has become more acute in the current strategic plan period due to the global context changes post-9/11, and the highly insecure countries MSF-H now finds itself trying to respond in. Serious security incidents that have impacted significantly on the organisation include kidnappings in the Caucasus in the early 2000s, the murder of five MSF team members in Bagdhis, Afghanistan, in

2004, and a targeted bombing in Kismayo, Somalia in 2008 that killed three colleagues. Organisationally, the result is that MSF-H is less risk-tolerant, and the days of teams in the field taking their own security decisions and informing HQ weeks after the fact are long gone.

The Iraqi war was a context where MSF-H felt it should be present due to the high level of violence against civilians and the major disruption to the health system. In 2004, all international staff were evacuated due to the high levels of insecurity for aid workers. A programme of support to emergency wards and operating theatres in hospitals in five areas affected by the fighting was started in 2006. Essentially it was a drug distribution programme, similar to the programme in Bosnia, yet with a critical difference - no MSF staff presence. The strategy was to bring out the hospital directors and surgeons from the hospitals to Jordan for training, updates on the programme and introduction to basic principles of emergency psychological first aid. The training aspect of the programme was judged successful. The impact of the drug supply programme was felt to be 'invaluable' by the Iraqi hospital directors⁶⁴, but was impossible to objectively assess. Statistics on surgeries performed were commonly understood to be 'wholly fictitious', and MSF's proximity to the victims was limited to a handful of senior Iraqi doctors. In 2009, a strategy change was made, due to both a decrease in violence and to less tolerance internally for the 'remote support' operational strategy that had now been ongoing for three years and was costing significant amounts. Assessments were made of several areas for new intervention, but the result was that either no gaps in the response existed or those that did exist needed a response with full international staff presence - which at the time was judged impossible. Finally the conclusion was that mental health was the only significant gap where MSF could respond effectively. A proposal was made to start a mental health programme that would involve an international staff presence in the form of visits, and the hiring of MSF Iraqi staff. The proposal launched a heated debate. Was it acceptable to put MSF staff lives at risk for

63 MSF policy (excerpt from "User fees -Dying for growth" paper endorsed by ExCom, Jan 2004)

64 McMaster P. A Surgery Strategy for MSF in Iraq. January 2008.

a programme that was not lifesaving? After much debate, and with serious concerns from the Dutch board, it was given the go-ahead. The Iraq example points to the dilemma of wanting to work in conflict affected areas but not having the operational presence to actually respond and, further, often not being able to identify strong medical needs.

Operational research

MSF-H became involved in research at an early stage, something that distinguished it from many other medical humanitarian agencies⁶⁵. The first paper published in the scientific literature was in 1989, a description of the kala azar epidemic in south Sudan in the Lancet. MSF's involvement in research was driven by the lack of knowledge in the wider medical community on how to respond to the unique challenges the teams were facing in the field. Neglected diseases were an obvious area for investment, as there was simply no commercial interest in developing proper diagnostics for kala azar or better treatment regimens for sleeping sickness. Most of MSF-H's research contributions are retrospective analyses of routine programme results. Where protocols did not exist or were not adapted, field teams would try something new and then document the experience. The documentation often did not happen, as teams were chronically short of time and the expertise to analyse and write up these experiences. The Public

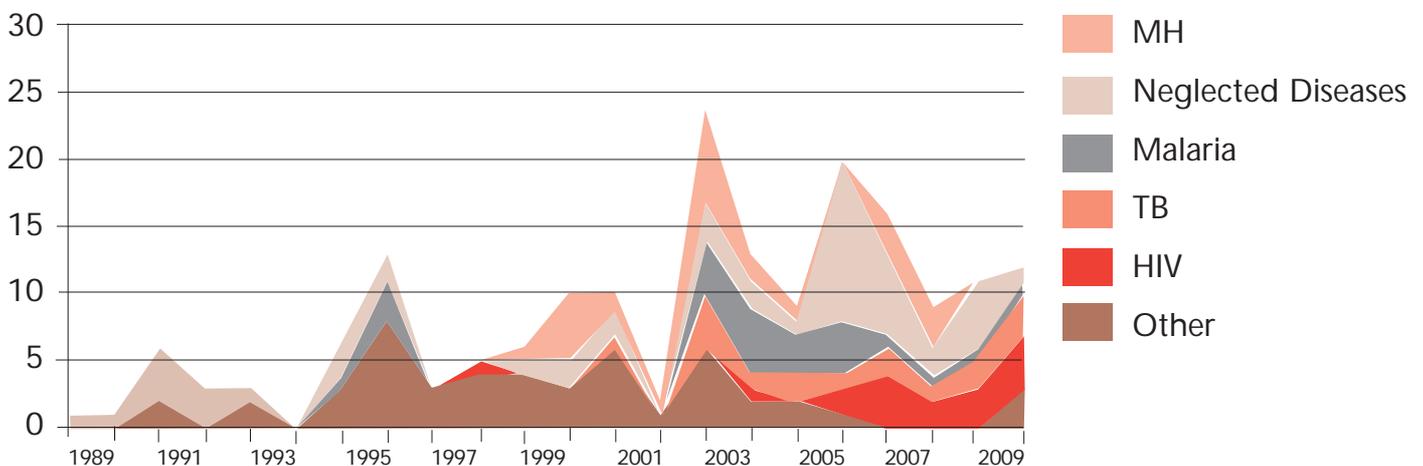
Health Department continually complained about the lack of dedicated support for operational research and for analysing and disseminating the experience. Some MSF medics used their field experiences to work on a PhD, and this proved important in producing a body of work on topics of relevance to MSF field operations such as resistance to anti-malarials in Myanmar, the response to meningitis outbreaks, TB in Central Asia and the diagnosis and treatment of kala azar. This relied on individuals with an interest in operational research and in documenting MSF's experience to produce the publications. Research support - in the form of an over-taxed health advisor/epidemiologist - arrived in 2006, and grew to three full-time epidemiologists when the Manson Unit in the London office added epidemiology to its areas of support.

Major operational research achievements that resulted in changing practice include the work on kala azar already described and the work on sleeping sickness. MSF-H initiated the work that led to the adoption by WHO of a new shorter treatment for sleeping sickness called NECT, or Nifurtimox-Eflornithine Combination Therapy. The trials were a collaboration with Epicentre and, later, the Drugs for Neglected Diseases Initiative (DNDi). These research initiatives were driven by the refusal of field doctors to accept the painful and poorly effective treatment protocols in existence. Malaria

drug effectiveness studies done again in combination with other MSF sections have contributed to policy change to ACT in a number of countries where MSF works. Reporting routine programme experience and outcomes from TB and HIV programmes in conflict and unstable settings contributed to gaining acceptance of these strategies to offer care to populations otherwise excluded from care. Documentation of the MSF-H mental health programmes and experience contributed to a substantial body of knowledge of these interventions.

The need for operational research to improve the care MSF was providing to patients in the field led to the identification of the need for an ethical review board (ERB) for MSF use. Review boards either did not exist, or were not sufficiently independent in many of the countries in which MSF was working. MSF's obligation to protect vulnerable populations extended to research subjects, and academic ERBs might not have the same understanding of the vulnerability and equity issues in MSF settings. The proposal to set up an independent ERB was taken by the head of the Public Health Department to the medical directors of the other sections. The result was the creation in 2002 of an independent MSF Ethical Review Board to be used by all MSF sections. In the first year of operation, MSF-H got approval from the new ERB for the first three proposals submitted: a malaria

Figure 1: Primary Topic of Publications



effectiveness study, a trial of two kala azar drugs in a high prevalence HIV setting in Ethiopia, and a report on justice and humanitarian aid distribution in south Sudan.

Collaboration with academic institutes and networks of experts has been important since the early days. The medical working group and then the early Public Health Department relied on these networks for expertise. Most of the links have been in response to immediate field or institutional needs for external support which align with the academic interest of the institution. The links are often informal, with individuals rather than institutions, and rely heavily on personal contacts. They have resulted in significant contribution to MSF field missions and also to the wider scientific community. There has been less willingness from MSF-H to invest in developing proactive links with institutions without clear benefit for MSF-H or without the personal relationships that have facilitated the willingness on the part of individuals in the department. Attempts by the Canadian MSF section to set up a formal collaboration with the British Columbia Centre of Excellence for HIV and AIDS were prolonged and demanded significant effort and discussion. Lack of trust between the two MSF sections and suspicion of internal political agendas complicated the issue. While the collaboration did bear some results, it is fair to say it did not reach its potential.

Conclusion

MSF-Holland's first project in 1984 was a cholera intervention. At the time of writing, MSF-OCA is responding to outbreaks of cholera in post-flood Pakistan, in northern Nigeria, and in an unofficial refugee camp for Rohingas in Bangladesh. Teams these days are better prepared, have an MSF guideline to read on the plane, and with luck have attended an intensive course in outbreak response prior to being sent out. No doubt this results in a better quality of the response than that in 1984 in Gannad Camp in Somalia. Since this first project, MSF-H has succeeded, together with the other MSF sections, in developing and documenting standard approaches to responding to major health emergencies. The approach developed in response to these large-scale emergency contexts was that of emergency public health, which focused on medical activities, supported by water and sanitation, nutrition and later mental health. At this period in time, MSF-H's operations were distinguished less by the medical care delivered and more by the ability of the organisation to be present and deliver results in hard-to-access, unstable settings.

The last ten years have seen a shift in focus. MSF-H has become more medical in its approach, due to the strategic shift towards a people-centred rather than a population-centred response. MSF is now recognised not only for its ability to operate in difficult contexts, but for the quality and standard of medical care it aims to achieve. The ambition has not simply been to transplant medical progress in the West to resource-limited settings, but rather to adapt the innovations to what is effective and feasible in the contexts where MSF intervenes. This approach has led to successes, such as the advances made in the diagnosis and treatment of neglected diseases, as well as proving the feasibility of ART and TB treatment in conflict settings. A critical stimulus to success and innovation has been the refusal of field teams and advisors to accept the status quo, such as ineffective drugs for malaria, or painful, risky treatments for sleeping sickness, or the exclusion of vulnerable groups from access to TB treatment. Wider implementation of these protocol changes across all the missions, however, has often been slow. Successful adoption of policy change has relied on capitalisation of learning from pilot projects, and the presence of champions in headquarters who are able to convince operations (and sometimes their own colleagues) and eventually the board of the need to move forward.

The persistent lack of medical profiles in positions of line management in concert with a management model that puts the Public Health Department in a support role to operations has been a significant impediment to moving forward with some needed medical programmes. Decentralisation of decision-making to the field, while bringing benefits, has in the case of medical policy sometimes allowed unacceptable medical practice to continue and slowed down the introduction of new innovations. If MSF-OCA wants to continue the focus on stronger medical programming and at the same time to adapt to the changing contexts and disease burdens, then the issue of investment in medical leadership at all levels of the organisation will finally have to be effectively addressed.

Appendix 1

Methodology:

The methodology for this document consists of a survey distributed at the 2010 Annual General Assembly to Association members, and to medical coordinators and senior national staff in the field. Additional interviews with key informants were conducted by Saskia Baas during July to early September, 2010. Individuals interviewed are as follows:

Barbara Lopes-Cardozo,
Christa Hook
Clair Mills
Egbert Sondorp
Gunilla Kuperus
Khaled Menapal
Koert Ritmeijer
Lex Winkler
Lucie Blok
Myriam Henkens
Riekje Elema
Saskia van der Kam

In addition, numerous 'corridor consultations' took place with people to verify and check information.

A selection of key documents were reviewed and consulted. The following is a partial list:

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Appendix 2

Time Line

20 December 1971

A group of French doctors found Médecins Sans Frontières (MSF), the first non-military, non-governmental organisation to specialise in emergency medical assistance.

1984

MSF-H is established in Amsterdam on 7 September.
Somalia: First project by MSF-H. Cholera intervention in Gannad Refugee Camp under direction of MSF-Belgium.

1985

Sudan: MSF-H first independent mission opens in Darfur to respond to famine with a supplementary feeding programme and primary health care programme.

1986

The board accepts adding rehabilitation projects to MSF-H's emergency assistance role.

1987

Suriname: MSF-H is expelled from Suriname as MSF's medical aid to the rebel territory is seen as collaborating with the enemy.
Somalia: The first surgical programme is started in Sheik, Somalia. After 14 months, the team is forced to evacuate as fighting overtakes the town and surrounding areas.

1988

The voluntary medical working group is replaced with the Medical Scientific Department which will eventually become the Public Health Department.
Sudan: First kala azar treatment programme in response to the outbreak amongst south Sudanese refugees living outside Khartoum.

1989

The Health Emergency Preparation (HEP) course begins as a pre-departure course for medical and para-medical volunteers.

1990

Gaza: Assessment done for first mental health programme in December. Programme opens in 1991.

1991

Uganda: First MSF-H AIDS project starts in Soroti as National AIDS programme is unable to reach the area due to insecurity. The focus is on prevention of infection. Draft Malaria Policy is formulated. MSF-H decides to focus work on emergency medical assistance in the so-called ABC discussions. A new NGO, HealthNet International, is started to take over the longer term 'C' projects.

1992

A psychologist starts working in the office to brief and de-brief expats and deal with mental health of MSF staff.

1993

The Medical Department is no longer represented on the Management Team. The re-structuring of the top layer of the organisation has the objective of improved decisiveness and flexibility to reflect the emergency nature of the organisation. The medical department is now represented by the manager of the Operations cluster.
The concept of Emergency Public Health (EPH) is developed. It becomes one of the three core competencies of MSF-H, along with logistical decisiveness and deployment of flexible, sufficient and committed staff.

A peer support network to provide psychosocial support to expats is established.

1994

Rwanda: Genocide starts on 6 April. MSF Nutritional Guidelines published.

1995

First MSF TB policy is agreed intersectionally. It advises against treatment in emergency or refugee settings unless strict pre-conditions are met.
An intersectional meeting in Chantilly adds témoignage and witnessing to the organisation's core mission.

1996

Myanmar: First ACT administered in an MSF-H programme.
Operational policies for water and sanitation projects developed.

1998

The new Public Health Department is formed through a merger of the Medical

Department, the Humanitarian Affairs Department and the WatSan Unit.

1999

The Nobel Peace Prize is awarded to MSF for its medical work and for standing up for people in need.
MSF International launches the Campaign for Access to Essential Medicines (CAME). Formation of Operational Support Teams (OSTs) to provide support to the field teams.
A guideline on emergency treatment of rape is written. It states that post-exposure prophylaxis for HIV infection is rarely feasible in MSF settings, and further that it is not the role of MSF to perform abortions.

2000

Ukraine: First PMTCT program starts using zidovudine in the third trimester and nevirapine for mother and infant. MSF Policy for Procurement of medical products paper is agreed by the international medical directors. It makes international procurement of pharmaceuticals the standard for all missions.

2001

AIDS advisor is recruited.

2002

Ukraine: First ART delivered to children in PMTCT programme. ART to adults starts in Odessa in 2003.
The new intersectional MSF malaria policy advocates the introduction of ACT in all field sites.

2003

Congo-Brazzaville: Protocol for NECT trial submitted to MSF's ERB in January. Study is executed in six centres by partners DNDi and Epicentre. Results lead to a change in protocol for treatment of sleeping sickness.
DRC: First HIV programme to provide ART in conflict settings starts enrolment of ART patients in October in Bukavu project.
Uzbekistan: Start of the first MDR-TB (DOTS+) pilot programme.
The PHD hires its first lab advisor.
The Manson's Unit is created in London as MSF-UK's expression of shared operability. The first task of the new medical 'innovation unit' is to support implementation of the ACT policy in the field.

2004

Five MSF-H staff members are killed in Afghanistan and MSF stops operations in the country.

2005

The Water, Hygiene and Sanitation (WHS) Policy is adopted, stating MSF's responsibility to intervene where poor WHS conditions lead to significant mortality and morbidity, and where no other actors are responding.

2006

An epidemiologist joins the department. On 1 October 2006, MSF-Holland and MSF sections in Canada, Germany and the UK start the Operational Centre Amsterdam (MSF-OCA).

2007

New nutritional strategies are introduced. Key changes are widening admission criteria to TFPs with a phase out of supplementary feeding programmes. A full-time surgical advisor joins the department in December.

2008

Three MSF-OCA staff members are killed in a targeted attack in Kismayo, Somalia. TB strategy paper is adopted stating the ambition to offer MDR-TB diagnosis and treatment in all TB programs. A full time Reproductive Health Advisor is added to the department.

2009

Sudan: MSF-OCA is expelled from a country for the second time in its history. The decision comes shortly after the International Criminal Court issues an arrest warrant for Sudanese President Omar Al Bashir. The Sudanese government mistakenly accuses MSF of cooperating with the International Court.

Appendix 3

List of publications

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Appendix 4

Publications analysis

Topic	Total	Type		Peer-reviewed
		Commentary	Research	
Environmental Health	7	1	6	7(100%)
General Humanitarian	24	21	3	22(92%)
Infectious Diseases	66	10	56	60(92%)
HIV	17	5	12	15(100%)
TB	17	2	15	17(100%)
Malaria	24	2	22	20(83%)
Other Infectious Diseases	8	1	7	7(88%)
Nutrition	5	3	2	2(40%)
Neglected Diseases	51	11	40	49(96%)
HAT	5	1	4	5(100%)
KA	44	9	35	42(95%)
Other	2	1	1	2(100%)
Mental Health	25	5	20	20(80%)
Other	6	4	2	5(83%)
TOTAL:	184	55	129	165(90%)

The table represents the overview of publications with a MSF-H/MSF-OCA author between 1984 and 2010. Each publication was classified on the basis of the primary topic. Research articles are those presenting primary data. Commentary is a broad category that includes articles written as commentaries or perspective pieces, viewpoints, reviews, editorials, or MSF-authored news. The peer review column is determined on the basis of whether a journal is currently peer reviewed.

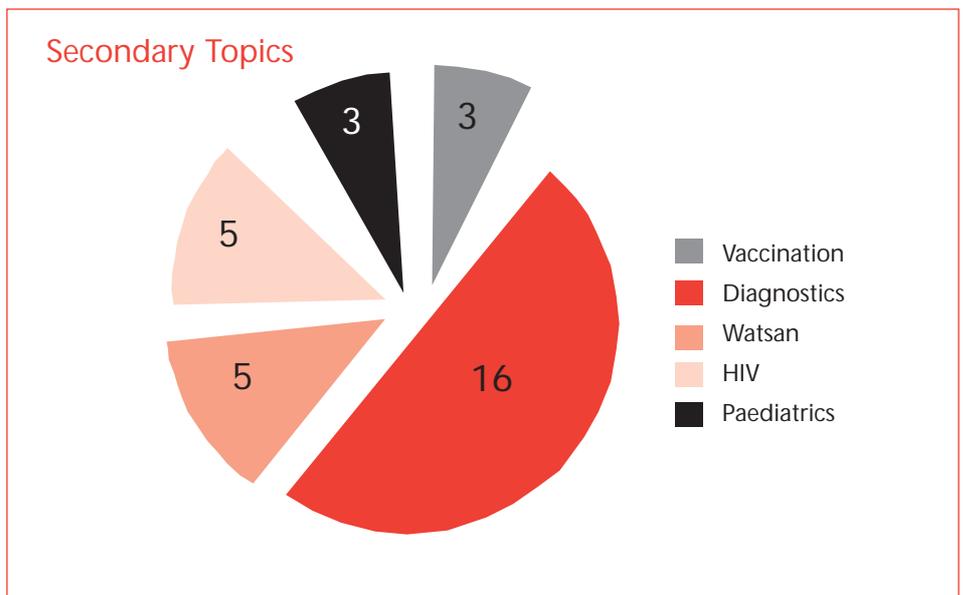
Publications are written in English, except for 6% in Dutch. No publications were made in French, despite a concentration of MSF programs in French speaking regions. There were several papers submitted to regional journals, however these journals were often not peer reviewed. While there is good reason to publish in international journals, it does raise the question as to whether the research findings are available to local medical communities and researchers where the language is not English. Approximately one third of the publications from the last two years were published in open access journals. Recently MSF publications are made available on the website, MSF Field Research¹, in an effort to improve accessibility of the research.

The research section includes 25 clinical trials defined as prospective studies which assign a group or group of participants to an intervention or interventions. This represents 20% of the research articles. The MSF-OCA operational research framework, states: "MSF involvement in "clinical trials" should be rare and well justified, given the complex ethical issues involved, and trials/studies proposing new treatments/regimens will be exceptional."²

Clinical trials involving new treatment

were performed almost exclusively in the area of neglected disease where there are few other research actors and where MSF has unique access to these neglected patient populations.

The topic division shows that most papers are linked to infectious diseases or neglected diseases. Malaria is the most common topic in infectious diseases. Secondary topic division reveals that many of the publications are linked to diagnostics, particularly for kala azar and tuberculosis.



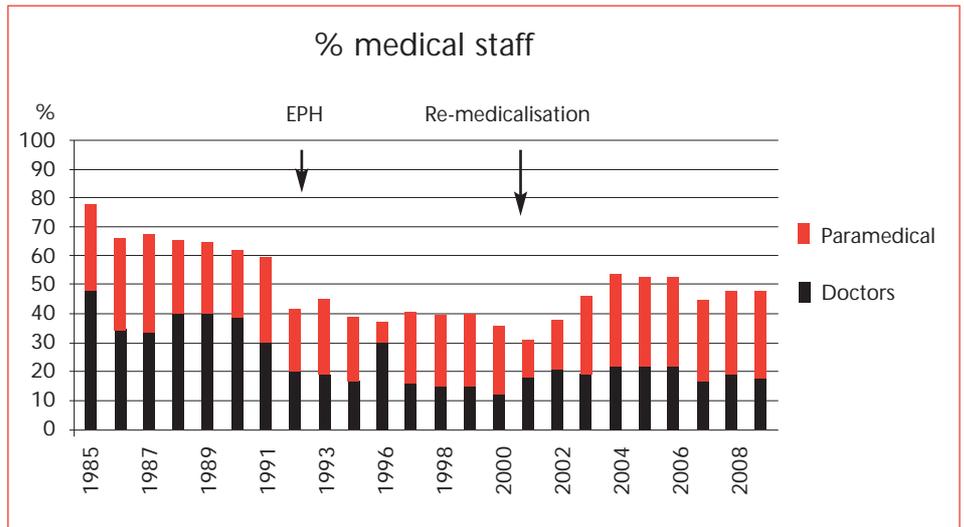
1 <http://fieldresearch.msf.org/msf/>

2 Framework for research in MSF-OCA. 2008. Annex 1.

Appendix 5

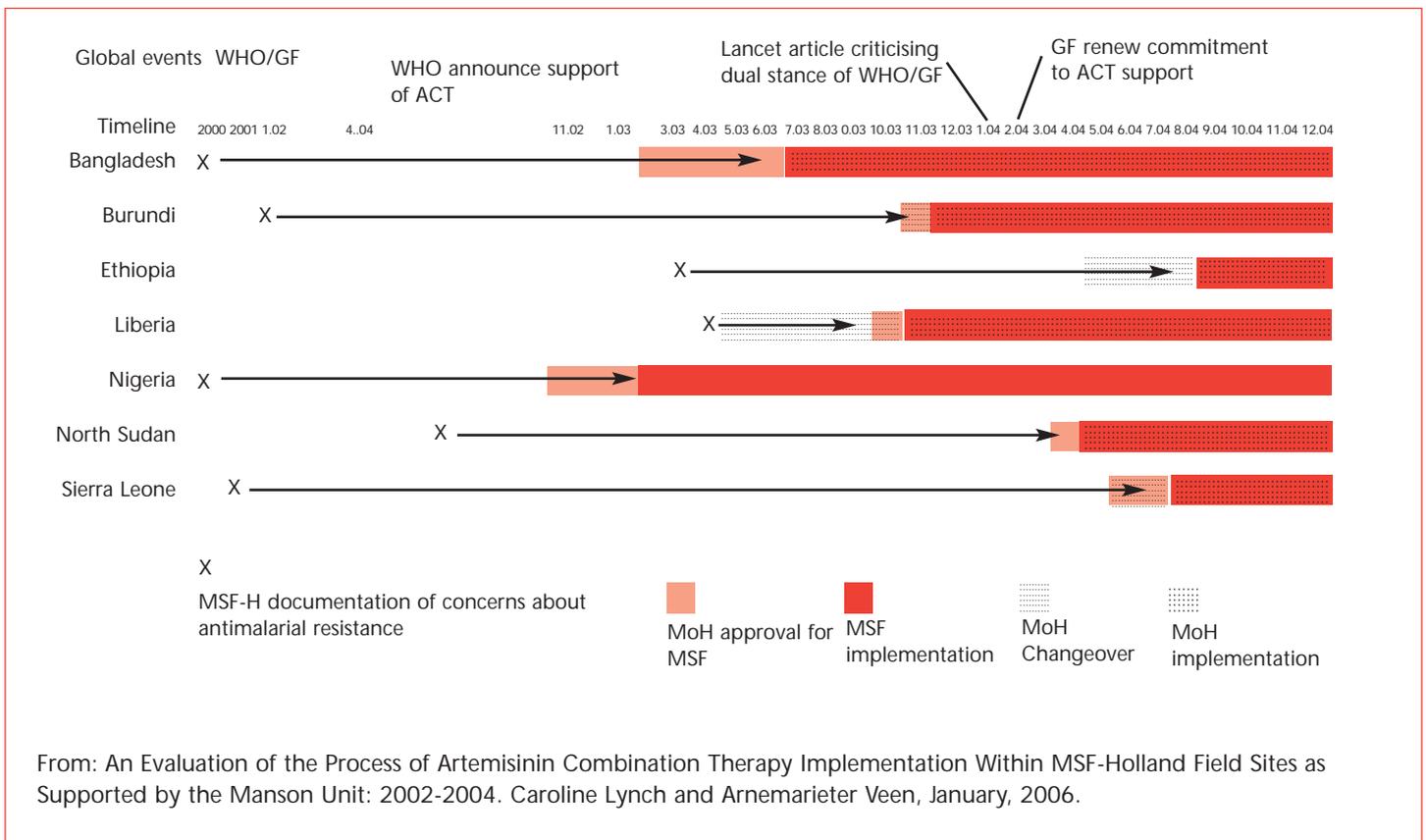
Human Resources overview

The graph above illustrates the relative proportion of international medical doctors and paramedical staff posted to the field. There may be variability in how the figures are calculated over the years. Targets for the re-medicalisation ambition are for greater than 20% of medical doctors and 55% overall for the combination of doctors and paramedical staff.



Appendix 6

Timelines for progress in ACT implementation in seven countries where MSF-H is operating



Appendix 7

Summary of medium term policies/strategic plans

Dates	1987-1990	1990-1993	1993-1996	1996-2000
Theme	<i>"1987 and Beyond..."</i>	<i>"MSF in the 1990s: Vision, desirability and maintainability"</i>	<i>"MSF in the 1990s: Decisiveness, involvement and independence"</i>	<i>"MSF in 2000: towards relevance in the next century"</i>
Objective	Professionalisation Desire to expand number of projects	Improve quality		
Internal challenges	Currently too dependent on institutional donors Cooperation with other sections "Coordinator problem" - limited availability of more experienced coordinators willing to make long-term commitment	Consolidating organisational growth Preventing bureaucracy Decentralise decision-making	Growth of the organisation Implementation of new management structure for HQ Strengthen relation between management and support departments	Integrating "witnessing" in MSF's activities Maintain 'volunteer atmosphere' of the organisation Need for increased cooperation with partner organisations External offices in Canada, England and Germany
External Challenges	Availability of volunteers Available funds	Changing North-South relations Slums and environmental disasters may change medical needs in the future	Collapse of the Cold War power blocks and changing nature of conflicts Labour market for medical emergency aid remains tight	Humanitarian aid increasingly used as a political tool More complex conflict situations due to collapse of the Cold War power blocks Growing medical needs: TB, AIDS, cholera, etc Urbanisation creating possible contexts for intervention Increasing security threats in the field Growing number of aid agencies Decreasing availability of qualified medical staff

Dates	1987-1990	1990-1993	1993-1996	1996-2000
Medical themes	How to measure impact of MSF's medical programmes?	<p>Prioritisation :</p> <p>Basic healthcare provision in (acute and chronic) conflict/ refugee setting (top-priority)</p> <p>Develop capacity to respond to acute epidemics (medium priority)</p> <p>Respond to chronic epidemics :malaria, TB, AIDS (no priority)</p> <p>Develop Watsan and nutrition components as part of the medical programmes.</p>	<p>Develop Emergency Public Health</p> <p>Integrate non-medical activities (Watsan, nutrition) in medical programming</p> <p>Adapt medical intervention models for open settings</p> <p>Guidelines for malaria, TB, AIDS</p>	<p>Ambition to increase impact, by improving the quality of interventions</p> <p>Further develop the Emergency Public Health concept in the areas of psychosocial care, nutrition and infectious diseases</p> <p>Develop the ability to respond to increasing drug resistance, increasing frequency and size of epidemics, emerging pandemics, food crisis and psychosocial care</p> <p>Develop new Watsan intervention models, including distribution through pipes, wells and trucking</p>
Hot topics	<p>Growth</p> <p>Take on structural/ developmental projects yes/no?</p>	Growth of the organisation	<p>Strengthen MSF's humanitarian role and non-political identity</p> <p>Aftercare of fieldworkers</p>	<p>Guiding principles as laid down in the Chantilly document (1995)</p> <p>Strengthen medical identity of MSF</p>
Internal organisation/ Operational models	Need to increase exploratory missions	<p>Projects require "needs-assessments" and planning and evaluation throughout the project</p> <p>National staff to occupy more responsible positions</p>	<p>New management structure consisting of four managers: operations(includes Medical Dept), HRM, control and marketing & comms</p> <p>Aim for zero growth in project turnover to allow consolidation of quality, development of competences</p> <p>No further involvement in C projects:</p> <p>Health Net International set up in 1992 for "C-projects"</p>	<p>New organisational structure: decentralisation of responsibilities to the field (Field Driven Model).</p> <p>New management structure with four operational directors, a director of resources and a general director in the MT</p> <p>Instead of ABC project focus, now a typology of four intervention types:</p> <p>Projects focused on acute survival, projects in (chronic) conflict settings, projects in non-conflict, rehabilitation</p>

Dates	1987-1990	1990-1993	1993-1996	1996-2000
Support requirements	<p>Increase fundraising from private sources</p> <p>Develop PR strategy</p> <p>Strategy to retain coordinators</p>	<p>Diversification of institutional funding</p> <p>HR development</p>	<p>At least 50 percent of funding from private donors</p>	

Summary of medium term policies/strategic plans (part 2)

Dates	2000 - 2002	2003-2005+	2007-2010
Theme	<i>"To be present, relevant and effective in the important humanitarian crises of the day"</i>	<i>"Fighting to Care"</i>	<i>Strategic Plan 2007-2010</i>
Objective	Catalyst for change: confronting the causes of humanitarian crisis.	(Re-)focus on medical needs and responsibilities, increase projects that facilitate direct contact between MSF doctors and patients, quality of care	Aim to be present in all major humanitarian crises, conducting relevant and high quality operations.
External Challenges	<p>New World Order: privatisation, deregulation and technology leads to increasing social exclusion of the poor</p> <p>Wars mutating into new and bizarre forms of extreme violence making access more difficult</p> <p>Growing number of aid agencies and UN agencies Loss of respect for independent, impartial and neutral humanitarian action: co-opting of humanitarian agenda</p> <p>Emergence of new diseases and resurgence of old diseases</p> <p>Ageing populations and chronic disease burden</p> <p>Front line media coverage</p>	<p>Collapse of public health systems (deterioration of facilities, absence of supplies and shortage of staff); no real belief anymore that all people should have access to healthcare</p> <p>Humanitarianism co-opted by political objectives</p> <p>Politics of fear and isolationism leading to clash of cultures and religions</p> <p>HIV represents single most important medical challenge of the generation</p>	<p>Global political focus on terrorism, nuclear proliferation, organised crime, poverty, and infectious disease</p> <p>Greater difficulty negotiating independent access and less space for direct and impartial humanitarian assistance</p> <p>Humanitarian assistance being made conditional on longer-term objectives towards addressing poverty, "fragile states," and nation building</p> <p>Effects of global climate change</p>

Dates	2000 - 2002	2003-2005+	2007-2010
Medical themes	<p>Medical ethics</p> <p>Focus on broad and flexible understanding of emergency public health</p>	<p>Usual killers of crisis victims - measles, malnutrition, diarrhoea, and respiratory tract infection</p> <p>Pandemics - HIV/AIDS, TB, and malaria</p> <p>Forgotten diseases - sleeping sickness, kala azar and Chagas</p> <p>Potable water, sanitation, food and shelter</p> <p>Psychosocial care</p> <p>Operational research on new diagnostics and treatment protocols (15 percent of resources dedicated to OR and pilot projects)</p> <p>Access to essential medicine</p>	<p>Emergency response and epidemics</p> <p>Surgical, sexual violence care, and mental health programs for direct victims of violence</p> <p>Major causes of mortality - malaria, respiratory and diarrhoeal disease, HIV and TB, obstetric emergencies, and vaccine-preventable and neglected diseases</p> <p>Greater focus on reproductive health</p>
Hot topics	<p>Catalyst for change</p> <p>Exit strategies</p> <p>Proximity of volunteers</p>	<p>Humanitarian action as an act of protest</p> <p>Definition of "good standard of care"</p>	<p>OCA development</p> <p>Direct medical effects of violence</p> <p>Responsiveness</p>
Internal organisation	<p>No change in management structure to allow focus on internal culture, spirit</p>	<p>Extreme importance of medical perspectives in operational choices and organisational policy</p>	<p>OCA development as a model of co-ownership</p> <p>Translate MSF values into an internal culture for OCA</p>
Support requirements	<p>Targets for MDs/paramedicals in field, line management, management teams</p> <p>Upgrading of recruitment, retention and staff development</p> <p>Ethical investment of reserves</p> <p>Commitment to complete transparency/accountability to donors/members</p>	<p>Focus on increasing number of medical doctors in the field and HQ</p> <p>Recruiting the right motivated staff, placing them well, allowing them to develop their own humanitarian position, and keeping them in the field and HQ</p>	<p>Position the OCA as responsible employer</p> <p>Reinforcing logistical decisiveness and strengthening logistical capacity</p> <p>Development and innovation in information & communication technology</p> <p>Enhanced control, learning, and accountability</p>

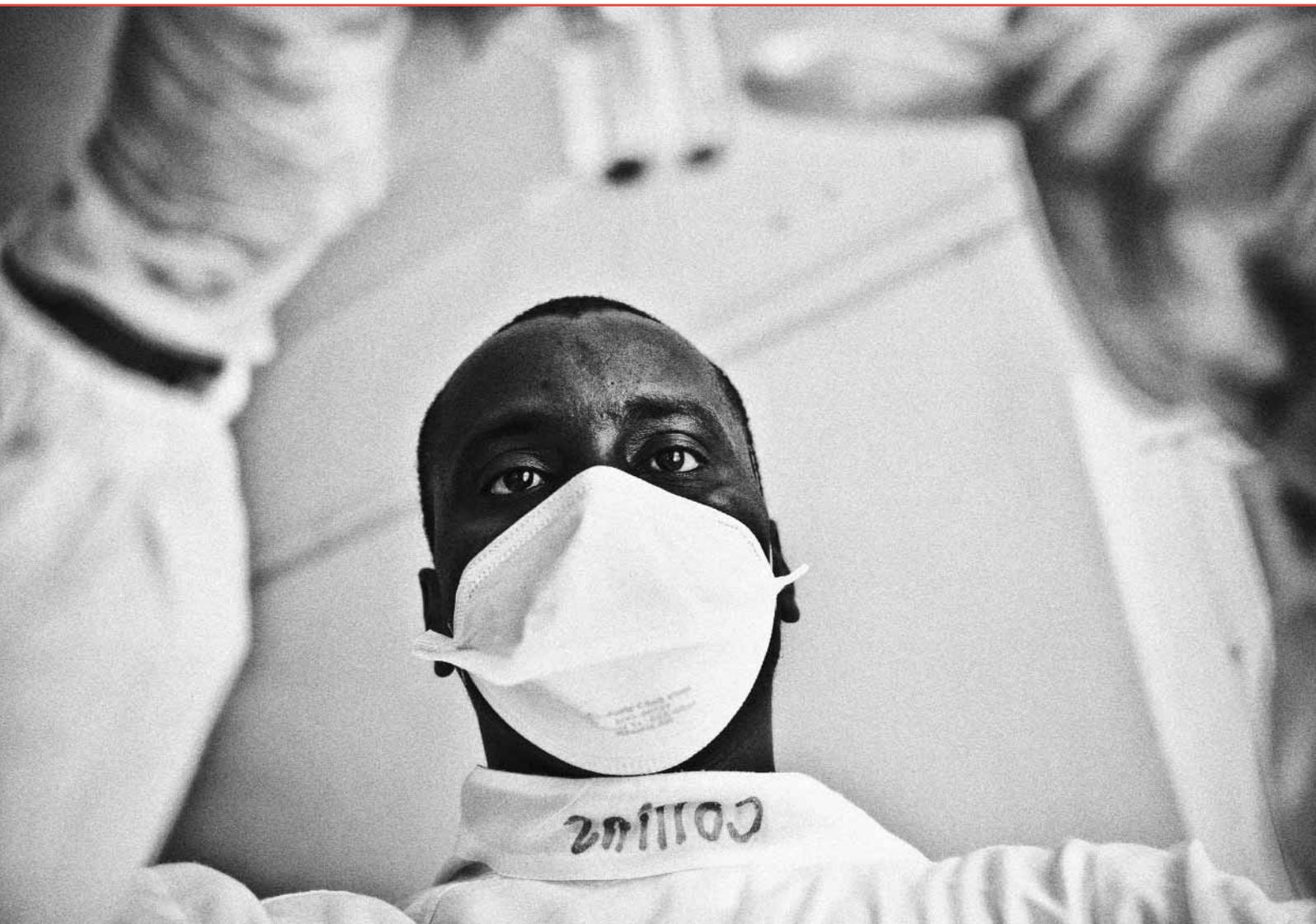


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