MEDECINS SANS FRONTIERES
LÄKARE UTAN GRÄNSER

Report on impact (Effektrapport) 2014

Läkare Utan Gränser
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Ideell förening

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1. What does MSF want to achieve and in which contexts?

Médecins Sans Frontières (MSF) is an international, independent, medical humanitarian organisation that delivers emergency aid to people affected by armed conflict, epidemics, natural disasters and exclusion from healthcare. MSF offers assistance to people based on need, irrespective of race, religion, gender or political affiliation.

Our actions are guided by medical ethics and the principles of neutrality and impartiality.

A worldwide movement

MSF was founded in Paris, France in 1971.

Its principles are described in the organisation's founding charter. It is a non-profit, self-governed organisation.

Today, MSF is a worldwide movement of 24 associations, bound together as MSF International, based in Switzerland.

Thousands of health professionals, logistical and administrative staff – most of whom are hired locally – work on programs in some 70 countries worldwide.

Humanitarian action

MSF's work is based on humanitarian principles. We are committed to bringing quality medical care to people caught in crisis, regardless of race, religion or political affiliation.

MSF operates independently. We conduct our own evaluations on the ground to determine people's needs. More than 90 per cent of our overall funding comes from millions of private sources, not governments.

MSF is neutral. We do not take sides in armed conflicts, we provide care on the basis of need, and we push for independent access to victims of conflict as required under international humanitarian law.

Bearing witness and speaking out
MSF medical teams often witness violence and neglect in the course of their work, largely in regions that receive scant international attention.

At times, MSF may speak out publicly in an effort to bring a forgotten crisis to public attention, to alert the public to abuses occurring beyond the headlines, to criticize the inadequacies of the aid system, or to challenge the diversion of humanitarian aid for political interests.

Quality medical care

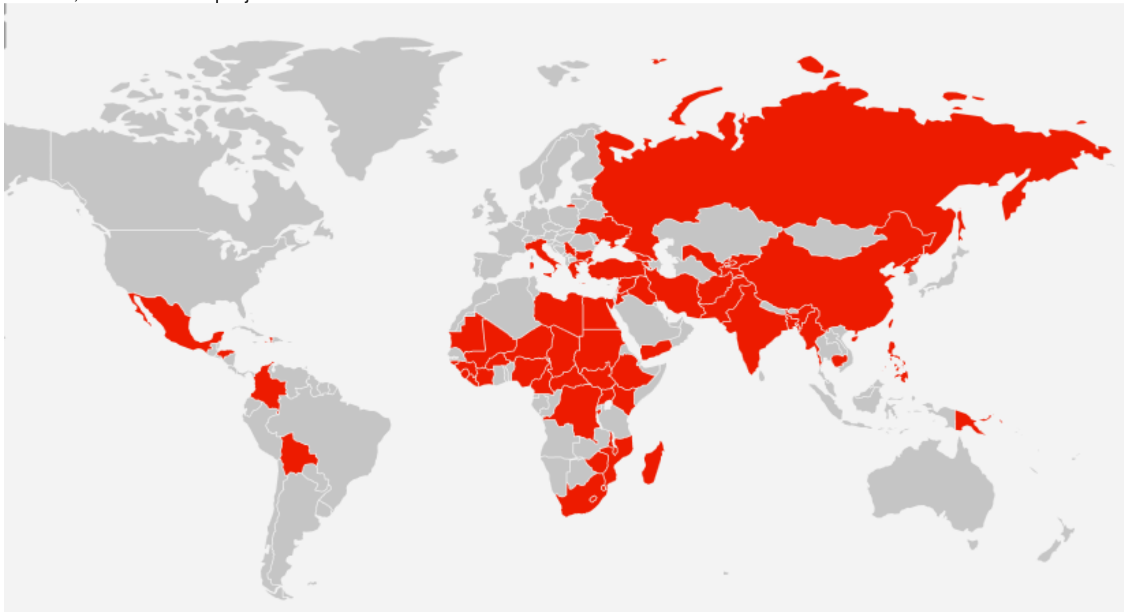
MSF rejects the idea that poor people deserve third-rate medical care and strives to provide high-quality care to patients. In 1999, when MSF was awarded the Nobel Peace Prize, the organisation announced the money would go towards raising awareness of and fighting against neglected diseases.

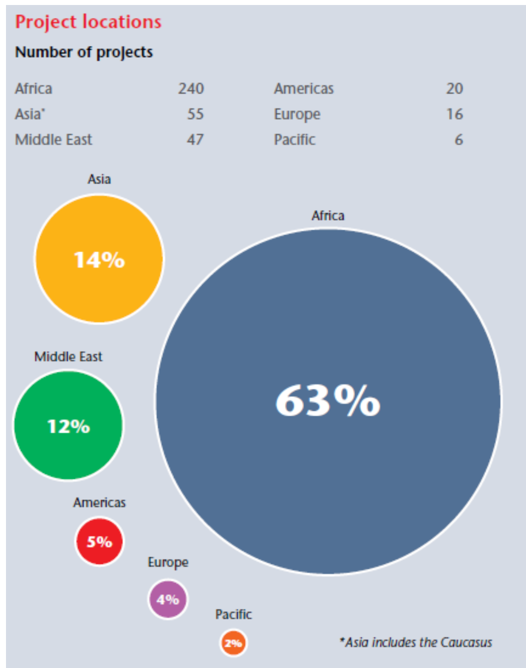
Through the Access Campaign, and in partnership with the Drugs for Neglected Diseases initiative, this work has helped lower the price of HIV/AIDS treatment and stimulated research and development for medicines to treat malaria and neglected diseases like sleeping sickness and kala azar.

MSF-Sweden contributes to the work of MSF in the field through the recruitment of fieldworkers, fundraising and advocacy.

MSF PROGRAMMES AROUND THE WORLD

In 2014, MSF had 384 projects in 63 countries





Project locations

Number of projects

Africa	240	Americas	20
Asia*	55	Europe	16
Middle East	47	Pacific	6

Staff numbers

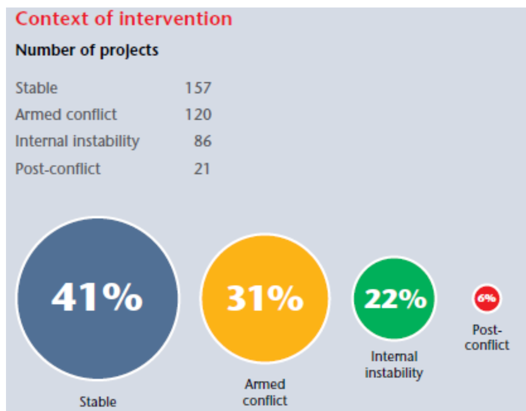
Largest country programmes based on the number of MSF staff in the field. Staff numbers measured in full-time equivalent units.

1. South Sudan	3,996
2. Democratic Republic of Congo	2,999
3. Central African Republic	2,593
4. Haiti	2,159
5. Niger	1,866

Largest country programmes based on project expenditure

1. South Sudan
2. Democratic Republic of Congo
3. Central African Republic
4. Haiti
5. Sierra Leone
6. Afghanistan
7. Niger
8. Liberia
9. Ethiopia
10. Iraq

The total budget for our programmes in these 10 countries is 380.5 million euros, **54 per cent** of MSF's operational budget.



Context of intervention

Number of projects

Stable	157
Armed conflict	120
Internal instability	86
Post-conflict	21

Outpatient consultations

Largest country programmes according to the number of outpatient consultations. This does not include specialist consultations.

1. Democratic Republic of Congo	1,593,800
2. Central African Republic	1,401,800
3. South Sudan	936,200
4. Niger	508,300
5. Ethiopia	347,700
6. Kenya	333,400
7. Afghanistan	306,600
8. Pakistan	279,900
9. Chad	257,200
10. Sudan	246,900

In 2014, MSF:[1]

- Provided almost **8,250,700** open consultations and care to **511,800** hospitalised patients.
- Treated **33,700** people for measles and vaccinated **1,513,700** people
- Vaccinated **75,100** people for meningitis
- Treated **2,114,900** people for malaria
- Treated **46,900** patients for cholera
- Admitted **250,900** severely malnourished children to inpatient or outpatient feeding programmes
- Held **185,700** individual and **32,700** group mental health counselling sessions
- Attended **194,400** deliveries
- Performed **81,700** major surgical interventions
- Treated **11,200** patients for sexual violence related injuries

[1] MSF International Activity Report 2014: http://2014.lakareutangranser.se/

- Treated **21,500** new people for tuberculosis and admitted **1,800** new patients for Multi Drug Resistant-Tuberculosis (MDR-TB)
- Had **229,900** HIV patients registered under care at the end of the year
- **7,400** people admitted to Ebola management centres in the three main west African countries, of which 4,700 were confirmed as having Ebola
- **2,200** people recovered from Ebola and discharged from management centres in the three main west African countries

Collaboration and integration in existing systems
MSF mainly focuses on providing emergency relief during medical and/or humanitarian crises and as such does not consider sustainability as a prerequisite in order to start humanitarian interventions. However, the longer term implications of its actions on the local context are thoroughly analysed and MSF always tries, whenever possible, to collaborate with local authorities and works within existing health structures. This can take different forms at different levels, depending on the context and settings. MSF does not want to purely substitute or run in parallel of existing facilities, which would indirectly undermine local capacity and jeopardise sustainability of results. MSF strives to hand over its activities where possible and incorporating initiatives into regular systems is the best way to ensure continuity of action.

The Ministry of Health (MoH) is in most countries the main counterpart and Memorandum of Understandings (MoU) are often signed in order to define and regulate the terms of the collaboration. In settings where MSF supports regular facilities, both MSF and MoH contracted staff work together. This can be a challenge in terms of management as expectations, tools and routines as well as working conditions differ. In MSF supported structures, whenever there are MoH human resources, MSF pays any salary difference and/or incitement to compensate higher workload, in order to secure well-functioning activities

Training of its own national staff, as well as staff in local health structures, is a key component of MSF's medical activities, both in order to meet immediate needs as well as to promote long-term capacity building. The areas where MSF intervenes benefit not only from well-trained staff, but also from investments made in health structures, such as buildings, equipment and water and sanitation improvements. Every possible effort is made to ensure that handover partners take proper responsibility for such investments once MSF leaves and reasonable resources are normally made available for continued maintenance.

2. What strategies makes it possible for MSF to achieve its goals?

MSF is impartial in that it is committed to bringing quality medical care to people caught in crisis, solely on the basis of needs, regardless of race, religion or political affiliation. Furthermore, MSF's operations are independent of any political, military, or religious agendas. As a medical organisation, MSF prioritises needs that impact morbidity and mortality, as well as focusing on the most vulnerable such as women and children.

As mentioned earlier, a fundamental principle of MSF is that at least half of its global income must come from private sources. During 2014, 89% came from 5,7 million individual donors and private funders and 9% from public institutional donors such as Sida and ECHO, other income was 2%. This specific funding mechanism makes MSF a reliable actor in the field of humanitarian assistance, as it is able to intervene quickly without having to wait for donor's approval and/or funding. It also contributes to ensure MSF's independence in highly politicised contexts, making sure decisions are based only on needs and humanitarian principles[2]. This combined with an intervention model based on proximity and direct involvement allows the organisation to carry on extensive advocacy work, based on first-hand information and evidence.

Assessments and/or exploratory missions are carried out prior to any intervention, in order to analyse the situation and determine a population's needs, and specifically medical ones, before launching activities. During the course of a programme or intervention, regular monitoring of activities, indicators and results serve as a basis for MSF teams to adapt strategies and means according to changing needs and context evolution. At the headquarters level, operations coordinators and humanitarian advisors make sure assistance is provided where it is most needed, prioritising and allocating resources adequately between current and potential areas of intervention.

MSF also tries to work ahead of emergencies and disasters, putting a lot of effort into capacity building at the local level and emergency preparedness. Contingency plans are developed in each country of intervention. This includes prepositioning of logistical and medical resources, as well as capacity building in terms of routines, training of staff and collaboration mechanisms with other stakeholders, national and international NGOs as well as local authorities.

3. What is the capacity of MSF, in terms of finances and HR?

In 2014, the total income of MSF worldwide was 1281 million Euro, out of which 89% was donated by approximately 5,7 million private donors.

Some 34,000 Médecins Sans Frontières (MSF) staff from all over the world provide assistance to people in crisis. They are doctors, nurses, midwives, surgeons, anaesthetists, epidemiologists, psychiatrists, psychologists, pharmacists, laboratory technicians, logistics experts, water and sanitation engineers, administrators and other support staff.

All our staff are professionals who choose to work for MSF because of a commitment to and concern for people's health and survival. More than 90 per cent are recruited in the countries where the programs are, and they work with a small number of international staff.

[2] If a donor country is involved in a specific conflict where MSF works, institutional funding from that donor will not be accepted. This is obviously the case when a country is taking part in a conflict, but also if it is involved as, for example, a mediator (e.g. Norway in Sri Lanka), strongly associated with other actors or plays a dominant role in the local context e.g. through UN representation or as a former colonial power. In highly politicised contexts MSF chooses not to accept any institutional funding. Acceptance of the organisation as an independent, neutral and competent medical humanitarian actor often depends on avoiding association with actors that are perceived to be involved at a political level. Sometimes this extends to UN agencies.

In our executive offices, operations, communications, advocacy, fundraising, finance and human resources teams all contribute to making sure MSF provides effective medical assistance to the people who need it most. Specialised medical and logistical support departments ensure that innovations and advances in research are incorporated into our work in clinics and hospitals around the world.
In 2014, the total income of the Swedish section of MSF was 595 million SEK, and 131 Swedish fieldworkers were sent to MSF missions.

4. How does MSF work with monitoring and evaluation?

MSF is working with result-based management tools (Logical Framework Approach) to steer, monitor and evaluate its projects. Indicators of success are defined with measurable targets for each objective, allowing adequate monitoring of the evolution of the project. This is done on a daily, weekly, monthly, bi-annual and yearly basis by the project teams. Statistics, management indicators and medical data are compiled and analysed at the field and headquarter levels. Visits from the coordination teams (based in the capital) and from headquarters' operational responsible, medical referents and technical experts are carried out on a regular basis, when a specific need is detected but also as a continuous support and follow-up.

Evaluations and reviews have long been used in MSF for assessing the quality of its interventions, in terms of medical and operational standards, with respect to the organisation's mission and principles. This is mostly being used as a tool for learning and accountability – but a more established and mainstreamed approach is being developed. The latest investments in evaluation capacity within the movement show the increasing recognition and acceptance towards monitoring and evaluation (M&E) in recent years. In Stockholm this capacity was formalised in 2012 (following a two year pilot) through the establishment of the Stockholm Evaluation Unit (SEU). The unit has been looking towards ways to improve dissemination of its findings and recommendations, as well as reflection and follow up. This helps bring together the lessons learned as well as strengthen the capacity of the evaluation to actually be a catalyst for change and improvement (implementation of recommendations). The current processes of presenting findings and recommendations on internal platforms, encouraging a management response and disseminating reports widely, help to ensure that recommendations are acted upon in the short run. In 2013, some of MSF's internal control mechanisms have started to include systematic follow-up of evaluations into regular monitoring. This is a major achievement when it comes to move towards institutionalisation and capitalisation of evaluation findings.

The annual evaluation event, as well as during many associative debates and discussions, are other ways that MSF shares "lessons learnt" within the movement. In July 2012, an intersectional evaluation group was created which joins all the evaluation entities within MSF, with the overall aim to share experiences and good practices in project reviews and evaluations. Also in 2012, the first intersectional transversal review of hospital evaluations took place and similar transversal reviews are planned on other thematic.

MSF also does other types of evaluations, both external and internal, such as mortality surveys, retrospective studies, coverage surveys, health promotion follow-ups, internal reviews of operations and/or ways of working etc. For epidemiological purposes MSF can require the expertise of "Epicentre" which is an internationally recognised institution that performs surveys and evaluations from an epidemiological

perspective. Less ambitious (more limited scope and resources) but still very valuable studies are conducted at the country level, by regular field teams, on various topics. The results are often aimed to stay at project or country level, unless findings can benefit other programmes and stakeholders. Whenever possible and/or relevant the outcomes are shared with national authorities and other actors in order to improve overall responses and planning of activities.

Besides the formal and structured initiatives described above, it is important to stress that MSF has a broad culture of continuous improvement and self-criticism, at all levels of the organisation. Each intervention or project is followed by debriefings sessions in order to capitalise on lessons learned. Protocols and ways of working are regularly put into question and all technical departments work continuously in order to improve efficiency of programmes and technical solutions, patients' treatment, national strategies, MSF routines etc. This work is carried out on a daily basis and at all levels of the organisation, including in the field. This is being done internally and externally, through experience sharing, learning platforms, implementation of best practices, wide collaboration with experts in humanitarian assistance and technical fields, other organisations, universities, research institutes etc. Formally and less formally, MSF is always renewing its ways of working, capitalising on successes and aiming to learn from its mistakes.

Some of the important key performance indicators used in the organisation are the number of consultations/treatments in OPD (Out-Patient Department) and IPD (In-Patient Department), ANC (Ante Natal Care), PNC (Post Natal Care), Surgery, Deliveries, HIV (treated), Mental Health Sessions, Malaria (treated), Malnutrition, Vaccination and SGBW (Sexual Gender Based Violence).

5. What has been achieved in 2014?

In 2014, the largest Ebola outbreak in history struck West Africa, the number of displaced people in the world exceeded 50 million and the war in Syria entered its fourth year.

MSF deployed teams to work in simultaneous emergency situations across the globe, from Liberia to South Sudan, from Ukraine to Iraq.[3]

Following initial needs assessments and baseline data when available, the logical rameworks developed in all MSF's interventions help implement activities and measure to what extent the objectives are met, through a close monitoring of a set of indicators. On the basis of those results, it is then possible for MSF to follow-up the relevance and appropriateness of its interventions and to identify and analyse any gaps in implementation. It is rare that MSF projects do not achieve all the objectives set, unless some major external factor impacts the ability for the projects to fulfil the planned activities. The degree of achievement can sometimes be impacted negatively by contextual changes (security, politics etc.), external and internal difficulties (human resources, logistics, administrative barriers etc.) or if targets have been set too high.

[3] Extract from MSF International Activity Report 2014, p.4-7

Overall the figures demonstrate major achievements, see a few examples from 2014 below. In 2014, MSF programmes around the world provided;

- almost 9 million medical consultations
- delivering 195.000 mothers
- Malaria treatment to over 2.1 million patients
- Measles vaccinations to 1.5 million children

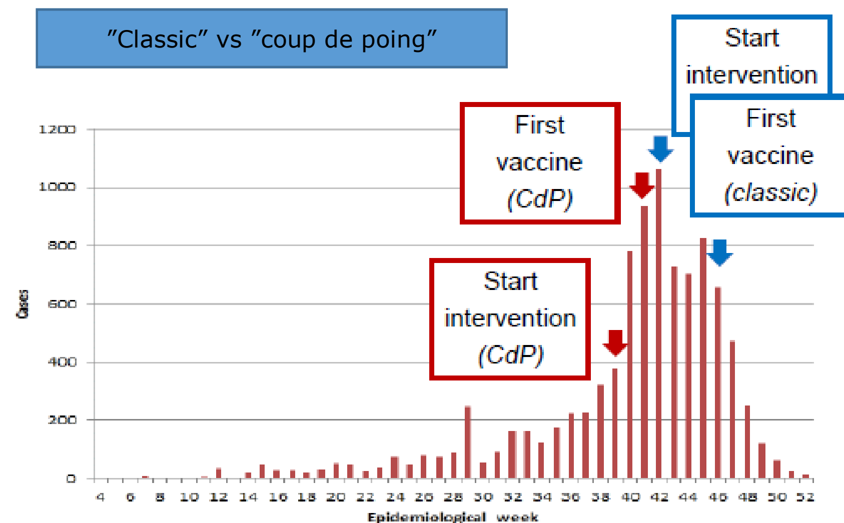
Measuring the impact of MSF operations – some examples

The figures above show that MSF projects do save lives and relieve suffering. However, measuring the impact of MSF activities is difficult due to several reasons. The situation in areas of interventions is often unstable, volatile, leading to quick changes in the environment, worsening of security situation and/or degradation of humanitarian and medical priorities, people moving, target populations shifting, other actors coming in or leaving etc. Furthermore, baselines are often missing, incomplete or unreliable, making it difficult to follow-up on the overall goal of MSF operations to reduce mortality and morbidity.

However, without being presumptuous, in terms of impact, MSF can argue that its programmes contribute to improvements in the areas of intervention. Projects lead to measurable results (mainly at an outcome and output level), some with immediate outcomes and other with more sustainable and/or longer term impacts. Moreover, in many of MSF's countries of intervention. MSF can, given the size and volume of its operations and the humanitarian context, assume that its programmes have a positive impact on the population, despite enormous needs and limited resources. For example:

- In South Sudan, MSF has been delivering approx. 900 000 OPD consultations in 2014 and the total expenditures accounted for 83 million EUR, which is more than the health budget of the national Ministry of Health. MSF was present across the country, carrying out activities where no other actors did. Many people only have MSF to rely on in order to get the healthcare they need.
- In West Africa, MSF was among the first actors to respond to the Ebola outbreak on the ground, long before the international community took its responsibility. MSF took often the lead in the response, given the lack of expertise and coordination capacity. MSF mobilized significant resources at all levels, from rapid response to hotspots in remote rural locations to high level meetings addressing the UN General Secretary. MSF opened its facilities to many actors so that they could be trained on Ebola and on setting up case management centres.
- In the field of vaccination, MSF is very reactive, quickly setting up emergency campaigns in the event of outbreak. In 2014, over 1,5 million beneficiaries got immunized against measles and meningitis. Facing the recurrent, long lasting and massive measles outbreak in DRC, MSF developed a different approach in 2014, implementing the so called 'coup de poing' methodology,

vaccinating more quickly the epicentre of the outbreak. Results showed a positive impact with attack, case fatality and mortality rates being below the ones seen after traditional immunization campaigns.



In the same sense, in its guidance document from 2014, MSF underlines the fact that emergencies settings may "trigger the need for preventive vaccination activities, different from or additional to those recommended for routine practice". In this perspective, MSF decided for example to deploy significant resources to vaccinate over 150 000 South Sudanese refugees and host population against cholera in Gambella, Ethiopia, hence diminishing significantly the risk of massive outbreak.

More generally, in all contexts of intervention, extensive health promotion activities go hand in hand with MSF medical input. Therefore behavioural changes and more adequate health seeking habits can hopefully be expected in the long run. For example, steps towards better hygiene practices consequently decrease the risk of morbidity and mortality. MSF has also been doing more and more in terms of water and sanitation, as this is one of the most important factors to reduce morbidity and often a pre-condition to any other interventions (healthcare provision, food and nutrition etc.), especially in poor settings and fragile environments.

Impact of MSF's field based research

MSF is known for its humanitarian medical work, but it has also produced important research based on its field experience. It has published articles in over 100 peer-reviewed journals and they have both changed clinical practice and been used for humanitarian advocacy. MSF's research can be browsed on http://fieldresearch.msf.org/msf/.

Research can also be used for advocacy purposes. One important way MSF can produce long-term impact is by witnessing and speaking out on situations the teams are confronted to. Case studies were originally designed for internal purposes but, with the hope of broadening their educational scope, the studies are now available to the public on the http://speakingout.msf.org/ website, as well as on the various websites of Médecins Sans Frontières. MSF is also publishing regular press releases as well as in depth reports that have hopefully contributed to catch the attention of the international community, media and decision makers.

Challenges in implementation, due to external factors

Despite all achievements, it is important to keep in mind that MSF was very much hampered in its action due to lack of access as well as the targeting of medical and humanitarian assistance, leading to unacceptable security issues. This is a major concern that actors and donors at all levels must be aware of. MSF is often operating in very challenging contexts, where many organisations choose not to be because of the risks linked to security situation, corruption, access etc. MSF programmes and teams regularly faced difficulties in the implementation of activities, with evacuations, lootings, suspension of activities, political and administrative difficulties, large scale epidemics etc. Exit strategies and preparedness, closing down and handing over projects remain difficult and plans to do so are often jeopardised or delayed due to changes in the context that affected the needs of the host population and/or the ability of other actors to take over.

During the years MSF teams have withstood several security incidents and faced serious barriers to access. The issue of incidents targeting MSF and other humanitarian organisations is of significant concern, not only for security, but also for the ultimate impact these events and their consequences – temporary suspension or revocation of medical services – have on the health and survival of the people we aim to help. In 2013, MSF began researching such incidents, their impact and our response in the Medical Care under Fire project. MSF hopes to identify ways to improve patients' safe access to healthcare and the security of healthcare structures and international and national medical teams. The Medical Care under Fire project continued during 2014 and MSF Sweden contributed actively to the ongoing research through the Humanitarian Advisor who joined the intersectional research team with quantitative analyses of MSF projects in Nairobi (Kibera) and Afghanistan. The findings and research issues have been presented on various occasions in Sweden, in cooperation with the Swedish Red Cross and the Stockholm International Peace Research Institute

(SIPRI) amongst others. The Afghanistan analysis was presented at a workshop in Kabul in December 2014 with a variety of Civil Society Organizations (CSO), government officials and UN representatives. A final report of the Medical Care under Fire project will be concluded in 2015.

MSF also has significant concerns regarding the need to separate the roles between humanitarian and military actors. MSF’s position on this topic is based on International Humanitarian Law (IHL) and on MSF’s operational principles and understanding of the role and responsibilities of different actors. The work of MSF is based on the humanitarian principles of neutrality, impartiality and independence. These principles are not only ethically important; in practice, they are extremely valuable as a tool in operations, especially in situations of armed conflict. In order to underline the importance of and challenges linked with civil military relations, MSF-Sweden has systematically brought up the issue at bilateral and multilateral meetings with participants from the Swedish Government, parliament, defence forces, NGOs, academics etc. During 2014, MSF Sweden’s Humanitarian Advisor have held lectures on the topic of civil military relations, MSF’s principles and operations, and MSF’s view and experiences from the field on the subject.

MSF was in 2014 able to have an impact beyond its immediate activities, reaching populations or pioneering the use of practices in ways that have far-reaching and lasting consequences, as this report has tried to highlight and explain.