MEDECINS SANS FRONTIERES
LÄKARE UTAN GRÄNSER

# Report on impact (Effektrapport) 2015

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## Contents

## 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.

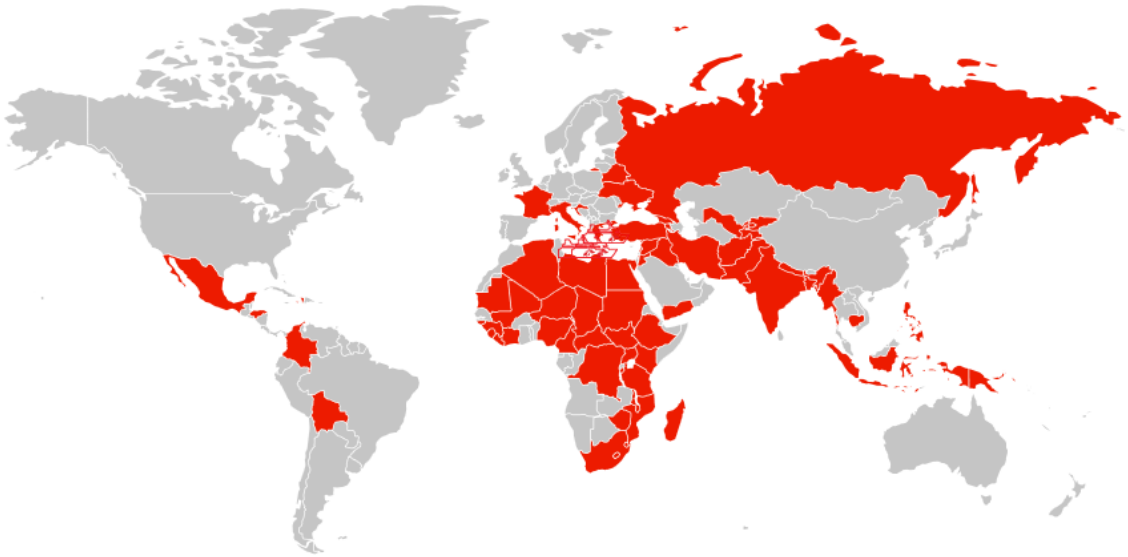
Through the Access Campaign, and in partnership with the Drugs for Neglected Diseases initiative, this work has helped lower the price of HIV/AIDS treatment and stimulated research and development for medicines to treat malaria and neglected diseases like sleeping sickness and kala azar.

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 2015, MSF had operations in 69 countries and the activities were conducted through nearly 3 000 international staff (full-time) positions, and nearly 31 000 local employees, supported by some 3 000 staff at headquarters.

In 2015, MSF had 446 projects in 69 countries



## Largest country programmes based on project expenditure

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

The total budget for our programmes in these 10 countries is 445.7 million euros, **51 per cent of MSF's operational budget.**

## 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 | 3,322 |
| 2. Democratic Republic of Congo | 2,867 |
| 3. Central African Republic | 2,629 |
| 4. Afghanistan | 2,303 |
| 5. Haiti | 1,835 |

## Outpatient consultations

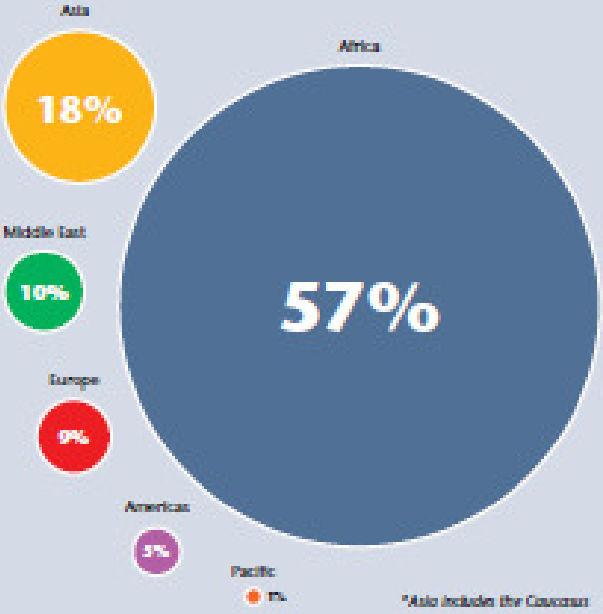
**Largest country programmes according to the number of outpatient consultations. This does not include specialist consultations.**

| | |
|---|---|
| 1. Democratic Republic of Congo | 1,652,008 |
| 2. Central African Republic | 1,016,096 |
| 3. South Sudan | 915,934 |
| 4. Lebanon | 683,385 |
| 5. Ethiopia | 413,195 |
| 6. Niger | 408,009 |
| 7. Afghanistan | 366,164 |
| 8. Pakistan | 358,308 |
| 9. Syria | 350,348 |
| 10. Kenya | 281,140 |

## Project locations

**Number of projects**

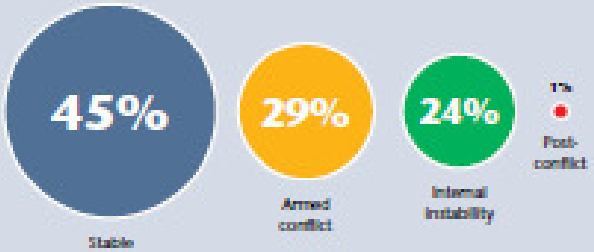
| | | | |
|---|---|---|---|
| Africa | 256 | Europe | 38 |
| Asia* | 81 | Americas | 22 |
| Middle East | 44 | Pacific | 5 |




## Context of intervention

**Number of projects**

| | |
|---|---|
| Stable | 203 |
| Armed conflict | 130 |
| Internal instability | 109 |
| Post-conflict | 5 |



**In 2015, MSF:**[1]

- Provided almost **8,664,700** open consultations and care to **598,600** hospitalised patients
- Provided **6,800** HIV-positive pregnant women with prevention of mother-to-child transmission (PMTCT) treatment
- Provided 4,400 eligible new-born babies with post-exposure treatment
- Treated **45,900** people for measles and vaccinated **1,537,400** people in response to an outbreak
- Vaccinated **326,100** people against meningitis in response to an outbreak
- Treated **2,299,200** people for malaria
- Treated **32,600** patients for cholera
- Admitted **60,500** severely malnourished children to inpatient feeding programmes
- Held **184,600** individual and **39,300** group mental health counselling sessions
- Assisted **243,300** deliveries, including caesarean sections.
- Performed **106,500** major surgical interventions
- Medically treated **11,100** patients for sexual violence
- Treated **18,100 tubercolusis** patients with first-line treatment, and **2,000** patients with Multi Drug Resistant-Tuberculosis (MDR-TB) with second line treatment.
- Had **340,700** HIV patients registered under care at the end of the year
- Had **236,800** patients on first-line anti-retroviral treatment by the end of the year.
- Rescued and assisted **23,700** migrants and refugees at sea

**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

[1] MSF International Activity Report 2015: http://2015.lakareutangranser.se/

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 2015, 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.

[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.

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

In 2015, the total income of MSF worldwide was 1332 million Euro, out of which 92% 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.

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 2015, the total income of the Swedish section of MSF was 648 million SEK, and 136 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 Stockholm Evaluation Unit (SEU), established in 2012, plays a significant role in making sure evaluations are conducted, recommendations made and followed up on. The SEU could in June 2015 launch its dedicated website http://evaluation.msf.org/ to help spread findings. This "one stop" access to all MSF evaluation reports is a big step towards better accountability and shared learning. Available reports have various access levels, and some internal findings are only available if having necessary credentials. However, there is a willingness to go towards a higher level of completely public documentation. The website also provides background information on resources, processes and people. In 2015 the unit

performed in total 9 evaluations and one of the major achievement was the completion of the extensive Ebola review. The unit also performed an evaluation on MSF's supporting activities in Syria and the trauma centres in Kunduz and Tabarre.

The annual evaluation event, as well as during many associative debates and discussions, are other ways that MSF shares "lessons learnt" within the movement.

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 2015?

In 2015, MSF worked in 69 countries, responding to sudden emergencies but also meeting the needs of chronic conflict and post conflict settings. The period saw multiple, complex, humanitarian emergencies and numerous attack on healthcare facilities, which challenged MSF's capacity to respond. Still, MSF managed to increase its operations in 2015 and the overall growth in MSF operations is mainly explained by the response to violent crises and conflicts (Syria, Yemen and South Sudan) and, to a lesser extent, by operations related to SAR and migrant support. Displaced persons and refugees represent an important part of MSF activities.

Following initial needs assessments and baseline data when available, the logical frameworks 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. Overall the figures demonstrate major achievements, see a few examples from 2015 below. In 2015, MSF programmes around the world provided;

- Almost 9 million medical consultations
- Assistance to over 243.000 births
- Malaria treatment to over 2.2 million patients
- Measles vaccinations to 1.5 million people

The Swedish section of MSF contributed with almost 563 million SEK to the international MSF activities,[3] and raised awareness about the ongoing refugee crisis and the need for safe and legal passage to Europe, the Ebola-epidemic, antibiotic resistance and the bombing of our hospital in Afghanistan, where we demanded an independent investigation. The Swedish section also recruited 136 fieldworkers, filling in total 176 positions in the field during the year. The Swedish innovation unit worked on several cases aiming to improve MSFs work in the field, for example related to the cold-chain ensuring that vaccines are kept cold at all times, and a new autoclave for sterilisation of medical instruments. [4] The Stockholm evaluation unit(SEU), established in the Swedish section of MSF in 2012, carried out several evaluations of field interventions, as further explained on page 8.

**Measuring the impact of MSF operations – some examples**

The number of performed consultations and patients treated only in 2015, shows 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,

*3 Annual report of MSF-Sweden 2015, p 29*
[4] Annual report of MSF-Sweden 2015, p 19-22

- In South Sudan, MSF has been delivering approx. 900 000 OPD consultations in 2015 and the total expenditures accounted for 83 million EUR. 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 total, MSF admitted 10,310 patients to its Ebola management centres of which 5,201 were confirmed Ebola cases, representing one-third of all WHO-confirmed cases.[5]

- In the field of vaccination, MSF is very reactive, quickly setting up emergency campaigns in the event of outbreak. In 2015, almost 1,9 million beneficiaries got immunized against measles and meningitis.

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

[5] See the *MSF Ebola accountability report* on https://lakareutangranser.se/sites/default/files/media/ebola-accountability-report-201603.pdf

the risks linked to security situation, corruption, access etc. MSF also saw that we in 2015, had an increase in the volume of remote activities, and medical donations (Lebanon, Syria).

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.

MSF was in 2015 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.