HOW MSF WORKS
QUESTIONS ANSWERED, EXPLORED, AND RAISED
Dear Friends,

Over the years, I’ve been asked many questions about the work that we do, and I’ve done my best to answer them, drawing on my own field experience to do so, and drawing even more on the ethics and principles this organization has aspired to uphold in the 41 years since it was founded.

For this issue of Alert, we thought we’d take the opportunity to share some answers to questions we get asked frequently both in our office and in the field. Alert is a publication in which we try to have deeper discussions about our operations, so it seems like an ideal place to continue what we hope is an ongoing conversation about our work, our projects, our people, and our ambitions and goals. In some cases, the questions have relatively straightforward answers. In others, the questions raise additional questions and inspire deeper thought on our part. We’ve also included some personal reflections from people who have worked in the field.

Given the inquisitive and reflective nature of MSF, we are more than happy to have these discussions—and in some instances, to introduce aspects of what we do that might not be immediately obvious. We are also happy to have this conversation because we greatly value your support, and we believe that we should be held accountable for the decisions we make by the people who in many ways make those decisions possible.

Unfortunately, we only have a limited number of pages to work with here, and thus we can only get to so many questions. But we hope you’ll visit our website for updates on our day-to-day work, and we hope you’ll appreciate this attempt to respond to your queries and concerns. We wholeheartedly invite people inside and outside the organization to continue asking questions, so we can continue answering, thinking, and reflecting, with the ultimate goal of improving the care that we deliver in the field to people who truly need the assistance.

Sincerely yours,

SOPHIE DELAUNAY
Executive Director, MSF-USA

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Right: During a 2011 cholera outbreak in DRC, an MSF staff member makes an announcement as part of an outreach campaign designed to help people understand how to recognize, seek treatment for, and prevent the disease. © Robin Meldrum/MSF

Cover: The gate of the MSF-supported Boost Hospital, in the city of Lashkargah in Afghanistan’s Helmand province. The 250-bed hospital is one of only two general hospitals in the whole southern half of the country. © François Dumont/MSF
A CONVERSATION WITH SOPHIE DELAUNAY, EXECUTIVE DIRECTOR, MSF-USA

Why does MSF stress that people in leadership positions have field experience?

MSF is governed by an Association made up of individuals who express their solidarity through the delivery of medical care in the field. Our Board of Directors is very connected with the Association, because the board is itself composed of former field staff and Association members elected by the broader MSF Association, which is largely composed of people in the field.

It’s important to ensure that throughout the organization, the decisions that we make are driven by field considerations and that those decisions benefit our operations first and foremost. To do this, you need executive level people who know the constraints and the needs of the field. It doesn’t mean that we don’t want to include external perspectives, but this ethos is important. For me, I don’t see how I could do my job without field experience, because donors and external partners constantly ask about our operations and our operational choices. Being able to speak from experience in the field helps me give credible responses.

How do you balance managing day-to-day operations and staying prepared to respond to new emergencies?

Emergency is in MSF’s DNA. Whenever there is an emergency, everybody has an intuitive way of focusing their priorities. You realize that there are always some things that can be put on hold. I experienced it when I was completely focused on our post-Hurricane Sandy operations for a few weeks last fall. I had a lot to catch up on afterwards, but dealing with emergencies forces you to adjust.

“MSF is governed by an Association made up of individuals who express their solidarity through the delivery of medical care in the field.”

What are some priorities for MSF-USA in the coming years?

We want to continue providing a critical amount of resources to the overall MSF movement, providing financial support and supporting human resources with the expertise we can offer, and in areas like communications and advocacy as well. We also want to further strengthen the medical expertise that we provide to operations. This will translate into the development of a new health information system, which will be a very big dossier. We will also continue to provide expertise in areas like antibiotic resistance and neglected tropical diseases. The ultimate goal is to improve the quality of our care and develop therapeutic or preventive approaches that are more adaptive to the needs in the field.

Are there areas where MSF has to improve?

Plenty. One major focus of the US Board should be to continue challenging operations on quality of care. We do a decent job of trying to assess our impact and learning from our mistakes and practices, given how complex it is to operate in unstable and resource-limited settings. It’s not enough to know that the treatments we’re using are working, though, or to know the number of people we’ve treated. We need to go further, to measure the quality of care that we’re delivering and its impact on the long-term well-being of the person who receives it. What is the survival rate? What kind of coverage do we achieve? Are our approaches as adapted to the context as they should be? We need to answer these questions, especially as we engage more in chronic disease care.
Does that include working on methods of handing over projects if or when MSF leaves?
There are already things in place designed in that spirit. There is the fact, for example, that 90 percent of our staff is national staff, or Ministry of Health staff, trained by MSF. This creates conditions for continuity. I also think the way we are approaching the health information system, for example, is very promising. Next year, when we start to implement the new HIV database we’re working on, we will set up platforms that are compatible with the platforms put in place by the Ministries of Health in the countries where we have our largest number of patients. Making sure we create something that Ministries of Health can use is an imperative.

You worked in several field projects. Do you miss being in the field?
Of course. It’s the most interesting part of the job. That’s why I worked with the Board to ensure that I can go to the field for one month every year. This year, I went to China for two weeks. Last year, I spent one month with our program in Central African Republic. The previous year, I was in Pakistan. I go to the field because it helps me rejuvenate myself in this position and helps me perform my job here.

HOW AND WHERE DOES MSF-USA RUN COUNTRY PROGRAMS?

MSF programs are run by “desks” in different headquarters offices around the world. Gwenola Francois, MSF-USA deputy program manager, talks about MSF-USA’s portfolio and the priorities for the year ahead:

We are now and will remain in charge of projects in Ethiopia, Haiti, and South Sudan. Workload related to country management changes depending on the contexts. New projects open, others close. Two countries like South Sudan and Haiti today can be equal to three or four “small” countries in terms of activity, human resources, and budgetary needs. New desks open, too, like the one MSF now has in Dubai. So it’s sometimes necessary to redistribute responsibilities. At times, we also might organize certain groups of countries, like the countries of the Sahel, for example, which have some common regional political dynamics, under desks in one office, for the sake of continuity.

In terms of our priorities, generally speaking, we have to manage the projects we are in charge of according to the evolving contexts and changing needs on the ground. This is particularly true for South Sudan, which is new to our project portfolio. It’s a large country with a complex context and huge health needs, some linked to ongoing conflict, some not. We have to manage the programs as efficiently as possible, take care of the security of our staff—that is always a priority!—and be ready to react to any new situations that arise.

Otherwise, we have our priorities set for the next few months, and then we will reevaluate according to the evolution of the contexts. We are always assessing, analyzing, and reorienting our work depending on circumstances. Today, for example, there’s much to do at Drouillard Hospital, in Haiti, where we want to further develop certain services, like the burn and trauma units. And we want to secure access to more refugee camps in Ethiopia, on the Sudan border.

Then we have to be ready for any new emergencies. Actually, it’s more the field teams that have to stay ready, because they’re on the ground. That’s why they try to maintain good information networks, so they can anticipate certain issues, like outbreaks, fighting, or population movements, and why they try to have supplies ready for different types of emergencies.

How does MSF find people to work with it?

Nick Lawson is MSF-USA’s Director of Field Human Resources:

We do a fair amount of outreach messaging. In 2012, we did 46 recruitment events that drew more than 2,500 people. Most people hear about us through articles or news reports about our work in the field. They see what we do and they like what we do. That’s the ideal recruitment scenario: They’re not so much inspired by the salary or the living conditions in the field—they’re inspired by the actions.

For medical staff, we’re quite clear about the qualifications and the experience we’re looking for. It’s more vague for non-medical staff. Logisticians, for example, come from a variety of backgrounds—people with liberal arts degrees, firefighters, engineers, architects, or mechanics. What’s most important is international experience and
Our Team from the US

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Occupations in the Field

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Team Leaders</td>
<td>4.3%</td>
</tr>
<tr>
<td>Doctors</td>
<td>11.4%</td>
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<tr>
<td>Specialists</td>
<td>22.3%</td>
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<tr>
<td>Nurses/Paramedical staff</td>
<td>27.1%</td>
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<tr>
<td>Non-medical staff</td>
<td>21.2%</td>
</tr>
<tr>
<td>Field coordinators/Heads of mission</td>
<td>13.6%</td>
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</tbody>
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NEW YORK STATE produced the most with 51 or 13.6%

Top 3 Project Destinations

- South Sudan
- Nigeria
- DRC

Number of people sent on their first missions

108

MSF Field Recruitment Process

Application and selection process

1. General Requirements
   - Do you meet all the general requirements?

2. Professional Requirements
   - Do you meet all the professional requirements?

3. FAQs & Info Sessions
   - Have you read our FAQs and attended an info session?

4. Online Application
   - Have you filled out our online job application?

5. Screening
   - MSF screens all applicants for suitability to work in the field.

6. Interview
   - MSF interviews applicants who passed the screening process.

7. Briefing
   - MSF briefs candidates who passed the interview.

8. Pool
   - MSF places all briefed candidates in a pool until they are needed.

9. Match
   - When an HR need arises in the field, MSF matches and contacts candidates.

HOW IMPORTANT ARE NATIONAL STAFF?

Kate Mort is an MSF-USA Field Human Resources Officer:

National staff is crucial to every MSF project; they are at the core of everything we do. National staff makes up around 90 percent of all MSF field workers, so they do most of the nuts-and-bolts work that keeps our projects running.

Generalizing is hard, because every situation is different. For example, South Sudan is a very challenging place to find people with the necessary training and expertise. I’ve worked in South Sudan a few times, most recently in 2012. The population has had very limited access to education because of decades of war. There simply aren’t many medically qualified people. In many projects in South Sudan, we train the staff ourselves—which also means we have to send more international staff to work in those projects.

India is on the other end of the spectrum, a place where there is a very high level of medical training and national staff tend to be very capable right off the bat, so they hold higher-level positions. The only difficulty is finding people who are comfortable working...
in conflict zones, where some of our projects are. They can work in a nice hospital, so why would they want to go to Chhattisgarh, a dangerous place in the middle of nowhere? That means that the international doctors that work in India tend to hold supervisory and clinical advisor positions, rather than doing more hands-on medicine, as they do in South Sudan.

With staffing, it’s all about context. And the individual. When I was in South Sudan in 2004, there was an enormously enthusiastic, motivated, and intelligent guy who started as a cleaner. Over the years, he was promoted to working in the pharmacy, working on pharmacy management, working with dispensing medication and patient care. Eventually, he became a medical officer.

We certainly try to encourage professional development. There are various trainings available to national staff within MSF, and we do more trainings in the field now. We also send people from different projects to trainings all over the world, which is great, because now we have a lot more national staff moving into higher levels of management and many who go on to work for us as expatriates themselves.

HOW DOES MSF MANAGE SECURITY IN THE FIELD?

Johanne Sekkenes is MSF Head of Mission in Mali, which has been gripped by conflict for the past year, and where the risk of attack or kidnapping remains high in certain areas:

We try to understand the context as best as possible, conducting extensive analysis, studying previous incidents and insecurity problems. This could be anything from a snake bite to an attack or kidnapping—absolutely everything. Then we try to assess the level or probability of each security problem, the relative risk in each area, the dangers posed to specific people. A threat might be “high risk” in one part of the country and “low risk” in another. Risks in capital cities will likely differ from risks in the more remote project locations, or risks on the route to those locations.

The Head of Mission is responsible for the overall evaluation, and he or she works with the logistics coordinator to constantly re-evaluate and monitor the evolution of the context. The project coordinator and the logistician implement and enforce guidelines and recommendations. Actually, the whole team is involved in some way, contributing to the analysis, making suggestions, or simply following our security rules and recommendations.

Events that can affect security include political changes like coup d’états, wars, violent attacks, banditry, population movements, and more. A population’s perception of our work will also have an impact.

In any situation, we have to keep an open dialogue with the various sides of a conflict and often to negotiate in one way or another. We explain our medical and humanitarian mission and make sure we act according to those principles. We explain who we are and also who we are not, making it clear that we are independent and neutral, not part of any government or international system. We negotiate to create space where we can implement independent programs, setting up a medical facility, for instance, or running mobile clinics. The more the parties understand what we’re doing and how, the better. Safety can never be guaranteed, but it can be improved, so we also do a lot of outreach with local communities, dress and conduct ourselves in an appropriate manner for the location and the culture, make sure our HR policies reflect our principles and don’t favor any one group over another, and, of course, make it clear to all, especially the warring parties, that no weapons are allowed inside our facilities.

In some cases, national staff may not run the same risks as international staff. In some, they run greater risks. In many settings, working for or being associated with an international organization can be a risk for national staff, as we saw in Iraq and elsewhere, and as we see in Pakistan now.

If the threats reach a certain level, we adjust our rules and our activities accordingly. From what I’ve seen, deteriorating security usually makes the teams more motivated to find solutions and ways to maintain activities. If needed, we can reduce the team, keeping only personnel who work on direct lifesaving procedures and refocusing activities on the most urgent needs. If a kidnapping does occur, or a project is robbed or a staff member attacked, our response will depend on the situation and the specific circumstances involved.

It is difficult to prepare someone to work in an insecure setting if he or she never experienced it before. We want people with experience, curiosity, and common sense, and we provide briefings and as much

“We send materials by sea, air, or foot, depending on what’s being sent and when it needs to get there.”
information as we can. MSF staff are volunteers and they must be clear about the risks before and during their mission.

There is an advantage to being an emergency medical organization rather than a development organization, I think. All populations have medical needs, and medical care can show results quickly. And in many contexts, armed groups respect MSF’s activities even in the midst of war, because they see the benefit for them and their communities of having free, high-quality, and impartial medical health care available. That’s why we try to make clear that we’re there to deliver care to whoever needs it, as our medical and humanitarian ethics dictate. That’s our best security measure!

**WHAT DOES A HEAD OF MISSION DO?**

Kassia Echavarri-Queen was an MSF Head of Mission in South Sudan in 2012:

The main responsibilities of a Head of Mission are understanding the humanitarian context of the country, implementing and managing the projects, properly representing MSF, and overseeing security. You also need to handle day-to-day management of your coordination team—finance, HR, and logistics—and make sure you are supporting the field coordinators so that we can all give the proper support to the teams that are working in the field. The working relationship with the medical coordinator is really important as all of us together work to ensure that the mission is following the best strategy, that it is clearly communicated, and that MSF is responding in the most effective way to answer the needs.

Representing MSF in the country also means working with people at other organizations or the ministries of health, and advocating for what we feel is needed. We provide day-to-day health care, but we also explain the reason we use certain medical protocols and work with health organizations at the national or local level to implement these practices. A large part of our sexual violence project in Guatemala, for example, was to stress the point that sexual violence is a medical emergency and that there is a medical protocol for it that should be not only adopted but implemented in the country. To do so and also ensure people knew to access care, we needed to work with media, other local community-based organizations, and with the community to promote health seeking behavior.

Challenges change from day to day. In South Sudan, we’d be working on human resource management and administration one day, and then the next day, we’d be communicating with UN agencies, human rights groups, and different organizations about a press release on abuses teams saw during a disarmament campaign in Pibor. The day after that you could be calling on other groups to devote more resources to refugees. Then a day of meetings, then days of field visits. And sometimes you just have to put out fires. It just really depends on the day. The work is challenging, but it’s always interesting.

**HOW DOES MSF RESPOND TO AN EMERGENCY, LOGISTICALLY SPEAKING?**

A report from the logistics team at MSF-USA:

The first thing MSF does is evaluate the medical needs on site. Based on those needs, we formulate our logistical response. MSF has worked hard to create agile and flexible systems that can mobilize people and resources quickly and efficiently. Among our tools are the logistics “kits” we have at our supply centers in Bordeaux, France, and Ostende, Belgium. They’re pre-organized according to past experiences and correspond to different populations. We have a cholera kit with enough drugs, etc. We also have water and sanitation kits with latrine platforms, water bladders, and pumps. The kits come in different sizes to correspond to different populations. We have a cholera kit with enough materials to cover a population of 10,000, for example. Multiple kits can be ordered for larger populations or programs.

A field assessment team recommends which and how many kits to order to the field coordination office and headquarters. In some emergencies, field teams request kits directly from the supply center, but in most cases, the requests are validated by headquarters to help ensure nothing is forgotten. When confirmed, the order is sent to a procurement center. Items that can be purchased locally, like building materials, are procured at the field level.

We send materials by sea, air, or foot, depending on what’s been sent and when it needs to get there. If it’s a three-month emergency vaccination campaign, for example, the first shipment might go by air, followed by a second shipment by sea. Existing programs may order emergency preparedness kits in anticipation of emergency needs. The most sensitive items, such as computers or communication devices, are usually carried by field staff traveling from headquarters.
Ensuring that our teams in the field have the right medicines and equipment is a major logistical challenge. We work hard to get material to our teams where and when they need them.

Vaccines are a particular challenge. From the moment of manufacture to the point of injection in the field, they must be kept at certain temperatures to avoid spoilage. A generalized version of the cold chain procedure MSF uses is mapped out below:

### Chain of Life

**Getting vital medicines where they need to be**

1. **WAREHOUSE**
   - Vaccines are stored in a refrigerated area of our warehouses.

2. **TRUCK TRANSPORT**
   - The vaccines are transported by truck in an ice-lined fridge in case of a power failure.

3. **CARGO PLANES**
   - Due to the need to maintain cool temperatures during transport, vaccines are sent to the field on cargo planes during emergencies.

4. **CUSTOMS**
   - Planes land in country and the vaccines pass through customs.

5. **CENTRAL MSF STORES**
   - Vaccines are taken to central MSF stores, which can be anything from a warehouse to a small shed, and placed in a refrigerated area or large fridge powered by a generator.

6. **STOCK REQUEST**
   - Field teams decide what they need, and the logistician creates a stock request.

7. **MSF LAND CRUISER**
   - Coolboxes full of vaccines are transported by MSF Land Cruiser to smaller MSF projects in towns and countryside.

8. **CARS, MOTORBIKES, DONKEYS, ETC**
   - In many countries, roads are unreliable, if they exist at all. To reach our more remote projects, we must therefore use the mode of transport best suited to the conditions.

9. **VACCINES ARRIVE**
   - Vaccines arrive at target location and patients receive their injections.

Regional supply centers in places like Kenya and Panama help facilitate transport and warehousing of supplies. They also ensure that drugs are kept at appropriate temperatures. Drugs are mainly procured by European offices to guarantee consistency and quality; the supply centers in France and Belgium are each licensed to procure and distribute pharmaceuticals. More generally, a centralized ordering system helps us guarantee an inventory and helps us respond rapidly because it means staff in different projects use the same materials, rather than constantly having to learn how to use something new.

We’ve made a lot of improvements over the years, but challenges still remain and we’ll have to keep evolving our methods. We can’t just think that because we’ve done a good job in the past, we’ll continue to do a good job in the future.

### HOW DOES IT FEEL TO LOSE A PATIENT?

**Dr. Lucy Doyle has worked with MSF in DRC and the Dadaab refugee camps in Kenya:**

Most patients’ deaths are anticipated by their physician. The doctor may observe a constellation of findings leading to a particular lethal diagnosis, and the physician prepares the patient as well as him or herself for this impending loss. This is similar in the field and at home, though in the field it hurts more to watch someone die of something that might have been treated easily here in the US.

The deaths that surprise us, that you can’t prepare for, are a different matter. At home, an unexpected death causes shock and questioning. It’s difficult to accept, for both the family and the medical staff. But I’ve seen different dynamics at work in my experiences in the field.

Perhaps my most unforgettable and unanticipated patient loss in the field was that of the five-year-old son of Abeli, one of our staff drivers at MSF’s project in South Kivu, DRC. Abeli brought the boy to our house one night with simple malaria. By the next morning he was declining despite oral anti-malarials, and we admitted him to the hospital. All of us on the team came to know him well. Two days later, however, after initial improvement, his condition deteriorated rapidly and he died.

It was a horrific death for a dear member of our team. Our whole expat team was shocked. But the national staff was not as visibly distressed. They calmly looked down and shook their heads, and continued on with their day. This is something they were more accustomed to than we were, given the realities they live with. They expect to lose patients like this. It’s not that they feel it any less deeply—the boy’s mother threw herself on the hospital ward floor, wailing at the top of her lungs and punching the ground. But Congolese families seemed to grieve with more fury and then complete the process and move on in a shorter time than we do.

A few days later we walked by the family’s home and saw that the national staff were making a quiet visit in solidarity with the grieving parents. The next week, Abeli was back at work. Tears came to my eyes as I asked how he and his family were coping. He just smiled and said, “C’est la vie,” and asked me how I was doing.

### HOW DOES MSF ADVOCATE FOR ITS WORK AND PATIENTS?

**Notes from the Advocacy team at MSF-USA:**

MSF’s operational advocacy occurs both in and out the field. On the ground, it might mean a project coordinator meeting with the military commander of an area to explain what MSF is, what we do, and why we do it. MSF works under the premise that there is no guaranteed “humanitarian space” for our programs, so we must constantly advocate for the various sides in a conflict or various officials and members of government to respect the neutrality of our medical structures and our medical work. Humanitarian space, after all, involves not only a physical space in which to deploy humanitarian assistance, but also the room to make independent assessments of the needs and to access patients who need assistance.

Away from the field, our advocacy takes place in capital cities, halls of government, and with other organizations or international institutions. MSF has advocacy positions in several headquarter offices around the world staffed by people who relay MSF’s field needs, priorities, and experiences to international and regional actors.
In addition, we advocate for neglected patients, for more effective delivery of humanitarian aid, and for specific needs we see in the field. For example, in South Sudan last year, we called for a swifter, more focused response to growing refugee situations in the north and east. And in DRC, we highlighted how persistent insecurity precluded the delivery of aid to many desperately in need of it. We also have advocated on broader topics, such as the shortcomings of the United Nations “cluster system.” Likewise, we advocate for greater access to specific and effective tools and drugs for patients. This has happened with treatments for malaria, for HIV, for TB, and other diseases. In many cases, MSF collected evidence to demonstrate the efficacy of a new treatment regimen. In many others, MSF and its Access Campaign push pharmaceutical companies to make their products available at affordable prices for people in developing and often deeply impoverished countries.

We don’t always “win,” but whatever the context, advocacy is a tool MSF uses in an effort to improve the health care outcomes and options in a given place. It always starts with, and comes back to, the field.

HOW DOES MSF SHARE ITS MEDICAL FINDINGS?

Patricia Kahn is an MSF Medical Editor based in New York:

In 2012, MSF published more than 100 papers, including some in leading journals like The Lancet and PLoS Medicine. Just before the big international AIDS conference last year, we had a very visible policy article in Science on scaling up HIV treatment. We also publish in more specialized journals, on topics like malnutrition, maternal health, and neglected tropical diseases.

Some of what we publish is based on MSF research that assesses the effectiveness in the field of different diagnostics, treatments, or program strategies. We have to adapt a lot of methods and practices that were developed for Western health care conditions—for example, we might evaluate a newer, shorter, or simpler treatment against a standard one. Some of our research concerns programmatic innovations, the results of decisions to work with our patients in ways that fit their context better. And some of our publications don’t cover research per se, but present perspectives from doctors on the front lines, viewpoints we think should be part of the medical literature.

In addition to sharing our findings with the medical community, these articles can help us advocate for changes in policy. When MSF shows in a peer-reviewed medical journal that one practice works better than another, it helps a Head of Mission say to Ministry of Health officials, “We’d like to introduce this innovation, we’d like to vaccinate, for example, in response to an outbreak.” Vaccination is usually viewed as a preventive intervention used in advance of outbreaks. But there are examples, such as measles, where MSF has shown the value of reactive vaccination campaigns—i.e. vaccination after an outbreak has begun. MSF’s data played a big role in the World Health Organization’s decision to recommend reactive vaccination in some circumstances after measles outbreaks.

You can’t come into a country and just do any medical intervention. Countries have guidelines. There are international guidelines as well, particularly from the WHO. In quite a number of cases, MSF research has played a role in moving national and international guidelines towards better practices that lead to better outcomes for patients.

WHAT ARE SOME NEW TROPICAL DISEASE INITIATIVES?

Estrella Lasry is an MSF Tropical Medicine Advisor:

In 2012, we did a big intervention for malaria in Mali and Chad, where it’s the highest cause of morbidity, and usually mortality, in children under five. This work, which is called seasonal malaria chemoprevention, was new for MSF, and it was the first time it was done at this scale outside research conditions. We provided prophylaxis to around 160,000 children under five in Mali and another 10,000 in Chad to prevent them from contracting malaria during the period of highest transmission. Results showed more than a two-thirds drop in simple malaria cases and a significant drop in severe malaria in the weeks that followed. We saw malnutrition levels go down, too, an important, unexpected outcome.

We’re going to develop this preventive intervention further in 2013, widening the areas where we do it and adding interventions for other diseases to improve child health. The roll-out is at community level, which helps us achieve high coverage.

Another relatively new thing is the launch of an intervention on schistosomiasis, a parasitic disease that can damage several organs, in Madagascar. We have experience treating schistosomiasis, but not in areas where it’s a major public health concern, as it is in Madagascar, which requires us to combine preventive and curative strategies.

We’ll help the Ministry of Health with mass drug administrations. We’ll also further develop protocols in hospitals to treat advanced or chronic cases of the disease, which will give us new insights on dealing with severe cases of liver and urinary dysfunction brought on by the disease. Hopefully we can introduce ultrasound, too, as part of the diagnostics, and we’ll also start preventative campaigns, working with the local communities to develop a sustainable strategy.

HOW DOES MSF CLOSE PROJECTS?

Recent examples from DRC and Liberia:

Planned or not, there always comes a time when MSF has to close a project. An emergency may have passed, a suitable partner might have been found to take over, or the conditions on the ground might have made it categorically unsafe. Whatever the circumstance, it is a complex procedure.

Nurse Carissa Guild and mental health officer Athena Viscusi were both part of teams that closed projects recently. In April 2012, Guild was with MSF in Nyanzale, in DRC’s North Kivu province. It was “kind of a forgotten district,” Guild says, a deeply impoverished place with minimal health systems. Their task was to support a local hospital so it could serve the local community and nearby health centers, then turn it over to the Ministry of Health. “It took a long time to get it going,” she recalls. Security was a constant issue for the team. Progress was visible, however: “Everything was open. Pediatrics was open. It was really working.”

But then a group of army soldiers that came to be known as M23 mutinied, rendering an already unstable area even more so. Following a series of armed robberies of MSF personnel and facilities, the expats were ordered to return to Goma. “We basically threw everything into our cars and took off not knowing when we’d be back,” Guild says. “I gave the key to the pharmacy to the people in Nyanzale, and then just made a lot of phone calls, trying to figure out how to get medications to the other three centers, trying to sort out how we were going to support them.”

She put together kits for each health center so they’d have supplies for the short term. The team hoped they’d return soon, but the worsening conditions suggested otherwise. During an earlier mission in Burkina Faso, Guild had seen how preparations for handing over a project can last months, even years. But in North Kivu, the abrupt departure meant making contingency arrangements on the fly. Staff in the health
posts they’d left was fretting about what would happen next. People were calling Guild asking, “Now what do we do?” “It was terrible to leave,” she says. “There was so much need there,” and the staff “were super motivated and had been doing everything exactly as we asked.” They didn’t have the resources or training that the now-departed teams had, however, and the systems that had been set up—for cold chain, for instance—started slipping as supplies dwindled. It was hardest on area residents because they were losing access to care that had been made briefly available to them. MSF may return if circumstances allow, but this is part of working in highly insecure environments.

Athena Viscusi also left her project earlier than expected but under better circumstances. Dispatched to Liberia in 2011 to support a project for refugees fleeing violence in Ivory Coast, she and her colleagues counseled people struggling with what they’d seen and experienced. Their work, she feels, “had become a part of the healing process in the camps.”

But the flow of refugees slowed, many started going home as the fighting eased in Ivory Coast, and MSF decided to hand over its projects. Unlike Guild’s experience, where there was no one to pick up where MSF left off, this was, Viscusi recalls, “an exceptional closure because we were able to hand everything over to other NGOs operating in the camps.” Viscusi helped train staff from other organizations to provide mental health services, and MSF donated drugs and supplies to the local hospital and the Ministry of Health, the International Rescue Committee, and Merlin, three groups present in the area.

“I learned a lot about closing a project in Liberia,” Viscusi says. “It’s always difficult, but it’s important to maintain the capability to be the first responders in conflict zones and not have our resources tied up providing primary care. You get attached to the staff, you get attached to the patients, but it’s important that MSF is able to maintain the capacity to do what we do.”

A CONVERSATION WITH MSF-USA DIRECTOR OF DEVELOPMENT JENNIFER TIERNEY:

What are MSF’s fundraising priorities in the year ahead?

In 2012, there were very few of what you might call “sustained visible emergencies.” Even where there were massive emergencies, like the refugee crisis in South Sudan, we saw sparse media coverage because the presidential election was the central story of the year. That meant that we received significantly less spontaneous giving than we did in a year like 2011, when the Japanese tsunami and the Sahel crisis were widely covered. We had to work really hard to bring in as much funding as we had the prior year because despite a shift in media coverage, our medical priorities and funding needs stayed the same. We did it, by just a percentage point or two, but we had to make sustained and concerted efforts to raise those extra dollars.

Planning for 2013, we’re faced with the challenge of keeping our programs well-funded when there is uncertainty about this spontaneous revenue, which can be close to 20 percent of our total income in some years. So, the question is how much do we invest in fundraising while keeping our low cost to raise a dollar? The best way to do this is to increase our multi-year pledges and monthly donations that we are fairly certain will materialize. We want to grow those areas.

Financially speaking, what is MSF-USA’s role in the larger MSF movement?

We raise from 17 to 20 percent of the total income for the movement in a given year. There are 25 offices that fundraise, so we clearly have a large piece of the fundraising pie.

What types of gift will MSF not accept?

MSF-USA created a gift acceptance policy that restricts us from accepting gifts from corporations that come into direct conflict with our mission: extraction companies, alcohol, tobacco, firearms, and pharmaceutical and biotechnology.”
pharmaceutical and biotechnology. We do this to maintain our independence. If we are advocating against a pharmaceutical company’s efforts to secure a patent that would increase the costs of the HIV medicines we use in the field, it would be difficult to have a strong position if we were taking money from that same company. Biotech companies don’t often adapt their technology to resource-poor settings where we work, so it is a similar situation with them. Extraction companies can cause a great deal of strife in the areas where we work—to me the starkest example is the Niger Delta, where conflict over resources exploits the poor and can incite violence. Alcohol, tobacco, and firearms are all clearly bad for your health, and our Board of Directors, many of whom are and have been medical field staff, feel strongly that we should not take money from these sources.

We also won’t accept gifts from a donor who wants to fund a particular project that we’re not already doing, or a particular village or something along those lines. We try to keep funding aligned with the needs in the field and stress private giving to maintain our independence and neutrality.

In the last year and a half, you spent two months at a project in South Sudan and another in Lebanon, helping with MSF’s projects in Syria. What did you get out of it?

Those were great experiences. And the projects were clearly relevant. We’re not kidding around when we talk about saving lives. We really do what we say we’re doing in the direct marketing pieces.

The team in Pibor, South Sudan, was amazing. They were so particular and careful about spending money, fearful of overspending money, on the project. They were almost too cautious in some cases, but it showed that people in the field are very cognizant of the fact that these are private donors supporting us and being very careful about spending funds on the most pressing needs. There are frustrations, too, of course. Working in Lebanon on the Syria project and knowing that security and access issues were limiting our work was incredibly frustrating, and by extension this limits the money that we can spend and the work that we can do there. In South Sudan, where we did have access, we spent a great deal of funds responding to the refugee crisis there. I believe that was the largest response we had in 2012, financially speaking, and it was incredibly relevant because there were not a lot of other actors on the ground.

Why did MSF work in the US, which it normally does not do, after Hurricane Sandy?

We learned from Katrina not to assume that the government was going to respond in the full-fledged way necessary to address the needs of the most marginalized people in these communities. So we were monitoring the situation, thinking there is probably a narrow role we can play in the medical field, and we did identify some very specific needs in different locations. I think it was an appropriate response. I think having returned field staff and office staff working as volunteers to assist people on the eighteenth floor of a housing development with no electricity, helping people who are elderly or infirm and can’t access their medication get the care they need, is a perfectly relevant thing for us to do.

“I think having returned field staff and office staff working as volunteers to assist people on the eighteenth floor of a housing development with no electricity, helping people who are elderly or infirm and can’t access their medication get the care they need, is a perfectly relevant thing for us to do.”
Is there anything else you think people should know?
I think they should know that the staff in the field has a real appreciation for their support, something I wish I could bring out more in the materials that we send. I’m not sure we’ve been successful at communicating what a community it is, and how essential every element is—the staff here, the people in the field, the donors. It’s all interconnected and I don’t think the donors hear that enough. So I’d be happy to have them know that people on the ground are very aware of the part the donors play in the work they do and the care they can provide others.

WHY DO YOU SEND SO MUCH MAIL?

Melanie West is MSF-USA’s Director of Marketing:

MSF’s direct mail program is designed to provide reports to our donors about the medical work we carry out in the field and to raise money for that important work. This year we sent out 12 direct mail campaigns informing our donors about our field missions. Topics included South Sudan, maternal health, nutrition, security in the field, and responding to outbreaks.

Each month, we send our mailings to donors who have not yet joined our Field Partners program in which supporters give a set monthly gift. We also send mailings several times a year to prospective donors, asking them to become supporters. If anyone contacts us asking to receive less mail, or just mail on a particular topic, we honor their requests.

At present, most of our donors are more comfortable writing and mailing checks than making online donations. MSF’s direct mail program raises $62 million per year, by comparison, our email program generates $1.6 million. So while we use email campaigns as much as possible, we can’t risk sacrificing income that we need to fund our medical programs.

That said, our direct mail program is constantly evolving towards less mail. For instance, we encourage people to become Field Partners, as I said, and we’re investing more heavily in alternative ways to give. But it’s a gradual transition. We know we need to communicate with our donors on a regular basis to provide channels through which they can give if they so choose; we often don’t know if a person is in a position to make a donation at a given moment, or which aspect of our work might touch and inspire them. And, of course, our overall mission is to serve our patients, and our mail program helps guarantee a steady stream of funds so we can do that.

HOW DOES MSF DISBURSE MONEY TO DIFFERENT MSF PROJECTS?

Mary Vonckx is MSF-USA’s Grants Officer:

To make sure the funds MSF-USA raises get to where they are needed most, MSF-USA supports all five Operational Centers, or OCs [the organizational bodies that direct our medical interventions worldwide].

The OCs and international fundraising departments work closely together to make sure the organization has enough funding to carry out its programs. Firstly, the OCs create four-year plans that include operational and financial ambitions. At the same time, the fundraisers develop a four-year projection for donations.

At the beginning of each year, each OC presents its action plan—and any special priorities or challenges—to our Board, including a list of projects to be specifically funded by MSF-USA, and a reserve amount that ensures the flexibility to respond to unanticipated emergencies. We transfer funds to each OC over the course of the year to be sent directly to fund the field programs. In 2012, MSF-USA provided funding for more than 130 projects in 57 countries, receiving regular operational updates from the OCs throughout the year.

The importance of MSF-USA’s contribution is not just its size, but the fact that we provide so much private funding, helping to ensure MSF’s operational independence. Unrestricted donations from private donors in the US have been invaluable in ensuring MSF’s ability to respond immediately to less visible and under-reported crises, like South Sudan, eastern DRC, Central African Republic, Zimbabwe, Nigeria, drug-resistant tuberculosis, and more.
Doctors Without Borders/ Médecins Sans Frontières (MSF) works in nearly 70 countries providing medical aid to those most in need regardless of their race, religion, or political affiliation.