MEDECINS SANS FRONTIERES
LÄKARE UTAN GRÄNSER

Report on impact (Effektrapport) 2013

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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

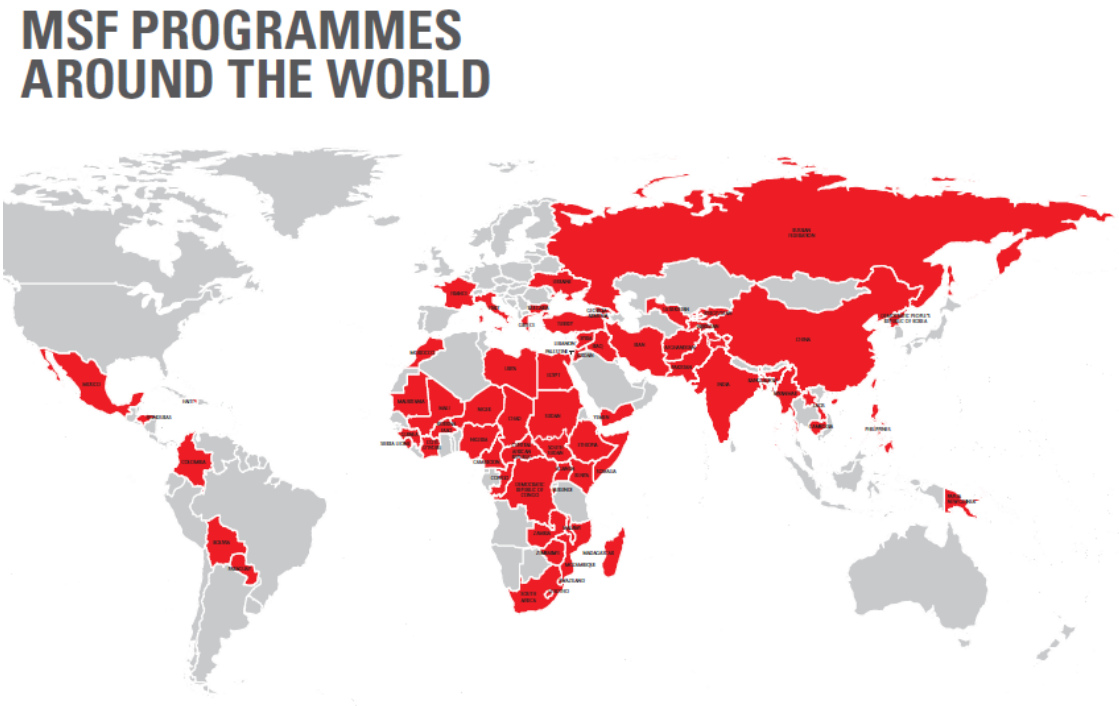
MSF medical teams often witness violence and neglect in the course of their work, largely in regions that receive scant international attention.
At times, MSF may speak out publicly in an effort to bring a forgotten crisis to public attention, to alert the public to abuses occurring beyond the headlines, 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.



Number of projects in 2013:		
Africa	240	62%
Asia*	108	28%
Americas	24	6.2%
Europe	11	2.8%
Pacific	4	1%

**Asia includes the Middle East and the Caucasus*

Context of interventions, number of programmes:		
Armed conflict	117	30%
Post-conflict	21	5%
Internal instability	88	23%

Stable	161	42%

In 2013, MSF:[1]

- Provided over **9 million** open consultations and care to **477,700** hospitalised patients.
- Treated **129,900** people for measles and vaccinated **2,497,250** people
- Treated **1,750** patients for meningitis and vaccinated **162,400** people
- Treated **1,871,200** people for malaria
- Treated **27,900** patients for cholera
- Admitted **250,900** malnourished children to nutrition programmes
- Held **141,100** individual and **14,200** group mental health counselling sessions
- Held more than **703,900** antenatal consultations
- Attended **182,200** deliveries
- Performed **77,350** major surgical interventions
- Treated **11,100** patients for sexual violence related injuries
- Admitted **1,800** new patients for sleeping sickness treatment
- Provided prevention of mother to child transmission (PMTCT) treatment to **18,500** HIV-positive mothers and **16,800** babies
- Treated **29,000** new people for tuberculosis and admitted **1,950** new patients for Multi Drug Resistant-Tuberculosis (MDR-TB)
- Had **341,600** HIV patients registered under care at the end of the year
- Distributed **146,650** relief kits

The largest countries of operations, based on the number of MSF staff in the field were in 2013 the followings (staff numbers measured in full-time equivalent units):

1. Democratic Republic of Congo	3,604
2. South Sudan	2,854
3. Haiti	2,324
4. Niger	1,879
4. Central African Republic	1,631

The largest countries of operations, based on the number of outpatient consultations were in 2013 the followings (specialist consultations not included):

1. Democratic Republic of Congo	1,654,119
2. South Sudan	981,543
3. Niger	916,009
4. Central African Republic	816,294
5. Myanmar	519,114

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

[1] MSF International Activity Report 2013: http://2013.lakareutangranser.se/

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. On average during 2011-2013, around 90% came from 4.5-5 million individual donors and private funders and 10% from public institutional donors such as Sida and ECHO. 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

[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.

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 2013, the total income of MSF worldwide was 1009 million Euro, out of which 89% was donated by approximately 5 million private donors.
Some 30,000 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 2013, the total income of the Swedish section of MSF was 564 million SEK, and 125 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 2013?

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 2013 below. In 2013, MSF programmes around the world provided;

- more than 9 million medical consultations
- delivering 182.000 mothers
- treating almost 1.9 million patients against malaria
- vaccinating 2.5 million children against measles
- treating one third of all cholera cases since 2010 in Haiti

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 more difficult to do 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 results and other with more sustainable and/or longer term repercussions. Moreover, in many of MSF's countries of intervention such as CAR and South Sudan MSF can, by the size and volume of MSF operations and the humanitarian context, assume that MSF's programmes have a positive impact on the population. Below we have listed some examples of where we can assume that MSF operations have contributed to reduced mortality and morbidity during the agreement period.

- In **South Sudan**, MSF has been delivering almost 1 million OPD consultations in 2013 and the total expenditures accounted for 51 million EUR, which is equivalent to the health budget of the national Ministry of Health. More than 3,000 MSF staff operated 16 programmes in 9 states, and 3 emergency projects were opened to care for the displaced and war-wounded. 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 2012, the massive influx of refugees into South Sudan caused MSF to launch one of its biggest emergency responses: MSF was quick to scale up its activities and adapt intervention to the increased needs, proving its ability to deliver health care in a timely response after the sudden onset of disaster.

- At the end of 2013 in the **Central African Republic**, 9 MSF emergency projects were delivering healthcare alongside 7 regular ongoing programmes, and over 800,000 medical consultations have been provided throughout the country. MSF is – unfortunately - the main employer and healthcare provider in the country, running its activities in very difficult settings, while many actors have chosen not to have any presence. In both CAR and South Sudan, MSF witnessed the failures of the humanitarian aid system and has been advocating for better responses and collaboration as well as quicker deployment.

- Once again, MSF's largest programme expenditure (78.3 MEUR in 2013) throughout the period was the response for the repeated displacement of people and the appalling lack of healthcare in the **DRC**. MSF undertook a number of emergency projects and vaccination campaigns in the country more than 1.2 million children aged between 6 months and 15 years were vaccinated against measles. The report "Everyday is an emergency" was released early 2014 and is based on medical data collated in 2013, 2012 and 2011 from MSF projects responding to violence and neglect in the provinces of North and South Kivu, Orientale and Katanga. Although MSF has had extensive activities in the country during the period 2011 to 2013, the situation has not improved and the needs remain enormous due to continuous instability and violence as well as chronic emergencies and outbreaks.

In several cases, MSF interventions did lead to a (measurable) reduction of mortality rates. An example of this is the **General Hospital of Lubutu in DRC**. MSF started the intervention in order to show that unacceptably high mortality rates were not a fatality and that the health situation could be improved in the region. Results were successful with a mortality rate down to 0.6 in 2010. MSF therefore decided to withdraw and hand over the facilities in 2011-2012 as the objectives had been met.

In **Niger**, a regular follow-up done by Epicentre (the scientific antenna of MSF) has monitored the mortality in the Magaria region since 2010. For example, in the Dogo-Dogo health area, the mortality rate for children under 5 years has decreased from 3.78/10 000/day in 2010 to 1.70/10 000/day in 2011 and 0.7/10 000/day in 2012, which can be at least partially attributed to MSF activities in the region.
In **Sierra Leone**, MSF showed that decreasing maternal mortality was possible. The national maternal mortality rate in Sierra Leone was the third-highest in the world in 2010, with 890 deaths for every 100,000 live births (For perspective: the maternal mortality rate in Sweden is 4 in 100,000). In order to counteract these deadly

trends, MSF initiated a programme in Sierra Leone's Bo District that set up free-of-charge central referral facilities and emergency ambulance services to bring women from remote health centres to hospitals where they could deliver safely, 24 hours a day, 7 days a week. Technically speaking, these were not the most medically sophisticated or resource-intensive responses—the annual costs amounted to about $2 per person per capita in Bo district—but they efficiently addressed the clear and present needs and the results have been dramatic. In 2011, with the programmes up and running, maternal mortality decreased by 61% in Bo. The MSF programme in Bo has proven that lifesaving emergency obstetric care doesn't have to be expensive or state-of-the-art to substantially reduce the number of women who die in childbirth, a powerful lesson for donors, governments, and other NGOs working to save the lives of mothers and children worldwide.

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/. MSF Scientific Days take place every year and are an event that enables the sharing of scientific publications on a broad range of medical topics. In the 2013 edition, a session was dedicated to the impact of MSF's research. Impact was defined as "effects on practice in the field, on clinical or laboratory guidelines, or on national or international programmes or policies". One of the studies found to have had an impact was the one on trials of malaria artemisinin combination therapy (ACT). MSF uses the data collected to improve its way of intervening. This work has already led to some significant changes in the strategy of the operations, such as the use of Seasonal Malaria Chemoprevention (SMC) in Chad and Niger.

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 and soon on Google Books. 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.

Impact of Seasonal Malaria Chemoprevention

Malaria kills more than 1,500 people around the world every day and is a leading cause of illness and death in many countries. The majority of its victims are children under the age of 5 in sub-Saharan Africa. In the summer of 2012, MSF teams working in Mali and Chad implemented a new approach, called "seasonal malaria chemoprevention," which means that all children in a given location are treated for malaria during the times when the disease is most likely to proliferate. The theory is that treatment during the months of highest incidence (usually the rainy season) makes it possible to both treat existing cases and prevent new ones. Using this approach, MSF treated 160,000 children under 5 in Mali and 10,000 more in Chad. Results showed more than a two-thirds drop in simple malaria cases and a significant drop in severe malaria in the weeks that followed. The number of transfusions in the hospital in Mali also decreased by over 70% while malnutrition levels went down as

well. This was an important and unexpected outcome. Even if the evidence only shows that this approach is effective in places where malaria is seasonal, SMC is an important new tool in the battle against malaria. MSF has already identified several ways to improve its implementation and data gathering operations in the year ahead. Given the promising results, MSF has decided to deploy the method in its projects in Niger as well.

Humanitarian challenges

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 (South Sudan, DRC, CAR), political and administrative difficulties (Sri Lanka, Ethiopia and Myanmar), epidemics (Hepatitis E in South Sudan, Ebola in Sierra Leone, cholera in Haiti), lootings (South Sudan, CAR). Exit strategies and preparedness, closing down and handing over projects remained difficult and plans to do so were 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.

In conclusion, MSF was 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 the examples above have shown. The above examples have been chosen as they touch Sida supported projects, but there are many more achievements that could be mentioned, for example in the field of HIV and TB as well as neglected diseases (HAT, lead poisoning etc.). Thanks to health promotion activities, that go hand in hand with MSF medical input, behavioural changes can 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.