MEDECINS SANS FRONTIERES
LÄKARE UTAN GRÄNSER

Report on impact (Effektrapport) 2017

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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 organization 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 and training of fieldworkers, fundraising, advocacy and with two units directly supporting the field with innovations and evaluations.

MSF PROGRAMMES AROUND THE WORLD

In 2017, MSF ran 462 projects in 72 countries.[1] The activities were conducted through 3,664 international staff (full-time) positions, and 37,844 local employees, supported by 3,724 staff at headquarters.[2]

In 2017, MSF ran 462 projects in 72 countries

[1] MSF International activity report 2017, https://www.msf.org/international-activity-report-2017 p 4-5. Countries in which MSF only carried out assessments 2017 do not feature on this map.
[2] Ibid p 101

Largest country programmes based on expenditure

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

The total budget for our programmes in these 10 countries is 571.2 million euros, **53 per cent of MSF's operational budget for 2017.**

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	3,574
2. Central African Republic	2,887
3. Democratic Republic of Congo	2,881
4. Nigeria	2,595
5. Afghanistan	2,282

Outpatient consultations

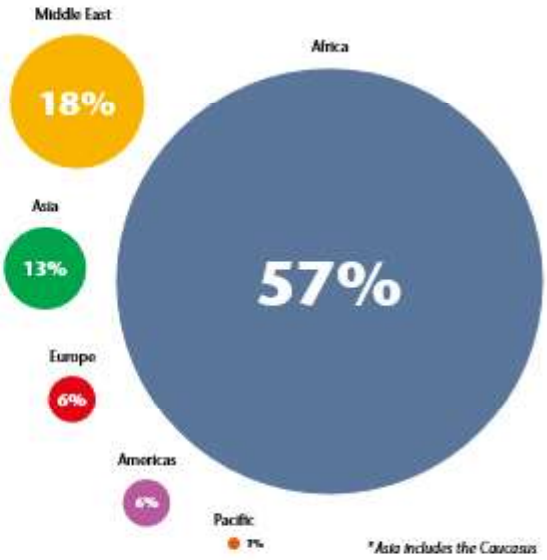
Largest country programmes according to the number of outpatient consultations. This does not include specialist consultations.

1. Democratic Republic of Congo	1,772,000
2. South Sudan	1,154,600
3. Central African Republic	748,600
4. Syria	647,600
5. Niger	523,400
6. Nigeria	512,500
7. Ethiopia	455,500
8. Tanzania	445,800
9. Sudan	394,000
10. Yemen	362,400

Project locations

Number of projects

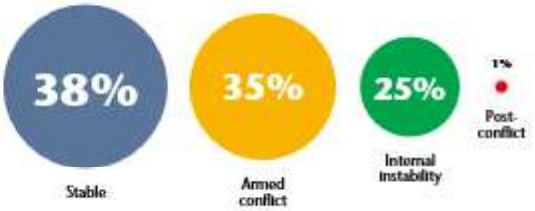
Africa	262	Europe	28
Middle East	82	Americas	26
Asia*	61	Pacific	3



Context of intervention

Number of projects

Stable	176
Armed conflict	163
Internal instability	117
Post-conflict	6



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[3] MSF International activity report 2017 p 10

In 2017, MSF:[4]

- Provided **10,648,300** open consultations and care to **749,700** hospitalised patients
- Vaccinated **2,095,000** people against measles in response to an outbreak
- Vaccinated **886,300** people against meningitis in response to an outbreak
- Treated **2,520,600** cases of malaria
- Treated **143,100** patients for cholera
- Admitted **81,300** severely malnourished children to inpatient feeding programmes
- Held **306,300** individual and **49,800** group mental health counselling sessions
- Assisted **288,900** births, including caesarean sections.
- Performed **110,000** major surgical interventions
- Medically treated **18,800** patients for sexual violence
- Started to treat **18,500** tuberculosis patients with first-line treatment, and **3,600** patients with Multi Drug Resistant-Tuberculosis (MDR-TB) with second line treatment.
- Had **201,300** patients on first-line anti-retroviral treatment and 15,400 patients on second-line anti-retroviral treatment by the end of the year.
- Had **5,900** patients on hepatitis C treatment
- Rescued and assisted **23,900** 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 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 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, 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 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

4 MSF International Activity Report 2017 p 9

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 2017, 94% came from 6,3 million individual donors and private funders and 2% from public institutional donors, other income was 2%[5]. 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[6]. 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, 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.

5 MSF International activity report 2017 p 98

6 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, as a former colonial power or as when the European Union and its member States decided to historically fail thousands of people and to compromise the very concept of asylum by agreeing to return to Turkey asylum seekers seeking safety in Europe. In highly politicized contexts MSF chooses not to accept any institutional funding. Acceptance of the organization 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 2017, the total income of MSF worldwide was 1532 million Euro, out of which 95% was donated by approximately 6,1 million private donors.[7]
In 2017, the total income of the Swedish section of MSF was SEK 618 million, and 121 Swedish fieldworkers worked in MSF missions.[8]

Some 41,000 Médecins Sans Frontières (MSF) field staff from all over the world work tremendously hard to provide assistance to people during 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 staffs 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, almost 4,000 staff in operations, communications, advocacy, fundraising, finance and human resources teams 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.[9]

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. Systematic and objective evaluation processes are important opportunities to reflect, explore and capture the many experiences teams have in the challenging context MSF works in. Evaluations are therefore a much-needed tool for organisational learning.

7 MSF International activity report 2017 p 98
8 MSF Sweden annual report 2017 p 7
9 Ibid p 99

The Stockholm Evaluation Unit (SEU) is part of the MSF's international evaluation group, consisting of three independent units in Vienna, Paris and Stockholm. The units work with evaluations of medical interventions across the world, and other initiatives in processes for reflection and learning.

During 2017 the unit carried out a total of eighteen evaluations and other learning exercises. These included anything from evaluation of emergency interventions in Syria, Haiti and Guinee, to aspects of leadership in operations and processes in human resources management. More information about MSF evaluation work can be found at http://evaluation.msf.org. Some evaluation reports are public and can be downloaded from this website, while others are restricted to MSF users. This limitation is mainly due to the sensitive nature of the operational contexts and the resulting content. However, there are internal discussions about making all evaluation reports publicly searchable.[10]

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 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 to capitalise on lessons learned. Protocols and ways of working are regularly put into question and all technical departments work continuously 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).

[10] Läkare Utan Gränser/MSF-Sweden Annual report 2017 p.11

5. What has been achieved in 2017

Violence against civilians escalated in Myanmar, the Democratic Republic of Congo (DRC), South Sudan, Central African Republic and Iraq in 2017. It continued unabated in Syria, Nigeria and Yemen. Entire communities paid a staggering price of death, injury and loss, and millions fled their homes in search of safety.
Treating the wounded and responding to basic health needs, malnutrition and outbreaks of infectious disease, Médecins Sans Frontières (MSF) provided lifesaving care to those caught up in conflict as health systems collapsed and living conditions deteriorated. Where we were unable to secure direct access to those trapped at the heart of the violence, in places such as Myanmar and Syria, we focused our assistance on those who had escaped.[11]

Meanwhile, governments in Europe struck deals with Libya to keep migrants and refugees from reaching their shores, fully aware of the widespread torture, detention and criminal extortion this left people exposed to. Smear campaigns were orchestrated to discredit lifesaving search and rescue efforts on the Mediterranean Sea, despite some 3,000 people drowning in 2017. Nevertheless, MSF remained committed to saving lives that would otherwise be lost, and to throwing light on the human cost of deterrence policies[12]

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 2017 below. In 2017, MSF programmes around the world provided;

- Over 10 million medical consultations
- Assistance to some 300.000 births
- Malaria treatment to over 2.5 million patients
- Measles vaccinations to 2 million people[13]

The Swedish section of MSF contributed with 517 million SEK to the international MSF activities, and raised awareness with the public, the Swedish government and other decision-makers about subjects such as the need for safe and legal passage to Europe, on the forgotten humanitarian crises and the lack of access to affordable medicines and adapted vaccines, attacks on health care and the civil population, the cholera outbreak and blockage of humanitarian aid in Yemen, the situation for the Rohingya-population fleeing persecution and violence in Myanmar, and humanitarian access to Syria.

[11] MSF International activity report 2017 p 5
[12] Ibid p 7
[13] Ibid p 9

Between August 2016 and August 2017 MSF ran a project in Sweden, promoting mental health amongst asylum-seekers in Götene, Skaraborg. The purpose was to see how a model of care used by MSF in other countries can work in Sweden and then spread new ways of working with early identification and psychosocial support to other actors. The issue has been raised with decision-makers at different levels.

During the year 121 fieldworkers recruited in Sweden, filled in total 165 positions in the field. The Swedish innovation unit worked on several cases aiming to improve MSFs work in the field. During 2017 the SIU worked with ten cases which are being tested in different contexts like Haiti (testing a steam-sterilization machine which is central for surgical equipment and that has been adapted for work in difficult conditions), Bangladesh (testing cold-chain indicators developed to ensure that vaccine is kept cold without disruption also in settings where the access to electricity is unstable), and Jordan etc**.** More information about the Innovation Unit's work and cases being worked on can be found here http://innovation.lakareutangranser.se. 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 9.[14]

Measuring the impact of MSF operations – some examples

The number of performed consultations and patients treated annually, 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,

- In **DRC**, MSF has been delivering more than 1,772,000 OPD consultations in 2017 and the total expenditures accounted for 101,7 million EUR. MSF was present across the country and many people only have MSF to rely on in order to get the healthcare they need. More than 1 million children were vaccinated against measles and 13,906 was treated for the disease[15]

[14] MSF Sweden annual report 2017 p.9-10
[15] MSF International activity report p 38-39

- Our search and rescue-vessels assisted almost 24,000 refugees and migrants on the perilous central **Mediterranean Sea** route, while facing increasing political and operational challenges.[16]

- In the field of **vaccination**, MSF is very reactive, quickly setting up emergency campaigns in the event of outbreak. As an example, in 2017, over 2 million beneficiaries got immunized against measles in response to an outbreak.

- MSF remains the largest non-government provider of **TB treatment** worldwide. Together with partner organisations and local health authorities, we are pioneering new drug-resistant treatment options, including regulated trials in South Africa and Uzbekistan, where our teams test shorter, more effective and better tolerated regimens. If successful, these clinical trials could revolutionise treatment of drug-resistant TB, provided that the drugs are made accessible to patients in need. In 2017, 18,500 patients started on first-line TB treatment and 3,600 patients started on treatment for drug-resistant forms of the disease. If successful, these clinical trials could revolutionise treatment of drug-resistant TB, provided that the drugs are made accessible to patients in need.[17]

- MSF's supply centres and Access campaign teams negotiated successfully with generic manufacturers to produce **medicines for Hepatitis C** to a substantially reduced price, allowing the teams to start more people on treatment[18]

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 often changed clinical practice and been used for humanitarian advocacy.

Operational research undertaken by MSF units such as LuxOR (Luxembourg), SAMU (South Africa), the Manson Unit (United Kingdom), Epicentre (France) and BRAMU (Brazil) is a vital component of effective humanitarian aid. The number of peer-reviewed publications in which MSF work has featured, has increased from barely five,

[16] MSF-International activity report p 76
[17] Ibid p 7-9
[18] Ibid p 24

mainly focused on HIV/AIDS, in 2000, to more than 200 covering a range of subjects in 2017. Since 2010, the MSF Field Research website (http://fieldresearch.msf.org), which archives MSF-authored publications and makes them available for free, has had over a million downloads from around the world. [19]

In early 2016, The Centre for Applied Reflection on Humanitarian Practice (ARHP) – which documents and reflects upon the operational challenges and dilemmas faced by MSF field teams – initiated the two-year Emergency Gap project[20]. Its final report, Bridging the emergency gap - Reflections and a call for action after a two-year exploration of emergency response in acute conflict is now available.

The project responded to MSF's concerns regarding the declining emergency response capacity and presence of humanitarian actors in conflict zones. The Emergency Gap work aimed to diagnose the drivers of this loss of emergency focus and to analyse the enablers and disablers for the provision of effective response in acute conflict settings. The project also aspired to stimulate debate with key humanitarian stakeholders, with the aim to identifying better strategic and operational approaches for delivering critical assistance to people trapped in situations of armed conflict. Sweden is one of the donor countries considered a priority by MSF based on the size of its humanitarian aid and technical expertise, and in March representatives from OCBA and MSF Sweden met with the Swedish MFA, Sida, and a variety of aid agencies and academic institutions, in order to share its Emergency Gap project analysis and gather reactions and alternative readings. Discussions such as these will help us deepen our understanding of the subject and re-assess our analysis as necessary; allow us to analyse the humanitarian sector's commitment to enhancing emergency response over the coming years; and help us make strategic choices for the coming years.

Operational research such as the Emergency Gap project allows MSF to improve programme performance, help patients, assess the feasibility of new strategies and/or interventions and advocate policy change. It also makes MSF accountable to its patients, its donors and itself, and consequently challenges the 'business as usual' approach. Furthermore, operational research leads to improved medical/scientific visibility and credibility, raises awareness of the scientific literature among field staff and facilitates networking and partnerships with other organisations. It also brings synergistic improvements to data collection, monitoring and feedback, which is vital for credible medical témoignage. The breadth and calibre of operational research has endowed MSF with international credibility but more importantly improved influence. Our unique perspective and strong evidence base has given us access to key decision-makers and bodies, allowing us to influence policy change and improve health outcomes in our programme locations.
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

19 http://fieldresearch.msf.org
20 https://arhp.msf.es/categories/emergency-gap

Challenges in implementation, due to external factors

Despite all achievements, it is important to keep in mind that MSF was very much hampered in its action due to lack of access as well as the targeting of medical and humanitarian assistance, leading to unacceptable security issues. This is a major concern that actors and donors at all levels must be aware of. MSF is often operating in very challenging contexts, where many organisations choose not to be because of the risks linked to security situation, corruption, access etc. MSF also saw that we 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 2017 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.