



LONE RANGER NO LONGER

MSF's engagement with
ministries of health

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Executive summary

Ministries of health (MoH) are Médecins Sans Frontières' principal collaborators in nearly all contexts.

The landscape of this relationship, however, is changing as governments are more willing and able to fulfil their responsibility to lead humanitarian responses, sparking fears among some in MSF about 'losing space'. This issue requires deeper reflection.

MSF's Reflection and Analysis Network has conducted a year-long study of how the organisation engages with MoH, which includes: an analysis of the project typology data, country strategies and project proposals; interviews with key informants from MSF, MoH and other health actors; and visits to four countries to see how the engagements are being carried out in practice.

Working directly with an MoH is already the principal way MSF delivers healthcare. Of 82 MSF Operational Centre Amsterdam (OCA) field projects that deliver healthcare services, 78% (n=64) feature a partnership or collaboration with an MoH. In most of the remaining 22% (n=18) of projects, MoH were simply not present in the setting (such as refugee camps).

Yet MSF has placed too little value on the relationship between the two parties and invested too little in more effective partnership approaches. Instead, what we have often seen is a persistent myth – that of MSF as the Lone Ranger, the heroic actor and leader – which is in conflict with, and therefore weakens, an evolving practice that is much more varied, effective and interesting.

The four countries we visited illustrated the variety of experiences.

- **In Sierra Leone**, MSF is seeking to reduce very high rates of maternal mortality, and so is adopting a 'light approach', 'primarily based on training, mentoring/coaching and supervision' in partnership with the Ministry of Health and Sanitation (MoHS-SL).
- **In Central African Republic**, MSF runs large-scale hospital programmes in partnership with the Ministry of Health and Population (MoHP) and is trying to invest more in relationship-building with the ministry at national level.
- **In South Sudan**, MSF's programmes are mostly independent of the MoH, but it is thinking about how it can help rather than hinder the ministry's long-term capacity-building needs.

- **In Myanmar**, MSF is adopting a 'lean-in' strategy towards the Ministry of Health and Sports (MoHS) for disease-focused vertical programmes in the country's north, while also partnering with the MoHS to ensure access to vulnerable people in Rakhine.

We propose three broad directions for MSF:

1. MSF should deepen its engagements with MoH. Government leadership of humanitarian responses is developing rapidly across all MSF contexts. Rather than fight against this tide, MSF needs to adapt to the new reality. Yes, there are certainly tensions involved in this, as states are often the cause of the very humanitarian needs we address – but a strong focus on negotiating space, finding allies and advocacy can serve MSF and patients well in the health domain, as it does in others. Further, MSF needs to improve aspects of its planning, strategising and technique in relation to this engagement. And, crucially, there is considerable space and legitimacy here for senior national staff to take the lead in this work.

2. MSF should develop a more supportive mindset and skill set. Murky concepts need to be clarified – that a 'support' programme really should be supportive, with the MoH in the lead, and not a cover for taking over its facility. And that 'substitution' is only applicable in a small set of specific circumstances. Some practical steps need to be taken to improve support programmes: in joint planning; in managing incentive payments to MoH staff; in aligning with MoH policies and protocols; in further developing monitoring, evaluation, accountability and learning; and in improving processes for handovers and project closures.

3. MSF should identify its responsibilities to the long-term health needs of the people it serves. Our concern with people's immediate and urgent needs does not mean we can ignore their long-term needs. Given its position of power and influence in the countries it works in, MSF should seek to have a more positive effect on the health system around it. This includes: by minimising its own negative harms; by planning and making long-term contributions to health system strengthening; and by investing more in primary and community levels of health provision that can cover larger numbers of people.

This orientation represents an enormous set of positive opportunities, we argue, for more effective medical operations in the short- and long-term, and for achieving its purpose and goals. Deepening engagement with MoH will open up new possibilities for people's access to healthcare, both at the level of individual projects and programmes, and for wider health systems.

And perhaps most importantly, the orientation we propose offers opportunities to provide **a more solid, ethical foundation for the humanitarian-health mission.**

We write this in a year dominated not only by the COVID-19 pandemic, but also by the **Black Lives Matter movement**

in many countries, and by many humanitarians raising their voices against the paternalism, white saviourism, racism and colonialism that are persistent and structural within the global humanitarian community and within MSF itself. In the light of this, it was impossible for us to listen to the stories of both MoH and MSF staff about the relationship between the two partners and not hear the echoes of this colonialism.

So we see that placing greater value on engagement and partnership with MoH can become one element in placing us all on **a more rightful, respectful, equal footing**, thereby strengthening the legitimacy of humanitarian action.

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Introduction

Ministries of health (MoH) are a major actor for Médecins Sans Frontières (MSF) – in fact, for all people – in all contexts, for good and bad.

They are MSF's principal collaborator on all manner of public health goals, including hospital management, outbreak response, introductions of new technologies and many others, and can be an entry point for MSF to promote wider changes in health policy and practice. They are also MSF's 'line ministry', the government institution we hold a formal relationship with, and the one that typically approves the main programmatic choices – from the protocols we use, to the drugs we import, to the location of projects.

These relationships are now changing. Today, governments and economies have developed, with MoH more willing and able to play a coordinating and directing (or, negatively, a blocking) role. As one piece of MSF's own analysis describes it, "The sovereign state will be more and more firmly in the driving seat".¹ This poses significant challenges to MSF's ways of thinking and working, including potentially meaning that it must adapt to working within a health system more actively managed by government, rather than being a highly autonomous Lone Ranger. The shifting landscape also offers opportunities too, as more capable ministries offer possibilities of expanded health programmes, new collaborations and impact at the level of policy and population.

This report concludes a year of study by MSF Operational Centre Amsterdam's (OCA) Reflection and Analysis Network into the relationship between MSF and MoH in the countries it works in.

Structure

This report follows the following structure.

1. Context – This chapter outlines some of the principal dynamics underpinning the need for change, in particular the growing role of government in leading and coordinating humanitarian responses. It also reviews some of the principal themes in MSF's previous reflections related to its engagement with MoH.

2. Analysis – This chapter summarises and updates our initial discussion paper on the issues faced by MSF

OCA when it engages with MoH.² This was based on an analysis of MSF OCA's project typology data, country strategies and project proposals, as well as a set of interviews with heads of mission, medical coordinators and headquarters advisers. It also includes the results of a survey of human resource (HR) coordinators on the role of incentive payments to MoH staff.

3. Case studies – This chapter includes summaries of four case studies carried out by the authors in late 2019 and early 2020, which involved visits to project sites, key informant interviews with MSF and MoH staff and other health professionals in capitals and project sites, and reviews of relevant documentation. The cases were:

- **Sierra Leone**, where MSF is seeking to reduce very high rates of maternal mortality, and so is adopting a 'light approach', 'primarily based on training, mentoring/coaching and supervision' in partnership with the Ministry of Health and Sanitation (MoHS-SL).

- **Central African Republic (CAR)**, where MSF runs large-scale hospital programmes in partnership with the Ministry of Health and Population (MoHP) and is trying to invest more in relationship-building with the MoH at national level.

- **South Sudan**, where MSF's programmes are largely independent of the Ministry of Health, but it is thinking about how it can help, rather than hinder, the ministry's long-term capacity-building needs.

- **In Myanmar**, MSF is adopting a 'lean-in' strategy towards the Ministry of Health and Sports (MoHS) for disease-focused vertical programmes in the country's north, while also partnering with the MoHS to ensure access to vulnerable people in Rakhine.

4. Discussion – This chapter synthesises the contextual understanding, analysis and case study findings, into a series of suggestions as to how MSF might improve its mindset and skill set in engaging with

¹ MSF OCB Analysis Unit, Medical humanitarian needs in a changing political and aid environment. Brussels: MSF; 2019.

² Harvey P, Aneja U, Healy S, DuBois M, MSF's engagement with Ministries of Health – what questions do we face? Amsterdam: MSF OCA Reflection and Analysis Network; 2019.

and partnering MoH – and in identifying its longer-term responsibilities to people in crisis. It builds on a provisional synthesis carried out in April 2020.³

5. Conclusion – This chapter briefly summarises the main conclusions of the report.

Terminology

This report uses a series of different terms to describe the relationship between MSF and MoH. While they might appear to be interchangeable, we consider them to be distinct:⁴

- **engagement** – an umbrella term that includes information-sharing, coordination, advocacy, negotiation and other forms of contact.
- **collaboration** – a relationship that has a common and shared objective as well as activities towards that objective, but is more informal and less structured than a partnership (e.g. a vaccination campaign where both parties participate and work together).
- **partnership** – a specific type of relationship that is based on common and shared objectives and activities, and that is structured, negotiated and formalised to some extent (e.g. a hospital that is jointly managed by both parties).

Finally, MSF is an international movement that includes five autonomous operational centres, but this study only looks at the experience of one of these – MSF Operational Centre Amsterdam (OCA) – and so cannot be extrapolated to all. Nevertheless, we use the initials 'MSF' when referring to general observations, patterns and suggestions, while reserving the use of 'MSF OCA' for things belonging specifically to only the one operational centre, such as data, reports, strategic plans, and so on.

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³ MSF OCA Reflection and Analysis Network, Building bridges: MSF engagement with Ministries of Health in time of COVID-19. Amsterdam: MSF; 2020 April.

⁴ This is consistent with the terminology we propose in: Healy S, Aneja U, DuBois M, Harvey P, Poole L, How does MSF relate to local actors? Amsterdam: MSF OCA Reflection and Analysis Network; 2019.

Context

A changing landscape

MSF everywhere is facing states that more deliberately exercise their sovereignty. Furthermore, the global order as a whole is less Western-led, more multipolar and less willing to accept Western interventionist approaches than 20 years ago.⁵ This is true whether states are labelled as strong or weak, or control all of their territory or only some of it. Even contexts that MSF tends to think of as 'classically humanitarian', where they can operate with a large degree of autonomy, such as South Sudan and Somalia, have governments that seek greater control over international actors.

In its practice, objectives and concepts, MSF's engagement with ministries of health (MoH) has become increasingly outdated. MSF needs to both update its orientation towards MoH and develop an engagement that will remain viable in the coming years.

Multiple facets of the landscape are changing:

- the landscape of how states understand and exercise their primary, sovereign responsibility towards the health of the people, and how citizens and the international community see and weigh that responsibility
- the landscape of growing national expertise, capability and capacity, with the positive result of improving health in many parts of the world
- the increasingly complex internal landscape of the health system, with new mixtures of public health, developmental and humanitarian approaches that are supported through evolving global health financing mechanisms
- the ethical landscape in which the actions and positioning of international actors are perceived and judged.

In recent epidemic responses, MSF has needed to navigate these stronger states, a more present World Health Organization (WHO), and a more complex mix of development and humanitarian actors and financing. These broader trends have clear implications for MSF's ways of thinking,

⁵ Kahn C, Cunningham A, Introduction to the issue of state sovereignty and humanitarian action. *Disasters* 2013, 37:2.

its mindsets, policies and operational culture. This includes how it approaches its commitments to core humanitarian principles of independence and neutrality, and core modes of action, notably *témoignage* (bearing witness). It also includes a range of practical programming challenges across types of responses from epidemics, to vertical programmes (tuberculosis (TB) and HIV) and support to hospitals.

MSF has recognised and grappled with these issues throughout its history. We outline here particular issues or themes that are of recent concern and that manifest in our case studies.

New health system architecture

Wider trends of international engagement in crisis-affected places are moving towards a stronger focus on state-building and health systems approaches.⁶ The Fragile States Principles, which many donor governments have committed to, have "statebuilding as the central objective", and the UN has long been committed to the "primary responsibility of the government to assist and protect" as part of UN resolution 46/182.⁷ Recent policy developments, including calls for a New Way of Working (NWOW), for a Humanitarian-Development-Peace nexus, and for localisation mean that international humanitarian actors are operating in increasingly crowded spaces where development actors are more present. The World Bank for instance has a new fragility, conflict and violence strategy, new financing instruments for crises, and commitments to be more present in crisis settings, such as South Sudan.⁸

These trends are also visible in the domain of global health. Health system performance, and therefore health outcomes, have been improving in many places over recent decades, including in countries affected by humanitarian crises, as shown perhaps most clearly by falling child mortality rates.⁹ The global health architecture has developed considerably, centred on the International Health Regulations (2005), but also due to greater engagement and funding from a wider

⁶ Harvey P, *Towards good humanitarian government*, HPG 29. London: ODI; 2009.

⁷ OECD, *Principles for good international engagement in fragile states and situations*. Brussels: OECD; 2007.

⁸ World Bank, *Group Strategy for Fragility, Conflict, and Violence 2020–2025*, Washington DC: World Bank; 2020.

⁹ Roser M, Ritchie H, and Dadonaite B, 'Child and Infant Mortality', *Our World in Data*, 2019.

set of development actors such as the World Bank and the Global Fund, and private foundations such as the Gates Foundation and various public-private partnerships, such as GAVI in vaccines.¹⁰ Since the West African Ebola outbreak (2014–2016), and now with the COVID-19 pandemic, that architecture has developed further, with WHO taking a more prominent role, both operationally and politically. All of these developments likewise place government response and leadership at the centre.

Compromising with 'strong states'

The issue of relations with MoH emerges in long-standing MSF discussions on negotiating access in various humanitarian settings, in which it recognises the need for compromises, agreements and alliances, but also worries about the cost and the risk of political manipulation.

Buth examines three specific cases of 'strong states' (Turkmenistan, Ethiopia and Sri Lanka), where MSF struggled to negotiate a space for medically-relevant operations with health authorities while maintaining its humanitarian principles in general and its commitment to *témoignage* in particular:

*"To negotiate and maintain operational or medical access, MSF often has little choice but to sacrifice its public voice ... In some contexts, especially in emergency situations, this may be a justifiable compromise, when sufficient space to be truly medically relevant is gained in return. But reducing its role to that of a medical service provider only is hardly justifiable for any longer periods of time. This is in particular the case in contexts where the risk of manipulation and complicity – the risk of doing harm – is high."*¹¹

More recently, Hofmann notes that, as the number of non-state armed groups (NSAGs) refusing to engage with international humanitarian actors has increased, "more and more humanitarian organisations find themselves working exclusively on the government side".¹² There are clear and long-standing dilemmas for MSF in both working with governments and MoH while trying to maintain neutrality and independence. McLean cites correspondence that MSF is "facing a surge of contexts where states are asserting their sovereignty that is hampering our access or complicating our operations and, in some cases, limiting our medical impact."¹³

10 WHO, Frequently asked questions about the International Health Regulations, 2005. <https://www.who.int/ihr/about/faq/en/>

11 Buth P, A line in the sand: State restrictions on humanitarian space. Amsterdam: MSF Hum Affairs Dept; 2010.

12 Hofman M, Humanitarians in the age of counter terrorism: rejected by rebels, co-opted by states. *Humanitarian Alternatives*, 2018: 7.

13 McLean D, Humanitarian Implications of a Re-Assertion of State Sovereignty. *Humanitarian Alternatives*, 2018: 7.

Health systems and access to care

Protracted crises (also known as "complex emergencies") have particularly serious effects on health systems. Evidence has long shown that most mortality in these crises comes not from the direct impacts (e.g. weapon-wounded in an acute conflict) but from the indirect impacts that arise from the negative effects of conflict on healthcare services (e.g. excess maternal mortality caused by destruction of a healthcare facility).¹⁴ Humanitarian health actors will then nearly always be working within a larger health system, and seeking to address the effects of the crisis on it.

Nevertheless, MSF's concern with compromise and politicisation has extended to the place of health system strengthening endeavours in conflict and post-conflict settings. Philips and Derderian critique not only the concept of 'health as a bridge to peace' but also argue that health system strengthening should be seen primarily as a political strategy in contradiction to humanitarian action:

*"The current drive to emphasize state building opportunities in health and health systems interventions is mainly based on political aspirations and concepts. ... In these situations, a significant tension is created between health interventions responding rapidly and effectively to urgent health needs of the most vulnerable and those with longer term aspirations of improving existing health systems. This can amount to barely concealed hostility."*¹⁵

In terms of broader health policy, MSF has strongly criticised those health systems that exclude the most vulnerable from care, in particular through user fees at the point of care. It has criticised government and international donor policies that call for universal health coverage (UHC) while leaving user charges in place:

*"Overall, commitments to support progress towards UHC are not backed up by the necessary resources and policies fail to be driven by the current health needs. Countries are expected to do more without a realistic assessment of their financial capacity. Moreover, international aid is increasingly used towards its transformative potential for the security, economic, or political interests of wealthy countries rather than for primary purpose of improving health outcomes. This does not bode well for global health."*¹⁶

14 Murray CJ, King G, Lopez AD, Tomijima N, Krug EG, Armed conflict as a public health problem. *BMJ*, 2002, 324 (7333): 346–349.

15 Philips M, Derderian K, Health in the service of state-building in fragile and conflict affected contexts: an additional challenge in the medical-humanitarian environment. *Conflict and Health*, 2015, 9: 13.

16 MSF, Taxing the ill: How user fees are blocking Universal Health Coverage. Brussels: MSF, 2018.

Epidemic response and 'shrinking space'

The Ebola outbreak in Western Africa prompted significant discussion within MSF about its place within epidemic responses, and its engagement with MoH. This issue re-emerged during the Ebola epidemics in Democratic Republic of Congo (DRC, 2018 to date), where relations with the government were strained, and which exposed flaws in both the national response and in MSF's attempts to find its place within it. This was discussed in depth in a 2019 meeting of MSF's operational and medical directors:

"[D]iscussions revealed that MSF can still perceive other actors and authorities as a 'necessary evil'. They 'shrink our space', which must then be 'carved back', especially when an outbreak is big. Conversely it was emphatically stressed that 'The choice is not ours anymore. It's now about how we use partnerships as a modality. This is the reality – of the MoH, of an operational WHO, of organizations that are in some cases first responders right after the MoH – and before us!'"¹⁷

This fear of 'losing space' has been an emerging issue in discussion of other outbreaks also, forcing a rethink about where the organisation stands in regard to MoH:

"I'm not sure we're reflecting on how we engage with these MoH actors, as I am struck over last 10 years, the expression of sovereignty has changed drastically. 10 years ago, we could go anywhere and fly and do anything. Now, even in fragile settings with weak institutions... they want to have a say, they don't want to be bypassed, even if they recognise they don't have means, they want to be party of the political decision. This is the big trend."¹⁸

The weighty challenge of hospital programmes

At the level of programme design and implementation, the issue of MSF's engagement with MoH also emerges, often framed in terms of what compromises MSF is willing to make to accommodate the demands of the MoH. This has arisen in relation to MSF's involvement in hospitals, which often belong to the ministry, and which are part of the public healthcare system – but where MSF brings considerable financial, technical and human resources.

Views and approaches can vary widely within MSF on this, however, as shown by these two excerpts from reports produced a year apart concerning one specific hospital (Baraka, DRC):

"MSF Holland is already taking the best course of action ... by implementing a new strategy change to begin handing over various departments of the hospital to the MoH while simultaneously engaging in capacity building ... The contextual challenges ... stem from the fact that MSF has significantly more resources than the MoH which creates an intrinsic power imbalance. MSF first engaged in the DRC in response to man-made conflict, but oftentimes it continues to engage there because there is no easy way to withdraw; the MoH does not have the financial resources to run national facilities without external partners. The power imbalance means that MSF is at risk [of] supplanting the MoH as a primary healthcare provider, instead of an emergency one, and that the MoH have limited if any strategic negotiating power in the partnership."¹⁹

"Yet there are important quality of care issues that need to be urgently addressed. Importantly, these quality issues are not the result of the limitations imposed by the hospital infrastructure. Instead they have been exacerbated by the unintended consequences of strategy changes implemented in 2016. These strategy changes were introduced to address the hospital manageability and to build the capacity of the Ministry of Health (MoH). Many of these changes have been positive and have brought gains to the partnership with the MoH. They have also resulted in a pulling back of MSF from the hospital which has led to unacceptable compromises to the level of functioning. The problem is a tension between the current project goal to save lives and alleviate suffering and the objective to build capacity of the MoH."²⁰

The events of 2020 as an accelerant

In the COVID-19 pandemic, states have moved swiftly to prepare for and respond to the predicted threat, including making moves to assert their sovereignty, control their external and internal borders and often impose wide-ranging lockdowns and other population-control measures.²¹ In most places, control measures have had positive impacts on slowing the pandemic's spread, especially where they were introduced early, but this can come at the expense of marginalised populations.

19 Bou Rhodes S, MSF and the Ministry of Health: A Hospital Management Partnership Project in the DRC, Baraka Hospital Case Study. Amsterdam: MSF; 2017 August.

20 Shanks L, Baraka hospital infrastructure assessment: Baraka, South Kivu, DRC. Amsterdam: MSF; 2018 April.

21 This section draws on: Healy S, Harvey P, Quick analysis of our COVID-19 responses so far. Amsterdam: MSF OCA Reflection and Analysis Network; 2020, June. This in turn was based on an analysis of all MSF OCA project proposals related to COVID-19 and country situation reports for weeks 18, 20 and 22, as well as interviews with 11 senior country and operational managers. We also note here our briefing paper: Aneja U, DuBois M, COVID-19 'futures' in humanitarian action. Amsterdam: MSF OCA Reflection and Analysis Network; 2020 August.

17 MSF, Operations reflection day outcome report: Outbreak response – primary focus on Ebola. Geneva: MSF; 2019 March.

18 Interview, MSF adviser, 2019.

In more resource-poor countries, the actual implementation and effect of lockdowns has varied widely. Government control measures have affected people's access to healthcare and levels of community trust and support. MoH have faced enormous challenges in mounting responses, especially in testing, contact tracing and case management. In addition, in many contexts, health facilities have seen reduced patient loads due to fear of transmission.

In some contexts, states have refused international assistance, refused to mount coherent national responses, and/or even refused to acknowledge the presence of COVID-19. In others, initial refusals to involve international humanitarian actors have started to give way to quiet requests for assistance.

The COVID-19 pandemic has also provoked a crisis of multilateral coordination and an upsurge in nationalist competition for control of resources, such as vaccines and personal protective equipment. States, including those in low-income countries, have had to rely largely on themselves and have as a result had to take firm leadership of responses.

The changes have not only accelerated on the side of states, but also on the side of humanitarians. The killing of George Floyd by Minneapolis police in May 2020 sparked massive anti-racist protests in the United States and around the world. Within humanitarianism, including within MSF, it led to calls by many to identify, examine and overturn the ways in which racism and colonialism were being replicated in daily practice.²² While much focus was on the discrimination faced by people of colour within humanitarian organisations, it has also extended to re-evaluating the relationship between humanitarian organisations and the societies in which they work, including with governments, local healthcare providers, civil society and communities.

²² Parker B, Médecins Sans Frontières needs 'radical change' on racism: MSF president. New Humanitarian, 2020 24 June.

Analysis

This chapter summarises and updates our initial discussion paper on the issues faced by MSF when engaging with MoH.²³ It is based on an analysis of MSF OCA's project typology data, country strategies and project proposals, as well as a set of interviews with heads of mission, medical coordinators and headquarters advisers. It also includes the results of a survey of HR coordinators on the role of incentive payments to MoH staff.

The picture that emerges is one of disconnection between MSF's practice of engagement and its policy and strategy, with neither sufficiently influencing the other.

- Partnership with MoH is the clear operational norm, not the disconnected autonomy MSF imagines and often conflates with 'independence' (being the Lone Ranger).

- Combined MSF spending in some contexts represents an extraordinary investment when seen in relative terms to MoH budgets or health systems more widely.

- MSF typically operates in situations of protracted crisis, not humanitarian emergency, and has been present in many of its largest operational missions for three or four decades.

Partnerships with ministries of health are 'the norm' for MSF

Working directly with an MoH is already the *principal way* MSF delivers healthcare (see Table 1).

Table 1: MSF-MoH partnerships

	Partnership with MOH		No partnership		Total
	n	%	n	%	n
All field medical projects	64	78%	18	22%	82
<i>* Context</i>					
Armed conflicts	21	68%	10	32%	31
Internal instability	20	74%	7	26%	27
Stable situations	21	95%	1	5%	22
Post-conflict	2	100%	0	0%	2
<i>* Intervention criteria</i>					
Targeted or persecuted	2	33%	4	67%	6
Affected by violence	17	71%	7	29%	24
Excluded or exploited	22	92%	2	8%	24
Neglected and inequitable	12	86%	2	14%	14
<i>* Level of care</i>					
Mobile	12	71%	5	29%	17
Primary	17	74%	6	26%	23
Secondary	34	83%	7	17%	41
Tertiary	1	100%	0	0%	1
<i>* Programme type</i>					
Vertical	28	88%	4	13%	32
Horizontal	36	72%	14	28%	50
<i>* Camp setting</i>					
Yes	1	11%	8	89%	9
No	63	86%	10	14%	73

23 Harvey P, Aneja U, Healy S, DuBois M, MSF's engagement with Ministries of Health – what questions do we face? Amsterdam: MSF OCA Reflection and Analysis Network. 2019.

In May 2020, MSF OCA had a total of 82 field projects that were delivering healthcare services.²⁴ Of these, 78% (n=64) featured a partnership or collaboration with an MoH, while the remaining 22% (n=18) did not. This figure includes various types of partnership, including: joint management of specific health facilities; MSF presence inside a larger MoH facility; long-term partnerships on a vertical disease programme; and research collaborations. It does not include the referral of patients between MSF and MoH facilities or project authorisations/memoranda of understanding.

Several patterns are discernible in the project typology data. **Firstly, it is far more common for MSF to partner with an MoH than not to** – in all types of contexts, levels of care and programmes. In armed conflicts, for example, 68% of field medical projects feature a partnership with an MoH, while 32% do not – making it more than twice as likely. A project can be vertical or horizontal in design, or address the primary or secondary levels of healthcare, and it will be twice, three times, four times as likely to be delivered via an MoH partnership as to be delivered via a stand-alone approach.

The only exception to this is when looking at the intervention criteria drawn from MSF OCA's latest strategic plan. In six projects considered to be designed for people who are 'systematically targeted or persecuted', four are delivered via MSF-only programming, while two (both in Rakhine) are delivered alongside the MoHS.

Secondly, **partnerships with MoH are more common the more stable a context is, and the higher the technical level of care.** Partnerships are more common in stable situations (95%) than in internal instability (74%) or in active conflicts (68%). Partnerships are also more common in secondary care facilities (83%) than in primary care facilities (74%) or mobile clinics (71%), and they are more common in vertical programmes (88%) than in horizontal ones (72%). This is as expected, given the disruption that crises have on state-run health systems and the greater likelihood of gaps at primary level and for vulnerable people.

However, this pattern could be an artefact of the specific balance of projects in MSF OCA's portfolio in 2020. A year previously, our analysis found "It is noticeable that the type of context does not seem to matter", with partnerships being just as common in active conflicts as in instable or stable contexts.

Thirdly, the exceptions seem to prove the rule. **The projects where MSF 'chooses' not to partner with an MoH follow one major pattern: the ministry is simply not present.** Almost half of such projects (8 out of 18) are in closed refugee or IDP camp settings, such

as in Bangladesh, Ethiopia, Jordan or Syria. In only one closed camp setting (again, in Rakhine) does MSF work in partnership with an MoH. Further, there are three cases where MSF works in areas controlled by NSAGs that do not have functioning health authorities, and two more (Tripoli detention centres, and search and rescue) where the MoH is not present either. This leaves five remaining projects where MSF could have chosen to partner with an MoH but decided not to – in Yemen, Pakistan, Russia, Ethiopia and Jordan – for a wide range of contextual reasons.

MSF investment is considerable in some countries

MSF operations are a significant part of the overall health system in some contexts – specifically low-income countries experiencing protracted crises (see Table 2). For instance, in CAR, MSF is running 12 projects in 10 different locations with an annual budget of € 53 million, and with a headcount of 220 international staff and 2,250 national staff. Most of these projects include direct support to MoH hospitals and health centres including through drug supply, payment of incentives, infrastructure construction, logistics and technical support. Martinez (2018) notes that this makes MSF the largest contributor to CAR health system financing – by comparison, the MoH annual budget is € 27 million.²⁵

Table 2: MSF-MoH budget comparison (2016 unless otherwise stated, in €)

Country	MSF budget*	MoH budget**	MSF start
DRC	105 million	188 million	1977
Yemen	60 million	188 million	1986
South Sudan	59 million	66 million	1983
CAR	53 million	27 million	1997
Haiti	40 million	59 million	1991
Afghanistan	25 million	98 million	1980
Chad	21 million	82 million	1981
Sierra Leone	10 million	67 million	1986

* MSF typology 2017; Description of MSF activities 2016, Geneva: MSF.
 **All figures except for South Sudan are from the World Bank's Human Development Indicators database, based on multiplying real per capita US\$ government spending by total population for the most recently available figures (2016 in all cases except for Yemen for which the 2015 figure was used). US\$ to € conversion is as at the XE estimated exchange rate on 31 December 2016 (2015 for Yemen). The South Sudan figure is from the WHO's Global Health Observatory for 2015, with currency conversion calculated on 31 December 2015.

²⁵ Martinez C, Central African Republic Health System Overview: Implications for MSF. Bangui: MSF. 2018.

²⁴ This excludes emergency preparedness and exploratory projects (18), as well as coordination projects of all kinds (42, including country coordination, intersectional coordination, liaison offices and logistics projects), as these projects do not deliver medical services.

It should be noted that, by percentage, CAR is by far MSF's largest contribution to a country's health system, proportionally speaking, and an outlier. Nevertheless, MSF is also a disproportionately large contributor in other contexts relative to the MoH. While MSF's investments are sizeable in these contexts, the principal reason for this imbalance appears more likely to be the very weak scale of government investment in health.²⁶

The table also shows the year in which MSF first started operations in the country. In most cases, MSF has been present for three or four decades, showing a long-term commitment that extends far beyond a role as an 'emergency responder'. Ironically, given its current levels of investment, MSF's presence in CAR is of shorter duration, beginning 'only' two decades ago.

Strategy, guidance, documentation and policy

As part of this research, we reviewed all MSF OCA country policies, project proposals and annual planning documents. This section examines how the relationship and engagement with MoH is dealt with in these documents – an issue central to several of our case studies and discussed further in the next chapter.

We found great variance across country policies and project proposals in terms of how they view the relationship with MoH. Some barely mention MOH – with MSF implicitly playing a direct implementation and substitution role. Others go into significant depth about the possible negative consequences of MSF on health systems and mitigation measures. And some country policies are explicitly framed around capacity building and health systems strengthening.

Country background analysis often contains descriptions of the dysfunctionalities of health systems – including chronic shortages of qualified medical staff. But any analysis of ways that MSF might link with other aid organisations working on health systems is largely absent – other than to dismiss others as ineffective. Drug supply systems and health financing are rarely analysed in any detail – the default assumption seems to be that MSF will have its own system separate from government. The HR implications of MSF interventions, such as risks of poaching MoH staff or distorting salary scales, are rarely mentioned.

While MSF programmes often include components on training or capacity building, it is rare to find much supporting analysis, rationale or direction of the exact approach taken. Exit strategies often make a brief reference to the possibility of handover to the MoH as a potential exit strategy but there is rarely any description of what programmatic adjustments

might be needed for this to be a realistic option, or what systems would need to be strengthened or put in place. A number of country policies just note that an exit strategy is unlikely to be realistic in the short to medium term.

The MoH appears in the advocacy sections of many country policies and project reports. In several countries, the phrase "catalyst for change" appears, and the MoH is also an advocacy target in many projects and countries around specific diseases and/or around access to health measures. But levels of engagement with the MoH – at capital ministry level, district level and in individual health facilities – are rarely discussed in country policies. Indicators in logframes for objectives related to MoH engagement are pretty thin, perhaps suggesting a damaging circular function of 'what's not measured isn't counted' and 'what's discounted or dismissed isn't measured'.

Incentivising ministry of health staff

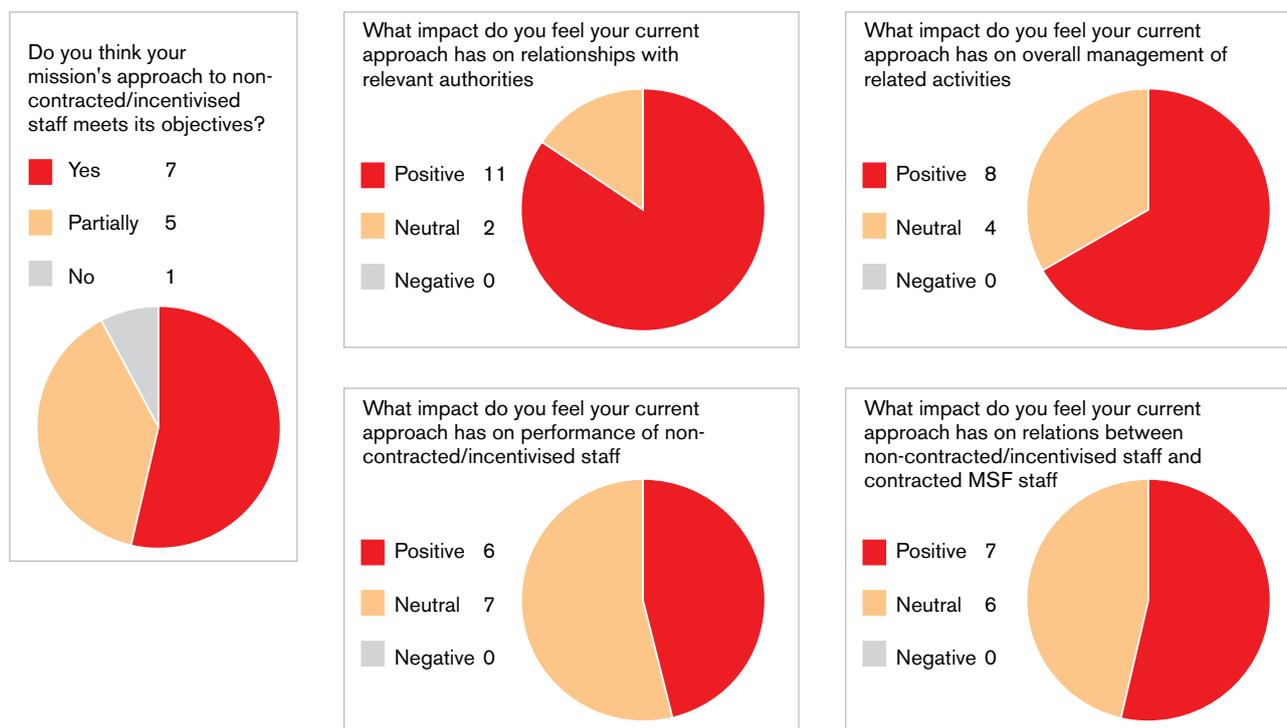
In many places where it partners with an MoH, MSF makes some form of payment to MoH staff – usually referred to as an 'incentive', but sometimes a 'prime', 'bonus', or 'top-up'. The motivations for doing so can vary quite widely: sometimes as compensation for the extra workload that MoH staff will be expected to take up; sometimes to create some kind of parity with the rates of pay of MSF equivalents; sometimes as a performance-based bonus to encourage adherence to raised standards of care; and sometimes to discourage MoH staff from only working a small part of the day, charging user fees or directing patients to private clinics.

In our initial analysis, this emerged as an issue. Further, it seems that record-keeping is weak for this group of staff, including mission-by-mission tallies of total numbers of staff, their payment levels and their qualifications and classifications. To fill some of this gap in knowledge, we conducted a questionnaire with HR coordinators of MSF OCA's missions. Of 26 missions, 17 replied (65%). Of these, 13 missions (76%) made some kind of incentive payment to non-contracted staff, and 10 (59%) made such payments to MoH staff.

In most cases, MSF has little management oversight of the staff it pays incentives to: for example, 2 out of 13 missions conduct job performance evaluations, 2 out of 13 would ever withhold incentive payments in case of poor performance, and 6 out of 13 have some kind of written agreement with incentivised staff. Incentive payments are often not aligned with other professional development or capacity-building efforts for such staff: for example, 6 out of 13 do not open courses to incentivised staff. Nevertheless, HR coordinators generally perceived incentives to meet their objectives, although they were more positive on its impacts with health authorities (11 positive, 2 neutral, 0 negative) than on its impacts with incentivised staff themselves (6 positive, 7 neutral, 0 negative).

²⁶ For comparison, the 2016 budget for the Austin Hospital, the nearest hospital to the residence of one of the authors in suburban Melbourne, was the equivalent of 514 million.

Figure 1: HR coordinator survey results



Overall, HR coordinators did not think that incentive payments had any particular effect on improving work performance, even though this was a commonly stated aim. Other stated aims included: a desire to consider long-term effects and work with a local partner; to bring in and compensate specific skills and capabilities in MoH staff that MSF did not have; working with a functioning MoH service that does not need full MSF involvement; legal status issues preventing MSF from contracting staff directly; and the obvious one ... “We are working in a Government owned hospital”. Greater inclusion and investment in incentivised staff was a clear recommendation from HR coordinators, to redress any perception that incentivised staff were ‘second-class citizens’ of some kind.

This survey did address some of the gaps in knowledge about incentivised staff, but it also certainly highlights how much is missing. There is a lack of basic data on incentives, who is being paid, how much and why. There is a lack of stated aims or clear objectives for incentives, a lack of monitoring as to whether or not those objectives are being met, a lack of analysis and monitoring as to what people receiving incentives think and feel about the arrangement, and a lack of analysis on whether incentives are creating tensions or negative impacts within facilities or between supported and non-supported facilities. The surveyed HR coordinators did not perceive any negative consequences of the policies. In contrast, our findings in several of the case study locations revealed various concerns and frustrations related to the payment of incentives.

An appetite for change

Policy and planning documents suggest that how MSF engages with MoH at different levels is limited and problematic. However, it was clear from interviews that, in practice, MSF staff are intensively engaging with MoH and local health authorities most of the time, and that considerable energy and analysis goes into building and maintaining relationships. This suggests two things – firstly a significant disconnect between what is written down and what is acted out, and secondly, the opportunity to improve what is now *ad hoc* and individually driven. Further, our interviews show a desire on the part of many field leaders to reconsider some of the ways MSF has engaged with MoH in the past, and to develop a more respectful and collaborative relationship.

As one interviewee noted:

“The stereotypes of MSF, not collaborating, mostly working in parallel systems, aren't true. There is a lot more collaboration with MoH's than you might think. There's lots on a technical level – just the day-to-day nuts and bolts of often working alongside MoH people. Much of which isn't written down. That's especially true where MSF is working in MoH facilities such as in Sudan and in Ethiopia. There is also lots of negotiation around programme design and choices and implementation.”

Another argued:

"MoH is our partner but we still use MSF protocol. We hardly even apply for permissions. When I arrived I got everything approved from MoH. It wasn't that difficult - but that wasn't the practice earlier. I asked HQ, and they also said they don't usually do it, so there is no need for it. But a more collaborative approach could be very beneficial, not just for us, but for MoH in developing its own protocols ... They now approach us for assistance on protocols and we have been included in their technical working group as well. They are now approaching us, asking us to help develop a strategy. This is not in our mandate, but we helped them, guided them in the right direction."

This was noted by one interviewee in relation to Somalia:

"MSF has had a new model since its return to Somalia – before they used to take over services and recruit staff which created major security risks around HR management. The new approach is to work hand-in-hand with the MoH – all services are owned by the MoH. MSF has an MoU with the MoH to provide resources, technical capacity, measurement and supplies. There is a minimal presence of expatriates on the ground and national staff are only in key management positions. All hands-on medical staff are MoH. MoH recruits and then seconds to MSF, MSF pays and monitors performance but it doesn't manage staff and is not involved in HR. MSF is part of hospital management committees."

And finally:

"MSF cowboy days are long over. We are working with the MoH because it is the right thing to do. Rather we want to do the right thing, and MoH is one of the ways we do it. We want to make sure that the mission narrative is that we have an inclusive approach to those most responsible for public health outcomes ... It can feel like a compromise and a dependence, but I doubt this conceptually. We can keep talking about how independent we are, but that could mean that we end up doing nothing. We need MoH to be effective here."

Such views would also seem to have some backing in MSF OCA's strategic plan too, as part of its vision statement reads:

"We will seek out alliances, collaborations and partnerships that support our pursuit of improved humanitarian and health outcomes for the people we assist. We have a responsibility to strengthen local capacity, knowing that our presence in any context is temporary."²⁷

²⁷ MSF OCA, Strategic Plan 2020–2023. Amsterdam: MSF; 2020.

Case studies

Sierra Leone

Projects and approaches

After the Ebola outbreak, MSF OCA debated whether or not it should have continuing presence in Sierra Leone. The decision was made to stay based on the very high, near-crisis levels of maternal and under five mortality and the fact that it represented a good opportunity to test new approaches and ways of working. In 2018, MSF OCA started to shift from the more direct provision of services towards more of a support role, working more closely with the MoHS-SL.

MSF OCA is currently working primarily in Tonkolili District, supporting the Magburaka District Hospital, a Mile 91 community health centre (Hinistas), and supporting maternal and child health services in nine primary health units (PHUs). A new multi-drug resistant TB (MDRTB) project started in 2019 in Makeni, Bombali District, in close cooperation with the MoHS-SL, piloting MDRTB decentralisation with a new short-course regimen.

MSF also fills gaps where drugs are not available and provides training, supervision and support to intensified community engagement and stronger referral pathways. Support has also been provided to repair facilities and to ensure basic equipment is available. MSF works to MoHS-SL protocols. Where these compromise patient care or are counter to basic WHO standards, MSF advocates changes. Health indicators in the supported PHUs are being regularly monitored and joint supervision visits are regularly undertaken with MoHS-SL staff.

MSF staff work in Magburaka District Hospital. In the PHUs, MSF pays incentives to MoHS-SL staff. The new approach to supporting PHUs is what MSF OCA describes as a "light model" and "an approach primarily based on training, mentoring / coaching and supervision". In 2020 MSF is planning to pay 243 people incentives (148 in the district hospital and 95 in the PHUs). In 2020 the incentive budget for Tonkolili project is € 180,997 which represents about 5.75% of the total project budget.

MSF coordinators have been discussing the prospective drawdown of support to the hospital at Magburaka with the MOHS-SL and the Ministry has looked to strengthen areas that MSF and the Ministry have identified together.

Views of the Ministry of Health and Sanitation

MoHS-SL officials in Freetown who liaise with MSF at the level of project agreements were very complimentary about MSF's approach and happy with the existing engagement and relationship. They described MSF as "playing by the rules", and "using the correct channels", adding that it "understands how things work and who to talk to and can appropriately knock on the doors that they want".

MoHS-SL officials interviewed also noted the high levels of professionalism and the impact that MSF support was having. They had observed that MSF-supported staff were noticeably better at dealing with people and "even in dress they are different". The one area for improvement noted was a possible need for more discussion and dialogue about how to get MoHS-SL staff more involved in supervision and monitoring. "MoHS needs to ask more and MSF needs to offer more."

At the district and facility level, MoHS-SL staff were very appreciative of MSF's support but were conscious that very little was likely to survive once that support is withdrawn, beyond skills and knowledge transfer. MSF and MoHS-SL staff were working well together on a day-to-day basis in the hospital and in the PHU support programme, with strong working relationships. MSF was seen as more hands-on and involved than other international agencies.

Issues

Uncertainty about MSF's length of stay

Continued uncertainty about MSF's length of commitment to staying in Sierra Leone makes it hard to plan for capacity building and exit.

The current approach might best be described as 'constructive ambiguity'. This has pros and cons but it does make it hard to have a clear multiyear timeframe and to make handover and exit plans. More thinking is clearly needed about how and when to stop support to the nine PHUs and what specific level of improvements in health outcomes should be aimed for that can outlast MSF's support.

What would success look like?

MSF does have a monitoring, evaluation and learning plan but, given the rationale for the project to enable wider learning from a potentially new approach, this could be further developed.

The current aim is to see whether or not there are improvements in maternal and under-five mortality in the catchment areas of the supported PHUs. That is one of the key potential outcomes but it does not answer the question as to whether improvements will continue once MSF support stops. MSF could usefully develop plans for when support to PHUs stops, and criteria for 'graduation' and monitoring health outcomes. This might allow a more experimental approach where the contribution of different aspects of the support package being offered could be examined.

What's the rationale behind the lighter approach?

The theory of change behind the lighter approach at the moment is not very clearly articulated. Is it a capacity-building and sustainability objective with the intention of enabling an MSF exit and having a more sustainable impact on high levels of maternal and under five mortality? Is there a cost effectiveness element, in that a lighter approach could be cheaper and therefore able to achieve greater coverage? Each of these imply different types of monitoring, evaluation and analysis.

What are the implications of high staff turnover?

Rapid turnover, particularly of international staff, was seen by MSF senior staff as a barrier to making progress on working more effectively with the MoHS-SL and in more of a supportive, capacity-building role.

It is hard for country missions to have bespoke job descriptions and they are often sent people for generic and standard MSF roles that do not necessarily match the approach that is being taken, or the expectations that many international staff have of working with MSF, particularly those on their first assignment. This in turn creates difficulties in sticking to the agreed strategy as staff tend to default towards more directive and interventionist approaches.

Are national staff empowered to play roles in managing the relationship with authorities?

People interviewed agreed that working towards more senior national staff leadership was the way forward but hard to achieve given MSF structures, culture and HR systems. A key constraint is that it is difficult to get senior national staff able to play more senior leadership roles given what MSF is willing to pay. In spite of these difficulties, efforts are being made and there are opportunities.

Incentives

It was agreed that the rationale and theory of change behind incentives was not very clearly articulated. The suspicion is that MSF started using incentives in Sierra Leone "just because it is standard MSF practice".

Evidence from surveys suggests that incentives do not prevent people being charged for services and that charging happens everywhere in Sierra Leone, including in MSF-supported units. Both MSF and MoHS-SL staff interviewed, however, agreed that incentives were critical

to supporting the basic functionality of health facilities. If the ultimate rationale is motivation, then this may be an area where MSF can usefully learn from wider experience about what motivates health workers and what works in terms of attendance and accountability.

Staff buy-in

There is some uncertainty as to whether all staff within MSF have bought in to the new approach – or whether some see more direct implementation as preferable. The temptation, given the nature of the organisation, will always be for MSF to step in and sort out problems, and for the MoHS-SL to expect this to happen.

Adaptability and flexibility

It was noted that the new 'light' approach was still more something decided by MSF than a more genuinely co-designed process with MoHS-SL, or one that corresponds to needs.

Advocacy and coordination

The mission has an advocacy strategy – but it is not very granular in terms of its analysis of who needs to be influenced and how in order to get policy change, and in order for change at the policy level to translate into practice.

MSF made a strategic decision in 2018 not to focus on advocacy at the national level as it felt that it was likely to have limited traction and could do more at the local and regional levels. The core problems that prevent more sustained impact on health outcomes and make any handover problematic however are the 'volunteer' issue, with many of the staff needed to run facilities properly not being paid, and the drug supply system. These are issues that can only be resolved at the national level.

The model that MSF is trying to move towards – less direct implementation, more support to MoHS-SL – depends on being able to advocate for the ministry to gradually assume more responsibilities. But, in MSF-supported areas, as long as MSF continues to step in and fix problems when they arise, so the incentives for MoHS-SL work in the opposite direction – of directing scarce resources to places where there is less international support. This represents a real dilemma for MSF, to which there is no easy answer.

Health systems analysis

The good engagement and relationship-building with the MoHS-SL seems to be more personality-based – in the sense of relying on the instincts of key senior staff – rather than systematic and so is in danger of being lost when staff change. There is limited evidence of analysis of how the health system works, the range of national and international actors involved in health systems strengthening, or where MSF fits within that.

Negative impacts

MSF does not explicitly consider potential negative impacts of its approaches and interventions on health systems or develop mitigation measures.

Examples of possible risks are that payment of incentives discourages people not receiving payments (for example in nearby but unsupported PHUs), that higher quality of care creates pull factors that increase costs and travel times for patients, and that the MSF drug supply weakens the government's own system in the district. Senior MSF staff are very aware of risks and have taken various mitigation measures but this tends to be a personal position and not an organisational one. More carefully mandating an assessment of risks, possible negative impacts, and mitigation measures in planning, guidance and reporting would be useful.

Support or guidance from headquarters

There was not perceived to be much guidance from headquarters in terms of how to engage with MoHS-SL or ways of working on health system strengthening. Technical support is dominated by medical technical expertise and is an area where headquarters specialists could helpfully do more. The Sierra Leone mission sees itself as having value as a place where new approaches can be tried and that it could potentially develop some of the tools and guidance that might be helpful. But what is meant by tools or guidance would need to be thought through.

Existing MSF guidance, tools and training could also usefully do more to signal and highlight the value in building relationships with the MoHS-SL and health authorities at different levels.

Central African Republic

Projects and approaches

Civil war has marked much of the past decade in CAR, bringing unprecedented levels of violence against civilians and systematic attacks on health facilities, staff and patients. CAR exists today in a state of precarious, fragmented stability. The government has recovered some authority but lacks the capacity to govern effectively or provide basic services. The CAR context is almost unique in terms of the imbalance between (a) major gaps in the government's healthcare capacity and (b) the extraordinary scale of MSF's operations relative to the overall health budget (see Table 2). One particular MSF adaptation to this situation is strong coordination among the four of its operational centres in the country, and an inter-OC special advisor.

Explicitly based on the MSF OCA strategic plan (2015–19), the country policy directs MSF to maximise access to healthcare through "community engagement and decentralization of health care." Somewhat misaligned, the MSF mission has been heavily invested in running two district hospitals, Bambari and Bossangoa. The latter

project was changed to support around 14 health structures, and in Bambari plans are under way to focus more on community health outside of town. Two community HIV support projects (Zemio and Boguila) have been phased down and handed over to MoHP, but still supported, with the aim of strengthening national policy and practice.

Views of the Ministry of Health and Population

MoHP holds diverse perspectives on MSF. At Bangui level, it sees its own large gap in terms of financial and human resources and believes that MSF should design its interventions more specifically in response, moving beyond a purely humanitarian response. As one MoHP director put it, CAR "needs MSF in order to develop". This statement highlights a significant appreciation. There is heavy praise for MSF's professionalism ('*savoir être*', not just '*savoir faire*'), MSF's commitment to patient needs, and the way it carries itself so as to demonstrate respect for patients. This is an impact that seems important and yet infrequently discussed in MSF. At the Bambari level, the MoHP finds MSF a well-resourced though difficult partner, contributing to complex administrative structures and undermining MoHP's leadership in the hospital and in the district. In both locations, these views come mixed with concerns related to MSF's attitude towards the MoHP and its staff, part of a perceived arrogance or paternalism on the part of MSF.

Issues

Strategic orientation lacks clarity

The high-level strategy documents for CAR (country policy and annual plans) do not meaningfully take up or provide direction to the mission's engagement with the MoHP. Where direction does exist, it is not actually directive because it uses terminology that remains undefined within MSF, open to wide variations of interpretation. The country policy declares MSF as being "in complete substitution of the MoHP".

In effect, the country policy provides no positive orientation in terms of MoHP engagement, and seems to define the MSF role in the negative, in terms of acute MoHP inadequacy: "MSF responds to the lack of access to health care related to an absent MoHP and lack of government investment in health".

The 2019 annual plan for the coordination team in Bangui attempts to provide orientation yet ultimately offers a vague endorsement: "A close collaboration with MoHP at national and district level is present. Working within MoHP structures so as to build capacity is an MSF operational strategy in CAR". The Bambari 2019 annual plan calls for "working closely with MoHP" and states that the MSF strategy "will be based in supporting the MoHP". Another annual planning document states that MSF should "request the MoHP to staff key positions in order to give the MoHP a certain degree of autonomy to prepare the future, but still keep MSF staff to guarantee quality care and access to health care". In the end, a more accurate description of the Bambari project would be that MSF is operating 'islands of substitution' under the name of 'support mode' to the hospital.

About the money – incentives and cost-recovery

Regarding incentives, there is friction between those with MSF international salary, MSF national staff salary, MoHP staff with incentive only, and MoHP staff who do not receive an incentive payment. A key question relates to whether the incentive is a guaranteed payment or can be linked to performance targets. In some health posts supported by MSF, MoHP staff see the payment of incentives as necessitated by the abolition of user fees – so incentives replace staff 'salary.' This second key area of tension, cost-recovery versus free at point of care, looks to become more challenging in the near or mid-term, as the MoHP will shift to 'development mode' and certain donors will require implementation of cost recovery. National staff and a majority of the African international staff interviewed tended to believe that free healthcare will devalue how the community sees healthcare, and as counterproductive in the long run.

The image of the Ministry of Health

One particular complaint among international staff interviewees is that headquarter briefings characterised the MoHP and MoHP staff solely in negative, accusatory terms – that staff were corrupt, inept, did not care about patients, were poorly dedicated, etc. These briefings were seen as unfair. They discouraged efforts to engage and fed into a narrative of maintaining control and an 'us/them' independence. In other words, this mischaracterisation fed into a narrative of superiority and disengagement.

The inter-OC special advisor role

The special advisor's role is to strengthen MSF's capacity to understand and engage with the MoHP in Bangui – and the key players in the health system more broadly – as well as to rationalise, harmonise and help ensure continuity and consistency in the relationship. The point is to establish not simply a relationship with the MoHP, but a high-level engagement that integrates an understanding of what is happening in the field with an understanding of the internal functioning of the MoHP.

Engagement with the Ministry of Health and Population – planning

Two different MoHP directors complained that MSF shows up with its annual plan as a *fait accompli*. The Bambari project offers a good example of how engagement might improve results on both sides. Such an engagement would hold four goals. First, to sit together and see what has been accomplished in the previous year. Second, for MSF to see MoHP's goals and potentially support where a good fit exists. It is more that MSF might find places where its planning overlapped the MoHP's needs. The *symbolic* value is thus important. Third, to discuss the MSF's plans in such a way as to allow the MoHP to plan accordingly. Fourth, for the MSF to profit from MoHP's own assessment of the health needs in communities and in the hospital *before* it formulates its own plan. One potentially disruptive future debate is that the MoHP will soon switch to a new health information and surveillance system and request that all health providers must follow.

Harmonisation and co-existence

One major challenge and source of continuous tension arises from the lack of harmonisation of MSF and MoHP treatment protocols, standard operating procedures (SOPs) and policies (e.g. treatment or prescription protocols), as the setup gives rise to mixed teams of MSF and MoHP staff working in the same departments and even within the same teams.

In Bambari, MSF is not using MoHP protocols inside the hospital and claims responsibility for 'its' patients. Just across the courtyard, International Medical Corps (IMC) instructs the MoHP staff that MoHP is responsible for the patients in 'IMC's' maternity ward. There is, thus, a larger symbolism to MSF's intervention – the visible power and wealth imbalance. MSF and MoHP thus work together from very different starting points, and active or latent resentment can block daily problem solving.

There is a concern that blockage will arise as MSF international staff object to a loss of control because it is viewed as leading to preventable harm to patients. It is an old issue and, problematically, it is an unsettled issue in MSF. Predictably, this and other issues are also further exacerbated by recurring challenges such as high staff turnover, poor institutional learning and the lack of staff with expertise in hospital management.

Engagement with the Ministry of Health and Population – culture and mindset

Our preliminary report on this topic concludes that the attitudes of MSF staff (especially international staff) can be patronising, causing damage to relationships with the MoHP. This was raised by international staff in almost all interviews as well as by the Bangui medical team. One cultural problem is the permanence of emergency mode. There is a consistent pattern of international staff (interviews suggest this is more common if from the West as opposed to the many internationals in CAR from non-Western origins) whose sense of urgency cancels out thinking about the medium and long term. This places MSF in a "state of impatience with the rhythm of the ministry".

Power dynamics

MSF's position sits upon a false foundation – in language and in deed it mistakenly considers itself as the guardian of the people, and the owner of the output. For example, the way MSF divides the hospital into 'ours' and 'theirs' and talks about "our patients" and "our wards". MoHP officials and MSF medical staff alike remarked on the fact that the Bambari hospital is a public MoHP establishment. As one MSF medical staff declared, "[T]hese are not our departments and not our patients". It can also be mistaken in its attributions: as one international doctor opined, "I understand why [MoHP staff] do not feel responsibility for anything when we MSF have taken away the responsibility for everything".

Urgent public health: MSF identity and its role and responsibility in CAR

The call to address '*urgence structurisante*' arises because the humanitarian health context places CAR in a special category. The MoHP can be characterised not as a system with gaps – a phrasing that might apply even in impoverished states such as Sierra Leone or DRC – but by the scope and depth of the absence of a system. The result is that to save lives and alleviate suffering, a purely humanitarian health focus on individual patient care is likely less effective at reducing morbidity and mortality. How should MSF think about responsibility that comes (or not) with the weight of MSF's health expenditure in CAR? What is MSF's identity in CAR?

Quality of care vs technology vs sustainability

High quality of care is often mistaken for the use of high-level technology, and often justified on the grounds of ethics – that it is unethical to provide a lower treatment unless forced to do so. MSF need not declare one policy on the matter – but in CAR there should be clear context-specific direction.

South Sudan

Projects and approaches

South Sudan has been affected by a devastating conflict that has displaced millions since 2013, and caused massive mortality linked not only to violence but also to malnutrition and disease outbreaks. A new unity government offers some hope of stabilisation, but the country is still *de facto* split into areas controlled by government and opposition groups. The fundamental issue faced by all health actors is the extreme weakness of the health system and the MoH. Nearly all health services in the country are functional because of international support by either humanitarian and/or development actors.

MSF OCA presently directly manages two hospitals, in opposition-controlled Lankien and in the Bentiu Protection of Civilians IDP camp, as well as a sexual and reproductive health clinic in Bentiu town. In Leer, it directly manages a primary healthcare clinic (PHCC) including an emergency room in the town as well as community-based medical care (CBMC) points in surrounding areas. And in Mundri, it established and runs the emergency room at the town's PHCC, directly manages an entire PHCC in the village of Kedibe and supports five CBMC sites. While Mundri is relatively new (2017), the other projects have been operating for a very long time: MSF has been in Leer and in Lankien since the 1980s and 1990s respectively.

In contrast to many other countries, MSF's chosen mode of operating in South Sudan is strongly 'substitutionist'; that is, it has established its own independent facilities and funds, and manages and operates them itself alone. Nowhere does MSF OCA use a common modality in other settings: 'partnerships' where MSF works inside an MoH facility, paying incentives to MoH staff, supplying medicines and

logistical support, and providing clinical supervision and *de facto* management. However, MSF has been more open to doing so recently in South Sudan, as shown by its presence inside the MoH facility in Mundri.

At national level, MSF has more or less constant engagement with the MoH but most commonly this seems to be on regulatory and administrative issues. At local level, engagement with the MoH varies widely. It is greatest in Mundri, and there are connections in Bentiu with the MoH-run hospital and involvement in MoH-coordinated outbreak responses from time to time. In Lankien the MoH is not formally present at all, although there is a county health director connected to the opposition.

Views of the Ministry of Health

All MoH officials we met with reported positive perceptions of MSF as an essential provider of health services and as a critically important partner: "as a brother", "as family", "as a strong partner". Most often, officials spoke of the importance of MSF as a site for referrals of urgent and complicated cases and for outbreak response.

In all locations, MoH interlocutors see their own priorities as being to restore basic functionality to the services they manage, especially at the primary level. One MoH interlocutor described his requests for MSF as: "respond to emergencies but don't leave too soon afterwards"; "stay in secondary care rather than primary"; and "expand your programs by opening up to international donor funding". This is notable insofar as, while MSF might see its role as 'substitutive', the MoH seems to see MSF's role more as 'complementary'.

Underneath all the gratitude and appreciation is the understated but unmissable resentment of health officials at being so dependent on external assistance. Said one: "I have no capacity to do anything: no HR, no supply, no anything". And, on occasion, their pride at being able to build up their own services themselves: "Before the crisis, this hospital was one of the best in Upper Nile. Due to the war, in 2016, it was just a PHCU really. In 2018, after some development, we got it to PHCC level. And in 2019 up to today, we moved somewhere to calling ourselves a hospital again".

Issues

Seeing connections and building on them

The overall impression is that MSF perhaps has more connections to the MoH than it realises or explicitly values. There was a notable contrast in the way that MSF and MoH staff spoke of their engagement with each other. MSF international staff tended to view it as minimal and as not particularly important for their main focus – immediate clinical outcomes. MoH staff, on the other hand, tended to view MSF as playing a crucial role over the long term, both for patients and also for the system as a whole. MSF national staff tended to hold mixed views, and were critical of both the MoH's inadequacies and of MSF's blindness.

Partnership programmes between MSF and the MoH do not seem to be needed at present in South Sudan, given the government's focus on primary care and the presence of many international actors supporting it at that level. This may change in the future, if MSF chooses to focus more on primary care and/or if MoH seeks to re-establish services in zones of MSF presence, such as Leer and Lankien.

MSF could consider the many different ways that it could help the MoH boost its own capacity, without redirecting all of its programmes. For example, MSF could designate a 'good neighbour' policy in relation to any MoH facilities adjacent to its own, whereby it agrees to assist such facilities whenever it can, by loaning staff or equipment on occasion, or by covering emergency ruptures. Or it could make efforts to strengthen the linkages and network between MoH-run primary level facilities and MSF-run secondary level facilities. Or it could extend training opportunities to MoH staff in neighbouring facilities, whether informally (such as between individual clinicians on specific technical skills from time-to-time) or formally (through the MSF Academy, discussed later).

Making longer-term plans

MSF has a long-term commitment to South Sudan and has made longstanding contributions to its health system, and yet it does not seem to think or act like it. Rather, MSF staff seem to feel that they are in eternal 'response mode', and that there seem to be few pathways out while the system remains weak. For example, in several locations, people spoke of international medical staff always getting drawn into frontline clinical care roles, even when they are supposed to be acting more like consultants.

MSF is already taking some steps towards making longer-term impacts and could develop these. Despite MSF fears that any long-term orientation will come at the expense of the immediate, these steps seem to be both helping immediate patient care and safety and strengthening the health system.

Both Lankien and Bentiu are presently in the middle of an infrastructure improvement push, such as new maternity wards and operating theatres. And all MSF missions in South Sudan will this year launch the 'MSF Academy', which aims to provide some 70 nurses' aides with more formal training in order to help them progress towards becoming qualified nurses, thanks to accreditation by the Nursing College and the MoH.

Greater investment in South Sudanese nationals would seem to be a major way for MSF to both achieve its immediate aims and make a contribution to the country's future. While the number and quality of facilities providing medical and paramedical training is still low, there are an increasing number of graduates from them, as there are from schools in neighbouring countries. Some are now finding their place in MSF's ranks and working their way up – and will need the organisation's support to go even further.

Of course, events may intrude that disrupt or destroy the best-laid plans for the future. But this is not a reason to avoid planning.

Coordinating and aligning with the system as it builds

In such a fragmented health system as South Sudan, MSF could consider further what contributions it makes to this state of affairs – and avoid actions, if possible, that add to that fragmentation. In particular, MSF could consider a greater degree of alignment with the MoH on both policies and protocols as the MoH develops.

While most of MSF's projects in South Sudan have been in place for a long time, it still wishes to remain open and able to respond to new needs. This means that MSF does still need to consider how it hands over and closes projects. And this point was raised by several MoH and other interlocutors, in particular in reference to recent project closures.

One prerequisite would be that MoH and its partners take up the provision of salaries and/or incentives to staff and the supply of essential medicines to the facility that MSF is leaving. This is feasible with a certain period of notice to allow them to integrate it into their planning (reportedly: 12 months). The level of MSF salary compared to the salaries of MoH staff and to the incentives they receive from other health actors is a major consideration in this. The choices here are difficult: any attempt to align MSF salaries to the (low and falling) incentive level of the MoH's partners would likely cause major labour issues, but not doing so would likely cause a massive drop in payments after an MSF handover and therefore staff flight.

An additional consideration is the extent to which MSF's services align with the overall health strategy of the country and its model for distributing the delivery of healthcare services between the different levels of the health system, such as between PHCCs and county hospitals. South Sudan has a detailed and well-designed Basic Package of Health and Nutrition Services that outlines the specific services to be provided at community outposts and at clinics. An MSF clinic that returned to MoH management would only provide the services, and receive the resources, that it is supposed to under this policy.

This then requires a degree of discipline from MSF to broadly stay within the bounds of MoH policy – to not turn a PHCC into a county hospital, nor to add too many services that a facility is not supposed to have. This can be difficult as teams will often seek to intervene wherever needs arise and will therefore find it difficult to limit their facility and services.

Confronting political failure

The root causes of the problems faced by all health actors in South Sudan are political – in particular connected to the prolonged lack of state investment in health and the health system. Government spending on health is a derisory 1.2% of its national budget, which explains why institutions are so

weak. Several health actors spoke of conflicts of interest in the MoH, which is responsible for coordinating the system, but which also does not want international partners sharing too much information with each other or speaking with a common voice.

In order to stabilise zones of excess mortality, humanitarian health actors need either infinite resources or a public health system that can serve as a guarantor of bare minimum service levels. This absence of a stronger state sector leads humanitarians to a set of challenges about working over the long term, which they never intended to have to face. (The problem is mirrored for development actors: "This is so far from development, this is humanitarian-plus", one key informant told us.)

Many actors are pushing for greater coordination. MSF could usefully support and participate more in the effort to improve state investment, performance and coordination within the health sector, in addition to what it is already doing. In the first instance, better coordination will improve overall health system strength and therefore improve health outcomes. Secondly, the distinction between 'humanitarian' and 'development' is hopelessly blurred by the reality of this context and many actors of whatever stripe are operating similarly. Thirdly, humanitarian suspicion of aligning too closely with development actors is inoperable in this specific context – as the problem here is not an excessively close relationship between government and development actors at the expense of humanitarians or of populations, but rather conflictual relationships between government and international actors. Finally, given that development actors in South Sudan are just as likely to suffer from difficulties with government as humanitarian ones, cross-sector solidarity will be key in pressuring the government to respect its international partners and take up its proper responsibilities to its people.

Myanmar

Projects and approaches

MSF operates across diverse operational contexts in Myanmar, with a varied set of needs, and a diversity of approaches. Across all however, albeit to a varying degree, there is now some sort of collaboration with the Ministry of Health and Sport (MoHS).

In three cases – Yangon, Shan, and Kachin – this includes cooperating at both the local level and with the national MoHS programmes for TB and HIV. In the north, the programme has mostly focused on HIV patients, with MSF being one of the largest providers of HIV care. MSF is now in the process of transferring this programme to the decentralised National AIDS Program, including patients on treatment for co-infections such as hepatitis C, TB, and MDR-TB. In late June 2019, MSF closed its clinic in Insein, Yangon, which had been running since 2003, and served

over 17,000 people. The focus is now on handing over the services entirely, eliminating any duplication of services, and building a stronger collaborative relationship with the MoHS.

In two locations in Rakhine state, MSF provides mobile clinics, primarily for the persecuted Rohingya minority but also for members of the Rakhine Buddhist ethnic group. These are *de facto* under an MoHS umbrella as part of a locally-negotiated situation that gave MSF better access without compromising programme independence. In all cases, a position that is open to collaboration with the MoHS is seen as critical to achieving the mission's desired health outcomes.

MSF has been present in Myanmar since the early 1990s when the country was still under military rule. Later in the 2000s, MSF started to scale up programmes in the north and east of the country to treat HIV and TB patients. The motivations were mixed. On one hand, there were certainly unmet humanitarian needs. But, on the other, the motivation was also strategic – to demonstrate MSF neutrality to the government and to dispel suspicion of MSF being pro-Rohingya, and thereby gradually expand access in Rakhine. As the conflict in Rakhine escalated in 2012, the relationship with the government became increasingly tense. This was while the HIV and TB programmes had already expanded considerably and would soon need to be handed over to the government for reasons of financial sustainability. The differing contexts in northern Myanmar and Rakhine state thus pulled MSF in different directions with regard to its relationship with the government.

Views of the Ministry of Health and Sports

A major limitation of this case study is that we were unable to speak with anyone from the MoHS – one appointment had been set up, but was cancelled at the last moment, and the delicate nature of the ongoing negotiations with MoHS made it harder to get other appointments.

Issues

'Leaning in' in the north

The orientation was described as a process of 'leaning in' to the MoHS, of recognising the need for collaboration and complementarity, at least where possible, rather than a substitution approach.

The transfer of HIV patients has made building a good relationship with the MoHS all the more necessary: "If we want to transfer our patients to MoH[S], this is only possible if we strengthen the MoH[S]". MoHS staff have been sponsored for an international conference and training abroad, and plans were underway to organise a joint TB symposium. This has reportedly made a significant difference to MoHS's perceptions of MSF. Staff also reported that they had increased their efforts to meet with MoHS – "This helps relationship building".

It was important to start collaborating and to identify the gaps and capacities early on, not only when the need arises.

A culture of sharing and collaborating needs to be cultivated – organising meetings together, and sharing data, learning and experiences. “Otherwise”, as one project coordinator put it, “it’s like trying to climb a tree from above.”

Cultural sensitivity and the role of national staff

Having more national staff seems to be beneficial from the perspective of engaging with the MoHS. National staff are able to pick up on cultural nuances – for example, not to introduce a sensitive topic in a big meeting as that is likely to embarrass the official in public. Another staffer mentioned that earlier all letters to the MoHS were written in English, which often irritated the MoHS. One rather startling point made by one of the staffers was that the reason letters used to be written in English was because MSF international staff didn’t trust the national staff, but others say this was representative of a particularly idiosyncratic moment in MSF history, and now the situation has changed. National staff echoed this, saying that there is now far greater trust and respect between international and national staff. Leadership is of clear importance in shaping these situations.

As of recently, the Yangon office has appointed one person who works to liaise, guide and coordinate the relationship with the MoHS – a national staff member – keeping in line with the MoHS’s preference for dealing with national rather than international staff. This was attributed to both language and cultural factors. The national staff interviewed almost unanimously pointed out that having greater engagement with the MoHS through national staff is key for building stronger relationships – particularly as it enables a more informal set of interactions and relationships.

Quality of care

The transfer of HIV patients to the National AIDS Program shows the importance of considering issues of quality of care.

It is important to take the capacity of the MoHS into account, and to tailor programmes accordingly, even if one of the implications might be a reduced quality of care. For example, this could imply using MoHS protocols in certain situations. While this could run the risk of compromising the quality of care, in the long run, it enables a more sustainable programme for patients, and makes the transfer easier and less burdensome for the MoHS. “Currently MoHS feel like we are dumping patients on them and even the patients are reluctant to be under MoHS.”

System strengthening

MSF has shown a growing interest and awareness of the need for health system strengthening, identifying the following priorities in Myanmar: HR; infrastructure; service delivery; and health financing. A number of health system challenges were also identified, including: availability and distribution of inputs; weakness in key functions; and lack of oversight, leadership and accountability. However, it is unclear what course of action, if any, MSF would be engaged in to address these needs. Some steps might include staffing appropriately, so

that there is capacity for meaningful engagement with MoHS; developing ‘smart’ or ‘strategic’ points of contact; and being clear on messaging on key issues, enabling a timely MSF input if and when an opportunity arises.

Programme design should start by identifying the gaps and needs of the MoHS. In this case, one of the key issues is around HR, both in terms of trained personnel and allocation of human resources, and system management. The knowledge and experience of MSF should be used to address this gap through, for example, training of staff and facility planning. MSF, however, has predominantly been providing infrastructure support in terms of the construction or renovation of an existing facility or technical support equipment. “The gaps that we are struggling with are also the same gaps in the ministry as well, such as human resources”.

Another way of thinking about this is to consider whether MSF can strengthen the health system by demonstrating and showcasing its strategies, models and ways of working. Equally, it is worth pointing out that there certainly have been improvements in MoHS’s own capacities. MSF is increasingly treating populations at the margins – in stronger health systems, this is probably where humanitarian actors should be placed. This is already a huge change from earlier years, where MSF was the largest provider of HIV and TB care.

A compromise approach in Rakhine

In Rakhine state, most of MSF’s activities have centred on providing primary and emergency care through mobile clinics, under the *de facto* umbrella of the MoHS, to facilitate access and acceptance. “MoHS had their logo, but we were essentially running the clinics, because we had the staff and supplies.” MSF “has had to compromise heavily on the principles of independence and impartiality in order to operate in Rakhine”. For example, project locations for both regular and emergency interventions were often chosen by authorities, and not always based on medical needs. MSF was also not allowed to conduct independent needs assessments. Further, by working in the IDP camps for Rohingya people in Rakhine, MSF could be seen as legitimising the segregation strategy of the Rakhine government.

Concerns about neutrality and impartiality in the areas of Rakhine state close to the capital of Sittwe have somewhat changed now because of the shift in the conflict dynamic. Earlier there were concerns about ‘balance’, that is, that MSF was asked to balance its operations between Rohingya and Rakhine, regardless of assessed needs. Now with the intensification of conflict between Rakhine separatist groups and the government, there are significant humanitarian needs to be met on both sides. “Even if MoHS agrees to send us to only Rakhine areas, that’s okay, because humanitarian needs are pressing and urgent”.

In contrast, in Maungdaw in northern Rakhine, only a few humanitarian actors have access. Here the main motivation for MSF’s continued presence seems to be to provide

medical care, but also to 'bear witness'. The calculation is different from around Sittwe: because MSF is one of the few NGOs allowed and owing to the ongoing humanitarian needs, there is a clearer justification for their continued presence. Here, MSF has also started some 'low-profile' activities, such as training of 'local health educators' with basic first aid skills, allowing them to deliver basic consultations for local people. These activities are now also expanding, and MSF seeks to make them more significant.

However, there were significant differences of opinion within the MSF team on this compromise. One argued MSF should take a much more vocal stance against the government: "The MoHS continues to restrict access to NGOs. We are all just waiting here for approvals. It would be better to make a huge fuss and withdraw if the situation continues like this for much longer, especially since access has barely increased in the past seven to eight years". However, a distinction was nonetheless made between Maungdaw and Sittwe – in Sittwe, there were other organisations that could pick up some of the load, but in Maungdaw, MSF was one of the very few, justifying therefore its continued presence, despite restrictions. In contrast, others argued: "We have to continue to negotiate access, slowly get as much as we can, and gradually increase our programmes. Moreover, in [Maungdaw] we play such a critical role of bearing witness that we cannot withdraw".

Handling policies of exclusion

A key issue in Rakhine was the referral of patients. Sittwe General Hospital has had, for years, a policy of discriminating against Rohingya patients, by putting them in a locked ward, and denying them adequate medical care or support. It has been challenging for MSF to get access and check on patients in this ward, making it harder to follow up. Rohingya patients are often terrified of being referred there, even to the point of refusing treatment. MoHS would like to see greater contributions to Sittwe hospital by MSF, but currently this has been limited. More than a dozen organisations and donors have offered support, resulting in a morass of poor coordination and planning. This has also made it harder for MSF to assess its contribution and respond accordingly.

This issue of referrals to government facilities has also become easier with the change in conflict dynamics, with growing needs among the Rakhine population as well. A significant development in this context is the plan to set up a fixed clinic in Sittwe, or to support an existing health clinic. Rehabilitation of the MoHS clinic in Sin Tet Maw has now been approved, and is soon to start. The plan is to provide MSF staff and all the components required to turn it into a fully functioning rural health centre that is open to the entire population. "The idea is to also piggy back on already existing ideas the MoH has in a way that it ups their profile and reputation."

Presence is also seen as the best way to tackle any exclusion issues that may arise. "It's hard to say that Rohingya are excluded from health infrastructure, if that health infrastructure is basically non-functional." In the event that patients are

blocked from access, MSF would seek to use its local community network to negotiate access. It should also be noted that Rakhine and Kaman populations in the area also have poor access to health facilities.

Perceptions of MSF

MSF's long operational presence and demonstrable track record has earned it a good reputation. Some of its pioneering treatments have played a catalytic role, and this makes MoHS take the organisation seriously. "People know us" was heard frequently, as was the paradox of MoHS being suspicious of MSF for being pro-Rohingya, yet at the same time recognising MSF as delivering technically sound programmes.

MSF is also perceived to be hard to hold to account because of frequent staff changes. "MoHS also finds us more difficult to deal with, compared with other agencies, because it is less willing to bend to their demand." One example cited was that the local authorities had asked for the opening of a new mobile clinic. MSF said it would not be able to do it, because it would only treat 10-15 patients, whereas another healthcare provider was willing to take it on. More broadly, while the government is concerned with its international reputation, this is only up to a point – it is becoming more confident in placing restrictions on international staff. For MSF, this has meant a massive reduction in international staff – while there used to be 90 staff, there are now only 25. MSF adjusted over time by shifting responsibilities to senior national staff, increasing length of contracts for international staff, and placing a greater focus on humanitarian training.

A nuanced approach to government

One of the issues for MSF is that lines of command and jurisdiction are not clear, change often and thus are hard to navigate. It is often unclear which ministry should be negotiated with, and at what level. Within the ministries, there is also a strong culture of fear – many within ministries are reluctant to take independent decisions for fear of what superiors may think. The military continues to have significant control. Having a good relationship with the MoHS thus does not necessarily mean that there is a good relationship with the state.

The relationship is good enough for MSF to have a seat at the table and join common platforms on issues such as HIV. But MSF does not always have access to higher level platforms, which deal with a broader set of medical issues at the national level. However, this is not unique to MSF – even large international development actors, for example, do not have such access. Further, MSF senior management said that the government engages when it is clear on its strategy – but this does not always align with MoHS planning cycles. This also makes it difficult to integrate with the national programmes.

Yet neither is the government a monolithic entity and there seem to be a considerable number of concerned individuals within the MoHS. Recognising this, the mission is reportedly trying to take a more nuanced approach to government.

Discussion

Our analysis and case studies demonstrate that MSF has a wealth of lived experience in terms of working with MoH, including both successes and failures, and yet has not addressed this relationship by placing it at the level of a key strategic concern. Nor has MSF taken the opportunity to capture, reflect and then build upon what it has learnt. Three areas stand out in particular:

- the need to promote a deeper, more strategic and deliberate engagement with MoH
- the need to nurture a more collaborative and supportive mindset and skill set in those programmes where it works in partnership with MoH
- the need to recognise its responsibilities to the long-term health of the people it serves.

Promote deeper engagement with ministries of health

Saving lives and alleviating suffering will almost always depend upon MSF establishing a respectful and productive relationship with MoH. This holds true regardless of the specific programme choices it makes – that is, whether it partners with the MoH at project level or not, it will always need to engage effectively with it.

This “connectivity” requires attention to the fundamentals of the relationship. **It is states that are the duty bearers for respecting and fulfilling their citizens' human rights, including their right to health, and so states will always be the primary engine of public health.** When they do so properly, this is a good thing.

It is also true that states are often the principal cause of humanitarian crises and health needs, and their political choices determine how severe those needs are, how they are distributed, who receives assistance and protection, and who does not. Even within relatively functional and legitimate states, health systems can often work to exclude and discriminate – and even more so during conflicts and other crises.

Given this, humanitarians can often find, or place, themselves in *de facto* opposition to states. This applies strongly to Médecins Sans Frontières, whose very name implies ‘doctors against sovereignty’. Famously, MSF holds dear a certain

“ethic of refusal”,²⁸ in which it “rejects the logic that divides humanity into those who may live and those who must die”.²⁹

But ‘refusal’ should not be mistaken for a call to side-step or escape the state and its central role in both causing and resolving humanitarian crises. Neither the principle of neutrality nor independence suggest such “state-avoiding” orientations. Rather, navigating this tension requires principled engagement with states in general – and health authorities in particular – through negotiation, advocacy, networking and relationship-building.

While the necessity of engagement seems well accepted by MSF when it comes to negotiations with the political or military components of states and even armed groups, our study finds that it does not yet seem so well accepted in relation to health authorities. And yet deeper engagement with health authorities offers significant opportunities for MSF to save lives, alleviate suffering and protect human dignity in the near (and long) term via the expansion of access to healthcare.

Perhaps the most illustrative example we found of this was in Myanmar. Here, the state has persecuted the Rohingya minority for decades, culminating in 2017 when more than 700,000 people were forced to flee the country. MSF is addressing the enormous health needs of those who remain – and is doing so in partnership with the MoHS. Joint MSF-MoHS teams visit the IDP camps and provide relevant health services together, because this mode of working stands the best chance of gaining government authorisation and building acceptance among all communities. Elsewhere in the country, MSF works closely with the MoHS to provide HIV, TB and other medical services to various groups of vulnerable people, and in Yangon it is in the midst of handing a large cohort of patients into the care of the MoHS. Negotiation and engagement has been a constant, careful and highly nuanced process, full of compromises certainly, but also full of meaningful collaboration. The same applies, in differing ways, in Sierra Leone, South Sudan and CAR, as well as many other examples we heard of.

Several key points stand out for us to guide MSF's relationships with MoH.

28 Orbinski J. The Nobel Peace Prize speech. Geneva: MSF; 1999.

29 Bradol J-H. The sacrificial international order and humanitarian action. In: The shadow of just wars. Weissman F, ed. Ithaca, NY: Cornell University Press, 2004: 9.

Accept and adapt to government coordination in humanitarian response

Government leadership in humanitarian response is an established principle and an increasing practice. At an elemental level, MSF's relationship must begin with respect. The relationship cannot be founded upon an MSF pride in its superior capabilities or moral legitimacy. We saw this leadership in all four cases, including in South Sudan and CAR, where government resources for health are the weakest in the world, and heard many other examples, such as the Ebola responses in West Africa and DRC. The central role of governments in coordinating their national responses to COVID-19, including in humanitarian settings, provides further confirmation, if it was needed. And yet more confirmation is provided in the calls by many within the humanitarian community, in the wake of a global upsurge of anti-racist campaigning, to 'decolonise aid'.

Humanitarian and emergency response systems will continue to integrate in the future. MSF has found it hard to participate as a 'junior partner' within government-led coordination systems, even when there has been no other role available. Striking the right balance between working under a wider umbrella and conducting appropriate advocacy when the responses were not so effective or respectful of communities has also proven difficult. It will need to find a way (or ways) to do so.

MSF should see a greater government role in responses as an opportunity – in the first instance, to meet a greater part of the needs of people in crisis situations. And also to increase the relevance, quality and impact of its own medical operations, through finding complementarities and collaborations with other organisations. In any case, we see no alternative for MSF other than to recognise this changing landscape and adapt to it.

See ministries of health as allies in opening humanitarian access

MoH have proven to be of great value in creating the space for MSF to work in the cases we examined and in other examples. Perhaps this is because of a shared belief that all medical professionals uphold the same fundamental values, or perhaps it is because MoH are often resource-starved and looking for allies of their own. It might help MSF to think of its work with an MoH not as collaboration with the regime, but as collaboration with the doctors, nurses and medical community of the nation in question.

Certainly, MoH work within limitations, and they can be as politicised, incompetent and self-interested as any government (or non-government) institution can be. But the openings that they provide are often critically important – and they should be recognised as central to how MSF negotiates access.

See engagement with ministries of health as a relevant method of 'localisation'

MSF has had an uneasy and at times defensive and sceptical approach to debates about localisation in humanitarian action.³⁰ In the context of the discussion on racism in MSF and humanitarian action, MSF urgently needs a more constructive approach to calls for localisation.

In part MSF's scepticism stems from the fact that the localisation debate has become increasingly focused on the role of national and local NGOs and ways they can be more effectively and directly supported. As MSF does not often sub-contract or work in partnership with local or national NGOs, it has not seen the calls for localisation as relevant to it. However, the original Grand Bargain commitment to better support national and local responders explicitly includes governments.

Improving how it works with and relates to MoH potentially provides MSF a lens through which to engage in localisation debates more constructively. MSF's position in relation to localisation could be framed around providing stronger and more effective support to local and national health authorities – both state actors and, in conflicts, with non-state authorities in line with commitments to neutrality. Complementing that, through stronger community engagement, MSF could also commit to supporting people to hold states and other authorities more accountable for meeting rights to healthcare. A further way to accomplish this could be for MSF to build the expectation and practice of local stakeholders holding to account the provider of health services (in the future, the government), by ensuring that they can hold MSF to account in the present.

Expand advocacy for access to health

All of MSF's medical activities can be conceived as strategies for (re-)connecting people to the healthcare services they need. This will most obviously be through direct service provision, but also through impact on policy, conducting research that builds an evidentiary basis for more effective practices, and various approaches to advocacy rooted in its medical action.

We saw a number of effective examples of where MSF is advocating for change in healthcare policies and protocols – such as by demonstrating models of care for HIV and TB in Myanmar. And we see greater space for MSF to expand its advocacy for improvements to health systems, for example, in drug supply and staffing, in expanding access to excluded and vulnerable populations and, overall, for greater government investment in health.

MSF tends to default to substitution, arguing that national and local health systems are failing (drugs are not present

³⁰ For example: Schenkenberg E, The Challenges of Localised Humanitarian Aid in Armed Conflict. Barcelona: MSF ARHP; 2016.

in clinics and staff are not being paid) and that MSF needs to step in to provide and support services. This is often true, but MSF too often takes these failures as unavoidable and hence neither advocates for nor engages in attempts to fix or resolve the problem, particularly in places where it has worked for decades. MSF struggles to leave or exit support to facilities because of these failures but often is not doing enough to get properly engaged in the granular advocacy needed to tackle systemic challenges in areas such as drug supply and staff payments.

Enhance roles for national staff in engaging with ministries of health

The empowerment of national staff fits into an overall (and somewhat glacial) MSF policy shift, placing them in more senior leadership roles and tackling structural racism within the organisation. In all of our cases, the presence of MSF nationals conducting negotiations and engagement with MoH officials proved highly beneficial to MSF, either in addition to engagement conducted by international staff or instead of it. But we also often heard that nationals were being overlooked and underutilised for these responsibilities. Greater involvement of national staff would be a useful strategy to address the rapid turnover of international staff, and the negative effect this can have on long-term relationship building.

Clarify engagement strategies, objectives and responsibilities

MSF should view its relationship to the MoH as a key determinant in accomplishing its objectives, and strategise accordingly. Its present *ad hoc* approach reduces its effectiveness and causes internal confusion about its aims and approaches. The case studies found many examples of such shortcomings, and the cost in terms of zigzagging discontinuity, burned or rickety relational bridges, and poor outcomes. MSF needs to set clear strategies for itself in each setting, which specify what it is seeking to do with its relationship, and how it plans to carry this out. Specific suggestions arising from this study include the following.

- *Stronger analysis* of health systems, MoH policy goals and the place of global, national and local health actors, and of MSF itself, in country policies, country advocacy strategies, and via specially commissioned reports and papers. This requires adequate resourcing.
- *Clear definition of specific objectives* in engaging with MoH. Similarly, MSF needs a clear understanding, to whatever extent possible, of MoH objectives in engaging with MSF.
- *Clear definition of methods and approaches.* MSF should define how it intends to engage with the MoH, including how it participates in various coordination and technical bodies, and how it shares data, information and reporting. It should also identify potential collaborations and allies.

- *Monitor, evaluate and learn from engagement efforts.* Specific indicators to govern the engagement with the MoH should be added to the project proposals of coordination teams and used to monitor progress. Better monitoring and evaluation of MSF's engagement with MoH, including metrics and outcomes, will also help in building in-country institutional memory, which presently can be difficult to maintain.³¹

Develop a more collaborative and supportive mindset and skill set

MSF's engagement with MoH extends far beyond coordinating and negotiating with them. MoH are MSF's principal collaborators and partners in the delivery of medical programmes, and the entity it jointly manages hospitals with in conflict zones, builds treatment programmes for vulnerable populations, and runs vaccination campaigns and outbreak responses, among others.

There are many reasons why MSF enters into such partnerships and collaborations. Sometimes it is to enable access where the MoH offers the best (or only) negotiable pathway to a given population. **MSF also does so for strategic medical reasons too, because it believes such partnerships and collaborations will maximise medical impact, or more efficiently build upon the capacity that is already present, or provide the best outcomes in both the short and long term.** In case study countries we saw a number of specific motivations for such partnerships:

- to add a needed but missing service to an existing, functioning MoH facility (Mundri, South Sudan)
- to maintain and improve medical outcomes in specific essential services when an MoH hospital had been stretched beyond its capacity and resources by health needs (Bambari, CAR)
- to lower crisis-level maternal mortality rates in the immediate and longer term through expanding and improving the coverage of health services (Magburaka, Sierra Leone)
- to plan and implement the handover of patients with HIV to long-term MoH care (Yangon, Myanmar; and Zemie, CAR).

So partnerships are central to MSF's medical strategy in many contexts. But we see two main obstacles: one is

³¹ The experience of working with an inter-OC special advisor in CAR indicates significant benefits arise simply from coordinating across OCs (e.g. not having four medical coordinations attend the most important committee meetings and then none in less important but nonetheless valuable committees).

connected to mindset – the way MSF thinks about and approaches its partnerships with MoHs; and the other is connected to skill set – the way particular components of these partnerships are conducted.

Value and commit to collaborations and partnerships as the norm

One of our interviewees argued forcefully that positive and respectful partnerships are a responsibility of MSF: “First, it is their country. MoH is first responsible. Our role is to support them.” We would agree, although perhaps with a little nuance: our first role is to figure out how to best save lives and alleviate suffering through collaboration and support of MoH; and, secondly, to do it ourselves when the first is not possible.

In the four cases we studied, we found multiple examples of MSF teams trying to find the best ways to partner with the MoH on the ground, devising ‘light approaches’ or ‘lean-in’ strategies. But we also heard stories of MSF arrogance and paternalism – of doing its own thing without consideration for the effects it was having on other health actors or the health system as a whole.

MSF would do better to recognise the work that its teams are already conducting to support MoH – and to decide to value, build upon, learn from and improve these efforts. Collaboration and partnership are, and should be, the norm.

Define ‘support’

We found many different interpretations across MSF about what the term ‘support’ actually means. For some, ‘support’ was intended to signify an effort to ensure delivery of medical services while also boosting the capacity of the MoH in the short, medium and/or long term. But for others, the concept of ‘support’ seemed to be more of a fig-leaf – a term to cover what was really an MSF project, led, managed and implemented by MSF, albeit inside an MoH facility. This needs to be clarified.

Firstly, if MSF launches a ‘support’ programme, it really should mean it as ‘support’ – that the lead role is being played by the MoH and MSF is backing it up in whatever ways are agreed. (We note that this is the default approach of the ICRC.)

Secondly, the language used to describe each support programme could be developed. We saw three different definitions of support in our case studies and in our analysis of the portfolio. Each has its own logic, and its own requirements in terms of approaches and ways of working – and so should be considered separately:

- *technical assistance* – in a few instances, the term ‘support’ described something akin to technical assistance – for example, supporting the clinical training, coaching and supervision of MoH staff
- *resource provision* – in most cases, the term was

used to describe situations where MSF provides medical supplies, logistical support, and incentive payments to MoH staff, as well as some form of supervision and/or management – but still under MoH leadership at facility level

- *management function* – in other instances, the term ‘support’ was used to describe situations where MSF stepped into a management function and so played a much more leading role, but within an MoH facility, and therefore still under an MoH umbrella even if there was little interaction with the MoH.

A naming convention or taxonomy could be developed for this to ensure all MSF staff understand the specifics of the ‘support’ concept similarly. The Yemen mission developed a system of graded levels of ‘support’, which could be adapted to other settings. The model differentiates six intervention types: donations only; donations and incentives; donations, incentives and training; remote co-management; onsite co-management; and independent MSF management.

Question ‘substitution’

MSF often characterises its interventions as falling into one of two modes: ‘support’ or ‘substitution’ (or ‘replacement’). But, in practice, only one-fifth of MSF OCA programmes meet any meaningful description of ‘substitution’, and even then only in specific circumstances, such as refugee camps or contexts where there is no MoH present. More commonly, MSF works in an MoH facility replacing the MoH in specific components and roles, therefore mixing substitution at a point of care level with support at the project’s strategic level. The choice to consider these hybrid programmes as examples of ‘substitution’, rather than examples of ‘support’, or even just ‘partnership’, suggests a problematic mindset that potentially undermines relationships with MoH.

Not all programmes need to be ‘support’ and there is value in MSF opening and directly managing its own health facilities, most notably in response to sudden-onset emergencies where the authorities are overwhelmed or in settings where health authorities are absent. In some circumstances, it is the most appropriate pathway. But even here, MSF cannot pretend that government does not exist and the limits of the concept of ‘substitution’ need to be understood. MSF does not, and cannot, genuinely ‘substitute’ for an MoH. A ministry has permanent obligations to the health and wellbeing of an entire population, so it needs to consider decisions on how to prioritise scarce resources entirely differently to MSF. At most, MSF can step in temporarily and partially.

Introduce joint planning and accountability structures

For a partnership to work, it needs to be properly structured. There is vital space here to improve on existing practice in MSF-MoH partnerships. MSF has its own systems for planning, managing and monitoring its projects – in the form of its project proposals and logframes, which are submitted

and approved twice a year. At present, there seems to be little if any involvement of MoH counterparts in this process, or of MSF in the respective MoH planning processes.

This has significant negative impacts on MoH capacity to plan or resource its facilities, because it can only learn of the commitments of a major partner after the fact.

This is also a significant missed opportunity for MSF to benefit from MoH's understanding of the needs and the crisis, to plan for rather than react to MoH gaps in programming, and to ensure complementarity and coverage. Better practice would be to ensure that there is adequate consultation and discussion between the two partners during the planning process on what is, in reality, a joint project.

Align projects as much as possible with national protocols and policies

MSF has a strong preference for its own standards, guidelines and technologies, which it believes guarantees a certain quality of care. The difficulty is how these (self-selected) standards interact with the national standards set by MoH in the present, and how they affect healthcare in the future. At facility level, we saw that mixed protocols can result in confusion. At system level, we saw that different policies can add to fragmentation.

In our case studies, we saw a growing interest from MSF teams in bringing their policies into sync with those of MoH in a variety of domains, including medical and diagnostic protocols, service package design, health information and data collection, and others. In some cases, we also saw MoH insisting more forcefully on humanitarian and health actors following their policies.

As a rule, it would be more appropriate for MSF to align itself with MoH policies, protocols and systems as they develop. Exceptions should of course remain possible. There might be situations where MoH policies or protocols are outright unacceptable from a medical or even ethical point of view, or where positive innovations are possible and should be tried. In these circumstances, MSF should do more to actively advocate for changes to policies, or develop new models of care with MoH based around new innovations, and be clearer about why certain exceptions are needed. There are also cases where MoH are actively seeking out the advice of MSF on new and improved protocols, policies and approaches – clearly a significant advocacy and engagement opportunity.

Review incentives and consider alternatives

Many MSF projects pay some kind of incentive to the MoH staff that they work with. The motivations for paying incentives can vary significantly – or might not be specified at all, other than 'this is just the way we do it'.

Our analysis and the case studies in Sierra Leone and CAR made clear that incentive policies need to be better connected to the broader support strategy if they are to

meet their objectives. If they are to encourage improvements in performance, then they need to be accompanied by wider efforts, such as providing access to MSF training for MoH staff (which presently only happens in half the cases). If poor performance never results in reduced payments (and in most missions, it never does), then such a policy does not necessarily 'incentivise' good performance. Without considering equity issues between MoH staff on incentives, MoH staff not on incentives and MSF staff, tensions might arise between people that MSF needs to cooperate with in order to help improve healthcare. If part of the rationale for incentives is to prevent the charging of fees, mitigating corruption risks or siphoning of patients into clinicians' private practices, then MSF should monitor the shifts in these practices and do more to put accountability, feedback and complaints mechanisms in place that can identify whether these measures are working.

Further, MSF could benefit from considering alternatives to incentives in order to better determine its strategy in each case. These might include: collective performance-based bonuses; structured and well-resourced training packages; the secondment of MoH staff to MSF, paid at full MSF rates and under full MSF management; or simply the payment of MoH salaries without any claim to incentivise. Presently, incentive payments are a blunt instrument, and need much more thoughtful design, monitoring and learning to be made effective.

Finally, MSF could also benefit from improved record-keeping and tracking relating to this group of staff. All missions should track and report on how many non-contracted staff are being paid, how long they have been 'employed' and the costs of these measures as a share of MSF's country budgets. Even from an accountability standpoint, incentivised workers are a significant financial outlay for MSF, over which there is presently little monitoring or oversight.

What would success look like?

In a number of cases we looked at, MSF is seeking to better adapt its approaches to the health context – for example, in Sierra Leone, by developing a model of care that would be easier for MoHS-SL to sustain, replicate and scale up. However, what it often lacks are efforts to capture the learning from these different approaches, to evaluate what has worked and what has not, and then to disseminate them to future teams. This is an organisation-wide problem, clearly. Measures to improve information management and institutional memory, such as via more accessible IT systems and document repositories, would also help here.

Support programmes need to have robust objectives and indicators built into their monitoring systems that not only focus on clinical outcomes but also on support outcomes. For example, if an objective is to improve the quality of care provided by MoH clinicians to a certain level and then hand over in three years, then relevant indicators need to be designed and included for that.

Consolidate and develop approaches to handover and exit

MoH are the main bodies that MSF seeks to handover projects, facilities and activities to, and MSF has a long and rich history of doing so, and of struggling to do so well. Today, handovers certainly remain a significant weak point, and need improvement.³²

One issue identified is that often country policies and projects start with good intentions that caution against having too 'heavy' an MSF approach, and not trampling on local systems. But, lacking strategic continuity, and as time goes by and with turnover issues, the project becomes larger, heavier and more expensive, with large numbers of directly hired MSF staff, MSF-dedicated supply systems that replace and disrupt existing medical supply systems, different payment systems, and other issues that make handover harder.

The Myanmar case study touched on the so-far successful handover of the Yangon HIV/AIDS project to the National AIDS Program. The key points identified by the team would seem to have a wider relevance, including: the need for collaboration on handover to start early (in Yangon's case, years in advance); the importance of bringing an MSF programme into line with MoH approaches, protocols and standards; and the necessity to identify the likely gaps in MoH capacity to build towards those, such as by training for key healthcare staff.

Further, there is a need for MSF to move beyond defining a process that leads to handover. The goal should not be handover itself (an output that often satisfies MSF's internal needs). The goal should be phrased in terms of outcomes, such as the project aiming to be functional at a defined level three years later (e.g. with criteria pulled from the MoH's definition of a basic service package or its national protocols). The establishment of these objectives will thus depend on the engagement with the MoH. The content of the engagement is *"how to achieve those outcomes rather than how to achieve a handover"*.³³

Recognise its responsibilities to the long-term health of populations

Humanitarians see their principal responsibilities as being to the people who are caught in the midst of crisis and emergency, and to the urgent and immediate needs that they have in that moment. But, when crises last for decades, as

they increasingly do, what happens to these responsibilities? What responsibilities do humanitarians have to the long-term health and wellbeing of the people they work for?

Over the course of our research, this key theme has emerged less by direct analysis than by digging deeper into the underlying MSF and external environments. We believe this requires further research and analysis than was possible within this project. Here, we choose to explain our preliminary views on a number of the emerging issues in order to open up the future conversation.

There are several reasons why this issue presented itself. MSF has worked for decades in many contexts, including the four case studies we undertook, in CAR, South Sudan, Sierra Leone and Myanmar. It clearly believes it has a long-term commitment to the people of these countries. In addition, MSF's levels of health expenditure rival those of the MoH in some countries; there is a contradiction between the urgent levels of the needs and the structural and systemic nature of the causes of the needs; there are negative effects of prolonged humanitarian operations on the people they aim to assist; and people in protracted crisis situations have consistently and expressly stated that their greatest needs are for development, livelihoods and sustainability.³⁴

All of these factors mean it is not so easy to just say "We are humanitarians, we don't do development" or "We are not responsible for the system" – because protracted crisis, weakened state capacity and large-scale, decades-long operations mean that "the system" has in some ways "developed" in such a way that humanitarians occupy a central place in it. Humanitarian organisations hold a position of significant power in such contexts, due to their resources, expertise and connections to the humanitarian system and the wider system of global governance. What then are the responsibilities for humanitarian health actors that come with such a position of power? While we do consider that humanitarians' primary responsibilities are to meet the immediate needs of people in crisis, we would argue that **humanitarian health organisations do have additional responsibilities towards the longer-term needs of people in crisis** too, including their need for an accessible and functional health system – and their loudly-declared need to not live in crisis forever. Further, the more protracted the crisis, the larger the scale of their operations, the longer their presence in an area, the greater humanitarians' long-term responsibilities are.

It is not up to humanitarians to "fix" the countries they work in. Humanitarians should not assume the responsibilities of development actors, who seek to rebuild health systems from situations of crisis, even less those of sovereign governments.

32 See: Gerstenhaber R, Success is also measured by what you leave behind, 2014 Handover Toolkit 2.0. Brussels: MSF OCB; 2014. Pett L, A different approach to ensure better outcomes for patients after MSF exit. London: Programmes Unit, MSF UK; 2011. Desilets A, Good Practice and Bad: A Reflection on MSF Handovers. London: Programmes Unit, MSF UK; 2010.

33 Desilets A, Good Practice and Bad: A Reflection on MSF Handovers. London: Programmes Unit, MSF UK; 2010.

34 See, for example, Anderson M, Brown D, Jean I., Time to Listen: Hearing People on the Receiving End of International Aid. Cambridge USA: CDA Collaborative Learning Projects; 2012.

Rather, humanitarians should shape their operations to prevent further dislocation, disruption or disintegration of the health system they find themselves in, as outlined by a report of the International Committee of the Red Cross (ICRC):

"The aim of the ICRC approach is to respond quickly and effectively to the direct and indirect needs caused by armed conflict, while simultaneously developing activities that provide a sustainable response to cumulative needs. Humanitarian operations that enhance the resilience of a service provider, or a community can constitute a response that mitigates cumulative impact effectively. In this way, these operations act as development holds, i.e. they hold off further development reversals."³⁵

Ironically, even if MSF does not yet fully recognise its long-term responsibilities, members of the communities it works in already do:

"We really appreciate MSF being here for 20 years. If we had the capacity we would give you citizenship."³⁶

So what might a humanitarian 'responsibility to the long-term' mean in practice? A number of specific responsibilities can be identified and are presented below.

Identify and seek to reduce negative consequences

MSF needs to consider more carefully whether its operations will have negative longer-term effects, whether those are outweighed by the immediate benefits, and what measures can be taken to mitigate negative consequences as much as possible. These negative consequences might include:

- healthcare staff leaving the MoH to work for INGOs or private practice ("brain drain")
- healthcare staff being trained in protocols and techniques that are not accepted by the health authorities
- loss of long-term public trust in government healthcare provision
- de-skilling of healthcare staff in their ability to address patient needs without high-investment approaches
- prioritising and advocating in such a way that pushes health authorities (and systems) towards worrying disproportionately about the urgent at the expense of the important

- undermining local capacity of the private health sector, traditional healers or social insurance.

MSF's mission strategies already require teams to assess such negative consequences – but only in some cases do teams invest seriously in identifying and mitigating them, while in other cases, this can be more a tick-box exercise. More should be done to systematically improve our institutional capacity to understand and mitigate such negative long-term consequences.

Identify, plan and make longer-term contributions

MSF already helps strengthen the building blocks of a health system in various ways, such as by training and developing healthcare staff, rehabilitating and fitting out healthcare facilities, reinforcing surveillance and medical supply systems, participating in technical working groups, building community capacity through various networks and connections to the (formal) health system, and so on. Even emergency responses can be seen as 'system-strengthening' over the longer term in the sense that health organisations (government and non-government) become more experienced and capable of responding, more adept at preparing and planning, and more used to working and coordinating with each other.

These contributions that MSF already makes could benefit from being more valued, recognised and extended. They could also benefit from being better planned and resourced as a stated objective over the long term, rather than being an accidental by-product of 20 years in constant 'response mode'. A positive example is MSF's Academy in South Sudan, Sierra Leone and the Central African Republic.

MSF's approach to supporting individual facilities is often dictated by the failures of the overall health system. MSF needs to procure and distribute drugs and equipment where national drug supply systems do not work, and it needs to pay incentives or directly hire medical staff where health workers are not being paid properly. But these are local fixes for national-level problems and mean that the impact of MSF support only lasts as long as MSF continues its work, thus condemning the population to endure the same problems again and again. An alternative that would be more beneficial in the long-term would be for MSF to become more engaged in efforts at the policy levels to improve health system functioning.

Rebalance approaches to coverage and quality

The principle of impartiality directs humanitarians towards those places where the needs are greatest – "in proportion to the degree of their suffering and to give priority according to the degree of urgency".³⁷ But it offers little guidance in terms of which forms of suffering to prioritise, and to what standard of care.

³⁵ ICRC, Protracted conflict and humanitarian action: some recent ICRC experiences. Geneva: International Committee of the Red Cross; 2016.

³⁶ Interview with local health actor, South Sudan.

³⁷ Pictet J, Fundamental Principles of the Red Cross: Commentaries. Geneva: IFRC; 1979: 27.

MSF has mainly chosen to focus on providing a good quality of care in line with standards that it sets itself. An issue with regard to effectiveness is that these standards create MSF-supported 'islands of quality' which require health expenditure per capita that is orders of magnitude larger than states can afford or are choosing to spend. This dooms handovers or exit strategies to fail. It also creates inequities across geographies between those lucky enough to be able to get to MSF-supported facilities and those who cannot. By local standards, this may represent an enormous opportunity cost, and one that seems dictated by organisational self-interest.

On the other hand, many humanitarian-health practitioners can reject the responsibility to install a 'coverage logic' whereby they are required to fill the health needs of entire populations (with the possible exception of camp settings, where humanitarian health organisations usually do seek to ensure adequate coverage of health needs). Humanitarians will rarely have the resources to do so even in small geographic areas and, in any case, that responsibility should properly lie with states.

There are no easy solutions to these problems, as they come from the fundamental mismatch between high needs and insufficient resources. Nevertheless, we do believe

that MSF could benefit from rebalancing somewhat, and by recognising the long-term practical and ethical benefits of programmes that focus on population-level health. Enacting this would require a deeper understanding of the nature and distribution of needs and vulnerabilities across a context – and a greater degree of consultation with MoH and with communities themselves on the design of health programmes. One consequence of this would be greater emphasis on preventative and other public health measures, as well as in a more balanced investment between the secondary (hospital), primary (clinic) and community levels of care in a health system. Certainly, it should be considered unacceptable that, over decades, MSF imposes its choices upon the communities and, by extension, upon the MoH that is responsible for the health of those communities.

This is not only an issue of balance, effectiveness or impact. It is our view that humanitarian ethics and principles also point in this direction – that the principle of humanity and the ethics of beneficence and do-no-harm require accountability to local communities. What is it they would like MSF to do? MSF could take a significant step in the direction of decolonisation if it recognised that "beggars can't be choosers" makes for an unhumanitarian approach to programme design.

Conclusion

MoH are central to MSF's action in the majority of the contexts where it works. Both in the sense that MoH authorise, direct and coordinate health services in their territories, as well as in the sense that MSF chooses partnerships and collaborations with MoH as the normal way of working. As we found, 78% of current MSF OCA medical field projects include a partnership with an MoH, while the remaining 22% of projects are mostly refugee camps or other contexts where an MoH is not present.

Yet MSF has placed **too little value on the relationships** between the two parties and invested too little in more effective partnership approaches. Instead, what we have often seen is a persistent myth – that of MSF as the Lone Ranger, heroic actor and leader – which is in conflict with, and therefore weakens, an actually existing practice that is much more varied, and much more interesting.

We hope this study can help to change that, by bringing to wider view the different sets of experiences that MSF teams are having with MoH, by drawing out the many things that can be learned from those experiences, and by highlighting significant space for both conceptual and practical improvements in MSF's engagement.

A basis for improved relationships and more effective programmes

Based on both the analysis we made and the four case studies, we propose three broad directions that MSF should take in order to make the most of its relationships and improve its programmes.

- **MSF should deepen its engagements with MoH.** Government leadership of humanitarian responses is here to stay, in all countries. That is the way it should be, and MSF needs to adapt to that reality. Yes, there are certainly tensions involved in this, as states are often the causes of the very humanitarian needs we address – but a strong focus on negotiating space and on advocacy can serve humanitarians well in the health domain, just as it does in others, and MoH can often be valuable allies, if approached as such. Further, MSF could improve aspects of its planning, strategising and technique in relation to this engagement. And, crucially, there is considerable space here for senior national staff to take the lead in negotiating and engaging with their MoH – an opportunity that should be embraced.

- **MSF should develop a more supportive mindset and skill set.** As MSF is choosing partnership with MoH as its principal way of implementing its programmes, then it should invent the right tools for doing them right. Some concepts need to be clarified: that a 'support' programme really should be supportive, with the MoH in the lead, and not a cover for taking over their facility; and that 'substitution' is only really applicable in a small set of specific circumstances. And some practical steps need to be taken to improve support programmes:

- joint projects between MSF and MoH should be jointly planned
- incentive payments for MoH staff need to have proper rationales and supporting measures attached to them in order to work
- if at all possible, a joint project's policies and protocols should align as much as possible with the national standards set by the MoH
- and steps need to be taken to further develop MSF's systems and policies for monitoring, evaluation, accountability and learning and for handovers and project closures.

- **MSF should identify its responsibilities to the long-term health needs of the people it serves.**

Humanitarian action is most concerned with the immediate and urgent needs of the people. But this does not mean not caring about their long-term needs, or their ability to emerge from crisis – our decades-long work in many countries shows that we do. Given its position of power and influence in the countries it works in, MSF should seek to have a more positive effect on the health system around it. Three ways can already be identified:

- it can seek to identify and then minimise negative harms
- it can plan for and make long-term contributions to health system strengthening, such as by educating and accrediting new generations of medical staff and by working with others to improve particular problem areas
- it can rebalance between its notions of 'coverage' and 'quality', to invest more in primary and community levels of health provision that can provide services to larger numbers of people.

We would argue that such an approach is not simply a necessary adaptation to a world that is rapidly changing around us. We would also say it represents **an enormous set of positive opportunities.**

Its most obvious opportunities are quite direct and immediate, in **more effective medical operations**.

Deepening engagement with MoH will help our teams avoid obstacles and constraints and open up new possibilities for people's access to healthcare. Improving the quality of partnerships will improve the quality of programmes and therefore the impact and relevance of medical care to the people who need it.

Further, deeper engagement and better partnerships with MoH offer **opportunities for expanded reach**. A model of care we develop might have better chances of being taken up by an MoH and spread regionally or nationally, if our partnerships with them are on a sounder footing (our successful HIV and TB programmes show this very clearly, in multiple contexts). A hospital whose infrastructure, staff capacities and clinical outcomes we have built might stand a better chance of being continued if our techniques for planning, learning and handover management are further improved. Improvements might be made to national-level healthcare systems, policies and protocols if our health advocacy on such issues is developed. And so on.

A stronger ethical footing

And perhaps most importantly, this orientation we propose offers opportunities to provide **a more solid, ethical foundation for the humanitarian-health mission**, at a time when it is being rightly challenged for drifting away from its ideals and centring and privileging itself.

We write this in a year dominated not only by the COVID-19 pandemic, but also by the **Black Lives Matter movement** in many countries, and by many humanitarians raising their voices against the paternalism, white saviourism, racism and colonialism that are persistent and structural within the global humanitarian community and within MSF itself.

In the light of this, it is impossible for us to listen to the stories of both MoH and MSF staff about their relationship and not hear the echoes of this colonialism:

"[MSF staff] think that because the people are poor and the state is bad then they have the right to treat people in a way that they are bad." (Quote from MoH staff.)

"For example, the way MSF divides the hospital into 'ours' and 'theirs', or talks about 'our patients' and 'our wards'. This use of 'us/them' – the Othering found in a phrase like 'they are not motivated' – is part of the change that needs to take place." (Quote from MSF staff.)

"We're paternalistic ... People say Ministries aren't competent at doing these things. A lot of them are competent but aren't given the resources. And I don't think we're that competent at them ourselves!" (Quote from MSF staff.)

So we see that placing greater value on engagement and partnership with MoH can become one element in placing us all on **a more rightful, respectful, equal footing**, beginning the work of redressing and healing structural racism and colonialism, and thereby strengthening the legitimacy of humanitarian action.

Indeed, we see connections between this issue and previous work carried out by MSF's Reflection and Analysis Network on MSF's partnerships with local civil society actors, and on its engagement with communities.^{38,39} In both cases, we found negative effects of unacknowledged power imbalances and an excessive focus on 'control', but also a willingness to self-critique and improve, and a desire to place the emphasis of humanitarian action back where it should truly belong.

There is a basis, which we saw in our case studies, for believing that MSF can do this. One MoH official, while critical, spoke highly not only of MSF's *savoir faire* (its ability to do, its technical competence) but also of its *savoir être* (its way of being; its way of carrying itself; and its commitment to patient wellbeing).

We hope that the time, then, has come for change in how MSF sees and works with societies in crisis: that communities are not helpless victims waiting for us to save them, but survivors and responders; that humanitarian actors are not the protagonists, but the supporting cast; and that ministries of health are not irrelevant bodies to side-step but, with the right approach, potentially powerful allies in efforts to assist and protect people in crisis.

38 Healy S, Aneja U, DuBois M, Harvey P and Poole L, How does MSF relate to local actors? Amsterdam: MSF OCA Reflection and Analysis Network; 2019.

39 DuBois M, Aneja U, Harvey P and Healy S, MSF and 'Community Engagement' Amsterdam: MSF OCA Reflection and Analysis Network; 2019.