2019 international FAD Synthesis

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In 2019, 47 FAD reports were received (over about 57 FADs that took place)[1]. More than 3005 MSF members participated in FADs worldwide, with at least 2,200 national staff and 438 international staff. This represents a slight increase compared to the 2018 numbers, where the FADs had gathered at least 2,804 participants, including 459 international and 2,041 national staff[2].

As every year, it is worth highlighting that a short document like this one is necessarily subjective and cannot reflect the depth and richness of the interactions between more than 3,000 people. Please do have a look at the FAD reports on www.association.msf.org/2019FADs (login: msf /password: asso).

The number next to the topics below indicate the number of FADs that discussed the subject.

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[1] Partial conclusions were also received from 2 FADs (Mozambique and Brazil); 2 FADs had to be cancelled for security issues (Afghanistan and Burkina Faso, however pre-FADs were held in those countries, with good attendance)

[2] One may note a steady increase over the past years. In 2018 the FADs gathered at least 2,804 participants, including 459 international and 2,041 national staff (number extracted from 50 reports received over 60 FADs held). In 2017, 56 FADs were organised; 53 FAD reports were received. At least 2,719 people participated in the FADs, including 1,972 national staff and 380 international staff.

Criminalisation of aid (9)

Discussed in: CAR, Central Asia, DRC, Kenya, Mali, Myanmar, Nigeria, Uganda, Venezuela

As some FADs mentioned, "even if we are impartial, we are not, or may not, be perceived this way" (*Myanmar)*; in fact, "our very presence in many contexts is already a political statement" (*India)*. Should MSF work in contexts where it runs the risk of being criminalised? How can risks be mitigated, for our patients, for our staff, and for MSF as an organisation?

Should we infringe on the law to bring assistance to populations where aid is criminalised? For some, we can look for the "grey zones in the laws… […] to not break the law but interpret it" (*Uganda*). The Mali FAD, after a controversial debate, concluded that we should, to respect the MSF Charter and the vulnerability of populations who deserve assistance like any other. However, risks for both the population and MSF staff should be assessed, as we are here to "save lives and staying alive" (*Mali)*. In those contexts, internal communications should be reinforced (*CAR, Venezuela*), notably so that (national) staff is aware of the different strategies at hand in case MSF or any team member is victim of criminalisation (*Venezuela*). To some, personal responsibility [or choice?] of all staff working in these contexts also plays as role, as "we accept the risk" and are "proud of being criminals" (*Central Asia)*.

A few FADs focused on the ways to **avoid or at least to mitigate the risks of criminalisation**. One key aspect is to increase acceptance of MSF within the community and by all stakeholders. This implies proactively communicating about MSF locally (including on social media) and raising awareness about our Charter, principles, activities and results with the populations, religious and community leaders, etc. The role of MSF staff as ambassadors was also a critical element raised by several FADs, and with this, the need to first properly train our own staff to pass on the right information about MSF (*Nigeria, CAR, Myanmar*). Indeed, diversity of MSF staff "can be used to minimise the risk of criminalising MSF" (*Kenya*). Some FADs also mentioned that all staff could benefit from trainings on IHL (*Central Asia*, *Yemen*).

Ways to **"counter" criminalisation** of aid were also discussed. Again, communication (notably at a local level) was seen as key to respond to media smear campaigns and disinformation, for example (*Central Asia, Mali*). The importance of advocacy; of maintaining dialogue with all actors including

governments as signatories of IHL (International Humanitarian Law); of "negotiating our humanitarian space" and reinforcing the capacity of MSF leadership to that end, was also mentioned by several FADs (*CAR, Nigeria, Mali…*).

The need to work with others was also another highlight of the discussions (*Uganda, Kenya, Nigeria*). "Isolationism of MSF increases the security threats and risks on MSF. Working with other NGOs in the humanitarian sector is essential to overcome criminalisation of aid and the sector (*Kenya*). In *Mali*, the idea of transferring competences to the community was also seen as possible way around criminalisation.

The question of the **compromises** MSF needs to make in face of criminalisation was a controversial point. While the Central Asia FAD reaffirmed that "providing aid based on our MSF principles is our identity", it also admitted that "in certain contexts, we might have to define limits of who we can provide aid to or in other words, we might have to accept compromises" as "we need to operate within the reality of the contexts we work in" (*India*).

Having said that, "we cannot let hostility towards MSF decrease our efforts to speak out on the reality we are bearing witness to" (*India).* Speaking out can take different forms – including enabling other local and third-party actors (e.g., link with journalists or other NGOs) to expose what we are bearing witness to without compromising our patients (*India*), sharing our ideas with other organisations including the media (*Uganda),* leading a coalition (*Nigeria*). In light of the fact that criminalisation of aid is a global problem (not a national one) and that "others are not stepping in", the *Nigeria* FAD concluded it is time to escalate the issue to the international level, proposing the following motion:

"The Nigeria Mission urgently calls on MSF to develop a public position on the misuse of counter-terrorism laws around the world in order to ensure that we can access populations impacted by conflict and maintain our core principles of impartiality, neutrality and independence; calling for the international community to re-engage and respect existing International Humanitarian Law."

This motion was later passed at the OCB Gathering and MSF Spain General Assembly.

Both the *Nigeria* and *Uganda* FAD agreed that MSF needs to challenge the laws leading to the criminalization of aid in international courts.

Medical issues

1. Termination of Pregnancy / Safe abortion care (8)

Discussed in Cameroon, CAR, DRC, El Salvador, Kenya, Pakistan, South Sudan, Uganda

Most FADs recognised that unsafe abortion is a major women's health issue, and that MSF has a key role to play in that regard. The *CAR* FAD for example made a statement to support the fight against maternal death linked to unsafe abortion. Specific recommendations were made by the FADs to advance on the topic.

On the **legal side**, MSF needs to develop our understanding of the laws in the country (*El Salvador, Uganda)* – and respect them. "If State laws and medical ground allows, MSF should go for termination of pregnancy (TOP)" (*Pakistan)*. To protect the organisation and its staff, "MSF should respect the legal framework and provide safe abortion care in line with article 14 of the Maputo protocol" – which authorises abortion under a number of conditions for therapeutic reasons only

(*DRC*). In some contexts or situations, MSF should refer patients to other NGOs rather than providing TOP ourselves (*Kenya*).

But then, as safe abortion care remains restricted or illegal in many places where we work, we need to strengthen and develop our **advocacy** and lobbying activities both at the central and local levels, to influence the legal framework on abortion (at times to legalise safe abortion) and protect medical staff who could practice abortions (*Cameroon, Pakistan)*. Our advocacy must be based on data from our programmes (*Kenya*), and we should work with other (local and international) actors fighting for the same cause (*El Salvador, DRC, Kenya*). In the same vein, we must network and engage with health authorities, community or religious leaders and the community we serve in general to address culturally sensitive health topics – e.g. through health promotion activities and awareness-raising sessions around women's health (*Pakistan, Kenya*), possibly after doing an anthropological study to understand the perception of the community, caregivers, partner NGOs etc. (*Cameroon)*.

On the **operations** side, MSF should also increase family planning activities and health education, "putting the emphasis on preventive and contraceptive methods", raising awareness about the different family planning methods, and doing community sensitisation about the dangers of unsafe abortion (*Cameroon, South Sudan, Uganda, Kenya, El Salvador*), but also work with others on this (*DRC*). We may also want to support the strengthening of national health systems in terms of quality of sexual and reproductive care/ sexual violence care (*El Salvador).*

Within MSF, on a more human resources side, several FADs noted that there is still a vast need to communicate internally about safe abortion care and the dangers of unsafe abortion from a medical perspective, and to engage with MSF staff on the matter (*DRC, Kenya, El Salvador*). The need for skilled medical staff to provide TOP was highlighted (*Uganda*) as well as the need to clarify who should perform TOP, i.e. international or national staff (*Kenya*). The FAD in *DRC* concluded that a well-trained team in favour of safe abortion care, should be put in place, as MSF medical staff should have the choice to practice safe abortion acts or not, without administrative consequences.

2. Patient's Charter (13)

Discussed in Bangladesh, Brazil, Burundi, Cambodia, Guinea, Greece, Iraq, Lebanon, Malawi, Palestine, South Africa, South Sudan, Ukraine

a. Why we need a patient's charter

Several FADs clearly saw a need, and a benefit in implementing a patient's charter. It could help build trust/improve the relationship between MSF and patients, and would have a direct impact on the quality of care; it could help with adherence to treatment (avoiding misuse of medicines), continuum of care (in terms of patients' follow up), spreading good practices, improving accountability towards patients; and avoiding tensions through the provision of information about MSF's services, scope and capacity (*Lebanon, Greece, Cambodia*).

Is the patient's charter the best way to achieve this? Some questioned it. For example, according to the *Greece* FAD: "the medical charter is a document written from a Western perspective with a focus on the individual perspective, not always applicable in cultures where the collective is the I." The *Ukraine* FAD also questioned whether the Patients' Charter was the best way to improve on quality of care, accountability and a patient-centred approach – or whether it rather meant a duplication of what we already have and do: should we waste our resources on compiling and explaining different Charters to patients, or is it better to just implement them in practice? The FAD suggested possible tools *instead of* the patient's charter: medical ethics trainings ("act better"); internal accountability (HR), feedback from patients. Indeed, the FAD participants believed that "the right to information

and choice is universal and does not require a legal background [or basis?]" (see below for more information on the views of the FADs on that 'legal' aspect). Some also suggested MSF could work on using medical ethics as a basis and 'just' complementing them (*Iraq*).

b. What to include in the Patient's charter?

- ***Rights of the patients***
  - Right to treatment – *Bangladesh, Cambodia, Guinea, Iraq, South Sudan, South Africa.* The *Palestine* FAD also mentioned "access to medical service transportation, good environment, enough clinics for the population". A dilemma was raised about whether to include the right to free healthcare/treatment (see below).
  - Right to information (on illness and treatment plan, medical procedures) – *Bangladesh, Guinea, Iraq, South Sudan, South Africa, Palestine*
  - Shared decision making/self-determination; informed consent; choice; "autonomy" - *Bangladesh, Cambodia, Guinea, South Africa, Malawi, Palestine.* Expressing consent is however not always as easy as it seems: language remains a barrier, and "in case of emergency and when there is risk of coercion, we can be flexible" (Greece*).*
  - Right to give feedback/complain – *Bangladesh, Cambodia, Guinea, South Sudan, South Africa, Lebanon, Malawi*
  - Confidentiality and privacy – *Bangladesh, Cambodia, Guinea, South Sudan, Palestine*
  - Quality of care (right person in the right position, right guidelines, professionalism) – *Bangladesh, Cambodia, Malawi, Palestine*
  - Right to be treated with respect and dignity (or even friendliness), adapted to the culture – *Bangladesh, Cambodia, South Africa, Palestine*
  - No discrimination/impartiality / Care based on clinical needs – *Bangladesh, Cambodia, South Africa*
  - Care according to ethical standards (do no harm, etc) – *Bangladesh, South Sudan, Palestine*
  - Right to information about the service and how to access it, its criteria (and limitations) - *Cambodia, South Africa, Lebanon*
  - Right to communication (e.g. translators) – *Bangladesh, Greece, South Africa*
  - Safety & security /right to be protected – *Bangladesh, Cambodia*
  - Right to proper referral – *Bangladesh, Lebanon*
  - Right to palliative care – *Bangladesh, Cambodia*
  - Right to choose the service facility and practitioner - *Cambodia, Guinea*
  - Right to be provided with medical documents after being informed about the sensitivity of the data – *Greece*
  - Right to psychosocial support – *Guinea*
  - Right to end the treatment at all time – *Guinea*
  - Personalised care – *Bangladesh*

A question was raised about free healthcare: should it be included in the patient's charter as a patients' core right? While the *Bangladesh* FAD included it, others indicated this would depend on the context and the package defined by MSF (*Guinea*), as it does not apply in the same way across our interventions. In the same vein, the *Lebanon* FAD asked the following question: what is MSF responsibility in providing free health care in countries where free health care does not exist? Is it doing more harm than good? "We committed to offer free health are across the world, despite the local health policy; this is what we promise our donors. And we always target people who are living in a crisis, not a normal standard life, where they have other options."

- ***Duties/responsibilities of the patient***
    - Be respectful to caregivers of the facility – *Bangladesh, Brazil, Cambodia, Guinea, Palestine* (regardless of race, gender and religion)
    - Maintain the hospital environment hygienic – *Bangladesh, Brazil*, *Guinea, Palestine*
    - Share their medical history/give proper information to the medical staff/cooperate – *Bangladesh, Palestine*
    - Proper adherence/commitment (after getting the right information and agreeing on the treatment) – *Bangladesh, Guinea, Palestine*
    - Respect the rules, procedures and regulations of MSF/the structure (after getting proper information) – *Bangladesh, Brazil, Guinea, Palestine*
    - Respect other patients' rights – *Brazil*, *Cambodia* (regardless of race, gender and religion)
    - "Contribute to improvement" (mentioned as a responsibility of the patient as opposed to the "right to complain" mentioned above – *Bangladesh)*
    - Handling treatment documents with care – *Bangladesh*

Do all rights and duties have the same "weight"? The *Greece* FAD suggested that internally, we should 'rank' rights in order of importance, as some of them are more important than others (and there may be tensions between some of them).

c. What are the challenges in implementing a patient's charter?

On the practical side, several issues were mentioned, such as: the lack of time (of the caregivers) to provide sufficient information to patients when clinics are already overcrowded; the educational level of patients; managing beliefs and culture; the risk of self-medication; making patients accept decisions about closing a project, or admission criteria (*Lebanon, Burundi)*. Proper implementation will mean that additional resources (in terms of staff and therefore budget) will be necessary, as patients' sensitisation will take time.

Additional ethical dilemmas can arise regarding providing information and leaving the choice to patients: what about extreme mental health cases, for example? (*Lebanon)*. Implementing the patient's charter could also be more of a challenge in times of emergency (*Burundi).*

And then, how to ensure respect of the duties of the patients? Where to draw the line in terms of accepting misbehaviour of patients? Shall patients be accountable and if so, how? (*Lebanon)*.

Several FADs mentioned cultural aspects/differences as a possible challenge to implementation. As mentioned above, the FAD in *Greece* mentioned that: "the medical charter is a document written from a Western perspective with focus on the individual perspective, not always applicable in cultures where the collective is the I." The FADs (*Guinea, Ukraine, Iraq, Lebanon, Burundi*) therefore insisted that the charter should be adaptable to the context, taking into account elements such as culture and religion – though difficulties may arise "if MSF values are not in coherence with the community values or religious believes (e.g. termination of pregnancy, or when the decision maker on a health issue is not the patient himself)" (*Lebanon).*

Some interrogations were expressed as to how to view the patient's charter. The *Lebanon* FAD wondered (and found debatable) whether staff and patients should sign the charter as we do for internal regulations. The *Cambodia* FAD had some disagreement about whether the patient charter should be "a sort of "contract" between the patient and healthcare providers, or between suppliers and buyers" with the potential conflicts it could entail. As mentioned above, to the *Ukraine* FAD, "the right to information and choice is universal and does not require a legal background [basis?]". There were also tensions in the *Greece* FAD between two views of the charter: either as an empowerment tool for patients, or as a tool to protect the professionals and organisation.

Several FADs concluded that the debate around the patients' charter is an interesting one, which allows the mission to reflect of what patient care looks like in MSF today (*Iraq)*, and therefore deserves regular discussions – for example on case studies, on everyday ethical issues etc. (*Lebanon, Greece).*

d. How to implement the patient's charter?

Clearly, a limitation to the implementation of a patient's charter is the lack of awareness/knowledge. This is therefore a starting point: both staff and patients should be fully aware of their rights and duties, as laid out in the patient's charter.

In practical terms, staff training/awareness sessions/briefings/workshops should be organised on the patient's charter, directly after recruitment (*Lebanon, Malawi, Greece)*.

Besides, the patient's charter should be visible in healthcare facilities, in format and languages that are accessible to all patients; additional tools in local languages (videos, leaflets, focus groups, drama, sensitization campaigns, suggestion box…) should be created – for both patients and staff (*Lebanon, Malawi, Palestine...).* The *Malawi* FAD mentioned that our partners should be involved in the dissemination of the Charter as they also need to be "compliant", and that we should advocate for more health resources to enable the Ministry of Health to look into patients' rights.

To avoid the risk that the patient's charter becomes just another "tick box exercise and empty element on the wall" *(*Greece), various FADs (*Ukraine, South Sudan, Lebanon, Malawi*) insisted that MSF needs to put in place mechanisms to check/monitor the implementation of these principles, possibly via questionnaires, call centres, forms, and a monitoring and evaluation system. A complaint management department/mechanism (local and anonymous) must be established so victims can report cases of violation of the patients' charter and be protected against retaliation; while clear and consistent disciplinary measures should follow violation.

Some missions showed eagerness to move forward in terms of implementing the patient's Charter. As the *Bangladesh* FAD indicated, as most participants agreed on the elements of the Charter during the FAD, these can always be implemented by the FAD participants in their everyday work. In *Lebanon* as well, the teams already created and poster with rights and duties of patients, which they have in all clinics; they are therefore interested in piloting the implementation of an intersectional Patient's Charter, when ready.

3. Other medical concerns (6)

The *Belarus* FAD proposed the following motion: "*Address TB treatment adherence issues caused by harmful alcohol use*: Harmful use of alcohol and other psychoactive substance use is one of the main barriers for adherence to TB treatment. Both TB infection and extensive use of alcohol are stigmatizing and cause massive marginalization to patients. To be able to reach the WHO EndTB strategy of ending the global TB epidemic by 2035, MSF needs to implement special interventions to address adherence issues caused by harmful alcohol use in this marginalized patient group in our TB projects".

Other medical issues discussed in FADs included: palliative care (*Cambodia)*, HIV (*Eswatini, Guinea, Malawi* – and the need to beat global HIV fatigue), mental health (*Palestine).*

Synchronisation of Strategic plans

1. Proximity and community engagement (12)

Discussed in Colombia, Dakar, El Salvador, Haiti, Mali, Mexico, Palestine, Sudan, Thailand, Turkey/Syria, Jordan, India (discussed accountability)

Proximity is one of our principles and determines the quality of our services. However, a few constrains or choices come in the way of our proximity to the communities we are working with: our security protocols, project/admission criteria (which restrict access to our activities to 'target' populations), ... As one of the MSF principles, proximity translates into a way of working/ an operational strategy or objective, but it is also a question of 'attitude': we should show a "clear identification with the community" (*Palestine*) and our solidarity: "showing we care in the heat of the crisis via both our communication and response" (*Turkey*).

Communication was definitely the first point discussed by most FADs to improve our proximity to patients and communities. Tools are already available; we 'just' need to make better use of them (*Haiti)* – notably social media, TV, radio, community leaders and influences, etc (*Mali, Iraq).* We should communicate adequately with the communities about our principles and objectives, but also about our intervention period, our exit strategy and the continuity of care; but also, about our limitations (*Colombia*, *Haiti*). Our communications – the 'way we speak' to the communities - should be adapted to contexts and groups (*Palestine, Turkey*). More broadly, our communications should be centred around the needs of the populations, using personal testimonies (rather than "carrying the image of an untouchable MSF"); and aim at more engagement with the civil society (*Colombia, Mali, Dakar*).

Our modus operandi needs to adapt, to put more emphasis on populations' **participation/inclusion** *(Mali, Dakar*) and ownership of the MSF strategy (*Sudan)*. Giving more autonomy to field projects may contribute to that direction (*Mexico).* Our approach should be bottom up rather than top down, focusing on building trust with the communities and adapting our operations to the context *(Palestine*). To that end, we must collaborate with key stakeholders and local partners, and learn from their experiences and what the population has expressed in terms of their needs (*Thailand, Turkey).* We can include the community in assessing the needs and results of our projects, work with local associations or partners, for example, and delegate some tasks to trained community health workers or local leaders (*Mali, Sudan, Dakar, India*). However, we should "not only talk with the top of the pyramid but also ensure that different voices are heard, both horizontally when dealing with different power structures, and not forgetting those who might not have a voice through leaders" *(Turkey/Syria).* For others, we should not forget to engage and involve state institutions, which are responsible for providing basic services and upholding human rights, as this will help support the sustainability of health activities in the long run (*El Salvador*).

The need to integrate anthropologic /ethnographic perspectives in our work, and/ or to hire staff with an anthropological/sociological background to understand the communities and what they want, and to get closer to them, was mentioned in many FADs (*Colombia, Palestine, Mali, Mexico, Dakar).* As a matter of fact, understanding and adjusting to cultural sensitivities leads to better medical services; quality of care and a patient-centred approach in turn leads to adherence to MSF principles and strategy, hence a higher engagement of the population (*Sudan, Turkey, Palestine).*

Monitoring the needs of the population (as they keep changing) and our results in terms of proximity should be an ongoing process – using qualitative indicators in addition to our traditional quantitative

indicators (*Colombia, Turkey*). Providing feedback and accountability regularly to the communities on our services is an element that is often missing from our side (*Colombia, El Salvador, Turkey*) – we too often limit ourselves to doing evaluations. We also need to implement systems where community members can safely provide unbiased feedback (*India).*

Our national colleagues are an extremely strong asset for proximity to the communities, especially if trained as ambassadors of MSF (*Colombia, Turkey/Syria)*, but staff could benefit from 'protection' meetings, to be prepared to respond to insecurity issues (*Thailand)*.

Practically speaking, several options were mentioned to get closer to communities: reinforcing the capacity of our health promotion (HP) teams, or having that HP component systematically integrated in all our projects (*Colombia, Iraq*) ; using more mobile clinics (*Iraq);* prioritising quality over quantity of our consultations (*Mexico);* and as mentioned above, decentralising care, delegating it to the community by empowering non-medical staff like community health workers, mothers, community leaders, to provide care for simple pathologies (with proper training and monitoring and evaluation in terms of quality of care) (*Mali, India*).

Interestingly some dilemmas were also raised in the *Turkey/Syria* FAD. If we define proximity as factors and elements enabling MSF to reach/ satisfy needs of beneficiaries within the scope/capacity of MSF, a question of importance is that of "satisfaction": should our work be driven by beneficiaries' needs only? Maybe at times MSF knows better than the patient and must act in a way that "doesn't satisfy" the patient?

Also note that community engagement was mentioned in multiple FADs beyond those that explicitly debated our proximity (see below – e.g. in *Partnerships and exit strategies*).

2. Beyond synchronisation of SPs: mutualisation and evolution (7)

A few FADs called for more mutualisation between OCs – some, in the context of the discussion on the synchronisation of strategic plans – at the local level (for example, the *Niger* FAD invited missions to consider having a single representation in the country) and at the global level.

In relation to the synchronisation of strategic plans, the *Lebanon* FAD called for "a systematic and persistent evaluation the different synchronisation and mutualisation initiatives that were done over the year, on the field and HQ levels, to learn from it; and for all MSF staff and entities, to look for opportunities for synchronisation and mutualisation in their day to day work".

The *Kenya* FAD adopted a motion going a step further: "given the ongoing call for change by the International Board (IB) asking to address the need for mutualisation and rationalisation, MSF should go beyond the strategic plans timing synchronization and set out clear parameters that will help avoid unnecessary duplication and wastage. We call on the IB to ensure justification mechanisms in case of duplication in the strategic plans of the different OCs (especially at country level)".

This motion was later adopted at the East Africa Association General Assembly.

Other FADs considered MSF's **evolution** in the longer term, from a governance point of view.

The *Dakar* FAD reflected on regional development in West and Central Africa. It considered that Dakar should be considered as a laboratory, focusing on support functions with an intersectional perspective to mutualise resources.

In *DRC,* FAD participants appointed a commission mandated both to lead a process aiming at the recognition of an "MSF-DRC" Association, and to initiate discussions with WaCA (West and Central

Africa initiative) with a view to mutualising efforts and sharing operational responsibilities, rooted in the region. Another associative evolution was considered in *Belarus*: "the establishment of a regional association of former Soviet Union states, because those states have many similarities which can be helpful in the future".

The *Jordan* FAD recommended "having one OC in the middle East where other ones would work under its umbrella instead of having different ones".

The *South Africa* FAD proposed a "one MSF" motion: "MSF size has increased greatly over the last decade but so has its internal complexity that has increased over the years. The change process proposal for MSF is to tear down the internal structure of the five OCs and to create one global organisation."

Operational strategies

1. Migration (7)

Discussed in Brazil, Colombia, Venezuela, Kenya, Pacific, Libya, Greece

The Brazil, Colombia and Venezuela FADs discussed the migration crisis deriving from the situation in Venezuela. The *Colombia* and *Brazil* FAD advised an expansion of our services. Colombian colleagues argued that expanding our programmes to provide assistance such as mental health to Colombians that do not have proper access to healthcare could help avoid resentment; the *Brazil* FAD recommended including street people in the project. We also need to try to understand better migration routes and get a regional overview of the migrants' movement, with a view to getting closer to the needs. The *Venezuela* FAD suggested initiating activities on the migration routes within Venezuela and at the border, while making MSF's criteria of intervention on migration more flexible, taking into account the multicausality of the conflicts that generate migratory crises.

Several missions also put the emphasis on communications: as we are working with and next to refugees and migrants, we should enhance our communications about what they go through, what they need, but also about our operations and what we stand for (*Kenya, Colombia*). In the case of Colombia, the FAD participants recognised that communications efforts should be articulated with the Venezuela missions, which could also slow down the process of increasing visibility in *Colombia*. The FAD in *Kenya* also mentioned that "the process of MSF intersectional communication and public positioning" should be "simplified", as the "bureaucracy of communication is too long now".

The *Libya* FAD called for raising awareness among migrants within detention centres and explain/clarify our role in the centres, but also for advocating against the existence of detention centres locally and internationally across meetings with officials and public debates.

The *Greece* FAD recommended that "projects treating population with chronicity and combined psychiatric and mental health issues, such as victims of torture, sexual violence and ill-treatment, are strongly recommended to have a three years circle of operations at every renewal.".

In two FADs, participants showed eagerness to develop/support alternative ways of intervening in their contexts:

- "mere need cannot be itself the sole driver for operations. We want to develop toolboxes and "sell them" to other organisations in order to contribute to a more effective humanitarian action in general" (*Greece).*

- "we as the Johannesburg association members, have requested the board of directors of MSF Southern Africa to enable the opportunity to engage the opportunity and become involved with migrant networks through our on-going activities" (*South Africa,* in relation to a discussion on mental health for migrants).

2. Partnerships and exit strategies (6)

Discussed in Belarus, India, Niger, Haiti, India, Libya

As in previous years, many FADs saw a benefit in developing (balanced) partnerships with local actors – and get closer to the communities (echoing the discussions on Proximity and community *engagement* (12)detailed above) – notably as a way to guarantee the sustainability of our projects even after MSF leaves. Partnerships however can mean a few risks in terms of quality of care, respect of MSF principles, etc.; some FADs explored some ways of mitigating those. Below are a few quotes summarising the thoughts of the FADs.

"To ensure continuity of effective and sustainable medical activities post-closure of projects in contexts where our aim is to be a catalyst for change and where we work in collaboration with local partners, MSF should actively engage with its local partners in developing and executing its medical operations [i.e. in the planning and carrying out of services to ensure that there is a knowledge transfer and a co-ownership of the activities throughout the life of the project.]" *Belarus*

Our operational strategy should be based on a community approach (*approche communautaire)* based on partnerships. "The partnership model envisaged is an inclusive partnership, having as a general objective to put vulnerable people at the centre of our preoccupations. This type of partnership will allow our activities to be efficient and effective, thanks to communications (with the community about our activities) and a better collaboration between all stakeholders (e.g. through involvement of the 'beneficiaries' and community leaders, transparency)". *Niger*

"We must change the way we involve local authorities in our interventions. Better relations with the local authorities and the civil society can feed our interventions; and help us, among others, to share messages with patients and the population and support a better handover of our projects upon exit". *Haiti*

"MSF should move closer local NGOs and CSOs (depending on the context) to gain [access to] information in order to respond to emergencies, increased access to patients who likely have greater trust in local actors, and capacity building via a replicable model of care where MSF practices can be integrated into [local] approaches". As a matter of fact, "we should always work with the assumption that MSF eventually has to leave and put more resources into investing in and empowering a community pre-closure". *India*

"MSF needs to create a clear agreement that will be implemented across joint projects with local NGOs, to prevent using the project for their own agendas and protect MSF image" and "evaluate all partners and seek to record their activities during their work with MSF". *Libya*

3. Other operational strategy considerations

a. Protection (2)

Discussed in Mexico, Nigeria

The *Mexico* FAD acknowledged that protection is increasingly becoming a demand of our patients. The first protection measures to adopt are to provide information, empower our patients and have

effective referrals to other social actors (which requires a constant mapping and evaluation of social actors), and more comprehensive networking.

During the *Nigeria* FAD 2019 participants agreed that the overwhelming protection needs we have witnessed support a proposal: to the executives of the five Operations Centres, to integrate protection activities into all MSF contexts where there are needs identified. In addition, the FAD considered that MSF shouldn't just think about protection but should also be speaking about it. If MSF will not commit to support protection activities, we need to identify actors that can.

b. Specific populations (3)

Discussed in Kenya, Philippines, Ukraine

Several FADs made a call to include specific categories of populations in our projects, especially young people (*Kenya, Philippines*), and the elderly (*Ukraine).*

Incorporation of youth friendly services in MSF activities: Young people (persons aged between 10-24 years) constitute 36% of total population and face diverse economic, social and cultural experiences. Young people face many challenges in reproductive health (teenage pregnancy, sexually transmitted infections, unsafe abortion, school dropout, drug abuse, sexual violence and female genital mutilation. Thus, MSF needs to incorporate youth friendly services which can be accepted by this specific vulnerable population. (*Kenya motion)*

Teenagers in the most vulnerable sub-populations, exposed to poverty, violence, prostitution, sexual abuse, substance abuse, dysfunctional families, early pregnancy, limited access to independent healthcare, etc. should be addressed by MSF as a group with specific needs. *(Philippines)*

The *Ukraine* FAD adopted the following motion: "To assure that this population has access to relevant healthcare, and insure inclusion, MSF should recognize the elderly as a distinctly vulnerable population; seek to understand their special medical and social vulnerabilities in the context of humanitarian crises.

Note this motion was passed at the General Assemblies of Canada, Switzerland, USA and OCB Gathering.

c. Prevention (2)

The *Sudan* and *Myanmar* FAD concluded that MSF should increase its attention in preventing and controlling diseases, as treatment and prevention complement each other, notably as prevention helps build a relationship of trust between patient and provider, which is important for treatment. Including prevention in our strategy will save lives, time and resources, and build the knowledge of the communities on prevention, even after MSF leaves. MSF also needs to invest more in advocating for others to invest in preventive measures.

People (8)

Discussed in South Africa, Jordan, Malawi, Eswatini, South Sudan, CAR, Kenya, Liberia

As last year but to a lesser extent, some FADs discussed the question of diversity and inclusion (focusing on decision-making, recognition, staff development etc.) but also the issue of preventing all sorts of abuse.

1. Diversity and inclusion

The *South Africa* FAD proposed the following motion: "Amend the Charter about no discrimination on sexual orientation". *This motion was later passed at the Southern Africa and OCB Gathering.*

Several FADs called for (more) inclusion of MSF staff in decision-making.

The *Jordan* FAD proposed to "have a staff centred approach to involve them in decision making".

The *Kenya* FAD launched a "A call for action on diversity and inclusion: A strong diversity and inclusivity in MSF strategies decision making should be promoted from international level to national level to ensure proximal decision making".

The *Liberia* FAD reiterated that "national staff should be involved in decision making at all levels" while capacity-building/promotion/recognition should also be a priority.

The FAD in *Chad*, discussing the values that MSF needs to protect and strengthen in the future, mentioned: inclusion (the fact that operational decisions must be taken in common and in agreement with the field); equitable management of the various categories of MSF staff; internal communications and debates, without distance between international and national staff; and mutual respect.

In line with this, a few other FADs also mentioned the need to improve on our internal communications (*Tanzania, Haiti*).

Other recommendations, related to staff development and wellbeing, included:

- to harmonise human resources policies in terms of training, by facilitating detachments and expatriation *(CAR)*
- to initiate MSF Academy in collaboration with the Ministry of Health and facilitate national staff to complete their education (*South Sudan)*
- to consider retaining MSF's workforce with specific skills/ specialisation and institutional knowledge by creating a regional pool for recruitment of regional staff who can be deployed around regions (*Eswatini)*
- to systematically and actively promote mental Health and prevention of mental health disorders among MSF employees, and make it part of the MSF staff health framework *(Ukraine)*

2. Abuse, harassment and sexual exploitation (3)

Discussed in South Africa, Malawi, Cameroun

Being under "the impression that the MSF movement is not doing enough to address sexual exploitation and harassment", *the South Africa* association members adopted the following motion: "The movement should revise existing mechanisms to address the following weaknesses – the protection of beneficiaries, preventative mechanisms, reporting mechanisms and support structure."

The *Malawi* FAD also called for "develop[ing] clear policies on sexual exploitation, with enforcement of these policies".

The *Cameroun* FAD, taking note of the fact that several cases of abuse had not been reported, recommended:

- Creating an independent listening cell (*cellule d'écoute)* in each mission with representation in the field (projects) for victims of abuse and harassment;
- That all those convicted of abuse be sanctioned;
- Briefing all expatriates' dependents on behavioural abuse
- Sensitisation of all staff on the danger of sexist remarks
- Promotion/simplification of the CRAC leaflets.

Transversal issues

Several transversal issues were mentioned in numerous FADs discussing a variety of topics - for example: communications and advocacy; MSF principles (and compromises on them); working with communities and other partners.

1. Communications and advocacy, speaking out

Discussed in Nigeria, Tanzania, Haiti, Yemen; but also, in CAR, Myanmar, Iraq, Mali, Colombia, Palestine, Turkey/Syria, Dakar, Kenya, Colombia (in relation to migration, proximity and community engagement, criminalisation of aid

Communications, advocacy and speaking out were probably discussed less as a topic per se than in previous years; but as a transversal issue, they were mentioned on numerous occasions in FADs that discussed *Criminalisation of aid, Proximity and community engagement*, *Migration*- among others (**see above or click on the link for details on those discussions, especially in relations to communications**). Below are a few quotes summarising ideas shared by many FADs.

As always, communication is seen as going hand in hand with our operations, as a way to gaining acceptance in the community, ensuring accountability and delivering on our speaking out principle. "We should show more the benefit of our actions towards the local and national community and continue (and even reinforce) our efforts to better be understood by the national authorities in order to facilitate administrative processes" (*Tanzania)*

Several FADs mentioned the fact that our communication needs to be adapted to the context and target audiences (including or especially in terms of culture, language and communication style), and that MSF staff are the best ambassadors of MSF - and should be trained adequately for this. Indeed "awareness begins with us talking to each other and our communities" (*Nigeria*).

But sometimes, "we should use other channels (NGOs) to do public communication if too dangerous" while "we have to reinforce our advocacy efforts and focus advocacy on mainly the serious incidents - not necessarily smaller violations" and "our advocacy needs to stay limited to what we see, and we are sure about" (*Yemen).* Advocacy was also mentioned in other discussions on *Criminalisation of aid* **(9)** and *Termination of Pregnancy / Safe abortion care* (8).

2. Principles and identity (6)

Discussed in Switzerland, Ethiopia, Belarus, Indonesia, Yemen, Haiti, Pakistan (in addition to other FADs that discussed about principles in relation to Criminalisation of aid (**9)**Patient's Charter (13)Proximity and community engagement (12) and Communications and advocacy, speaking out.

a. MSF: still an emergency organisation?

"To what extent is MSF still an emergency organisation?" asked the *Switzerland* FAD. "Could MSF incorporate development aspects to achieve sustainability of projects?" questioned the *Belarus* FAD.

The question of the emergency nature of MSF, versus the introduction of some "development" components in our work, was raised in a few FADs, though not at length.

Some FADs suggested improvements to ensure MSF does not lose sight of the 'emergency' essential component of its identity. The *Ethiopia* FAD proposed the following: "Responding to emergencies in alignment with our identity of being an emergency organisation, we request that all MSF missions be fully empowered and capacitated to respond to emergencies as autonomously as possible within their country of operations".

The *Switzerland* FAD suggested that MSF focuses more on training for staff in HQ and in the field, with a view to regaining agility in rapid responses to crises. The *Indonesia* FAD also recommended organising an emergency response training to create local capacity to respond to emergencies. Indeed, the FAD agreed that, since emergency is one of our core mandates, MSF should be an active partner in emergency response in Indonesia. However, there are real barriers to this - our local HR capacity (staff experience) and government's regulations towards foreign NGOs.

To the contrary, discussing about how to address new humanitarian challenges, *Haiti* introduced the idea that MSF should question its mandate and mission, maybe transitioning from being an emergency organisation to a development organisation, while reviewing our intervention model.

b. Compromises

The *Pakistan* FAD adopted the following motion: "The Association recognizes that the Executive faces immense complexity and many constraints in its efforts to implement MSF's life-saving work. That said, it remains the core responsibility of the Association to define, embody and protect the raison d'être of MSF and its fundamental principles.

It must be noted that the Association is very concerned about and extremely uncomfortable with the acceptance of armed escorts in countries such as Pakistan and Somalia. The Association believes that this policy has a profound negative impact on what we do and who we are.

Therefore, the motion is put forth that the Executive must approach the Board/Council/Agora of the Operational Centre for discussion and presentation of the rationale before undertaking decisions that have such an impact on our identity and principles."

This motion was later passed at the OCB Gathering.

The *Yemen* FAD re-emphasized that: "Our principles should not be significantly compromised by efforts to increase acceptance. We need to differentiate authorities' acceptance, community acceptance, and patients' acceptance"; as well, "MSF should not significantly compromise on quality of care to increase its capacity."

Annex

List of FAD reports received: *Bangladesh, Belarus, Burundi, Cambodia, Cameroun, CAR, Central Asia, Chad, Colombia, DRC, Dakar, El Salvador, Eswatini, Ethiopia, Greece, Guinea, Haiti, India, Indonesia, Iraq, Jordan, Kenya, Lebanon, Liberia, Libya, Malawi, Mali, Mexico, Myanmar, Niger, Nigeria, Pacific, Pakistan, Palestine, Papua New Guinea, Philippines, South Africa, South Sudan, Sudan, Switzerland, Tanzania, Thailand, Turkey/Syria, Uganda, Ukraine, Venezuela, Yemen*

Conclusions were also received from Brazil and Mozambique (no report due to emergency),

FAD reports missing: *Egypt, Belgium, Malaysia, Bolivia, Guinea-Bissau, Sierra Leone, Georgia, Iran, Ivory Coast, Brazil*

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