MAY/JUNE 2018 #58

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INTERNAL MSF NEWSLETTER

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MEDECINS SANS FRONTIERES

47TH GENERAL ASSEMBLY OF MSF FRANCE

MSF FRANCE'S GA DEBATES

ASSO CORNER

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Thanks to everybody who contributed in a any way to the making of this issue!

EDITO

Soon the MSF France GA

Dear friend,

I am writing this as a letter to the GA; for myself and many others who cannot speak so openly. I deeply love this organization and what it has brought me, but a sense of exhaustion and frustration with some aspects of MSF makes it impossible to stay quiet any longer.

I am tired of being asked to vote on sparkling white candidates for the Board every single year, of not feeling represented in the Association I am a part of, of not seeing faces like mine when I visit the Paris office. There are limits to those from the global South – we can have positions in support departments in HQ, we can be coordinators in the field, but where are those like us making crucial operational and strategic decisions for OCP? I can't help but find the irony on a GA that discusses inclusion without a single Board candidate representing national staff or non-Europeans – the answer I always have is that this is the MSF-France board, but what is the space for the rest of us wanting to have their say in OCP?

I am tired of seeing extremely qualified and experienced team members reaching glass ceilings, being overlooked and not considered. Of watching their nervousness with every expat end of mission report as their entire careers could be challenged by a single comment of an expat manager. I am tired of expat "colonialists", occupying low ranking positions in their jobs back home but elevated to unquestionable power in the field; of watching national staff face bureaucratic challenges and numerous "validations" by those in power to be detached or have a chance at expatriation, being judged at much higher standards than I have ever seen in an expat recruitment. I am also tired of seeing extremely senior and qualified staff unable to access HQ positions because the "visa is difficult" when I watch the hurdles and challenges we go through every single day to bring Europeans to Yemen, Iraq, USA, Japan, Brazil and wherever they want to go.

I am tired of this supposed decentralization based on what are in fact European offices and desks overseas – how delocalized is decision making in these offices with limited autonomy, responding to their European "sponsors" and with key positions staffed by Europeans? It feels ridiculous to celebrate a Brazilian General Director for MSF Brazil, but after so many years we really do.

I am tired of the fear of being judged for lacking "humanitarian motivation" when I complain of not making the same salary as my European colleagues for the same job. Of my national colleagues being questioned on their MSF "commitment" when they are not interested in expatriation as this would mean no job security, no health insurance for their families and lower salaries. I am tired of hearing people from developed countries talk all they want of "true volunteerism" and "self-sacrifice" when they come back to safe and stable societies, unemployment insurance paychecks, universal health care, public schooling and, in the case of many medical expats, long term governmental contracts; and to be told patronizing complaints of the supposed "careerism" of African, Latin American and Middle Eastern expats trying to support themselves and their families. I am tired of having to read someone in the Portail say that our African colleagues who need or aspire for fair care packages and career planning can be shown the door out to the UN, as MSF "is not about us" – I guess the "us" here includes only one type of expat.

I am tired of being asked to wait, to be patient, or to be told that "things were much worse before". Of having my concerns minimized, of hearing "but there is Mego" as if an exception justifies the systematic discrimination in the organization. As MSF keeps talking and talking about gradual change on a pace decided by those who are not affected by exclusion, I watch the best among us leave - despite their desire to stay, despite their commitment to the organization, despite their unquestionable humanitarian motivation.

"We know through painful experience that equality is never voluntarily given, it must be demanded. I have yet to engage in an action campaign that was well timed in the view of those who have not suffered unduly from the disease of discrimination. For years now I have heard the word 'Wait!'. It rings in our ears with piercing familiarity. This 'Wait' has almost always meant 'Never'. We must come to see that justice too long delayed is justice denied." Martin Luther King

Ana Nery
Medco in Yemen

EVENT EVENT EVENT

47th General Assembly of MSF France

47TH GENERAL ASSEMBLY OF MSF FRANCE

The MSF France General Assembly will take place on June 9 & 10, 2018 at the public botanical garden Parc floral de Paris. In the meantime, find out everything you need to participate in this key associative life event!

PRACTICAL INFO

WHEN IS IT?

June 9 & 10, 2018

WHERE IS IT?

La Chesnaie du Roy
Parc Floral de Paris
104, Route de la Pyramide
75012 Paris

HOW TO GET THERE?

PUBLIC TRANSPORTATION

* **Metro line 1** get off "Château de Vincennes"
* **BUS line 112** get off "Stade Léo Lagrange"
* **RER A** get off "Vincennes"

Once at the Floral Park, don't enter but go along it to the right. La Chesnaie du Roy will be on your left.

BY CAR

5 minutes away from the périphérique,
exit at "Porte de Vincennes"

ROAD SAFETY

* **A free shuttle** will make the round trip between the GA site and Bastille from 23:00 to 05:00.

HOW MUCH IS IT?

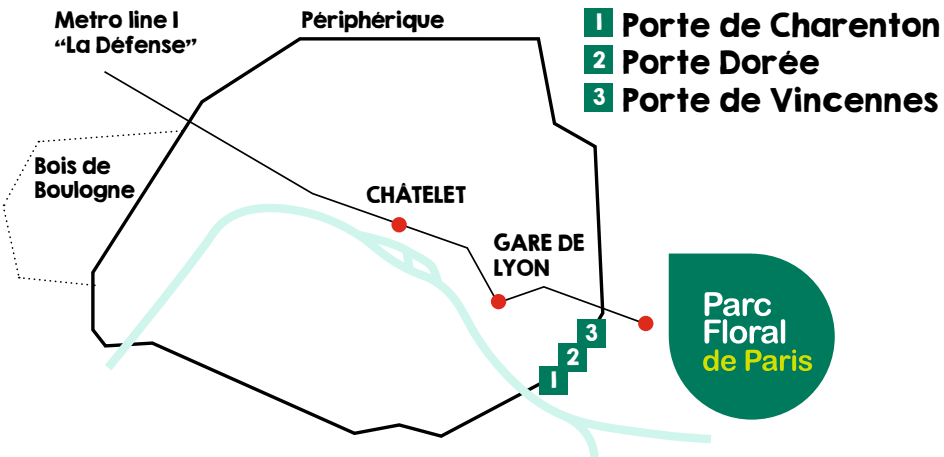
* **The participation fee is €35 for the two days on site.** If you buy your entrance online before Thursday June 7th, you get €5 discount.

Register online:
http://fee-ga-msffrance.portalocp.org

HOW TO FOLLOW THE GA ONLINE?

You can't come to La Chesnaie du Roy?

No worries! You can follow the GA remotely via streaming, on The Portal, and organize a live viewing with other members in the field or elsewhere!



EVENT EVENT EVENT
47th General Assembly of MSF France

PROGRAMME

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SATURDAY JUNE 9TH, 2018

9:00 am	Arrival, coffee & croissants, membership formalities
9:30 am	Election of the GA committee and finalization of the agenda
10:00 am	President's report
11:30 am	Treasurer's report
12:30 pm	Lunch
2:30 pm	Board candidates' presentation
4:00 pm	Break
4:30 pm	Debate **MSF, the new World Health Organization?**
7:00 pm	Drinks, dinner and party

SUNDAY JUNE 10TH, 2018

11:00 am	Brunch
11:30 am	Screening of A Year in Focus
12:00 pm	Questions and answers with the Board of Directors
1:30 pm	Debate **Diversity and inclusion: How to make MSF a more inclusive association?**
4:00 pm	Debate **The Libyan mission / In-country migrants' issues and humanitarian situation** + End of voting and counting of the votes
5:30 pm	Results of the Board election
6:00 pm	Closed Board meeting to elect the officers
7:00 pm	Announcement of the BOARD OFFICERS, followed by drinks

MEET THE CANDIDATES

**Here are the candidates for the MSF France Board of Directors.
We asked them questions about current ongoing issues in MSF.
Operations, association, international...
The candidates have chosen to answer three questions.**

**Discover their answers and do not hesitate to visit The Portal
to continue asking your questions or commenting.**

SYLVIE CUSSET

EMMANUEL DROUHIN

DENIS GOUZERH

CENDRINE LABAUME

XAVIER LASSALLE

MARC LAVERGNE

YANN MENS

VÉRONIQUE URBANIAK

QUESTIONS TO THE CANDIDATES

SYLVIE CUSSET

"As a paediatric nurse, I am, of course, particularly concerned about women's health and maternal-child programmes. I am, however, also concerned about projects in conflict zones because they raise the question of whether all the constraints are intended, chosen or imposed and whether they comply with our charter."

Please tell us about yourself
I am a paediatric nurse and long-time member of Médecins Sans Frontières and I have also been active with the Lyon office for a very long time. I just spent a year on the board of directors. The year was very enriching and I would like to continue my involvement with the board. As a paediatric nurse, I am, of course, particularly concerned about women's health and maternal-child programmes. I am, however, also concerned about projects in conflict zones because they raise the question of whether all the constraints are intended, chosen or imposed and whether they comply with our charter. These are the issues I would like to address this year on the board of directors.

Is there any field of endeavour in which you believe MSF should be more involved?
I think we could put more effort into direct training. We have training programmes for administrators, logisticians and medical professionals, but to my knowledge we do not provide any live training in the field. Expatriate jobs are often supervisory and coordination positions. What's more, fieldworkers returning from their first assignments are a little frustrated that they were unable to provide direct care and be in direct contact with beneficiaries. One idea might be an MSF training hospital where fieldworkers on their first missions would be included in the rotation schedule with the national staff, which would give them a better understanding of the way we work and the various cultural situations. They would also gain greater insight into positions of responsibility if they wish to continue working at MSF. These training programmes could cover all areas of expertise, including sanitation, logistics, medical disciplines and allied health professions.

What changes would you make to foster inclusion and diversity?
One issue is how to define these terms, which have been endlessly discussed in recent years. What do they mean? Do they refer to percentages? If so, I'm against that. But if they mean giving everyone an opportunity to express themselves and give their opinion, then yes. That said, MSF's commitment is a personal commitment. We want to work with MSF, and MSF must listen to its members' ideas. Aside from that, MSF is engaged in a wide range of programmes that must take into account that

patients, cultures and programmes are part of our mission and our compliance with our charter. So for me, the terms "inclusion" and "diversity" have so many different facets and have become buzz-words that are repeated so often by organisations and politicians that I believe they have become too vague and need to be better defined.

Is MSF's cumbersome bureaucracy unavoidable or should the organisation reinvent itself?
MSF has grown significantly in recent years and we should re-examine the way we operate. Do we need the same management structure at all of our field projects? Do we need the same organisation? Should small missions or a single project in a country have a coordination office in the capital? Couldn't we work and pool resources with another OC that also has a single field project, for example? We can discuss that. It's true that our management structure has become way too large. I find it unwieldy. Is it really necessary? Do we need to systematically and formally duplicate the same function in every country and mission? I don't know, but it's an issue that I would really like to address.

IN CONCLUSION...

I wish to say that the word "human" is part of the term "humanitarian". Let's not forget that there are real faces behind all of the statistics that we collect throughout the day, with our eyes glued to our computers. These are the faces of our beneficiaries. And we must care for these beneficiaries with the money we receive from our donors. So let's not forget that they are not just statistics. ■

"I think having a conversation, informing young people going on mission, that critique is not a form of accusation but a way to improve our assistance. Everyone can understand that it's in our interest to cultivate a critical approach."

Please tell us about yourself
I first worked in the humanitarian aid sector in 1985, with the ICRC. Then, in 1989, I joined Médecins Sans Frontières for the Liberian crisis and I began a succession of emergency and field missions. I ended up spending six years as programme manager in the operations department at MSF Paris. I now work for the World Food Programme. I'm based in Jordan where I'm in charge of operations for Syrian refugees. I'm standing for the board of directors because MSF is part of my life and I really want to participate in creating the MSF of tomorrow.

Delegation, decentralisation, independence: are we ready to share responsibility?
I'm one of those people who believe we should hand back more responsibilities, more decision-making powers, to the teams in the field. Why? Because that's where it all happens. It's in the field that decisions should be made before going off to

assist people. Ok, the European centres have set up technical platforms and operational support, and these have improved operations considerably. But, they've had their side effects, if I can put it that way, like making relations more difficult between the teams in the field and headquarters with the decision-making process. I think there's a real political will within MSF to hand back more responsabilities to the teams in the field. I think it should be done, it'll be a real addition to operations and improve our assistance.

What do you propose to allow everyone concerned to take a critical look at what we do?

With its culture of debate, I think MSF already has a critical attitude towards its activities and operations. This critical approach has allowed us throughout MSF's history to improve our emergency response and the standard of our operations. To allow everyone in operations to have this critical approach, I believe one solution is to have a conversation, and at all levels. This means at headquarters, at the operational level, during briefings of course, but most of all, within the coordination teams. This is part of the MSF culture and its philosophy. And I think having a conversation, informing young people going on mission, that critique is not a form of accusation but a way to improve our assistance. Everyone can understand that it's in our interest to cultivate a critical approach.

Is MSF's cumbersome bureaucracy unavoidable or should the organisation re-invent itself?

No, I don't believe it's inevitable. Bureaucracy is in fact a type of work organisation. And we need to organise our work because we often operate in complex settings we know little or nothing about. We need to organise our work in a certain way, and that means bureaucracy. The problem is we've added layers and layers of it. Lots of departments in the various headquarters send out messages and impose procedures on the teams who end up filling in more and more forms and tables. I don't think that kind of bureaucracy is helpful. It puts more work on the teams, and they're using their energy in the wrong place. I trust them to put their energy to good use—assisting people, not on time-consuming red tape. I think there's a commitment among MSF's management to change this, but everyone has to get involved. It's not going to happen in a few weeks or even months, it'll need time. I also believe the teams in the field should at times, in the interests of assistance, know how to ignore the bureaucracy, rather than always responding to mostly pointless bureaucratic rationales. ■

"I firmly believe Médecins Sans Frontières is at a turning-point in its existence.
We have to come up with another way of functioning with the various entities.
I think we should also call on our African, American and Asian colleagues to instil renewed impetus into the association."

Please tell us about yourself
I'm Denis Gouzerh, and I'm standing for a third term on the board of directors of MSF's French section. During the six years of my first two terms I was treasurer and then president of the MSF Foundation. I currently work as a consultant with the UNHCR and I'm also a National Court of Asylum judge. Asylum has become an extremely important topic, which MSF has addressed by opening a centre for unaccompanied minors in Pantin.
As the Foundation's president, I've been able to support the areas for development it has adopted, which is something I hope to continue. Applied medical research and technical innovation have been of particular interest to me, and the technology deployed in our highly-innovative 3D prosthesis project in Amman is set to benefit patients in other fields where we work.

Can you give us an example of a success, and of a failure?
One of the MSF association's strengths is its ability to look critically at its operations in order to drive continuous improvement. Let me illustrate my point with two examples from 2017—Syria and Yemen. The war in Syria began seven years ago but we haven't been able to deploy international staff in the field during the past four years because of the abduction of our colleagues, and this has meant working via networks of doctors set up locally. Our projects are of a good standard, but there's some frustration at not being able to be present like we usually are, with international teams on the ground. Although not an actual failure, the project has its shortcomings. But, at the other end of the scale, there's Yemen, a project where MSF is able to deploy both national and international teams. We're able to provide real day-to-day assistance to the most deprived and worst affected by the conflict. Take the 55,000 surgery patients the teams have treated since March 2015—a truly astounding number. I would like to take this opportunity to salute the courage, the strength and the high standard of our teams who've worked in Yemen over the past three years.

What's the board for and do we still need it?
In 2010, the MSF movement's international bodies decided, quite rightly, to introduce a new salary scale for international employees working in the field. Even though the vote on what's become known as the IRP2 was passed, I think it's extremely discriminatory. In fact, I was one of the few who voted against it during the 2012 international general assembly. It took five years to get this very unfair salary scale amended. It's also a perfect example of the limits to a board member's freedom of action.

An operational centre in the South is on everyone's lips. Should we go for it?
The WACA (West Africa and Central Africa Association) held a meeting in Dakar in April to prepare the groundwork for an alternative to the associative and operational dimensions of Médecins Sans

Frontières. We're heavily concentrated in Europe and I think the way we function has reached its limits. The five OCs, including OCP in Paris, have shown their limitations, partly due, I believe, to their size and geographical location. The WACA is an example of an operational centre as the decision has been taken at long last to turn it into an operational centre within the next two years. This shows we're committed to overhauling the functioning of the entire MSF association. As member of the board, I'll make myself available to assist my WACA colleagues with moving forward so as to secure a real operational project at the earliest possible opportunity.

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I firmly believe Médecins Sans Frontières is at a turning-point in its existence. We have to come up with another way of functioning with the various entities. I think we should also call on our African, American and Asian colleagues to instil renewed impetus into the association. Thank you. I'm available to answer any questions you may have. ■

CENDRINE LABAUME

"Let's start by evaluating our practices and their impact to determine which part of bureaucracy is necessary, i.e. necessary for transparency, project performance and accountability, and which part is unnecessary, redundant and even harmful."

Please tell us about yourself

Hello, my name is Cendrine and my career in the humanitarian field began in 1996 in Rwanda, followed by eight years as an expatriate in Georgia, Kosovo, Palestine and Chechnya, season 1 and season 2. I then went to Marseille to coordinate healthcare access programmes at Médecins du Monde for seven years. I recently resumed working as an international consultant after several stints in a wide range of professional capacities.

Why am I interested in joining the board? First, because I have some free time and second, because there are so few opportunities to exchange views, discuss and reflect on humanitarian action and geopolitical situations, making them highly valuable and appealing.

How do I plan to be involved? By contributing my time, my "grey matter" and possibly my pen. Which issues? In general, everything interests me, but if I

had to choose three, I would pick: France, Europe and migration issues; governance and the issues of decentralisation and representation; and lastly, mental health. And I would obviously add operations and operational methods as a whole.

Is there any field of endeavour in which you believe MSF should be more involved?
Clearly yes ¬– when it comes to migration issues in France, both in terms of advocacy and operations. Of course the government is involved, but it has a tendency to be disengaged. And there are private players, too, but given the number of migrants abandoned on our streets, their response has been inadequate at best. I also think speaking out has a role to play in the sense of both expertise and activism.

What's the board for and do we still need it?
I've been asking myself that question for 20 years as an employee of the association. Maybe with your help I'll finally find the answer. But perhaps the better question is, "Which board? How do we move beyond the familiar? How do we free ourselves of geographic and mental boundaries that limit representation? What role do employees play? How can we manage the information gap between the board, headquarters and the field?
And what should the board's function be aside from its traditional role of steering the association and apart from the fact that the board serves as a forum for exchanging views and ideas that is even more enriched by outside expertise? In my opinion, the ideal board is a board that fosters innovation, with a public voice that inspires MSF international movement.

Is MSF's cumbersome bureaucracy unavoidable or should the organisation reinvent itself?
Both nationally and internationally, the increasing bureaucratisation of NGOs is, in general, closely related to the growing number of donors and various reporting requirements. In MSF's case, the first question that comes to mind is figuring out who would replace institutional donors. My second comment is: cutting the bureaucracy means relocating, decentralising, delegating and thus accepting the risks resulting from a loss of power and control. That is basically a subjective goal related to the issue of relocating operational centres.
What are some ways to move forward? Let's start by evaluating our practices and their impact to determine which part of bureaucracy is necessary, i.e. necessary for transparency, project performance and accountability, and which part is unnecessary, redundant and even harmful. One of the criteria we could consider using is service to our beneficiaries, for example.

IN CONCLUSION...

By way of conclusion, what I mainly want to emphasise – rather than my slightly awkward writing style (which you may have noticed) – is my strong desire to join you and help improve MSF's operational effectiveness in Yemen, Syria, Congo, France and elsewhere.
Talk to you soon. ■

"Do we have the ability to assess the quality of our programmes? I'm not so sure. A number of direct and indirect indicators have been introduced in recent years, but I think there aren't enough or they aren't being used sufficiently to monitor and assess the quality of our programmes."

Please tell us about yourself
I'm 62 and an anaesthetist nurse. I work in a hospital near Paris. My first mission with MSF was in 1989 and I was thrilled at the opportunity to combine my professional work with a commitment to assisting victims of crises. I went on missions of varying lengths until 2000, which was when MSF offered me the job of anaesthetist advisor, which I did at the same time as my job at the hospital until 2017. During this period, MSF decided to get involved with developing hospital projects. This led to several major large-scale projects I was fortunate enough to participate in: developing modern anaesthesia practices, setting up a biomedical department, specialist units for burn patients, emergency departments and intensive care and introducing tools to better measure our work and the quality of our programmes.

After all these years, I would now like to continue this commitment by giving it a new direction. I want to become a member of the board of directors to put to good use the 30 years of experience I've acquired both at headquarters and in the field and help MSF.

Is there any field of endeavour in which you believe MSF should be more involved?
There are several, one being medical quality. It's talked about a lot, but do we have the ability to assess the quality of our programmes? I'm not so sure. A number of direct and indirect indicators have been introduced in recent years, but I think there aren't enough or they aren't being used sufficiently to monitor and assess the quality of our programmes. I would therefore like my presence on the board of directors to be used to support all initiatives addressing quality to enhance the transparency of our medical activities for our patients, our colleagues and our donors.

A second area is training. MSF has invested heavily in in-house training for its managers, and this has been a success. But a lot less has been put into preliminary skills training, even though the resources are available in some of the countries where we work. I believe it's necessary to provide skills training, which is also a good way to foster integration of national staff.

What do you propose to allow everyone concerned to take a critical look at what we do?
Everyone agrees that the members of the association, in the field and at headquarters, must be better represented and that their voices must be heard more loudly. The tools exist, but there's not enough feedback. This is why the proposals to make the platforms more dynamic and to open up board elections to members at headquarters are steps in the right direction. The board must support these initiatives, and facilitate the strengthening of ties with the field during visits—there may need to be more—and at events held at headquarters, like coordinators week.

An operational centre in the South is on everyone's lips. Should we go for it?
Yes, I think it's a logical step and one I'm totally in favour of. Whereas most of the operational centres are in Western Europe, the majority of our programmes are in countries in the South. Our colleagues from these countries have proven their effectiveness in positions of responsibility so the board must assist with getting the application prepared for 2019. This issue must be included in the four-year strategic plan, so that we can address the sharing of financial resources, the provision of support services and establish the level of independence of the new operational centre. The board has to get involved to be able to participate in the debates as well as the process of reflection. ■

"I think we should try to foster women's education and family planning. This is how to make an impact on issues like malnutrition and, of course, violence against women."

Please tell us about yourself
I'm a geographer and a research supervisor at the CNRS. I specialise in the Middle East and the Horn of Africa. Why am I standing for the board of directors? Well, MSF and I go back a long way. I've already served on the board and, with important turning points lying ahead for humanitarian aid in general and MSF in particular, I want to get back in the saddle.

Is there any field of endeavour in which you believe MSF should be more involved?
I think MSF already does a lot. But there's one health aspect that's important—prevention. In particular everything to with women's health. In the places where we intervene, women have crucial roles in health and raising children. I think we should try to foster women's education and family planning. This is how to make an impact on issues like malnutrition and, of course, violence against women.

These are areas I believe are increasingly important and where we need to do more.

What's the board for and do we still need it?
A clearly provocative question, but justified, as it's probably one lots of people in the MSF cosmos ask themselves. It means that people in the association, at headquarters and in the missions sometimes wonder what's the point of the board. The statutes and the charter define its role. It could be said it's a kind of MSF parliament. In my opinion, the board is also the nerve centre of the association, headquarters and the field. Even if its role is not always fully understood, it's the board that manages, votes the budget and makes the strategic choices implemented by the executive. However, I think the board would benefit from being better known and more present within the association via the branch offices. For example, board members could undertake to visit and present what they do at the branch offices. They could do the same in the missions. There are the FADs that help to meet regularly with people in the field. But I think that beyond the FADs, it would be worthwhile for members of the board to go to missions that pose a problem, which are in somewhat awkward situations, to be able to inform the board while enhancing its visibility.

An operational centre in the South is on everyone's lips. Should we go for it?
Yes, it makes sense. It's a logical evolution, and a logical evolution for MSF. Because after many years, a lot of progress has been made with diversifying the teams as well as the managers. But, there are practical considerations. Firstly, cultural, because MSF is well on track with its five operational sections that are progressively more international and which benefit from various types of support. But right now the South would pose a practical problem, a problem of support, a problem also of culture and training transfer. I see only advantages to these transfers to teams in the South to enable them to assume responsibility and fulfil their role within the MSF movement.
I believe it would be sensible to have a trial period for the new operational section. We need to select its location and size carefully, determine its responsabilities and then, within a given timeframe, assess it.

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I would like to take advantage of this opportunity to express my concern about how activities are evolving in our fields. Increasingly weighed down with administrative, management and accounting tasks, they seem somewhat inward-looking in relation to the communities we assist. There's also a loss of perspective—what made MSF? What does MSF stand for? What are our values? Ultimately, what is the meaning of our combat, our engagement? This is why I offered to participate in the Kesako sessions organised by the GUPA. I spent several days with the teams in the field to explain all this to them—the organisation's institutional memory but also with an eye to the future based on what we do in these fields. ■

YANN MENS

"I think the board must be informed of the most challenging dilemmas, notably those involving security. The board must not leave it to the teams to deal with quandaries like, should we go there? or, should we stay in a particular field? The most important of these dilemmas must be communicated to the board."

Peux-tu d'abord te présenter ?
I've been a member of MSF's board of directors since October 2014. I served as a co-opted member for a little over six months before being elected during the June 2015 general assembly. I've worked as a journalist for around 30 years, so I'm not a humanitarian aid field worker. However, I've often come across teams from MSF and similar organisations in the field and, as a journalist, I've had the opportunity to explore humanitarian issues extensively. If I'm elected for a second term, there are two areas I would particularly like to get involved in. Security issues, because I have a professional interest in the situation of countries in crisis and more specifically in conflict. I think security is really important to MSF, because it has to ensure its teams are provided as much security as possible even if, obviously, it's never possible to offer a 100% guarantee. The second area I'd like to get involved in is migration as I believe this is only the beginning. To some extent, MSF France has had to improvise, and all the better, as that's something MSF does very well. But there are still a lot of other challenges along migrant itineraries—particularly on the way from Africa to the shores of Europe.

Delegation, decentralisation, independence: are we ready to share responsibility?
I think that if decentralisation and delegation are complex, it's partly because MSF has grown enormously since the early stages. Back then, MSF had to play it by ear and be creative. They weren't so much amateurs as people forced to invent solutions along the way. We've become a vast and very important organisation, with large-scale projects and programmes of a very high standard. I think this insistence on quality exists in all links in the chain, which probably partially explains the centralisation and difficulty with delegating. Many people at MSF, and it's a good thing, consider themselves custodians of at least some *quality control*, whether it be medical quality of operations, quality of logistics or administrative and financial quality. I'm insisting on this because MSF is accountable to all its donors who put their trust in the organisation. Most of MSF's funding is generated from private donors. We have to be demanding of the quality of our programmes. Many people in MSF's chain of command, dare I say, consider themselves custodians of *quality control*. Perhaps each of us, everyone in the teams, should ask themselves which part of their small power they can relinquish without jeopardising the quality of operations. Only then, when all those concerned rationally perform this little exercise on the power they hold, will it be easier to delegate, and consequently, decentralise.

What's the board for and do we still need it?
The board can seem remote, particularly by team members in places like Kabul, Mosul, Bangui and Bukavu. It sometimes gives the impression of being

some far distant entity. I think to a certain extent the board's role is to be the guarantor of the principles and values that have underpinned MSF since its inception. As members of the board, we act as a kind of stimulus for the executive and ensure that it, the teams and all those who constitute MSF work in accordance with its principles and values. The board is somewhat peripheral to everyday operations and it must make sure we don't get bogged down with technical routines and mechanical reflexes. I think the board must be informed of the most challenging dilemmas, notably those involving security. The board must not leave it to the teams to deal with quandaries like, should we go there? or, should we stay in a particular field? The most important of these dilemmas must be communicated to the board, which must discuss and deliberate them. That's how I see the board's role.

An operational centre in the South is on everyone's lips. Should we go for it?
I think we should go for it. It's a natural progression—of history, of the de-westernisation of the world in general, and MSF in particular. I find it hard to believe that an operational centre in the "North" would evaporate to make way for an operational centre in the South. I think an operational centre in the South will be added, most likely in Africa, as it's something we're moving towards. But, I believe it's very important that the will to create this centre be echoed by the board and that it must originate from a region, not in the North, but in the South. I also believe it's very important that this centre or operational section have its own funding. Otherwise, it will always be dependant. Either way, the continent that sets up this entity will have to find local funding to start to exist independently and not have to rely yet again on the North and Westerners. ■

"We're too big and we have too many operations to be able to manage effectively from headquarters. I don't know if we've ever been able to do it. So we have to give the teams more space, which calls for competent, trained and responsible people."

Please tell us about yourself
I'm a doctor and at the moment I work in the WHO's emergency department. I've worked both in the field and at headquarters for MSF and the ICRC. During my three years on the board, I've been a member of Epicentre and I've represented MSF France to the Group Committee, two posts which really sum up what MSF means to me. On the one hand, there's Epicentre that conducts scientific and operational research. In other words, it works with operations to ensure medical standards and assist our teams in the field. And on the other, there's OCP. A forceful, motivated and cohesive group that MSF France is part of. It hasn't always been easy but because we're together now, we manage to push pertinent topics to the international level. This encapsulates what MSF means to me today.

Delegation, decentralisation, independence: are we ready to share responsibility?
Delegating to the fields and their independence are essential. We're too big and we have too many operations to be able to manage effectively from headquarters. I don't know if we've ever been able to do it. So we have to give the teams more space, which calls for competent, trained and responsible people. It's a real challenge. We're going to have to work on training, but even more on retaining our managers. Once we have the right people in the field it will be much easier for the executive in Paris to delegate and have staff they can engage with to drive forward our operations, which will benefit our patients.

What's the board for and do we still need it?
The board brings together people who have experience with MSF and other organisations, which is what makes it interesting. The fact of having other experiences, of working elsewhere and not having to keep up with day-to-day running of operations enable board members to maintain some perspective and debate the topics we believe are valuable and important to support the executive. The idea isn't to oppose the executive or to want to control what it does, but to try, at times from a different standpoint, to improve the way we do things and help our missions and activities. I think that's real support. And when we address subjects important for our operations, we show we can bring some value. So yes, I think we still need a board, but a dynamic board that really knows MSF and is ready to engage with its teams.

An operational centre in the South is on everyone's lips. Should we go for it?
Yes, why not a section in the South. I'm quite in favour. But it mustn't be just one more section or *Branch office* like the entities that have emerged in various countries in recent years. We have to establish what we want it to achieve and the value it can bring. An operational centre in the South also seems to me be a good idea because we have more and more colleagues who come from the South. It would help them to continue engaging with us while being close to where they're from. That's important, because we all have to make choices at some point. So is complementarity. The aim isn't to replicate what already exists five times over in Europe, but to see what advantages are to be gained from being in the South. Operational proximity is definitely one of them. But I'm not sure that's what's most important. I think it's more about thinking differently and re-inventing MSF. It's a real opportunity for us to see things from a totally different angle.

IN CONCLUSION...

This a brief summary of what I wanted to share with you today. But with so many other topics to debate, let's meet again via the association website or during the general assembly and continue the discussion. I would also like to take this opportunity to tell you how delighted I am to introduce myself to you for a second term on the board. Thank you. ■

HOW CAN I VOTE?

© Bruno De Cock / Médecins Sans Frontières

The MSF France General Assembly will be held at La Chesnaie du Roy, east of Paris. But even remotely, it will be possible to participate and vote, under certain conditions. When and how to vote, online or in person?

Find here all the information as well as the electoral regulations.

There are two types of votes at the GA:

* **Voting to renew the Board of Directors,** for potential motions or other votes decided by the Board: managed by Néovote®, an external provider
* **Voting on the financial and moral reports** and some motions: managed by the GUPA

Voting to renew the Board of Directors

* **Members can vote online or by postal vote** using the paper voting kit sent to all members who have paid their subscriptions before April 30. For those who want and for those who updated their membership after April 30, the voting will only be online.

Voters can choose from the list the number of candidates they want (up to 6 open seats).

* **Abstention votes are counted:** a "blank vote" option is provided for this purpose.
* **Paper ballots must be sent to the GUPA** who will send them to the vendor.

Voting for the President's and Treasurer's Reports

* Only people present at the General Assembly or who have given proxy to a person attending the GA may vote. Remember to arrange a proxy if you cannot make it to the GA (you can download the form on the Portal). On the day of the GA, voting ballots are distributed while signing in. The people overseeing the election are appointed by the electoral commission of the GA and assigned to counting votes.

Online Voting

* **Go on the voting platform and vote online from a computer, a tablet or a smartphone.**
* For any issue about onlie voting, postal voting or voting codes, please contact Néovote at **0.800.808.900** (toll free number from France) or **+33 (0)1 75 43 99 24** (national toll to France).

When to vote?

* **The vote for the Board for Directors will be open from Thursday May 31th, 2008 at midnight (Paris time).** It will be closed Sunday, June 10th, at 16:00 (Paris time).
* If you have any issue, contact the GUPA team: **msf.asso@paris.msf.org** or **+33 (0)1 40 21 28 01**

Who can vote?

Associated members who are up to date with their membership dues. New this year: following recent changes in the by-laws, employees of MSF France headquarters and satellites who are members of the association can also vote.

The deadline to renew membership is Saturday June 9, 2018 at 16:00, onsite at the GA. Online membership ends on June 7, 2018 at 17:00 (Thursday before the GA). Membership fee is €26 or US$10 for the national staff.. ■

VOTING RIGHT FOR HQ EMPLOYEES: HERE WE GO!

After a long process, very long indeed, now, that's it! The new by-laws have been definitively validated by the competent authorities. At the 2018 General Assembly of MSF France, headquarters and satellite employees who are members of the association will be able to vote.

Since the validation of our new by-laws and internal rules and regulations in 2017, the voting right has been granted to all members of the association (field employees, headquarters, satellites or former MSF). But beware, membership is not automatic: to become (and stay) member, you must make it happen. For more information, visit The Portal.

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FOLLOW THE GA ONLINE

© Sylvain Cherkaoui

The MSF France General Assembly is taking place in the Paris region, but all members (in the field or elsewhere) are invited to participate in the event via streaming!

A few explanations...

It is possible to follow the GA live, even if you are hundreds of miles away from Paris, thanks to streaming! But it doesn't mean you have to watch it on your own and can't participate! If you are in the field, you can organize a group viewing and share this moment with other asso members!

Some practical tips

* It will work better if you connect to the internet through a wire and not through Wi-Fi
* Check the Internet connection before the GA! Try the link from last year and see if it works **http://www.yuca.tv/en/msf2017**
* If it is slow, no worries! Alternatively, you can choose a lower resolution

Everyone can participate

* Get to know more about the topics of the debates and participate in the discussions on The Portal
* Ask Board candidates your questions on The Portal
* Organize or help set-up your own GA event on the field (install a voting booth with a computer available for online voting, meet to watch a specific debate etc.)
* Watch the discussions, ask questions via the live chat and send photos of the team by email to **msf.asso@paris.msf.org**
* And don't forget to vote, of course! ■

GENERAL ASSEMBLY DEBATE

© Anthony Jean

Libya: Challenges and Dilemmas

Libya is a divided country still prone to clashes between armed groups. It is also situated along routes taken by migrants seeking to reach Europe. What can an NGO like MSF contribute to Libya? What are the challenges and dilemmas the teams have to contend with?

These questions will be central to the debate to be held at this year's General Assembly-at 4 p.m. on Sunday, June 10.

Seven years after the war that led to the collapse of Kaddafi's regime, Libya remains divided, with one government in the east and another in the west controlling just a small part of the country. Towns, tribes and local militias are allied more or less durably to one or other of the two powers and clashes are frequent in regions such as Tripoli, Sebha and Derna. Jihadi groups are also present, including Islamic State, which, although dislodged from Syrte in December 2016, continues to be active.

Libya is a major hub on the main migration routes to Europe, not only from the Horn of Africa but also Central and West Africa. Although statistics are hard to obtain, there are several hundreds of thousands of migrants in the country who either want to get to Europe or stay put and find work. Libya has a history of migrant workers as it employs many Sub-Saharan nationals.

Consequently, OCP's projects are aimed primarily at migrant populations, either longer-term residents or those in transit. Regarding people in transit, our projects include providing medical care to migrants who fall victim to extortion and torture meted out by traffickers during their journeys and assisting people attempting to cross the Mediterranean and intercepted—with the help of European countries— by the Libyan coastguard or arrested in the country itself. Whether intercepted at sea or arrested in Libya, these migrants end up locked up in government or militia-run detention centres. If they hold one of the seven nationalities the Libyan authorities considers as entitling them to asylum, they are referred to UNHCR, which, with no mandate in Libya, is unable to conduct independent assessments. The rest are repatriated to their countries of origin by IOM.

OCA is also deployed in detention centres and on the Aquarius, which rescues vessels in distress in the Mediterranean. OCA's teams have to contend with an increasingly aggressive Libyan coastguard during the Aquarius' operations.

These projects raise several dilemmas. Does assisting migrants tortured by people traffickers make us *de facto* one more link in the chain of extortion they are victim to? Should we denounce the inhuman living conditions and abuses inflicted on migrants we sometimes witness in detention centres and run the risk of being ousted and no longer able to provide medical care to those detained in them? What services can we offer that are most suited to a young and mobile population? And, at the same time, what actions and services can we make available to the people of Libya to gain their acceptance? These are the questions we will seek to address during the debate to be held on Sunday, 10 June at the General Assembly. We invite you to participate—either in person or on the Portal where the debate will be streamed live. ■

"Should we denounce the inhuman living conditions and abuses inflicted on migrants we sometimes witness in detention centres and run the risk of being ousted and no longer able to provide medical care to those detained in them?"

DEBATE

Medical Research and Strategy: MSF-the new WHO?

© Gwenn Dubourthoumieu

What should MSF's medical strategy be now, and in the future? Should limits be set, and if so, what should they be? In terms of research and the choice of our orientations, are we ahead of the pack or toeing the line? What is the actual purpose of our ambitions and our expectations regarding health? These are some of the questions we will attempt to address during the debate on our medical strategy at this year's General Assembly. Drawing on various examples (Multi-Resistant TB, Hepatitis C, etc.), we will first discuss the direction MSF has taken in terms of research, the dynamics of our approach and the pertinence of our decisions. We will go on to examine the blind spots in our strategy and the medical practices we apply to our patients. We will also address other areas of research we have already or might explore and what these say about our shortcomings and how we might evolve. MSF-the new WHO?

These are the questions we will discuss during the debate to be held at 4.30 pm on Saturday June 9, at the General Assembly. We invite you to participate- either in person or on The Portal where the debate will be streamed live.

"Critical support, yes. But rivalry, no"

MSF, the new world health organisation?
This somewhat provocative question that'll be debated during this year's general assembly poses the question of MSF's medical strategy and health policy. What are our medical objectives and our strategies for research? Aren't we being too ambitious? Aren't we in danger of taking ourselves for what we aren't? Should we set ourselves some limits? What could they be?

Interview with Dr Jean Rigal.

"MSF, a new world health organisation?"
What lies behind this question?
I ask this question because I would like us to debate the trend towards the institutionalisation of MSF. With our organisation positioning itself as a key spokesman on public health issues, there's a sense at times that MSF is engaging in actions and giving itself the right to make public recommendations traditionally the prerogative of the WHO. Is this really our role? That's what I'd like to see discussed, so we can examine with a critical eye the question of knowing if we're not going a bit too far, if we're not being arrogant and if we're not spending money without due consideration. Are we getting out of our depth?

Could you give us some examples?
I'm thinking first of the risk of MSF losing its way by getting involved in strategies disconnected from reality. That's what happened at the end of the 1980s when we participated in the Bamako initiative that sought to improve access to primary health care by generating funds in communities. It's still happening today, like after the Ebola epidemic in West Africa when some organisations offered to work in a consortium of universities and research centres to come up with a treatment or vaccine. Examples like these show the risk of MSF cultivating a sense of invincibility and believing we're capable of changing the world—based less on our own experiences than on utopic convictions.
What I would mainly like to address, however, is not so much to do with convictions or sententious statements but rather a will to put the focus on our medical strategies and our health policy. This means, during debates at the general assembly and elsewhere, analysing them and highlighting their priorities, since other stakeholders, whose job it is in principle, are better placed than us in certain areas, even if we have become involved in them. To put it plainly, what I want to challenge are the times when we consider ourselves able to establish partnerships or replace the WHO, even if some experiences have proved that we were right to do so.

Which experiences are you thinking of?
Take the example of vaccination. Are we able to do more, and better? The ICG (International Coordinating Group), whose members are the WHO, Unicef, the Red Cross and MSF, was created on our initiative. We therefore manage a worldwide stock of meningitis vaccine, which has now been extended to include yellow fever. This initiative came after the meningitis epidemic in Nigeria when we used up all the available vaccine. We had to change strategy, so we called on Epicentre and decided we had to group together and create a stock of vaccines. We contacted the WHO and set up the ICG, which allows States to obtain vaccines easily and rapidly. The four partners take turns at supervising the stock. Some of our colleagues regularly criticise our participation in this entity because they don't see it as our role, that it's arrogant and too institutional. Personally, I think it's a good idea. In fact, we could have done the same thing to make infusions more rapidly available in countries affected by cholera.

But, our vaccination activities often highlight the lack of a more permanent solution. Thus, in DRC, we continue to vaccinate hundreds of thousands of children against measles, without the slightest hint of solution in the offing.

"Let's not forget one of our first rallying cries: "go where no-one else goes". Nobody's interested in trypanosomiasis? Ok, let's go for it. The drug used to treat trypanosomiasis is crap? Let's come up with an alternative."

Should we impose limits on our medical strategy?
I don't see imposing limits necessarily as a good idea because, as the saying goes, the very nature of borders is to render inconceivable things that can be on both sides at the same time. Nevertheless, I believe it's worth raising the question of limits if it helps to re-open the debate on our strategies and policy on health. Take the example of the DNDi. Its creation has at times sparked some resistance within MSF. The DNDi enabled the development of a drug administered orally for treating trypanosomiasis, which will soon be available in a single dose. That's quite a victory! The DNDi is just a small initiative thought up by MSF after confronting the problem of neglected diseases in the field. Can the DNDi now count on MSF's support with taking on illnesses like hepatitis C? Is this what the DNDi should be doing? And why wouldn't it be, when one of the aims of the DNDi is to show we can carry out research that costs less and saves us the burden of patents? The manufacturer of Sofosbuvir—a drug that's effective in treating hepatitis C—claims that the price of the treatment (41,000 euros for a 12-week supply in France) is justified by the investment in research that will save future patients having to spend money on drugs that don't work. This kind of thinking shows the relevance of the DNDI, which fosters cheaper research through the setting up networks of laboratories, universities and public institutions. That was one of its original objectives, initially intended exclusively for neglected diseases. So there's been a move away from those original objectives, but there have been results too.

Precisely, isn't it the responsibility of the WHO to invest in research?
WHO's ambitions in terms of supporting research have plummeted, to the benefit of semi-private and private bodies like the Gates Foundation,

© Nicolas Postal

or GAVI—with vaccines, for example. Whereas the WHO's independence from States was a decisive advantage in combatting epidemics, this independence also finds itself seriously compromised. We're seeing a kind of erosion in the WHO's prerogatives. That the organisation is shifting towards operational emergencies is also new. Is this something we should oppose? There again, I think we have to get away from positions of principle. A few years ago, during the Darfur emergency, we saw the WHO open a new blood bank in Al-Genaïna hospital. It wasn't logical. The way the WHO intervened in Mosul, where the organisation supported embedded facilities tasked with treating casualties on the frontline, is another example of the redefining of its objectives. But was it necessary to criticise the WHO in the name of humanitarian principles, when we knew the fate suffered by civilians and the difficulties we faced in moving beyond the role of powerless bystanders? What matters, above all else, is the result—even if the question works both ways: "MSF, the new WHO?" or "WHO, the new MSF?"

What attitude do you think we should adopt with regard to this shift at the WHO?

We need the WHO. WHO's standards don't appear out of thin air. They're the result of a lot of serious work accomplished by qualified people. When we go to ministries of health and challenge their protocols, we go armed with WHO recommendations—and it works! The lists of essential drugs help us too, if only as a basis for discussion. As for research, we expect the WHO to support and steer it according to the priorities, particularly demographic. But conversely, we don't need a bunch of incompetents to construct and call an empty building in Al-Genaïna hospital a "blood bank". We must therefore adopt a strategy of critical support to the WHO—and even of substitution in some cases—but very definitely not one of rivalry. Let's not forget one of our first rallying cries: "go where no-one else goes". Nobody's interested in trypanosomiasis? Ok, let's go for it. The drug used to treat trypanosomiasis is crap? Let's come up with an alternative. ■

DEBATE

Diversity and Inclusion: Things Need to Change

Following the 2017 International General Assembly, the General Directors of the whole movement issued a joint statement on diversity and inclusion in MSF, pledging to act to move the situation forward. These concerns were indeed already brought to the associative level through motions and have recently been reaffirmed by Joanne Liu, International President, who calls on the executive to make concrete decisions so that "respect, inclusion and protection are at the heart of our Movement". Thierry Allafort-Duverger, General Director, and Mélanie Cagniart, Director of Human Resources, review the situation as well as their priorities to move the lines in MSF France.

© Malin Lager

MSF's General Directors recently issued a joint statement on diversity and inclusion at MSF, acknowledging the organization's weaknesses on these issues and affirming a strong will to improve along these lines. How was this positioning born?

Thierry Allafort-Duverger Following the International General Assembly, where several motions on the issue of diversity, inclusion and abuse within MSF were made, all Directors General (Full ExCom) signed a joint declaration. We collectively share the belief that the principles set by La Mancha are not respected and that inclusion is currently not satisfactory within MSF.

This positioning is also linked to certain processes and rules in force in the organization, some of which are considered to be discriminatory. There are substantive discussions between sections on topics such as IRP2 (International Remuneration Grid) or HR principles.

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Differences in the conditions of remuneration and access to positions of responsibility for different types of MSF staff also raise questions. Similarly, on the associative side, until recently, you could not become a member of MSF France in the same way as national or international staff. We must fight against this and identify all the principles and policies that we apply, as well as the ones that go against the Charter, the principles of Chantilly and the La Mancha agreement.

"Differences in the conditions of remuneration and access to positions of responsibility for different types of MSF staff also raise questions."

Mélanie Cagniart The statement made by the GDs also echoes the discussions we have, in terms of human resources, on the issues of discrimination, gender and diversity or glass ceilings. Studies and surveys conducted recently by OCB, OCG and OCA have revealed significant warning signals, which also resonate with concerns in civil societies and businesses, such as abuse of power or harassment.

© MSF

Regarding diversity and inclusion at MSF, these issues were already present in La Mancha as they represent a strength for the organization. Our diversity should be reflected in our governance, including in the highest decision-making bodies, but this is still not enough. It was perhaps thought that the existing diversity within MSF was a guarantee of inclusion, but we realize that these two notions do not have much to do with each other. There is an institutional awareness that needs to be translated into action, particularly through our HR policies.

Thierry Allafort-Duverger MSF is not very inclusive. The Paris office, for example, is not representative of the diversity of people working for MSF, including in the field. In addition to internal barriers to MSF, it is not necessarily easy for a colleague from Africa or the Middle East to come to live in Paris, given the salaries that are offered, housing options or administrative difficulties. We must therefore put in place proactive inclusion policies.

The important thing for me is that we remain an organization of practitioners and that the field managers can make their voices heard. They must be represented in all decision-making, associative or executive bodies. MSF is still a fairly centralized organization, with much of the power and decision-making places concentrated at headquarters level. Yet, from their experience, field staff – no matter what their skin color is -- are often in the best position to consider the interests of our patients in decision-making. Today, many of our caregivers are national staff.

"The important thing for me is that we remain an organization of practitioners and that the field managers can make their voices heard."

Are we hearing them enough in the different instances? I'm not sure.

My main concern is the success of our operations, and I think that means reducing the gap between our field and headquarters teams. For the benefit of our operations and social mission, it is necessary that field staff be represented in decision-making positions, be they French, Chinese or Congolese. This requires practical measures including widely disseminating job postings and working administratively to facilitate mobility, especially for our colleagues who are not European.

The La Mancha Agreement placed the fight against discrimination at the center of concerns and signaled the desire to offer the same opportunities to all MSF staff members, whether national or international. What has been implemented in practice since 2006, and what are the areas of improvement for MSF France?

Mélanie Cagniart In recent years, we have been striving to create an environment that facilitates access to the career path for all staff, from recruitment to skills development and access to training and positions that allow for professional progression.

We have therefore put in place a mobility policy, especially for national staff. It aims to favor detachments, which can be a first step towards an expatriation path, which, so far, has been relatively complicated. This is how we have seen the development of a generation of executives from national staff who now occupy positions of responsibility in the coordination (including medical coordinators).

We also wanted to promote expatriation by allowing national staff members to spontaneously apply without going through an identification and a recommendation by the coordination, which is the current process. We still have to make progress because, when you have 10 years of experience in the field as national staff, having to apply online on the site like any other candidate seems superfluous. This is already a step forward and recruitment teams treat these applications as a priority, but we must continue our efforts! On the other hand, through our pilot recruitment platforms in Dubai and Abidjan, we want to eventually reverse the model, and recruit decentralized profiles required for our operations in these regions with high potential.

The other priority is on-the-job training, particularly with respect to national staff, with the implementation of training plans. We have invested very significantly in this way, and this is just the beginning.

Finally, if we want to encourage mobility and taking over responsibilities, and aim to retain staff with a

"If we want to encourage mobility and taking over responsibilities, and aim to retain staff with a commitment in the long term, to speak of one united staff, whether national or international, we must keep a coherence in the policies and the systems we implement, particularly regarding remuneration."

© Julie Rémy

commitment in the long term, to speak of one united staff, whether national or international, we must keep a coherence in the policies and the systems we implement, particularly regarding remuneration. With the IRP2, we can see today that the economic conditions (remuneration, medical coverage etc.) of expatriation are not the same for all. What does it say about the reality of this inclusion? I think we should be honest about asking these questions, especially when 80% of our heads of mission are still white, Western men.

Thierry Allafort-Duverger If we want true diversity and real inclusion in all MSF bodies, we must also move places of power. It is notably the goal of the regional association that is being created in West Africa. To have all labor forces and experienced people who will fill executive and associative positions in different places would be a form of inclusion. The delegation on the field is also one form of inclusion. The momentum is set and it's a good time to continue the work, both at institutional and individual levels. ■

2018 FADs: Overview of the Debates

Approximately 24 FADs reports were received from across the OCP countries of intervention and many vibrant debates occurred in 2018. This year there was a strong emphasis on diversity and inclusion, partnership, associative life and discussions about doing more in stable context countries such as Kenya, Philippines and Russia. Also on the radar, termination of pregnancy was discussed in Cambodia, Malawi and Nigeria.

You will find below a synthesis of the debates which are not meant to substitute the more complete and detailed reports or the debates themselves. You will be able to read the full reports on The Portal.

DIVERSITY, EQUITY AND INCLUSION (DEI)

What does MSF need to be a more inclusive organization? How does our current approach to inclusion & diversity impact our social mission?
The field is LOUD & CLEAR when talking about DEI, and inclusion resonates as the ability to be listened to and heard in terms of planning, decision-making and access to training, management level positions and expatriation opportunities. A strong emphasis needs to be made on national staff and beneficiaries. Something needs to happen. DO YOU COPY?
Below is a breakdown of what field teams in each country are requesting in terms of DEI and improved management strategy.

Diversity is seen as an opportunity to gain from different experiences, perspectives and ideas. This diversity should be reflected at the management and coordination levels with the recruitment of more national/local staff for these positions. Decision making and strategic thinking need to be more inclusive of national staff and people who are not necessarily managers. Local staff want to feel part of the wider MSF movement, more consulted and listened to. DEI is not a onetime discussion—more in-depth training about the issue is needed and could be incorporated in pre-existing training opportunities such as the PPPD, KESAKO and Field Management Training. *(GEORGIA)*

* * *

National staff do not feel they have equal access to proper opportunities for career development and trainings. When we talk about diversity and inclusion, beneficiaries and patients should be part of it. *(IRAQ/KURDISTAN)*

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Being inclusive for MSF means recruiting the right people for the right job. We need to review our policies in that regard, to attract and retain our staff. There is also room for improvement regarding gender representation and the inclusion of persons with disabilities in our operations and teams. There is a feeling that the power is in the hands of HQ and is not shared, with less attention given to national staff. MSF needs to come up with a clear implementation framework to improve inclusiveness in our operations. MSF clearly needs a diversity and inclusivity promotion strategy that is informed by an accessible discussion channel between national and local staff and HQ. Unbiased recruitment, the same expatriation policies for national staff as those moving to take positions in HQs, and MSF career development opportunities for national staff should be included in this strategy. *(KENYA)*

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Decision making is very top down and not well rooted in the field. We need to provide more opportunities for national staff to engage, and give more voice to beneficiaries. Our diversity should be reflected at management positions and national staff should have more access to coordination level positions. Discrimination can happen at different levels and to different groups of people, including national staff, based on gender or sexual orientation, or even our patients. One idea to start with could be to remove the use of "expats and locals" from our policies and procedures, forms, templates and websites and just use the terms national and international staff. *(LEBANON)*

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There should be equal opportunities for employment (more women, people with disabilities and minorities) and to get on the Board. Inclusion also means that stakeholders and beneficiaries should be involved in project planning and development of exit strategies. Operational Centers (OCs)must ensure that national staff have equal access to applying to become international staff, and that applications from the southern Africa region can be submitted directly to any OC. *(MALAWI)*

The issue of inclusion cannot be separated from either the MSF Charter and Principles, or the operations and contexts in which we operate. We are all actors of inclusion. The main concerns lay in the lack of general transparency towards the staff as well as inequalities of compensation and benefits, career development (training, carrier management), working conditions (especially security), access to information and participation in decision-making. We also want to involve more of our partners and actors of the civil society (heads of villages, local associations), in various forms of co-management, consultation and evaluation. *(MALI)*

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There should be more equity in the treatment between national and international staff and more management and higher responsibility positions accessible for national staff. Recurrent team-building initiatives would help enhance the relationships between staff members and trigger a respectful environment. *(NIGER)*

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A diverse workforce is more innovative, able to handle change and adapt more easily when required. Inclusion can help fight the misconceptions that populations might have about MSF being a European or religious organization. The community feels secure if they are involved with MSF. We should provide equal opportunity for all our workforce including women and national staff, for advancement, growth and development within MSF. *(NIGERIA)*

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Our recruitment policy should be designed to attract more female applicants through proactive

recruitments, facilitation for transportation and other measures like flexible working hours or childcare assistance. The scope of inclusion also integrates questions related to access to expatriation, power-sharing, remuneration and cultural diversity. National staff and non-European staff should be empowered, assume senior roles and be included in the decision-making process at all levels. *(PAKISTAN)*

There is a big gap between talking about this and actually making changes. The field should have more voices listened to and acted upon, not just being patted on the head and then disregarded. Depending on the decision, people should be consulted based on their jobs and not just their position. MSF is diverse, yet inclusion needs to happen. *(RUSSIA)*

✸ ✸ ✸

National staff at all levels feel excluded from decision-making and want to be part of the planning and decision-making processes. Decision making should be delegated to the field to promote a bottom-up approach. There is a need for more transparency, communication and information sharing with national staff. *(SOUTH SUDAN)*

✸ ✸ ✸

There is inadequate diversity and inclusion in terms of decision making, recruitment and trainings. There is not enough involvement of national staff in decision making processes. *(UGANDA)*

✸ ✸ ✸

There shall be equal opportunities to access management positions. *(CAMBODIA)*

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PARTNERSHIP, PARTNERSHIP, PARTNERSHIP

Should we rethink or reinvent the way we work with state authorities, especially the Ministry of health (MoH)? How can MSF better work with community-based stakeholders and root partnership within our modus operandi?

PARTNERSHIP AND COMMUNITIES

Local population, local organizations, migrant communities, refugees, grassroots organizations, volunteers and INGOs…The importance and necessity to interact, collaborate and partner with other communities is ever-growing for MSF, especially when we start operations, close activities or think about our exit strategy. We should create better networks, listen to local communities and integrate official partnerships in our strategies from the start. There is a need to develop a vision strategy on partnerships and networking as an integral embedded plan. *(GREECE)*

PARTNERSHIP AND CIVIL SOCIETY

Most of the time, partners have been present longer than MSF and can facilitate us access to certain populations. Whereas, training and capacity building brought by partnership is a valuable way to leave a long-term impact on the population and the level of care in the community, quality of care might not be met. Indirect care is an appropriate manner for MSF to operate. *(GEORGIA)*

✸ ✸ ✸

Should MSF review its modus operandi by moving towards partnership with local actors? There were many shifts in the strategy which led to confusion about our goals. It has been chosen to talk about the operational future of the mission, a subject that is frequently discussed at HQ level without the national staff. *(PAKISTAN)*

✸ ✸ ✸

Engaging with non-governmental actors and not exclusively with the authorities could be a way to fight TB in PNG. *(PAPUA NEW GUINEA)*

PARTNERSHIP AND STATE AUTHORITIES

What kind of collaboration do we want to adopt with state partners? Is our collaboration with the MoH necessary in all our types of actions? To ensure good collaboration with state partners and the MoH, MSF must involve state partners in the elaboration of projects, encourage reflection on the methods of disengagement of a project and discuss a reflection on the involvement of the MoH staff in the projects. *(CHAD)*

✸ ✸ ✸

The teams in Kenya questioned and looked back at the handover of Kibera as a case study. Should MSF only hand over projects to MoH or is it time to look for other reliable and long-term partners? Should we reduce our quality of care to be realistic in terms of what the government can provide? The 20-year project in Kibera which was handed over to the MoH last year showed the negative impact of the MSF's withdrawal in terms of access to care for the community. This was received as a wakeup call for all the sections on the pit falls of our current handover strategy. We need to focus on the role of MSF after handing over instead of just focusing on WHO we deliver the handover to. Once again, the handover strategy needs to be developed from the inception of the project, with the capacity of the MoH gradually built in. *(KENYA)*

ASSO CORNER

A GLANCE BACK AT THE FADS IN LIBERIA, MALI, CAR AND HAITI

Reinforcing operations with the association- *The teams discussed the associative model and it supports MSF's social mission the West and Central African (WaCA) region. Haiti discussed maintaining associative life especially after closing a project.*

A strong field associative life reinforces operations by enabling MSF to stay in contact with the community, raise awareness of MSF and attract human resources. A stronger collaboration of the associations of the region via the WaCA structure is an opportunity to mutualize experiences, create a platform of exchanges between countries and give more space and inclusion to civil society and beneficiaries in the decision making of MSF. Associative activities must be rooted in the civil society (state, local or medical academic institutions) and bring a sense of community (awareness, group activities).

FOCUS ON THE FADS IN KATIOLA, CÔTE D'IVOIRE

© MSF / Côte d'Ivoire

When field-associative debates are part of the dynamics of inclusion and diversity.

In Ivory Coast, debates took place around the theme of the civil society's place in MSF's social mission. Hundreds of participants gathered, including representatives of associative members from neighboring countries (Mali, Niger, CAR, DRC and Chad) as well as the civil society of Katiola. Short account of this inclusive story here...

A GLANCE BACK AT THE FADS IN KENYA

MSF in stable contexts- There is significant debate that MSF should move away from stable contexts to dedicate resources to emergencies and chronic conflict areas. Is this the more traditional MSF path or should MSF evolve across contexts? Is there a role for MSF's involvement in long-term projects (research, training and communication hub, established MSF regional health centers)? If so, should the stable missions only be in volatile regions where regional support can be anchored, or what can be our expanded role in quieter regions?

The Kenyan mission is in a unique position to see the benefits of a mission in a stable context. The stable country lies adjacent to conflict zones and serves as a platform to support the challenging contexts of Somalia and South Sudan with supply, HR support and as a host for displaced populations. In this case, as there seems to be little chance of improvement in the chronic conflicts of the neighboring countries, Kenya is ideally located to continue to play a pivotal role.

On a broader scope, as populations and urbanization continue to rise unabated, there are heavy burdens placed on many developing countries around the world and MSF should have a role to play in assisting populations under pressure. The high quality of people and targeted resources that MSF can bring to the table, plus the innovative programming focusing on underserved groups shows the great potential MSF has.

MSF, traditionally an emergency intervention oriented organization, needs to clarify its overall strategy the rationale for having projects in stable contexts. Then, when planning to open projects in these contexts, all phases of the project management cycle can be followed, from inception to exit strategy. Are we still a solely emergency oriented organization or have we already incorporated developmental aspects? ■

© Bryan Jaybee/Kenya

ASSO CORNER

THE MIGRATION CRISIS AND MSF'S RESPONSE

The debates in Greece emphasized the need for a coordinated approach on communication and advocacy on migration, whereas the discussions in France focused on the operational side—should we do more and expand our activities?

France: In 2015, with the migration crisis, MSF made the decision to restart activities with new objectives, and a common desire—to perpetuate MSF's operational footprint on migration issues in France.

Should MSF be more operational on migration, especially in Europe? To what extent and for what reasons?

Migration is a social issue, which will continue for a long time, so we must build links with other actors in Paris, Europe and also Libya. We note that MSF isbeing perceived as disruptive and should be more militant, better committed and position ourselves politically at the European level. We need to communicate better and more consistently with other actors and the general public. There are no MSF migration coordination projects in Europe. But there is a willingness to exchange information and work together at the borders and facilitate the exchange of information and alignment in Europe. Coordination is needed all over France and the rest of Europe and surrounding countries. A transversal project is a novelty for MSF and everything must be put in place. We must remain active throughout France and must denounce both the French and international stances on limiting migrants. MSF has made great efforts to create links with other associations and state institutions—it is essential to continue. It is necessary to collect information and consolidated data that can build advocacy on health issues and access to the law. There is a real challenge with health care: many migrants have experienced hyper violent journeys. 70% of migrants have psychological care needs and 20% have posttraumatic stress and psychological disorders. These are problems that can potentially create future generations of precariousness.

© Maud Veith

How does MSF stand out publicly between activist groups and authorities? Is it the role of MSF to mediate, be an ombudsman? Should we denounce the authorities at any cost? Should we collaborate with the authorities?

We prefer to talk about commitment rather than activism because the connotation is more sustainable. MSF prioritizes advocacy over mediation and aims to create links rather than collaboration. It is necessary to promote public awareness to change the image of migrants and denounce the situation, by associating with actors on the ground who are more experienced on the subject. We do not want to substitute common law, but emphasize the fact that authorities and governments must assume their responsibilities (like in the situation of unaccompanied minors). ■

GREECE

© Mohammad Ghannam/MSF

Since 2015, the context in which MSF is operating in Greece has been characterized by an aggressive communication agenda adopted by the EU that criminalizes migration.

It has proven very difficult for an emergency actor such as MSF to operate and speak out in this environment where there is a high control of both populations and borders. What are the recommendations to move forward with a stronger and more coherent operational and advocacy approach on migration in Greece and globally?

Our objectives on migration should be more specific and create a long-term and coordinated communications and advocacy strategy between the different OCs. Advocacy should start in the field and move forward to national and international level, through a global MSF approach and strategy on migration. There is a need for guidelines on the process of advocacy and with regards to how to measure its outcomes and effectiveness.

FADS AT THE OFFICE, MSF FRANCE WONDERS: "ARE WE STILL AN ASSOCIATION?"

At the initiative of the head office employees in Paris, FADs were organized for the first time this year in rue Saint Sabin. A non-exclusive list of topics for discussion had previously been voted upon. The theme with the most votes was "Are we still an association?" It gave rise to an afternoon of discussion and exchanges structured around four questions.

What does the MSF association mean to you?

Among the sixty or so participants, the notion of commitment often came up as one of the answers to this question. Two ideas were regularly expressed here to define the association: the idea of a group of people united around jointly defined actions, and the idea of a group of people united around common values. What the word "value" contains, however, varied among participants: is it principles, is it a shared appropriation of MSF's history, or is it an ethical issue? The question remains open and the concepts of free expression and participation in decision-making are among the central elements of the associative dimension.

Was the asso better before?

Some disqualified or redefined the question: "No, we weren't there!" or "Isn't it always better before?" were remarks heard in the discussions. Opinions were sometimes less clear-cut: if the commitment remains, if the voting right for office staff now exists, if the quality of care and the number of projects have improved, if the size of the association and the distance it imposes between people are regularly pointed out. Professionalization can also be perceived as an obstacle to the associative spirit, especially when it models our functioning as a business type and favors specific competence and hierarchy over versatility and autonomy. The risk of disconnection with the field also exists, said participants who pointed to a "loss of common vision", perhaps to be linked with a "fragmented work environment.".

MSF defines itself as an organization that leaves room for debate and criticism: is this a reality?

Yes, but" the participants seemed to answer: certainly, the culture of debate and criticism are part of our identity and sometimes even nourish a certain feeling of pride, but if communication gaps exist, they are apparently not always addressed. Many FADs participants do not dare to express themselves, do not feel legitimate, doubt that their views are considered, or feel that only a certain "thinking elite" has the right to speak. The freedom to say what one thinks and the culture of debate come up against a form of self-censorship, a search for consensus and a hierarchy strongly felt by some. Fear of being judged was also mentioned by participants.

What can we do at headquarters level to make the association live?

This fourth and final question sought to formulate a number of recommendations and proposals. At the end of these first FADs, several ideas were put forward to strengthen links at several levels (headquarters/field; international staff/headquarters employees; new/old, sponsorship, etc.) but also to stimulate criticism and to take or retake ownership of MSF, notably through the spaces for debate that exist or remain to be invented. From the boldest suggestions (the creation of an associative radio station) to proposals that could be implemented in the short term (being able to influence each month the choice of one of the topics discussed at the Board meeting, for example), about ten participants in these first FADs volunteered to synthesize and present these recommendations. ■

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WaCA: They did it!

April 28, 2018 - Second high point in the construction of a West and Central Africa association. About 40 people from different MSF sections met to lay the foundations for the construction of WaCA. An interim Board of Directors was elected to further develop the project and a declaration was drafted to set the course.

Background and Rational

- Since 2007, there have been initiatives, one after another, encouraging the creation of an association in West and Central Africa At the same time calls, papers and motions around the Movement have been requesting[1] the emergence of new organizational models that are more centered on the field and less Eurocentric.
- In 2017, the WaCA initiative was launched during the first General Assembly in Grand Bassam, Côte d'Ivoire, with the ambition to begin an "*association to act*".
- MSF's operations in West and Central Africa are numerous and varied; regional support is developing; today the ambition is to connect these operations to an associative dimension. Executives present in the region with many operational responsibilities will become pillars of this initiative.
- On April 28, 2018, at the second General Assembly in Dakar, Senegal, this ambition was ratified by the members of WaCA during the election of the provisional Board of Administrators. We subscribe to the MSF Charter, the Chantilly and La Mancha agreements, as well as the international by-laws and regulations of the association.

WaCA's Ambitions

- Become an MSF association with an operational directorship, part of the Movement, and in partnership with other partners of MSF (OCs, partner sections).
- Build a model that serves patients, an alternative to existing ones: multicentered, with a strong network, and working beyond national interests.
- Bring an autonomous regional dynamic designed for international operational response.
- Anchor MSF's action in regional civil society by mobilizing resources and local expertise: academics, research, medical skills, etc.

WaCA's Timeline

- As part of the three-party and non-exclusive engagement between MSF OCP, MSF OCG and WaCA, we plan the following:
- Declaration of Intent for the 2018 IGA
- License agreement for an operational directorate for the 2019 IGA
- Participation in the cycle of the 2020 synchronized strategic plan

1. [1] Référence: motions AG, AGI, Grand Bassam, OCG Congress, GC OCP

ASSO CORNER

HERE IS MSF JAPAN NEW BOARD OF DIRECTORS

MSF Japan's General Assembly was held on March 24 & 25, 2018. This year, discussions focused on termination of pregnancy and vulnerable groups. New faces of the Board were elected, see the new composition below.

1.

DR HIROYUKI KATO
Pediatrician,
President (2018-2019)

2.

DR. TAKASHI KURUMIYA
General Surgeon,
Vice-President (2017-2018)

3.

DR. MIYUKI YOSHINO
General Surgeon,
Vice-president
(2017-2018)

4.

DR. YUKO NAKAJIMA
Anesthesist MD,
Secretary (2017-2018)

5.

HIDEKI SOEJIMA
Business Consultant,
Treasurer (2017-2018)

6.

DR NOBUKO KUROSAKI
General Surgeon
(2017-2018)

7.

JEAN FABRICE PIETRI
Head of Mission
(2017-2018)

8.

MOTOI SUZUKI
Physician, Epidemiologist
(2017-2018)

9.

TOMOAKI TAOKA
Nurse
(2018-2019)

10.

RICHARD SEBEL
Human Ressources
Consultant
(2017-2018)

11.

DR. SEUHEE YOO
Medical Doctor
(2018-2019)

12.

GILLES DELMAS
Epidemiologist,
Nurse and Logistician
Controller (2017-2018)

ASSO CORNER

AND HERE IS THE NEW BOARD OF MSF-USA

The MSF-USA General Assembly was held on May 17, 18 & 19. The situation of the Rohingya refugees was debated in particular. Abuse and harassment as well as the evolution and growth of the MSF movement was also discussed during the debates. The motion on voting right for office staff was approved. At the end of this General Assembly, the MSF USA Board of Directors was renewed.

Meet the new Board.

1.

JOHN LAWRENCE
President (2017-2020)
Surgeon

2.

KASSIA ECHAVARRI-QUEEN re-elected
Vice-President (2018-2021)
Head of mission

3.

JOHN WETHERINGTON
Appointed in 2017
Treasurer

4.

ALISON LUDWIG
Secretary a.i.
(2016-2019)
Medical Doctor

5.

AERLYN PFEIL
(2016-2019)
Midwife

6.

AFRICA STEWART
re-elected
(2018-2021)
Obgyn

7.

ALI N'SIMBO
(2016-2019)
Medical Doctor

8.

ANDRE HELLER elected
(2018-2021)
MSF UK Programme Manager

9.

BRIGG REILLEY
(2017-2020)
Epidemiologist

10.

MEGO TERZIAN
MSF France President
Paediatrician

11.

PATRICIA CARRICK
(2017-2020)
Nurse

12.

PHIL SACKS
(2016-2019)
Logistician

THEY ARE CANDIDATES FOR THE MSF AUSTRALIA BOARD OF DIRECTORS!

The MSF Australia association recently met and held their Annual General Meeting on May 26 and 27, 2018. Our operations in Bangladesh and CAR were discussed. The results of the election are available on The Portal.

This year there were 4 vacant seats for the Board of Directors. Elected Board members are nominated for three-year terms and, therefore, this year two Board members, Dwin Tucker (Treasurer) and Matthew Reid (IGA representative), came to the end of their term. As well Philip Humphris resigned from his position at the AGM, after almost three years on the Board. The position held by Patricia Schwerdtle, as a casual appointee to the Board was vacated. Dwin Tucker stood for re-election and Patricia Schwerdtle stood for election.

1.

EMMANUEL LAVIEUVILLE
Operations Support Services Manager

2.

BRONWYN LOCKE
Nurse, midwife

3.

DONALD MCCALLUM
Development Manager

4.

AMY ALEISHA NEILSON
Medical Practitioner

5.

PATRICIA NAYNA SCHWERDTLE
Nurse, midwife

6.

DWIN TUCKER
Financial director

7.

LUIS VILLA
Research & Evaluation Manager

8.

CHATU YAPA
Medical Epidemiologist

Freedom for Mukanos!

It will soon be five years since Philippe, Richard and Romy were abducted by the ADF in Kamango in North Kivu province. Mukanos, a former member of the crisis cell set up in DRC to find our colleagues, has been wrongly accused of collaborating with the ADF and Mai-Mai. At the end of September 2017, despite a very weak prosecution case, the operational military court in North Kivu sentenced him to 10 years in prison with a minimum term of two years. We are doing our utmost to secure his release and support him during his time in prison.

Mukanos is being held in a hut put up just for him in the military justice compound in Beni. He is allowed regular visits from his relatives and recently he has been authorised to spend two nights a week in his home. We not only hope to be able to negotiate a remission of his sentence in the coming weeks but also that our plea for a presidential pardon will be successful and Mukanos will be among the prisoners to be granted an amnesty when the country celebrates its independence on 30 June. We have also requested a meeting with President Kabila in July.

After Mukanos' arrest, the crisis cell suspended its search but is still monitoring the situation. We continue to support the families of our colleagues abducted in Kamango on 11 July 2013.

Please leave a message on The Portal for Mukanos as well as Philippe, Richard and Romy.

IN MEMORIAM

CHRISTIANE TOMASZEK

We regret to announce the death of Christiane Tomaszek.

Born in 1947 and engaged with MSF since 1979, Christiane passed away on April 18, 2018.

As a nurse and association member, she carried out many field missions, from Armenia to Yemen via Liberia, Haiti, Chad, Nigeria or Jordan, Palestine, Pakistan and more recently the Philippines. Her dynamism and commitment remain in memory of those who have crossed his path.

From her experience, she published a book called *Emergency missions, 25 years of humanitarian experience*, in which she looks back on her extraordinary journey alongside her husband Michel, between Africa, Asia, the Caucasus and the Middle East.

Her funeral will take place on April 25, 2018 in Saint Martin de Bellevue, near Annecy.
Our thoughts are with our colleague Michel and with Christiane's family.

BRUNO GERBAUD

We are extremely sad to inform you of the death of our surgeon colleague and friend Bruno Gerbaud.

Bruno started with MSF in 1989. Aside from his professional activities, he shared with us his skills and know-how in Romania, Sri Lanka and Burundi.

Always very committed to fulfill work and sharing of best practices within MSF projects, he kept on leaving on missions after he retired; as it happened in Yemen and in CAR, only a few months ago.

We will remember his constant enthusiasm.

All our thoughts are for Bruno's family.

NADIA AÏD

We are extremely sad to hear the sudden death of Nadia Aïd. Nadia passed away on November 20th, 2017 at her home in Nice.

Nadia joined MSF in 2001 and worked at our reception for many years before joining the operations team as the assistant of this department. She was very fond of this ope team.

Nadia was also involved in helping the Afghan refugees located mostly close to the canal St Martin between 2008 and 2011. She left MSF, following some health issues, and moved to Nice. Since her departure, she was regularly asking news of the operations and the movements within our big house. Nadia had not forgotten us and really loved us.

Nadia was very appreciated by her colleagues. Her serenity, kindness and constant great mood will always be remembered. We are going to miss Nadia. Our thoughts and deepest sympathy are with her family, her partner Alexandre, her son Anys and all her friends.

Nadia wished to be buried in Algeria.

IN MEMORIAM

DR. MUSA HAMDAN

We are saddened by the death of Dr. Musa Hamdan after long and courageous fight against a long illness. Musa passed away peacefully in Berlin, surrounded by his family and close friends.

We are saddened by the death of Dr. Musa Hamdan after long and courageous fight against a long illness. Musa passed away peacefully in Berlin, surrounded by his family and close friends.

Dr. Musa joined MSF in Sudan in 2005 and worked as TB/HIV doctor in Upper Nile, South Sudan. In 2006 he joined OCP and worked in Bentiu, South Sudan as Medical Referent for the TB/HIV project. In 2007 he worked as emergency coordinator covering Darfur, Southern and Eastern Sudan. Between 2008 and 2012, Dr. Musa worked as medical Coordinator in Yemen and Malawi, and medical Referent Doctor in Bocaranga in Northern Central African Republic. In October 2012 until his passing, Musa worked as Health Adviser for OCA in Amsterdam and then in Berlin.

In addition to his professional career with MSF which expands over 12 years of continuous work, Dr. Musa was a furious activist and advocate of democracy and equality back home in Sudan and he played instrumental roles in the students and doctors movements in the mid nineties and 2000s.

This news has sent waves of shock and sadness among his friends and colleagues.

His wife, Christina and his two daughters Amina and Nura will accompany him for his last journey to Sudan. You can send them your condolence messages at tinajung@gmx.de. You are also very welcomed to share a personal word of sympathy with his family under: remembrance@berlin.msf.org

HARMONY MARKA TORMUSA

He had worked in Nigeria as a Supply Manager.

We learned the sudden death of Harmony Marka Tormusa, who worked in Nigeria as a Supply Manager with OCP from February 2016 to February 2017. He returned to Nigeria with Alima until June of this year and also did a mission with OCBA in 2010 in South Sudan. Harmony has died of an illness at home in the United States.

He was very appreciated by his colleagues and his smile will be remembered for a long time. Our thoughts are with his family, especially his wife and daughter.

ISHAKU ALHASSAN BWALA

We are saddened by the loss of our colleague Ishaku Alhassan Bwala.
He was the supervisor nurse in Bollori, Nigeria, on “Maiduguri” Project.
He died as a result of a sudden worsening of a chronic disease last October 17 early in the morning.

Our thoughts go to his family and his relatives. We express them our deepest condolences.

COME MIHIGO

Stretcher-bearer at Rutshuru General Hospital, he passed away on October 21st, 2017 following a shooting on the road from Goma to Rutshuru.

It is with deep sadness and consternation that we inform you that our dear colleague Come Mihigo, stretcher-bearer at Rutshuru General Hospital, has passed away on October 31st, 2017 following a shooting on the road from Goma to Rutshuru, in which armed attackers were unidentified. He has been burried on November 1st, 2017.

Come joined MSF in May 2009. He was married and a father of 9 children. The team remembers his dedication, his great wisdom and his calm.

Our deepest condolences go to his family and to the MSF family in DRC.

DR. MAX D'AURIOL

Dr. Max d'Auriol left us abruptly on Sept. 20, 2017, early in the morning, at St Louis Hospital, where he was followed regularly.

As a doctor, he worked several times with MSF in the early 1980s in complex missions such as Somalia and Afghanistan, and in the 1990s in major crises like Turkey (Kurdish refugees) and in Goma, DRC (refugees from Rwanda, cholera, 1994).

Max was also a member of the Board of Directors of MSF France in the late 1980s and early 1990s.

He also coordinated missions for the ICRC (Chad, Ethiopia).

Back in France, he settled down as a general practitioner. Passionate about his profession, he has always been of great availability listening to his patients with sincerity. His concern was to practice quality clinical medicine. In this sense, he rendered so many services with great humanity.

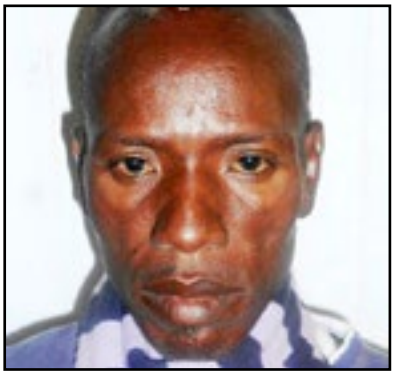
All these years he listened to the crises that are shaking our planet. He insisted on writing in a book the account of his humanitarian missions with populations that profoundly marked him.

We think of his family, his wife, France, and his 2 children, Pierre and Louise, his 3 brothers and his mother, and all his family and friends.

The ceremony will take place on September 26 at 10:30 am at Eglise Ste Clothilde, Paris 7è, Metro Solferino

You can send your condolences to his wife France d'Auriol fdauriol@noos.fr

IN MEMORIAM



KOULSI WONGTOLOUM

He was a driver in Moissala, Chad.

As MSF staff and members of the MSF Association in Moissala, Chad, we are sad to inform you that that Koulsi Wongtoloum, our colleague and fellow associative member passed away.

Koulsi was born in Moissala, Chad, on January 1st, 1977 and he was working with MSF as a driver since May 6th, 2013. He officially became a member of the Association on December 18th, 2015.

His beloved ones had given him the nickname "*Supporte*". he is remembered as a kind, smiling and devoted person. He will be sorely missed by all those who have known him.

Koulsi was already suffering since a few years, but his health deteriorated in recent months. Concerned about the evolution of his health, he was transfered from SARH Hospital to the Central Hospital of Ndjamena on July 28th, 2017 at the request of MSF. He passed away on Saturday, July 29th, 2017 around 11am. The funeral took place on Tuesday, August 1st, 2017 in Moissala.

He leaves behind him a widow and an orphan. Our most sincere condolences to his family and loved ones.

May he rest in peace.

DR PHILIPPE LE GALL

We are saddened to share the news of the loss of Philippe Le Gall, on July 19th, 2017, aged 65.

Since 1999; Philippe had taken part in several missions, including Armenia, Afghanistan, Iran, Ethiopia and Invory Coast.
Our thoughts are with his family and loved ones.

JEAN HERVÉ GUÉDÉ

We are shocked and saddened by the loss of Jean Hervé Guédé who passed away on July 10, 2017. Our thoughts are with his family and beloved ones.

We have learned yesterday, Monday, July 10, 2017, the sad news of the loss of our colleague, Jean Hervé Guédé, who worked as radio operator for Médecins Sans Frontières France in Katiola, Côte d'Ivoire.

Guédé worked with MSF France from 2014 until the day he sadly left us. He was a pillar of the association in Ivory Coast, deeply committed, always available and well-liked. He was also the key person in the organization of 2015, 2016 and 2017 FAD.

The death of Guédé is a great loss for the assocition in Ivory Coast and particularly Katiola. Associative members in Katiola remain speechless.

Our fraternal thoughts go to his family and beloved ones, and also to the teams in Ivory Coast.

MSF Côte d'Ivoire

ALAIN LAGOUADE

The MSF France Central African Republic team and in particular its logistic department has the deep pain of announcing the death of one of its family, Alain Lagouade. He was a guard for MSF France in Bangui since June 1st 2006 and was 56 years old.

He was a courageous man who worked to help humanitarian action in the Central African Republic. He left us on May 3, 2018 following a long illness, leaving behind six children and a widow, to whom all our thoughts go.

FRANÇOISE COURTEVILLE

We were informed about the death of our colleague Françoise.

Françoise retired from Epicentre in September 2016 after a long and fruitful career. She joined Epicentre in 2001. We have all had the occasion, at one time or another, working, discussing, listening and being heard by Francoise.

She was always available for whatever happened, whomever was arriving or leaving, in Paris, in Niger, in Uganda, for our meetings and CAs. She will be missed and not forgotten.

KARINE PETIT

It is with great sadness that we learned of the death of Karine Petit following an illness that quickly and sadly took place in the beautiful age of life.

Karine was part of the MSF family from 1992 to 2003. She was in charge of the legacies at the Fundraising Department.

All those who knew her remember a smiling, sweet and involved woman.

After leaving MSF, she had retired in La Manche with her husband.

We join in the grief of her husband Philippe, her parents, her brother and her friends.

FIELD VACANCIES

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