



# OPERATIONAL PROSPECTS

## OCB 2020-2023





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# INTRODUCTION

**The Operational Prospects provides a strategic framework for the global operational priorities for OCB for the period 2020 to 2023. This document should guide field teams to propose strategies and action plans, based on their analysis of the needs and demands of the populations served. Setting priorities for four years will allow OCB to plan and allocate resources for the most appropriate support to operations. This document aims to support the missions and project teams, rooted in their environment, to set their objectives and prioritise their activities accordingly.**

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These Prospects are the result of a wide and inclusive consultation inside OCB. This process started in early 2019 and resulted in a series of strategic papers which formed the basis of discussions with the heads of mission and medical coordinators at the co-days 2019. This document reflects the outcome of these consultations.

The Operational Prospects are also part of the broader 'OCB strategic orientations 2020-2023' and should be read in this overall frame. The OCB strategic orientations are synchronised with the strategic plans of all MSF Operational Centres, which will allow the wider MSF movement to plan and prioritize on a global level according to each OC's strategic choices.

These Prospects are based on the analysis of our existing operational portfolio in 2018/2019, presented during the 2019 Co-days in Brussels<sup>1</sup>.

OCB will organise a midterm review of these Prospects in 2021 to allow for adaptations reflecting any changes in priorities of MSF and OCB based on an updated analysis at that time.

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<sup>1</sup> OPS Portfolio Analysis – OCB (06.2019) on MSF OCB Strategic Orientations 2020-2023 Sharepoint: <http://bit.ly/2PlgJti>

# MAIN TRENDS

**The medical and humanitarian activities described in this document are broad on purpose, to allow the OCB missions and project teams to propose activities according to what their environment needs. However, which proposals will become projects will depend on the available resources for OCB and the wider MSF movement.**

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Also, to maintain a diverse and rich portfolio for OCB, we will continuously monitor for duplications as well as areas of neglect and provide the missions and field teams with regular recommendations on preferred options and current priorities.

The table below describes the main trends for 2020 which formed the basis of these Prospects. This table will be regularly updated and shared. The focus is on continuing what we already do with more quality and more comprehensiveness and not so much in opening new fronts.

TOPIC	TRENDS	STRATEGIC DIRECTIONS
Epidemics	↗	Reactive & innovative; VHF, regular & re-emerging outbreaks
Conflict & violence	↗	Direct & indirect victims; urban & forgotten conflicts; post-violence care
Trauma	↗	Timely; CoC; multi-disciplinary; +/- burns
SRH & Women's Health	↗	Scale up SAC & TOP; Family planning; comprehensive SGBV; STI; Cervical Cancer
SRH	↗	BEMONC & CEMONC
Child health	↗	CHP; Missed opportunities; NCD; IPD; eCARE, Adolescents
HIV low prevalence/coverage	↗	Vertical / Integrated; conflict; advocacy
Tuberculosis	↗	Opt out for TB; DRTB: vulnerable population, Integration, Impact transmission
Continuum of Care (CoC)	↗	PHC including community; quality, up & down referrals to /from hospitals
Clinical Care	↗	Multidisciplinary; patient-centred; quality; MSF Academy; eCARE-POCUS
Antibiotic Resistance	↗	Prioritise basic package; selected sites with full package
NCD (integrated)	↗	IPD, HIV& TB, paediatrics, migrants, insulin advocacy
Environmental health	↗	Adapting to new challenges; innovative catalytic projects; OCB's footprint
VOT	•	Migration & detention but also integrated in other projects
Migration	•	Vertical and integrated; vulnerable groups
Detention	•	Linked to migration, TB
HIV high prevalence/coverage	↘	AIDS; MoC, neglected population; advocacy
Hepatitis	↘	1 vertical; integrate; HBV screening among PLHIV
NCD (vertical)	↘	Landing towards 1 vertical project; MoC; advocacy
Cancer treatment	↘	No involvement, except for cervical cancer, Burkitt Lymphoma and Kaposi Sarcoma

Legend: ↗: Active Investment; •: Maintain same level of investment; ↘: decreasing investment



Patient Information	
Name	
Age	
Sex	
Address	
Phone	
Medical History	
Current symptoms	
Duration of symptoms	
Previous treatments	
Family history	
Other relevant information	





# TOP 10 STRATEGIC ORIENTATIONS 2020-2023

To frame the rationale of our choices and priorities, we have defined 10 key strategic orientations for the period 2020 -2023. These describe not only *who* we focus on (1 & 2), but also *what* we plan to do (3, 4 & 5) and *how* we will create the capacity enable that (6 to 10).

## 1. MEDICAL - HUMANITARIAN IDENTITY

As a humanitarian organisation, OCB is led by its humanitarian principles placing the human being at the centre and responding to medical and humanitarian needs and demands through the provision of medical humanitarian aid and témoignage.

As a medical organisation, health care is our focus of intervention and we choose to develop medical programmes with respect for human dignity and in solidarity with neglected populations. We are a primarily a hands-on organization, working in direct proximity with the communities and patients we assist. Clinical care should be comprehensive, ranging from preventive to palliative and inclusive of social and environmental health. Our projects should be holistic, relevant to the patient's needs, the local health context and aligned with our medical and operational capacities. OCB will place renewed emphasis on the health impact of our response and the quality of clinical care (QoC).

Priority will be given to those interventions in settings with excess morbidity and mortality and acute suffering. Recognizing MSF's history and charter, responding to medical and humanitarian needs in situations of conflict, natural & man-made disaster, epidemics and displacement should remain the priority for the OCB portfolio, as vulnerability and

exclusion are likely to increase in these periods of disruption.

Due to the additional investment (networking, HR, logistics) needed for working in conflict settings, we will continue to maintain and improve our capacity to respond on key health issues in such contexts. This focus however is not exclusive but is weighted, considering the needs, the presence or absence of other relevant actors, and the potential impact of MSF's action.

Wherever needs exist that MSF is unable have an impact, due either to our failure to negotiate humanitarian access, or lack of capacity or expertise, OCB will seek to obtain these capacities and/or to collaborate with others to do so rather than abandon such contexts.

## 2. FOCUS ON VULNERABILITY AND NEGLECT

As a medical humanitarian organisation, OCB will focus on populations in situations of need, which are triggered by disruptions of their fragile environments and their usual coping mechanisms, such as conflicts, epidemics, natural disasters, exclusion, economic crisis and other disruptive situations.



In conflict settings, health care provision is disrupted or destroyed. Overall vulnerability and exclusion are often massively exacerbated in such contexts. The direct effects of conflict and violence are compounded by indirect effects on health, such as lack of health care due to a collapsed health system. Mortality and morbidity in the post-conflict period also remains high due to precarity of the situation and gaps in damaged health care systems. These are also important settings where OCB will act.

Victims of violence, including victims of Sexual and Gender Based Violence (SGBV) and Victims of Torture (VoT) have limited access to care, and caregivers that are usually not well trained to respond.

Women increasingly face obstacles to family planning and Termination of Pregnancy (TOP) services. This is even exacerbated for young and unmarried women.

Population growth, climate change and poverty often lead to unstable and precarious living conditions and may result in more displacement and greater vulnerability.

Other excluded populations will remain particularly vulnerable and suffer disproportionately in situations of crisis. Sex workers, Men having Sex with Men (MSM), Intra-Venous (IV) drug users, migrants

and prisoners are often out of reach from health and protection services. We will also be attentive to increased vulnerability of specific demographics, such as the elderly, children and adolescents, ethnic minorities, rural populations, patients suffering from neglected tropical diseases and victims of political exclusion.

Growing urbanisation comes with specific vulnerabilities causing increased numbers of people being more disease-prone. Under-resourced health systems don't manage to keep up with health needs of increasing urban population numbers, leading to more and deeper gaps in health care.

International Funding Institutions (such as World Bank) are withdrawing their support to health. Their policies and resource allocation decisions are dominated by macro-economic considerations, a tendency towards privatisation and prioritisation of return on investments, privileging funds for states and systems with disregard for the human factor and quality of care state donors of international health aid increasingly base their funding decisions on their internal agenda such as deterring migration and domestic health security. Health needs that do not fit these criteria are considered a domestic responsibility, only to be addressed if the country or the patient can afford it. Consequently, gaps in the health response are growing. Several countries have

resumed or increase patient fees, straining or excluding those who can't afford it, and without improved quality of care. This results in an increased exclusion of a large chunk of populations from access to healthcare.

### 3. THE PATIENT AT THE CENTRE

Vulnerable and neglected people and their health needs are at the centre of the action. Proximity to these people is essential. We need to engage, involve and root with our patients, their communities and civil society in our projects to ensure the relevance of our actions and enable accountability to our patients and their communities.

We need to know to establish shared goals:

- What is important to our patients, to identify patient's health needs and priorities.
- What is important to the communities we assist?
- How do they experience MSF's action?
- What would I need and demand, if I would be this patient?

This requires us to listen to and act on feedback and needs. We should provide patients with the opportunity to understand and influence our key decisions by providing them information that is necessary for them to take the appropriate decisions about their own health. This requires an open mind and a collaborative approach between the clinical team and the patient. Patients should not be seen solely as passive beneficiaries of care, but also as active participants in their own health care.

### 4. CONTINUUM OF CARE BETWEEN COMMUNITY, PRIMARY HEALTH AND HOSPITAL

Continuum of Care (CoC) starts with primary health care (PHC) within the community, with health promotion, patient & community empowerment and community-based case prevention and management. CoC continues with prevention activities and case management at PHC facilities, with referral and counter-referral to and from a referral hospital, where quality in-patient care and post-hospitalization management is provided.

Accessible PHC, with proper investment to ensure quality, equity and access to the most vulnerable and/or excluded, will not only have a high impact on mortality, but also helps referral hospitals to assure entry points for those most in need and hospital projects to maintain a reasonable size and complexity.

The strategic and tactical decision at which level(s) a project should intervene, depends on the defined goals and objectives of a project aims at. Based on these, one should determine along the CoC chain which action is needed when and how.

### 5. TÉMOIGNAGE AND SPEAKING OUT: LINKED TO OUR MEDICAL ACTION

Our direct medical action, together with 'témoignage' based on what we witness in our operations, should remain at the core of our identity. This will require OCB developing strong private and public positions on the human suffering we face on the field, and global topics such as the criminalisation of aid, the global health security agenda, privatisation of health care and other trends that currently shape the aid environment and lead to inappropriate or substandard medical practices & policies which do not consider the impact on the patients' lives.

MSF will also bring evidence from new diagnostic or treatment strategies, tools and evidence of the impact of (increased) quality medical care on patient's health outcomes. This implies also strengthening our knowledge of cross-cutting issues of health systems, such as health financing, health workforce and medical supply chains. MSF's patient-centred focus can bring important evidence which may help developing an advocacy agenda on top of our operational ambitions (catalytic dimension) to address the negative impact of ill-designed (or resourced) health systems.

MSF rarely invests in clinical trials, description of routine activities and operational research usually feeds our evidence and shares it through external evaluations, publications, workshops, toolkits and other reports. Operational research should always be integrated in projects targeting directly beneficiaries. Research objectives should be carefully balanced with direct operational ones.

Giving a voice to our patients will remain central in our message.

### 6. HAVE A MANAGED PORTFOLIO DIVERSITY

OCB aims to play a critical role in addressing a diversity of medical needs, bringing evidence and speaking out where and when needed. Our diverse portfolio of operations will remain responsive to the medical consequences of emergencies and heavy burdens of diseases anywhere in the world.



Our actions will involve a variety of interventions, from response to the main infectious diseases, disease-specific care such as for HIV/TB, trauma care in hospitals, sexual, reproductive, environmental and mental health and women's and child health care. This diversity will also be found in the strategies we design to address these needs in a most adapted and contextualized manner.

### 7. THINK GLOBAL, ACT LOCAL: FIELD RECENTRALISATION AND REGIONAL HUBS

The **Field Recentralisation** programme aims to put decision-making as close as possible to the medical-humanitarian act and to the people in need. This will be achieved by increasing the autonomy of the field teams and ensuring accessible knowledge and adapted support.

Key to the provision of adapted support will be the decision to have OCB's coordination & other support teams improve their mentoring skills, to allow field staff to learn by doing and designing approaches adapted to the reality they face. This will be augmented by enabling peer-to-peer support and the creation of communities of practice.

Moreover, we will develop '**Operational Support Hubs**' rooted in sections and branch offices located in proximity to our operations and closer to our patients. These support hubs will build on their regional expertise and proximity to partners, to optimally contextualise and customise our response. However, these hubs should also be able to serve outside of their regions for more global support not only to OCB but also other MSF Operational Centres: in the true sense of 'sans frontiérisme' and with the objectives to learn from what is done elsewhere.

### 8. GETTING THE RIGHT STAFF IN THE RIGHT PLACE, TIME AND ROLE

We reconfirm in our operational frame the OCB management values: respect, transparency, accountability, integrity, trust and empowerment<sup>2</sup>.

The 'global diverse workforce' needs to become a reality through an HR approach where we take the labels of national, international and HQ staff away and prioritize deployment according to project needs in terms of competencies and not according to these classifications. However, to keep our 'sans frontiérisme' alive and where technical expertise,

<sup>2</sup> MSF OCB Management Values: A framework for our daily interactions (07.08.2017) on MSF OCB OOPS: <http://bit.ly/32dVWjG>

management capacity, context security or other requirements are relevant, we will continue to need both mobile and more office and mission-based employees to ensure a mixed and complementary workforce. An optimal balance needs to be found between national and international staff, to safeguard our impartiality, enrich expertise, analysis, debate and ultimately decision making.

We will continue to ensure that all staff is competent, professional and autonomous in their role through adapted professional development. Mentoring, training and coaching are necessary to overcome the challenges of working in harsh environments. This objective will be supported by the OCB.

The Learning & Development unit and the 'MSF Academy for Healthcare' focus on quality professional development of health care workers. Training MSF staff is the main objective for the MSF Academy, but we will also create training and exchange opportunities in our projects for staff of our partners such as Health Ministries in solidarity with our medical colleagues of countries or regions where quality of healthcare is most neglected.

## 9. BE A RISK-TAKING ORGANISATION

Due to the explicit choice of OCB to intervene in conflict and war-torn areas, the provision of humanitarian aid will often entail a variety of physical and mental risks to our staff and a risk to the institution. These factors, among others, define OCB by choice as a risk-taking organization.

One of the principles of our security policy is negotiated acceptance of MSF, which is achieved by reaching explicit agreement with governments and non-government groups that have the capacity to block access to population and to harm MSF's patients, staff and assets. We want to negotiate our access to the beneficiaries with tact. We want to expand our networks, deepen our analysis and improve our ability to navigate complex political environments by keeping our neutrality and impartiality central<sup>3</sup>.

## 10. ACT RESPONSIBLE AND ACCOUNTABLE

OCB will strive for outward accountability at all levels, starting with accountable towards our patients and the communities with whom we work and extending to the rest of the movement and the donors who make our actions possible. Our accountability will necessarily take many forms, from being transparent with information to engagement and participation in the field with other partners. Being able to account for our actions should not be limited to communicating on our achievements but also on our challenges and setbacks. This requires two-way communication, a dialogue, with our beneficiaries about our decisions and choices, the result of our actions, resources spent, successes, failures and challenges.

We will also share our questions and dilemmas more broadly, to increase the chance that people outside our organisation contribute to our learning and give the opportunity to the general public to understand the complexity of medical humanitarian assistance. By being more open about our shortcomings and failures, we set ourselves aside from the aid sector in which generally communication has become a public relations exercise.

Closure of projects should happen on a responsible & accountable manner, where we agree to achieve acceptable and realistic milestones (in line with the project goal & objectives) within a realistic timeframe. Sustainability is never a precondition for MSF, but we are accountable to aim for responsible handovers to capacitated partners. In some contexts, the catalytic or replicability dimension of a project or a strategy may be an end on itself.

In support of these ambitions OCB will systematise its evaluation framework and ensure that all projects are routinely evaluated or when there is a major shift in context or operational priorities. We will also continue to encourage learning through other capitalisation and critical learning exercises. We will commit to routinely share the outcomes of these exercises to broad audiences in support of learning in and beyond MSF. We will also strengthen routine monitoring using the dashboard and the Quality Framework<sup>4</sup>.

<sup>3</sup> Outcomes of the OCB extended Co-Dir (04.2019) on MSF OCB Strategic Orientations 2020-2023 Sharepoint: <http://bit.ly/2NbvDX4>

<sup>4</sup> OCB Quality Framework: <https://msfqualities.wordpress.com/>



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As a medical humanitarian organisation, guided by our MSF charter, we are responsible for the patients we care for and will assure an optimal quality of care, according to our medical standards.

OCB is also committed to the principle of 'Duty of Care' and the legal and ethical responsibilities implied. This sets in place preventive and protective measures towards work-related risks exposure to all our staff. We also develop duty of care principles towards our beneficiaries. This entails the duty to warn on known risks of treatment or procedures and put mechanisms in place to avoid failures to diagnose and/or treat and to allow for reporting of medical errors within a reactive accountability frame.

To optimally support this in our operations and decrease the frequency of punctual internal procedures, allowing for a responsible management of our resources at each level, we will work with rolling forecasts, quarterly monitoring meetings, multi-year planning cycles, round tables and mid-term reviews, whilst keeping yearly planning cycles for shorter term operations.







# MEDICAL HUMANITARIANISM IN A CHANGING POLITICAL & AID ENVIRONMENT<sup>5</sup>

## POLITICAL AND AID ENVIRONMENT

MSF – like many other medical actors and humanitarian organisations – faces extreme challenges in delivering aid in a context of changing global power dynamics. Strong states assert their sovereignty by blocking or distorting/controlling humanitarian aid. In weak states fragmented powers render access for humanitarians difficult and dangerous. Basic protection of people and continued services are missing. In many places, patients and their care providers are under attack. This requires MSF to forge a wide variety of new alliances and approaches as we seek to overcome those challenges.

For people caught in conflicts, the political landscape is creating space for wars to be fought without limits. The underlying principles and international legal mandate for humanitarian assistance (IHL) is under threat through expanding counter-terrorism logic.

For people on the move, the deterrence of migrants and the externalisation of borders are the new normal. Refugee law providing rights to those seeking asylum including the right to receive assistance is also challenged; not only the recipient but also those who assist are prosecuted.

For women, attack on reproductive rights is seeing a resurgence in the restrictions on safe abortions and other sexual and reproductive health services. For minorities and specifically vulnerable groups, stigmatisation and criminalisation are being normalised often with the backing of organised religion.

Western aid donors have narrowed the scope of their aid objectives away from poverty reduction projects and from the millennium ambitions of eradicating major diseases like TB, HIV and malaria to a reduction of international aid in the health sector. Aid is dominated by a narrower definition of national self-interest to contain threats such as terrorism, migration and disease, as well as using aid as

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<sup>5</sup> The three following documents can be found on MSF OCB Strategic Orientations 2020-2023 Sharepoint.  
01\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Political\_Environment: <http://bit.ly/2NFHD28>;  
02\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Aid\_Environment: <http://bit.ly/2NbP42d>;  
03\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Medical\_Needs: <http://bit.ly/33eycL>

a public investment that can benefit businesses at home. The global Health security agenda distorts priorities away from the needs of affected people and contributes to creating additional and deeper gaps in health care. There is a move away from international solidarity to achieve basic health care improvements and an excessive push for this burden to be laid on domestic resources and capacity.

These political changes are occurring in a period of rapid urbanisation and population growth, with growing inequalities and a risk for more isolated and neglected rural populations and where the effects of climate change, and the political reality of its denial, are becoming more apparent.

What does this overall political landscape mean for MSF and our patients? In short: humanitarianism is under attack. While the need for our independent and direct model of operational delivery remains in demand, we are increasingly targeted in the countries we work and in our home societies. Within this political environment a defence of impartial humanitarianism is essential. The direct act of saving lives in accordance with medical ethics is a radical position in a political environment of exclusion, nationalism and criminalisation.

The long-held desire to merge state-building and development with humanitarian aid resulted in the so-called humanitarian-development nexus whereby development, humanitarian aid and peacekeeping should all work together in conflict-induced emergencies to support the host government responding to crises within their sovereign territories. This has serious implications for humanitarian action due to the instrumentalization and distortion of any health intervention for political agendas.

The United Nations pledged to implement this in their so-called New Way of Working (NWOW) which puts host governments firmly in the driving seat of the aid machine and encourages local and national actors to respond. While the merging of humanitarian and development aid is not new, it is now much more overt and widely accepted. Impartiality comes under threat if governments control which people aid agencies can reach.

The private sector and private foundations are viewed as natural aid partners and possible solution or efficiency creators. A wave of so-called 'innovative financing' schemes is proposed or tested, with aid and other public resources channelled to private and commercial investors. The World Bank has become increasingly active in the humanitarian and

health arena, particularly in fragile and conflict-affected states, operating its usual model of a top-down, systems-building approach, with funds funnelled directly through the state.

Our efforts to influence the global health financing system to consider vulnerable populations and specific diseases need to adapt to this changing power dynamic. A more strategic approach needs to be developed, in which MSF builds alliances but also distinguishes itself from the traditional aid system through its operations and public voice.

### MEDICAL HUMANITARIAN NEEDS

The medical humanitarian needs that we encounter are intricately linked to the environment: the political environment generates exclusion and vulnerability and the aid environment shapes the way in which needs are prioritised and addressed or not.

The concept of a global 'epidemiological transition' claims a change from one of high mortality among infants and children alongside episodic famine and epidemics, to one of degenerative and man-made diseases. Non-communicable diseases are emerging everywhere, but acute and chronic infectious disease remain the primary burden of disease and cause of early mortality in most settings where MSF works, such as in sub Saharan Africa.

The rising number of armed conflict and violence in this changing world confronts MSF to significant medical and humanitarian needs which are directly related to the violence encountered but also to needs which are amplified by the collapse of the surrounding health system tissue.

Even in so-called 'Middle Income' settings where the non-communicable disease burden (including cancer) is the highest, health problems like measles, cholera, malnutrition, TB and HIV continue to exist, often limited to specific vulnerable sub-populations or in neglected geographic areas. Inequity within these countries is rising and the aid transition, with less international funding and higher prices creates additional gaps in health care and quality drugs.

The rapid rise of antimicrobial resistance (AMR), remains largely invisible. MSF has been witnessing the increase of resistant pathogens in a health landscape where treatment guidelines and practices regarding infectious diseases are ill-adapted, where privatisation of health services is promoted, the pharmaceutical market is poorly regulated,

access to quality-assured medicines is challenged, patient-literacy (empowerment) is neglected and where microbiology diagnostic capacity is largely insufficient.

### DECISION MAKING ACCORDING TO IDENTITY AND NEEDS<sup>6</sup>

The environment in which we operate requires difficult choices with regards to where we invest and how we choose to implement our medical humanitarian identity. The decision-making process for the prioritization of activities is built on four pillars that are based on our approach to medical humanitarianism:

#### CONTEXT:

Disruptive events exacerbate vulnerabilities by eroding health systems, creating blockages in access to health. In recent years, conflicts also increasingly target directly civilian populations and its health care provision. Assessing and analysing the environment, including the barriers to health care, the available quality of care and the role and contributions of other stakeholders within the healthcare ecosystem is a key element in our decision-making process.

#### VULNERABLE POPULATIONS:

The MSF charter has a focus on epidemic, disaster and conflict contexts. In other contexts, specific policies and failures of health systems act as barriers of access, increasing vulnerabilities or excluding populations. We will keep the patient at the centre of our activities as we save lives and alleviate suffering. By doing so, we ensure the dignity of the most vulnerable. Solidarity with patients and front-line workers guides our medical and humanitarian response.

#### MEDICAL NEEDS:

Through comprehensive field assessments, epidemiological analysis, discussion with stakeholders and beneficiaries and, where/when possible, anthropological & social assessments, OCB will prioritize & define its response to the medical needs of populations in distress.

#### IMPACT:

Impact relates to improving the health condition of a population by reducing mortality, morbidity and suffering, with the most appropriate quality of care, timely responsiveness and an acceptable resource – output balance. Our responses should correlate with

the OCB/MSF medical expertise gained through the vast experience of our teams, and ‘learning by doing’ remains a key part of our approach, as it is important that our medical expertise continues evolving in this changing world. Other contexts may invite us to develop models of care (MoC) or alternative approaches that can catalyse change of policy and practice and increase thus the impact for a broader number of people.

All these four factors are carefully analysed when deciding on designing an operational response. Strategic decision making should be done at the level of the project teams. Project teams have indeed an important role in the operational translation of policies and guidelines given the context, the opportunities and the very objectives and goal of our presence in a specific context.

OCB projects are dichotomized between default and choice projects.

**Default projects** are triggered by disruption with high mortality and/or morbidity and where OCB can make a difference through its presence, its direct action and its témoignage. Prolonged emergencies, post-conflict settings and other disruptive environment, where access to care is restricted systemically, is also considered a place to be for OCB by default. These situations usually have the worst health indicators and are places where others don’t go.

**Choice projects** on the other hand are projects which are selected around medical and humanitarian needs in situations where we can maximize both the health impact on the population and a systemic change in the environment through our action, our evidence and our advocacy. These are usually situations which are not acute disruptions but chronic health crises, where OCB believes it can make a difference. In these interventions OCB may develop new expertise and recommendations to others, by showing a medical innovation or a model of care which can be replicated by others. A strategy to leverage our impact should be explicitly part of the project design.

Both default and choice projects can have a **catalytic dimension**, trying to work towards systemic policy change or structural solutions to the health needs we address. This needs to be based on a sharp understanding of the environment we work in; the underlying causes or aggravating factors of the

<sup>6</sup> 03a\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Medical\_Identity on MSF OCB Strategic Orientations 2020-2023 Sharepoint: <http://bit.ly/2Nx4Y6c>

disruptions and the added value OCB can bring in such circumstances through intelligent partnership.

To maximise our strategies for leverage, building and strengthening of our analysis and advocacy capacity – especially at project level- is needed.

#### **MULTI-DISCIPLINARY APPROACH TO PROJECT DESIGN:**

When designing a project, a multi-disciplinary approach is needed. Project teams should bring all viewpoints and information together to develop the most coherent and comprehensive project proposal and implementation strategy. This should consider the epidemiological information, the needs and demands of the population, presence activities of other partners and stakeholders, OCB resources and the security situation. Our work culture should be built on participative leadership in multi-disciplinary teams working in a transversal way. Key is to define clear and realistic objectives and expected results within realistic timeframe and scope and that these objectives are understood by everyone involved. Networking and external partnerships are essential to optimally design our projects, enhance our interaction with the environment, our impact and our acceptance.

Internally, framing strategic objectives is the result of discussions between the Operational, Medical and Analysis Departments. The Logistics, Finance, HR and Supply Departments are the backbone of our capacity to deploy and run operations. They are engaged at the initial discussions of new projects, participating in the resource calculations and providing an understanding of their implications. At all times, when we engage with the resource departments, they should be able to forecast and monitor these needs. Priority setting of all departments should be geared towards making our operations effective and efficient. Support strategies should thus be anchored in our strategic orientations framework. However, specific policies, standards and guidelines outside this framework may be designed to adapt to contextual realities.

As speaking out and témoignage are at the core of our identity, a very direct link with the Communication department is necessary in the strategic framing, execution and closure of all projects.

Vertical responses, integrated approaches, punctual interventions, scalable and replicable models of care, substitution and support to existing health capacities all have a place in our operational portfolio.

There is no default OCB approach and according to the specifics of the environment, the acuteness of a situation and the objectives of the project, the approach and project design may differ.





# OUR OPERATIONAL PRIORITIES

## EPIDEMICS<sup>7</sup>

Communicable diseases still account for the biggest share of the global health burden and in low income countries specifically this still accounts 60% or more of the burden of disease. Evidence shows that some infectious diseases are (re)emerging due to low vaccination uptakes and evolving environmental factors, such as climate change and rapidly growing urbanization. In conflict settings, the disease burden can increase dramatically, when multiple risk factors collide, enhancing the emergence and transmission of infectious diseases. OCB should therefore continue to be on the front line of responding to epidemic outbreaks.

To increase our chances to timely detect and effectively respond to outbreaks, we should invest in good emergency preparedness (EPREP), in-depth context analysis, situation monitoring and investigation capacity. Investing in a field-based epidemiologist pool will be crucial to achieve this.

OCB, wants to be an early responder providing direct patient-care, using the opportunity to perform more in-depth descriptive studies and early reporting of outbreaks and disseminate these findings for future operational use, as well as for scientific and, as needed, testimony purposes.

For certain research topics OCB may have to create partnerships with research institutes.

Outbreak response interventions should be 'holistic', including medical management, laboratory confirmation, community engagement, health promotion (using social and anthropological science), environmental health activities, vaccination, data collection and support to health structures. Community acceptance and trust should be built through effective, context-adapted community engagement approaches.

The preparation to respond to epidemics should not overshadow the need to prevent as much as possible the occurrence of epidemics. In humanitarian emergencies, multi-antigen preventive vaccination campaigns should be rapidly organized to prevent the most likely disease outbreaks in specific settings.

Appropriate Environment Health conditions can drastically reduce disease burdens. The lack of this is often the cause of preventable burden of disease and overwhelmed health facilities. In situations where Environmental Health has a significant influence on the scope of the epidemic, OCB should, where required, define a pragmatic response to the most crucial health risks that can be addressed by ensuring adequate Environmental Health conditions. Not deploying Environmental Health activities in these contexts should be well justified exceptions.

There is an increase in the global interest and with it an increase in the number of responders like WHO's emergency response teams (EMT) intervening in

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<sup>7</sup> 04\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Epidemics on MSF OCB Strategic Orientation 2020-2023  
Sharepoint: <http://bit.ly/2pBX3MZ>



outbreaks. This is mainly the case for outbreaks of diseases that are high on the 'Global Security Agenda' (Ebola/Marburg, SARS, and, to a lesser extent, Lassa). 'Classical' outbreaks (such as measles and cholera) get far less attention. OCB should reflect on the reduced space to work in the high-profile outbreaks and be open to alternative ways of intervening. But we should remain vigilant, when negotiating and cooperating with others, to keep our (medical) standards and humanitarian values. Especially when health securitisation dominates the agenda, MSF may be among the few agencies to truly give a voice to the interest of the patients and the affected communities.

The focus for the period 2020-2023 OCB will be:

- Continue testing and implementing **innovative tools**, such as new data collection tools, Rapid Diagnostic Tests (RDT) and other Point of Care (PoC) tests.
- Remaining engaged in responding to the main outbreaks of **cholera and measles**.
- Responding to **malaria** outbreaks which can have a devastating effect, especially in non-immune populations. Monitor the spreading drug resistant malaria and consider alternative ways to remain involved on the issue of artemisinin resistance in the Mekong or elsewhere. In some settings, more attention should go to P vivax malaria, including radical treatment.
- Reacting to re-emerging outbreaks caused by suboptimal vaccination coverages, such as **yellow fever and diphtheria**.
- Invest on **innovative vaccination strategies** to reach efficiently hard-to-vaccinate populations, document and disseminate lessons learned.
- Remaining attentive to **outbreaks of typhoid fever**, with a specific attention on resistant typhoid strains. Experience shows that most successful strategies combine vaccination, Environmental Health activities and curative services.
- Maintaining its capacity as a major player in **viral haemorrhagic fevers** (VHF) response, considering our unique expertise, the high case fatality rates, the risks for health staff, the associated stigma and the expected rise in number of outbreaks. Climate change and the disruption of the natural habitat of vectors by human activity are believed to lead to an increase in the number of VHF outbreaks in the future, enhanced by an increase in awareness and detection. OCB should also consider involvement in other public health interventions in VHF outbreaks, such as malaria mass drug administration in malaria high endemic areas with overloaded health facilities.
- Maintaining its capacity to intervene in outbreaks caused by **monkey pox and pneumonic plague**.
- Keeping a targeted approach to tackle epidemics in **specific vulnerable groups**, such as zika & hepatitis E among pregnant women.
- Maintaining a reactivity for major outbreaks caused by **airborne pathogens** such as corona-virus or pandemic influenza outbreaks. Respiratory supportive care should be added to our EPREP plans in these situations.
- Remaining attentive to repetitive outbreaks of **methanol intoxication** in settings where we work and consider an engagement in capacity building of local actors, together with partners specialized in these events.

## CONFLICT AND VIOLENCE<sup>8</sup>

Situations of armed conflict and violence are likely to lead to significant medical and humanitarian needs and amplify pre-existing vulnerabilities and exclusions. OCB, in line with its MSF charter and the humanitarian imperative, commits to maintain and if necessary invest in medical humanitarian projects for populations affected by conflict and violence.

Both states and non-state armed groups often reject or restrict humanitarian aid. There is also a tendency in the aid sector that development activities should take precedence over saving lives. OCB will continue implementing and defending the principles of impartiality, neutrality and independence, not only through its continued application of negotiated access with all parties to any conflict, but also through its needs-based approach. We will safeguard our independence by using, by default, private funding in conflict settings.

If the choice of medical interventions will be depending on the security environment, OCB should develop new strategies to access the wounded and populations in need, through new partnerships, as much as possible safeguarding our direct contact with the patients. When MSF loses its proximity with the communities and patients, MSF also loses its credibility and its legitimacy.

<sup>8</sup> 14\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Conflict\_Violence on MSF OCB Strategic Orientation 2020-2023 Sharepoint: <http://bit.ly/2C7bTNY>



The medical activities OCB will continue to invest in are:

- Direct **victims of violence** which include **medical** care for wounded (war & non-war), victims of torture, victims of sexual and gender-based violence and displacement.
- **Victims of exclusion**, which can include general healthcare for populations denied access to existing health structures.
- **Increased vulnerability** often linked to the deterioration or destruction of existing health systems.

Our medical intervention can include vaccination campaigns, mother and child health (MCH), general primary or secondary health care or a vertical focus on chronic diseases such as HIV, TB and life-threatening NCD.

Whatever choice is made, key for any medical activity will be the pertinence of the action, the impact and the level of quality that OCB can achieve. The humanitarian imperative is not solely defined by the medical outcomes in terms of numbers, but also by the impact we can have on vulnerability and exclusion in conflict zones.

Public communication plays a key role in supporting a population under siege.

The focus for the period 2020-2023 will be:

- Expanding OCB's **medical action in conflict** affected areas; A specific attention should be given to victims of **urban warfare** and **forgotten conflicts**;
- Paying specific attention to building expertise in **post-violence** care, such as reconstructive surgery and antibiotic resistance (ABR);
- Developing strong **access negotiation** capacity in hostile environments.
- Maintaining an **expertise on VoT** through some vertical projects and integrating VoT care into other projects. (also linked to migration and detention)

Maintaining and, if necessary, expanding OCB's medical action in conflict areas is difficult and will require significant and continued investment to gain access and stay present safely.

OCB needs to be flexible on its operational models (profiled missions, remote management, partnerships) whilst safeguarding the impartiality of the operational choices and the quality of the medical intervention. Such alternative operational models deviate from the direct medical action with mixed teams and involve a transfer of risk from international teams to local, profiled or third-party teams. These models should remain the exception and of a temporary nature.

## MIGRATION AND DETENTION<sup>9</sup>

Displacement and forced migration remain one of the key humanitarian concerns prompting OCB to intervene, both operationally and for advocacy. Migrant communities are a mixed population with different health profiles, health-seeking behaviours, and vulnerabilities. Medical needs may not be always the most acute in migration contexts, however, the health and safety of migrants are compromised by migration and asylum policies, and other factors.

MSF's independence, its strong medical humanitarian action and voice have its relevance, as we can restore non-discriminatory access to care and dignity beyond legal categories. Providing humanitarian assistance is more difficult as migrants are taking more complicated and hard-to-reach journeys or due to the criminalization of migration flows.

MSF has developed expertise in migration and health which includes working in detention and containment settings, search & rescue at sea and documentation of institutional violence.

According to the situations, medical priorities in migration and detention settings include - besides acute illnesses or trauma - mental health, sexual violence care, family planning, care for victims of violence and torture, abortion care, continuity of care for chronic conditions (such as HIV, TB, diabetes, epilepsy) and Environmental Health. OCB's migration projects may integrate socio-legal support and projects may establish referral pathways in the early stages of an intervention. Where possible, community interventions with a focus on health promotion should be strengthened to enhance MSF's proximity to communities, community resilience, and peer-support networks.

OCB's approach in migration and detention projects has relied on partnerships with civil society organizations (CSO's). These are usually small scale or volunteer-based, often lacking resources and credibility. In terms of advocacy, CSO's may be part of social movements, which can be an opportunity for OCB to build new coalitions, but risks to our perceived impartiality must be considered.

OCB operational assessments and interventions will by default be triggered by situations of mass displacement or spikes in movements, as well by

health indicators including increased mortality and morbidity. OCB should monitor indicators such as shifts in policy and social environments (e.g. xenophobia), that may increase forms of structural violence and exclusion, exacerbating negative health consequences for migrants or people with a migrant background.

The focus for the period 2020-2023 will be:

- Providing direct medical and humanitarian assistance to migrants with a specific focus on Europe, the Middle East, Asia & the Pacific region, Southern Africa and Latin America. Adapted models of care will be developed to address the needs and demands linked to mobility and exclusion. Documentation of what we see and what works will be done and shared.
- Developing a few detention projects responding to the health needs of detained migrants with very clear objectives, such as decreasing the most severe health consequences, advocating for alternatives to detention and the release of patients.
- Re-examining our approach to refugee and IDP camps as there is a decrease in humanitarian assistance to many of these camps and an increased pressure from States for early returns of these populations.
- Integrating migration and mobility as a transversal topic into other OCB projects. Migrants are often neglected in many of OCB's operational settings and present very specific needs and demands for which we will remain open and responsive.
- Maintaining some vertical migration projects, primarily responding to the needs and vulnerabilities of migrants. Often these projects will be linked to advocacy and catalytic objectives, such as:
  - Feeding through our operational evidence by positioning on key problematic humanitarian trends.
  - Establishing models of care.
  - Documenting and witnessing in hard-to-access contexts.
- Defending humanitarian space & independent medical care.
- Developing a few projects focused on specific vulnerable groups, needing specialized care which is not provided by any other stakeholder, such as undocumented migrants excluded from health systems, victims of torture and violence, SGBV, minors, isolated mothers and pregnant women, victims of human trafficking and migrants with

<sup>9</sup> 15\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Migration on MSF OCB Strategic Orientation 2020-2023  
Sharepoint: <http://bit.ly/2JMosTa>

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severe mental health disorders, patients with HIV/TB and life-threatening NCD conditions. These groups will need specific patient-centred project designs with an adapted advocacy package.

To maximize response in migration contexts, OCB must integrate advocacy into the design of interventions. Whilst increased anti-migration politics and sentiments might render advocacy efforts difficult or even dangerous, OCB can strategically erode harmful policies at multiple levels through individual patient support, supporting strategic litigation, presenting new evidence, building coalitions with medical association and civil society, targeting health actors and the global health debate, defending humanitarian action and opposing policies. To maintain coherence and increase strategic engagement, OCB will need to frame interventions into a strategy and vision which supports engagement and leverage in the long term.

A good understanding of the legal contexts and of the operational and ethical dilemmas is necessary in migration and detention projects. Field teams are often faced with multiple ethical concerns and dilemmas, often responding to populations exposed to extreme risk, and political environments which raise questions on harm to patients, complicity and substitution. OCB should develop support to its staff and create platforms to discuss these ethical questions in partnership with others.

### SEXUAL, REPRODUCTIVE & WOMEN'S HEALTH<sup>10</sup>

In many of the contexts in which OCB works, obstetrics and new-born care are in a constant state of emergency. Quality Basic Emergency Obstetric and New-born Care services (BEMONC) and Comprehensive Emergency Obstetric and new-born Care services (CEMONC) will be considered by default in any emergency or conflict setting. Next to the investment in health facility-based care more attention will be given to the continuum of care, including at community level, where components as contraceptives, ToP, antenatal care (ANC) and SGBV care can be offered.

Safe Abortion Care (SAC), Post Abortion Care (PAC) and provision of contraceptives are the 3 most important medical activities to prevent and manage unwanted pregnancies and its related

maternal mortality and they continue to need specific attention.

The focus for the period 2020-2023 will be:

- Providing contraceptives in all relevant projects including in non-reproductive health (RH) activities, specifically when addressing young women, adolescents, female sex workers and populations in unstable settings. Male involvement needs to be strengthened;
- Scaling up SAC services and offer ToP on request in all projects with an RH and/or SGBV care component or wherever acute needs & demands are not met.
- Developing a few projects to pilot interventions and take a catalyst role, contributing to the development of new approaches, such as task shifting and de-medicalised (community based) models of care both for contraception and for ToP. This is important to learn new strategies, develop better tools and guidance and to feed our advocacy messages.
- Strengthening our expertise in developing comprehensive sexual and gender-based violence (SGBV) care, which will include medical and psychological care, social, legal and protection assistance and advocacy. New models of care will be developed for specific populations such as sex workers, males, adolescents and children. OCB will work on sexual risk assessment and strengthen the identification of SGBV survivors. Some projects will take a catalyst role.
- Including sexually transmitted infections (STI) screening in all consultations. With the increase in antibiotics resistance, we need to explore and introduce new diagnostic methods as GeneXpert® or point-of-care tests and adapt the syndromic approach where needed.
- Expanding human papillomavirus (HPV) vaccination in countries with high cervical cancer prevalence and invest in at least one additional screen & treat project for precancerous lesions.
- Integrating adolescent friendly approaches in SRH/SGBV/HIV vertical projects and improving access to comprehensive sexual education.
- Integrating prevention of mother to child transmission (PMTCT) in all projects where the prevalence of HIV amongst the target population is  $\geq 1\%$  and identify options to address barriers for integration in contexts of lower prevalence and for the populations at higher risk, such as female sex workers.

<sup>10</sup> 09\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Reproductive\_Health on MSF OCB Strategic Orientation 2020-2023 Sharepoint: <http://bit.ly/36oN91T>

- Strengthening, where relevant, **obstetric fistula repair** capacity, as it has a major impact on a woman's quality of life. All projects with obstetric activities need to implement a fistula registration system for later referral to care or organization of campaigns.
- Strengthen the concept of **Women's Health** beyond the mere dimension of Sexual & Reproductive Health.
- Developing **CHP in community** interventions with adapted strategies, such as looking at caretakers as partners in prevention, surveillance and treatment.
- Improving paediatric care in vertical projects, such as surgical, HIV, (DR)TB and NCD care.
- Investing in **better quality clinical care in outpatient** activities through eCARE, diagnostics tests and associated testing algorithms, training and clinical mentoring.
- Investing in services and approaches **to reach adolescents at community and PHC level** (in SRH and beyond).

## CHILD HEALTH AND NUTRITION<sup>11</sup>

Children aged 5-15 years account for a quarter of the patients seen in outpatient clinical consultations and 19% of the patients exiting our inpatient departments. Malnourished children only represent 2% of paediatric outpatients, but 21% of the paediatric inpatients.

In early childhood, the mental and physical health of the mother and child is inextricably linked, and we must care for them together. There should not be maternities where we neglect new-born care or paediatric/nutrition services where we admit a young child, without properly assessing the physical and mental health needs of the mother. To have the biggest impact on child health, we need to care for the mother and infant and then later, the 'whole child'. Children are individuals aged 0-19 years. We need to start caring more for children over 5 years old as well with their own specific needs and characteristics. This age group is often neglected or de-prioritized.

The focus for the **period 2020-2023** will be:

- Reducing **missed opportunities** for caring for children at every contact.
- Integrating **older children** in paediatric projects.
- Addressing **missed vaccination** opportunities for children in IPD ward.
- Vaccinating (**beyond the EPI target group**) eligible children at each contact. This may include HPV vaccination for young adolescent girls in countries with high cervical cancer prevalence.
- Developing **Child Health Packages** (CHP's) to operationalise a child health approach in clinical services with adapted tools and looking at their specific environmental, mental, protection and education needs.

Paramount in our strategic approach will be to care for the mother and new-born together. This can happen on different ways, such as:

- Developing models of 'Comprehensive Family Consultations' which links paediatric and nutritional care, ANC, Family Planning (FP), SGBV and vaccination in one structure.
- Developing new born care integrated within maternities, including PMTCT and HIV early infant diagnoses.

## TRAUMA CARE<sup>12</sup>

MSF is one of few independent, medical humanitarian organizations with the capacity to become an expert leader in trauma care in humanitarian settings because of its access to areas of conflict and disaster. Early access to essential emergency and critical care for victims of trauma can save lives in these contexts. OCB's strategic package of trauma care will ensure that each link within the patient care continuum is addressed (whether it is by MSF or a partner organization), from first aid at the point-of-injury, to Emergency Department (ED) entry, to a surgical intervention or Intensive Care Unit(ICU) and to ongoing post-injury medical care and rehabilitation.

As much as the focus of our trauma activities can be oriented towards direct victims of violence, admission criteria should always be based on the medical condition and not on the mechanism of injury. Our goal is to save life and limb of the trauma patient.

<sup>11</sup> 10\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Child\_Health on MSF OCB Strategic Orientation 2020-2023 Sharepoint: <http://bit.ly/36oN91T>

<sup>12</sup> 08\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Trauma on MSF OCB Strategic Orientation 2020-2023 Sharepoint: <http://bit.ly/338VGns>

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The focus for the period 2020-2023 will be:

- Ensuring the timeliness of the access to trauma patients.
- **Bringing innovation** in trauma care by bringing the realities of high-quality care towards humanitarian settings: blood product resuscitation, internal fixation, negative pressure wound therapy, acute and chronic pain management, antimicrobial stewardship. (including microbiology)
- Establishing **peripheral trauma care**: supporting community/PHC health staff/organizations in resuscitating and preparing for referral of trauma patients, the use of ambulances, development of trauma stabilization points.
- Recognising the importance of a **multi-disciplinary team** approach where attention should be secured for nutrition, management of NCD exacerbations, rehabilitation and mental health.
- **Securing capacity** for resuscitation, adapted diagnostic imaging, laboratory and microbiology support and waste management.

Trauma care with surgery services is offered in general hospital projects, in vertical trauma centres and in reconstructive surgery hospitals, according to the needs and opportunities of each setting. We will recognise the role of existing health services and how they can contribute to an organised trauma system. However, we should be aware that in acute conflict settings existing health services may not be accessible to all victims from different parties due to lack of neutrality and independence of such structures.

**Burn patients** can be encountered in any of our settings with trauma activities and the principles of CoC are applicable also to burn patients. Women and children are disproportionately affected by this type of injury. During the period 2020-2023 OCB will not aim to develop vertical burn care centres but aim for the provision of better burn wound care to prevent disability and death by:

- Investing in the **integration of a burn wound care** in general hospitals and trauma hospitals.
- Investing in **emergency preparedness** (at mission and HQ level) to respond to large scale incidents with a high number of burn patients.

- Allowing for possible integration of **chronic burn care** into our reconstructive surgery projects, if appropriate resources and expertise are available.

Trauma should be approached as a disease: OCB will explore the role of health promotion in injury and burn prevention.

The number of trauma care activities OCB is planning for in the coming period 2020-2023 will be balanced between the medical needs and our own internal capacity (such as the need to specialised professionals) to manage such complex projects.

The **Hospital Management Unit** of OCB's Operations Department is of strategic importance in developing OCB's expertise in the management of the complex hospital settings needed for such programmes. Its presence within the department allows to naturally guide programme managers and project teams in hospital management skills, capitalising on our experience and training the professionals needed for the running of these structures.

### CHRONIC INFECTIONS: HIV, TB AND HEPATITIS<sup>13</sup>

#### HIV

HIV remains an exceptional humanitarian and medical crisis. We remain far from achieving 90-90-90<sup>14</sup> and the predicted end of the epidemic. High needs and low treatment coverage remains a reality, particularly in fragile and conflict affected states. Poor access, increasing treatment failure and drug resistance lead to nearly 1 million AIDS deaths. AIDS exceptionalism is over as there is competition for reduced resources. In this period of disengagement, OCB aims to remain a leader, with a unique combination of field presence, a patient-centred approach, cumulative medical experience, independence and commitment to catalysing change and ensuring impact beyond MSF patients. Lessons learned around patient-engagement and activism, approaches to R&D and drug pricing, monitoring and evaluation (M&E), supply chain and task-shifting. will be developed and applied in fields beyond HIV.

The focus for the period 2020-2023 will be:

<sup>13</sup> O6\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Chronic\_Diseases on MSF OCB Strategic Orientation 2020-2023 Sharepoint: <http://bit.ly/2NcNFZm>

<sup>14</sup> The ambitious WHO target to achieve by 2020 that 90% of all HIV patients know their status, 90% of those receive treatment, and 90% of these treatments successfully suppress the disease.



- Further developing an HIV response in **low coverage** settings including West and Central Africa, with a focus on conflict areas and areas with an increasing incidence and a very low coverage of needs, while retaining sufficient critical mass of activities in **high prevalence, high coverage** regions to support the development of models of care and evidence triggering change.
- Addressing **mortality reduction and advanced disease** within the CoC perspective and a continuous push for decentralised care. A simplified clinical approach to advanced disease management for adults and children will be prioritised.
- Addressing **neglected populations**, such as key populations and others left behind in the roll-out of care, such as men and adolescents. OCB will develop a more holistic person-centred approach towards these **stigmatised and hard-to-reach populations** through peer-led models
- Aiming at **integrating HIV/TB** care in non-HIV-focussed settings. A small number of focussed projects - both rural and urban - will develop a 'vertical' focus on integration to improve our understanding of the complexities, ensure capitalisation and maximise chances of catalysing replication and rollout of successful pragmatic approaches.
- Continuing **advocacy**, in close partnership with other stakeholders, on the above issues along with funding gap, stock-out and supply chain issues, and capacity building for civil society engagement.

## TB AND DRUG RESISTANT TB

Tuberculosis (TB) is the main infectious disease killer worldwide. Despite the ambitious global target to end the TB epidemic by 2030, decrease of TB incidence and mortality is slow: in 2018 it is estimated that 10 million people fell ill with TB (1 million children), and 1.3 million deaths occurred.

Drug-resistant TB (DRTB) represents a major public health threat and outcomes remain poor.

MSF is recognized as a leading organization in TB, especially in HIV co-infection and DRTB, playing a key role in advocacy and policy change about patient-centred and decentralised approaches and a new oral treatment for DRTB.

As in HIV, The Global Fund is reducing its support for TB and the funding gap remains massive, undermining any global response to achieve concrete targets and international commitments.

The focus for the coming **period 2020-2023** will be:

- Developing strategies aiming to **impact transmission and mortality**, for both drug sensitive and drug resistant TB;
- Targeting the **most vulnerable populations**, such as (malnourished) children, people living with HIV, pregnant women, prisoners, mobile populations

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and people living in conflict, through adapted and integrated patient-centred models of care.

- Improving the integration of TB/DRTB diagnosis & treatment in contexts with other operational priorities. OCB will implement an opt-out policy for TB, a project will need to have good reasons not to include TB diagnosis & treatment in its overall programme.

Strategies of special interest for OCB will be:

- Using context-adapted use of available diagnostic instruments (LAM, GeneXpert, CXR, POCUS, clinical algorithms), and piloting some new tools (genome sequencing, GeneXpert XDR, FujiLAM) in some vertical projects.
- Using community case-finding strategies across certain settings to reduce late diagnosis, while improving facility-based detection, to impact morbidity and mortality.
- Piloting experience in latent (DR)TB prevention and infection control with new and shorter rifampine-based treatments in specific populations.
- Strengthening of infection control measures across all settings, especially in non-vertical projects where risk of transmission is high and mostly neglected.
- Implementing short oral regimens for DS/DRTB and producing evidence to fuel advocacy and policy change.
- Offering (innovative) paediatric formulations.
- Developing differentiated service delivery models with strong patient and community support for vulnerable populations.
- Sustaining a strong advocacy agenda on these topics.

### HEPATITIS

In 2015 hepatitis B & C caused 1,34 million deaths and 71 million people live with chronic hepatitis C (HCV). Hepatitis B (HBV) prevalence ranges between 10-20% in Asia and Africa. Vertical transmission of HBV is high and can be prevented by prompt vaccination just after birth. OCB has rolled out programmes using directly acting antiviral agents (DAA's) in settings with high HCV prevalence among the general population and accompanied those successfully with research and advocacy towards DAA pricing, access and models of care.

The focus for the coming period 2020-2023 will be:

- Developing one vertical HCV programme with a model of care including the prevention & treatment and one project with integration of HCV care as a horizontal component of primary care in a high prevalence population.
- Continue building experience in providing to people who inject drugs (PID) a comprehensive care package including HCV diagnostic and treatment, alongside prevention and harm-reduction strategies, in one project
- Supporting, implementing and advocating for universal HBV vaccination at birth and for individuals at risk, such as health care workers, PLWHIV, IV drug users and MSM.
- In routine projects, Hepatitis C care will be integrated and should no longer require special expert HR. HCV treatment will be an integral part of a comprehensive patient-centred response for specific populations as IV drug users and prisoners.
- OCB will integrate HBV screening for all HIV patients into HIV care. In specific sites with a high-level HBV prevalence, OCB will decide on a case/case base to treating advanced HBV patients.

### NON-COMMUNICABLE DISEASES<sup>15</sup>

OCB projects targeting NCDs should give high priority to patients with installed/symptomatic disease or at high risk of complications, treating the disease and not the risk factors. OCB should develop a pragmatic approach, with a staged investment in NCD care and a targeted approach to hypertension, type 2 diabetes, asthma and epilepsy.

OCB will build on the lessons learned in the existing three vertical NCD projects and invest in the integration of NCD care in regular projects. No new vertical programme will be opened. Simplification of NCD management will be further developed. Appropriate choice of thresholds for treatment and treatment targets must be ensured when engaging in NCD management.

The focus for the period 2020-2023 will be:

- Improving NCD treatment for HIV/TB patients.
- Focusing on paediatric NCD management for some neglected or poorly documented pathologies (such as rheumatic heart disease, thalassaemia, sickle cell and nephrotic Syndrome).
- Integrating the essential management of psychiatric patients in primary care settings.

<sup>15</sup> 07\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-NCDs on MSF OCB Strategic Orientation 2020-2023 Sharepoint: <http://bit.ly/33d691j>



- Addressing decentralised & quality management for **cervical cancer** and Kaposi sarcoma, whilst keeping an eye open for other opportunities (such as Burkitt’s lymphoma) and new developments.
- Developing adapted models of care in **middle-income** environments, where private providers are competing with public services.
- Developing expertise and recommendations in **mobile** populations and **emergencies** where only a short contact with patients is possible.
- Investing in **IPD quality management** of NCD’s, including in general and trauma focused emergency departments where NCD complications and exacerbations are seen. Treatment should be looked at through the whole continuum of care.
- Opening one project with emergency and **critical care services**, where thrombolysis can be offered to patients presenting with acute myocardial infarction, as this will contribute to develop further expertise.
- Advocating for specific access issues, such as for access to insulin for type 1 diabetes patients.

#### CONTINUUM OF CARE<sup>16</sup>

Continuum of care belongs to our 10 key strategic orientations for the period 2020-2023. Health care can only be ensured if there is a functional primary health care and referral services to secondary care.

Well-implemented PHC has a high impact on mortality, but is neither cheap nor easy, and in many places, quality standards are below acceptable. PHC implementation can be more difficult in insecure areas, as PHC usually requires an increased mobility of our teams, it can also be protective because of the community links it creates.

Where access to care cannot be ensured by in-facility case management, **community-based case management** will be organised. In areas with high childhood morbidity/mortality due to infectious diseases & and neonatal vulnerability, this can be based on integrated community case management (iCCM), focusing on early diagnosis and treatment of pneumonia, malaria and diarrhoea, based on strict algorithms. In other contexts, this can be done by organising mobile clinics. Community-based approaches are also key when addressing malnutrition, family planning & early pregnancy, chronic

diseases, or when planning to set up surveillance systems and prevention activities such as vaccination and environmental health.

Every project should develop a community involvement component. From the community to **PHC facilities** and from PHC facilities to hospitals, pre-referral treatment must be ensured. Correct counter-referral is equally important to ensure post-hospitalization management.

The package of services in PHC centres must be adapted to the needs and context.

In line with our patient-centred paradigm, we will reflect on how patients will be referred to a higher level, when working at community or PHC level. Similarly, we will address the issue of patients going unnecessarily to a hospital or patients staying too long in wards, when engaged in a hospital-based project.

We will consider the potential to work more in partnerships, in hospitals as well as in PHC, avoiding situations where MSF does it all. In some settings this may also imply interacting with the private sector.

The focus for the **period 2020-2023** will be:

- **Re-engaging and reinforcing investment in PHC**, as it has a clear impact on morbidity and mortality, if well implemented, and it increases the proximity with the communities. Hospital projects are encouraged to develop a PHC perspective to address unnecessary hospitalisations.
- Investing in the **quality of care** at PHC & community level. This will include improving prescription practices through the introduction of diagnostic innovations, such as e-supported patient management and Point of Care Ultra Sounds (POCUS).
- Investing in **training and clinical mentoring** to ensure quality of care at Primary Health care level.

#### CLINICAL CARE<sup>17</sup>

Clinical care may be described as all direct and indirect interactions that occur between the patient and a multidisciplinary healthcare team to better serve patient needs. These relationships should be

<sup>16</sup> 05\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Continuum\_of\_care on MSF OCB Strategic Orientation 2020-2023 Sharepoint: <http://bit.ly/2NAWPOf>

<sup>17</sup> 11\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Clinical\_Care on MSF OCB Strategic Orientation 2020-2023 Sharepoint: <http://bit.ly/2CaKyL3>



considered as the core of our medical activity. Clinical care should be comprehensive (from preventive to palliative), holistic, relevant to the patient's needs, and appropriate to the resources available, the local health context and to our medical and operational capacities. Patients should remain the central concern, but not considered in isolation from all others. Clinicians should be mindful of the contributions of the patients' family and community to what can and should be accomplished.

OCB will place renewed emphasis on the quality of clinical care (QoC) provided in our projects. Patient safety is the cornerstone of QoC and a culture that prioritises this should be the norm in all OCB projects. However, the majority of OCB clinical activities takes place in contexts that are (at times extremely) challenging and dynamic. For this reason, all norms and levels of QoC cannot be reached in all projects or at the same time. Still, the same dynamic view to improve QoC for all patients should exist in each project, each with adapted ambitions and priorities and with a specific plan to reach the intended level.

The focus for the period 2020-2023 will be:

- Promoting and facilitating an effective multidisciplinary patient-centred approach.
- Developing a real focus on quality of care and patient safety within a proposed standard framework, considering the reality of the settings where we work.
- Developing a catalytic dimension around our projects by promoting a patient safety culture and quality of care standard tools and strategies to health systems & partners.
- Integrating recommendations about clinical care into all emergency responses in a way that their application will not slow down the response and will improve the outcome.
- Developing clinical teams with appropriate training and skills, facilitating the development of appropriate clinical competencies, providing clinical mentoring support and continuous clinical learning opportunities to field teams and rewarding clinical career pathways. The role of the MSF Academy will be paramount in this.
- Supporting clinical care activities with adapted smart technologies, clinical techniques and equipment relevant for MSF contexts, such as telemedicine, eCARE, POCUS, new surgical techniques, new (POC) diagnostics, etc.

## ANTIBIOTIC RESISTANCE<sup>18</sup>

Antibiotic resistance (ABR) will have a disastrous impact within a generation unless the world acts now. ABR infections can be deadly and are expensive to treat – often requiring long hospital stays, complex testing and expensive drugs. Resistant infections already kill hundreds of thousands of people annually and scientists predict that drug resistance, including tuberculosis, could kill 10 million people per year and cost the global economy trillions of dollars by 2050.

Drug-resistant organisms exist in all countries. In low-resource countries, its spread is accelerated by widespread overuse of antibiotics in the public and private sectors, high burdens of infectious disease, high transmission rates, and weak regulations and enforcement in the use and quality of antibiotics.

Technical pillars of **ABR control** consist of:

- **Infection Prevention and Control (IPC)**: reducing infection risk through improved hand hygiene, cleaning and disinfection of material, appropriate isolation measures and water & waste management.
- **Antibiotic Stewardship (ABS)**: ensuring proper use of antibiotics (right time, right dose, right duration).
- **Diagnoses and Surveillance (D&S)**: improving diagnostic quality through microbiology and other point-of-care diagnostics.

MSF's engagement with ABR has 3 main objectives:

- Improving patient care outcomes of morbidities affected by ABR, such as sepsis.
- Mitigating adverse consequences of antibiotic misuse, such as resistance, side-effects and unnecessary cost.
- Avoiding the spread of health-care associated (nosocomial) infections in our health facilities.

The focus for the **period 2020-2023** will be:

- Developing a **basic package** (IPC + ABS) in all OPD and IPD facilities;
- Developing a **full package** (Basic Package + D&S) in hospital ICU's (ventilation, central catheter or internal fixators) and in high ABR prevalence

regions or regions with high-risk populations such as trauma and burn patients; neonates, mal-nourished children and HIV patients.

At **IPD level**, this will represent:

- Assuring IPC as basis for prevention of avoidable nosocomial infections and outbreaks.
- Setting up stewardship committees, with its specific activities and tools.
- Developing models of isolation of patients with resistant infections.
- Proposing structural requirements in infrastructure, water, sanitation and waste management.
- Improving our capacity to diagnose and manage nosocomial MDR outbreaks.

At **OPD level**, this will represent:

- Assuring IPC as the basis.
- Setting up of stewardship activities to monitor prescription practices and ABS.
- Introduction of specific diagnostic tools in clinical algorithms (eCARE), severity biomarkers or specific point-of-care-tests.

At **Community level**, this will represent:

- Contextual assessments of AB-use/perception and prescription according to the needs.
- ABR preventive activities: investment in vaccination and WASH in the community. Changing community behaviour is however not an ambition for OCB.

Transversally, a specific focus should be given to Sexually Transmitted Infections (STI)

Where possible & relevant, projects should develop a **catalytic** dimension and produce evidence & models of care to minimize the consequences of ABR in areas where we work.

OCB will ensure a sharing of laboratory and training capacity (through the MSF Academy) on this field between all OC's.

<sup>18</sup> 12\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-ABR on MSF OCB Strategic Orientation 2020-2023 Sharepoint: <http://bit.ly/34xfiSJ>

## ENVIRONMENTAL HEALTH<sup>19</sup>

WatSan/WASH in OCB has been reframed as part of Environmental Health, which is a branch of Public Health. Environmental Health (EH) addresses all the “physical, chemical, and biological factors external to a person, and all the related factors that can potentially affect health. It is targeted towards preventing disease and creating health-supportive environments.” This reframing was implemented in May 2018 in OCB and should provide a solid base to develop an Environmental Health scope within the programmatic medical discussions in OCB.

Over the past years the Environmental Health teams in OCB have implemented projects and activities in key components of Environmental Health: providing adequate water and sanitation in facilities and to populations; preventing exposure to chemical and biological agents (hazardous pharma and lab waste); implementing vector & infection control measures; reducing EH risks in specific high-risk environments (prisons, urban slums).

Climate change is currently on track to have a devastating effect on the environment and on health and is likely to lead to massive displacement and other disruptions. The impact of climate change is disproportionately affecting the health of vulnerable populations in low- and middle-income countries. In this perspective it is obvious for OCB to start getting involved and develop expertise and experience and adopt, in network with other partners, an **OCB Vision & Positioning on how respond to the challenges brought by climate change.**

The focus for the **period 2020-2023** will be:

- Further **refining and developing** an adapted **Environmental Health package** in our programmes, in the fields of:
  - Inadequate water and sanitation (quality & quantity)
  - Infection & vector control
  - Chemical pollution & radiation exposure
  - Occupational Risk
  - Construction programmes
- Developing and adopting an **OCB Vision & Positioning** to climate change
- Adapting to **new challenges**, linked to the environment, such as:
  - Changes in the disease burden, due to air pollution, inadequate or poor quality of water, poor

sanitation and hygiene and/or exposure to toxic substances

- Changes in outbreak patterns: 80% of the world’s population is at risk from at least one vector-borne disease like malaria, dengue, leishmaniasis or Chagas
- Extreme weather events, such as floods, droughts and heat waves
- Learning by doing: OCB will have a limited number of **innovative catalytic projects** addressing environmental health issues. They can be stand-alone vertical health-oriented projects or be integrated in existing projects. The interventions should target affected vulnerable/marginalised populations with significant and chronic environmental health needs that OCB can impact on and where the local health system response is unlikely to address those needs.
- Developing a **‘Do No Harm the Environment’ awareness & response** by looking at OCB’s responsibility in terms of reducing the environmental footprint where possible and proposing realistic adaptations. VII.

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<sup>19</sup> 13\_OCB\_Strategic\_Orientations\_2020-2023\_discussion\_paper-Environmental\_Health on MSF OCB Strategic Orientation 2020-2023 Sharepoint: <http://bit.ly/32aN4vs>

# ABBREVIATIONS

<b>ABR:</b>	Antibiotic Resistance	<b>M&amp;E:</b>	Monitoring and Evaluation
<b>ABS:</b>	Antibiotic Stewardship	<b>MCH:</b>	Mother and Child Health
<b>AMR:</b>	Antimicrobial Resistance	<b>MoC:</b>	Model of Care
<b>ANC:</b>	Antenatal Care	<b>MSM:</b>	Men having Sex with Men
<b>BEMONC:</b>	Basic Emergency Obstetric and New-born Care services	<b>NCD:</b>	Non-Communicable Disease
<b>CEMONC:</b>	Comprehensive Emergency Obstetric and New-born Care services	<b>NWOW:</b>	New Way of Working
<b>CHP:</b>	Child Health Package	<b>OCB:</b>	Operational Centre Brussels
<b>COC:</b>	Continuum of Care	<b>OPD:</b>	Out-Patient Department
<b>CSO:</b>	Civil Society Organization	<b>PAC:</b>	Post Abortion Care
<b>CXR:</b>	Chest X-Ray	<b>PID:</b>	People who Inject Drugs
<b>DAA:</b>	Directly Acting Antiviral Agent	<b>PHC:</b>	Primary Health Care
<b>D&amp;S:</b>	Diagnoses and Surveillance	<b>PMTCT:</b>	Prevention of Mother to Child Transmission
<b>DRTB:</b>	Drug-Resistant Tuberculosis	<b>PoC:</b>	Point of Care
<b>eCARE:</b>	Electronic Clinical Algorithm and Recommendation	<b>POCUS:</b>	Point of Care Ultra Sounds
<b>ED:</b>	Emergency Department	<b>QoC:</b>	Quality of clinical Care
<b>EH:</b>	Environmental Health	<b>RDT:</b>	Rapid Diagnostic Tests
<b>EMT:</b>	Emergency Response Team	<b>RH:</b>	Reproductive Health
<b>EPI:</b>	Expanded Programme on Immunization	<b>SAC:</b>	Safe Abortion Care
<b>EPREP:</b>	Emergency Preparedness	<b>SARS:</b>	Severe Acute Respiratory Syndrome
<b>FP:</b>	Family Planning	<b>SGBV:</b>	Sexual and Gender Based Violence
<b>HIV:</b>	Human Immunodeficiency Virus	<b>SRH:</b>	Sexual and Reproductive Health
<b>HBV:</b>	Hepatitis B	<b>STI:</b>	Sexually Transmitted Infections
<b>HCV:</b>	Hepatitis C	<b>TB:</b>	Tuberculosis
<b>HPV:</b>	Human Papilloma Virus	<b>ToP:</b>	Termination of Pregnancy
<b>iCCM:</b>	integrated Community Case Management	<b>VoT:</b>	Victim of Torture
<b>ICU:</b>	Intensive Care Unit	<b>VHF:</b>	Viral Haemorrhagic Fever
<b>IHL:</b>	International Humanitarian Law		
<b>IPC:</b>	Infection Prevention and Control		
<b>IPD:</b>	In-Patient Department		
<b>IV:</b>	Intra-Venous		





**MEDECINS  
SANS FRONTIERES**



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