Abstract

Providing aid to people in crisis is never enough—it must meet their most urgent needs and be grounded in sound science. Aid agencies have a responsibility to determine the effectiveness of their response and use evidence-based approaches. This article describes the history of Médecins Sans Frontières’ move towards professionalization in response to the challenges it faced in the field and explores the sometimes unintended organizational consequences that accompanied this move. The article highlights key questions linked to professionalization and accreditation of aid agencies that are part of an ongoing debate in the humanitarian sector through a review of the practical experience of one organization and outlining some of the pitfalls of the approaches currently proposed. Responding professionally to increasingly complex needs while retaining the humanitarian spirit that responds to unacceptable human suffering is a major challenge facing aid agencies. This challenge will not be addressed simply by introducing more regulation, as proposed...
recently by schemes to credential aid agencies, but requires old-fashioned idealists willing to challenge the status quo while providing professional interventions appropriate to the context.

**Introduction**

Humanitarian aid has transformed from its ad-hoc volunteer-led origins to become the preserve of large professional organizations. Over the past few decades, the humanitarian sector has attempted to create global standards and codes of conduct and to explore the idea of an international system of professional development and accreditation [1] [2]. Here I describe how Médecins Sans Frontières (MSF) moved towards the professionalization of the organization in response to the challenges faced in its work. The article will analyse the consequences of these changes and link the organization’s experience to the ongoing debates in the aid world on professionalization of humanitarian work and accreditation of NGOs.

**MSF’s early challenges**

The history of MSF is fairly representative of the transformation of most major international humanitarian aid agencies. The organization started as a collective of committed and idealistic volunteers, many of whom were medically qualified but had no experience of working in tropical regions. Over its forty-plus year history, MSF has developed country hubs with hundreds of staff, standardized and evidence-based programs, a research program, and strong links with academic centers.

The early MSF projects focused on delivering basic healthcare and responding to war and outbreaks of disease in settings that were often little more than the proverbial clinic under a baobab tree. Doctors would see up to two hundred patients a day, handing out large quantities of chloroquine for fevers, simple antibiotics for respiratory infections and paracetamol for aches and pains. Life-saving trauma and surgical care were provided in basic settings by doctors who were forced to improvise constantly. There were no formal criteria for volunteers aside from a medical degree and a desire to help.

Standardization was quickly recognized by the organization as being essential to deliver a high quality response. Cholera kits were designed with all the items needed to rapidly install a treatment
center, including rubber boots for the medical staff. The accumulated experience of MSF aid workers started to be recorded as guidelines. One of the most important of these guidelines was the Refugee Health Manual [3]. It pulled together the operational experience and learning of MSF in dozens of contexts and defined the top ten priorities for refugee healthcare. It became widely used by both MSF and other humanitarian actors, and remains so today.

In the 1990s several major issues led to further professionalization of MSF. One was the recognition of the problems of drug resistance, whether to chloroquine in the treatment of malaria or to the drugs used to treat tuberculosis. The other was the spread of HIV/AIDS and the revolution of antiretroviral therapy (ART). MSF medical teams began to refuse to accept the double standard whereby the standard of care for their patients at home was so radically different from the patients they treated with MSF. HIV programmes that focused only on what was euphemistically called home-based care, but was in fact palliative care, became increasingly frustrating for doctors to accept when in the rest of world, people with HIV had stopped dying. Yet there were daunting barriers to this concept, not the least of which was the price of antiretroviral drugs.

**Access to Treatment: lobbying and advocacy**

The lack of access in the less developed world to drugs, diagnostics and vaccines became a major issue blocking MSF’s medical ambitions. Sometimes it was a question of price, while other times it was a lack of research and development exploring, for instance, neglected diseases. MSF, known for speaking out against violations of international humanitarian law, started to speak out against the poor standards of medical care doctors were forced to accept. The MSF Access Campaign was launched in 1999 to lobby for access to and development of essential medicines, diagnostics and vaccines. It allowed the organization to respond at the field level by providing direct medical care in humanitarian crises, and on an international level as the Access Campaign worked on getting the tools the doctors desperately needed at prices that were affordable. One of the earliest and most important successes of the Campaign was the dramatic decrease in the price of antiretroviral drugs due to the introduction of generic competition. Suddenly, not only was it possible to treat selected cases of HIV, it was also possible to scale up treatment.

The early days of MSF’s response were largely free of external restrictions on its medical practice.
Negotiating access to affected populations with the parties to the conflict was its main challenge. Today Ministries of Health play a much stronger role in regulating the medical practice of non-governmental organisations (NGOs). MSF doctors spend considerable time negotiating access to the latest treatments for their patients. To operate in this changed environment, MSF needed to develop strong medical credentials in order to lobby policy makers. Links with academics and experts were critical, as was a capacity to perform and publish credible operational research. For example, in making the switch from increasingly ineffective chloroquine to treat malaria to the more expensive artemisinin combination treatment (ACT), MSF did forty-three efficacy studies of antimalarials in nineteen countries. Results were successfully used to formulate national policies, and to convince donors and governments of the need for switching treatments [4].

The introduction of ART for HIV, together with the care of associated opportunistic infections, signalled a major shift in MSF programs. These breakthroughs built confidence in the organization to push the therapeutic boundaries further towards increasingly complex care. A basic drug list was no longer enough, and new, more complex therapies necessitated better diagnostics and monitoring tools. To safeguard the quality of care, strict standards were put in place for the quality of medicines used in MSF programs [5]. The need for sophisticated diagnostics to accompany these complex therapies demanded skilled laboratory specialists and robust quality control [6]. Professional development and in-service training courses, introduced in MSF in the 1980s, were expanded in number and range. Recruiters looked increasingly for specialists and were less willing to send out junior doctors with little more than good intentions to offer.

**Evidence-based guidelines: appropriate for which setting?**

The shift towards evidence-based guidelines is as valid in resource-limited settings as it is in more developed countries. Yet for many of the settings that MSF works in, very little evidence for best health care practices and treatments exists. Simply applying protocols and standards from highly developed settings to resource-limited contexts often fails to account for differing health needs and disease burdens. Further, many of the protocols physicians apply in wealthy countries are driven more by fear of litigation or persuasive pharmaceutical marketing strategies than by evidence of clinical impact [7] [8]. In humanitarian interventions, where needs always outstrip available resources, it is especially important to determine what is essential for the patient and what is
merely reassurance for the clinician.

The Development of AntiRetroviral Therapy in Africa (DART) trial is a rare example of quality research done in a resource-limited setting. The trial, funded by the Medical Research Council of the UK, set out to evaluate the benefit of the routine laboratory monitoring of ART, which is widely practiced in wealthy countries. By comparing routine biochemistry and haematology monitoring of ART with clinically driven monitoring, the study found that there was no benefit to the more expensive routine monitoring [9]. Applying this evidence allows limited laboratory resources to be focused where there is an actual benefit for the patient and frees up needed resources to get more patients on life-saving ART.

The need for evidence to guide practice in MSF settings, and the lack of investment of the research community in resource-limited settings, has led MSF to focus increasingly on research. In 2010, MSF authors published 104 articles in the peer-reviewed press, over seventy percent of which were research articles [10]. The majority of MSF research is operational research, measuring and analysing the outcomes from innovations in medical projects, in particular in HIV and tuberculosis. A small but significant proportion is on neglected diseases, such as kala azar and sleeping sickness. The aim of all MSF research is to improve treatment for its patients. A recent analysis showed that over eighty percent of studies presented at MSF’s annual Scientific Day conference had a direct effect on MSF programs and around fifty percent fed into MSF or international policies and guidelines [11].

The organizational consequences of professionalization

The external factors described here, such as rising drug resistance, the HIV-TB pandemic, lack of adapted evidence and increasing regulation by Ministries of Health are common to medical aid agencies operating over the last few decades. The choices MSF made in response to these external challenges have changed the organization to become more professional and, at times, have brought unanticipated consequences or trade-offs. This experience is discussed below with the hope that other medical aid agencies may be able to benefit from this discussion.

The professionalization of MSF’s medical response has had the unintended but perhaps inevitable result of adding new layers of complexity. Such complexity impacts not only the medical
departments directly involved in the response, but also all areas of the organization. Standard drug and equipment lists have ballooned, as has the support needed to manage the entire procurement supply management chain. Biomedical technicians are now needed to support installations of radiological equipment and ventilation systems for MDR-TB projects. Architects and specialized construction experts get involved to advise field teams in specialized units such as orthopaedic operating rooms or high level laboratories. The demand for new technologies to support the complexity of care has increased and brings with it a demand for new expertise and partnerships. Each of these inputs, while important, adds to a greater or lesser extent, organizational growth. The continuing challenge is to keep the focus on simplification, such as that offered by the DART trial results, and adapted solutions. Otherwise, the growth of staff and infrastructure becomes too large a management burden and risks adding unwanted layers of bureaucracy.

At the field level, the increased size of teams has required larger management teams and more experienced managers to handle not just the greater quantity of staff, but also the parallel increase in budgets. This has prompted the development of new methodologies for training managers and supporting their career path in the organization. Gone are the days when an employee moves from a logistician role to become a country manager with only a few missions under their belt.

The shift towards more specialized human resources means that there is less room for generalists. Yet generalists continue to be needed to help MSF adapt to the continually changing environments that characterize today’s humanitarian settings. An HIV-TB program in South Sudan, for example, has to be able to respond to urgent medical and surgical needs when fighting erupts unexpectedly. Generalists are also needed for medical coordination positions where their broad knowledge-base makes them suitable for the variety of medical programs MSF now delivers. They can also play an important role in the difficult task of making resource allocation decisions.

Finally, the increased demand on human resource departments to fill more and more specialized positions has led inevitably to debates about levels of remuneration. Can an organization deliver a ‘professional’ response when staffed by volunteers, or when it maintains a deliberately low salary scale? Or does a ‘professional’ response imply a highly-paid workforce? Clearly, the issue of remuneration is complex and one that provokes strong and diverse opinions. What is important is to move away from the false dichotomy between professionals and volunteers that equates a quality
response with a highly paid workforce and an amateur response with a low paid workforce. Instead, it is possible to have a professional response that delivers a high quality intervention, while maintaining the “volunteer motivation” of individuals who are compelled to respond as humanitarians, even when that response comes at a personal cost.

**Future challenges for humanitarian aid**

Medical humanitarian action will continue to demand innovative and skilled responses. Urbanization, for instance, is changing the landscape. More and more disasters will take place in urban settings, necessitating adapted responses. The challenges of providing refugee health care in an urban setting are fundamentally different to those in refugee camps. Cholera response in Port au Prince, Haiti is complicated by the dense urban environment seen, for example, in the lack of options to dispose of infectious waste water [12]. The damage to nuclear reactors in Japan in the aftermath of the 2011 earthquake required an extremely complex response, necessitating highly sophisticated knowledge. With natural disasters increasing in their frequency and intensity, it is predicted that the number of people affected will climb as population increase is greatest near coastal regions and in areas prone to flooding [13]. Finally, the nature of conflict, the traditional sphere of humanitarian actors, is changing, demanding far more in terms of security management and at times the adaptation of medical responses in order to reach those most in need. [14] [15]

One of the responses of the aid sector to the increasing complexity of humanitarian response is to propose credentialing NGOs. Following the massive aid response to the Indian Ocean tsunami in 2004, the Tsunami Evaluation Coalition called for accreditation and certification of aid agencies to help donors and governments to distinguish agencies that ‘work to a professional standard’ from those that did not [16]. Similar recommendations surfaced following the Haiti earthquake response in 2010 [17]. Despite this understandable tendency to regulate the aid system, it is unlikely that such certification schemes will be effective in practice. Rather such systems risk being subject to the political agendas of those bestowing certification on NGOs, effectively undermining their independence [18]. There is a risk that certain governments will use certification as a means to deny access to NGOs therefore further shrinking the already limited humanitarian space and effectively instrumentalizing the certification process itself [19]. Whether in West Africa, in Syria, or in South Sudan, those affected by humanitarian emergencies deserve skilled and appropriate
responses that are executed based not on political or donor agendas, but on the humanitarian principles of independence, impartiality, and neutrality.

**Conclusion**

In a survey of nearly 1500 humanitarian aid workers, most were in favor of professionalization and standardization. But concerns were raised that it will turn humanitarian aid work into simply another service delivery business [20]. Clearly, aid workers must not become automatons executing protocols and guidelines irrespective of the situation they find themselves in. Indeed, providing medical aid in a crisis requires an extraordinary ability to innovate and adapt to people’s needs. Even more, the humanitarian response must be based very simply on the human response to suffering, the refusal to accept the loss of life, human suffering and loss of dignity of those affected by conflicts, crises and natural disasters. It is this human and moral response to suffering that compels humanitarians to speak out and loudly challenge the status quo when conditions are unacceptable for individuals needing assistance. This humanitarian impulse cannot be regulated, nor can it be taught in a classroom. And yet a commitment to help without the necessary professional experience and organizational infrastructure can lead to poor quality assistance, as has been seen most recently in the response to the Haiti earthquake [21]. The challenge for MSF and other agencies in this new era of complexity is to maintain that balance between professional response and the human response to suffering that is at the core of humanitarianism.


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ABSTRACT: With the end of the Cold War, both the concept and [...]