MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

In Service of Emergency:

Understanding Power and Inequality in MSF

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Preface

This research holds a mirror to the Médecins Sans Frontières movement, based primarily on the views and experiences of its staff. It captures issues of power and inequality – what forms they take, what impacts they have, and how dynamics vary among and within the large and complex set of entities that makes up MSF. Its portrayal of MSF reflects a particular moment, coming after several years of increased attention on racism, discrimination and injustice both within and beyond the humanitarian sector. It is hoped that, by holding up this mirror, the research will be a resource for those who seek to spark critical reflection and change within MSF. This was the intention of its sponsors in the Manson Unit, the medical support unit in MSF UK that commissioned the study.

While the research focuses on internal dynamics, it recognises the paramount question of power between MSF and those it aims to serve. Patient interviews formed a small but vital part of the study. A patient in South Sudan, when asked whether she felt respected during the week when she was being treated in an OCA clinic, responded through an interpreter:

> "She says that the nurses and the doctors would respect her. The fact of talking with them shows that they respect her. The fact that they wanted to test through echography shows again that they respect her and they respect also life, they give value to human life."

The woman had been impressed by the commitment of the staff she interacted with – most of whom, it is important to remember, share the same nationality as their patients. For staff and donors, too, the insistence upon human life is part of humanitarianism's political and emotional appeal. At fifty years old, Médecins Sans Frontières is one of the most prominent and recognisable expressions of organised humanitarianism, adept at using this appeal to capture attention and funds. Thousands of MSF staff around the world work daily in the wide range of roles that this vast, sophisticated, and wealthy movement requires. Yet, as an institution, MSF has repeatedly had to confront moments of disregard for the dignity of those to whom it offers care. Is this inevitable in an organisation focused on responding to threats to biological life in situations of emergency?

The emergency imaginary and the culture it produces is, we argue, at the root of many of the power dynamics between MSF and patients as well as within the organisation. The organisation's vocation of 'life-saving' action means an emphasis on rapid decision making, flexibility, and prioritisation. This idea shapes the organisation's work and helps justify a range of structural hierarchies. In some situations, these hierarchies are considered within MSF as indispensable, and the costs that come with them are, so the argument goes, justified by the benefits. In others, MSF employees recognise damaging inequalities that make people feel unwelcome, interfere with their professional roles, and are contradictory to MSF's Charter, yet appear to bring few sustained or significant benefits in return.

The study explored some of the most important manifestations of power and inequality in MSF, focusing on Operational Centre Amsterdam, as described by employees. One of the most striking forms of formal authority it identified was the power invested in coordination positions. These positions – the senior roles in country programmes and at the head of projects – play a filtering role enabled by their lynchpin position for both 'headquarters' and 'the field'. They can act as channels, blockers, or circuit-breakers for information, opportunities, and access to safety and protection.

The routes to potentially reaching these senior positions look very different depending on whether a person is working in their country of origin or has been recruited to travel; in the former case, routes to these positions may not exist at all, or have only recently opened. This points to the way that an MSF identity has been constructed, based on the idea of international volunteers. Despite decades of critical debate and several reform efforts, the MSF movement still depends on a two-tier system that distinguishes 'locally recruited' staff from 'internationally mobile' staff. These two groups are conceived differently and treated differently. 'MSF-ness' is not equally available to all. Racialised tropes in MSF continue to influence who is understood to embody MSF's values, and who holds expertise and competency. Yet within these contract types of 'national' and 'international', there is also diversity and intersectionality. People navigate the organisation by drawing on resources, knowledge, and currencies of influence.

Sources of legitimacy within MSF are closely tied to the organisation's 'social mission', with some roles and some individuals more able to lay claim to that 'mission' than others. Notably, volunteer spirit and proximity to operations carry weight in MSF, shaping its systems and internal conversations. While the big machine of MSF today includes many specialisations, those that best fit the historical image of the 'French doctors' that co-founded MSF remain recognisable. As efforts to address internal inequalities continue, some employees expressed concern that some internal conversations are 'going too far' in taking up time and energy, diminishing the space and ability to grapple with the ethical and practical challenges that humanitarian work inevitably, and incessantly, presents. Yet these challenges themselves demand recognition that humanitarianism goes beyond biomedical interventions, engaging with the social determinants of health and interrogating the roles, power dynamics, and impacts of different actors.

How much of the reference to emergency is received wisdom? How much is convenient alibi? Many employees were critical of the way that reference to 'life-saving' can be used to end discussion or cut off potential pathways – pathways towards alternative ways of imagining the organisation or conceptualising relationships between different staff. They pointed to the wide range of MSF's projects, many of which are not acute, temporary, or unpredictable, as a sign that 'emergency' is not always the reality.

There are thus different opinions within MSF about whether its inequalities are on some level unavoidable, and why the organisation has seemingly done so little to create more equitable systems. Said one person we interviewed:

> "A lot of the ideas that didn't necessarily start off as being racist, or an expression of white privilege, over time, because we didn't keep up with all the changes that were happening in the world, have been perceived and seen, or baked-in, [in] a way that perpetuates certain inequalities and inequities."

Said another: "Policies are made by people, and I think the way they are made, they have made them with a certain group to benefit." Concerns like these suggest a lack of trust in leadership, or at the very least a lack confidence in the ability of leaders and managers to prioritise and resolve the issues that affect different groups of staff. Today's leaders must confront these concerns and other interpretations of the institution as inherently paternalistic, Eurocentric, or unable to change. Discourses within the organisation have power; they affect the scope and prospects of action.

To invite external researchers in with the specific goal of illuminating the internal workings of power is an act of commitment and courage. So, too, was the choice by participants in this study to share their perspectives – their experiences at the hands of colleagues, their beliefs about the desirability or potential for reform, and their interpretations of MSF's past, present and future. If the research becomes a living and consequential document for the MSF movement, it will be thanks to these contributions and because of the work of its readers – employees, members and managers in OCA and MSF; patients and communities – who choose to challenge those inequalities that, individually and collectively, they affirm cannot be tolerated.

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Acronyms and abbreviations

AIDS	Acquired immunodeficiency syndrome
ALFie	Associative Life in the Field (promotor of)
CAR	Central African Republic
DEI	Diversity, equity and inclusion
DRC	Democratic Republic of the Congo
E-desk	Emergency Desk
ExCom	Executive Committee
FAD	Field Associative Debate
FTE	Full-time equivalent
GD	General Director
HIV	Human immunodeficiency virus
HR	Human resources
HQ	Headquarters
IGA	International General Assembly
LogCo	Logistics Coordinator
MedCo	Medical Coordinator
MoH	Ministry of Health
MSF	Médecins Sans Frontières
NGO	Non-governmental organisation
OC	Operational Centre
OCA	Operational Centre Amsterdam
OCB	Operational Centre Brussels
OCP	Operational Centre Paris
OSCAR	Operational Support Communications, Advocacy, Reflection
PC	Project Coordinator
PCC	Person-centred care
PPD	Preparation for Primary Departure
RBU	Responsible Behaviour Unit
UK	United Kingdom
WaCA	West and Central Africa Operational Directorate

See also the 'MSF Glossary' available here: https://www.msf.org/glossary

Chapter 1. Introduction

In 2021, Médecins Sans Frontières (MSF) marked its fiftieth anniversary. The organisation that had begun with twelve people – all men, all French – around a table in December 1971 had grown to employ some 63,000 people across 162 nationalities (Cragg and Linna, 2022). That year, MSF ran programmes in more than 70 countries. In the top ten countries by expenditure, MSF's combined spending was 570 million euros (MSF International, 2022a, p. 12). Across the world, it provided more than 12.5 million outpatient consultations, administered over 1.6 million measles vaccinations, performed some 112,000 surgeries, offered nearly 400,000 mental health consultations, and assisted 317,300 births (ibid, p. 13).

It is already obvious that an organisation operating at this scale cannot be just one thing. Indeed, inside MSF it is rarely even thought of as an organisation. MSF literature often refers to a 'movement' rather than an organisation, suggesting multiplicity and co-existence. One experienced MSF-er memorably described it as "30 boats with 30 captains," each choosing to sail more or less together in the MSF fleet. Should any of those captains choose to take their boat in a different direction, the rest of the fleet has no recourse other than persuasion and consent. There is an internal lexicon to help describe the different kinds of boat in this fleet, from the 'Operational Centres' (OCs) that manage the movement's medical humanitarian work, to the 'partner sections' that support the OCs, to the 'associative' structures that create space for MSF employees and former employees to be part of its governance at different levels. To study power within an organisation like MSF is therefore to study multiple things at once, and to leave many out.

Indeed, at the heart of our findings is recognition that power manifests differently in different places in MSF. As a result, what people describe as important depends on where they sit – both geographically and within existing political and social structures of inequality. Our study shows that inequality is inherent to MSF's work, often justified by an appeal to emergency. This 'emergency culture' shapes many facets of MSF's work – how decisions are made, how discussions are conducted, how the capacities and roles of different people are conceptualised, empowered, or constrained. Formal and informal powers are both crucial; abstract influences (such as values, imaginaries, and ideologies) have been codified and embedded in structures – such as contracts and policies – that bind some people more than others. Based on our research, many of these issues appear to feature across the MSF movement, although this varies and takes distinctive forms in Operational Centre Amsterdam (OCA, the focus of our study) and elsewhere. Throughout the research, we show how these dynamics manifest and we highlight some of their impacts, focusing on areas of particular relevance to OCA.

1.1 Studying power in MSF

This research was commissioned to analyse internal power dynamics while at duty and in day-to-day relations, between staff members and with patients. While it examines MSF, focusing particularly on Operational Centre Amsterdam, it has relevance for other humanitarian organisations. The objectives of the study were:

1. To document and assess how institutional and hierarchical power, both formal and informal, is distributed and functions within OCA both in the context of operational decision-making and in daily human relations.
2. To understand how inequalities, for example, those based on race, gender, nationality or professional domain (while recognising that identities are intersectional) are perpetuated by, and within, OCA.
3. To provide insight into how 'coloniality' may remain embedded in everyday humanitarian practices and discourses.
4. To provide an analytical resource for MSF to use when adapting human resources (HR) and operational structures so it can aim to be transparent about power and inequalities.
5. To inform MSF as it reflects on the legacies of its own action and presence in the many countries in which it operates.

The study contributes to understandings of power dynamics, inequalities and inequities within aid organisations and aims to provide a resource for those who seek to address the negative impacts of these. While unequal power dynamics within any organisation may raise questions of respect, justice, and dignity, in humanitarian organisations they are also closely tied to organisational values, identity, and purpose. Acknowledging prejudice and discrimination within a humanitarian organisation can lead to people questioning the integrity of their employer, of their colleagues, and of their own position. As a consequence of the commonly perceived overlap between what one *does* and who one *is*, addressing power inequities in MSF and the sector more generally can seem harder. Acknowledging power inequalities can be equally challenging, particularly in light of claims that aid agencies work 'in service' of communities facing crisis. Yet humanitarian organisations are no more exempt from power dynamics than they are exempt from politics – and indeed inequality is arguably a constitutive feature of the environments in which aid organisations work so it impacts their very ability to offer assistance.

In keeping with its objectives, the results of the study are analytical, not prescriptive. Nonetheless, they may – if explored and applied – have implications for the way that members and leaders of the MSF movement undertake their work or seek to influence the institution. By describing power and inequalities, this research may help to identify and prioritise potential target areas for reform. Importantly, although the research does not propose any specific approaches or solutions, it shines a light on the dynamics that reform efforts should take into account and which will shape perceptions and reactions to them.

This is far from the first study, within or beyond MSF, to consider power dynamics and inequalities within humanitarian organisations and in their practice. Exposure of power dynamics within the humanitarian sector has recently accelerated (The New Humanitarian, 2022). In 2020, the Black Lives Matter movement renewed the energy behind calls for reform. After decades of discussion around the need to 'localise' aid and shift power to actors and organisations in the Global South, humanitarians, activists and academics alike turned their attention to the explicitly racial nature of inequality and hierarchy in the aid sector. In particular, they highlighted the structural racism embedded in everyday aid practices, as well as in the hierarchy of trust, opportunity and pay that discriminates against locally hired staff (Ali and Murphy, 2020; Peace Direct, 2021; Hirsch, 2021a; Khan, 2021; Khan et al., 2021; Chaudhuri et al., 2021). As the critical literature on global health, aid and peacebuilding has shown, everyday interventions can end up reinforcing inequities among the very populations they are meant to help, as well as between humanitarians themselves (e.g. Kothari, 2006; Fassin, 2007; Benton, 2016; Pailey, 2020; Partis-Jennings, 2019; Hirsch, 2021a).

Within the aid sector, the MSF movement is a prominent player, comparatively heavily researched, and a producer of analysis and debate in its own right (e.g. Fox, 1995; Brauman, 2006; Redfield, 2006; Fassin, 2008; Rambaud, 2009; Abu Sa'Da, 2012; Desgrandchamps, 2011; Givoni, 2011; Magone, Neuman and Weissman, 2011; Redfield, 2013; Fox, 2014; Healy and Tiller, 2014; Abu Sa'Da and Crombé, 2015; Davey, 2015; Healy, Aneja, DuBois and Harvey, 2020). Internally, discussions about the treatment and representation of different staff groups are long-standing and detailed. MSF's interventions have been shown to enact racialised inequalities among staff, which reflect and reproduce global structures of postcolonial inequity (Fassin, 2007; Shevchenko and Fox, 2008; Redfield, 2012; Souley Issoufou, 2018; James, 2020; James, 2022). Operational Centre Amsterdam, which today is the operational structure comprising MSF Holland and its partner sections (see box 1), has also been the subject of a series of studies on internal culture primarily at headquarters level (Heyse, 2006; Damman, Heyse and Mills, 2014; Rengers et al, 2019).

BOX 1: THE PATH TOWARDS TODAY'S OCA

Médecins Sans Frontières was founded in Paris in 1971, formed out of the shared interests of doctors and medical journalists to establish a medical humanitarian service, more agile than existing humanitarian organisations. For several years MSF remained small. In the early 1980s, however, the organisation grew rapidly in size and prominence and by the middle of that decade it was one of the most high-profile emergency aid organisations in France with growing international recognition. As more people gained experience of working for MSF, those who came from other parts of Europe founded new MSF sections in their home countries.

After the founding and consolidation of MSF in France, the second section to be established was MSF Belgium (1980), followed by MSF Switzerland (1981), MSF Holland (1984), MSF Luxembourg (1986) and MSF Spain (1986). A bitter dispute between MSF France and MSF Belgium in 1985 ultimately led to recognition that the existing organisation(s) held no power to stop new members from establishing or developing their own independent directions. Notwithstanding their common purpose and shared principles, as declared in the MSF Charter and elaborated in the Chantilly Principles of 1995, there were and remain differences in medical and political cultures in different parts of the movement.

The potential and actual expansion of the organisation in its early decades provoked contestation. In the early 2000s, there was a restructuring of the constellation of MSF entities. By this time, there were criticisms of what one former International Council President called "*a worrying, but consistent pattern*" that the "*farther we go from the field in our organization, the more we grow*" (Rostrup, 2002, p. 5; italics in original). Five of the oldest and largest sections became Operational Centres, mostly known by the city where their headquarters sat – MSF France became Operational Centre Paris (OCP), MSF Belgium became Operational Centre Brussels (OCB), and so on. Each of these had associated sections, however these were not distributed geographically. This structure allowed for variations in the way different OCs operate and how they relate to the rest of the movement.

Operational Centre Amsterdam was formed in 2006 from MSF Netherlands and its partner sections at the time – MSF Canada, MSF Germany, and MSF United Kingdom (UK) (Binet and Saulnier, 2019, p. 224-229). A 2009 guide for Heads of Mission in OCA described the centre's desired management style as "a fine balance between demand-driven and desk-driven" (MSF OCA, 2009, p. 3). Today, the OCA Management Team comprises the General Directors (GDs) of MSF Netherlands, MSF Germany, MSF South Asia, and MSF UK, along with the MSF Netherlands Deputy Director, its Director of Operations and Advocacy, Medical Director, Staff Director, and Director of Resources. The General Director of MSF Netherlands serves as the Chair of the OCA MT. Partner sections are also represented on the OCA Council – the centre's governing body – which includes representatives from the associative bodies of the constitutive sections (see MSF Netherlands, 2022, p. 75

The members of the research team for this study were all external to MSF, a departure from standard practice in an organisation that has significant internal research and evaluation capacity. At the same time, insider access and a broad remit gave this study the opportunity to explore dynamics which are not often formally captured or considered together. As one person remarked during a consultation for the study design, at MSF "we write a lot but there's a lot we don't write down." One of the benefits of this research, therefore, is providing space for a range of views and experiences that may be excluded from, or siloed and isolated in, institutional documentation or independent studies.

Another benefit is the chance to have different formulations of systemic challenges that have already been recognised at different levels of the MSF movement. A different lens on these known challenges may help with the development of new approaches. As one participant said, speaking from their position in one of OCA's country programmes, this is why "MSF needs to have you to do research on inequality and power dynamics in MSF. Because you lose it when you are in MSF every day, as much as you lose it when you live here every day."

1.2 Challenging inequalities within MSF

This study has an ambiguous relationship with reform in MSF: on one hand, it was often perceived as part of such reform, because it provides analysis that may inform those seeking change. On the other hand, it treats reform in MSF as an area of academic investigation. It is beyond the scope of the research to give a full account of these reforms and the changes to the MSF movement over time; however, this history and current practice constitute an important context for the commissioning and conduct of this study.

The 'La Mancha' dialogue process and conference of 2006 are arguably the most important institutional touchstone for the reform of MSF. Held after a period of strong growth for the movement, they were designed to confront internal tensions over prioritisation and decision-making. During the discussions, the neglect and marginalisation of locally recruited staff (who made up 92% of MSF's personnel) emerged as one of the central themes. It was at La Mancha that the prejudices and inequities hardwired into MSF's principles and structures began to be recognised and challenged. This led to a broader discussion about the identity of the organisation; recognising that key decision makers and headquarters are in 'the West', attendees asked "are we French, European, international, global?" (Fox, 2014, p. 108). With the La Mancha Agreement (2006), MSF sections committed to "provide fair employment opportunities for all staff based on competence and commitment" (Article 2.12) and to "take proactive steps to ensure fair opportunities for access to meaningful membership in associations, while preserving the spirit of volunteerism" (Article 2.13).

In the years since La Mancha, these issues have ebbed and flowed in their prominence and in the level of institutional investment in addressing them. Although it is clear there have been changes, perceptions of them vary and this study did not seek to assess the extent of progress against the La Mancha commitments or any other benchmark. In our interviews, notably with OCA staff but also others, there was widespread agreement that meaningful attention dates only from 10 years ago at most. One interviewee with a long involvement with OCA reflected:

> "There was inequality from the beginning, but it was not recognised as an issue and it is only in recent years that it has become an issue. I think under the influence of Me Too and Black Lives Matter movements, in general the world is taking a different view these days. And that is very recent in my perception, [this is a] different view as to how we should position ourselves towards one another and how we relate and divide power between different entities, power holders, in this world. All this […] has become an issue in the last... I think if I say 5 to 10 years then that might already be a wider timeframe than it actually is."

Within this timeframe, there have been a range of initiatives – from institutional commitments at the international level, to projects spearheaded by or within specific OCs or sections, grassroots campaigns by employees taking action in their own workplace, and insurgent pressure groups aiming to leverage external attention.

These initiatives included:

- The 2017 'People, People, People' statement from the Executive Committee (ExCom), the highest executive body of the MSF movement, which affirmed that the Full ExCom "commits, as a group and individually, to exercising the leadership required to bring about this change, restoring the trust between the organisation and the individuals that are an integral part of it. It will be pro-active, face the hard questions and take action" (MSF Full ExCom, 2017, p. 2).
- The 2018 'Call for Change' issued by the International Board outlined four key areas requiring concerted effort: medical relevance and quality of care; value and support given to people in MSF; the effectiveness of the organisation's public voice; and the cultural and organisational shifts required to achieve change (MSF International Board, 2018).
- The 2020 Core ExCom 'Message to Our Staff on Discrimination and Racism within MSF', which stated that "despite years of raising awareness and efforts at implementing new policies – we acknowledge that progress is nowhere near fast enough" and "we know that these changes need to go much further to provide a more just and equitable environment to our staff" (MSF Core ExCom, 2020).
- The 2022 update on 'Tackling Institutional Discrimination and Racism within MSF', from MSF International, which captures joint work arising from the Core ExCom's 2020 message (MSF, 2022). The related action plan features seven priority areas: management of abuse and inappropriate behaviour; staff reward, including remuneration and benefits; exposure to risk – safety and security; people recruitment and development; communications and fundraising; standards of care for the patients and communities with whom MSF works; and executive governance and representation.

There are also several internal networks and projects addressing discrimination, inequities, and inclusion within OCA specifically and MSF in general.

Unofficial initiatives have also presented opportunities for different voices to speak on these issues and in some instances have driven responses from leadership. Most notably, in the wake of the Black Lives Movement, a 'Decolonise MSF' group formed, which aims to "abolish all kinds of discrimination at MSF, and to empower labour in service to this goal."[1] In 2020, an open letter that denounced MSF as institutionally racist and reinforcing white supremacy in its work was signed by over 1,100 current and former members of staff, including some at the time or recently in positions of leadership. In 2021, two Decolonise MSF organisers published *Dignity at MSF*, a movement-wide report on abuse and discrimination based on findings of an online survey with 359 current and former staff and stakeholders (Mukerjee and Majumdar, 2021; see also Majumdar and Mukerjee, 2022).

1 https://decolonisemsf.onuniverse.com/

These different efforts and conversations have highlighted questions of exclusion and discrimination within MSF. The approaches to these issues – the terminology, the concepts, the thresholds of action – have changed over time and vary in different parts of the movement. By examining power, this study aims to enable reflection on the fates and prospects of these discussions and actions, the terms on which they are undertaken, and the dynamics that shape how they play out.

1.3 About this research

This research offers a partial view of a very complex and multifaceted issue. The study has its origins in internal conversations but was designed and conducted by external researchers. Inevitably, it is shaped by its own subject matter, as the processes of defining the scope of the research and how to go about it were themselves affected by power dynamics. More information about the origins of the study, the approach we took to the research, and some of its limitations, is discussed in Chapter 2.

At this point, we want to draw attention to some things all our readers should be aware of. First, this research gives significant space to the views that we have heard from participants in the study and its analysis is a result of these many voices. While there are patterns, the views are not always reconcilable and the extent to which they align with official institutional positions varies; although the research highlights potential implications of these portrayals, experiences and opinions, it is not an audit or a work of investigative journalism. Where relevant and possible, we have also used documents that often capture specific moments or attitudes.

In reading this research it is important to pay attention to the language used by interviewees to describe power hierarchies and inequalities in MSF. Depending on people's positionalities and lived experiences, their political affiliations and activism, narratives range from mentions of 'discrimination' or 'structural inequality' to 'racism' or 'white supremacy'. Different people use different vocabularies to speak about witnessed injustices, their roots and personal and professional consequences. In our analysis we have followed the lead of the people we spoke to. This means that, depending on the positionality of the reader, our analysis may at times seem either too muted or too forceful. We did this not to align ourselves with a particular politics, but rather to remove our own views and lenses as much as possible and to foreground the views of study participants. As such, the political language of the research is a reflection of the myriad views and dominant cultures in MSF.

Second, despite our attempts to create space for the range of perspectives, we have worked within significant constraints. As we discuss in Chapter 2, our sample inevitably reflects diverse and particular perspectives. We have interviewed many different people with different roles and relationships with MSF. Given the number of participants, many are not directly represented. However, all the interviews helped this project and we want to reiterate our gratitude to everyone who took part.

Third, it is important to make clear that the majority of people who contributed to this study described feelings of belonging and loyalty to MSF even as they articulated criticisms that sometimes cut to the heart of the institution. While this tension was often visible, the subjects of critique and the motivations for continued engagement vary from person to person.

Finally, we have chosen not to name anyone. When given the choice of how their interview could potentially be used, participants had three main options:

1. For quotes to have their name attached.
2. For quotes to be de-identified (removing not only their name but any information that would link the comment to the person).
3. To inform the study as background only.

A significant proportion were comfortable with their names being associated with their comments. A larger group opted for de-identified contributions, meaning that their views could be directly represented but suggesting that they were not comfortable being associated with those positions. A smaller group preferred to inform the study only on background, and an even smaller number were not comfortable with being recorded – even for notetaking. The politics of who feels safe to speak are complex, unpacked in different parts of the research, and they have influenced our choice to de-identify all participants in the study.

1.4 Roadmap

Chapter 2 discusses our scope and methodological approach in further detail.

Chapter 3 sets the scene by introducing the notion of emergency culture, which runs as a thread throughout the power dynamics in the research. MSF's work is shaped by the idea of an emergency: a sudden, unpredictable break from normality that requires urgent and immediate action. While not all of MSF's work can be characterised in this way, it is an imaginary with important material consequences: the framing of a situation directs some actions while precluding others.

Chapter 4 introduces key axes of inequality within the movement: the most frequently referenced inequalities within MSF, that both reflect and reproduce broader structures of inequality. It then describes six 'currencies of influence' frequently raised during interviews with MSF employees: time in 'the field'; friends in high places; whiteness; English language skills; masculinity; and medical expertise.

Chapter 5 explores who is understood to 'be MSF', arguing that the way MSF identity has been historically constructed draws on certain tropes about who is neutral, and who embodies expertise and competency. It shows how this reinforces power hierarchies in countries of operation and in the movement's associative structure.

Chapter 6 examines the power concentrated in coordination positions. It argues that, as intermediaries between headquarters and the majority of (locally recruited) staff, coordination posts filter information, opportunities, and particular policies into practice. This form of power is strictly hierarchical but also highly individualised, with direct consequences for career progression, opportunities for participation, and the handling of the safety, security, and health of different staff.

Chapter 7 considers the politics of legitimacy at headquarters level. It focuses on the spirit of volunteerism and proximity to 'the field', outlining their impacts on opportunities to enter the organisation and internal dynamics. In so doing, it highlights one of the ways informal power is used: to define what subjects or activities represent legitimate uses of resources. The chapter focuses on time because this is a key resource within the emergency culture of MSF.

Chapter 8 lays out some of the main narratives that staff used to describe perceived blockages to the reform of MSF or the evolution towards greater equity and inclusion. Recognising that these discourses can shape the space and motivation for action, it does not seek to test the validity of these claims but to document their presence and the way they reflect and produce disconnects across the movement.

Chapter 9 concludes with reflections on efforts to make meaningful change, different ideas about how that could or should happen, and the combination of faith and dismay that appears to shape how employees in OCA and MSF relate to the institution.

Ultimately, emergency shapes what reform initiatives are deemed possible. The organisation's structures, and the inherent inequalities they reproduce, are justified by the moral appeal to saving lives in an emergency. Formal and informal inequalities are interconnected and interact in complex ways, they cannot be addressed separately. As some interviewees concluded, more radical change might need to be epistemic as well as structural: not only diversifying who carries out MSF's work, but also giving people the power to shape and conceptualise what MSF is fundamentally about.

Chapter 2. Methodology

This chapter outlines the origins and approach of the study. It includes reflections on the study's limitations and the positionalities of the researchers.

2.1 Origins of the project

At the end of 2020, several members of the research team were contacted by members of the Manson Unit (part of MSF UK) who invited us to take part in an MSF-funded and facilitated research project on the theme of 'power inequality' in the organisation. This occurred amid renewed calls for reform in the humanitarian sector. In MSF, a 'Decolonise MSF' group had formed, and an open letter that denounced MSF as institutionally racist and reinforcing white supremacy in its work was signed by over 1,000 current and former members of staff. In this context of renewed critical discussion, several members of the Manson Unit and their networks envisaged an externally led, but MSF facilitated, research project that could empirically examine the intricacies of how power inequalities broadly, not racism or coloniality specifically, manifest in the organisation's everyday work. The hope was that the project could eventually provide a resource for initiatives that seek to make power and inequalities more transparent, and which could also spark critical reflection within Operational Centre Amsterdam.

The research project was conceived as a 'non-typical consultancy'. It was commissioned by the Manson Unit and attached to their social science research team: researchers external to MSF were not self-appointed but invited to participate on an existing research theme proposed by MSF. Yet there were no Terms of Reference. While members of the Manson Unit had written a research brief, it remained vague. Instead, we were invited to lead the project with editorial and analytical independence. Rather than following a template with specific objectives and recommendations, we were encouraged to conduct an inductive piece of academic research. That is, the research was shaped by the emerging themes and topics discussed during early consultations and by the participants. Despite this analytical freedom, the study was not a wholly external and independent project. The research team, although external to MSF, was guided by an advisory group made up of members of OCA, OCP, and MSF International. Staff members from the Manson Unit managed the composition of the advisory group. This group provided feedback to the research team during the course of the project, and helped with facilitating access to different networks in the organisation and field sites. They also advised on promoting engagement with the finished study, a process led by the Manson Unit.

In 2021, three members of the team, Lioba Hirsch, Eleanor Davey and Myfanwy James, agreed to participate in the research project on a part-time basis – averaging 1 day a week each – alongside their existing professional commitments. We were approached because of our relevant past research, which was already known to networks inside MSF. Davey's research explores histories of aid and activism, and how historical perspectives can inform current debates. She has written about the way ideas about responsibility for the suffering of others shaped political and humanitarian engagements in France, including the creation of MSF. Hirsch examines colonial and anti-black entanglements of Western biomedicine and global health management. Her work has focused on the British-led international Ebola response in Sierra Leone in the wake of British colonialism and the transatlantic slave trade, and she led a project examining the colonial history of the London School of Hygiene and Tropical Medicine. James' work examines the politics of humanitarianism and social identity in violent conflict. Her past research considered the experience of Congolese MSF employees and politics of identity when negotiating humanitarian access in eastern Democratic Republic of the Congo (DRC), as well as the debates surrounding an Ebola vaccine trial in DRC led by MSF.

The team spent a significant period of time considering how to approach a topic as broad as 'power inequality' in a movement as vast as MSF, even with the focus on OCA. The team had conversations with members of OCA, the Manson Unit, and other MSF sections aiming to delimit the themes and remit of the project. While the research team had existing expertise in inequality and discrimination in humanitarianism and global health, it became apparent that an additional focus on the power dynamics inherent in the medical work of the organisation would be beneficial. In December 2021, Molly Naisanga was invited to join the team and focus explicitly on patient-healthcare worker power dynamics. Naisanga is a psychiatrist based at the University of Gulu, Uganda, who has conducted qualitative research in medical settings. As well as this clinical background, Naisanga brings to the analysis the grounded experience of living and working as a medical professional in the Global South.

2.2 Methodological approach

Research Questions and Themes

The research examined how different forms of power affect the way MSF operates, focusing on OCA, both in terms of operational decision-making and in daily human relations. It considered how inequalities are perpetuated by, and within, MSF OCA. Recognising that the humanitarian sector is shaped by legacies of colonialism, the study sought to shed light on how these legacies may remain part of everyday humanitarian practices and discourses.

The study was structured by five research questions, developed by the research team following consultations and feedback:

1. What are the currencies of influence within MSF?
2. Who holds these currencies, and how do they operate?
3. How do they interact with inequalities (in the organisation, the humanitarian sector, and societies)?
4. What does MSF do to counteract these inequalities or perpetuate them?
5. What are the implications for the medical mission?

We focused on four interlocking themes. Each theme was led by a different member of the research team, although data collection, analysis and writing were conducted collaboratively:

Being and becoming MSF, Myfanwy James

The first theme examined opportunities, career progression, and ideas of 'expertise' in MSF. It sought to understand who is considered to embody the MSF identity and principles, and how this interacts with imaginaries of neutrality, authority, and expertise. It considered different stages of a career path within MSF: training, opportunities for detachment and expatriation, and 'nationalisation' (appointing locally recruited staff to positions previously held by internationally mobile staff) of coordination positions. Throughout these different stages, the theme covered notions of 'expertise', and how they shape progression through the organisation. What kinds of knowledge are valued in the organisation and why?

Care and protection, Lioba Hirsch

The second theme examined how MSF protects or cares for its own employees, and how this interacts with and reinforces structures of inequality. It asked how 'care' is conceptualised in MSF, and what provisions are made for staff welfare before, during, and after an assignment. In addition, it examined the security infrastructures and protocols established during MSF's work and asked how these perpetuate existing inequalities between staff.

Inclusion, change and participation, Eleanor Davey

The third theme examined discussions and approaches to institutional culture, and who is able to speak within the organisation. It looked at how power dynamics shaped participation in different forums, notably the spaces for associative life in the movement. It also considered how 'diversity, equity and inclusion' (DEI) are understood and how this understanding reflects and shapes different contexts, attitudes, or practical possibilities.

Healthcare provider-patient dynamics, Molly Naisanga

The fourth theme examined how power dynamics manifest in the course of medical activities within MSF staff and at the staff – patient/community interface. Aspects of the healthcare giving and receiving process in the context of MSF were looked at, including: decision making (at both macro and micro level); the approach to the actual practice of clinical care; and the positioning of patients and communities.

These four themes act as threads throughout the research, and were central to guiding our interview questions and discussions.

Multiple MSFs: Scale and focus sites

Based on these key themes, the research aims to capture broad dynamics of power inequality in the structure of OCA and to some extent the wider MSF movement, while also illustrating with empirical specificity the precise power structures that play out in particular project sites at particular moments. By weaving together interviews and relevant literature, we describe how power inequalities operate: at 'headquarters' (primarily in Amsterdam); in associative governance structures; in specific project sites; and in the whole MSF structure.

The research is not an exhaustive account of how power operates throughout MSF because MSF is far from a homogenous entity. The study concentrates on OCA but even this one centre comprises multiple MSFs. Today, the movement is a vast network of different Operational Centres, governance structures, coordination offices, and project sites. Individuals' experiences of MSF vary enormously, and the way that the movement and organisational structures operate differs across time and place. So we describe the experiences within multiple MSFs, which co-exist. Not all MSF OCA projects, offices, and structures are the same, nor are the experiences of different staff and patients. The way that inequalities manifest in MSF, and interact with existing societal inequalities, is temporally and geographically situated.

To capture some of the specificities that illustrate our broader analytical points, the study used three OCA case studies:

- North and South Kivu, eastern Democratic Republic of the Congo: DRC is host to a large and long-standing OCA programme entailing primary and secondary care. In North Kivu, OCA has projects in Mweso, Walikale and Goma; it operates the South Kivu Emergency Response Unit from a base in Bukavu, as well as 'vertical activities', currently focused on treating malaria. With MSF first present in DRC in 1977, Congolese staff and communities' contact with the movement has deep roots. The movement's combined activities in DRC are among its largest country programmes by expenditure and number of staff, reaching €95 million and 2,650 full-time equivalent positions in 2021 (MSF International, 2022a, p. 12).
- North East Syria: OCA's programmes in North East Syria were until recently managed by the Emergency Desk, shifting from addressing acute needs towards more chronic health and humanitarian interventions. From early 2011 when the Syrian war started, MSF was not able to be present in the country but since 2016 has established access to North East Syria via Iraq. It has projects in cities within the Autonomous Administration of North and East Syria and in detention settings in the region (such as in Al Hol camp and annex; see MSF International 2022b).
- South Sudan: Providing primary and secondary healthcare, OCA has multiple project sites in South Sudan (including Lankien, where it has been present for 28 years), a base in Loki-Choggio and a coordination office in Juba. During the period of the study, OCA was also managing emergency projects to respond to people affected by flooding and seeking to further increase its collaboration with the country's Ministry of Health. The country constituted the largest nationality group among MSF staff in 2021, with 3,754 South Sudanese employees across the movement (Cragg and Linna, 2022, p. 36); at time of writing, OCA had approximately 1,300 locally recruited South Sudanese employees.

In selecting these case studies, our aim was to span a variety of different continents and regional settings where OCA works. However, this case selection was also shaped by the logistical practicalities and availability of MSF teams and their interest in participating in the project. Another case study, which would have facilitated research on OCA's public-facing voice, including practices and ideas of *témoignage* and advocacy, fell through. By the time this happened, discussions had already drawn attention to the value of expanding the focus on internal participation.

Methods

The research is based on document analysis, in-depth interviews, focus groups and ethnographic observations.

Documents

The research draws on analysis of a range of internal MSF documents. We reviewed internal and external reports; policy documents related to areas such as security protocols, human resources, training, and communications, as well as operational updates and minutes or recordings of different kinds of meetings. To understand how inequality and discrimination have been debated within MSF, we also examined documents related to previous reform efforts, such as the La Mancha process. Articles, discussions and comments on Souk, MSF's internal publishing platform, provided insight into contemporary sources of contention, as well as recent related initiatives. We did not access any medical or patient records.

Ultimately, these documents provide an insight into historical and contemporary debates around inequality and discrimination in MSF, and an insight into organisational procedures, policies and regulations. These documents were important in grasping particular organisational structures and discourses – especially those related to security, staff health plans, and human resources. Many of them have been used as background to inform our understanding and only some of them are directly cited in the text.

However, as with all archives, these documents bring into question the politics of institutional memory: they are products of recording and remembering, but also forgetting (Stoler, 2020, p. 23; Davey and Scriven, 2015). The OCA SharePoint was a bewildering experience for external researchers; while we could find many formal policy documents on the site, not only are documents laden with unelaborated acronyms, systematic searches are almost impossible. Many document sets have their own gatekeepers, who were in a position either to enable the research by facilitating access or to block it by denying access, delaying or restricting it, or simply not responding – however, it should be noted that most people were supportive. Yet documents do not capture the complexities of personal experience, nor the everyday debates and disagreements surrounding various policy decisions and organisational structures. Crucially, the voices of the majority of MSF's employees – those who are 'locally recruited' – remain remarkably absent in the institutional archives, as do the perspectives of MSF's patients. The institutional memory concerning the social relationships and complex hierarchies inherent in MSF's work lies with personal histories, rather than archives.

Interviews

The research draws from 147 in-depth interviews with current and former MSF employees, as well as patients. During interviews with staff, our aim was to capture a range of different personal experiences of MSF's work, from people who have occupied different posts within the organisational hierarchy and worked in different locations. Interviewees therefore included MSF staff from headquarters, coordination and project level. This included senior managers of OCA, internationally recruited employees in different countries, as well as a range of locally recruited staff in different regions (see box 2 on terminology); Ministry of Health staff were not included. The interviews lasted between one and two hours, and were semi-structured: we asked questions related to the research themes and questions. However, the interviews remained open ended, guided by each participant's experience and comments.

The majority of interviews were conducted online, either on Microsoft Teams or WhatsApp. This facilitated the participation of MSF staff located all around the world. Document analysis helped identify potential participants. However, as the project progressed, participants were identified through snowball sampling. Given the broad range of different networks in OCA, we endeavoured to talk to a broad range of employees – including those with conflicting views.

Some interviews were also conducted in person during visits to eastern DRC, South Sudan, or in Paris and London. Each participant was sent an informed consent form and information sheet. Where consent was given, interviews were recorded and subsequently transcribed by an external transcription service. If consent was not given for us to record, we took detailed notes. Participants were given the choice whether to remain anonymous.

Interviews were conducted predominantly in English and French. When necessary, the help of translators was enlisted for interviews with staff in Syria, DRC and Uzbekistan, and with patients in South Sudan and DRC.

BOX 2: TERMINOLOGY

The terminology used within the MSF movement has evolved over time, in some cases due to intentional policy. One of the most important areas for this is the terminology used to describe staff groups according to contract type – a major category of analysis for human resources purposes but also a crucial axis of power inequality within the movement. The current, officially preferred language recognises two main types of 'programme' contracts, for 'locally recruited' staff and for 'internationally mobile' staff. These are distinguished from 'headquarters' staff; in some documents, headquarters staff are also described as 'locally recruited', so to avoid confusion the research does employ this usage. In addition to the officially preferred terms, however, interviewees and documents also used terms such as 'national', 'local', and (in French) 'staff nat'; or 'international' and 'expat'. Other terms have also been challenged for their colonial and/or military connotations, including terms such as 'field' and 'mission' which are "considered outdated by many staff" although they are still used within terms with specific meanings (such as Head of Mission, social mission) (Cragg and Linna, 2022, p. 14) as well as by some staff members. At different points in the research, we examine some of the implications of this terminology. Throughout the research, the terms used reflect interviewees' speech and/or written practice.

Focus groups

The research also draws on seven focus group discussions held in person or on Microsoft Teams with MSF employees. The focus groups helped to facilitate discussion and debate from different perspectives and among people with different experiences. These discussions enabled us to gain an insight into not only how people narrate their own experiences, but also how they interact and debate with colleagues. Focus group discussions were recorded and transcribed by an external transcription service.

Fieldwork

Naisanga travelled to DRC in June 2022, and South Sudan in September 2022, to observe healthcare delivery and gain a better understanding of the existing work dynamics. These visits included being part of the project's day-to-day life and being involved in research-relevant clinical activities such as attending routine briefing meetings within the teams and training sessions, and participating in ward rounds and patient consultations as an observer with no clinical involvement. Consent was sought from those present before these observations were initiated. These visits also allowed an opportunity for face-to-face interviews with both staff and patients at these project sites.

Ethics

The project was envisaged to run for one year during 2021. However, there were significant delays to beginning the research. The study went through an approval process with the OCA Research Committee (this was after and separate from the commissioning of the study). In 2021, we were granted access to MSF OCA SharePoint, and began documentary analysis while awaiting ethics approval. In January 2022, the MSF Ethics Review Board granted ethics approval and data collection began. Additional approvals were obtained from in-country ethics review boards in DRC and South Sudan.

2.3 Positionality

It is important to note that our own positions are inseparable from the relations of power that this research describes. 'Studying up', or the study of elite actors and institutions, is always relative and contextual – our own positionalities shape the nuances of 'up' in different contexts (Peters and Wendland 2016, p. 252). Two members of the team identify as white women from Europe and Australia, one as a Black woman of European and African origin, and another as a Black African woman. Three members of the team are based at or have affiliations with universities in high-income countries, and have built careers at institutions which have been similarly shaped by colonial histories of knowledge production. The diversity in our personal and professional backgrounds means we bring a mix of methodological and conceptual approaches to this study and this research contains a plurality of voices and analytical lenses. We do not always speak with one voice, nor have we sought to necessarily homogenise our analytical styles.

Nonetheless, as a research team, we possess many of the forms of influence and privilege highlighted in this research: a base in the Global North, an elite education, a medical degree, and/or an ability to work in English. When discussing the dominance of Anglophones in MSF OCA, the concentration of power in the Global North, or the pervasive power of whiteness and medical expertise, undoubtedly our own position influenced the research process, and clearly situated us in similar power structures. Our position was also complicated by our varied past experiences and interactions with MSF. While none of us have previously been employed by the organisation, two of us have conducted independent research on it. There was a degree of facilitation by MSF, as well as public dissemination activities to discuss our findings. This, along with the situation of several of our team in the European countries where MSF is headquartered, may have influenced how comfortable some employees felt in participating in the research and offering candid critique. However, we stressed to all participants that we would not share their identity or details of our conversations with anyone outside the research team.

For other members of MSF, our position in relation to existing internal reform initiatives remained ambiguous. Indeed, many potential participants asked how our research was different from current DEI initiatives, and the reaction to our research was often shaped by the internal politics surrounding existing reform processes. This is likely to have also shaped the sample of people we reached. One participant mentioned a conversation that captures some of these dynamics:

> "Before my mate [...] mentioned the power study, I had stumbled across it in SharePoint, and I was thinking, like, 'Wow, this is really interesting, what they're doing,' and so I tried to talk to a few people about it and people are, like, 'What's the point? It's just another pointless initiative that nothing's going to change, because MSF is like this and it's been like this for a long while'."

Ultimately, we emphasised that our role was simply to understand better how power operated in the organisation. MSF is our object of study; our aim is to understand power structures in the organisation as academic researchers, rather than to identify how to somehow 'solve' these power inequalities as practitioners. Indeed, none of us have any experience working as humanitarians – this is not our skill set. In short, this research is not part of ongoing DEI initiatives. Instead, these DEI initiatives are part of our object of study as we trace how the organisation thinks about inequality, discrimination, and change.

2.4 Analysis

Rather than searching for a single 'truth' in a positivist sense, our research is rooted in the constructivist tradition of the social sciences. In short, this research is based on our interpretations of the various forms of data that we collected, and the deeply intersubjective meanings that formed during the process of data collection. Positionality is important because knowledge is always partial and situated: we can only ever understand something from a point of view (Haraway, 1988). The process of understanding is inevitably shaped by our own situated-ness (Gadamer, 1999, p. 296). Rather than triangulating the data, we sought crystallisation; we aimed to understand the topic from a range of different perspectives, which each provide a different viewpoint on the same phenomenon (Janesick, 2000). Over time, this provides a fuller picture.

After reading the transcripts, we aggregated common analytical themes which guide the chapters of this research. While the research was guided by an interest in the four research themes outlined, the analysis took the data obtained from documents and interviews, rather than those themes, as a basis. Therefore, instead of being structured according to the pre-determined research themes, the research is inductive and follows a logic that emerged from research participants and materials themselves.

2.5 Challenges and limitations

The subject of this research is daunting in scale: there is a myriad of ways that power manifests itself in the complex, transnational organisation of MSF in different project locations and across time. So this research project is not an exhaustive analysis of inequality in MSF's work, but instead highlights several key points of analysis, based on conversations with a broad range of employees. This presented particular challenges. For example, during our conversations, it was difficult to separate OCA from the broader MSF movement. 'MSF' as an acronym acts as a catch-all – it was at times difficult to know which part of the organisation or movement people were imagining or referring to during our interviews.

Our analysis has inevitably been shaped by who was willing and available to talk to us, and who we were able to reach. The research process was itself shaped by the very same power structures that are the subject of study. The advantage of commissioning a team of researchers outside MSF was the idea that we would bring an external perspective and could be more attuned to the particularities of how power works within the organisation. On the other hand, this also meant that we had to rely on existing power and institutional structures in order to get access to documents, key stakeholders and permissions. In particular, the top-down nature of OCA's management meant that contact with locally recruited personnel mostly had to pass through supervisors, HR Coordinators, Heads of Mission and Operations Managers. It was senior coordinators in each project and country, positions usually occupied by internationally mobile staff, who gave us the authorisation to begin contacting MSF staff. This made locally recruited staff less accessible and meant that identifying their voices was always going to prove more difficult than reaching headquarters staff. Field visits enabled us to address this limitation to a certain extent; further still we produced posters that were put up in project sites, and our emails introducing the research were forwarded to the personal email addresses of as many staff members as possible. The predominance of staff of European descent at headquarters and in senior roles in 'the field' also meant that they are overrepresented in this study and that they were often necessary for – or privy to – the researchers' access to locally recruited staff. Hence, while this project explores power relations internal to OCA, its design and implementation are necessarily subject to those same relations.

This was compounded by challenges surrounding travel: during the course of this project, successive waves of Covid-19 hit at different times, and travel restrictions have ebbed and flowed. As a team based in different countries and conducting the project part-time, long-term fieldwork was not feasible. Instead, we aimed to talk to a range of different people during short visits and using online conference technology. Our aim was also to shift the focus away from 'the field' (which is central to the humanitarian imaginary), to 'study up' and to include organisational governance structures themselves. Despite the study being grounded in multiple sites, the lack of long-term fieldwork may influence its credibility in the eyes of an organisation that accords such weight to experience in 'the field' – a theme that is itself examined in this research.

Chapter 3. Emergency Culture

Introduction

In 1999, MSF won the Nobel Peace Prize. In his acceptance speech, the President of the MSF International Council explained: "Wherever in the world there is manifest distress, the humanitarian, by vocation, must respond" (Orbinski, 1999). He described humanitarianism as "an immediate, short-term act" that "aims to build spaces of normalcy in the midst of what is profoundly abnormal" (Orbinski, 1999). This focus on saving lives appeals not only to the idea of immediacy, but also to the allure of the moral clarity offered by the urgent preservation of human life. A former Head of Mission summarised the spirit of MSF: "We, as a population of this world, we have a responsibility not to accept these sorts of realities, we have to do something about it, and we can."

This chapter sets the scene for the rest of the research by examining MSF's 'emergency culture'. The first section describes how MSF's work is shaped by the idea of a sudden, unpredictable break from normality that requires urgent and immediate action. This has important material consequences: the framing of a situation directs some actions, while precluding others. The second section reviews the healthcare delivery process within MSF through the 'emergency' lens. The third section describes particular elements of the *sans-frontièriste* identity developed over time, notably its emphasis on exceptionalism and debate. Finally, the fourth section examines how an 'emergency imaginary' shapes MSF as a workplace. Ultimately, the focus of emergency relief work is directed towards urgency and speed, with a short-term vision that is concerned with the here and now. This encourages a particular form of interventionism: in a context of exceptional need, exceptional measures are considered necessary, with external decision makers needing to make decisions quickly and urgently.

3.1 Emergency imaginary

MSF's work is shaped by the idea of an 'emergency': a sudden, unpredictable break from normality, which requires urgent and immediate action to 'restore normality'. As an experienced European Operations Manager put it, emergency is "the DNA of the organisation." The term evokes a site of largescale human suffering. But what is an emergency? Rather than an objective reality, the term emergency is an 'imaginary' with important material effects (Calhoun, 2010). Emergencies are exceptions: a threat to the norm which is seen to be something worth protecting (Rubenstein, 2015). The term frames an event as sudden and unpredictable, brief and exceptional, against a background of supposed normality.

This framing is important because it dictates the understanding of an event or situation and the appropriate response to it. Labelling something as an emergency communicates a moral imperative to act. It focuses attention on the immediate event rather than its longer-term causes, or the voices of those affected (Calhoun, 2010; Redfield, 2013; Rubenstein, 2015). Unlike development, emergency relief is not transformative; intervention is conceived as short term and limited. Emergencies necessitate speed and include the hope that human agency can stop harm to something that has been deemed of value (Rubenstein, 2015).

This emergency imaginary remains central to MSF's culture and identity; responding to an emergency remains the organisation's raison d'être. In an ethnography of the organisation, Peter Redfield (2013) concludes that MSF's work is a form of "minimalist biopolitics"; the organisation tackles threats to biological life by intervening directly with a technical capacity, but without addressing the root causes of social breakdown. The organisation's sophisticated logistics infrastructure, universalised medical and logistical kits, reliance on the hyper-mobility of internationally mobile staff, are all designed with immediacy in mind: "We can provide assistance quickly, when and where the need is greatest," the website explains. In theory, MSF seeks to offer a "minimal and temporary response," not the "basis for a new regime" (Redfield, 2013, p. 21). The organisation addresses political problems through a medical prism, focusing on bodily rather than social breakdown. This "pathos of minimalism" involves a categorical "concern for life and suffering" (Redfield, 2013, p. 237).

The idea of emergency enables MSF's work but also shapes how it unfolds in practice. The ability to act rapidly, mobilising significant resources, is highly valued. The nature of this study and the culture of criticism within MSF both contributed to a heavy emphasis on critique during interviews, but employees also acknowledged the positives of an 'emergency culture': "When it lines up well, MSF can be absolutely brilliant, right? You know, I can sound negative, but it's a brilliant organisation. When you need surge capacity in a meningitis outbreak, don't go to [another organisation]." Yet, as interviewees described, the idea of 'emergency' is not just a trigger for MSF's work, it affects how that work is carried out. Despite the long-term nature of many projects, planning remains fixed on a one-year cycle:

> "There is a very short-term attitude going on because next year, we might be doing something else because we're an emergency organisation […] So, you're 20-30 years in one place, in one hospital, still you do annual budgeting because next year, you might be leaving."

Employees described how this focus on emergencies means that the organisation does not plan for the future, nor consider what will happen once it withdraws. An interviewee based in MSF South Asia, one of OCA's contributing sections, described:

> "We go in with the highest level of care, and the moment we step out, it drops ten times below. So, with sustainability, MSF has been very clear about it. We're not there to do that. But […] on average, our project life is between seven and ten years. And we still deny the fact that we need to talk about sustainability. Ten years treating the disease, and after ten years, we're still back to ground zero."

Even if MSF has been working in certain countries for decades, this is framed as 'temporary'. According to a perspective from the Amsterdam office, "there is a very short-term attitude going on because next year, we might be doing something else because we're an emergency organisation." This has been set against the viewpoint of affected people: "MSF has a very crisis emergency-oriented response," a psychosocial specialist commented, "but in fact, the people in places where we operate are not seeing the experiences they have as crisis. It's their life, and often it's long term and protracted." As one emergency coordinator explained, MSF's attitude is "we just do today, and then tomorrow we see." Emergency framing, therefore, circumscribes MSF's interventions:

> "I think we've found a good way out in an ethical dilemma […] short-term, medical, tangible, impactful […] for us we just do today, and then tomorrow we see. So, I think in that sense it's good to be able to defend the accountable and defend what you are doing every day but as I've worked in more long-term development issues, the reality is more complex. So, I think we've found a good way out. Not fully way out […] because then we call emergency even when we are 30 years in the same place, and there's still emergency."

As discussed in box 3, this framework of work impacts on what MSF leaves when it closes programmes.

BOX 3: WHAT DOES MSF LEAVE BEHIND?

There was concern among employees about the impact of MSF's projects in the long term; for instance, how MSF's presence can create 'dependencies', or can impact on the relationship between leaders and community members by changing people's expectations. They linked this to short-termism in MSF's emergency culture – as an advisor put it, speaking of general tendencies: "We are definitely destabilising a lot of communities by: 'It's a short-term activity, it's a small project, it's not going to impact anything.' No, it will impact a lot of things." This point appeared to be illustrated by the experiences that a former Project Coordinator (PC) gave of a rushed project closure. They described having to act on a "very directive, dictative" closure decision by OCA headquarters, which they felt did "not even think about the wider consequences […] and how we could stagger our exit so it doesn't look like we're just leaving people in the lurch." From their perspective the top-down decision to close "wasn't a discussion and there was no room." The allocated timeframe went from six months to four and a half, and then "we were out of there, but it was so messy. We didn't take into account the environment, the other actors, the gaping hole that we're going to create and how it could have been better managed."

This may or may not be a representative case, but it draws attention to the power dynamics at play. It also suggests that short-term mindsets are exacerbating the inherent challenges of decisions about withdrawing from a given setting or prioritising between shifting needs and access. This was illustrated by one of the clinicians who reflected on their experience of setting up a new project: "There wasn't a proper long-term thinking of: 'When do we say we have reached our goal and when is it okay, then, to [...] walk back, then what would be the next step?'" They argued that a lack of consultation fed into a lack of strategic thinking about goals – even in instances when the project was not a rapid response, 'lifesaving' initiative as is understood medically. Ultimately, the closure of the project happened with neither predictability nor rationale, with consequences described as destabilising for participants in its programmes.

This is particularly important given that, as discussed below, MSF provides its services free of charge. Interviewees in this study attested to predictable, undesired impacts of when short-lived free healthcare eras end. MSF's standards are difficult to attain for many national governments where MSF operates and there is evidence that economic and medical turbulence follow when the population can no longer access free healthcare (Abu Sa'Da, 2012). Some OCA projects are engaging directly with these questions: with a more consultative approach, a team in Chad learned that, to prepare for MSF's eventual departure, community members preferred to have a system of payments for community health worker services that would contribute to sustainability over time. The open approach and the resulting feedback about payment both represent challenges to established processes. The Project Coordinator there wrote: "We dare to admit that our old methods created and contributed to a power imbalance here. And that, whilst many lives were saved, at times this approach had unintended, negative side-effects" (Cornelissen, 2022).

BOX 3: (continued)

Discussion of humanitarian action's intended and unintended impacts goes to the heart of how the movement defines its mandate. Some interviewees argued that it was not MSF's role to be building health systems or 'local capacity'. Others criticised the limits of an emergency approach. For instance, some highlighted the way it reserved key roles for internationally mobile staff, crippling efforts at capacity building:

> "How many years has MSF been working in South Sudan? […] at least 40. What would be left in terms of infrastructure if MSF left South Sudan tomorrow? [...] I've heard people say, 'Do you know? We should have set up a medical training college instead'."

The impermanency of MSF, some argued, was used to rationalise inaction or non-engagement on local staff concerns about salaries or health coverage:

> "I just remember a lot of: 'Yes, but this is not an MSF thing.' A sort of: 'This is not open for discussion'. Or if people wanted certain things, then we might be told something like: 'Yes, but MSF is not a permanent employer, it's not what we're here for,' and 'MSF leaves.' Whatever it is that you do, always remember that MSF leaves. So, you might hear things like: 'If you do find a job somewhere, we encourage you to apply, because MSF is not really here to stay', which is odd and I find very rude."

There were concerns about the impact on locally recruited staff when future plans for projects are not clearly explained. Lack of information, even when staff members are directly asking about the plans for the mission, creates uncertainty and anxiety. This encourages people to adopt self-protective positions, anticipating "what I can do just to save myself," and "when you are in that position, you cannot give the best of yourself […] which is not good for the life of the mission." This can also affect Ministry of Health personnel working with MSF as so-called 'incentivised' staff (see Chapter 4). Short-termism therefore creates an unsettled workforce preoccupied with the possibilities of sudden job loss, with impacts for recipients of care, as may be seen with attempts at achieving long-term goals. One clinical colleague concluded: "The motivation to bring about long-term change is not there if they don't know that they'll be in the job maybe the next day or the next week or the next month."

The reality, as many acknowledged, is more complex than the emergency imaginary. Emergencies are not sudden and brief, but cyclical, and embedded in longer term processes of crisis (Vigh, 2008; Lees et al., 2022). In practice, the moral clarity of responding to emergency wavers when faced with the complexity on the ground. Despite the focus on impartiality and alleviation of suffering, organisations like MSF must in practice determine where to respond (Krause, 2014). These decisions are influenced by organisational priorities, existing networks, individual decisions and personal interpretations (Brauman, 2012).

Moreover, a great deal of MSF's work does not fit the imaginary of emergency response – but instead focuses on more complex, ambiguous and longer-term processes of crisis. A clinician said that across most MSF Operational Centres there are different types of programmes: "You have a lot of these long-standing programmes that have been going on for years and years, and you also have programmes that are for research, and you have programmes that are very vertical for certain issues." In many contexts, MSF is faced with a chronic 'emergency,' taking on more and more responsibility within a dilapidated health system. In some areas, MSF has been supporting hospitals for over a decade – creating access to care that did not exist before and will not exist after the organisation leaves. MSF's presence is therefore not temporary, but instead "something of a tradition" (Redfield, 2013) – the organisation has become a permanent institution in the local political economy, reshaping access to healthcare and local job opportunities (James, 2022). Often, MSF is not a 'lone actor' but works in partnership with domestic institutions (Healy et al., 2020). MSF has focused on chronic diseases, HIV/AIDS, and processes of 'social exclusion' (Véran, Burtscher, and Stringer, 2020; Hanrieder and Galesne, 2021). Its work thus has an "expansive horizon" that illustrates "the elasticity of the concept of crisis and its increasing extension beyond medical understandings of emergency" (Redfield, 2013, p. 26).

The idea of emergency has important material effects in practice: the framing of a situation conditions the range of possible interventions. As Roitman (2013) argues, epistemological claims (such as 'this is an emergency') render certain interventions 'knowable' and 'thinkable,' while precluding others. What is communicated is the moral imperative to act, urgently, to do something to restore things to normal. Yet the idea of normality itself is predicated on global political structures. For MSF, the moral imperative is most often cast as an imperative to 'save lives and alleviate suffering.' This drives processes of prioritisation in the organisation, helping to justify exceptional measures and particular (unequal) intervention structures. Yet defining which lives to save, from what, is contested and defining what constitutes 'suffering' can be extremely complex. One MSF employee illustrated this complexity:

> "Mental health is a good example. Is mental health part of a first, initial response? […] I still don't even know, myself, because at the end of the day I'm not going to sit around doing counselling with people if they need to get out and be evacuated."

In situations characterised as a medical emergency response, some employees argued that some aspects of power – such as hierarchies – can be indispensable. For example, a Project Coordinator argued, in some settings power inequality "can be a positive […] it's not necessarily a bad thing." During a mass casualty incident, for example, "where we activated the plan and we want to respond to it efficiently, categorising patients and attending to their needs according to severity, it's important that these power dynamics exist." As they explained, this applies not only to the structures of formal decision-making authority but to informal power, because: "that's a moment of tension, stress and everyone's overwhelmed." Staff will seek guidance from certain leaders:

> "You may have three MDs [medical doctors] on shift at that time or responding to the mass casualty, but maybe one of the three is the informal leader generally, and then he's recognised or she's recognised and they go tell us what to do and we'll do."

Similarly, a staff member in South Sudan said that "in an emergency setting, you need somebody to say: 'This is how we're going to do it.' You can't have everybody question that all the time because it's not going to work." As another Operations colleague pointed out, such dynamics can make it difficult to sift through "what should be equal and not?"

At the same time, some MSF employees argued that the myth of emergency was a means for the organisation to avoid confronting certain challenges or potential changes to its approach. One employee said the recourse to 'emergency' was used to justify ignoring diverse needs and realities on the ground:

> "In MSF, we always say: 'We are an emergency organisation.' […] but about 50% of programmes are much more long term, TB [tuberculosis], HIV/AIDS, and those projects are absolutely not in a context of emergency […] So the argument 'There are emergencies so we can't do anything' is not very valid because […] emergency is a minority of our projects. So to take these kinds of project as an argument to say 'we don't do anything' for me is completely wrong."

A range of examples of this mindset emerged in interviews. An internationally mobile employee said that a short-term approach to structural issues meant that MSF does not engage with 'local communities' to think about prevention:

> "When you talk about things like measles, that comes back every few years. That's a revolving disease. You can't really treat it like just an emergency. It is a structural problem. So I think it's worth looking at it with a bit more of a mid-term, long-term view, and looking also at it maybe more with a prevention view of what role the communities can play."

Another example given was of attitudes towards disability inclusion. A colleague leading disability inclusion explained:

> "Some people really told me, 'But you know MSF it is an emergency organisation, I mean you have been in the field, you know the pressure. Think about all these missions where there is emergencies, there is war. Do you think people will have time to think about inclusion of persons with disabilities?'"

That colleague's observation was that this argument was more likely to come from internationally mobile staff or headquarters. Indeed, not everybody shared this position – even some of those from 'the field' themselves. Another interviewee described the insistence that MSF leaves "as soon as the emergency's gone" as an outdated conception of MSF's role that inhibited proper project design, saying that "this space we work around also has evolved a lot. So, the attitude around how we start off our projects and our missions also needs to adapt to this." Finally, as explored further in Chapter 8, employees described the way that an emergency culture in MSF inhibited consideration of longer-term or strategic issues, such as the environment. For example, a manager expressed their surprise at the fact that in 2021 "for the first time, MSF went to Glasgow for these climate summits. Sustainability is a long-term thing. We're in emergency aid."

Discourses that emphasise or even overstate the importance of 'emergency' may persist because it is so important to the organisation's identity, as well as because of the potential to use this discourse, in a self-serving way, to justify or rationalise certain choices. These dynamics are explored in the following sections.

3.2 Emergency and paternalism

The social settings where MSF works are shaped by existing power structures, those particular to the period of 'crisis' as well as deeper ones. Locally recruited staff working for MSF claimed that the organisation's presence was seen as reassuring: "Even without giving anything, only the fact of [MSF] being there is a relief." Locally recruited medical employees contrasted this initial welcome with the public when decisions are made to close projects with the "jubilant celebrations as if it [is] a festival" when projects are re-opened. This image of opposing emotions encapsulates the power inequality between MSF and the people it finds on the ground, of which employees are strongly aware: "Clearly there's a huge imbalance between the power MSF wields just in its ability to either provide the service or not."

Nonetheless, being welcome does not remove the need for power negotiations so as – in the words of one Head of Mission – "to create a protected space where you can plan activities, missions, projects, et cetera." Representatives of the organisation thus make an effort to find the right footing, with implications for clinical care and resource management – human or otherwise. The nature of negotiations also depends on the structures and relationships in place. Staff claimed that, in instances where MSF is acting independently, at least at the health facility level, "MSF has full control of what we need to do in the project." Yet, as an OCA study (Healy et al., 2020) pointed out, MSF is no longer the "lone ranger" of its self-image, with over 70% of projects involving collaboration with a Ministry of Health (MoH). Interviewees described collaborative work as confronting MSF with additional considerations:

> "When we work with MoH, there tends to be a lot of struggles, different struggles with MoH. There tends to be differences between MoH and MSF staff in terms of competency, in terms of benefits, in terms of salaries, respect et cetera, which can create conflicts between MoH and MSF. Management issues can't be directly addressed with MoH staff et cetera. So when you have quality of care issues, you have to go through MoH management, which is not necessarily the same as being able to directly manage something yourself."

As this quote indicates, for some members of MSF staff, MoH-linked projects tend to be characterised by greater turbulence and less enforceable hierarchies. This is suggestive of the potential for paternalism to also shape interpretations of the relationships between MSF and the government structures with which it collaborates.

Once present, MSF delivers a service to people who in their own eyes may sometimes perceive themselves as powerless, especially in comparison to MSF. In these settings, including beyond its own clinics, MSF is a powerful machine. As one patient said: "No hospital can have that capacity of treating without the support of MSF. Many medicines in boxes are provided by MSF." Supplies are key – and not just any supplies but free and high-quality supplies.

The importance of supplies and services being provided free cannot be emphasised enough, as interviewee after interviewee echoed the same mantra. According to a clinician in Uzbekistan, this offer was widely understood, and provided incentives for people to access MSF's services:

> "The general population have understanding about MSF […] they understand that whatever services we provide, we provide for free of charge. This is one of the leading indicators why people always try to get, as much as possible, the services we provide because they don't have to pay from their own pocket. They understand the humanity, from a humanitarian point of view, that our basic ideal goal is treat, care, cure and stuff like that, not to make business on people."

Another doctor, from DRC, linked the provision of free healthcare to patients' willingness to engage, seeing it as "making the patient very confident with us, and they could discuss with us regarding any matter." Participants who had used MSF medical services expressed gratitude to the organisation: "MSF has been good for me. It's a miracle. Without MSF, passing seven days in intensive treatment, I wouldn't have been able to pay." Another said:

> "If MSF could not be here, the lives of people here can be very bad. Because very many people, especially with kids, they obviously admitting here in the ward. It can be very bad if there's no MSF here. So MSF, people are grateful with MSF."

Considering that free healthcare is welcome at all times, how much more welcome can we expect it to be in the circumstances in which MSF often operates? The provision of free healthcare is often characterised by a power shift in favour of the 'giver' of the service; provision of free healthcare is an important form of power and leverage for MSF. This is the double-edged sword that free healthcare represents, at least as far as power is concerned. One operational leader summarised:

> "When you think about communication with beneficiaries, in a lot of places – and South Sudan is a great example of that – where healthcare infrastructure is poor and weak, MSF is a Godsend, essentially. We deliver free quality healthcare but that comes at this price, which a lot of people I think sometimes don't acknowledge, which is that MSF then has power over the community through the act of delivery [...] When we say something to the community sometimes, they may be receptive or seem receptive and accept what we're saying. That's not really because they accept it; maybe they do, maybe they don't. But that's also partially because us are the ones who hold all the power, the ones who give the healthcare, the ones who save the children."

The focus on speed and urgency means that the organisation often does not consult local communities when designing an intervention, or only minimally. Instead, external intervenors act quickly, and implement their programmes as fast as possible with the aim of saving lives. For instance, one locus of emergency imaginary in OCA is the Emergency Desk (the E-desk), which sits in Amsterdam and manages the Emergency Support Department teams across MSF projects. One former E-desk member said: "The emergency team makes a lot of things happen" but "sometimes they can also really overwhelm existing missions or even really ignore the fact that we need to, even in emergency situations, consult the population we're working with." One employee described the doubt they had encountered within MSF that a more collaborative approach could be integrated into emergency programming "where we have to be quick." They argued that it was possible: "It's just about taking a minute before we start and listening, and asking people, what do you think your community needs now?"

This question is not only about prioritisation, however, but necessitates confronting the limits of MSF's action and, more fundamentally, how people both outside and inside MSF view the organisation and its role. The perception of MSF by communities has been studied in detail in research instituted by Operational Centre Geneva (Abu-Sa'Da, 2012); in interviews for the present study, patients noted that MSF tends to do different things at different times, though did not always differentiate between different Operational Centres. These conversations revealed a complex set of expectations, which often fell beyond MSF's actual intentions and outside of its medical mandate. For instance, one patient explained their requests to MSF: "To give food, flours, for children suffering from a lack of food. They don't have an appetite, children don't have an appetite, food to provide, to provide energy." A Health Promoter described common requests on the part of local populations to MSF: "Safe drinking water, hygiene, and also healthcare, and also, surgical things. So these are the four things they want, and the community needs, from MSF." Reflecting on such requests, a Project Coordinator said: "They always ask us to do more and more and more, and we tend to refuse." But patients and community members are not the only ones questioning the limits of MSF's chosen roles. Among employees within projects, there was some debate about the limits and possibilities of MSF's medical action. While some argued that MSF does not do enough, in South Sudan, there was an impression that space should be made for other actors to take responsibility and fill in different services. These discussions parallel wider debates, with the approach of attending to only a particular set of needs contrasted with that of attending to the many needs that may present alongside healthcare, as for example in the 'Partners in Health' model (Farmer, 2013).

Several OCA projects have recently tried a new 'community co-design' approach, involving the local population in the design from the onset. An interviewee involved in one said:

> "There's this imagination or assumption that, in an emergency, immediate action is required, and MSF has the expertise of doing that, and the means. I think the step we miss there is: what expertise and what means do the community have? I think that is a lot more than MSF usually assumes it to be."

These employees argued that a focus on saving lives in an emergency encouraged a paternalistic interventionism, where patients are subjects to be acted upon, and treated as if without expertise or agency (see especially Chapters 4 and 8). Yet, there was also concern about how elements of saviourism might be *reproduced* within MSF. MSF still relies on a model of internationally mobile staff who are brought in from abroad, and too often considered to be 'experts.' As one partner section staff member reflected:

> "Our staff come with big cars, places with fences […] quite isolated from the local population […] And of course, we still do represent the white saviour pattern, with our fundraising, also with our communication. This is somehow unavoidable. I guess there is an awareness about the structural similarities [with colonial history], and we try to not fall into some traps, or at least be more diverse and more aware."

Another interviewee at OCA headquarters described the problem of "mindset" in MSF among young medical graduates from Europe or North America who are brought to contexts where they consider themselves to have more skills than local medical staff, when this is clearly not always the case:

> "But that's not the picture we paint on our advert in Europe, so of course the junior doctors and nurses want to go and save lives. Whereas he or she should go to help others to do a better job to save lives, to manage, train or coach them. Again, except the 5% primary emergency, where we really need to go and stop the bleeding, but that's a small part at the end of the day-to-day work that we do."

To highlight the saviourism in the emergency medical culture, one interviewee described how they often asked during internal debates: "Could a patient be a General Director of MSF? Could a patient be on the board? Could a patient be a Head of Mission?" They argued that, although "we all go to the doctor, we will all have health issues," the potential for this to be a "universalising" point of connection between staff and patients is undone by a reliance on placing people in what they called "categories" that carry assumptions and judgements. In the logic of these categories, there would be no value in having patients serve on a board or in an executive function. These propositions about patients are a provocation, and they have limits when applied in practice – any given patient is no better placed than any given employee to become a General Director; not all are suited to it. Where they help is in highlighting how certain imaginaries within MSF limit action, with implications for the organisation's stated goals and commitments, such as to person-centred care (see Chapter 8). These imaginaries are also shaped by MSF's history and culture.

3.3 Emergency mavericks

While the imaginary of emergency is important across the humanitarian sector, within MSF it is particularly tied to the organisation's origins (Vallaeys, 2004; Brauman, 2006; Davey, 2015). Two traits in MSF's emergency culture interact to create an image of MSF as the 'mavericks' of the aid sector: a sense of exceptionalism – the idea of doing work that no one else is – and the idea of the movement as an association.

A perception of MSF's operational distinctiveness seems to be one of the main reasons why people want to work for the organisation and, if they stay, develop strong loyalties to it. One locally recruited employee who had worked for multiple non-governmental organisations (NGOs) valued MSF differently because "it's only MSF that can give you access or that have the zeal to go and reach the people who are in need, no matter what difficulty they are facing." Another said: "I'm lucky to be with MSF, because wherever there is a dangerous challenge, MSF never hesitated for support." A senior colleague in Operations at headquarters similarly explained that "MSF offers me opportunities to respond to an emergency in a way that no other organisation will." MSF's financial independence, secured through its strategy of fundraising from private, individual donors rather than taking public money, is an enabler of this ability to take action. Employees valued MSF's "independence on decision-making and money" and "independence on all levels" in making it resistant to pressure. Loyalty was often cast in the language of 'love' and speaking of MSF as 'family'.

Conversely, the sense of exceptionalism was also presented as one of the biggest impediments to change. The organisation maintains an attachment to doing things differently because MSF is different from other organisations. OCA employees described a sense of scepticism towards 'external' experience, that might be too muddied by politics or 'development' agendas. These views came from long-standing OCA employees as well as more recent arrivals; from colleagues in operational, communications, and health roles; in executive positions and governance roles. "MSF is really insular, and people look inwards," one said, while another noted "it is amazing how people simply don't appreciate that somebody comes with something new." Another described how "MSF has this bit of rebel spirit still that sometimes makes us a bit sceptical" about what others are doing. This rejection of the outside was described in one interview as enhancing "the cult-like nature of the organisation," a characterisation arguably also seen in another's critique that "we do not want to mirror ourselves to the outside world. The outside world doesn't understand that we are different."

This sense of self-reliance may lead to benefits for staff, with one locally recruited Health Advisor explaining that MSF is regarded as a powerful "training ground" for developing professional knowledge: "If you need training, come to MSF." (They went on to say: "If you need money, go to another organisation.") However, it also appeared to have indirect manifestations related to a sense of internal closure and lack of accountability. For locally recruited staff who were often excluded from strategic decision-making, they described how there was "always a reason for things to be done a certain way," but that these reasons were rarely explained at project level to those affected.

In MSF structures, the emergency function of the executive is contrasted with the debating role of the association. The association is an important part of MSF's governance and identity, reinforced in the Chantilly Principles of 1995 which tie associative life to "a capacity for questioning ourselves." In brief, the association is a set of membership-based governance structures in which individuals vote for representatives and motions; their representatives can then take the motions to higher levels of movement governance. Once a person has worked for MSF, they have the right to join various associative bodies, and can remain a member of them even after they have left. 'Debate' is foregrounded as key to the association. For example, a training course for locally recruited staff on 'MSF: An Association' presents the association as the part of the movement that "defines MSF's identity, principles, ethics and orientations," is "democratic" and "about debate and discussion." The executive, in contrast, is presented as the part that "translates ideas and plans into action in [the] field," is "hierarchical" and "is about getting things done."

Interviews with locally recruited staff highlighted the importance placed on the association for people's sense of belonging in the movement. For example, a long-standing staff member who had joined MSF not knowing much about the organisation said that the fact that it "gives people the opportunity to speak up" became "something that makes me want to continue working with MSF […] It's not something that other organisations across the world offer." They described the association as a forum where the hierarchy of executive roles gives way to greater democracy: "The ideas of the Head of Mission, of the guard, of the cook, they all matter." Another interviewee said: "Any changes that are coming to MSF are coming from the associations […] That's why we are MSF. MSF always are looking for the motion. If you raise it, you can look at it, then agree or not agree on it."

The power of initiative offered to individuals within these collective spaces converges with an image of MSF as an "organisation of mavericks." A range of interviewees highlighted the importance of "charismatic people" and "outspoken individuals" in pushing the organisation to think differently. A locally recruited colleague summarised that "the will of some individuals," particularly those who "refuse certain things," can be a "catalyst" of change within the organisation.

The idea of charismatic, somewhat contrarian leaders driving an anti-establishment organisation taps into the story of MSF's origins and early years. NGOs have origin stories that narrate their past in ways that serve agendas in the present. In MSF's case, the importance of individualism has been reinforced through repetition of a story that situates the seeds of MSF's creation in the act of French doctors who 'spoke out' about what they had seen during the Nigeria-Biafra war (Desgrandchamps, 2011-2012). In the early years of the founding French section, leaders sought to capitalise on media attention and built a tradition of written analysis, reflection and testimony (Davey, 2015). In the 1980s, employees from other parts of Europe established sections in their home countries, so that the movement benefited from, but also perpetuated, the influence of individuals who galvanised others into action. By the end of that decade, the internationalising network had developed a paradoxical image as "an informal movement with a culture of debate that nonetheless acted decisively, an organization of swashbucklers with technical expertise that spoke with equal parts brazenness and sophistication" (Bortolotti, 2004, p. 14).

The role of outspoken individuals within the organisation mirrored the role of an assertively independent organisation within the humanitarian sector and on an international stage. The concept of *témoignage* (sometimes translated into English as 'speaking out' or 'bearing witness') plays an important role in the organisation's culture. It is enshrined in the current Charter, the Chantilly Principles, and the La Mancha Agreement, the preamble to which declared that "the separation of the concept of *témoignage* from operations has disappeared" (MSF International Council, 2006, p. 1). Despite its centrality, however, *témoignage* has no agreed definition (Gorin, Guevara and DuBois, 2021, p. 30). It connotes "notions of humanity and solidarity" and "encapsulates a medley of ideas: proximity with people living through crisis; the intent to listen to them; the swelling anger at their plight; the desire to change their situation; and calling out the manipulation of humanitarian action" (Claire, 2021, p. 47; see also Redfield, 2006; Givoni, 2011). Some of the ways *témoignage* has been described resonate with the depiction above of how individuals can make their mark within the movement, hinting at the value placed on exceptionalism within the MSF culture.

Institutionalisation and bureaucracy have been presented as a threat to the movement's ability to maintain this spirit of openness to question. The maverick spirit is pitted against the "institutional thickening" (Fox, 2014, p. 5) that has accompanied MSF's growth. As one employee said:

> "If you're awarded a Nobel Prize you become part of the system. With hindsight we should have refused it. Simply for the statement of it, 'No, we don't want to be part of the establishment. We want to remain outsiders, kicking and pointing at the fact that the emperor is naked.' And now we became part of the naked reality of the emperor."

This is not, as one senior manager explained, simply a question of institutional scale but of changing expectations:

> "Now you can't be so rebellious any more or you don't have access to patients, so that generates a lot of tension between the spirit of the founding fathers, or the cowboy spirit, and the compliance standards which we have today. They can't co-exist with the cowboy spirit. One says: 'we are without borders and we go wherever' and the other one says: 'you don't have a registration, you don't do anything – period'."

Historicised narratives about MSF's identity also shape perceptions of what is possible in the present. A former General Director in the movement captured how the place of history in MSF's emergency imaginary is both meaningful and somewhat mythical:

> "You are running to a country to save lives because that was basically the image of the 70s. That has changed a lot, let us be honest, but the perception is sometimes still very present. […] Because the French medical thing is not so much French, not so much medical, and not so much running alone there in the field."

A senior employee described the weight of this legacy in thinking about personnel on assignment. Within MSF's particular ideology of emergency humanitarian intervention, they said that "the makeup of the staff" and "the idea of *sans-frontièrisme*" are "essential to the identity of the organisation." This places limits on the ability to discuss issues such as team composition in a nuanced and context-specific way:

> "We could probably recruit most, if not all, of the expertise that we need within the country. But MSF has said very clearly that we don't want to have just local teams even in contexts where we could do, because we think that the international nature of our teams is really important and it brings a really important added value and it's essential to the identity of *sans-frontièrisme*. But what we haven't done is defined what that means."

Several interviewees described such issues as blockages, dynamics that are explored in later chapters.

3.4 Emergency as a workplace

Employees described the ways that MSF's emergency imaginary – the combined pressure of urgency and importance – and the legacies of its history impacted their experiences of MSF as a workplace.

The focus on a fast and urgent response to immediate need created a work culture whereby "MSF becomes a bit your life." For instance, international employees often live together, are considered constant representatives of the organisation and must act accordingly, while security measures restrict their ability to spend time beyond the logistical infrastructure of the organisation. Meanwhile, all employees work long hours and described MSF as a demanding part of their life. A medical programme employee said that in her experience:

> "Sometimes you have, like, 70, 80 patients which you have to see them, alone by yourself. So, of course, we were so dedicated to that, we were doing that. And though it was a workload, we did not realise, because we also like our work. So, you will do all the rounds on this patient, and still be able to offer them some of the care you can give. Because, of course, we know very well that not everybody will get the quality care. But of course you can be able to end up seeing them all, making plans for them. But the workload within MSF of course can not be talked about. It is the usual thing."

Indicating the value placed on work itself, one interviewee commented: "I think a lot of the people we work with are quite overwhelmed and overworked because there is so much to do. And if there's not much to do, they make themselves a lot to do." A Health Promoter reflected on how this culture affected the collective ability to think outside of current conditions (see also Chapter 8):

> "I think it could be the fact that it's an emergency and there's always a lot of work. [...] There's never an opportunity for people to sit around and say, 'Okay, what are we going to do next?' There's always like, 'Go, go, go'."

'Being MSF' required a degree of personal sacrifice, which was understood as central to the 'volunteer spirit'. As one employee said: "Because we work in emergency, we expect our staff to be responsive and dedicated 24/7 to what we're doing. That doesn't necessarily align to what's best for their day-to-day lives, or ours, for that matter." Experienced fieldworkers described receiving limited support from managers: "I just think people are busy and people have different ideas about what good management is or how much of their role they feel like they need to offer to the management responsibilities." Locally recruited staff described working long hours, which they often have to juggle with other responsibilities and pressures. One employee in Syria described:

> "We work from eight to five, then when we go to family, from five we have our home tasks […] Sometimes we work after work time […] a silly question that we get from international staff, they say: 'How do you spend your weekend? Did you go somewhere, did you travel, did you go to a restaurant, did you go somewhere celebrating?' We are just laughing. Because I spent all weekend to fix something at home and to work on the pending home tasks. So, we never have a rest."

Among some employees, there was concern about the burnout rate, and an organisational culture that prioritised doing whatever it takes in the context of emergency. These also reflect one of the themes to emerge from interviews, distrust or lack of confidence in management:

> "We were trying to share with the higher ups saying: 'How do we ensure we have less of a burnout rate? Because we're losing a lot of good people. Our contracts say we work 40 hours. We actually work 100 hours. The 100-hour people continue with the organisation, because they can handle it, but […] we're losing retention on this amazing group of people'. [...] And we brought this up to the general direction some years back, and we were told: 'That's MSF. We like people to continue working with us who have the passion'. And it's an undertone that this is the way you work. You learn or you burn."

Attempts to manage burnout risk through short-term assignments can create problems of continuity. A member of the Operations Department in Amsterdam explained: "We fix the length of missions for some positions for very good reasons. If it's active, front-line work you have external stress, which after certain time the exposure is damaging, so we need to limit it." A colleague described the problem of high turnover, as each Head of Mission came in and tried to implement new ideas:

> "We get a HoM or Project Coordinator who is in for three months and says: 'Hey, we need to do this', but we've already tried it three times. Or […] we know the long game on that doesn't play out in the way that would be beneficial for the population."

In some settings, it was argued, it should be possible to reduce turnover, yet the emergency DNA of MSF takes over: "we manage things with a short-term mindset, and [...] we also justify it when it shouldn't [be the case]." The high turnover of what were often described as top-down decision makers has implications for the constructiveness, or otherwise, of the workplace. One clinical staff member explained:

> "Let's say I spend four years in a project and every six months you have to change supervisor, for you have not much power, you have not much authority to do anything other than to follow what the supervisor wants you to do […]. So, of course when today somebody comes and tells you, 'let us do A'; another comes tomorrow and says, 'no, A doesn't work […] let us do B'; another comes and says, 'let us do C'. You know how this person is going to be very confused, you know. So, he's going to be completely confused and there's nothing he can do other than just to follow, do this, he will do that and do that, yes – but when you pull people together and treat them as a team, when there is decision making to be made they are also involved, I mean, I think it will give them that much interest to work."

Similar dynamics of short-termism were described in the conditions for locally recruited staff despite these positions not being identified as requiring turnover to avoid burnout. Locally recruited staff raised concerns about being shuffled between projects and sections, with contracts described as often being short-term and subject to renewal despite many locally recruited staff working for the organisation for decades. These accounts may reflect inconsistencies in approaches at a range of potential levels, as from a headquarters HR perspective, OCA's standard approach (adapted to meet national employment law requirements) should be to offer an open-ended contract after 24 months of continuous employment. According to OCA data, 57% of the Operational Centre's locally recruited personnel were on open-ended contracts as of April 2023.[2] Beyond formal contract issues, short-termism was described as shaping the organisational approach to its personnel: "Being an emergency organisation, the idea is you go in and you [go] out. By design, you're not supposed to be a really good employer, right?" As one senior manager explained, the focus on saving lives "also means that you're not investing in society around it or trying to give capacity to local staff because: why would we?" Locally recruited staff argued that the short-term postings of senior in-country decision makers reduced the responsibility that these managers feel to think strategically about the longer-term vision of the organisation's projects, or to solve structural problems that affect their colleagues. Here again, in a different form, a lack of confidence in management is visible. One local employee explained:

> "That is another issue with MSF: the fact that they bring international staff for two, three, six, or nine months, and then they leave. Then, someone else comes for the same amount of time, and they do not feel responsible for anything. Everybody tells you they do not know why things are this way and what can be done about it."

2 By way of comparison the proportion of open-ended contracts in the Netherlands-based headquarters staff was 67%. Data provided to the authors, May 2023.

Many interviewees argued that the institution's willingness to offer poor employment conditions and its tolerance of poor behaviour was a product of its emergency culture. A senior manager criticised the organisation for systematically "paying people badly" due to this culture, summarising the logic as: "we need to save money for saving the world, and because you are so lucky you can work with us, and it's so fulfilling for you to work with us, we are okay with not paying a proper salary." Some implications of this attitude are discussed in Chapter 7. Another interviewee put the stakes even more starkly: "I think the organisation recognises that it offers this amazing opportunity, but also leverages this in playing off of you. So, I could easily walk away, but I choose to be here, and I choose to be abused." Locally recruited staff described how discussions around per diems, pay grades or medical benefits seemed to be approached as a distraction from the medical mission of MSF. Narratives on this issue are often strongly presented, reflecting what employees describe as a failure to make meaningful progress on issues that many see as fundamental to the movement's integrity (see Chapters 5 and 8). One interviewee with experience of advocating for improved conditions, especially for locally recruited personnel, said:

> "HR and MSF is just a nightmare. It is a nightmare even though the people are what gets the job done. It isn't okay in MSF to think about what individual people might need or what they feel or what brings them to being valuable contributors to the MSF thing. You're very much a cog in the wheel of operational service. Everything is a slave to Operations basically. So, trying to fight against that is one of the hardest jobs in MSF."

Reflecting on different aspects of their workplaces, employees described the strength needed to build a career in MSF. Some evoked a stereotype that they found in the organisation, an attitude of "I can be very shit to my colleagues and it's fine because I'm doing something good, because I'm a humanitarian." Interpersonal communications can become hostile, with some "using the word of emergency" to put other views down. The culture was described as at times "oppressive", "toxic", "abusive", ill disposed towards discussion of vulnerability, and making people "reluctant to engage with one another's criticism." This echoes earlier studies of the movement that have highlighted how: "The 'social mission first' imperative can be used to justify or accommodate disrespect or neglect toward others" (Harvey and Delaunay, 2018, p. 9). Some interviewees had the impression of different styles or tones of communication across the offices of OCA and partner sections, although not sufficiently to temper the idea that strength and confidence is required to speak within MSF and that if you experience a problem "you're supposed to kind of work through it." This is also a part of being an "organisation of mavericks," as one person said:

> "There's a way to move up the ranks to be heard, to be known, to make your mark and it's very much about seizing sort of the moment when you run against the current […] because you just put it out there at the right moment when the debate has to happen and it's all a mess and you need somebody to walk into the middle of it and say, 'This is what we need to talk about'."

This culture was identified as resting on privilege and interacting with the material privileges that create favourable circumstances for an engagement based on the spirit of volunteerism. A person of colour reflected that:

> "Whether it is white privilege or privilege for people like me, privilege is clearly at play. It's who you have access to, whose ears you have, the ability for you to travel, the language you are able to speak, the education you've had, all of that and maybe much more; the confidence, a certain sense of confidence that you have, that you can challenge, and you can engage, and you can be heard, and without your ego getting too bruised, or you recover from that bruising. All of that is privilege, right?"

Conclusion

MSF's work is defined by an aim both minimalistic and expansive: to save lives. While appealing to moral clarity, this emphasis on emergency is more complex in practice, and shapes the organisation's work and culture in specific ways. As this chapter outlines, emergency culture in MSF redirects the organisation to the here and now, responding with urgency and speed in the short term. At least in principle, the focus remains on short-term intervention, rather than longer-term processes or questions of sustainability. The organisation's intervention structures, and the inherent inequalities they reproduce, are justified by the moral appeal to save lives in an emergency. Emergency programming, MSF argues, often requires external intervenors, who act quickly, sometimes with little input from local populations or patients in the design of projects. However, by not thinking about health and the political contexts in which it intervenes sustainably, MSF contributes to a mode of short-term emergency planning that leaves the door open for ever more emergencies, thereby reaffirming global relevance and legitimacy for outside interventions.

MSF's emergency culture is a thread that runs throughout the rest of this research. The power dynamics inherent in the organisation's relationship with the people it aims to serve is another theme, including the approach to healthcare which is underpinned by the mantra of saving lives in an emergency context. These dynamics are inherent in the way that locally recruited staff are positioned, as Chapters 5 and 6 show, with their assumed proximity to communities where MSF works, sometimes treated as an asset and sometimes as a risk. Chapters 7 and 8 describe in greater depth how an appeal to 'emergency' shapes what reform initiatives are deemed possible. The next chapter introduces some of the currencies of influence that hold sway within this culture and how they interact with inequalities within and beyond the MSF movement.

Chapter 4. Currencies of Influence

Introduction

The previous chapter outlined MSF's emergency culture and operations, and described the environment in which employees work. This chapter examines what this means for people within the organisation – how is MSF experienced and navigated? Previous scholarship on values-based organisations has highlighted the informal powers and privileges (or disadvantages) of certain individuals, position-holders, or social groups (Hopgood, 2006; Benton, 2016; James, 2022; Kothari, 2006). Research on MSF has shown that norms within parts of the movement reflect different forms of cultural capital and intersect with social and political hierarchies and inequalities (Rambaud, 2009; Shevchenko and Fox, 2008; Souley Issoufou, 2018). Histories of MSF highlight the role of key individuals in defining, expanding, transgressing, and subverting formal structures, further valorising and mythologising the role of individual agency in an emergency culture where improvisation is often more important than institutionalisation (Vallaeys, 2004; Davey, 2015; Redfield, 2013).

Interviewees pointed to the importance of considering informal powers – and the related dynamics of discrimination – beyond formal hierarchies. One experienced MSF member described the limits of formal power: "for, me it is about four things that are interlinked and which the distribution in our organisation is extremely skewed. It's power, it's influence, it's privilege and opportunity." What matters is: "can I get people on board for what I truly believe is the right course of action?" Another who had worked across programme, OCA headquarters, and international roles argued that informal power is "related to the position but also to the personalities of people who are more powerful and influential than others […] There is always a way to influence, in one way or another."

We use the term 'currency of influence' to describe some types of informal power that people invoke or draw on when trying to exert influence or seek authority within MSF. Currencies can become a means of advancing professionally and bring the ability to set and shape MSF's agenda. When speaking about these topics, MSF employees used various terms, often referring to factors such as personal profiles, backgrounds, behaviours, assets, or identity traits. Currencies of influence are not necessarily stable, differing between geographical or professional contexts and changing over time. They represent informal forms of power, but some have become codified in formal structures and powers.

The first section maps some of the most frequently referenced inequalities within MSF, which both reflect and reproduce broader structures of inequality. The remaining sections examine six major 'currencies of influence' frequently raised by MSF employees: time in the field; friends in high places; whiteness; English language skills; masculinity, and medical expertise. Throughout the chapter, we use examples to illustrate how these interacting currencies may look in practice. This chapter thus documents what different employees see as contributing to some people being more able than others to operate, rise, and influence inside MSF.

4.1 Axes of inequality

Existing research on humanitarian intervention has detailed how aid practices based on ideas of 'universal humanity' can reproduce post-colonial power relations between the Global North and Global South (Duffield 2008), as well as inequalities between the populations they are meant to help (Bardelli 2020; Ticktin 2011), and between humanitarians themselves (Fassin 2007; Peters 2016; Benton 2016). A growing literature on MSF has documented racialised inequalities among its staff (see overview in Chapter 1). It has been argued that understanding these dynamics is important because "the structure of the work itself influences the outcome" of such interventions (Fechter and Hindman 2011, 2). Paradoxically then, humanitarians reinforce hierarchies of humanity.

This section briefly outlines several axes of inequalities around which MSF is structured. These axes of inequality are developed in further detail throughout the research so this section acts as an overview for the reader. Crucially, for this study, we did not define 'inequality.' Instead, we asked participants to describe the inequalities that they saw and experienced in the organisation, or the key structures of inequality that shaped MSF's work. As one senior OCA employee put it: "inequality would be an absolute defining characteristic of MSF." The organisation is, in effect, structured around inequalities: power imbalances between 'patients' and 'humanitarians', 'volunteers' and 'employees', remain integral to how the organisation was established and continues to operate.

Humanitarian subjects and agents

As the anthropologist and sociologist Didier Fassin (2007) articulated, humanitarianism is a 'politics of life'; it gives specific meanings and value to human life, distinguishing lives that may be risked, and lives that can be sacrificed, despite its egalitarian aims. This has implications for the people that humanitarian organisations aim to serve and for their employees. The power inequality of who is able to shape this politics of life was recently highlighted in a research paper by Tammam Aloudat, President of MSF Holland, arguing that the 'subjects' of global health institutions – or the 'health subaltern' – cannot speak (Aloudat 2022; Spivak 1988). He described how the 'beneficiaries' of global health institutions have no place in the discourse, nor in the decision-making processes, that determine their fate.

Humanitarian medical intervention is structured by a power imbalance between the intervenor and the intervened upon. Some employees argued that MSF's focus on saving lives encouraged a paternalistic interventionism, where patients are subjects to be acted upon, imagined to be without expertise or agency. An experienced nurse said that "we come with this idea of providing assistance and aid, and helping other people, with this idea that they can't help themselves," speculating that this may come from "our foundations of medicine, as a profession, which is paternalistic in many ways," and historically is "a very middle-class profession, a very male profession and a very white profession."

This fits with a broader post-colonial critique of international humanitarian aid and global health which describes its imperial traces (Affun-Adegbulu and Adegbulu, 2020; Abimbola and Pai, 2020; Khan et al., 2021; Chaudhuri et al., 2021; Hirsch, 2021a; Hirsch, 2021b) embedded in the imaginary and treatment of the suffering 'other' (Ticktin, 2011; Abu-Lughod, 2013). The idea of responding to an emergency suggests the need for decision makers from outside, to come to help an overwhelmed population; an emergency is an exceptional time, legitimising exceptional measures; so, according to this logic, in some cases hierarchy and decision-making by outsiders is necessary.

As many employees reflected, MSF's work to 'save lives' during 'missions' in countries predominantly in the Global South is a product of colonial history and a reflection of post-colonial global inequality. That "people from the Western world can afford to go to other countries and care for people there" is "just thinkable because there are these power imbalances in the world," one stated. Another employee suggested that MSF's hierarchical mode of operating is a product of both colonial history and medical paternalism:

> "Globally, there is a power imbalance between the healthcare staff and patients, or communities. That is reflected, I think, in MSF as well. We're not any different to that. I guess, for us, it's complicated even more so, or worsened, by the kind of colonial roots that we have, as well. I don't think we've perhaps, reflected enough yet on just how imbalances and inequality and the power that medicine, the medical profession has."

Yet, as the previous chapter described, appealing to a focus on speed and urgency means that MSF consultation with communities is often minimal or contained within a narrow scope. Despite the project cycle featuring several steps that eventually culminate into project implementation, the community is often only able to influence the implementation phase. Other consultations may happen but they are more of a tick box exercise. Many times, MSF has already decided on what they want to do. One programme staff member said: "MSF bring[s] their decision and to give it like the water 'Okay, take it now and drink', without taking care about observation of beneficiaries." The conclusion drawn is that "ultimately we [MSF] want to keep that power, the power of choice."

Additionally, when attempts for consultations with 'communities' are made, it is the leaders who are often consulted. A doctor working as locally recruited staff has shared a probable explanation for this approach:

> "People who are not leaders, they have no influence on the community. If you choose someone who is not a leader, it cannot give any influence on the community and so we need to choose the people who are going to understand what we are talking about and make a change with them and then they can go in the community and speak to the community or to us who have been discussing and then the message can be very well understood."

On the flip side, "community leaders and a lot of the context where we speak are already the power holders in the community." Hence the approach taken by MSF risks a perpetuation of already existing power imbalances within the community.

However, despite a heavy imbalance of power, all is not lost – people still retain some degree of power in their dealings with MSF at both individual level and community level or even national level. This most commonly presents as refusal of treatment, according to a Nursing Activity Manager: at individual level, as people "refuse medication sometimes if they don't feel that it is okay for them, they refuse," or refusal of an intervention altogether at community level. They further shared:

> "Maybe that we think that we are in power a lot in our health facility, and in the programmes we run, but on the other side when the community really doesn't want something, I think then you also see we are just visitors. They have a lot of power also."

The power dynamics inherent in the medical work of MSF, and the interactions between healthcare workers and patients, feature in several places throughout this research.

International/National

The most frequently cited inequality among MSF staff was between 'internationally mobile' and 'locally recruited' employees. Some MSF employees have referred to a 'two-tier system' (Majumdar, 2020; Campbell and Kardas-Nelson, 2021); others used the notion of a 'caste system.' One locally recruited employee said:

> "From the first day I joined MSF, I felt there were two camps: The nationals camp, and the expats camp […] I asked [my supervisor] about it. I told her that I didn't get it, that we had principles defining the organisation. I wanted to know why there were two camps, a camp for people like me, the locals, and another one for people like her, the expats. So, she looked at me and told me she did not know what to say, but that was just the way it was."

The vast majority of MSF's employees work in their country of origin – around 80% in recent years.[3] They have remained largely invisible in the organisation's public discourse and organisational narratives – instead, the focus remains on topics "which concern less than ten per cent of our population," in the words of one senior manager. The split system is embedded in policies, creating what one interviewee condemned as an "ingrained inequality":

> "The intention is not that, but very plainly put it's basically putting a different value on different people's lives. That's just not acceptable, and it's hurtful, and it contributes to [...] ingraining in people that we are different and that we should be valued differently, even in very subtle things it still sends that message."

This ingrained inequality permeates the organisation to influence the healthcare giving processes at the level of clinical work. Many by virtue of their 'international' status will come in automatically as supervisors irrespective of their previous experience or inexperience of management. A locally recruited staff member observed:

> "I witnessed this myself on a project that included a local nurse that had great experience and work ethic. There was also an international unqualified nurse who was promoted to the Head of Mission and supervised that local nurse. There was no valid reason for that, it was just the mentality that said, 'can national staff supervise international staff?' It is a matter of perception, the fact that someone from the international side is coming to supervise national staff without proper experience."

Additionally, there were concerns that a perception of requirement for 'international' supervision was creating redundancy and inefficiency. A manager working in health said that "We are bringing NAMs [nursing activity managers] in higher salaries and higher positions and they're just here for mentoring and sometimes they're just doing just nursing work, doing cannulas, and they're not even taking part in doing rosters [as expected] of the supervisor." Conversely, their locally recruited counterparts sometimes have to work in positions lower than they are qualified for simply because of the prevailing unemployment within their countries. One hospital coordinator support shared the plight of a colleague:

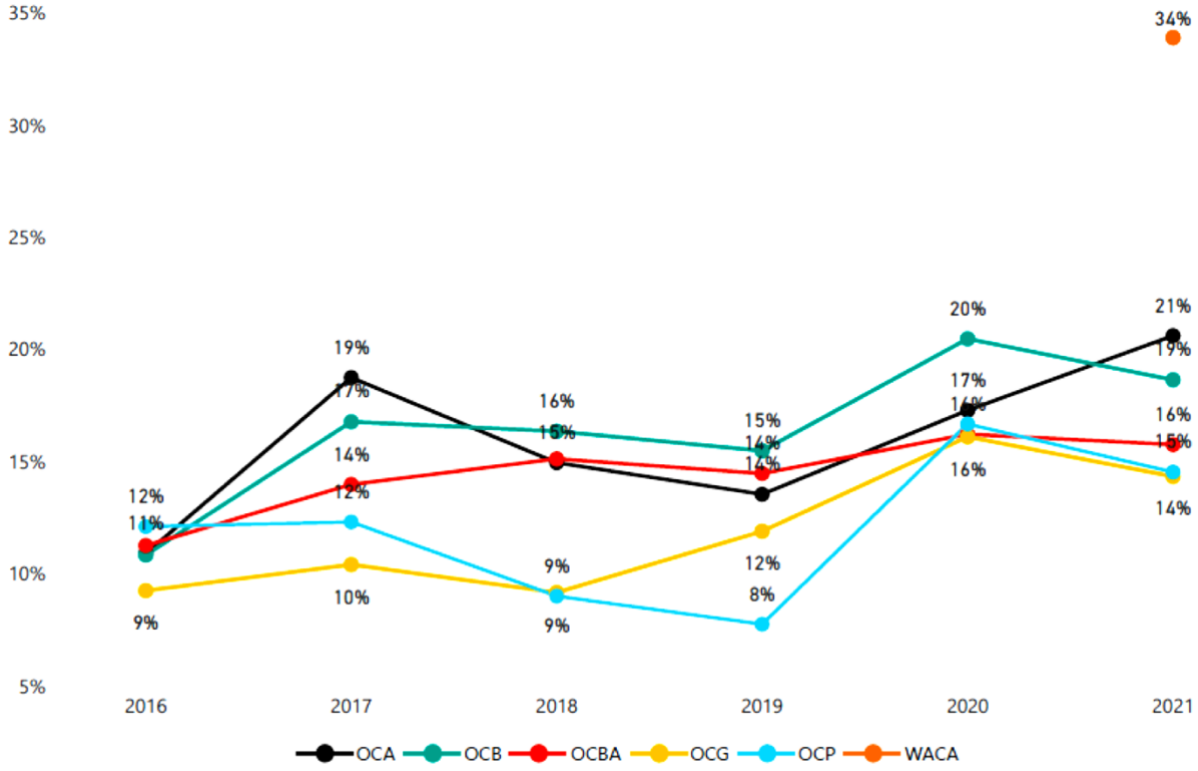
> "He applied for it, there was only a vacancy open for clinical officer, and he qualified for the position. He has a bachelor degree in medicines and surgery. So, that was the outcome, he's a medical doctor recognised in the country. He chooses to work here, give him the position of medical doctor, instead of maybe bringing someone from [elsewhere]. He's from the community, let him work."

3 In the past, locally recruited staff in programmes represented over 90% of MSF's workforce. In 2021, they were 78% of the total number of employees (Cragg and Linna, 2022, p. 18), a proportional decline that can in part be explained by the growth of headquarters over time. Headquarters staff are now also described as 'locally recruited', although not all are nationals of the countries in which they are based.

The position of locally recruited staff in the organisation has long been a subject of concern. In 2006, the La Mancha Agreement (MSF, 2006) committed to: "provide fair employment opportunities for all staff based on competence and commitment rather than mode of entry into the organisation (either through national or international contract)." However, the fundamental structure has remained the same: a group of foreign mobile staff in senior positions and a pool of personnel recruited in-country with a different contract type (Redfield, 2012; Pechayre, 2017). This results in an ever-shifting powerbase – "all the high-level positions, it's for international," as a focus group participant said – made up of individuals who are constantly on the move.

Locally recruited personnel have faced difficulties progressing beyond a certain ceiling, largely because of bars preventing them from occupying senior roles; as Chapter 5 explores, this is an ideologically grounded barrier based on the idea that outsiders are neutral in a way that 'locals' cannot be. Thus, in the six years from 2016, although the number of locally recruited staff in coordinator positions increased, in four of five operational sections, they remained below 20% (Cragg and Linna, 2022, p. 41). In OCA, notably, they rose from 16% in 2020 to 21% in 2021 (ibid., p.42; see figure 1), potentially reflecting the impacts of travel restrictions due to Covid-19 which some interviewees alluded to anecdotally. Even more striking is the percentage of full-time equivalent (FTE) coordination positions held by locally recruited staff in the recently founded West and Central Africa Operational Directorate (WaCA), the only MSF entity with operational authority to be based outside Europe – an outlier at 34%. Across the movement, nonetheless, 95% of Head of Mission FTEs and 92% of Medical Coordinator FTEs were held by internationally mobile staff (ibid., p. 44).

Figure 1: Evolution of locally recruited staff coordinator FTEs by Operational Centre, 2016 to 2021



Source: Cragg and Linna, 2022, p. 42

There also appear to be obstacles to locally recruited personnel being hired onto international contracts. In 2021, across the movement, only 5.6% of people recruited to work as internationally mobile staff (by headcount) came from the pool of (former) locally recruited employees (Cragg and Linna, 2022, p. 47). In practice this meant that MSF recruited only 167 people who had previously worked on local contracts, and of these OCA recruited the fewest: seven. OCA also had the fewest 'detachments' (secondments of up to three months) of locally recruited staff to a programme in another country: 18 out of a movement-wide total of 358 (ibid., p. 46).

In interviews, there were perceptions that the goal of 'saving lives' had come to present, or could be deployed to create, obstacles to greater investment in local personnel. "Our money is going towards saving lives, not that hump of bullshit of building national capacity," was how one experienced employee captured the attitude. Indeed, this reflects MSF's historical stance on 'localisation.' In 2016, the UN Secretary General argued at the World Humanitarian Summit that humanitarian action should be "as local as possible, as international as necessary" to remedy North/South power imbalances (Bennett, Foley and Pantuliano 2016, p. 46). In response, an MSF report emphasised "reservations" with the idea that "international actors should make themselves redundant by building local capacity and enabling local actors to run their own response" (Schenkenberg, 2016, p. 3). Instead, that report argued that "building local capacities is not an objective for MSF per se" as it would "diminish" humanitarian assistance's "essence" and the "specific role it plays in conflict settings where a distinct and principled approach is required" (Schenkenberg, 2016, p. 9).

The two contract types determine vastly different relationships between employee and employer. As explored in subsequent chapters of this research, MSF's split systems reflect and sustain power dynamics and have material consequences across a range of areas. This includes differential access to opportunities, leadership positions, and mobility, different pay and per diem policies, but also (as discussed in Chapter 5) a hierarchy of trust that imagines foreign workers as neutral, and local staff as entangled in particularist attachments. Locally recruited employees have differential access to healthcare and health referrals, and to MSF's security apparatus and evacuation procedures. Fassin (2007) argued that through its unequal security provisions, MSF makes a distinction between lives with higher value (internationally mobile humanitarian workers), and those that can be risked (locally recruited staff).

Interviewees spoke in extremely strong terms about the social segregation between locally recruited and internationally mobile staff. Several people reported being shocked during their first international assignment by what one described as the "impression that there was a total apartheid between the expatriates and the national staff," such as separate eating and sleeping quarters. While conducting short-term or exploration trips, Congolese employees who were brought into an area described being lodged in cheap hotels, when their international colleagues were placed in expensive hotels with better security. Some sites have separate toilets, as described by this internationally mobile employee:

> "You go to the expat area and it's […] not fancy, but nice and very well taken care of. And you go to the area that the local team is using, and it's a project which is active for more than 10 years, and the toilet and the shower that we prepare for our team is made of plastic sheets. […] Nobody ever questioned this. [… The] water supervisor, who is responsible for water sanitation, making sure the toilet's working, he's the one taking care of the expat area. So, this guy [is] going and taking care of all the nice toilets for expats. And then he himself [is] using this toilet made of plastic areas and what message are you sending him?"

Many internationally mobile staff working in MSF were uncomfortable about inequalities with their local colleagues: "it's one big thing that I'm ashamed of." This structural inequality between locally recruited and internationally mobile staff is a thread that runs throughout the rest of the study, as we unpack how it manifests in particular settings, and is reproduced by particular organisational logics and assumptions.

Intersecting axes of inequality

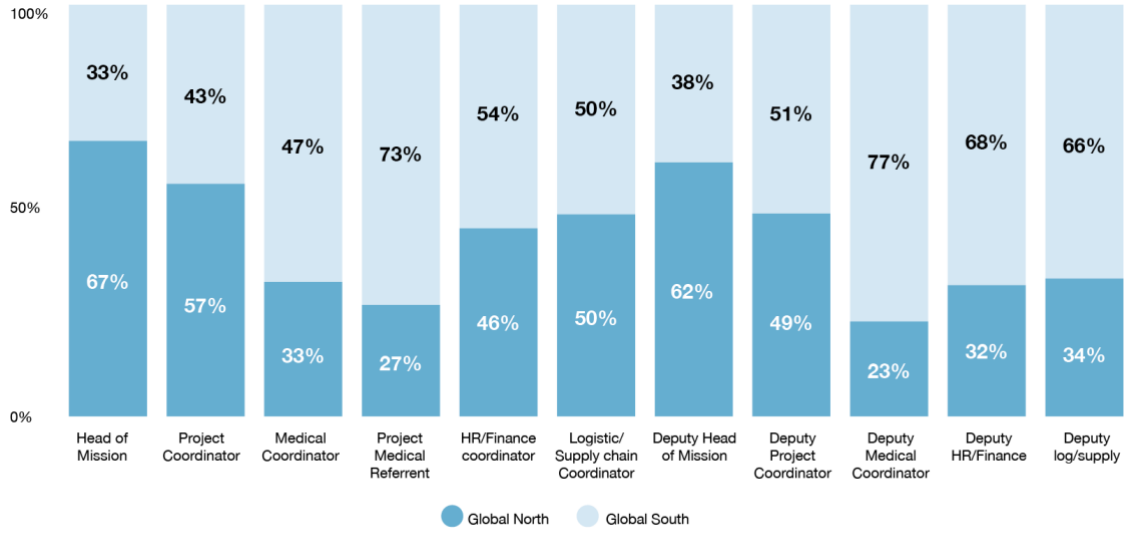
MSF employees also discussed other axes of inequality (beyond 'international' and 'national') which are too often overlooked. Notwithstanding this lesser attention, the institution is certainly aware of the importance of "non-professional criteria, including nationality, skin colour, gender and religion" within its workforce, as these are the basis of the practice known as 'profiling,' undertaken when security threats target specific kinds of staff (Duroch and Neuman, 2021). The categories need to be deconstructed, as does the assumed internal coherence of these labels, to instead examine the experiences of different humanitarians from an intersectional perspective (Martin de Almagro, 2018).

Some interviewees described how the organisation reproduces hierarchies between the Global North and Global South. Despite claiming an international identity, MSF remains headquartered in Europe, with its senior decision makers in headquarters predominantly from the Global North, intervening upon populations in the Global South. This overlaps with the structural power imbalance embedded in the way MSF's operations are managed: decision-making power remains concentrated at headquarters in Europe, among former international staff members who are predominantly from the Global North. In effect, this means decisions about programmes and strategy remain in the hands of individuals based in the Global North, while the majority of MSF employees (and those who receive MSF aid) remain excluded.

These dynamics are reflected in recent Staff Data and Trends reports. Across the movement, in 2009, 74% of internationally mobile FTE staff positions were filled by people with the nationality of a country in the Global North (Cragg and Jager, 2021, p. 35).[4] In 2021, for the first time, more internationally mobile staff FTEs were filled by people with the nationality of a country in the Global South than the Global North (Cragg and Linna, 2022, p. 38; see figure 2). That said, numerically speaking there are still more internationally mobile staff from the Global North; this combination reflects the length of assignments that each group undertakes and is suggestive of some of the dynamics shaping access to posts. As internationally mobile staff can have preferences about length of assignments, an interviewee noted that: "the nice cherries of the short missions, sometimes also the priority goes to certain people, all the time." Though they did not comment on the nationalities of people in that group, according to movement-wide data the shorter an assignment is, the more like it is to be held by a staff member from the Global North. Specifically, 63% of assignments of less than 1 month are undertaken by personnel from the Global North but only 36% of those over 12 months, with the percentage gradually dropping as the length of assignment increases (Cragg and Linna 2020: 33). Further, staff from the Global North continue to dominate powerful coordination positions such as Head of Mission, Deputy Head of Mission, and Project Coordinator. Leadership positions in the medical line appear to be more open to staff from the Global South, who represent 67% and 77% respectively of Medical Coordinator (MedCo) and Deputy MedCo FTEs, raising questions about whether factors that have shaped this pattern can be applied to promote diversification of leadership in other lines. This also raises the question whether staff from the Global South are more entrusted with work requiring more technical decision-making.

4 For the list of countries considered Global North and Global South, see Cragg and Linna (2022), p. 64-65.

Figure 2: Distribution of senior role FTEs between internationally mobile staff from the Global South and North in 2021



Source: Cragg and Linna, 2022, p. 45

Despite this, many interviewees said that inequalities remain between people on the same contract type. This began from the offset for people who are recruited from a country that does not have an MSF office: "If you're international staff recruited from anywhere beyond those 19 countries, you are in the Bermuda triangle." Interviewees also pointed to the difficulties of obtaining visas for some nationalities to come to Europe. This is a major disadvantage when access to networks of influence and therefore opportunities (see currencies of influence, below) is considered:

> "I don't have scientific studies, but observation over the years is that if you are not from northern Europe or for whatever chance able to relatively regularly call into the headquarters, your career is progressing much slower. […] And just picking DRC, if you're a DRC national working as an international member of staff, you miss a Schengen visa for the briefing or debriefing, you miss really out on your career."

While the granting of visas is beyond MSF's control, the concentration of formal power in Europe amplifies the impacts of these external inequalities. There was also discontent about how pay is calculated; the fact is that people occupying the same position are paid differently, depending on their country of origin. This is part of the salary structure known as IRP2 (for International Remuneration Project, version 2), which pegs salaries of international staff to rates in their countries of origin.[5] While its first aim was to "attract, motivate, and retain international staff," IRP2 has the effect of creating differences between the pay of national and international staff, and between the pay of international staff from different countries (Désilets and O'Brien, 2017). In essence, those from higher-income countries are paid more than those from lower- and middle-income countries. As a result, if the lens of Global North and South is once again applied, the impression of a privilege or bias in favour of internationally recruited staff from the North is reinforced. Simply stated, being 'international' alone is not enough to determine conditions or experiences, one's exact origin is equally important.

These inequalities also manifest more indirectly. One internationally mobile staff member from the Global South described how "institutionally, our policies are very much influenced by the setup of Europe or the setup of the developed countries." These policies disregard unequal government welfare provisions between countries in the Global North and South which influence MSF internal career choices and trajectories. They described "the insecurity of not having anything to provide for my family" in-between missions:

> "To some extent it is impossible to give something in-between the mission for the expats but if I have said I am available to go in three months, I am planning myself that I have enough money to cover my finances and provide for my family for three months. After the three months if I am just waiting for another three months then I have nothing."

This forced them to make difficult choices, accepting compromises that others may be able to avoid: "Even though that decision I would pass it and take something else but I don't have the liberty to do so." They persisted because: "I don't want to jump into another boat and leave MSF" – another example of the loyalty that we often heard expressed towards the institution even when staff perceived it as contributing to or exacerbating challenges in their own day-to-day life.

5 At time of writing, IRP2 was being examined through a process known as the Rewards Review, which "aims to develop a new rewards framework for the whole MSF global workforce" to help the movement "better meet operational needs" and to "contribute to MSF becoming a more equitable, just and diverse global organization" (MSF International, 2023, p. 1).

Other interviewees said that these inequalities are not just shaped by nationality, but also by race. As Adia Benton (2016, p. 268) points out, while critiques of humanitarianism focus on power, they have not explored how humanitarianism is organised "along racial lines, alongside those of national citizenship and class." The Black Lives Matter Movement in 2020 renewed critical discussion around structural racism in MSF, both in headquarters and in locations of intervention (see e.g. Aizenman, 2020; Al Jazeera, 2020; Caramel, 2020; Parker, 2020; Stewart, 2020). Interviewees for this study likewise described the varied ways that racial inequality was reproduced within MSF's everyday structures. This is another key thread that runs throughout the research and is examined in further depth in the following section on how whiteness operates as a currency of influence in the organisation.

MSF employees pointed to the ways that gender and class intersected with race and nationality to produce situated forms of inequality in MSF's organisational structure. As discussed in Chapter 7, the spirit of volunteerism that underpins MSF's vision of its workforce is can be exclusionary with regard to different socioeconomic backgrounds. First-hand testimonies of MSF employees in headquarters and different countries of operation also revealed the complicated ways that gendered power dynamics shape MSF's everyday work. Crucially, as explored below in the section on masculinity, gender intersects with race and nationality to produce forms of privilege, power, distance or disadvantage (Roth, 2015; Martin de Almagro, 2018; Read, 2019). The position of women in the organisation looks radically different at different levels of OCA. As an employee working in HR explained, staff data reveals a high percentage of women among internationally mobile staff from the Global North and even more at headquarters level. However, there are far fewer women from the Global South working as internationally mobile staff (see Cragg and Linna, 2022, p. 48). Similarly, there are far fewer women working as locally hired staff: "Our gender ratios are poor and the lower down the level you go, the worse they get." This means that as MSF focuses on ensuring that the internationally mobile staff pool is more diverse, expatriating more locally hired staff from countries in the Global South: "the gender ratio is getting worse." In WaCA, women represent 27% of internationally mobile FTEs, compared with between 37% and 46% for the other OCs, OCA representing the highest proportion (Cragg and Linna, 2022, p. 48).

The binary of national/international overlooks another group of employees: 'delocalised' staff, or 'in-pats'. Whereas 'locally recruited' staff originate from near the project site itself, and 'internationally mobile' staff have been brought there to work from abroad, in-pats sit somewhere in the middle; they are nationals who have been 'in-patriated' from their region of origin to work elsewhere in their own country (James, 2020). In-pats described the difficulty of falling between two categories of staff. For instance, evacuation procedures for in-pats have been developed over time, with the conclusion that because in-pats were brought in, they should be taken out in times of emergency. However, interviews revealed this was not always the case. At some projects, in-pats are evacuated alongside foreign staff, however at other sites, they were not. In-pats argued that OCA treated them tactically as local, "to avoid worrying about our fate when there is a problem." One interviewee described how during an exploratory mission with international colleagues: "we worked on the project, and we all lived in the same house," but when approval came to officially start a project, "that meant that we had to operate as local staff and leave the house […] our contract would change, and that we were no longer entitled to evacuation […] They [internationally mobile staff] told me that I'm on my own."

In-pats often have to cover their own costs when leaving or returning to a project once employed. There is no global policy on the issue of in-pat compensation. In cases where OCA has actively sought to recruit outside the local area, relocation expenses may be offered to incentivise applications. However, interviewees argued that not providing in-pats with support to cover ongoing travel expenses was unfair, because the organisation pays for the travel of international staff, who are paid more, and because in-pats often had to travel to nearby cities to access their salary at a bank. In locations where travel was expensive, these problems became more acute. For instance, at a project in eastern DRC (Walikale), in-pats must pay for their own plane ticket to travel to and from the project. An employee explained: "MSF knows that I was recruited from Goma. I did the whole process by Skype. I came to Walikale on MSF planes […] But the organisation tries to ignore all this."

Another category of staff that complicates the picture of 'local' and 'international' is that of 'MSF incentivised' staff, who constitute a distinct group within MSF. This category is the result of MSF's collaborations with Ministries of Health. According to a manager in one of these collaborative sites, these people are "supposed to get a salary from the Ministry and then a salary top up from MSF." On the whole, human resource management pertaining to this group is in the hands of the MoH. Based on interviews for the present study, MoH incentivised staff – which are numerically important but have been an "underanalysed" group (Harvey et al, 2019) – appear to occupy an ambivalent position. The institution appears to be less able to exercise control over this group. A quantitative survey in 2019 indicated that OCA had limited control over incentivised staff and struggled to address poor performance, although overall country offices reported that projects are still able to meet set objectives (MSF OCA, 2019b). An experienced programme employee said:

> "If I ask something of the MoH staff, they can just listen from here and [it] just [goes out the other side] away from there. Because they are not afraid, they have nothing. Because they know we couldn't terminate them. But if you have an MSF staff, they have strongly conducted their work."

This led them to conclude that "if the MSF is working alone, it will be better." As shown in Chapter 5, the construction of MSF identity opens the door for judgements about the motivation and level of commitment of different groups, judgements which were applied harshly to MoH staff. At the same time, MoH staff experience different, often more precarious, conditions from other staff. In DRC, it was noted that despite these staff being employed primarily by the MoH, should MSF leave or stop paying incentives "many of these staff will lose their jobs as well because the government without support of other partners will not be able to continue many of the services being offered." MSF employees were confident that "many of them would like to work as MSF staff." There are some glaring system "distortions" (Harvey et al, 2019) facing incentivised staff, including in remuneration. An MSF employee who had worked in Tajikistan recalled commenting on the programme having many challenges, and being told that an MoH doctor was paid 1,300 somoni per month, while an MSF nurse was paid 5,000 and an MSF doctor 9,000; this "pay differential" was presented as "part of the reason why this dynamic doesn't work." There are thus inequalities between this group and the rest of the MSF staff, yet they are held to MSF standards when it comes to their duties. One Activity Manager said:

> "I think there's some quite challenging things about [...] the difference in privilege between MSF staff and between Ministry of Health staff, even if they are effectively doing a very similar job and were recruited from the same place. The MSF staff have healthcare guaranteed, they have a reasonably good salary, they have access to training, et cetera. And then, meanwhile, the Ministry of Health staff have none of that, but we're pushing them to work in the same way."

Overall, the categories explored in this section are not static or immovable. Rebecca Peters (2016) illustrates how the 'local' is socially produced: aid workers may strategically position themselves as 'local' within institutional hierarchies in order to access employment and to further personal interests (see also Heaton Shrestha, 2006; James, 2022). Rather than employees positioning themselves as 'local', in one of situations described above, MSF management strategically positioned in-pats as 'local', despite having facilitated the mobility of this group of employees. In a further subclassification of the local, we find the MoH incentivised staff come in at the bottom of this 'caste' system yet can be closest to the MSF patient when MSF works within the MoH structures. Ultimately, the labels 'local' or 'international' may obscure, rather than describe, the complex social positions of people working for humanitarian organisations.

BOX 4: ETHNICITY AND RECRUITMENT

When discussing inequality, locally hired staff in different contexts described concerns about the way MSF's presence interacted with, or exacerbated, existing structures of inequality. Many of these concerns were articulated with the language of 'ethnicity' – staff were concerned that MSF's recruitment processes might be interacting with existing societal cleavages. Patients, too, make observations, as seen in an interview in South Sudan, where a patient's concerns about unfair treatment were attributed to 'clan level' as a basis for segregation. Humanitarian agencies are powerful actors in the political economy and their resources and employment become entwined in local power contests. Recruitment, then, is not simply a human resources process, but becomes an arena where people contest who has a right to the resources MSF's presence brings. Who gets to represent and work for an NGO is a fraught issue.

In Syria, OCA works in an area controlled by Kurdish self-administration. There were tensions about how MSF's presence and recruitment interacted with existing social dynamics between Kurdish and Arab communities. One Syrian employee said: "we Kurd staff often feel that there are some expats who rely, trust, or have a good relationship with the Arab staff rather than the Kurds." Some employees argued that this "leads the strategy of the project," with a focus on Arab areas rather than Kurd areas: "then the community, the authorities, ask 'why […] is it all going to the Arab area?'"

In eastern DRC, there were concerns locally about 'tribalism' in recruitment processes, with frequent perceptions that some groups were being favoured over others. This was a priority for DEI efforts in the country. MSF must navigate historically laden conflicts and highly politicised notions of belonging about who is considered 'autochthonous' to a particular place. Autochthony is a slippery concept, politically manipulated and itself a colonial import, that operates at several levels (Jackson, 2006). At a territorial level autochthonous groups were pitted against speakers of Kinyarwanda, and MSF was sometimes accused of favouring one group over another. Sometimes, this was expressed in ethnic terms. At a provincial level, where supposedly 'authentic' provincial identities have become increasingly politicised, MSF faced criticism for the 'importation' of in-pats from other provinces. Even the term 'local' was highly contested. Employees indicated that perceptions of "favouritism or partiality" were the "cause of many security problems" for MSF in the region.

4.2 Currencies of influence

This section identifies and unpacks the key currencies of influence that emerged through our interviews. While it indicates some of the complexity inherent in these currencies, highlighting variations, intersections and contradictions in different settings, more detailed and nuanced discussion of their impacts comes in the chapters that follow. The currencies of influence we heard most about were: time in 'the field'; friends in high places; whiteness; spoken English; masculinity; and medical expertise.

These currencies will not all be treated in the same way. Some were discussed more frequently than others, in stronger terms, or with more specificity. For example, there is discomfort around talking explicitly about racism. This reflects a broader issue in that, as one interviewee commented: "It's going to be really hard for you to talk about stuff that people don't know how to talk about. They don't have the lexicon for it and there are […] quasi-visible or invisible barriers to even thinking about this." They cited the word 'effective' as an example of how terminologies also hold currency in MSF's emergency culture, justifying certain choices and masking or dismissing their impacts, ultimately making it more difficult for underlying issues to be explicitly recognised.

Time in 'the field'

References to 'the field' in MSF can mean a lot of things: a location juxtaposed to headquarters as the place where MSF's medical humanitarian work is carried out, or a body of personnel ('we want to hear from the field'). Stellmach (2020) found that in MSF, the field was a receding horizon depending on perspective – from programme countries to project sites, to places beyond the clinic. This field imaginary as exotic and strange is rooted in colonial history (Gupta and Ferguson 1997), invested in "old fantasies of remoteness and otherness" (Andersson 2016).

Time in 'the field' is a pre-eminent currency of influence in MSF. It gives you "street credibility," it's what gets you "the stripes on your shoulder" that legitimise you to represent MSF externally and "join the conversation" internally. The depth of this experience is important. As one headquarters employee commented: "Gap fills are not really considered field experience; I think field experience is six months or longer in a project location." Geography also matters, reflecting the importance of certain large and long-running country programmes within MSF and the humanitarian sector in general (Taithe, 2016). Interviewees linked 'field experience' to MSF's emergency culture and the production of the 'MSF family': "When you spend times in the most difficult situations with a group of people, you form certain connections, you form certain bonds that stay with you."

Moving into a headquarters role after international operational experience is a common trajectory, meaning that MSF offices include employees with twenty, thirty, or more years of experience in the movement. Interviewees have referred to this as a phenomenon of "lifers", "veterans", and – with an air of playfulness, from someone who considered themselves as not qualifying quite yet – as "MSF dinosaurs." In an organisation where "the years in the club count very much for your legitimacy," a person with external experience noted "every conversation starts with: 'I have been short with this organisation. I've only been here for eight years, so I'm really new'." In this environment, an employee in OCA's Operational Support Communications, Advocacy, Reflection (OSCAR) noted, "the longer you've been with MSF, the more weight you have."

However, as Chapter 5 describes, the length of service of locally recruited staff does not carry the same weight. One interviewee said:

> "We have been trying to send people to the field, first missioners, who could work under senior locally recruited staff. But the mindset is as such, and the informal curriculum is as such, that by default when they get to the country, they believe they're the supervisor."

A former locally recruited employee who has since worked abroad described how: "For expats, it's usually the first mission you work with a peer, the second mission, you're automatically a manager." For former locally recruited staff, they suggested, there is often a criterion that "you have been a manager or supervisor for a whole team." Indeed, a person will be considered a 'first missioner' on their first international assignment, even if they have come to that appointment following extensive experience as a locally recruited employee. Being 'from' the field does not represent the currency that having visited it does.

For all staff, MSF operational experience also holds currency over 'external' experience (Harvey and Delaunay 2018, p. 5). This was seen across various routes into the organisation and roles. When locally recruited staff take on international assignments, notwithstanding the attitudes to length of service described above, broadly speaking, interviewees found these experienced staff easier to live and work with than the 'first timers' who came in directly through the international route. Staff with prior MSF experience elsewhere thus remained the preferred option. This was also the case within the circuits of internationally mobile staff and headquarters staff. One employee described how starting at MSF can feel like joining an "odd cult" because of the way that:

> "Anything that you take with you is disregarded, almost very explicitly, even. When you're just having salary negotiations, there's an actual grid that you have to fill out with HR, like, 'What kind of positions have you had?' Then you get graded on percentage: 'How relevant is that to MSF?' so things like you've worked in X, Y, Z countries. Sometimes that can be considered fully irrelevant."

This applies to people who join MSF after experience elsewhere in the NGO sector. As another commented: "All my experiences of working with other organisations, other NGOs in the humanitarian sphere were never seen to have any weight, and do not provide me with any seniority or recognition within the organisation." That these attitudes can coexist with the apparently contradictory placement of trust in newly recruited internationally mobile staff and not their more internally experienced locally recruited counterparts suggests just how powerful the 'mindset' and 'informal curriculum' are, not just in the assumptions of new international recruits but in the organisation's systems and structures. These are explored further in Chapter 5, while dynamics at headquarters level between staff members with different professional backgrounds are considered in Chapter 7.

Friends in high places

Being well connected, in particular with senior international decision makers at headquarters, is another key currency of power in MSF: "The organisation, historically, has been one where, if you have a strong network and you have a strong set of interpersonal relationships across the organisation then, obviously, that works in your favour." An internationally mobile staff member who had worked for different Operational Centres commented that in MSF – and OCA specifically:

> "Things are down to influence and things are down to personal connections and not necessarily merit. So, it's not about how well you do your job technically, managerially, how we can weigh you against indicators and professional competencies. No, it's not about that, it's about who you know, what influence they have, what influence you have with them, the strings you can pull, and I think that goes a lot into power, and that affects at all levels – team within a project, department within a project, the entire project, the entire mission, OC in between missions."

Having friends in high places enabled people to construct themselves as legitimate and important. For example, an interviewee described how those with connections "would want to show that they have [power] not actually related to the position that they are holding but related to the connections that they have" concluding that "they feel that they have power over anyone who is not connected to that." As one former Head of Mission explained, social dynamics in MSF could be summarised as "discrimination by proximity." According to this logic, your ability to access different opportunities is determined by "how close you are to the decision-making body, and how many people you know." As shown in Chapter 6, because of their position as filters and circuit-breakers, people in coordination positions play a key role, although they are far from the only conduits for this form of influence. Suggestions that this might be changing were far outnumbered by examples that showed these networks at work in OCA.

For example, employees in Amsterdam described the importance of personal networks in placing internationally mobile staff on postings: "I'm not proud of it, but I think the informal information sharing is way heavier than the formal side of it," one interviewee explained, describing the importance of the "usual suspects list" of people "that you already work with and that you know can deliver." Personal recommendations could get someone onto this list: "One good recommendation from a trustworthy source would be enough […] it's only that. It's a WhatsApp, and sometimes, especially for detachments, I really try and create opportunities for that." Therefore, being well connected shaped access to different postings, and for locally recruited staff, a recommendation from the right person could facilitate opportunities. Similarly, friends in high places can facilitate access to particular postings, such as family missions: "If someone has been working for a long time for MSF and wants a family role, it will be easier for him to negotiate because he is close to someone."

Being well connected can also determine safety and access to support. For example, personal networks shaped who had access to different duty of care committees to bring up specific cases of staff needing protection. The instances where locally recruited staff were evacuated or taken out of high-risk contexts were sometimes the result of "individual informal initiatives" led by internationally mobile staff:

> "It is a matter of proximity. The better you know the people the more you will do something for them. […] There is a lot of distance between the top and the bottom and that's structural […] Individuals can easily create proximity whereas the institution cannot break that distance."

These testimonies suggested that informal paths are needed to overcome inadequacies in MSF's formal structures and solve problems. In improvising responses to systemic problems affecting their colleagues, people feel that they are overcoming structural discrimination rather than perpetuating a different kind of discrimination. The fact that there is a significant margin for discretionary decision making allows the organisation to be responsive to the complex and rapidly evolving situations in which it works, while also opening up space for this system of "institutional favouritism," in the words of one senior manager, to operate.

Whiteness

Some MSF employees described how whiteness continues to operate as a marker of power and competency in the organisation. During our interviews, 'expat' was often equated with whiteness. In fact, several terms seemed to stand in for whiteness during our interviews: expats, international staff, internationally mobile staff, Western, or European. In this context, the change in MSF's institutionally preferred terminology from 'expatriate' to 'internationally mobile staff' recognises that 'expat' is not race neutral (Kothari, 2006). Yet it was noticeable that most concern with such terminology came from headquarters staff, while locally recruited staff focused their comments on the manifestations of inequality.

Interviews gave examples of white entitlement within the organisation ranging from conceptualisation to implementation: "It's only just recently that, for the nursing group, we were all white, Global North, writing guidelines and standards for black and brown nurses with black and brown patients. Like, it needs to look different, and it needs that diversity of just thought and experience." We were told how a white employee without any medical training "tried to impose his point of view on a midwife who was Ivorian, who works in the maternity ward. What is a laboratory technician doing in the maternity ward?" Whiteness is a "configuration of power, privilege and identity consisting of white racialised ideologies and practices, with material and social ramifications" (Zyl-Hermann and Boersema, 2017, p. 652). It needs to be understood beyond the physical: whiteness is also a socio-political and economic order, which involves a set of cultural practices which are wrongly considered to be universal. Crucially, whiteness is not a static or uniform category; the boundaries of whiteness shift and change in different localities, but also over time (Roediger, 2005; Twine and Gallagher, 2008). Mills (2007) concludes that whiteness is also an epistemic position, a form of Eurocentricism that wilfully ignores centuries of conquest, colonisation and enslavement and their continued impact on the present.

Employees described forms of racist thinking that marked certain staff members as 'Other', not neutral, or not MSF. While some of these examples were drawn from several or even many years ago, they were positioned as being relevant to understanding the ideologies of the institution and the deep-seated attitudes to different staff. For example, one employee remembered "sitting in on a discussion about, for example, Congolese national staff who were being expatted" wherein the conversation turned towards deciding what the "cap" should be on the number of Congolese who could have international assignments because "we wouldn't want to have too many." They described a feeling of disbelief, looking back at such conversations, reflecting the gap between such attitudes and current values: "Did this actually happen?" The same colleague described having a colleague who "wore a hijab, and people discussing it, like: 'Whoa, she's never going to be able to go to the field, because she's not going to be neutral. She's not going to be perceived as neutral, because she's wearing a headscarf'." As further examined in the section on gender, this suggests that access to MSF identity is predicated on conformity to a cultural type identified with whiteness, Europeanness, and atheism or covert religiousness. As one employee of colour recalled, "the first year, a lot of the experience I had with other staff members was really terrible. I was even told: 'You're not MSF.' Implying, you know, that my almost non-European presence or engagement was not MSF enough." There remains a racialised image of the humanitarian worker, with whiteness still operating as a marker that signals belonging to MSF identity.

Many participants in the study described how imaginaries of authority, expertise and competency were racialised in MSF. Access to senior roles was one area of attention. In DRC, for instance, Congolese employees described: "The majority of department heads are Westerners. Other races weren't well represented. Even the heads of projects were mainly Westerners." This echoes findings from a 2017 study in OCA of a "strong belief that there is a glass ceiling for people of colour, or for people who are not perceived as belonging to the 'majority'" (Adatia, 2017, p. 10). Several interviewees commented on the lack of racial diversity of leadership across the MSF movement.

As described in different sections of this research, inequalities between national and international staff are often racialised, but MSF employees also described racial thinking that cut across the national/international division. In country programmes, interviewees described how black internationally mobile staff were viewed as less qualified. For example, locally recruited employees described how when a Project Coordinator was evacuated because of Covid-19, a white employee said that "there was no one capable of taking over whilst the manager was away," despite the presence of the experienced local team and black African employees. In the end, "the person who came to replace our manager didn't even stay for four days. Because they felt that we were sufficiently qualified to manage on our own. They assigned a substitute who was a Kenyan to take over." Scholars writing on development and humanitarianism have criticised the colour-blind stance of the aid sector which ignores how authority, expertise and knowledge remain racialised (Adeso Africa, 2020; White, 2002; Crewe and Fernando, 2006; Pailey, 2020; Kothari, 2006; Benton, 2016). Robtel Pailey (2020, p. 16) describes how Western whiteness remains "a signifier of expertise" in aid work and the "referent of power, prestige and progress", while Adia Benton (2016, p. 270) describes how African expatriates work in an infrastructure where "assessments of their expertise, mobility and professional success are racialised." In short, certain types of body are thought to possess superior levels of knowledge and experience.

Indeed, interviewees reflected that when staff members of colour occupied decision making positions, they had less authority than white Western employees. In Syria, for example, there was an impression that "expats have more power" when they are from Europe or North America, "not Africa or Asia." A Syrian employee described how African expatriates did not wield the same influence as "if you're Dutch, for example, or […] European":

> "I really notice that some Africans, and I have two Africans that were my line managers before [as Medical Team Leaders] and when I asked them, like: 'I have this problem with the MedCo. Can you speak with them?' […] they are not enabled and empowered from the MedCo and they feel scared as well from the MedCo. They really say, like, 'You are protected more than me. You can speak with the MedCo'."

While some of these comments reflected perceptions of relationships between programme colleagues, others were about who was perceived to be influential in relation to headquarters. In DRC, black internationally mobile staff were placed closer to Congolese staff in a racialised hierarchy:

> "If we have an African supervisor, a dark-skinned supervisor, whether he's African or American or from anywhere else in the world, his decisions are not considered in the same way a Westerner's decisions are […] This generates some lack of trust within MSF OCA."

This hierarchy was described as extending into a racialised politics of life (Fassin, 2007; Hirsch, 2021b) in other areas of practice. For instance, several employees perceived different treatment of black and white internationally mobile staff:

> "I also noticed discrimination among the international staff. Because I have realised that when it's an international dark-skinned staff that is evacuated for treatment, it's done at the last minute but when the health of a white person deteriorates, the procedure is quickly set in motion. They are evacuated in no time […] There was a black employee who got Covid […] At the same time, by coincidence, there was also a white international staff member who got sick, but we were told to keep checking on him as much as possible."

What is creating such situations can be difficult to assess given the range of possible variables (nature of illness, health conditions, evacuation route, and so on), however it was clear from interviews that people base their conclusions of bias on a web of observations and stories, not any one incident. Given this racialised hierarchy in MSF, there was some concern about challenges facing employees of colour in influencing roles: "With their African and Asian nationalities, I am not sure Westerners will appreciate all they do." Here racialised hierarchies can interact with the national/international divide, as for instance DEI leads and person-centred care focal points in country programmes are often locally recruited colleagues.

Comments from staff who had worked in a range of countries suggested that black African staff were considered to embody a higher degree of otherness. For instance, interviewees described staff from South Asia or the Middle East as more competent, or 'closer' to Europe than "contexts where we normally work." This speaks to the continued perceived hierarchies anchored to a European and white standard; those with greater proximity to this standard are perceived as more able and capable (Pailey, 2020). Another interviewee described how Indian staff were more trusted with responsibility:

> "My last Head of Mission stint was three years in India, and it was totally different. I mean the relationship with national staff was much more equal in many ways than it would have been in Chad or in CAR [Central African Republic]. And where does it have to do with it? I find it hard to describe, is it education? Is it exposure? I don't know, I can't really name it, but there were differences between the different settings, and the different, yes, backgrounds of people that was clear. Yes, I definitely didn't see the same level of, let's say, maybe hierarchies […] as when I was Head of Mission in Chad and CAR."

Racialised colonial imaginaries of Africa as lacking competency and expertise appeared to justify continued and increased power inequalities in these settings. When discussing the fact that duty of care was discussed much more in relation to Syria than other regions in conflict, another interviewee said:

> "There is a racist component [and] I don't think MSF was special in that. If you look at any humanitarian organisation, the way they treated Syrian staff was completely different from the way they treated African staff and I use 'African' in the racist sense, if you want. But those wouldn't even be individual decisions or conscious aspects. It's really just structural biases in our mind."

While leaders at international, Operational Centre, and section levels have recently recognised the existence of 'institutional racism' within MSF, many staff are still waiting for signs that related steps have had an impact and, as Chapter 8 documents, are sceptical about the likelihood of change.

English

The ability to speak English was identified as a route for accessing positions of power in OCA. English has become the lingua franca of the aid world (Roth, 2019). OCA's working language is English, and the MSF movement's international working languages are Arabic, English, French and Spanish. To borrow Silke Roth's (2019) term, the ability to speak English has become an important form of "linguistic capital" in MSF that intersects with other axes of inequality. While this section focuses on OCA, comparable dynamics are likely to be present in other parts of the movement.

Research elsewhere has shown that linguistic skills can create ambiguous dynamics among the humanitarian workforce, potentially increasing a person's utility to an organisation, while reducing the range of opportunities for which they are considered and contributing to hierarchies between 'local' and 'transferable' knowledge (Hassemer and Garrido, 2020; Garrido 2017). One Syrian employee said: "There are lots of really vulnerable staff that they cannot speak, share, defend their ideas, defend their rights, because they don't speak the language, because nobody's asking them, nobody thinks that they know something. So they keep silent, and their rights are gone, you know?" In DRC, English was described as a key barrier for staff trying to progress in the organisation. Without English, Congolese employees described being blocked from decision-making posts, expatriation or training that was only provided in English. One locally recruited employee described their difficulty working in a post that required contact with Amsterdam. "I was judged worthless because I did not know English," they said, continuing:

> "In OCA, you need English to advance. You can even say that English is the most important skill. Even if you don't have any other skill required for that decision-making role, if you speak English, you can easily be given that role […] that is crazy. It doesn't make sense that English is such an important factor. For us Congolese, when we debate about this, we think it is a form of colonialism within MSF."

Additionally, the organisational dominance of English presented as extra work to the locally recruited staff who have to attend to their own tasks and also carry the unpaid task of translating: "We were in a survey in the field one time, and I had my supervisor. He didn't talk in French. I became at the same time the interpreter, and also the supervisor of the team, because he didn't speak French." Looked at from another perspective, given that only a limited proportion of OCA's internationally mobile personnel have French language skills, those who do may find it easier to access opportunities in programmes in Francophone countries. Arabic was also cited as one of the "prestige languages" at headquarters and valuable when seeking positions.

English as a currency of influence interacts with axes of inequality around nationality and contract type, which are seen as double standards. In the words of one Congolese employee: "To be expatriated, you need to speak English and French. But then expats come here, and they don't even speak French!" Language was described as a barrier in other programme sites, too. An employee involved in medical research highlighted how the dominance of English affected clinical discussions:

> "Something else that was spoken about a lot in terms of barriers around access to roles, access to clinical roles, but also, like, who has authority to speak up in certain situations, was on the basis of who spoke English, which I thought was fascinating in countries where, you know, the predominant languages would be Russian maybe, and then actually regional languages, like Tajik and Uzbek, but even in Uzbekistan where in the north you speak Karakalpak. […] So, that is another barrier that it's like, 'Well, you can't possibly participate in this case discussion because the supervisor or the medical team leader doesn't speak Russian, or Uzbek, or Karakalpak."

As this example illustrates, dynamics are further complicated when taking into account the existence of vernacular and regional languages, even less likely to be spoken by internationally mobile staff than European (and former colonial) languages.

Interviewees suggested that when OCA accepted a lack of language skills among internationally mobile or headquarters staff, while using lack of language skills as an "excuse" not to give locally recruited staff opportunities, this was evidence of a "racist" double standard. For instance, one employee described "international staff in Francophone missions that could not speak a word of French […] could not understand what was happening around them or understand other staff," yet were given high levels of responsibility and remuneration. Another noted that advisors at headquarters level were not expected to be able to speak the language of programme staff that their roles are designed to support. Multiple interviewees made a link with security. For example:

> "They had a Project Coordinator who is the highest level of person in the project, responsible of security, who [...] didn't speak French or Swahili. You're putting someone with zero language skills as the highest level of security responsible. Then please don't give me a reason that the language is the reason that you're not giving the opportunity [to locally recruited staff]."

These practices limit the pool of originally locally recruited staff within the internationally mobile community, with implications for OCA's leadership cohort and the ability to shape OCA from the top.

They also implicate MSF's social mission, with employees raising questions about "our ability to actually connect with the people we're working with, and also to connect with the population that we're working with." Although some MSF projects do have professional interpreters (or 'cultural mediators'), and some positions (notably Project Coordinator Assistant) officially include translation roles, such staff are not necessarily present in all projects or available in all situations. The choice to invest in translation is case-by-case; there is no official guideline. Other research has found that it is often taken for granted that local staff can translate and communicate with patients (Peters, 2016; James, 2020). Interviews for this study revealed a mix of negative consequences deriving from this presumption, whether based on perceptions or experiences. Some participants felt that locally recruited clinical staff were not best placed to serve as interpreters, citing issues of insufficient mastery of language, mistrust by patients, distortion of message, and implications for the confidentiality of healthcare worker-patient interactions. A patient raised concerns about when staff are expected to translate patient's speech for their colleagues, saying: "it's never a correct translation. Some of it will be missing because they don't know how to translate to English." Preferences for certain treatments can lead patients to challenge the translations, according to one locally recruited healthcare worker during a focus group in DRC:

> "When the medication was prescribed, how people only trust when they were given an injection, what they like. If they're given oral, they said, 'Maybe you didn't explain it well.' So this is another issue we [healthcare workers] also face when we are translating."

Participants in the same focus group reflected that patients' willingness to disclose sensitive information can also be affected if they "do not trust the one who will be doing the translation. Yes, if there's someone you trust, yes, he would tell you everything." On the other side of the exchange, English-speaking employees described realising that the message they were trying to pass on was not being accurately represented:

> "I had a conversation with the mother via a nurse translating. I couldn't exactly [make out] what was being translated, but it definitely had absolutely no resemblance to what I said. He was saying all these positive things about how she would be cured, and I was saying, 'I think there probably won't be a cure.' And in the end, I went and found somebody else to translate who was more honest, but I think that just shows that people are terrified to give the bad news. But then that just gives families the impression that people aren't being honest with them, because they're not."

Ideas about expertise and authority strongly inflect these accounts, which show that concerns are influencing behaviour even when no wrongdoing or error is apparent. The clear impression throughout is that in non-Anglophone countries, the working language is determined by the smaller number of senior staff who speak only English rather than the vast majority of staff and patients whose mother tongue is often something else.

Masculinity

Masculinity, and sometimes even the ability to perform or occupy a particular macho persona, was described as another currency of influence in MSF. In Amsterdam, interviewees of different genders referred to an "old boys' clique" (despite the presence of women) and to a retreat at the end of the day to the Eik en Linde (the bar next door to the Amsterdam office) to talk shop. Interviewees described the difficulty of challenging "the conventional wisdom or the old guards, the old boys' networks," especially for women, and especially for women who had joined headquarters from outside MSF. Interviewees cast aspects of emergency culture in gendered ways, and described a particular type of macho masculinity as rewarded and respected. For instance, one former OCA employee described:

> "Women who have to, every day, act more aggressive […] to be seen as legitimate in their roles […] The ops is the guys who act with their guts. Guys as in men and women […] It is the most gendered thing I've ever seen. It is like the masculine traits are what gets you into ops successfully. The feminine traits, like being self-doubtful [are] not seen as something you do if you're in ops."

With strong attention in recent years on women's experiences of aid work, some of which directly implicated OCA (Martin, 2018; see also Riley, 2020), gendered experiences may be evolving. There was a sense of improvement over the last decade or so, "when a lot of women went into these positions of desks," often coupled with recognition that it was "not easy for them, some of them were becoming heroes, some of them were leaving." Nonetheless, one experienced female colleague reflected that, overall, "the informal culture of the organisation to my mind is quite macho and it's not easy."

Masculinity as a currency of influence interacted with whiteness and a form of Eurocentrism in MSF, where secularity and whiteness were seen as 'neutral' (see Fernando, 2014; Beanmann, 2018). The imaginary of the MSF humanitarian worker was shaped by gendered and racial histories (Ticktin, 2011): it was imagined to be a young, European, atheist, white man. This was linked to leadership. One interviewee said that "power in MSF is Eurocentric, white and mainly male […] We do have more and more female white leaders within MSF […] but this is still a very male, white, European oriented organisation." They reflected: "no one wants to give away their own power." While this was less explicit in most interviews, it is highly likely that this imagined worker also reflects a heteronormative idea of male identity.

Masculinity was also raised as a factor in day-to-day experiences across different parts of the organisation. A man of colour working at headquarters described gaining a new view of the culture in Amsterdam after moving to a different entity within MSF:

> "A few years later, someone who had difficulty in OCA told me in no abstract terms, 'You bought a white guy's ticket to OCA.' And by that she means I am non-religious. I am an atheist. I drink alcohol. […] She was a woman of colour, a Muslim with a hijab and she said, 'You know what? All stuff happened in the Eik [en Linde]. All relationships were built around beer and boy's clubs' – including women's participation in the boy's club didn't make it less of a boy's club – and she said, 'This wasn't open to everybody but you found a ticket in'."

Or, as another interviewee described, masculinity interacted with a form of "cultural proximity." "If you don't have the same culture, a distance is created." The MSF volunteer, then, is imagined to be highly mobile, free of social responsibility at home and acquiring few attachments in the field (Redfield, 2012). This is a product of the fact that the MSF volunteer was built around the social position of young men in France in the 1970s. As a result, as a woman who has occupied senior Operations positions in the MSF movement for years explained:

> "It's a man's world really in MSF. I mean the whole staffing model which is around people going for extended periods of time away from their family and the fact that those are the people that do the senior jobs, that of course means that women with families are automatically at a disadvantage."

This was highlighted by women working as locally recruited staff. For example, when asked whether she would like to be expatriated if presented the opportunity, one Congolese woman explained that this would only be possible if she had a posting where you can bring family, which she was unlikely to get: "If I had a family mission, it would be nice. Then I wouldn't have to leave my daughter for nine months, who is about to turn one. She would forget me. […] It is difficult being a working mum." As the same interviewee described, in DRC, men had an advantage in expatriation processes: "You will never see a father asking to take his children with him. He leaves them at his mother's, or at his sister's." The ability to secure a family mission was perceived as subject to the currencies of influence of length of service, and friends in high places.

Locally recruited staff highlighted gendered power dynamics in country teams. For instance, when asked about inequality in MSF, one experienced nurse said: "Well, firstly, the problem is that there are not lots of women!" Indeed, the privileges afforded to masculinity find fertile ground "in some places [where] there are just no women because women aren't given the same access to education and jobs for whatever reason, so all of the medical staff will be men." The majority of female locally recruited staff "are in either housekeeping or caregiving. Men occupy all the other positions." Congolese women described how internal power dynamics in MSF reproduced gendered norms in DRC. Despite the fact that this experienced nurse is a supervisor: "In meetings, it is the men who like to speak […] because women shouldn't speak in front of men, they should let men speak." She described an example where a colleague told her that "women can't supervise men." Drawing attention to the different authority afforded female internationally mobile staff, she added: "it is mostly national staff women who experience this, there isn't much we can do and we are not listened to." Male staff also observed these dynamics, with gender differences coming through the clinical practice stage:

> "The paediatrician, she is specialised. She is more experienced and more capable of taking decisions when it comes to paediatric cases, but she meets more resistance than I do with some male clinicians, and that's just because of gender, I think. This is also being shown in the patients' perspective."

Existing gendered dynamics were reproduced within MSF's organisational structures. For instance, some women described a closed circle of men who occupied senior national posts, and seemed to control the circulation of information about opportunities:

> "I noticed that certain opportunities such as detachments and expatriation were only accessible to men from certain groups […] We are not in a world where we should have to push women forward any more. It's just about giving them the liberty to choose what they would like to do and have access to information."

This also had repercussions on project management: "I remember a couple of years ago we closed a project in [country] that was a sexual violence project. The team making that decision was a male team."

Medical expertise

Medical expertise was described as a key currency of influence in MSF, which enabled people to exert influence and set and shape agendas. The name Doctors Without Borders, one nurse has explained, "suggests the hierarchical importance of a single role to the apparent exclusion of others," of which employees have long been aware (Carrick, 2020). This overlooks the importance of nurses in the organisation's medical programmes, as well as the crucial role played by a broad range of other employees at operational level and elsewhere. Of course, the medical side of MSF is far from homogenous, with medical hierarchies between, for instance, nurses, generalists, and specialists such as surgeons and "power struggles even within the medical line and medical team." Many of these reflect encounters between different forms of expertise, which may be embodied in personnel, clinical guidelines, short-term trainings such as workshops, or institutions such as the MSF Academy for Healthcare.

In Amsterdam, interviewees described a "deference to medical expertise." As one interviewee summarised: "that's one thing that gives you a lot of credentials: if you come in and you're a medical doctor." MSF employees said that pointing to a lack of medical expertise could be used to "undermine" some critiques, sometimes citing the positioning of different departments (particularly the Public Health Department's relationships with others) and sometimes interactions between individuals. They described how those without medical or health expertise could be the subject of commentary to the effect of: "Oh, they just don't get how it works. They're not medics, so they don't get it."

In some cases, medical expertise is institutionally recognised and given a privileged position. For instance, OCA's statutes require at least half of the Board to have a medical background and the President of the Board must come from their ranks. This is intended to safeguard and support the organisation's medical and health work. In others, the structures do not favour the medical line. In OCA headquarters, much as medical expertise may appear as a currency of influence, the medical department as a whole is not the locus of decision-making power. As discussed in Chapter 7, this lies with the Operations Department. Yet this was also considered to interact with individual attributes:

> "There's a certain stereotype within MSF where it's not only the fact that the operational line has probably more decision-making power than the medical line, but it is also the case that stereotypically, you've had stronger people in the operational line who have not necessarily used that position in the most constructive and collaborative way."

While it is normal that different roles come with different remits, in operational settings, some interviewees described how "respect" could be tied to individuals' professional areas. A former international health advisor observed that often:

> "The doctor is way more important than the cleaner, and […] the nurse is way more important than the guards. […] I think it's an art to have your door open for people. To not only greet the doctors in the morning, but to also greet the rest of the staff, to have your chat with the cleaners, to appreciate our cooks. And that takes effort, but it also makes it better. Because I think that a group of people who do the job, and that is from drivers to the MedCo, is as strong as the weakest link. So that respect, that mutual respect, is something I always wanted, when I visited, or wanted in my missions. But of course, that's not always the fact."

Across the board, different currencies of influence overlap and intersect with axes of inequality within the organisation. As an example of how medical and health hierarchies interact with MSF's internal dynamics, an employee with a nursing background commented that tendencies of "medical doctors, especially surgeons, really feeling that they have so much education and are higher than others and thinking that they should be served" are exacerbated by the difficulty in securing this expertise for MSF projects, meaning that "due to scarcity, people get very much served in doing very short missions and then you have high overturn, and they can just demand whatever they want." These dynamics then interact with nationality, length of service, and racism in the organisation. To illustrate this, a doctor with MSF described an anecdote:

> "We have one example where you have one medical doctor who has worked with MSF for quite some time […] He went out and came back to MSF. He is supervised by a Medical Team Leader who happens to be a nurse, and who happens to be of African origin. And he happens to be from a European origin. So, he was using the power of, one, being from where he comes from, two, of having worked with MSF for a long time and also some time ago, and now again. So, he was always looking down upon his Medical Team Leader who is a nurse, and who is also of African origin. Because some of the things that he would mention were like: 'this African medical team leader and other African colleagues were only with MSF because of the benefits'."

Conclusion

This chapter described several key structures of inequality in MSF, and currencies of influence that enable certain people to exert influence or obtain legitimacy within MSF. Among these structures are demographic factors like race, gender, ethnicity, which are a reflection of wider societal structures. In such circumstances, MSF will play either an accentuating or alleviating role depending on the stance it takes. Other structures (time in the field, friends in higher places, medical expertise and spoken English) are inherent within – if not unique to – MSF's systems and cultures, reflecting the scale of the movement, the setup of its structures, and the medical work that characterises MSF's primary duty. These currencies of influence act as threads in the following empirical chapters.

Chapter 5. MSF Identity

Introduction

Arguments about the identity of the MSF movement are as old as the organisation itself. They often relate to conceptions of MSF's social mission and how it is embodied in, or achieved through, the individuals who make up the movement. In the early years, tensions emerged along the lines of 'Paris versus the province', over the amount of freedom that leaders had to represent MSF publicly, and after accusations that non-French speakers were being excluded (Bradol, 2020; Davey, 2015, pp. 181-214). Since the mid-2000s, debates about organisational structure have been tied up with questions of staff identity and the way that the movement reproduces broader post-colonial inequalities (Redfield, 2015; Fox, 2014; James, 2020). In the words of one contributor to the La Mancha reflections: "MSF always presents itself as an international organization. But how truly international are we?" (Van der Tak, 2005, p. 384)

This chapter examines the persistence and effects of certain tropes in MSF that influence who is understood to embody MSF's values, and who holds expertise. The first section examines the two-tier system between MSF staff in countries of operation, and how these tropes have justified the exclusion of locally recruited employees from occupying senior decision-making posts. Despite recent policy changes to enable locally recruited staff to occupy coordinator posts, the experience of these new coordinators illustrates how these tropes can still shape who is seen as legitimate and who can hold responsibility in practice. The second section examines training and guidance documents, focusing on induction processes, to provide an illustration of how certain ideas about organisational identity become embedded in MSF's processes from the onset. In so doing, it suggests that imaginaries about 'the field' as a bounded site of intervention 'elsewhere' contribute to an exclusionary notion of humanitarian identity. The third section examines how, despite recent attempts at reform, hierarchies remain entrenched in MSF's associative structures, influencing who can contribute to shaping the organisation's identity and agenda.

5.1 Trusted to lead?

In countries of operation, certain tropes about who is 'neutral' or who holds certain forms of expertise continue to influence who is seen to be legitimate and trusted leaders of MSF operations (James, 2022). While there has been movement to open up additional posts and greater formal authority to locally recruited staff, many locally recruited staff were under the impression that this has not always been done voluntarily, fully, or equitably.

Imaginaries of Neutrality

There is still a degree of distrust surrounding locally recruited staff and their ability to embody MSF's principles in practice. MSF prefers mixed 'national' and 'international' teams: the presence of internationally mobile personnel is understood as important for combatting local manipulation, and 'safeguarding' the organisation's real or perceived impartiality, neutrality, and independence (Hofman and Heller Pérache, 2014). One experienced internationally mobile employee described this as central to work in conflict settings:

> "It is so important to have this international staff group because in the end it is all about neutrality and then, not about whether we feel ourselves neutral and impartial, but what the perception is […] This group [internationals] – in most settings where we are relevant, settings of conflict – then we need this. It's part of our being. We need this group. Now if you're now back to equality it has nothing to do with one is more valuable than the other but, in those settings, there is obviously a totally different role for the international staff than there is for the national staff, who are not necessarily part of the conflict, but part of that setting."

While proximity to 'the field' is a currency of influence among internationally mobile staff to construct their legitimacy, locally recruited staff proximity to 'the field' (or being "part of that setting") to some extent excludes them from being able to fully lay claim to MSF identity. Some staff described how they initially internalised this logic:

> "The information that is sold to you, is sold in a way that even though it's against you, you still support that information because you don't see the bigger picture. You just believe so much that it's true unless you really see the other side […] we were all convinced that following the MSF neutrality principle, that as a local you cannot be in a decision-making position […] automatically you just saw all the international employees, this holy person, this pure person, that comes and is purely neutral, follows MSF's principles."

This employee, who entered MSF through local recruitment and has since held other types of contracts, argued that the idea that only expats can be neutral is about:

> "Keeping that MSF flag, MSF principles, with the only guardians being expats. Being a national, I suffered a lot of times from it, even though I was kind of trying to convince myself: 'it's great, I should not suffer that, it's for good reason.' But I felt disrespected."

A locally recruited employee argued that: "It is as if headquarters don't have confidence in national staff, because of corruption, conflict, poverty, so headquarters don't give authority to national staff, and keep everything in the hands of international staff." Another added: "For them [expats], there is no way things would work if there was not an expat or a Westerner in decision-making roles. It's like they think we are incompetent, thieves."

International employees also highlighted this distrust:

> "There's almost a suspicion when it comes to national staff. And I hear a lot of dialogue between expat staff that is also, to me, unsettling. Like, 'Oh you can't hire national staff in these positions because they would be more open to being influenced by people that are corrupt, or they wouldn't be able to manage the finances appropriately because of the pressure that comes.' […] To me it is quite racist to say that because you come from this country, you wouldn't be able to manage the finances. It's inferring that you would necessarily misappropriate funding when you wouldn't assume that about a European coming in."

The idea that aid workers in the Global South cannot be given leadership in their own country because of concerns about nepotism, mismanagement of funds or neutrality, perpetuates structures of inequality (Peace Direct, 2021, p. 18; James, 2022). Yet, some locally recruited staff were also concerned about corruption or "power abuses" if their colleagues were put in senior decision-making roles: "for technical positions national staff may occupy by them, but for making decision it's better to give them to international staff." One locally recruited employee concluded that although corruption exists, MSF risks assuming that corruption is somehow inevitable among local employees: "We must try to look at things on a case-by-case basis."

Imaginaries of competency and expertise

MSF employees across the organisation highlighted that only certain people in the organisation were assumed to hold expertise. Different employees gave detailed examples of how this manifested in practice in different settings, and the underlying values they believe are in operation. "Expats are experts," is how one former locally recruited employee summed up the widespread perception.

As many pointed out, this assumption was embedded in the way that MSF operates – the assumed need to bring someone in from elsewhere suggests that existing 'capacity' is lacking. Some explained this with reference to the specialised and hierarchical nature of medical care, as in the description by an employee with a public health background:

> "My perception is it's […] less so that MSF is sending doctors to the bedside, so much that they're sending expertise to crisis areas. So, it's not saying that Lankien in South Sudan doesn't have enough doctors. It's saying: 'You don't have the right expertise. So maybe you've got doctors but you don't have doctors who do burns operations or can use ultrasound.' Or whatever it might be. So, there is something of: 'Oh we're coming to provide capacity and hands but also to train and build capacity.' That's my perception of what MSF perceives itself to be doing."

Others pointed to structural inequalities in the settings where MSF works. A senior programme colleague described why top positions in 'emergency' contexts are often held by internationally mobile staff:

> "The national staff are not ready for it. Most of the internationals, they have expertise, they have higher degrees, they have experience. […] Here, because most of the population are affected because of conflict or whatever, they don't have that experience because they have been, for example […] excluded from continuing their higher studies at university."

While there are clearly some settings where access to further education has been limited by recent violent conflict, this generalised interpretation seems to risk reinforcing historically-laden tropes about who holds expertise in the organisation. One locally recruited employee summarised: "it is sometimes perceived that international staff are more intelligent and competent compared to national staff." This was part of a broader structure, they argued, which meant that international staff "can supervise national staff without proper experience." Another locally recruited employee said that the "mentality" of MSF is revealed when one asks: "Can national staff supervise international staff?"

Among some locally recruited teams, there was discontent at the fact that when a foreign coordinator leaves the project and is not immediately replaced, their 'assistant' rarely fills their position: "What are the assistants accused of? Aren't they qualified to replace their colleagues?" Instead, OCA sometimes hired people from other organisations to fill senior decision-making roles immediately. One employee who joined through this route said:

> "MSF has a deeply ingrained culture of valuing internal experience over external experience and that led to the wells drying up basically so at some point by necessity the organisation started to experiment [...] bringing in people with relevant outside experience into management roles."

Here, the 'wells' of competency refers only to internationally mobile staff. Rather than giving nationals management positions, OCA hired those who had never worked for the organisation as the best way to find the necessary expertise.

The "mindset", one employee described, was that an expat is "someone with knowledge, with expertise […] The expats are trained, or will get trained, or are experienced, by learning on the job, doing a couple of missions, and suddenly, they're coming to teach you how to do things." Another interviewee described receiving the same training repeatedly over at least five years from various internationally mobile staff, but that MSF continued to frame these exercises as "capacity building."

Indeed, the justification for bringing in foreign expertise was not always clear to locally based teams: "Visitors are there, but what are the bases of their visit?" In one country, a category of supervisory position occupied by internationally mobile staff was phased out, only to be reaffirmed two years later. No explanation was given, according to one interviewee, who speculated:

> "I don't know, it's because they want to control the project so that they have more, you know, when you have more people, you have power. So, the number of people you have is the number of power that would determine, you have. So, I think there are fears if we have less international people, the power, the voice of this [locally recruited staff] will be more powerful and then we may, they either climb up and they get stronger and there are no room for international again. So, I don't know, really, what happened in the HQ, why they keep sending, why no one ever takes time to evaluate. We have been doing this for the past seven years, where have we reached now?"

There was an impression among locally recruited staff that employees from the Global North are "given the benefit of the doubt" and given positions of responsibility based on the "understanding that they come from this European education system, or this American/Canadian system, that you're still going to be of value to the team." Meanwhile, as one interviewee pointed out, "you don't see us giving that same benefit of the doubt to the Congolese people that are applying – like, an engineer from Congo, we're not just going to assume that they have the people skills or the management skills that we all assume a European engineer has." Another interviewee argued that MSF's model reproduced ethnocentric assumptions about expertise:

> "MSF does this thing where we hire lots of managers who have no prior managerial experience […] So, they come to these missions […] and there is superiority complex. They come in from the US, the UK, from Australia, 'I have graduated at the top of my class, I know what I'm doing' […] They then superimpose upon the teams their way of working or their way of doing something […] disregarding their agency, disregarding any kind of background or knowledge that they [local colleagues] may have accrued."

This devaluing of existing expertise poses a problem considering that the breadth across which some supervisors are expected to be subject matter experts makes it necessary to learn from others; one person cannot know it all. One employee working in a highly specialised clinic described the repeated challenges of having a supervisor responsible for many departments. At least one is bound to fall outside their area of expertise:

> "There is a problem […] when it comes to managerial positions. They can hire someone to cover two to three departments but within those departments, it's not expert or it's not well experienced enough to run those departments but they're wanting to lead. How will you lead if you lack those? You are given that position to mentor, to train, to bring those people up, you know, empower them. If instead, you have been given that position and you know it is mandatory, you have to do the evaluation anyway, how will you evaluate someone you don't know what they're doing? Like, in my department, it happened several times. They bring somebody who does not know what we are doing actually."

The practice of describing people by their contract type was highlighted as a sign of prejudice: "in my opinion, those terms should only be used if you're referring to someone's contractual status. You don't need to say, 'this expat doctor', or, 'that national staff doctor'." This employee described arriving on assignments to be told "doctor so-and-so will brief you. He's national staff, but he's good."

One particularly detailed example given by an interviewee in South Sudan illustrates how assumptions about existing medical expertise played out in practice. This South Sudanese interviewee described how many internationally mobile staff seem to think that medical knowledge coming from locally recruited colleagues cannot be trusted – as a result, internationally mobile staff "might not believe in the [clinical investigation] results that you are telling them." As a result of this "disbelief", the interviewee explained, internationally mobile staff may try to fill the perceived gap themselves, even if they are missing the specific expertise (skills or contextually relevant knowledge) it requires:

> "We have a lot of cases, for example someone has no background of [this procedure] and is international staff and then we have the trained staff on ground. So, instead of going to this person and saying: 'Hey, this case of mine I want to post on telemedicine, can you get for me the images?' someone will not be able to do that. He will try to do the [investigation procedure] by himself and he has no idea [of the right processes], everything is done differently."

"Telemedicine" refers to a platform for digital consultations that MSF has set up to provide support for challenging clinical cases. Staff can post information about a case, including history and any images or scans, and receive advice from specialists. One of the consequences of internationally mobile staff taking these processes upon themselves is the lower quality images they produce, which can result in their locally recruited colleagues facing reproach because they are nominally the technicians of these systems: "out there the specialists will be shouting, you guys are sending us very poor images." Virtual connectivity within the organisation, therefore, can have perverse consequences. So too can the very human responses that individual personnel may have: "the next time when you call me to do [a procedure] for you, I may not come. Or, if you have another colleague call me to do a [clinical investigation], I may not go because I'm completely demoralised." The number of people involved increases, and the set-up may already differ from what personnel from foreign countries are used to, so new managers react negatively. In the words of this staff member:

> "Of course it will be a shock, but for a better practice and to be a better person I think it is good to sit down with that person, yes. To ask questions and say 'Hey, what is going on here?' And then someone will be able to help you completely, but when you don't ask questions and then you just begin to change things and it becomes very strained."

Here, medical staff described a working culture where foreign managers are assumed to hold superior expertise. With a focus on transnational connectivity between (presumed) specialists and amidst a high turnover of foreign managers, local medical staff found that their own expertise was too often dismissed.

Implications for protection

Tropes about neutrality, expertise and competency have prevented locally recruited employees from holding responsibility. However, there were also genuine concerns about how locally recruited employees in coordinator positions might be more at risk of pressures or threats, especially in settings of violent conflict. Locally recruited employees described how making key decisions about, for instance, recruitment, might expose them: "For me, I prefer not to be in a position to hire staff, because you will always be accused of bias or hiring your relatives." An interviewee in Syria described how having an international boss:

> "Is kind of protecting us, from being exposed in front of authorities, or the community. If let's say, if someone knows I'm involved in making decisions about a project here, I might be at a risk in front of the community. 'Why do you lead the project here, because you have a family, or friends there?' So that's why, we say MSF protects us, when we talk to authorities, we keep saying: 'it's a decision made by international staff, not us'."

Other staff were concerned that a logic of protection helped justify power hierarchies. Rather than being applied systematically, they argued, the positions of locally recruited staff should be examined on a case-by-case basis. As one employee in DRC explained, keeping foreign staff in decision-making roles has a "certain logic behind it":

> "It aims to reduce local pressure. For example, when I have to hire someone in the organisation, and I have a recommendation from the governor stating that this or that person should be hired, I would not have the capacity to say no […] But if it's someone from the outside, they can refuse, and three to five months later, they will leave."

Nonetheless, this employee concluded:

> "It shouldn't be systematic, because there are areas where a national project staff member might negotiate the humanitarian access better than an international Project Coordinator. Sometimes, some groups look at internationals as spies […] or people who are here to exploit the country's resources. That can create a barrier for the organisation."

While these issues of identity and protection often came up when interviewees discussed who could or should be placed in highly visible, senior decision-making roles, another important area that appears to have received less institutional attention is the position of staff involved in decision making about patients seeking care. Locally recruited medical staff explained that decisions at clinical points of contact can leave them exposed, specifically when decisions differ from patient expectations. For example, when triage staff deny access to patients who do not fit the inclusion criteria to receive care at a given MSF healthcare facility. One activity manager explained why locally recruited staff may try to avoid these sensitive stations:

> "When they go to the communities, they get some challenges. So you know, it's sometimes difficult for them since they are living there, so we understand. Even feeling that they don't want [to be assigned] in to that area [the triage area]. Because they complain they want to shift to other areas because of this challenge."

A triage nurse concluded: "I was feeling guilt for those people. They came at 7am, morning. I sent 11 patients back home who were normal in their vital signs [they did not fulfil criteria to be seen at this MSF facility]." This raised the question of why these sensitive decisions are not made by internationally mobile staff; the argument applied to supervisory roles has not been extended to these basic clinical duties.

Other interviewees highlighted another inconsistency: when security conditions deteriorate, it is often locally recruited staff who are left to continue working, despite being exposed. In Syria, for example, MSF evacuated international staff in 2019. A group of Syrian staff were tasked with helping to close the mission, maintaining a network among political leaders, and collecting security information. As one of these Syrian employees described:

> "They [expats] keep managing the project and the mission remotely. And they put us in the front. They created a committee, for national staff […] I accept the responsibility and I accept the risk […] because I have obligations with MSF, I need to continue my job and continue protecting the mission and the staff. Plus, this is the only way to support my family."

An internationally mobile employee with experience in Syria described how these Syrian employees became "representatives of MSF" and were "instrumental in allowing MSF to come back." However, when the projects reopened and international teams returned, these Syrian staff were, in effect, told: "You go back to being [support staff]." Meanwhile, the political authorities continued to contact these Syrian staff, rather than the foreign coordinators. These Syrian employees, therefore, found themselves treated as representatives of MSF locally, but without influence in the organisation. They "cannot, of course, call the desk and tell them what to do. So, they […] developed a system to make the message pass, because they still care about what's going on. They have a commitment to MSF that none of us have," one senior employee concluded.

Nationalisation, or Pasteur Bizimungu?

There has been a recent shift in human resources relating to the position of national staff in their own country. The 2020 Staff Data and Trends Report indicates that the percentage of coordinators who are locally hired increased from 10.88% in 2016 to 17.6% in 2020 (Cragg and Jager, 2021, p. 31). This was in line with the 2018 'Human Resources Principle on Staff Mobility and Team Diversity', which states that all positions should be accessible to staff based on their competencies rather than contractual status. The report describes how this shift was also pragmatic: "One of the factors that contributed to the increase in locally hired coordinators in 2020 was that many of the Covid-19 interventions in countries where MSF does not normally have projects were staffed by locally hired staff" (ibid). Indeed, interviewees described this shift as "opportunistic":

> "Covid didn't allow us to move people around and then we start to promote and to be opportunistic to local staff, but if you ask me, it hasn't been ingrained in the policy in the procedure, but not really. I think it has been opportunistic, with the current, one month before Covid: 'no, impossible to have the national staff taking this role'. One month later, Covid hit: 'Oh yes, for sure, this person is very qualified'."

In DRC, for instance, some decision-making posts have been opened for Congolese staff since 2020. A Congolese employee explained: "There are many jobs that are being nationalised…This was not possible at the time that I joined the organisation." As senior international staff returned home at the onset of the pandemic, MSF began to replace them with interim national staff, including staff who had previously been expatriated. Congolese employees described the shift:

> "Activities in the field had to continue but they had to rely on the national staff since expats were going back home […] I think they realised that the test worked, and they were like, why not? […] we can thank Covid for that, there are some positive sides to Covid after all."

Another employee added:

> "There are indeed changes when it comes to local staff in responsibility roles, which is something that used to be a taboo, but today we're talking about it […] Covid taught us a lot, because it made it difficult to find international staff. And that made MSF look for alternative solutions. It made MSF start to think differently."

However, other Congolese employees considered that the changes had not gone far enough. Although locally recruited staff were now allowed to occupy coordination positions, there was an impression that they were not trusted with the same degree of responsibility. One employee who was given a coordinator post previously reserved for internationals described his experience:

> "MSF is changing, but changes are not yet radical. There are still areas where we should improve, where we should really completely change because some changes still aren't fully applied. Responsibilities are still not the same. It's like if you give someone a role, but the responsibilities are a bit reduced, you deprive them of certain opportunities. These are things we should still work on […] when the FinCo left, he preferred giving the keys/password to an expat Project Coordinator that now has to do all financial transactions. If I was an expat, this wouldn't have been the case…I think it's clear that there is not enough trust here. They do give us responsibilities, but we still don't have the same level of trust as our international colleagues."

In other contexts, interviewees also had the impression that locally recruited staff in coordination positions were not given the same responsibility. In South Sudan, a clinical employee remembered that when a South Sudanese staff member began a newly created position, in practice they were not granted the full powers in the job description:

> "When I look at that when the position was advertised, I see the description for the deputy, what he will do and all this. But when you get the position, the powers that were put in the paper, he is not exercising them now that he has become it. He is someone who is just presenting there, he has less power when he speaks. And I know maybe it is because he is the only person there, and he cannot do this and do that and then people are like this. So he has less power."

Some of these powers, they observed, in fact sat with the hospital coordinator, who was technically the assistant to this 'nationalised' deputy role.

Reflecting on these dynamics, a Congolese employee concluded:

> "They had to give national staff some key positions, but the ones who were given these roles were not even trusted. It was like they only had that role as a label. In Congo, we call these people Pasteur Bizimungu. Pasteur Bizimungu was the president of Rwanda […] He was the Rwandese President who ruled after the genocide of 1994 and was appointed to try to establish an equilibrium between the Tutsi and the Hutus. He was a Hutu, and it was his assistant, the vice president, who actually ruled the country. Bizimungu was just for appearances; labelled as president, but more like a puppet. He did not make the decisions, even though he was the president. The Vice President, Paul Kagame, is the one who made all decisions, and that story inspired the saying I just used. So, we say someone is a Pasteur Bizimungu if he is given a role, but just as a label, without actually being given the right to make decisions […] That is how our staff were treated when given decision-making roles."

Several locally recruited staff argued that this was because of a belief that "when you give national staff responsibilities, they will steal."

5.2 Constructing MSF identity

Ideas about differences between locally recruited and internationally mobile staff are highlighted during new employees' first introduction to the organisation, and provide an example of one of the ways that this two-tier system is reproduced and normalised. The distinction drawn between 'national' and 'international' is based on ideas about MSF identity, and influences who is able to access it and on what terms. This section examines some of the core ways that OCA initiates new employees into the organisation and how the training reproduces certain ideas about 'the field' and locally recruited personnel, that elsewhere (as seen above) the organisation has sought to move beyond.

Preparing for a first 'mission'

Preparation for Primary Departure (PPD) is a training for newly recruited international MSF employees. As the OCA PPD introduction explains, the aim is: "to prepare all new field volunteers for their first mission by introducing them to humanitarian aid, the MSF identity, programs (operations), and roles and responsibilities within MSF." This training is intended for internationally mobile staff, while locally recruited staff do a different training, called Sanou, held in their country of origin and employment. Setting aside the practical advantages of this arrangement, it has another social, cultural and arguably ideological impact: a distinction is drawn from the start between 'international volunteers' and 'locally hired employees.'

The PPD training is informed by, and reproduces, a particular "field imaginary" (Stellmach, 2020). The training is framed as essential for 'pre-departure,' rooted in a particular imagination of 'the field' as somewhere distinct and different from home. As Peter Redfield argues, MSF is based on the model of a transient expatriate. Its "assumption at the outset," he wrote, is "that its volunteers would be eagerly and effortlessly mobile. Unencumbered by social obligations at home, the medical humanitarian should likewise acquire few in the field, living lightly on the landscape, and always ready to leave once urgency passed" (Redfield, 2012, p. 362).

Alongside briefings on topics such as MSF's history and structures, security considerations are an important feature of the PPD. In the first PPD module: 'MSF Identity and Actions', remaining detached is described as essential to security. In the training, 'local perception' is framed as key to security, with fieldworkers needing to consider how they are perceived at all times. Similar considerations are found in other guidance materials. The 'OCA General Safety and Security Policy' from 2017 explains: "MSF OCA and its staff's adherence to core humanitarian principles is instrumental in gaining acceptance by all relevant stakeholders […] acceptance remains the dominant security strategy" (MSF OCA, 2017). A Code of Conduct (MSF OCA, 2018) explains:

> "When working for MSF-OCA, you are representing the organisation and your behaviour influences the way that the organisation is perceived. Your statements as well as your conduct can be interpreted as an expression of MSF's point of view. If you do not observe the framework, you may bring yourself, your colleagues, your mission and MSF-OCA in danger."[6]

Where are MSF employees performing this identity? The 'field' is constructed as a site of action "out there" (Malkki, 2015) – a place of hardship and danger (Stellmach, 2020). For example, during PPD, participants take part in the Orienteering Game, which aims to teach them the "importance of teamwork for the proper functioning of any MSF project." The team, here, comprises solely international employees (though in practice, the majority of their colleagues will be 'nationals'). The game takes place in Kottenland woods in Germany: teams must conduct an 'exploration mission' in order to "assess the medical and humanitarian needs of the population in Kottenland with a main focus on malnutrition." The teams navigate roadblocks and negotiate with local leaders. The imaginary land of Kottenland is described to be: "populated by two tribes, the Venus tribe and the Eiffel tribe," the Venus tribe are described as: "hunters and cattle-traders by nature." The facilitators who act as local political leaders are instructed to "act bossy, authoritarian, top-down," while the training notes instruct other facilitators to: "behave like opposition leaders, who are economically in a poor state […] you don't like these foreigners." The head of the Venus tribe is to act as if: "you don't give a shit about people from the Eiffel tribe," and the ministry of health representative is instructed to act as if: "the little hut is your office and nobody should dare to enter your office without invitation."

6 A revised Code of Conduct began being rolled out in OCA in 2022.

The separation of home and field tries to cultivate some sort of "detachment as a marker of professionalism" (Okely, 1992, p. 8). However, this risks reproducing binaries such as us/them, strange/familiar – a 'field' with a native 'other' that is different and potentially dangerous (Gupta and Ferguson, 1997). This racialised construction of 'the field' also seems to present violence in the Global South as irrational and identity based. 'The field' is presented as a risky environment, and a potential cause of stress for internationally mobile MSF volunteers. For example, the PPD Stress Management module focuses on 'Stress in the Field,' and emphasises the fact that the Pychosocial support is 'available to expats.' One of the accompanying resources for the training module is the 'Practice Guidelines for Dealing with Ongoing Stress and Traumatic Stress in the Field,' written by the Psycho Social Care Unit. These guidelines explain that: "in the field, you may experience stress when challenged with the unknowns of living in a foreign country…you may experience stress when dealing with environmental hardships such as a harsh climate or primitive living conditions" (MSF, 2009 p. 9). The Guidelines warn that: "field workers may experience feelings of sadness and hopelessness when they see bombed villages, refugee camps overflowing with sick and starving people or people dying unnecessarily" (MSF, 2009, p. 17). While such portrayals are intended to prepare personnel for difficult experiences, they risk reinforcing reductive ideas about the societies among which MSF works. Imaginaries of 'the field' as a distant and inherently risky place, emphasised in the induction training for international volunteers, overlook the fact that the majority of MSF staff are working in their own country. They contribute to differential understandings of who can assume an MSF identity and on what terms.

Who is really MSF?

Induction trainings and guidance documents reflect a view that MSF is differently constituted by different kinds of staff members. MSF employees are required to perform a distinct, detached MSF identity as a matter of security (James, 2020; James, 2022), as these materials make clear. The prescribed codes favour internationally mobile staff by presenting them as better suited to holding positions of responsibility.

While the behaviour of all MSF employees is considered a potential source of insecurity, the PPD's materials describe a distinctive position for locally recruited staff in relation to the management of security and wellbeing. Locally recruited staff are described as key representatives of MSF, actively contributing to 'acceptance', which is in turn interpreted as key to organisational security. However, they are also presented as part of 'the field'. For instance, in the PPD module on 'MSF Identity and Actions', new volunteers for international posts are asked to consider "perception issues": "How is MSF perceived by populations, beneficiaries, national staff, other organisations, host governments?" This places locally recruited staff in the same frame as external actors. By listing "communication with national staff" as one of the "stressors in the field" (p. 12), the module on Stress Management does something similar; if communication with colleagues is a potential stressor, why single out one type of contract holder?

Instead of PPD, locally recruited staff do the Sanou – a training that runs across three days and is delivered by locally recruited staff in 'field missions.' The overall stated objective of Sanou, as explained in the facilitator guide, is to: "strengthen the ability of MSF staff to act as 'Ambassadors of MSF' both internally (with colleagues and beneficiaries) and externally (with family, community, other partners, etc)." Sanou aims to facilitate 'intercultural understanding' of MSF as an organisation: its work, principles, and history. In effect, Sanou introduces locally recruited staff to MSF's identity and history, so that they too, can become 'ambassadors' of the organisation. Differences in how locally recruited staff are initiated into MSF identity draw distinctions between international volunteers and local employees.

As the OCA Onboarding Guideline for National Staff (MSF OCA, 2017, p. 8) explains, there is a security logic at play. The additional objectives of Sanou are to: "contribute to increased acceptance of MSF and thereby contribute to MSF's security strategy in the mission" and "enable national and international staff to improve their mutual understanding in this multicultural work environment." By initiating locally recruited staff into a particular MSF identity, the aim is also to prevent local staff behaviour from being detrimental to MSF's image and thus security; to encourage staff to communicate MSF's work locally; and to prevent tensions in the team which could result in security incidents.

This logic also appears in some of the PPD materials that relate to interactions among employees. Further, these are geared towards the management role that almost all internationally mobile staff take on, given the way that senior roles in the organisation are distributed and in certain cases ring-fenced. In a PPD training module about 'Responsible Behaviour,' one prompt describes: "One of my national staff made a huge mistake and I get angry with him in front of the team. As I am his boss, it is justified to do this so he and the rest of the team understand the consequences of his mistakes." The PPD trainees are asked to respond yes, no, or maybe. The correct answer is 'no', because (it explains) of a need to avoid "disrespect of cultural customs" and because this could lead to "unintended consequences." Instead, "criticism has to be given professionally and, if possible, constructively." This risks suggesting that international staff hold expertise in MSF, and need to carefully manage 'their' locally recruited staff.

There is thus a possibility that MSF inductions normalise from the off-set a hierarchy whereby internationally recruited staff are decision-makers, managing teams of locally recruited staff. One employee remembered:

> "It had been made explicit in welcome days that all international staff are, by definition, managers of national staff. And there was an exercise […] where within each table, there was a board, where there was a divide between national staff and international staff, and folks were supposed to write down on this board the advantages and disadvantages that each group would bring […] So folks did say things like: 'national staff, it's great that they know all the local areas of the work, but they're probably not objective' as an example. Right? […] I, as a foreigner, am automatically objective and capable to see what's actually going on, these kinds of things."

This hierarchical construction of MSF identity also manifests in other practices or settings and is at the same time reinforced by them.

A System Reproduced

Interviewees who began on national contracts described how the two-tier hierarchy was internalised during their time in the organisation, and in turn reproduced when they themselves became international staff. After being 'expatriated,' one interviewee explained: "I was behaving [towards my staff] the way that the expats had behaved towards me." After realising that they had internalised the same attitudes that had once excluded them, this employee reflected on how the "culture" in MSF reproduces a sense of superiority among international staff:

> "The fact that you just enter into another country and you have a car waiting for you, someone opening the door for you, someone taking your luggage, you already feel that VIP [very important person]. And then you have a luxurious house where your colleague is not, well, don't even have a proper shelter. You have a car picking you up, dropping you to the office, picking you up in the evening. You have the weekends where you have access to luxurious restaurants and stuff like that...then the weekends, the parties that you have there. So, this whole process, it already puts a big gap, and puts you in a higher status, regardless of how much you know or you don't know. Regardless of how much knowledge your local colleague has. And you already feel that superiority."

Describing the processes of revising security policies in a country, a former deputy Head of Mission described how a two-tier system that excluded locally recruited staff from strategic decision making was reproduced, despite recent nationalisations:

> "With these documents you have to update them […] every year, the mission has to do it. Usually, you do it – I don't say superficially, but you just put in some new context and maybe some new issues they've seen. But this time I really thought I needed to revise it. […] This was after all the debates that were coming out about inclusion, differences, coming out etc. But one paradox was that one of these documents was revised by the PC of one of the projects and he is actually [a local staff member], and he actually wrote, or maybe kept the writing: 'This document is not to be seen by the national staff'."

Meanwhile, many locally recruited staff described their frustration at working in similar roles for over a decade, while junior or recently recruited internationally mobile staff rotated in and out with significant career progression: "Promote people! Or they rest in the same routine, lack of motivation." Project staff described adapting to annual operational plans which were formulated without their input, and were instead dictated by "people who do not stay long in the mission. Those people dismiss the concerns of others, and then move on, leaving everyone in a mess." One interviewee concluded: "MSF is far from reaching that equality we dream of." This claim made about the 'executive' operations of MSF also resonates with critiques of inequalities in its associative life.

5.3 Associative life

Despite attempts at reform, structural hierarchies also remain entrenched in the associative structure of MSF, influencing who can contribute to shaping the organisation's identity and agenda. Associative structures are a fundamental part of what makes MSF a 'movement.' They give MSF's staff and former staff the nominal power to direct its formal leadership: "MSF is an association; the association members are like the Board and they appoint a 'GD' – a General Director – who leads the business on behalf of the Board and the association in their interest." The association can, for some, be part of the appeal of MSF. Yet even among those who value associative life, its functioning was described as ineffectual at best, and discriminatory at worst: "The stones that you pick and there's a lot of worms under, that's how I see the association."

Tiers of membership

While membership of an association brings the possibility of engaging with MSF's identity and how it is understood and put into practice, what this looks like in reality depends on giving people an incentive to engage, creating equitable systems, ensuring access to information, and executive accountability for acting on associative decisions. In theory, association membership is open to everyone, and all members are equal. In practice, interviewees described a system with different tiers of membership for staff, reflecting broader structures of global inequity.

The association's role in defining MSF identity raises the stakes on who is able to join. The possible participation of 'local personnel' in the association was first floated in the 1990s by MSF Belgium (Binet and Saulnier, 2019, p. 313-14). The MSF Holland Association passed a motion allowing local staff to become members in 2004 (ibid., p. 317). However, there were concerns about how this would alter MSF's identity. A 2007 review noted concerns that: "The number of national staff who potentially could join the associations could have an overwhelming and radical impact on MSF and dilute or change its identity" (Fotiadis and Stevenson, 2007, p. 6). The reasons given included persistent racialised tropes used to justify the marginalisation of local staff in various domains, including claims about capacity, self-interest, lack of respect for humanitarian principles, and security risks.

Today, associative life in countries of operation was described as 'fragile.' Although there have been efforts to increase participation, uptake remains limited and there are still obstacles. In 2022, for instance, when MSF's programme staff were around 57,000 people, an estimated 1,450 people participated in Field Associative Debates in 42 countries (Ponpon, 2022, p. 1).[7] One person who had been active in the association recounted being told by drivers that it was: "'one of those things for the big bosses, it's not for us, because no one cares for our voices.' And it was not like a complaint, it was like a fact."

Interviewees pointed to different treatment of locally recruited and internationally mobile staff. While access to information was often highlighted as a general obstacle to associative engagement, at times this was explicitly connected to a lack of trust in people considered 'other.' For one interviewee, concerns about "what we're sharing to whom" revealed the nature of the power dynamics in associative life:

> "When it was a group of 20 Dutch association members, they had no problem sharing the information and sending an email. Now, it's 1,000 members with I don't know how many in DRC, how many in Zimbabwe, they're like, 'Can we trust everyone?' Nobody says who you're not trusting, but you know what they're saying when they say, 'We don't want information to end up in the wrong hands.' Yes, it's very clear you don't mean your Dutch colleagues."

Some employees described a lack of consideration for what happens when OCA closes projects or country programmes as evidence of the lesser value placed on association membership of locally recruited staff. Association members were described as "left behind":

> "They don't have the same value, which is very clear to me. Their voices, their opinions are not valued in the same way as an association member whose base was Dutch, who probably has family who have been donating for years and years, and is influential within the networks that are important to MSF. That's a different association member and we will treat them as such. The association member that we left in Zimbabwe, in Mozambique, in Afghanistan: 'Yes, maybe when we need to start another project, maybe they can help, maybe we can call them and ask them how it looks,' but [their membership is] not so important."

7 This is a minimum figure, coordinators noted that reporting is incomplete and participation was affected by Covid-19.

In principle the association is a channel for all staff to shape the identity and priorities of MSF; however, in this description, it is instrumentalised when locally recruited staff become relevant to operations. As we heard from another employee: "for me, as an expat, MSF is like a cooperative, but I am not sure the national staff in a mission in Iran would feel the same way, that MSF belongs to them and they can carry weight."

While the past few years have seen increased investment in promoting associative engagement, this was criticised as insufficient in light of both practical and normative challenges. Interviewees described biased structures that concentrate institutional support in the OC and section offices, rather than in countries of operation. One person involved in supporting the association said:

> "I believe that is a form of discrimination. MSF claims the association is important but does not grant equal access to it. So, if you're in Paris, you get to be close to very active coordinators, but if you are in Congo, you're in an association that is much less dynamic and organised."

The problem has been recognised in efforts to promote engagement, including through supporting roles known as 'ALFies', which stands for Associative Life in the Field. ALFies are locally recruited staff members who are representatives of the association from their project. There has been investment in strengthening the ALFie role, connecting ALFies with OCA Council members and committees. Yet these roles are unpaid and add to existing workloads.

This critique deepens into an argument that the fragility of associative engagement was also due to normative, Eurocentric biases in its assumptions. Explaining the concept of the association outside French or European contexts often requires translating it, trying to "make people understand that the association was cooperative and that everyone was a stakeholder" or "describing MSF as a family business, a business where everyone contributes to making it work." Even more fundamentally, a former ALFie described how approaches to improve participation in programme countries were constructed around the 'Western' humanitarian value of volunteerism. For staff in crisis-affected countries, they asked:

> "Why for me should it be a priority to invest my private time to come to an association discussion to engage people to talk about something that may impact 10 years later, maybe, my context? […] Why don't I have a priority of making sure that my kids are not starving, that my home is not burnt, […] psychological things that are going on in my context?"

To overcome these challenges would require more sustained investment, particularly in paid association staff where MSF is working. Yet, the institutional attitude was described as: "if people don't care about something we don't want to force them, and they are not committed." This attitude is likely to reproduce existing power dynamics, which are weighted towards headquarters and partner office countries.

This unequal weighting of different members was also seen in descriptions of how associative forums run once people have engaged. The chain of motions and votes – from the Field Associative Debates (FADs) to General Assemblies and on to the International General Assembly (IGA) – is long and involves obstacles of language and distance. The chance of decisions being communicated back down again was described as even smaller. The one-member, one-vote principle is challenged by practical access inequities:

> "In a General Assembly my vote equals the GD's vote or the Board member's vote. But individually I agree, but what about collectively? How many people from my country can come to the GA in Brussels or in Amsterdam?"

Under these dynamics, and despite formal distinctions between the two, associative and executive power can appear to overlap when association meetings become dominated by the contributions of headquarter staff and senior internationally mobile staff – and particularly, in the case of the MSF Holland association, Dutch staff. As discussed in Chapter 6, in cases where associative decisions require implementation or changes to ways of working at operational levels of the organisation, if people (usually internationally mobile staff) in coordination positions are not interested in, or supportive of, decisions taken by the association, those decisions are highly unlikely to be carried forward despite the nominal role of associations in directing the executive.

Strategies for increasing engagement and participation may be unintentionally reinforcing these dynamics; they certainly influence how governance plays out. As individuals can choose which associations to join, opportunities for meaningful participation may be increased if a person joins an association tied to where they live. However, this would tend to lead locally recruited staff towards joining regional associations, reinforcing the dominance of internationally mobile staff based in Europe within the associative structures of sections with operational roles. These dynamics are closely related to inequities of representation in MSF governance.

Governance and representation

Interviewees described how key associative structures reproduced the dominance of powerholders within MSF. The two tiers of association members reflect not only differential opportunities for participation, but also who is more likely to be part of governance. Participants emphasised the impacts of restrictions on who can serve as board members.[8] One person contrasted the goal of inclusion with the realities that undermine it:

8 Some of these restrictions may derive from domestic laws. For example, UK Charity Law, with which MSF UK must comply, requires that trustees be volunteers; MSF UK has received an exemption from the Charity Commission so that the position of chair can be remunerated.

> "We talk about diversity, we talk about all of that, but we don't say who can join the boards. It's an unpaid position, so [it is] people who have some amount of financial security, and who are able to devote the kind of time you need on a board. If you want real diversity – that is young people, and then maybe non-European members of the board – you have to recognise their life situations and life conditions, and make it possible for them to engage on MSF discussions [...] otherwise there will always be information asymmetry, it makes it impossible for people to engage fully."

The requirement for board members not to be employed by MSF creates complications for the idea of building engagement among ALFies and other locally recruited staff for involvement in board or council structures.

A former board member highlighted the implications of board make-up for issues of power and inequality, arguing that despite boards often including people who are "quite conscious and quite aware of the power imbalance" and who want "progress on creating a more equitable, inclusive organisation," ultimately "it's not treated with the urgency it needs" because "there's just a lack of knowledge, and a lack of personal experience on being on the negative receiving end of power imbalance."

Effective use of the existing structures requires an understanding of how they fit together. Moreover, knowledge of governance systems, strategy, and executive actions is crucial to members' ability to hold boards accountable, meaning that inequities in access to information affect whose opinions matter in the governance of MSF. There was a consistent view that (to quote one person who raised this) the approach of "sending people documents" without sharing with them "where the sticky points are" or what is driving discussions internally and at Management Team level, means that "you're not bringing people along." Another said: "ALFies can play a role, but therefore the ALFies need to know what is in the strategic plan and what is in the annual plan, normally it's not so easily accessible."

Different strategies for increasing engagement will shape how these dynamics manifest. In the words of one coordinator: "my aim was also to inform our association members what kind of power they have. Because for most of them, it was a signature and showing […] their […] cards during the General Assembly." Another coordinator described their strategy as using the General Assembly "as shows, as theatre, as events to enthuse people," rather than emphasising understanding, "so that we had people who would become board members." These two approaches – strengthening capacity to engage versus strengthening desire to engage – will shape relationships between the membership, board and executive. They offer advantages and disadvantages depending on the member profile and the sphere of action of the associations in question.

International governance is also unrepresentative. The last major round of reforms (see Binet and Saulnier, 2019) embedded a bias that many interviewees raised as an example of inequitable power dynamics within the MSF movement. In brief, newer associations have been created on a regional basis, while older associations representing a single country have not been required to merge or regionalise.[9] The regional associations represent countries in the Global South and the majority of the single-country associations are in the Global North. Proportionally speaking, this system is a mismatch not only for the locally recruited staff that make up most of MSF's personnel, but also for the changing profile of internationally mobile staff: "half of our international mobile staff come from the Global South now, half, and half of our boards aren't in the Global South." With each association holding equal votes in the IGA, this means that MSF's highest body of associative governance gives proportionally more weight to members who constitute a minority of MSF staff.

This issue has recently received much attention, suggesting another round of reforms is on the way. Yet, as has been observed in relation to other areas of MSF's governance and operations, a seeming willingness to change has not necessarily been accompanied by processes that make this possible. The burden of resolving this tension was characterised as contradictory and inequitable:

> "On one side, you're asking the newer voices or the emergent voices in the movement to think about different models and different ways of working. And on the other side, you give them a prescription to fix. It's a box you have to fit yourself in."

Concerns were also raised about the concentration of operational decision-making authority in Europe, a long-standing subject of criticism within MSF. The transformation of European operational sections into Operational Centres took place in the early to mid-2000s (Binet and Saulnier, 2019). As a result, the Operational Centres hold greater power than other entities in the MSF movement. As one staff member in a partner section noted, "they are the places who have the information and the insights and the possibilities to take decisions and to prioritise one thing over another," meaning that other sections feel "a little bit on the margin of MSF." Their concentration in one privileged region is both entrenched and outdated:

> "As an organisation, we evolved, and we wanted to be a global or international organisation with a footprint closer to operations around the world, where our people were. But next to that, we forgot that there is architecture that is missing to enable that."

9 Every national section has an association, including the national sections that lead the Operational Centres such as MSF Belgium and MSF Holland. There are regional associations for MSF East Africa, MSF South Asia Regional Association, MSF Southern Africa, and MSF West and Central Africa. MSF International has an association and there is also a Movement Wide Association.

Motions challenging the European dominance of Operations were brought to the IGA from its earliest years. Several of these motions were the result of discussions and resolutions in Field Associative Debates (annual associative discussions timed to feed into the international associative decision-making cycle) showing the interest and concern of country programme staff regarding MSF's governance. For example, a 2012 motion that originated in the Zimbabwe FAD argued that: "MSF's Northern identity/image at times limits our access to humanitarian space and complicates negotiations in Southern conflict settings." In 2014 the Nigeria FAD put forward a motion describing the concentration of operational power in Europe as a reputational, security, and personnel management risk and argued that with 50% of its operations in Africa it was 'logical' for MSF to develop an Operational Centre on the continent. A 2018 motion by MSF Japan linked the current set-up to a Eurocentric bias in associative power, arguing that the model "creates a two-tier system where association members of operational sections, and their boards maintain a disproportionate influence on the operations and the movement compared to other associates."

Interviews for this study revealed a range of views about the initiatives that have emerged in the absence of wholesale reform of operational decision-making to address arguments like the above. The creation of the West and Central Africa Operational Directorate, based in Abidjan, to join the five European OCs, for example, was described positively as "a really big deal," something that "didn't fit in any box in MSF, completely from left field." WaCA is significant as the first entirely new operational entity since the 1980s and the first ever outside Europe.[10] While it is rooted in the engagement of locally recruited staff in its region, WaCA's scope of action is not limited to Africa, and it has already undertaken activities in Myanmar and Indonesia. In contrast, more mixed views were expressed about the creation of regional hubs such as in Amman, Dakar, and Nairobi. These hubs house functions of multiple OCs, including hosting operational desks, as well as intersectional work. Some interviewees argued that regional specialisation through these hubs may make it easier for desks to manage their portfolios and make consultation more straightforward. One interviewee suggested that, over time, the presence of such hubs will mean more opportunities for internationally mobile staff from regions of MSF operations to access managerial positions – essentially changing the composition of headquarters staff by changing the locations of headquarters functions. Others contested these kinds of arguments, suggesting that the problem was not location per se but the perpetuation of the same kinds of people in decision-making, which (they argued) would not necessarily be changed by opening new offices.

10 From initial discussions in 2016, WaCA gained IGA approval as a new MSF association in 2019, began operations in 2021 and in 2022 had eight projects in four countries.

Opinions on the regional hubs – both positive and negative – thus reflected the importance of identity for how MSF works, both identities of individuals and of the organisation itself. One person stressed a distinction between changing location and diversifying personnel: "It's all about people who you put in these positions, and this is what we didn't do. We didn't have a lot of effort to move diverse people, experienced, the really experienced, clever people to Europe." Another pointed to the number of European 'expats' based in Nairobi, implying that what they called the organisational "rat race to go to Nairobi" is more about appearances than fundamental change. Fundamentally, these critiques suggest that such approaches reproduce current power structures rather than challenge them:

> "It's symbolism in my opinion because the power division remains exactly the same, and the same people. In the end, in the Amsterdam offices or the Brussels offices, they are the ones to decide to go to Nairobi. Nairobi is not making the decision to start in Nairobi. No, the decision is made in Amsterdam. There is a lot of that sort of artificiality that I believe will be recognised as artificiality."

Conclusion

The way that MSF identity has been historically constructed in OCA draws on certain tropes about who is neutral, and who embodies expertise and competency. These informal power dynamics have been formalised over time, and interact with formal hierarchies in the organisation in complex ways. In countries of operation, the first section described how these ideas about who embodies expertise and who can embody symbolic principles justify the continued structures of inequity between different categories of staff, and continue to limit the responsibility and legitimacy accorded to certain staff members, even after structural reform. The second section outlined how these ideas about MSF OCA identity are reproduced when people are introduced to, and initiated into, the organisation, its values and its principles. As the third section describes, these dynamics are mirrored at a movement level. Despite its egalitarian aims and the recent attempts at reform, imaginaries about who is 'really MSF' support structural hierarchies that remain entrenched in the associative structure. This dictates who can (and cannot) contribute to shaping the organisation's identity and agenda in practice.

Chapter 6. Filters and Circuit Breakers

Introduction

This chapter examines the power concentrated in international staff in management positions, and in particular, coordinator positions, which are seen by many locally recruited staff as 'filters' for the opportunities, security, and participation of 'local' employees at project sites. First, the chapter describes these positions and their capacity to filter information, translate policies in practice, block actions, elevate individuals, or to act as circuit breakers pertaining to opportunities, career progression, security, and participation. The second section examines some of the implications, drawing on the experiences of different staff members. It examines the potential of coordination positions to shape opportunities for locally recruited staff, such as access to training or postings; how opportunities for participation can be mediated or enabled by those in coordination positions; how they influence decisions around security; and how they have direct and indirect implications for the health of various staff members.

6.1 Who are the filters?

Filters of coordination

MSF country management structures are hierarchical. Decision-making power is centralised in coordinator positions, which are the contact points that link projects 'in the field' with senior programme managers at 'headquarters.' At country level, a Head of Mission and Deputy Head of Mission oversee operations, manage security, and are responsible for the in-country team as a whole. The country teams are divided into different departments, such as Medical, Logistics, Human Resources, Finance, Humanitarian Affairs and Communications. Each department is led by a coordinator: Logistics Coordinator (LogCo), Human Resources Coordinator, and so on. Medical Coordinators and their deputies are responsible for medical programming in country as well as for staff health. At project level, this structure is mirrored. Project Coordinators and their deputies lead daily operations and security management of specific project sites, and are managed by the Head of Mission. Each department is led by a manager or 'team leader' at a project level.

Coordination positions are deputised, and often paired with a locally hired 'assistant'. Ultimately, coordinators supervise a department with a majority of locally hired staff. In most cases, these senior leadership positions are reserved for internationally mobile staff on short term 'missions' or 'assignments.' As the review of diversity and inclusion in OCA from March 2017 explains, these positions are viewed as "'feeder' positions for operational decision-making positions in Headquarters" (Adatia, 2017, p. 4). The ideal length of a 'mission' is 12 months. However, the length of these postings ranges from three months in 'emergencies', to up to three years in some settings.

What is filtering?

Coordinators have the power to filter information and determine action and may act as either blockers or circuit breakers – to translate, rework and apply existing rules and structures in a way that they see fit. This has important operational functions in an organisation that specialises in emergency medical programming. The organisation prioritises flexibility and speed; the ability to respond to urgent need quickly (see Chapter 3). In this context, individuals need to be able to make decisions quickly, rather than relying on lengthy bureaucratic processes – processes which may not, in any case, be well suited to the specific situations they encounter.

There are long running tensions in MSF about the degree to which operational decisions should be made at headquarters, or in project locations by coordination teams. While different coordination roles have different spheres in which they exercise their decision-making, the Head of Mission position was frequently raised to illustrate the level of power as well as the varied forms authority can take:

> "There's the power that you can have as a Head of a Mission, you can inspire your teams and they give you the power to accomplish what you need to do. Or you can leverage the power that you have in the name of your position to do what you need to get done. I think depending on who you are and depending on what the situation is, you use both of those, well, to varying degrees, to accomplish what you need to do. Depending also on what context you're in and what, yes, what the urgency is, also depends on how you use that power."

Heads of Mission and Project Coordinators, another suggested, were like "mini-General Directors" at different scales.

Heads of Mission are managed by 'Desks' – Operations Managers in Amsterdam who oversee a portfolio of different countries. Coordinators are the leadership of the organisation in the country. The Head of Mission is legally responsible, and decisions about what takes place operationally in a particular country are the outcome of discussions between the Coordination and the project, and the Coordination and the Desk. The annual strategic planning for programmes is proposed by projects before being discussed with coordination teams, and ultimately decided at headquarters. However, employees in Amsterdam highlighted that day-to-day, coordination teams have a significant degree of autonomy. Despite the oft-repeated narrative about power being centralised at 'HQ', the daily running of operations is managed by country coordination. They are "strongly influenced and constrained by what is discussed within the movement, but there are nonetheless a lot of things that can be managed at this level." An experienced employee said that rather than strictly following pre-planned policies, "MSF is based on people, so people have a lot of power when you are Head of Mission, you can really be a nightmare for the project, or be a changemaker." An experienced Head of Mission agreed:

> "As the Head of Mission, you have an enormous power. What we do, how we do it […] you have an enormous freedom to set it up the way you want to do it. From the desk level, they will influence you but if you are a strong Head of Mission, and if you have the trust from headquarters, you are pretty much free to organise it the way you want to organise it […] the way the teams are working […] how you work with your national staff, how much influence you give them, you really have that power as a Head of Mission."

When describing how power operates in MSF, locally recruited staff described coordinators as filters between headquarters and 'the field'. While coordinator positions inherit position-specific email addresses and are a direct line of contact with headquarters, not all locally recruited staff have MSF email addresses. Usually, email addresses extend to the supervisor level in projects, along with all office positions in coordination. As a result, many locally recruited staff at a project level are not in contact with OCA beyond the country in which they work. As a result, their managers can mediate the projects and their relationship with Amsterdam. Language also plays a crucial role: as outlined in Chapter 4, management positions need to be able to communicate in English. In many countries where OCA works therefore, many staff were excluded from these channels of communication, which were instead filtered through coordinators. In effect, these coordinators could become communication conduits.

6.2 Filtering in practice

This section describes some of the implications for different staff members within the organisation. Locally recruited staff described four main mechanisms through which coordinators and international staff in management positions acted as filters and circuit breakers: mediating opportunities and career progression; limiting or enabling opportunities for participation and communication; translating policies on safety and security; and health evacuations for staff members in practice.

Opportunities

Locally recruited employees argued that coordinators can filter which opportunities are forwarded to whom, and who is recommended for new positions in country, or for trainings, detachments, and expatriation abroad. Therefore, international staff in management positions can shape the career prospects of the team they manage: "It's a great thing if you have a supervisor that appreciates you. And it's kind of sad for people who have no one to push them forward." Interviewees described the importance of personal relationships:

> "That's why I said that the inequalities are created by the head office, although they send out documents and procedures to follow, even if it is well thought out, they are not respected at the project coordination level and that's where it gets tricky."

In DRC, for example, there was frustration at the perceived role played by recommendations from internationally mobile staff in shaping career trajectories: "In short, national staff who are not friends of expats or senior staff will have difficulty if they are trying to change positions, even if they have skills." Another locally recruited employee added: "When someone is in a position of power, everybody wants to get close to them […] they are influenced by their network in the decision-making process, and that can affect other people." Local staff were concerned about how key decisions were taken by international staff in management positions who may be inexperienced or easily influenced:

> "If you are friends with a supervisor who doesn't really understand his job, they may only give incentives to some people and leave out the others, be it training, work, or benefits. This is problematic because it is the manager who is supposed to evaluate the abilities of the employee and determine if they deserve their position or not, in an impartial way and not according to the affinities and the friendships between colleagues."

Rather than promoting staff, human resources open internal recruitment processes within country programmes, with the aim of mitigating against favouritism. Nonetheless, locally recruited employees had the impression that these positions were opened with somebody already in mind, based on who the supervisor thought was fit for the role, "the decision was already made," one Syrian employee explained. Another concluded: "some people don't apply for internal recruitments, because they know already who will be in the position."

Learning and Development posts have recently been developed in OCA, with some positions established in different 'missions' to help facilitate training and career progression. Online training modules have been developed. For instance, 'Tembo' provides learning development opportunities for MSF staff anywhere with an internet connection, with the objective of enabling "everyone to be better prepared to contribute to MSF operations." Locally recruited employees described an improvement in access now that trainings were online, "Before, if your supervisor, who was supposed to let you know about new training courses, wanted to do it himself, he wouldn't let you know. But now, if it's online, everybody can do it." Despite this, locally recruited staff described how they still relied on coordinators forwarding potential opportunities for in-person trainings, or recommending them. "It depends on the supervisor! If they like someone, then you will see that person is always going to things."

As a result, some locally hired teams had the impression that the same colleagues were being selected to attend trainings, even if these individuals were not in the best position to share these new skills with the broader team. In one focus group, an employee described:

> "Covid was very new. So, we asked for some training. At last, later, the training was given […] and we [hoped, that from] the Covid, or ER for emergency room, one of the staff should be taken for training. So that we can manage the Covid [...] but later we find out, somebody, our boss just went and picked from other department [….] not Covid, not ER, they just went to other department: 'Come and do the—, go and attend the training'… So now that guy might not manage to come and work in ER or in Covid. He just keeps the skills there with him […] So the skills that he gained from that training, it stayed with him, died with him, without practice and where can we go from there?"

Career progression

To occupy senior decision-making roles, most locally recruited staff must leave their country. There are two processes for this. The first is a 'detachment': being employed for a short period of time abroad in an international posting. This is a means to increase mobility and opportunity for locally recruited staff in MSF, but also a means for OCA to fill 'gaps' in personnel. The second is 'expatriation': applying to become an internationally mobile staff member. This requires a level of English, being added to a 'pool' and being matched with a 'mission.' Although there are formal application processes, again, locally recruited staff stressed the role of international supervisors in forwarding opportunities and making recommendations. In terms of who is selected, employees felt "there is no transparency with how these decisions are made, we are not informed at our level. […] We remain lost in the clouds."

As a result, interviewees argued that the process should be further formalised and oriented away from recommendations by supervisors:

> "If you are a national staff, you must get the recommendation from your top managers […] but how can my coordination know my core status or my capability? […] Instead of centralising the power of recommendation, if you are national staff you should be able to apply for the position, and then indirectly they can check your HR, look at your record, check your evaluation, your capabilities […] maybe they can call and do an interview with you […] If it's something you've been doing for 10 years, you must have some knowledge. How can the person know? You need to give them a test. Test them. Give him an assignment."

In this way, locally recruited staff were critical of the fact that international staff in management positions were often only there for short periods and remained removed from local staff's everyday work. Yet, it was these managers who could shape career trajectories.

Internationally mobile employees recognised that recommendations played an important role:

> "It is sad to see, but it is related to who you are friends with. If you're a national staff and you have a good relationship with a LogCo who is an expat, that LogCo can easily push to get you detachment. If you are a little bit shy or you're not very open to speaking, nobody will give you the opportunity."

Employees at Amsterdam contact HR Coordinators to ask if they have any recommendations for locally recruited staff who might be suitable for detachments or expatriation. This means that "it depends, within the mission, whether a person is on their radar or not, if he or she is pushed forward." In effect, internationally mobile staff had access to headquarters that locally recruited staff lacked, also allowing them to break through circuits that appear closed. A Congolese employee gave an example of applying for two international training courses (for which they had official approval) and being told that both were full. They mentioned this to an internationally mobile colleague, who said: "No, I know how things work in Amsterdam, give me those applications, I will come back to you." Two days later, they received a positive answer from Amsterdam that there was availability.

Once in the 'pool' of potential internationally mobile employees, people who are well known may find international postings more easily, highlighting the currency of friends in high places. Being known or connected "makes it easier to get the position, as long as you have the skills and experience that we need." While some emphasised the perceived functionality of this approach in an organisation that often works in unstable environments, others highlighted its potential to reproduce existing patterns of dominance or marginalisation. One internationally mobile employee commented:

> "As an example, a guy admitted in the pool from Uzbekistan waited a year and a half, national staff, before having an international position assigned. I can tell you, I'm sure there were a lot of other vacancies […] because he's national staff somewhere, maybe he has less means than if he was a Dutch person who lives here and knows people in the office and went and pushed for his own matters."

An employee who had moved from an internationally mobile career to a headquarters position described how sometimes the career trajectory of locally recruited staff could be influenced by:

> "The right conversation, the right night with the right person, who then starts the process. And, that starting is random […] Unfortunately, the fair part of power, of that type of power in MSF is here, here and here is completely unfair, and completely random. Random in this situation, not random in this one. So, the 20 years European person will still have a voice in panels, will still be invited in the 'MSF We Want To Be' et cetera. The 20 or even 30 years Congolese will not. And so, there is an aspect here of, I wouldn't say equality, but fair opportunities that is limited."

This comment highlights the links that some draw between individual career paths and patterns in who is able to participate in the organisation, as well as the self-image that the organisation puts forward to its personnel.

Good relationships with international managers at different levels, then, was seen as an important source of power among locally recruited staff. This created tensions within MSF teams. A former locally recruited employee described how pursuing an opportunity within MSF:

> "Depends on your connections and how many people you know at different levels [of the organisation] because certain individuals might be more in touch with people in power, and there is not a system, there is a lot of reliance on these individuals... they [headquarters] trust them and there is a lot of work done only through this channel."

At a project level, they described the realisation among locally recruited staff that being close to an internationally mobile supervisor was important: "The moment the mission is over [for that supervisor] someone else comes and they start getting connected with someone else. This results in conflicts internally...it can create a lot of clashes among the team members."

Coordinator positions also had the power to block – not forwarding opportunities to locally recruited staff at all. For instance, regarding detachment opportunities, one employee claimed: "It goes like this: HR asks your supervisor and if they agree to let you go then they inform you. But otherwise, you'll never know." One employee working in Learning and Development at headquarters said that "in the past, it [international training] was only there for expats, and in certain cases, we had certain national staff also attending trainings, but it was looked at rather as a favour." The expectation is now that OCA should be sending more locally recruited staff on international training, but this relied on internationally mobile staff to help facilitate. The employee explained:

> "The difference of resources [attributed] is huge for development of a national staff versus an international staff, but also, that expat who's supposed to support their staff, they don't [...] I can easily say 80% of the time, they don't have the expertise to give the adequate support. 80% of the time, they don't even know for themselves how to develop their career. […] It's always hierarchical, and thinking of that hierarchy, […] it's 80-90%, again, people not from that country and 70% of the time from Europe, who make a decision about someone's career."

The employee described the reaction from Amsterdam when they put forward locally recruited staff for training opportunities abroad: "We'd rather recommend to send trainers to your mission and we do training there." While there is a rationale for this in learning on the job, the contrast with the practice of travel for training abroad – and the perceived access of internationally mobile staff to such trainings – sent the message that "they're still biased, these people in HQ, the Europeans, they still want to keep that power. They don't want us to learn."

Locally recruited interviewees had the impression that internationally mobile staff were too often prioritised for some opportunities. In DRC, a locally recruited member of staff said: "For example, I request this training for at least two years, but the team leader will give preference to the expatriate who recently arrived over me because there is only one place." This was further complicated by the fact that the majority of training in OCA was in English, meaning that locally recruited staff were unable to access it, or believed that they were immediately filtered out by their Anglophone managers.

Communication and Participation

Coordinators can become the key channel of communication between Amsterdam headquarters and staff in project sites. One international employee said: "There are set communication lines and it is hierarchical. There are also people that don't like it if you don't follow those communication lines. So, I just think there is a lot of opportunity for information to be missed." Indeed, locally recruited staff described a "communication hierarchy," whereby many staff in their day-to-day work in programmes have no direct communication with headquarters. Information was filtered through their senior international colleagues. As a result, among locally recruited staff, there appeared to be some confusion about how strategic decisions were made. One local employee explained:

> "I, for example, can't write to Amsterdam and ask why things are the way they are because I do not have the authority to write to Amsterdam, communication-wise. But is it a sin if I write to the headquarters to tell them about a problem and ask if they can clarify things? It's not possible, because, on the communication hierarchy level, I am not allowed to do this. I should be reaching out to my supervisor or my Head of Mission, but that also depends on whether I am on good terms with them. If that's the case, I can take advantage of that."

In a focus group in DRC, an employee summarised the general feeling when they joked: "If you try and get contact with Amsterdam, you are creating your own tomb."

The dominance of those in coordination positions is seen in the emphasis on English (see Chapter 4). Staff in the country programmes have to find ways of navigating the presence of people who do not speak any of the national or vernacular languages. One international employee described it as "troubling" that in OCA programmes:

> "You would have a large team of expats that didn't speak the local language, and I've been in missions where you have a Project Coordinator that doesn't speak French and so we're holding meetings in English with an entire national staff that doesn't speak English, for the benefit of the Project Coordinator."

A senior Congolese staff member described the added work of translation that falls on multilingual locally recruited personnel who serve as points of exchange between staff who work in different languages. A Syrian employee initially downplayed language requirements, saying (via an interpreter) that "there are some positions that really require you to speak English, and there are many other positions that don't require you to speak any English, just Arabic." They went on to describe the level of proficiency required:

> "You don't have to be very knowledgeable about English language, you should only be able to communicate on a daily basis, just to give them [internationally mobile staff] an idea about the concerns at work, and you speak that in English [...] just give them an idea about what happens in the region."

Some country programmes are seeking to develop policies for English language development for locally recruited staff. However, one interviewee challenged the motivation behind such programmes:

> "It looks like the goal here in MSF Holland is they want all staff speaking English here. […] We had a course here in English, just pushing people to speak English, because tomorrow, they are going to ask you to write a report in English, because Amsterdam they don't know, they didn't speak in French."

In all of these examples, it appears locally recruited staff play a central role in making a multi-lingual environment work.

Despite this translational labour, interviewees highlighted the limited participation of locally recruited staff in operational discussions. An international employee explained:

> "I can say that in technical aspects almost no one from the local team gets involved in the high-level planning. It's just 10 expats sitting in a room deciding where the project needed to go for the next year which is really sad actually because you're basically ignoring all past history and you're not giving the responsibility to people to be involved, and they want to be involved."

Every year, the strategic priorities for the next year of a project are discussed in country, and then discussed with Amsterdam, in order to make strategic choices about programme design. However, for locally recruited staff, it often remains unclear why certain decisions are made. Sometimes, the final decisions do not seem to reflect the opinions and ideas that the teams in country had shared with coordination: "It's up to the personal relationship that you have with the supervisor, but if you don't have a good relationship perhaps all your good ideas will be rejected." Another local employee added:

> "At the very least, a meeting should be held to inform employees and explain the strategic choices. But this has not been done. So, people wonder why they were included in a long strategic thinking process, at the end of which nothing suggested was adopted. This is not right…. I don't know if these people decide on their own not to justify themselves to the staff or if it comes from their hierarchy."

In effect, there was a widespread lack of trust among locally recruited teams in OCA's formalised decision-making processes. Indeed, national teams said it remained unclear who had made the final decision: "they [coordination] say Amsterdam, but who is Amsterdam? Amsterdam is a man or a woman?" Many concluded that coordinators in country make key decisions: "perhaps Amsterdam is not even informed about that decision." As foreign employees rotated in and out of different programme sites, staff experienced a process of what one interviewee called "repetitive reinvention," led by the same individuals who have the power to filter the information they receive and to shape the ideas communicated back to Amsterdam.

Locally recruited teams working in the medical department questioned how decisions were made in the organisation, and in particular, the role of "the data." One interviewee summarised that a "semblance of legitimacy [is] provided to the decision making because it was based on data." Locally recruited medical employees described collecting vast quantities of 'data' in project sites. This data was then passed 'upwards' and the 'users of data' were at coordination level or headquarters. A hospital coordinator support said:

> "When it comes to the decision making, for us in the field, we only give the information to coordination. For example, if we identify alarming things, we have to give the reports to coordination, and coordination will have to either go with other actors or maybe report it as well to the headquarters. And the headquarters, now, will have to think what can be done, what could be the role of MSF and should we give it to other actors?"

There are "piles and piles of data," an evaluator indicated. However, for employees at a project level, it was less clear how this data was subsequently used, or how it influenced decisions that were then made in the organisation:

> "A lot of energy at the project is going into this medical monthly reporting, and there are questions about whether or not the purpose and the use is clear. Also, whether or not project level staff and co-ordination level staff are benefiting from the process."

In short, information for HQ was described as paramount – the way that this data was then used to make decisions remained unclear. One focus group participant said: "Everything we have said about healthcare, they have to wait for decisions from the headquarters." Others concluded that "'Amsterdam has decided' is like the word of a Catholic priest"; it cannot be debated.

Coordination roles were also described as communication conduits when it came to associative life and processes. Although, in principle, motions passed in associative forums should have implications for country programmes, in practice, as a rule, interviewees argued that "we don't have proper systems [to ensure that] there is space for people to raise issues and to see their recommendations put in place." Congolese employees, like locally recruited staff we spoke to elsewhere, valued the association as a space to challenge and shape the organisation. Yet as one employee explained, filtering and circuit-breaking roles apply to associative life too:

> "The association is the only opportunity one gets to point out things and suggest alternative ways. But sadly, on-site, the associative has to be supported by the Heads of Mission or the Project Coordinators. Sometimes, these people are not associative members. They don't care about these associative things, and they sometimes do not even know how it works. And sometimes they do not agree with what you plan or suggest, and they tend to defend themselves instead of accepting the recommendations and seeing how to improve things. But these challenges don't stop us from going on with the debates, or from sharing our suggestions and recommendations to make things better."

A member of the association support team at headquarters level agreed that the buy-in of staff in coordination roles is essential because "if they are not aware of it or if they don't accept it, it's very hard for the ALFies [who promote associative life] in the field to get some space." Numerous interviewees highlighted factors such as staff in senior roles who are not invested in the field aspect of associative life, resistance to input, day-to-day operational priorities taking over, and turnover of individuals resulting in lack of knowledge so that "the chain is completely broken." According to experiences in DRC, there is also a lack of financial autonomy: "The executive can just not allocate a budget to the association, or decide to use that budget for other purposes that the Head of Mission or PC chooses without even notifying the associative members."

The attitude of individuals plays such a large role because, although there are mechanisms to convey motions or reports from the Field Associative Debates to higher levels of the associative, there is no system for follow-up or accountability. A former Head of Mission explained:

> "Basically, what the [country staff] have to say is not escalated, and if an answer has to be communicated back, that too takes a lot of time, as it needs to go through the Operational Centre, the General Director, the Operational Director, the Desk Manager, and the Head of Mission. It is a very long process, so the probability of a message or the voice of the [locally recruited] employees getting through is very low."

The result is that "the associative is controlled by the executive, when it is supposed to be watching this executive closely."

Evacuation and security

Locally recruited staff were critical of the fact that they were often excluded from decision making around security protocols and procedures that directly impacted their own safety. Indeed, many interviewees highlighted that the security plans for different projects were often formulated without input from locally recruited staff.

There was much debate about MSF's evacuation policies. The general principle in MSF was described by interviewees as: "the role of MSF is to bring you back to your exposure level before MSF […] so we don't evacuate people from their own countries." While some locally recruited employees suggested that MSF may not have the capacity to evacuate hundreds of staff (indeed, in some contexts, such as Syria, this was impossible), others were generally critical of evacuation procedures. At project sites in eastern DRC, for example, employees said: "They tell us: 'expatriates are not at home, you are at home.' So, people who are at home must flee, to survive. But ultimately, we all have the same risk of losing our lives." Locally recruited staff said that when they asked about evacuation policies: "We are told that you ask for too much."

In North-East Syria, locally recruited staff are at particular risk precisely because of their work with MSF, which is described as a terrorist organisation by the Syrian government. OCA operates in the region without the permission of the central government; locally recruited staff were exposed to risk precisely because of their employment with MSF. While recognising that it is extremely difficult for Syrian nationals to leave Syria (passports are issued by the central government in Damascus, which is in opposition to the Kurdish-dominated Syrian Democratic Council which governs the North-East of the country), Syrian staff were critical about the way that MSF provided protection in vastly different ways for employees on different contract types. This raises particularly salient questions about MSF's obligations or 'duty of care' (see box 5).

BOX 5: DUTY OF CARE IN SYRIA

Syrian staff described facing multiple personal security risks. One Syrian interviewee said: "The Syrian regime considers them [MSF] a terrorist group. But at the same time, the result of lack of job opportunities […] means that you need to work. Money doesn't fall from the sky." For many, their impression was that their ability to seek help from MSF depended on the personality and views of the particular foreign coordinator in place:

> "OCA cares more about the work, than people [employees]... I live in an area that's under the Syrian government. So, for sure, I have loads of security issues, but when they come and they bring this on the table of the PC or someone, and they say that: 'It's work. We don't care, find your solution.' […] You know, the problem with OCA, there's no strategy in place. You depend on the people. This PC, she's really caring a lot, and she even called me to speak and find the solution for my situation, while the previous PC did not."

Locally recruited staff gave their informed consent to work for MSF, and the organisation developed a 'duty of care' policy. This policy provided Syrian employees with a 'package', which included a financial payment (the equivalent of three months' salary for contracted staff and two months' for incentivised staff), or compensation in case of a major event; the number of a psychologist; support for people to seek jobs with another organisation if they felt that offered additional protection; and support with documentation in case they wanted to apply for asylum. At the same time MSF's official position remains that they cannot help employees claim asylum in other countries. The idea behind the package was to provide people with the financial means to improve their situation and take care of themselves and their families. However, according to one Syrian employee, the duty of care stipend falls short of meeting the costs of leaving Syria:

> "So, the monthly stipend is not really enough for the national employees to flee, in case anything urgent happened. Also, the stipend is not really enough and if there is any possibility that you could increase this stipend—, because even if the national staff want to run away or to be, actually, smuggled out of Syria, they will need more money because smuggling really requires a lot of money."

BOX 5: (continued)

In practice then, the package falls short of its implicit goal. Another central part of the Duty of Care policy was the continued attempts on the part of OCA to gain registration with the Government of Syria, which have thus far remained unsuccessful.

In 2019, Turkey invaded North-East Syria. OCA evacuated internationally mobile staff, and all programmes were suspended. All staff were paid their salaries as well as the additional payment for 'duty of care.' After these payments and suspensions had taken place, it became clear that there might be an opportunity to work in the area again. As a result, a small team of Syrian employees restarted activities, while international staff led operations through remote programming for several months before returning to Syria.

For Syrian employees, this event highlighted the limits of the duty of care package. As one employee summarised: "In 2019, we recognised that MSF left the national staff behind them, and the mitigation process, the thing that protects the international staff, it's much, much stronger than to protect national staff." Another staff member reflected: "I know the duty of care needs to be re-discussed, not just amount of money to provide to staff, to protect them. There should be another way to protect national staff." In a focus group, other Syrian staff agreed:

> "We are assuming that the Syrian regime is not coming here, but once they are here [...] all the staff who had worked with MSF or MSF specifically, they have more or less a problem with them [the Syrian regime]. They would have had many issues, many problems with the regime. The package, is not, not only the package that the staff need, they need protection. We ask a lot, we mention in a lot of meetings that at least, to have this approval with Damascus."

Another employee said:

"If MSF evacuate or the Syrian government come back to control these areas, so we're all going to be at a big risk actually. I don't know how MSF can solve this issue, but I think that they need to take it seriously."

In other settings, interviewees were also critical of the way that decisions about evacuation were made in OCA. Their impression was that certain evacuation decisions depended on the international staff in coordinator positions, who could determine how security plans were implemented in practice. As one operational employee in Amsterdam put it, "because it's so hierarchical, the Head of Mission is king or queen. […] Your life is literally in their hands." There appear to have been instances when international coordinators made the decision to evacuate everyone, even local staff, where they could. A Congolese employee gave an example:

> "But that also depends on the decision-making power. I always give the same example of [this] project. At some point, the evacuation had to happen. I remember the Head of Mission at that time decided to evacuate everyone, even the locals and their families that were part of MSF. So that was also a situation that made me think that within MSF, you have that space to contradict certain decisions and to decide otherwise and take responsibility. But if we have to follow all the MSF rules, it can be pretty discriminatory."

Coordinators could therefore act as circuit breakers – getting past restrictive policies on paper to go beyond these commitments on the ground. Nonetheless, this depended on the decision-making of one individual, in the context of high turnover in the organisation.

Similarly, the way that duty of care was applied to different cases was a process of interpretation. 'Duty of care' and 'solidarity' are two contested concepts within the MSF movement, that are applied differently in different contexts. In general, as one former Head of Mission explained, duty of care refers to a "contractual relationship and exposure caused by MSF," while solidarity is "more about what can be done beyond the employer's responsibility." However:

> "The duty of care is sometimes used as an excuse not to help people as if there is no duty, then we should just not care […] people were twisting the concept and turning it into a tool to avoid having to do things. We were both the judge and the defendant at the same time."

Instead, this employee explained, the instances where locally recruited staff were evacuated or taken out of high-risk contexts were the result of "individual informal initiatives" led by different international staff. Similarly, an international employee in Amsterdam described how duty of care "is not a science," but an act of interpretation: "the moment we have a criteria for it, then it should be called something else." Instead:

> "It's made out of principle, it is those in charge at the moment that make the decision and the rest should just respect that and defend it […] While I want our Head of Mission to be able to explain all of their decisions, duty of care decisions cannot be explained fully, (a) because they're confidential, and so others should not know about it or (b) because they were decisions that were made out of principles, not out of policies."

In this way, coordinators could facilitate the evacuation of particular staff members. However, as an interviewee added, this meant that personal relationships shaped how duty of care is applied in different cases:

> "Personal relationship, of course, like in everything, plays a role. It's not only personal relationship with the person concerned but personal relationship with those decision-makers, among the decision-makers […] we see personal relationships play out way more than in any other organisation that I've worked for, regardless of the job description, how strict it can be, we have a flexibility that I have not seen in any other organisation, for the good and the bad at times."

Health evacuations and referrals

Locally recruited employees highlighted the different health referral processes for locally recruited and internationally mobile staff as central to how inequality manifests inside the organisation. The issue of health referral was described as a major ethical dilemma in MSF: not only in relation to staff health, but also patient referral. In effect, decisions about whether to refer patients and staff bring into stark light the profound inequalities in health provision based on geographical location, and illustrates how MSF's everyday work may reproduce, rather than actively combat, such structural inequalities and politics of life (Fassin, 2007).

Drawing a distinction by staffing contract in the provision of healthcare is key to how power is inscribed in the organisation. So great is the difference between the two systems the organisation uses that one medical employee insisted: "we cannot compare the management of local and international staff healthcare." Locally recruited staff discussed the intricacies of specific referral policies in different settings, and the ways that they reproduced forms of inequality. These dynamics must be approached empirically, although they reflect widespread and perpetual tensions between different considerations that shape MSF's work and the care its employees receive. The discussion here is based on issues raised by interviewees in DRC.

Two key features of health provision for staff are relevant to understanding the powers of filtering and circuit-breaking roles, as well as inequalities more broadly. First, that provision of care is structured by contract type. According to the policy, internationally recruited staff can be transferred within DRC, but also outside the country, for emergency medical care. The cost of medical care, travel, and accommodation is covered by MSF. Meanwhile, Congolese staff are treated locally. If the required services do not exist locally, then staff are referred within the country and MSF will pay for their treatment. In the case of an emergency, MSF covers domestic travel and accommodation as well as the medical treatment. Otherwise, Congolese employees must cover the costs of their own transportation and accommodation. MSF does not pay to transport Congolese staff outside DRC or for international care.

An experienced Congolese employee described the problems with this system. Congolese employees and their families struggled to pay the costs of travel from rural project locations to Goma or Bukavu, as well as accommodation. In Walikale, for instance, travel to and from the project requires flying, which is expensive and does not always follow a frequent or reliable schedule (flights are operated by the UN Humanitarian Air Service). As a result, local staff who require a referral need to find the money to pay for the ticket as well as accommodation until a return flight is possible, even if the treatment itself takes less time. Because seeking medical care requires taking time off work, employees described waiting for approved leave to get treatment. Travel to Kinshasa was more expensive still; one employee noted they had never seen Congolese staff referred to Kinshasa for treatment. Kigali, the capital of Rwanda, offers quality treatment and is closer to eastern DRC, with affordable travel options, yet because it requires crossing a border is excluded from care options for locally recruited staff. Congolese staff criticised the fact that MSF does not pay for healthcare for locally recruited staff beyond state borders: “That would allow us to benefit from high quality care for the staff. When it comes to international staff, the question is not even asked.”

Because this policy entails different allocation of resources to staff on different contract types, it has prompted questions among locally recruited staff about the value placed on different lives. Interviewees were critical of the fact that financial costs and logistical challenges are no obstacle to internationally mobile employees receiving care outside the country, yet, according to them, locally recruited personnel are denied this option even when it would mean reduced financial and time costs – i.e., the non-medical costs which, unless it is an emergency, they pay for themselves. This led Congolese employees to conclude that: “they [MSF] will spend as little as possible on national staff.” Another employee added: “What’s the point of working in a humanitarian organisation that can’t even take care of its own team? Without the staff, you will never be able to reach or help the population.”

Second, implementation of the policy relies on the internal hierarchy of decision making. Decisions about medical evacuations and referrals are taken by the Medical Coordinator, in liaison with the Medical Team Leader in a project. If it is not considered an emergency, then the Medical Team Leader writes to the medical department at coordination to organise treatment outside the project location. However, if a locally recruited employee needs an emergency referral, then the Medical Coordinator makes the final decision. As one Congolese employee summarised: "everything begins and ends with the MedCo. He is the first referral person and the last decision maker."

To further argue that there were stark limitations to the staff health policy, Congolese employees highlighted two recent staff deaths, which they attributed to medical complications after delayed referrals to Goma from rural project locations. In both cases, the conclusion among many locally recruited employees was that there had been "hesitation about whether an evacuation had to be arranged or not" on the part of the Medical Coordinator and coordination colleagues, because "emergency transfer is not obtained that easily with MSF when it's for a national staff member." In one case, Congolese employees were under the impression that coordination had suggested that the employee "wait a bit until their day off" because their condition was not considered a medical emergency. Another Congolese employee thought that the employee had been refused an emergency evacuation and had to ask for annual leave to go and seek treatment.

Beyond the medical specificities of these particular cases, they bring into question a set of broader issues related to health referral in MSF. First, is it a conflict of interest that an employer is also one's health provider? Locally recruited employees described an uncomfortable dependency on MSF as an employer: their managers were not only responsible for their wages, but also their access to healthcare provision, including emergency treatment. This accentuated the stark power imbalances within MSF teams. One Congolese employee concluded that MSF's approach was like a business, in which "they need the work done more than they need the personnel." There are "so many rules and regulations" for healthcare, they concluded, because "MSF accepts without really accepting" responsibility for all their staff.

Second, these cases raise important questions about accountability and transparency. How are decisions about referrals made, and what obligations does MSF have to its workforce to explain these decisions? Among local teams, it remained unclear what clinical governance processes were in place. It appears that the decision-making process behind these referral cases has never been explained to Congolese teams. In relation to one of the referrals, for instance, employees asked: "But what were the parameters that made you [MSF] judge that they [the colleague] could wait until the day after tomorrow?" This has echoes of the lack of transparency and communication that staff described as affecting MSF's medical and health work more broadly.

Congolese employees were concerned about how decisions about how staff health referrals were made by a few individuals occupying coordination positions. There was clearly a lack of trust in this process, and concerns that these coordinators might have been given "bad briefings" that would lead them to dismiss their colleagues' requests for medical help:

> "For example, they are warned not to get too close to the locals in Goma. Or they are simply told to ignore the complaints of the staff. They are told that it's not even worth noting. Because otherwise how to explain that a medical supervisor who sees his own staff sick decides to wait when they don't even have any medicine to give. When you know there's nothing left to do but transfer. What are they waiting for? So, it's almost again a policy but an informal one, it's not written but somewhere the message is well conveyed. No. The healthcare policy is there, but [...] followed halfway or not followed. There are clauses that I find weird in a policy, that say we have to study each case individually. When we say this it's problematic. It becomes the supervisor's prerogative alone."

Congolese employees described medical coordinators as filters between them and Amsterdam, but also questioned whether headquarters was taking sufficient responsibility. One employee in DRC, for instance, suggested that Amsterdam remained largely absent from these processes, and had not investigated the likely reasons behind the cases and the potential impact of delayed medical referrals:

> "There is a policy that has been developed and approved by the headquarters, do they see what's going on? After losing [someone], for example, did they ask themselves the right questions? Did they reassess the situation? Did they look closely at what they could do to solve the problem?"

Another Congolese employee explained:

> "Now it is the first time I talk about it. I was never approached by MSF and asked about this, about whether it was normal or not, and what could be done to prevent that from happening again. We can't stop people from dying, but we can prevent events like these […] These are not only structural challenges, they [MSF] have to take responsibility."

Finally, while evacuations of internationally mobile staff are not necessarily straightforward (see for example McLean, 2017), the refusal of the possibility of international health care for locally recruited staff raises questions about how MSF understands the relationship between its 'social mission' and the majority of its personnel who both come from, and work in, the countries where MSF seeks to act on that mission. In DRC, several employees recounted a heated exchange with a former manager about the health evacuations policy: "When we confronted our manager, I don't know if it was simply out of anger, but they said: 'we are a humanitarian organisation for the patients, not for the staff'." This instance was mentioned to capture the conclusions that locally recruited staff drew about their paradoxical status: the organisation focuses on saving lives – 'the patient' – rather than on the treatment of the workforce, even when members of the workforce come from the same communities as the patients. This appears to reflect the organisation's emergency culture and re-emphasises the importance of the 'suffering Other' at the heart of MSF's raison d'être and decision-making.

Yet care for patients, too, has limits. As an interviewee speaking in a different context commented, "the clue's in the name, we're Doctors Without Borders, we're not Patients Without Borders." At the time, they were highlighting the institution's emphasis on defining different groups within MSF (the 'who' matters, as discussed in Chapter 5). However, it also suggests the boundaries of the care that it will provide to patients. When locally recruited staff become patients, these limits are exposed. As a former Head of Mission in Congo said: "Another question arises here, of whether MSF would send patients abroad for healthcare if needed. That does not happen, so why would it be done for national employees and not for patients?"

Conclusion

Coordinators hold the power to block, or to elevate, and to act as communication conduits in a vast and dispersed organisational structure. In either case, they act as filters – filtering information, opportunities, and particular policies into practice. This form of power is hierarchical, but also highly individualised. As a result, proximity to, and networks with, internationally mobile employees in management positions were seen as a form of influence by (and for) locally recruited staff. Clearly, there is a great degree of distrust among locally recruited staff in project sites towards coordinators, and a lack of clarity for many about how decisions are made in OCA. It seems that this power to filter, reinforce, or break through is a mechanism through which inequalities are reproduced within the organisation. This determines opportunities for locally recruited staff and has potential consequences for the way that staff security and health policies are put into practice.

Chapter 7. Keeping the Flame

Introduction

In the MSF movement, the "high degree of internal politics" can take many forms, influenced by "the fact that we have so many different offices now" as well as by the internal dynamics of any given site. The OCA office in Amsterdam has been the subject of several studies examining the experiences of specific groups (Heyse, 2006; Damman, Heyse and Mills, 2014; Rengers et al, 2019). This chapter takes a different approach, drawing on the study's concept of currencies of influence to examine the politics of legitimacy at headquarters level. What are key markers of legitimacy in MSF's organisation, how do they manifest in the offices of OCA and its partner sections, and how do they intersect with or counteract existing inequalities within MSF? The chapter draws primarily on interviews from current and former headquarters personnel, focusing on the dynamics they experienced.

These politics of legitimacy play out in a context where organisational arguments can take moral forms. To illuminate these dynamics, the chapter borrows from Stephen Hopgood's analysis of the "keepers of the flame" in Amnesty International, who "form a kind of amateur (vocationally oriented) profession inside a bureaucracy," acting as the "border guards" of the "sacred core" of the organisation: its moral authority and role (Hopgood, 2006, p. 15). In MSF, the ability to lay claim to certain markers of legitimacy, derived from the organisation's principles and mythologies, can form the basis of prominence or influence in internal discussions and ultimately creates or blocks pathways to change.

The first section looks at the spirit of volunteerism within MSF's ideology and how it presents in attitudes towards remuneration, impacting upon access to the organisation for people of lower socio-economic backgrounds. The second section shows how the ability to represent MSF's 'mission' at headquarters level is derived from experience in the field. It argues that operational experience serves as the foundation for an "old guard" to occupy decision making posts and speak with authority, with implications for priority-setting within the organisation. Throughout, the chapter highlights how the politics of legitimacy also contribute to a lack of trust in 'management' and leadership of different kinds, seen in competing narratives: about the willingness or unwillingness of formal authorities to act, their ability or inability to do so successfully, and the merit or demerit of different areas in which MSF and its staff should invest resources.

7.1 The spirit of volunteerism

The principle of volunteerism has been an important marker of MSF identity since its founding. In this, it is not alone: organisations such as the International Committee of the Red Cross, for example, also relied upon volunteer staff in their early years (Palmieri, 2012) and "voluntary service" remains one of the fundamental principles of the International Red Cross/Red Crescent Movement. Amnesty International also began with a volunteer ethos, gradually evolving towards a distinction between members (who remained volunteers) and staff, who were paid but retained and reproduced a sense of an original moral calling (Hopgood, 2006). In MSF, the spirit of volunteerism has two main aspects: an emphasis on values-based, individual commitment, and a valorisation of 'disinterest,' These aspects are reproduced in specific policies, with impacts that interviewees described as exclusionary.

Reproducing volunteerism

Volunteerism is written into the foundational texts of MSF. The current MSF Charter, described as: "The document that cements the collective identity of the organization and its members" (Abu Sa'Da and Crombé, 2016, p. 134), states as one of its four core principles that: "As volunteers, members understand the risks and dangers of the missions they carry out and make no claim for themselves or their assigns for any form of compensation other than that which the association might be able to afford them" (MSF, undated). The Chantilly Principles of 1995 further cemented MSF's identity as "an organisation of volunteers," meaning that the "principle of disinterest" is at once an ideal for the organisation, a material consequence for its employees, and an intended guarantee of a "spirit of resistance against compromise, routine, and institutionalisation" (MSF, 1995). The La Mancha Agreement also referred to "preserving the spirit of volunteerism" (MSF, 2006).

Interviewees described the importance of being seen as a 'volunteer' in the sense of a commitment to the humanitarian imperative. In MSF's emergency culture, this often manifests as a willingness to work long hours:

> "If you come in and you haven't swallowed the MSF pill, and completely align with our principles, and our values, and you come in and you do the 9 to 5 and you're not willing to give more, then you're not seen in the way that, maybe, you would be in another organisation, because that's the culture and environment that's perpetuated."

In this culture, negotiating individually on pay is out of step with organisational culture, the attitude being described as: "if you're not happy with the salary, then you're welcome to leave." The emphasis on altruism was parodied by one interviewee when asked about their MSF career: "I've had a few other interviews and I start with this: it's not going to be a fancy story. It's not going to be like I talk to many field workers and they're like, 'Yeah, I dreamed about MSF when I was a little child'."

The notion of volunteerism is part of the importance of external intervenors. A senior employee explained that the principle of volunteerism "means something very different in English as it does in French, this *sans-frontièrisme*, which is very much in the charter of the organisation that doctors and other medical staff and support staff go freely to support others in need." This, they argued, was fundamental to a way of thinking that centres on who can or should adopt certain roles. As Caroline Abu Sa'Da and Xavier Crombé (2016, p. 136) explain, the Charter's reference to 'volunteers' came to mean those who worked for the organisation in the 'field'; while internationally mobile staff could be understood within this spirit of volunteerism even when they were remunerated, organisational practices relied on different assumptions about locally recruited staff until the early to mid-2000s, when the topic of staff categories became the subject of discussion.

Today, despite the intervening decades, the influence of this differentiated access to the 'volunteer' spirit is still felt by locally recruited staff (see box 6). Interviewees argued that volunteerism also has direct impacts for recruitment by MSF's national sections, whether for headquarters roles or for international contracts. These impacts are discussed in the next section.

BOX 6: VOLUNTEER SPIRIT AND LOCALLY RECRUITED STAFF

Historically, across MSF, the identification of the organisation with its internationally mobile 'volunteers' meant that the number of locally recruited personnel and their conditions of employment were not recorded by the organisation, nor were these staff allowed to join associations (Dollé, 2006). A decade and a half later, there continue to be split systems in many areas – different induction trainings, different HR monitoring systems, different health care policies, and so on. This is in part a necessity, as MSF entities must comply with and adapt to national employment legislation.

However, internal consultations in 2018 found that volunteerism was still associated with crossing borders and additionally with origins in wealthy countries. The report summarised that:

> "[V]olunteerism is considered by many an out-dated and divisive notion ('volunteerism excludes') that warps people's ability to recognize the multiple shades of commitment to MSF's social mission that actually exist and negates the day to day necessity of earning a living and – if possible – having access to a social security safety net as faced by the vast majority of MSFers today." (Harvey and Delaunay, 2018, p. 13)

Interviews for this study continued to highlight it as an issue. For example, one employee said: "We still have meetings, we still have comments in Souk about if we pay people from the Global South equally, what guarantees that they don't want to do it for the money?" MSF employees who were initially recruited on local contracts described the difficulty of proving their "MSF-ness", and countering assumptions that they were simply joining the organisation for money. A Learning and Development specialist observed that during recruitment interviews:

> "If the question is, 'how do you see yourself in the future?' if they say, […] 'I hope after a couple of years of experience here, I would like to become an administration manager in the government structure.' Immediately, it's a, 'No, because you're working only for 2 years with us? How dare you? You're not committed to the organisation. You love your government better than MSF. So, we don't want to recruit you.' Well, the issue is, first, what opportunity or guarantee do you provide from in MSF, for the person to grow? Well, none, usually."

BOX 6: (continued)

Locally recruited employees described having to enter MSF through routes that discounted their professional expertise. A person with a medical background described how after several unsuccessful attempts, a friend inside MSF advised them to change strategy:

> "Since you are trained and have ambitions, start at the lowest level – apply to be a guard – because there aren't as many requirements to get in. After that, with your background, it will be possible to access other roles because you will be already inside the organisation. It was the best way to join."

Another person had been positively surprised: "when I applied, I was told that MSF never considers applicants who hadn't worked with it before, those from outside," yet was one of two appointed, and considered the other (who had already worked for MSF) to have been appointed on merit. Such stories suggest that recruitment to MSF can (in some places at least) become the subject of received truths, which may or may not reflect documented policies and practices, but which nonetheless raise questions about how different staff perceive their value in the eyes of the organisation. They also raise questions about how recruitment processes interact with wider socio-economic inequalities: entry into the organisation, even at the lowest grade, may favour those with access to education and/or to the linguistic skills (requiring colonial rather than vernacular languages) that are often expected of locally recruited staff, reinforcing class barriers.

Barriers to entry

One of the perceived impacts of the emphasis on volunteer spirit is to create barriers to entry for staff from lower socio-economic groups. This is because of the way that the 'disinterest principle' is embedded in MSF and OCA's salary system. The Chantilly Agreement (MSF 1995) specifies that in MSF "the proportion of salaried positions remains limited" and "Management staff salaries are lower than those in comparable sectors of the employment market." In the Amsterdam office, salaries are benchmarked to the lowest quartile of salaries in chosen sectors (MSF Holland, 2008, p. 2). A headquarters employee with children said: "I cannot work for less, literally." The emphasis on 'commitment' is integral to the pay scale (under revision at time of writing), which classes jobs according to internal "perspectives" on their complexity, level of responsibility, and so on; the framework explicitly excludes any consideration of "required qualification or competences," "performance of the jobholder," or "inconveniences that are an inextricable part of a job such as field visits, on-call duties or regular work beyond office hours" (ibid, p. 4). The effect of the salary framework, a senior manager in Amsterdam argued, is that "if you select on that level, you select higher middle class, people that have an extra [source of support] somewhere." The impacts of this approach have been the subject of previous internal discussions, as among OCA networks – and more widely – there have been calls for MSF to consider how the volunteerism principle is contributing to its workforce being most accessible to those in a financial position to accept low remuneration.

With these dynamics in mind, interviewees noted a "class divide" affecting MSF. One described MSF as "a project of internationally-orientated, well-educated, somehow privileged part of the [partner section] society." "Middle class, white, university trained," another summed up, referring to a partner office. This affected the recruitment of internationally mobile staff, a senior manager noted:

> "I do not see a Dutch nurse [from a low-income, immigrant background] working for us because if you finally got yourself through nursing education, and you've got your higher education degree, you have debts, and you cannot work away your debts working for us. You probably still live with your parents in a social housing complex, and they are not going to say: "Sure we're going to finance you for another year so you can work for almost nothing with MSF in the field somewhere."

As these examples suggest, socio-economic privilege was often linked to broader racialised inequalities in European society, which interviewees argued were being reproduced within MSF as a result of its policies. Access to education was repeatedly underscored as a form of "class power." A partner section employee working in communications reflected on the "bias" in the workforce: while the need for specific qualifications or expertise may be shaping profiles among internationally mobile staff, they observed that their office also lacked "a good representation of the [partner section] society as a whole. Perhaps sometimes we are a bit blind to some realities of the [partner section] society, but this is also not our main scope." As this interviewee observed, the operational mandate of MSF may serve to distract organisational attention from understanding and then addressing exclusionary elements in its own ways of working.

Indeed, the idea that the organisation lacked awareness of or "attention" on class was often raised in these discussions. One senior manager commented on the reduced attention on issues of class within OCA:

> "I very often think that we look at passports or colour. […] Because this is a super international bunch that I've got here in the Amsterdam office, and therefore it is diverse, but whether they're black or white, they're all upper middle class, and that's not necessarily diverse."

People are told "everything is open, but you need to initiate the opening," said an employee based at another office, arguing that "the organisation is designed for a certain socioeconomic background […] and I would wonder whether, to an extent, that prejudice is the bigger prejudice than others that we worry about within MSF." Another argued that lack of "social class diversity" affected the "diversity of thought" in MSF:

> "How does the organisation genuinely put in systems to improve diversity of thought? I don't think we do enough. The UK is one example but even, say, in the India context, in India office, how many of them are from the same caste? How many of them actually are privileged middle-class Indians and how much do they really represent the rest of society?"

Support for relocation costs to work in Amsterdam was also highlighted as an example of how "the concept of MSF modesty" can translate into "policies being structurally racist" when applied to employees from the Global South appointed to positions at headquarters level. For example, a 2019 version of OCA's relocation policy reportedly defined a list of eligible items and specific shops from which expenses will be reimbursed. In the words of a participant in consultations on revising the policy, "you can only get basic stuff from IKEA and they had a list of furniture and cooking items that you could get," prompting feedback highlighting diverse needs, such as, "what if somebody wants a rice cooker because they've come from South East Asia […] what if somebody needs an orthopaedic mattress rather than the IKEA basic mattress because they have chronic pain or back issues." Although a new policy has been drafted that would see these lifted, they remain the normative basis for the estimation of relocation costs; in other policies, provisions are tied to minimums in Dutch law. When concerns about the equity impacts were raised, employees described how the organisational priority remained "saving money" rather than creating a welcoming and inclusive environment. They concluded: "stop saying you're writing these policies with an equitable lens" if equity is less important than "MSF modesty." The dual goals of perpetuating a 'volunteerist' ethos and saving money contribute to the imposition of constraints, showing how MSF's emergency culture extends into areas of organisational practice far from programming and operational decision making.

7.2 Proximity to operations

As outlined in Chapter 4, 'time in the field' is a significant currency of influence in MSF. As one person said: "legitimacy is conferred from having worked in Afghanistan, DRC, South Sudan. You've got to be able to tick off the big five or six, otherwise no-one's interested." In this environment, proximity to operations allows some MSF-ers to rhetorically occupy positions as the guardians of MSF's identity and mandate, whether that be in discussions about where and whether to open or close projects, for example, in conversations about the movement's structures, or in debates about its potential futures. This contributes to an organisational culture similar to that described by Hopgood (2006, p. 191), in which "management has no natural writ over identity" and "authority was so dispersed that individuals felt empowered to speak even against corporate decisions of the management and movement." This section argues that the legitimacy held by those with operational experience affects internal communication, management and where attention is directed within the organisation.

Who represents operations?

At headquarters level, legitimacy was considered integral to the pre-eminent position of operational teams. This power is both formal and informal. Formally, in the words of a senior manager, OCA's Operations Department makes decisions about issues such as "which country to go [to], how many projects there are," while the Management Team is responsible (in concert with the OCA Council) for the overall budget; the General Director can "have an opinion" on operational issues and "of course the opinion is heard, but the decision is not there." Informal power in Operations is strongly tied to currencies of influence within the organisation:

> "There's a lot of informal power-wielding that goes on in MSF, as well, and I think that if I was to really say, 'Well, where does the power reside within MSF?' If I had to summarise that in one sentence, I would say: 'The power resides within the operations teams.' That's where the true power in MSF sits. It is the operations teams that spend the majority of MSF's money. It is the operations teams that, obviously, have the day-to-day connection with the country programmes, and there is a huge amount of moral authority as well, if you like, that is held within operations teams in terms of who has the power to, and the legitimacy to, speak on certain issues."

Numerically speaking, the Operations Department is small within the overall workforce of OCA headquarters yet oversees the direct action in which the majority of MSF's staff are engaged. In 2022, OCA's annual plan had 470 posts at headquarters level, adding up to 416 full-time equivalent positions; of those posts, the Operations Department represented roughly 30 positions. It is organised into 6 cells – 3 based in Amsterdam, 2 based in Berlin, and 1 based in Nairobi – as well as an Emergency Support Department. Each cell is headed by an Operations Manager (an OM, sometimes referred to as the 'desk') who is responsible for managing their portfolio of countries. These structures head OCA's operations, which in 2022 engaged 752 internationally mobile staff and 11,264 locally recruited staff. As the boundaries between roles in the Operations line are not fully fixed or enforceable (despite the existence of job descriptions), who is in what position interacts with contextual conditions to shape the reach or scope of those roles, resulting in a shifting series of negotiations as people move in and out of programme positions.

The power of ops is formally inscribed in the way that the Operations Department interacts with other departments or teams in OCA. In brief, and to generalise, formal decision-making authority lies with the Director of Operations or the Operations Managers. The Operations Manager manages Heads of Mission, who in turn manage Project Coordinators. Outside operations, other colleagues are in advisory roles, of which there are many. One member of the department summarised: "we have a lot of advisers. We have a health adviser, an HR adviser, a logistics adviser, and some are more adviser than others. Some are advisers on certain parts of their job profile and decision makers on others." This advisory relationship carries through into programme structures, for example through the medical support team chaired by the health management.

As outlined in Chapter 4, being a medic may carry leverage for individuals but in the larger scheme of things the Operations Department prevails. Two scenarios described during different interviews illustrate this dynamic, one at headquarters and one at programme level:

> "The MST [Medical Support Team] might be having all these technical discussions about how to do a particular [project], where to start a new cholera project for example, but in ops they've already taken the decision. 'Well, we don't care about that region.' Or 'This is a security whatever.' And, almost, this discussion's happening in parallel and you find out in the next MST: 'Oh hey, this has been decided'."

> "For example, here in the field, we may give suggestions for a given intervention, we have data which proves that the intervention is possible, and the medical coordination encourages us to make and give suggestions, but once we've finished doing that work the answer is 'This is not the priority. Cool it down. Get on with some other things.' Operations are the only decision-makers."

Questions of credibility, legitimacy, and influence are perceived as very important to internal exchanges. While colleagues in other departments may also have significant experience and credentials, including ones that are internally valued, they tended to describe their views as lacking authority or weight in the eyes of colleagues with operational experience. Some spoke of having to counteract assumptions that undermined their contribution or pointed to the importance of being able to speak in the 'language of operations' when making a point. For these reasons, some staff emphasised the value of institutional know-how, such as the knowledge and ability to persuade key decision-makers, including notably in exchanges between Operations and OSCAR. Thus, in advisory positions, one said, "you have to fight for influence, to exert your influence on the decision-maker." Another example is the high regard in which the 'ops platform' is held, seen in the idea that it was "the height of influence for a humanitarian affairs adviser to be able to engage with the people who sit at that meeting." However, not all members of the Operations Department interviewed described the ops platform as primarily a decision-making space, highlighting its consultative role with regards to the ultimate decision-making authority of the Operational Director.[11]

People spoke of the networked connections between staff members within Operations, which add up to a strong concentration of internal power. The people in this group have often served within MSF, and OCA particularly, for many years. They tend to know each other, their careers having criss-crossed through many of the same places and they have potentially worked together in different configurations, including who is managing whom. They form "very strong bonds" from working in "volatile settings," said one experienced colleague. Historically, the E-desk has been characterised as "a very closed circle of people who are extremely comfortable and familiar with each other and have very high levels of confidence in each other's capabilities." Experience in high-profile, acute emergencies can catapult a person up through the ranks of prestige; having an assignment "in a huge emergency that has everyone looking at you" is a stepping-stone that can change an entire career.

11 The ops platform, which has doubled in size over the past twenty years, brings together the Director of Operations, Deputy Director of Operations, Senior Operations Advisor, Medical Director, Deputy Medical Director, Head of OSCAR, Head of E-Desk, and the Operations Managers.

If programme or 'field' experience is at its most concentrated in the Operations Department, it is also frequently found elsewhere in headquarters. Indeed, as anthropologist and former MSF staff member Darryl Stellmach (2020, p. 5) has written: "Many office people are field veterans: career aid workers who moved to the headquarters to maintain family ties and a more sustainable rhythm of life." One interviewee pointed to the pattern in which:

> "A lot of the people that have taken the seats, taken the senior management seats, particularly the ones that are more medically operationally related, they have gone through a similar trajectory of having spent that time in the field, and then therefore earned that recognition."

Staff members who had worked outside OCA in section offices also described situations where "the entire upper echelon of the management team was composed of individuals that had previously worked in the field but were not necessarily seen as experts or qualified in the positions that they were working in."

This reflects MSF's operational culture, which perpetuates the currency of influence of time in 'the field' (see also Chapter 4). In interviews, internal complexity was cited as a reason for MSF's "priority on growing our own leaders," because alongside "the complexity of the places that we work […] MSF is a complex animal" with many different and interacting parts. Exposure to acute emergency settings was contrasted with "giving the right answer in the book" as a form of expertise, a justification for the emphasis on length of service "not because we need to win a badge of honour but because there's only so much you can be taught on how to be a Project Coordinator." 'Field' experience, then, becomes a short-hand for a proven ability to cope and perform in the challenging environments with which MSF is most associated. While it appears to be most visible and authoritative in the Operations Department, it also sits across headquarters departments and shapes the way staff members interact, cutting across departmental lines and formal seniority. The impacts of this on internal communication are outlined below.

Internal communication

Proximity to programmes can be invoked as a way to marginalise the roles or voices of staff members with less or no equivalent experience. Hopgood (2006, p. 17) found in Amnesty that a strong values base can make "problematic the integration of those with commercial skills who could not, almost by definition, be 'part of the heartbeat'" of the social mission. In OCA, headquarters employees without programme experience described their feeling of being delegitimised. The example of conversations about HR was used to capture calls for non-operational colleagues to "shut up, because it is your fault that we don't have staff in Ethiopia and people are dying because of that." Commenting on the resulting culture, a manager argued that "we need to modernise and respect staff also if they say, 'Hey, give me decent pay,' or, 'I am for the cause here, but I don't need to go 15 years in the field before I can run your database management'." Headquarters staff said that entire departments can be marked as distant from programmes and 'HQ-centric' despite having mixed staff profiles (including individuals with 'field' experience), operationally relevant roles, and daily contact with the country programmes. As explained in Chapter 3, this can contribute to an at times heated or antagonistic approach to communication, although some headquarters offices have invested in processes to articulate and improve cultures of interpersonal communication.

The keepers of MSF's flame appear to assume an entitlement to speak that others are not able to access. Perceptions of legitimacy affect people's decisions about whether to participate in internal discussions, as seen in one person's account of deciding to speak up on an issue even though, with several international assignments and roughly two years at headquarters, they considered themselves "kind of a nobody" who did not yet have "organisational headquarters tenure." Conversely, people who can speak from proximity to operations are able to challenge those further up in the formal hierarchy, as authority and legitimacy are independent from formal structures. A senior manager, while recognising the centrality of the social mission, argued that:

> "Saving lives is also used in order to get your way against compliance, get your way against funding and so on, because who can argue with this? If somebody says, 'patients are dying because we don't put more money in this,' then I could never get money for an investment in HQ because there's always a patient somewhere that deserves more than an investment in an IT tool. So, that is something that can be very dangerous in the organisation if it's misused."

Although these dynamics were very pronounced at headquarters level across different departments or between colleagues with different backgrounds, prestige related to length and locations of service also shaped dynamics within the Operations line in-country. One person in a coordination role recounted their experience of debates among Operations colleagues:

> "I've been told a lot of times, both at country level and OC level, 'I've got 25 years' experience,' 'I've got 28 years' experience,' 'I've got 20 years' experience.' I'm, like, 'That's commendable, that's respectable, and your input is valued, but can we not use that as the end-all of a conversation? Can we not use that as the justification for why we should take your approach and not another approach?'"

The identity of MSF becomes essentialised, with phrases like "that's not how we do things" being "used with great frequency to shut down ideas that don't fit a certain mould." Another employee gave an example of this in action:

> "In everyday meetings, when something would come up, a practice, a policy, a way of working – and I would share: the Interagency Guidelines actually don't recommend that any more, this is not what others are doing in other organisations – the reflection still was this tension of, 'Do you know us, and are you one of us?' Like: 'The MSF way is the right way, and we don't have this outside perspective'."

It is possible that this dynamic is limiting both the contribution of a more diverse range of staff to MSF's existing work and the development and/or implementation of different approaches. For example, one interviewee identified a "catch-22" affecting operations. On one hand, in the Operations Department, "most of our time is spent staying afloat and trying to do a good job by the missions, and not so much succeeding and revising the way we are organised" because "we just generally speaking don't have a lot of brain space for reform." On the other, the department is unlikely to accept outside help: "whether it's appropriate or not, that centrality of ops means that if an initiative doesn't come from that department, things are not likely to progress." The gravitational pull of operations, by this account, is not something that the Operations Department is able to harness. Instead, it perpetuates the influence of individual keepers of the MSF flame across the executive and association, who can leverage a position of legitimacy to push their own, personal version of what they believe is right or necessary.

Underpinning the clashes described above is a profound question about the stewardship of the organisation. Inevitably, priorities conflict – between different programming possibilities, between 'institutional' and 'operational' domains. Some, perhaps many, staff members hold strong views about where resources should be focused, which tap into ideas about the identity and purpose of MSF. An Amsterdam-based employee described the dynamic:

> "A lot of people in Operations have quite a clear point of view on how it should function. And also they see the field as the core of the organisation, and they find sometimes that other priorities step a little bit away from that core, and that can sometimes clash a little bit."

Views from 'the field' are agreed to be essential. Yet the many obstacles in the way of programme personnel being able to participate in discussions, especially the locally recruited staff who make up the vast majority, increases the importance of voices within or accessible to headquarters that can claim to speak with authority from a 'field' perspective. At the same time, many staff appear to also have a lack of trust that managers are properly positioned to make the right choices and see 'management' shortcomings as part of the problem. These dynamics raise the stakes for discussions about conflicting priorities. How legitimacy shapes management is discussed in the next section.

Management

Interviewees frequently expressed a lack of confidence in what could be summarised as the 'higher-ups.' Depending on the speaker and context, this could refer to supervisors, line managers, decision-makers, or 'management' in the sense of organisational leadership (whether at OC level or at international, movement level). The lack of confidence thus appears to inform, for example, Project Coordinators' attitudes to key coordinators in the capital, capitals' positions towards headquarters, and views from a range of staff about senior OC and international management. In OCA headquarters, the lack of trust in 'management' was multidirectional – that is, it was expressed by some staff about various layers above them in the hierarchy; by some of those in senior management in relation to layers of management below them; and by some with associative governance experience about the executive (and indeed about associative leadership as well). Additionally, there were several critiques of management approaches and habits overall. This section does not seek to explain all these concerns and criticisms but to highlight those that relate to the legitimacy that operational experience carries in the organisation.

Though turnover also affects MSF's workforce, there are colleagues in headquarters and elsewhere who have spent many years working for OCA or other parts of the movement. Having personnel with internal careers that can sometimes be counted in decades is perceived to affect management styles, not just in OCA but in MSF at large. Interviewees described how career trajectories shape how people approach management roles, amplifying the weight of precedent and maintaining the emphasis on direct intervention even for those who sit at more strategic levels. According to these accounts, managers are too focused on understanding detail and not sufficiently concentrating on strategic considerations. "I think that different managers and advisers and decision makers of all kinds exercise their authority quite differently," one person said, but "a generalisation that holds is that everybody's working two levels down from where they should be." Another said that as people move up the management line, "they come from below, and they bring an attitude from, 'this is how we used to do it,' and a very hands-on attitude," which makes it "very difficult for people to space out and think, 'let me only do the highlights'."

While this may not be particular to MSF, or indeed to humanitarian organisations, there may well be specificities to how these legacies shape choices. The humanitarian sector has undergone rapid professionalisation in the years since MSF first arrived as a prominent player on the international stage. Some interviewees highlighted the impact of this evolution on the attitudes of different generations of humanitarian workers. A key cohort in MSF, it was argued, experienced formative years when the organisation's identity was dominated by the emergency imaginary in its most archetypal form:

> "A lot of the people who worked in the late 80s-90s, they are the ones who, when they joined MSF, the version of MSF that they saw was the one – I'm physically going to go to these countries and help people now. I'm going to stop people from dying, now. I'm less worried about stopping people from dying in 5 years' time, by changing this policy or by doing this research that allows this new drug cure to come on the market."

While the number of people still working in MSF who started their career in the 1980s may be few, the legacies of this period are perceived to still be active in attitudes that have been replicated and passed on within the organisation and in the modes of action that are valued according to MSF's self-identity (see Chapter 3).

Several triggers over the past five to ten years have brought intense scrutiny to questions of expertise, professionalisation, and identity in relation to the upper levels of management and governance in OCA. The resulting discussions have at times pitted internal and external expertise against each other, resulting in aggravated discussions in executive and associative forums alike about whether, for example, people would "rather see a person who knows all about the MSF supply chain and has experience of 20 years than somebody with a Masters, without any experience in that." While few interviewees argued that expertise developed outside MSF has no value, many sought to articulate limits on how much value should be placed on that expertise (the 'balance' between staff with different backgrounds) or the levels of seniority to which it is relevant (the rank that so-called 'externals' should occupy).

A distinctive element of current positions is the identification of a cohort of experienced staff with the legitimacy, assuredness, and motivation to challenge formal powerholders. This sees the keepers of the MSF flame operating as a kind of bloc: interviewees identified an "old guard" cohort of operations veterans as constituting a kind of "middle management" in OCA, with one interviewee describing this as a form of "networked nepotism." Some interviewees linked the influence of this cohort to their roles within management structures. In this telling, as we heard from one senior manager, there is a pattern of former leaders returning to less senior positions after the end of their tenure (contracts for directors are limited to a maximum of two terms of three years). While some former directors move on, others return:

> "They go out for half a year on unpaid leave or they go somewhere else or they take a break or they need to mend their mental issues, and then they come back in middle management with lower pay, but they're willing for the good cause, the social mission, and, 'This is my family.' So they come in middle management, which means that they then have all the informal power to continue what they were doing, and the person that took their place is put in a spot where the former boss is working lower there."

A consistent perception of interviewees was that this bloc was opposed to at least some of the current calls and drives for reform in OCA and MSF. It appears as a counter-power to the formal leadership in the OCA Management Team and able to apply that power in both executive and associative forums.

Several interviewees observed that the top management of MSF reflected broader racialised dynamics within the organisation. One person said, "whiteness is still very dominant," which they felt posed challenges for the present and future identity of the organisation:

> "If you look at the composition of the key international decision-making bodies, it's changing a bit, but it's changing very slowly, and I think we have to ask the question whether the current leadership in MSF is capable of implementing a much more radical change in the distribution of power and influence. It's very hard for anyone to jump over their own shadow, obviously, so I don't mean that as criticism, but as a key question underpinning all of this."

Another reflected on the potential for such arguments to be experienced as a personal affront, as individual profile becomes decoupled from and stressed more than MSF-ness; a feeling that "I've dedicated my career and life to this organisation, now you're coming and telling me that I'm not a legitimate representation of everybody in it." While not everyone used the language of race, many felt that the ability to access and define MSF identity played a part in resistance to change:

> "There is a big middle part of the organisation who really, either don't want to change because that is something that personally will affect them, or they want to be in charge of the narrative. So they want to lead that change on their own terms. Or they simply believe that the organisation doesn't need to change, because what they're doing is right."

During interviews, these differences of opinion became apparent in different attitudes to what constituted legitimate issues on which to focus collective attention. As the next section discusses, proximity to programmes brings advantages when defining what constitutes legitimate priorities.

Defining legitimate attention

Within the frame of operational decision-making, disputes between Operational Centres are infamous in the history of the MSF movement and colleagues have alluded to the "transactional costs" that can mount when there are disagreements in intersectional platforms. When looking within OCA, there are "battles" and "old turf wars" about operational decision-making both in terms of collaborations between departments and different approaches within them. These may be on a wide range of topics, such as use of resources, risk management, medical techniques, advocacy choices, and so on.

On a strategic level, given that resources are finite, choices about how to invest can falsely appear to be a zero-sum game where what goes into the 'institution' takes away from what can go towards the 'social mission'. According to a senior manager, this creates a dilemma for requests for support services, because "you can't just ask for a lot of resources, you know very well that any of this resource would be best placed to save a child."

While this applies to funds, interviewees often raised it in relation to attention and time, both also finite resources. This attitude shapes responses to calls for a focus on MSF as an institution, including on issues gathered under the 'diversity, equity, and inclusion' agenda. DEI was described as "the institutional sanctioned terminology" for addressing interpersonal as well as structural problems affecting staff members, attached to the creation of strategies, action plans, and focal points. Although 'DEI' is a widespread shorthand, and definitions of its component terms are made available, as a grouping it is not clearly defined nor are its boundaries made explicit. OCA's DEI page on SharePoint highlights the goal in the 2020-2023 strategic plan of becoming "a global organisation within which all staff are valued and respected, and do not face structural barriers to communication, mobility and professional development" – with DEI by inference referring to activities in support of that goal.

While no interviewees expressed opposition to the broad idea of ending discrimination and valuing all staff, some expressed considerable reservations about the level of attention on institutional issues. In this line of argument, examining biases in organisational culture or structures becomes a 'distraction' from 'core business.' It feels, in the words of one senior manager, like "an addition." In short, as one sympathetic staff member summarised: "ops, they do ops. They save lives. They respond to emergencies. They cannot sit there and listen to racism topics all day."

Being part of operations allows these critiques to be presented as channelling 'field' priorities. This was summed up by one OCA employee reflecting on the need to maintain focus on the social mission:

> "Your goal is still your beneficiaries in the field, and not just – sometimes we talk more about diversity than about our operations, our beneficiaries, and this is what is starting to bother me, because I feel that the balance is really shifting. I know it's also a big hype in the world, people talk about climate change, diversity, et cetera. But sometimes we spend too much time on it, we are not discussing our choices in some countries, we don't discuss what's going on in Ethiopia, we're not going to push, to speak out on all this Tigray conflict, whatever. We talk a lot about diversity, and it's important but we will not change it at once, and you really need to balance it."

There was a disconnect in how different employees understood the relevance or importance of DEI, in particular in relation to OCA's operational priorities and emergency programming. In some discussions, 'DEI' was pitted against operations and the medical mission. The focus, interviewees argued, was on short-term, lifesaving programmes: discussions around internal inequalities were navel-gazing, especially when MSF has 'actual' work to do (saving lives in the field). For instance, one employee expressed their concern at the "tremendous quantity of attention going, but also of resources going" into "DEI efforts":

> "It's always at the cost of something. All that attention and all the discussion and it is also at the cost of what happens […] and what it is all about in the end, and that is delivering quality medical humanitarian assistance to people who are victim in conflicts and natural disasters. If I summarise, basically […] I'm afraid that what happens at this moment, it's positive that the discussion is there, but I am a bit afraid that it's too much."

Some of these criticisms were framed as less about the importance of the goals themselves than the approaches to achieving them (see discussion of DEI in Chapter 8). In contrast, other interviewees emphasised the connection between internal inclusion and OCA or MSF's ability to maintain the quality and reach of its work. At headquarters level as much as elsewhere, some argued, "ultimately, who we recruit and how they feel in their jobs impacts how well we're able to do our patient care." According to this logic, attention devoted to DEI does not come at the cost of operational matters but supports them, a view that has been substantiated by numerous studies relating to medicine and organisational and corporate development more generally (Rosenkranz et al., 2021; Cohen et al., 2002; McKinsey, 2020). Yet, as explored in the next chapter, lack of confidence in management was also often expressed by those who support calls for greater attention to be paid to internal questions of diversity, equity and inclusion. People with diverging views of where collective attention should be directed thus find common ground in narratives about the capacity – or otherwise – of leadership and the institution at large to meaningfully address the major problems of which many are aware.

Conclusion

Building on preceding chapters, this chapter examines perceptions within MSF that current approaches to 'keeping the flame' in MSF involve negative consequences for individual staff and for some of OCA's ways of working. Certain value systems have become embedded in structures and perpetuated both through codification in policy and in norms that shape expectations and behaviour. Specifically, the chapter focused on some of the forms and implications of the spirit of volunteerism and proximity to operations, both deeply rooted in MSF's emergency culture and the currencies that hold sway in the organisation.

Amnesty International and MSF have different dynamics; their purposes, structures, and identities are not the same. Nonetheless, understandings of power dynamics inside both are furthered by reflecting on the role of a core group of keepers of the flame, strongly associated with the identity of the organisation, able to speak as guardians of its moral authority and role. An organisational culture built on debate and individual initiative favours those who feel legitimate and equipped to wade in. What this looks like in practice is inevitably shaped by internal currencies of influence and by internal and external axes of inequality with which they interact. As one long-standing employee reflected, MSF's culture appears to be built for a certain type of person:

> "One needs to be bold, not even maybe bold, but just have the assumptions as part of one's way of thinking that if I speak up, my voice – if I'm engaged – my voice will be heard. [...] But, if you don't initially have that mindset, way of thinking, then in many senses, the doors are closed, because one wasn't encouraged in."

There are many forms of privilege, some of which intersect with currencies of influence, that interact to produce this effect, and many reasons why a range of staff may not feel "encouraged in." Some interviewees reported successes in promoting changes to cultures, such as working on communication styles in specific offices or holding constructive self-reflection processes among their departments. Some interviewees also recognised the potential for line managers to create positive environments for their colleagues: "When you feel safe normally it is when you are working with a manager, with a boss, that is very comprehensive and respectful towards what you have to share." However, in Amsterdam in particular, the politics of legitimacy were described as creating barriers to entry and participation. These dynamics are both distinct from and tied to the ways that unequal systems structure MSF's operational workforce, adding to an image of the organisation as damagingly hierarchical, exclusionary, and paternalistic. Chapter 8 considers how employees described the likelihood and potential routes for this to change.

Chapter 8. Diagnostic Disconnects

Introduction

This chapter examines how members of OCA and MSF understand the organisation's ability to conceptualise major change and react to it. It offers a series of diagnoses, put forward by interviewees, about why – in the views of those cited – the organisation struggles to act on its stated ambitions to change power dynamics. These diagnoses are not coherent. There are contradictions both between some of them and within some of them. That is, in some cases, even when the diagnosis is similar, the logic or the conclusions that are drawn can pull in different directions. This chapter thus highlights disconnect in OCA and MSF more widely – disconnects that reflect the scale and complexity of the movement. Despite the imagined unity of MSF, in reality, these disconnects in how its concepts, ideas and policies are understood and experienced are fundamental to how components of the movement relate and how staff experience their work and associative engagement.

The chapter explores a widely and strongly stated opinion that MSF is "glacially slow" – in the words of one senior manager – to address problematic power dynamics and inequalities. In some places, mechanisms such as employee representation and union delegations have helped staff to raise awareness of problems, but major issues were described as, to quote a locally recruited staff member, being "either addressed with years of delay or hardly addressed at all." Observing the fallout from the increased debate about inequality in 2020, an employee commented how slow the response was: "There's a lot of time taken investigating to say if this is actually what is happening, or did this actually happen?" Similar critiques were made about relationships with the individuals and communities among which MSF works:

> "There's been some ways in which it's been operationalised quite well, but that no-one would even go back to La Mancha and say, 'But where's the accountability of the beneficiaries?' It gets looked at every now and then, and people just say, 'We can't do it'."

This study asked for people's views on power and inequalities, subjects that lend themselves to critical assessments. In MSF and in the humanitarian sector more widely, this is a moment when the penitent mode is extremely influential; in public forums, narratives that identify major shortcomings are far more acceptable than those that portray problems as minor, which risk being labelled ill-informed, prejudiced or self-serving. It is potentially difficult to meaningfully dissent from the near consensus in MSF that 'nothing has changed,' though some interviewees did. Indeed, this very emphatic line of argument should not be taken too literally: many things have changed, but there are also profound continuities in some of the problems perceived as most important, most tied to MSF's identity and values. The vast majority of interviews had critical views, which we have organised into a series of discourses to allow their effects to be considered both individually and collectively.

These discourses in themselves hold power. As the previous chapter showed, influence derived from institutional legitimacy can be used to encourage or discourage a focus on different potential priorities. Michael Barnett and Duvall (2005) refer to the 'productive power' held by those in a position to generate or mould concepts and discourse, and they point to the power of discourse itself as a determinant of action. At the same time, these discourses have the potential to be disjointed or contradictory. They reveal disconnects within the organisation, between values, incentives, access to information, and ways of working across different parts of the movement and the places it works.

This chapter introduces five narratives about MSF's nature:

1. Paternalism
2. Cultural 'others' and othering cultures
3. Lack of vision for change
4. Lack of appetite for change
5. Action-oriented

Each section shows how employees of OCA and other parts of MSF illustrated these dynamics, or used them to explain slowness of change, with reference to major internal agendas in two spheres. The first of these spheres concerns relationships between the organisation and the people it aims to serve. The second concerns experiences and treatment of staff members within the organisation. While it is beyond the scope of this study to document how these diagnostic discourses have impacted specific choices, this approach allows us to draw attention to the weight that discourses can carry within the organisation.

8.1 Paternalism

As outlined in Chapter 3, there is a pronounced power imbalance between humanitarian organisations and the 'communities' they aim to 'serve', as well as between providers of care and their patients. Analyses of the colonial dynamics of aid date back decades, and critique of the paternalism inherent in humanitarianism has intensified markedly in the past 20 years. While by no means a consensus within MSF, this understanding of humanitarianism remains key to debates about the organisation and its work. Paternalism among MSF's employees is one of the key themes in critiques within the organisation of the limits of its willingness – and even ability – to give up power.

Paternalism was described as an elemental challenge for MSF. An interviewee with a medical background made this point:

> "You can be diverse and inclusive and still perpetuating a particular type of humanitarianism that is deeply problematic, because the power that we haven't really talked about [in the interview so far] is the power that manifests between MSF staff and the people that we purport to support. That's the gravest imbalance of power, really, that we still have a very paternalistic, very prescriptive, kind of, imposition of a certain way of seeing the world and a certain way of conceiving of an active humanitarianism that precludes the involvement of those people in the care they receive."

This is described as reflected in the skills and competencies that MSF employees hold. When asked whether MSF was good at listening, one health advisor said that "we are very bad at it [...] people find it very intimidating to sit down and to ask open questions, and to hear, because we don't know if we can solve everything, but we also don't have to." Even when the listening happens, another said, it does not necessarily translate into "doing things differently."

MSF communications has been critiqued both within and outside the organisation for paternalism and racialised images of suffering. Scholars of humanitarianism going back decades have drawn attention to the use of racialised and paternalistic tropes in the public messaging of NGOs, concerns that have also been recognised within the humanitarian sector through initiatives such as codes of conduct (e.g. Benthall, 1993; Burman, 1994; Boltanski, 1999; Franks, 2013; Chouliaraki, 2006; Benton, 2016b). A series of controversies around awareness-raising and fundraising campaigns has recently shone a spotlight on problematic practices by different parts of the MSF movement (e.g. McVeigh, 2020; Batty, 2022). At the heart of the disconnect in communications is a clash of values and expectations, between an organisation that – in principle – has committed to ethical approaches to how it represents crises and people affected by them, and target audiences of potential donors in the Global North who tend to respond more generously to emotive, paternalistic and racialised imagery than complex information. One interviewee identified this as pressure to cater to "what our donors are telling us. […] They don't want to hear about, as they would call it, 'fortune seekers' crossing the Mediterranean: 'We want the mother and child health in Chad. We want the babies'."

While this situation arguably does create incentives for the use of white saviour tropes in the name of fundraising, some in MSF are concerned that such tropes also reflect internal attitudes to the people among whom the organisation works (and therefore also to the majority of MSF employees). As one interviewee observed, communications constitute "the public-facing aesthetic of MSF, so it's often exposed to internal and external critique, but comms is just a window into how humanitarians and how MSF sees the world that it operates within." Repeated signs of failure to "respect people's dignity and agency," in the words of a recent institutional apology for violating a child's rights to privacy (Christou, 2022), lend credence to this view.

'Person-centred care' (PCC) was another subject of critiques of MSF's paternalism, specifically the difficulties in relinquishing decision-making power. In OCA, based on our interviews, PCC is perceived as a new ambition. It was not mentioned in OCA's 2015-2019 strategic plan, although the plan states that one of OCA's values is to "look at the whole person, not just their disease" (MSF OCA, undated, p. 9) – "looking at" the person being, of course, very different from involving them. In contrast, PCC features prominently in OCA's 2020-2023 strategic plan, which makes "a PCC approach across all MSF OCA projects" a core goal (MSF OCA, 2019, p. 20). Another OCA document provides the following explanation:

> "Whereas person-centred care is commonly understood as focusing on the individual seeking care (the patient), a person-centred approach encompasses these clinical encounters and widens it to also include attention to their families, networks and communities and the crucial role of communities as part of the health system." (Hoetjes, undated)

Person-centred care encompasses patients and communities (see Harding, Wait and Scrutton, 2015), spanning the entirety of the movement from "our senior leaders, to our doctors and nurses, to the guardians who welcome people to our gates," as it was captured in one MSF-wide conversation. Participants with a range of roles were insightful about PCC in ways that suggested it was meaningful to them. One medical programme colleague described it as "focusing on the individual engagement to make sure that what we are doing is according to that individual's needs and said by that individual that they would want their care to be that way." A PCC ambassador said that at its fullest this agenda meant "looking at the people more than just patients," in a way that includes staff as well as patients, so that the "style of the mission" overall is more about people. The examples they gave included changing the ways that healthcare worker-patient consultations and assessments are conducted, how meetings are run, or how decisions are taken. By definition, one interviewee in headquarters said, there cannot be standardisation: "It looks different because we're working in different projects, in different contexts, people with different cultures, values, perspectives, and so forth." Another interviewee pointed out that monitoring progress on PCC "should be not us defining that what we're doing is patient-centred" but rather understanding the views of those affected.

Nonetheless, person-centred care was sometimes described as more talk than action. One MedCo argued: "The talk about being person-centred versus the reality of the projects and the places we work in are very different." A former Project Coordinator said:

> "I've heard a lot about it [PCC], but in terms of implementation, again, because it's done in a very *ad hoc*, piecemeal, unstructured manner I've not seen a lot of implementation. I think that also comes down to the lack of follow-through we have for patients."

These views may reflect the difficulties of trying to implement an agenda of such high ambition across the large scale of OCA's projects. At the time of research, there were six country programmes formally implementing PCC initiatives at operational level. These initiatives, which are often in 'piloting' mode, have varied: from co-design of a project in Syria for people living with non-communicable diseases, which began with interviews with some people in this group as well as their caregivers; to plans in Sierra Leone to use exit interviews with patients to understand their experiences; to initiatives in partnership with communities in Chad to promote sustainable health services. Yet the discourse of PCC has been applied across OCA, with the 2020-2023 strategic plan calling for "all MSF OCA missions and projects" to have contextually appropriate PCC approaches (OCA, 2019, p. 20). While there are other smaller-scale or more *ad hoc* steps being taken, the apparent gap between discourse and implementation may lead staff members not based in participating programmes to question the extent or sincerity of OCA's commitment to its stated goal. This implementation gap is further sustained by the resource pressures in many of the settings where MSF works. According to interviewees, because of the vast need in many of the settings, there is an ever-present dilemma on how to distribute resources – including time, supplies and labour – necessitating a trade-off between quality and quantity. In some situations, the demands placed on MSF clinics create practical challenges, as one locally recruited employee described:

> "The fact of the free charge for MSF taking care of the population, everyone has to come to benefit from free of charge. Everyone comes, most of the patients. With several patients, there is no room, no space for everyone. They don't have the time to ask the patient to give his wish and the person also doesn't have the time to participate in that decision making. On that fact, there is no patient-centred care because the person doesn't have time to participate in the decision making."

Participants were also concerned with power dynamics within the implementation of person centred care (see box 7). Some argued that paternalism shaped internal power dynamics more broadly, discouraging power sharing and shaping interactions. One person argued that the gratification derived from helping others feeds a paternalistic approach across different levels of the organisation:

> "You want to follow the path of power always. Where you find a place where you're at a critical juncture where you might cede power, it is always in favour of people maintaining power. I don't think these are people who are power hungry. I think these are people who have an addiction to contributing to saving the world."

In the name of this contribution, as discussed in Chapter 3, individuals may permit themselves behaviours that appear to be at odds with the values of the organisation.

While paternalism in the medical profession is widely acknowledged, there was significant emphasis on the additional effects of the legacies and geographies of colonialism within MSF. “We come with this idea of providing assistance and aid, and helping other people, with this idea that they can’t help themselves,” one nurse reflected. An employee from Afghanistan said: “MSF itself is a Western ideology, it’s a Western organisation, that’s where the idea came about, that’s where it started.” Interviewees saw this as going beyond MSF specifically to the historical legacies inherent in the humanitarian endeavour itself: “If you see the history of the humanitarian sector, you can see this is something that came from Geneva, from Switzerland, after a war in Italy, Solferino. You have these human principles, that you name it and you choose the words according to your own thoughts. You were not giving a tour in Africa or in Southern Asia or in Latin America to ask people what they think about it.”

However, it is important to note that not everyone in OCA agreed with the notion that this implicates humanitarian gestures in racialised power dynamics. One interviewee pointed to the non-partisan aspect of the humanitarian imperative to explain why “humanitarian action as it is defined and how MSF has defined it […] has very little to do with any colonial heritage [...] it was two countries at war and a neutral party in between, and that was the humanitarian action.”

BOX 7. POWER DYNAMICS IN PERSON-CENTRED CARE

Like DEI efforts (see below), the institutional push for person-centred care has seen the attribution of dedicated posts or duties. In addition to a lead at OCA headquarters level, some country programmes have PCC ambassadors. These are sometimes dedicated positions and sometimes a role added to an existing position – either way these roles are usually undertaken by locally recruited staff.

Some interviewees highlighted how ideas of authority and expertise can be used to justify paternalistic approaches. A PCC ambassador said that when they initially brought feedback from patients to staff meetings, "people start[ed] laughing, and they said, 'Those patients, they don't understand. We are the medics." It was difficult, they argued, for MSF staff to "involve the other side" – a choice of language that reflects the assumed distance that this staff member was seeking to bridge. Another argued that difficulties with PCC revealed paternalistic assumptions in "what we read as beneficiary and patient":

> "We all go to the doctor. We will all have health issues. This should be a very universalising thing, but, in fact, the categories we put, and the ways that we see expertise, are communicated so clearly."

Interviewees described how these dynamics interact with internal power inequalities. Reflecting on OCA's experiences of promoting PCC, one interviewee spoke of dynamics with negative implications both for the individuals involved and for the overall goal:

> "It is very hard to get, as a medic, to get feedback that you're doing something wrong. And in the meantime, we're educating patients, we're trying to empower patients. But then we also need to really work on getting our staff ready to receive feedback and they need to receive the feedback that the patients said: 'Okay, no, you gave me 2 pills but I'm supposed to only have 1 pill.' And the same I've also seen with the PCC ambassadors, that our roles where we're really trying to make them speak up and make a bridge between the community and MSF, and sometimes also really give reflections of: 'The community thinks that.' That is sometimes very critical feedback that comes out and perspectives on how we do things, which I think is really good but we are not always ready for this in our organisation. And then, with these person-centred care ambassadors, unfortunately it really depends which international staff is standing next to that as a colleague. And there are international staff that embrace and that are very happy, and there are international staff that can totally put someone down."

BOX 7: (continued)

Currencies of influence related to expertise and contract type (tied in with ideas of MSF identity, see Chapters 4 and 6) are both at play here. The interviewee suggested that PCC ambassadors are "not always in a safe position" and can have their loyalties or motivations questioned when they relate critical feedback – affecting their safety at work and creating additional barriers for 'community voices' to be heard. This offers a particularly striking illustration of how power dynamics within MSF can affect the organisation's social mission.

8.2 Cultural 'others' and othering cultures

As many employees pointed out, MSF's approach was imagined to be universal, but in reality, proved to be ethnocentric and specifically centred around white European cultural normativity. This argument was made in relation to operations, professional and organisational standards and norms, and how the organisation supports its staff. It was made using a variety of terminologies and vocabularies. Most of these were used to describe a sometimes fixed, sometimes shifting, cultural and racialised 'other', although only very few participants used exactly the terms 'cultural' or 'racialised.' While a majority of respondents spoke about 'culture' rather than 'race', it is important to point to the ways in which descriptions of human difference have increasingly moved from being grounded in racial difference to being explained through culture (Lentin, 2006). As interviewees described the implicit and explicit hierarchies expressed through this ethnocentrism, their language showed that these could be characterised in different ways: as a European dominance, as a Global North dominance, as a racialised hierarchy. These categories must be approached with caution, as the binaries they imply (European/non-European, North/South, centre/periphery, headquarters/field) and their application to different groups risk perpetuating reductive generalisations that dehistoricise and essentialise cultures and societies. However, this only adds to the importance of considering their prevalence and effect within the organisation and the often-coded languages used to describe them. On some level, there is potential common ground in the various critiques, which all single out practices they see as disrespectful, counter-productive, and inequitable. Yet they can also represent strongly divergent diagnoses of 'the problem' with different implications for how to resolve it.

While there was acknowledgement of a will to adapt to different settings, participants in the study questioned the extent to which white Western ethnocentrism in MSF operations has been addressed. Like other humanitarian organisations, OCA began to employ anthropologists, who are seen in MSF to have a role in addressing 'biases' in MSF's programming (Véran et al., 2020). There have been broader debates about the role of anthropology in medical emergency response, with concerns that anthropologists are positioned as 'translators' or 'cultural brokers', there to decipher 'the culture' of the 'Other' with the aim of increasing 'acceptance,' rather than re-directing the critical ethnographic gaze towards the intervenors themselves (for this debate, see for instance, Lees et al., 2020; Benton, 2017; Enria and Lees, 2022). In any case, some staff questioned how far such changes went, arguing that, despite superficial changes such as women wearing headscarves or travelling in different cars from male colleagues, "certain things in the principle we don't adapt, we don't adapt to the context."

There were numerous comments about 'Western bias' in operational standards, and racialised ideas about 'professionalism' – the markers of doing a good job or being good at one's job. Expectations of how things should be organised can sometimes be "too European," an experienced employee commented, using the example of a vaccination campaign: "people queueing up and everybody has his turn [...] a typical international staff member maybe sees it as that is the way to organise it, but it may also be that something which looks 'unorganised' is actually still working." Another employee argued that the production of standards and guidelines involved subject matter experts in their area being "all white, Global North, writing guidelines and standards for black and brown [staff] with black and brown patients." The lack of representation was perceived as linked to potentially inappropriate or poorer quality of care for black and brown patients.

Observations about biased standards were frequently presented to explain (at least in part) why locally recruited staff struggled to access opportunities. In these narratives, there were certain fixed ideas about 'Western culture' being posited as the norm. An internationally mobile staff member reflected that "what we're valuing in terms of work output is people responding to emails quickly," describing this as "a very Western value in terms of our work culture and our idea of what it means to be a good staff member." Similar reflections were applied to "how we appreciate evaluations done by certain nationalities different from other nationalities" and to staff learning and development, where there were comments about the need for greater attention on different cultures of learning because "the learning psychology that we use and therefore the learning methodologies that we use […] are very, very Western in their approach." Other interviewees discussed other forms of professional development, such as whether MSF's "concept of coaching" is a "Western concept."

Staff members criticised biases in the conception and provision of psychosocial support structures in MSF, which were described as modelled on the experiences and needs of internationally mobile staff. For example, one programme employee talked about the visits of psychosocial experts, whom they saw as not reflecting gender, racial, or cultural diversity: "Nothing against white women, but I think it would be more beneficial to the communities that we're working in […] to have a more diverse – regionally, linguistically, culturally – to have that team be a bit more diverse and a bit more present in real life." This staff member was thus concerned about the perceived imposition of a white ethnocentric positionality and a sense that this created a gap in support, specifically through its aspiration towards a non-racialised universality. Another staff member argued that the problem was the denial – not the extension or imposition – of common standards. They described this as resulting from unrealistic, historically-grounded, racialised expectations of local staff:

> "What we expect some of our nursing teams do, the hours that they work, the under-resourcing, I mean, honestly, for some of our midwifery teams and some of our paediatric teams, if you had that many patient deaths in a week, I mean, that is just unrecoverable […] I think, we fall guilty to the strong black woman trope, if I'm honest."

While these critiques thus have slightly different logics, they portray a lack of institutional investment in tailoring psychosocial care to different staff. As highlighted in Chapter 4, MSF's institutional structures result in different levels of support for internationally mobile staff from different countries. When awareness of gaps in support for locally recruited staff is combined with awareness of reduced support for internationally mobile staff from (predominantly) Global South countries, the national/international division appears less important than other ways of drawing lines between different staff groups, leading some staff to draw conclusions that MSF is ethnocentric, Eurocentric, 'institutionally racist,' or 'white supremacist.'

The accessibility of support when faced with inappropriate behaviour from other staff was also questioned. In OCA, complaints about staff conduct are handled by what is known as the Responsible Behaviour Unit (RBU), which was established in 2019 as part of an overhaul of the 'integrity system' following an independent review. Although there are now multiple channels through which to reach the RBU, several interviewees described access as inequitable. Issues raised included language and challenges around ensuring confidentiality in isolated locations. How widespread these challenges are is unclear. Records kept by the RBU show an increase in reporting of harassment and discrimination, but this is still believed to under-represent the frequency of incidents. What is clear, however, is that perceptions of bias and exclusion persist and are strongly held, undermining confidence in the system. One employee said: "it's known that MSF doesn't punish anyone, even if he does something wrong, they just send him to another mission, a different position, which is really painful." In the words of one person: "I find it hard to say anything can work if you have people it doesn't work for." There is a strong emphasis on practicalities in some of these questions: do the systems operate in a way that means some people can't access them?

More profoundly, there is a tension between universalism and ethnocentrism that affects the very way 'appropriate' behaviour is defined and how violations are identified and handled. Internal attention on these issues was heightened during the period of research for this study due to the issuing of a revised Code of Conduct for OCA staff. Members of the RBU drafted the new Code of Conduct in 2021-22, with the process including consultations and several rounds of revisions. The RBU began the process of rolling out the new code in 2022.[12] This process has re-exposed the challenges the organisation and it staff face in navigating different social and legal norms. These challenges present under many guises. Sharing information about the code can be difficult: an interviewee based in Yemen described how the country office was having to seek advice on "how we can take some of the topics that make more sense to the mission, because staff on the mission don't accept some of the topics which is related to the culture, to the religion." Specifically, sections of the Code of Conduct that deal with sexual activity (including the prohibition of exploitation, abuse and harassment as well as intimate relationships between staff members or between staff members and patients) were described as culturally inappropriate to discuss at a workplace, especially with both men and women. Translating the code into policies is also fraught. For example, in some contexts the code's rejection of 'child marriage' presents challenges: not all countries consider anyone under 18 to be a child (as the code does) and in some cultures marriage below this age is considered normal. Does MSF have the right to pressure its staff not to enter relationships that are both legal and culturally acceptable where they live? Should employees already in such relationships be removed from their jobs for a breach of the code?

12 Consultations were held with seven country programmes (managed by coordination-level staff), headquarters departments, partner sections, and association representatives, and individuals with relevant roles. The Code of Conduct also went through review by the OCA Management Team, its Works Council (a body required under Dutch employment law), the OCA Council, and the latter's Duty of Care Committee.

In this context, while some employees criticised the imposition of universalist norms, others described racialised notions of 'cultural difference' as shaping responses to behaviour that contradicts MSF's stated values. One staff member said that "some of the conversations I've listened to, particularly around domestic violence or intimate violence," included comments along the lines of "'oh, it's a cultural thing' […] this word 'cultural difference' I think, is used quite a lot, but incorrectly." The focus on 'culture' also serves to distance debates around responsible behaviour or DEI from whiteness, that is to say from people holding on to the most power within MSF. This raises questions about how far the institution can reach into its employees' private lives. OCA's Code of Conduct officially applies to conduct outside working hours or locations "to the extent that it has a demonstrable negative impact on MSF-OCA's stakeholders, work or reputation" (MSF OCA, 2022, p. 2), and employees are also expected to comply with the MSF movement's "behavioural commitments," which include the commitment that "MSF staff members and operational partners shall not abuse anyone physically (i.e. physical violence, sexual aggression or other forms of physical abuse) or psychologically (e.g. bullying, abuse of power, harassment, discrimination or favouritism)" (MSF, 2018, p. 1). While domestic violence was not a frequent topic in interviews, comparable concerns can be seen in other issues, such as whether MSF should offer services that may be contentious (such as abortion) or – as discussed below – how to support queer communities and staff in countries where homosexuality is stigmatised or criminalised. These suggest complexities of understanding, conceptualising and responding to the perceived 'differences' that the organisation encounters in the course of its work. Responsible behaviour tended to be seen as something that would help adjust non-European behaviours to European standards and not the other way round, thereby perpetuating MSF's power imbalance between headquarters and 'the field.'

Similarly, issues around ethnocentrism were also prominent in discussion of the DEI agenda. While "responsible behaviour" frameworks are concerned with individual incidents, DEI is conceived as addressing systemic issues. A manager with an intersectional role observed:

> "Doing DEI in an organisation that, say, works in the UK when all of your staff are UK residents, that's very different from having discussion on DEI and racism within an international organisation that has not only 25 different offices but also thousands of staff employed in over 70 different locations. Then it becomes so much more complicated, and everything could be tied to DEI."

From this perspective, some of the concerns already raised (such as exclusionary professional expectations, culturally specific conceptions of care, or inequitable access to support) could be considered within the remit of DEI.

Almost everyone we spoke to – in every setting, at every level, and in all types of roles – rejected the idea that 'DEI' can be universally applied, offering critiques of Western ethnocentric and top-down approaches. Yet locally recruited staff, in particular, emphasised the risk, in practice, of DEI becoming another concept imposed from elsewhere. In the words of one local programme manager: "We have to be careful about this, because it can be frustrating for locals who feel that we [MSF] want to impose international beliefs and trends locally." In DRC, for example, sexuality was raised in relation to the notion of imposition of outside norms:

> "I can give the example of homosexuality here. It is a complicated matter to deal with on a local level. And such matters can make locals think that we are trying to introduce these trends and cultures. This can create problems. These are things we should look into to evaluate where resistance will be. What are the sensitive topics, and how should we frame them?"

For some locally recruited staff, there was a concern not simply about the values being imposed, but also the categories according to which these values are structured. Congolese employees described disconnects between the framing of DEI, and questions of equality and difference specific to eastern DRC. One person said:

> "DEI should definitely be adapted to the environment and the context. For example, if we are talking about diversity and inclusion in regards to the Congolese, are they selecting a specific category of people and tribes? Are we ready to deal with that by establishing quotas? MSF should think of this when launching projects, and structure strategies and mechanisms in a way that it doesn't create additional difficulties."

Conversely, there was also concern that DEI in 'the field' was focused on real (or imagined) divisions among locally recruited staff based on ethnic categories, rather than structural inequalities within the organisation itself. Such questioning contributes to concerns about the level of institutional commitment to change, discussed below.

Another staff member, based in Amsterdam, argued that the prevailing way of talking about the institution is "too much European and North American driven" and revealed disconnects between headquarters and countries of operation:

> "If I just look at how much attention, it's what I call the flavour of the day, and mainly in headquarters, we go from MeToo to Black Lives Matter, to institutional racism and so, and then it's almost like if there's a new thing, a new flavour of the day, that we forget the other one. It's all the discussions are focused around headquarters and people in headquarters and their opinions about what is happening in the fields, without otherwise having much clue over what is really going on."

Disconnects between implementation of DEI in different parts of MSF and OCA can be profound. Thus, while some interviewees expressed frustration at DEI being treated as another universal framework, imposed from headquarters, others criticised what they saw as a failure to stand up for these very same values. This dynamic was vividly captured by comments related to a campaign for inclusive toilets at the Amsterdam office, presented as a motion in the association's General Assembly. This episode was cited as an example of the privilege of headquarters staff: "Of course, there will be people sitting in the Netherlands, that's the amount of problem they have, they don't have a gender-neutral toilet in the office." According to the interviewee who raised this concern, the "two hours of debate and discussion" on the Amsterdam toilets during the General Assembly marginalised association members from other countries and reflected the structural issues that prevented them from putting issues on the agenda. From the perspective of Amsterdam-based staff members who supported the motion, however, this was described as an issue of inclusion and accountability. For example, one interviewee expressed frustration that, after the refurbishment of the building and an associated consultation process, "the redesign was finalised, and there was no gender-neutral toilet, and there were only three accessible toilets for a six-floor building." Using the associative route allowed staff to express their support for what they saw as a commitment to inclusion, setting "an example to the rest of MSF," and to "future-proof" the building by making it welcoming for all.

Reckoning with the tensions produced by encounters between MSF's values and principles, often assumed to be universal, and different norms, cultures and value systems is complex. While the imposition of outside norms poses problems, so too does the prospect of reinforcing inequalities. The dynamics perceived to be influenced by Western ethnocentrism are also multiple, and responses to them could therefore take a variety of forms. Employees' observations then inform their readings of the institution, so that different perspectives on perceived ethnocentric biases in the treatment of staff, whether in terms of care or discipline, may result in diagnoses of the institution as (among other things) hypocritical, uncaring, indecisive, inconsistent, insensitive, or overbearing. As the following sections explain, interviewees expressed doubt about the potential for these challenges to be addressed.

8.3 Lack of vision for change

Another prominent line of argument among interviewees was that MSF struggles with large scale visions for change. This argument was made regularly in relation to the movement's relationship with political issues and frequently in relation to internal dynamics. This implicates MSF's emergency culture: as Chapter 3 described, MSF's focus is on the immediate, urgent problem at hand. Restoring 'normality' has generally been seen as the priority, rather than long-term structural issues, but whether this constitutes a sufficient political vision is disputed. This means that for some, critiques are not simply incorrect but entirely misplaced – MSF, by this counter-argument, has reached its current status not by shying away from vision but by defending and expanding its original goals. Like other debates, therefore, discourses around 'vision' also reflect MSF's scale and the disconnects that come with being such a large and dispersed movement. Put simply, with many people come many opinions – in MSF's case, most of them strongly held.

So, how good is MSF at thinking big? Some senior figures argue that its ability is limited. One argued that the movement has "trouble formulating coherent positions on big issues of our time, on migration, climate change, populism, all of the political changes that are going on, and how to operate within these big changes that are happening." For instance, on climate change, another interviewee said, "a mountain went into labour and gave birth to a mouse":

> "Instead of saying, 'What sort of MSF will be able to address, not 70 million displaced people but potentially 500 million displaced people, in 20 years? How should we look like, where should we exist, to be relevant in 20 years?' the question becomes, the evolutionary question becomes, 'How do we reduce our footprint?' And even that we cannot agree on."

The Access Campaign is sometimes seen as an exception to a culture of short-termism, although it may today be better considered symptomatic of the challenges. The Campaign for Access to Essential Medicines launched in 1999 to advocate for the development of new drugs and improved access to treatment, identifying ways to fill gaps in access to medical products and seeking to "humanize" relevant intellectual property rules (see Binet and Saulnier, 2019, pp. 201-02). That year, MSF received the Nobel Peace Prize, investing the money in this new policy advocacy unit, with then International President James Orbinski declaring in his speech: "What we as a civil society movement demand is change, not charity." The Access Campaign website uses this quote at the top of its 'about us' page, emphasising its ambitions for political impact. However, only a couple of sentences earlier, Orbinski (1999) had said: "If civil society identifies a problem, it is not theirs to provide a solution," delineating the limits of that ambition.

This tension continues to shape attitudes towards the Access Campaign today, which has been the subject of a difficult internal discussion. Weighing the potential gains or losses of campaigns on root causes is daunting. Reflecting on the need to reassess, one interviewee said:

> "We may have been able to shift the needle on certain things, but the forest continues to burn [...]. So, in this new landscape, where there's been a pandemic, certain things have come to light, and all of that, what is our new political analysis? And what are the structural barriers we want to tackle, and what is the new Access project? We don't have that analysis."

There are other examples of sustained campaigns that seek to go beyond emergency response. The Drugs for Neglected Diseases initiative, for instance, dates from the same era as the Access Campaign (indeed, it also benefited from the Nobel Prize award). As an example of a vertical initiative, OCA has been driving MSF's campaign for greater recognition and improved treatments for noma, for which it runs a specialised hospital in northern Nigeria. Despite the life-changing impacts of the hospital's work for survivors, staff members recognise the limits of the emergency response approach. A nurse working in the hospital wrote:

> "Right now, MSF is trying to go into preventative mode. It's very challenging, because how do you prevent noma? One of the contributing factors is poverty. How do you alleviate poverty? Can MSF do that singlehandedly? No. That is why the world needs to join in." (Emeh, 2021)

An application to the World Health Organization to have noma placed on the list of neglected tropical diseases is part of the campaign to bring 'the world' in. To further this goal, OCA staff members have contributed research to help improve awareness and understanding of the disease (e.g., Farley et al, 2020a and 2020b), supported the production of a documentary about noma by an external team, and publicised the existence of noma in mass media (Johnson, 2021).

Despite these examples, discourses critiquing the organisation's ability to formulate political positions take a range of forms. Some highlighted the limits of MSF's role in sounding an alarm, a lack of appetite to engage with providing solutions that reflects the organisation's emergency response culture. Limiting itself to an emergency lens, we heard, means that MSF "can tell you the story of what we're seeing" but when asked what should be done about it "there is no answer because we're not stepping into that." Or, as another said: "all we do is tell the world again how shit everything is, and we're not mature enough to actually start putting solutions on the table."

This idea was raised as compromising MSF's ability to influence others to take action, although it is also an important part of the moral underpinning of the concept of *témoignage*. The relationship between advocacy and *témoignage* is complex, especially as people may hold various working definitions of these terms. Nonetheless, to the extent that *témoignage* can take the form of "the *cri du coeur,* a moral outrage being expressed" (Gorin, Guevara and Du Bois, 2021, p. 29), it does not require the act of speaking out to include a prescription on what should be done. This is not the case for advocacy, which as a contemporary practice is generally considered to require a defined end goal and a 'theory of change' indicating how to influence other actors to act.

Disconnects created by the movement's size were also cited as a key factor limiting politically informed visions of MSF's potential roles or actions. The institution's growth has brought "splintering and atomisation" as well as bureaucratisation. An institutional culture that emphasises debate and participation – even if these are in practice limited by power dynamics and inequities – also contributes. "We are a consensus-based organisation, at the bigger scale of our governance, which comes with its own limitation." This means that, when parts of MSF do seek to push for a particular vision, action, or proposed solution, it is "watered down" (in the words of an interviewee with experience of international collaboration) due to the need to find agreement across a complex and competing set of actors. Protection and advocacy expert Arjun Claire (2021, p. 51) has argued that "speaking out for MSF has also carried moral significance, where remaining silent in front of grave human rights violations was seen as an act of complicity." This means that arguments over what position to take can easily shift from a tactical register to a moral one, increasing the potential for internal confrontations.

However, the challenges are not just about sheer size – they also reflect differences of opinion and perspective on fundamental issues facing MSF. For some, the focus on emergency programming (at least in principle) remained the defining characteristic of the organisation: "Our task is bringing back the normal for the most vulnerable groups." This is, in itself, a vision of refusal of the suffering of others and a vision for MSF's place in the world (Davey, 2015). For others, questions such as 'Where do we see ourselves? What is our social mission?' are more open for discussion:

> "Are we simply just a healthcare provider in humanitarian settings? Or given the size that we are, given the influence that we have in the world, do we have an obligation, [...] is there a role that we play as an influencer in, for example, what the global systems [are] that have that negative impact on the work that we do and in the countries that we work in?"

The tensions between these two positions go to whether MSF's identity and role are fixed or – as the logic of the associative structures would suggest – have the potential to evolve.

The idea of a lack of vision was a prominent theme in the discussion of how OCA and MSF approach efforts to address discrimination and inequalities. Indeed, these efforts are often formulated as a reaction: as a desire to "tackle institutional racism," for example. OCA personnel spoke in a range of ways about this vision gap. One observed there was no "lighthouse on the horizon" for institutional change efforts, without which the movement is left "drifting in all kinds of different directions" and individuals faced with a given action "sense that it might be the right thing to do, but they don't really have a frame for why we are doing that." As if to illustrate their point, an OCA employee posed the question: "The end goal is often we want to be a diverse and inclusive organisation but then what does that mean?" OCA does have a "staff vision," however no interviewees referred to this document.

Some interviewees at headquarters level – particularly those with extensive or high-level experience – expressed beliefs that such ambitious changes to the way MSF works were difficult, or undesirable, or both. Discourses about whether the institution or its top leadership are able to change are thus entangled with discourses about whether they are willing to do so.

8.4 Lack of appetite for change

The idea that MSF lacks appetite for change is closely related to claims that it lacks vision, but distinguishing these two narratives allows a clearer view on the extent to which a lack of trust of high-level leadership is shaping current discourse. Compared to the vision narrative, the views about appetite for change are less likely to speak of 'culture' and more likely to speak of 'leadership' or 'management,' Although, as seen especially in Chapters 6 and 7, interviews captured a general lack of confidence in those 'higher up,' the critiques under consideration in this chapter reflect a very strongly held view that those in perceived positions of power, whether formal or informal, want to maintain their dominance. The lack of appetite for change therefore relates specifically to change that would address internal inequities and injustices. Given that DEI is the dominant frame through which issues around power and inequalities are approached, this was the topic that most often provoked such reflections. Throughout the organisation, staff members are drawing their own conclusions based on what they see as a gap between rhetoric and practice. In the words of a locally recruited staff member in Nigeria: "We are discussing it at the top, HQ. All the HQ are discussing it. Why is the real implementation not in the place?"

During interviews for this study, staff with a range of perspectives portrayed the organisation as being unable to face fundamental and structural reforms. One person who argued that MSF's organisational culture was ill-equipped for difficult, ethical and strategic discussions gave the example of conversations about how operational teams might be composed to illustrate the reticence. Another gave the example of resistance to moving the bulk of Human Resources structures from headquarters offices to countries of operation, despite the fact that the latter are where the majority of personnel are from and are based. Similar dynamics were raised when interviewees spoke about disability inclusion. Locally recruited personnel in multiple sites were critical of perceived inaction from headquarters. For instance, one locally recruited employee said that in 12 years with MSF, with different OCs and despite seeing different "missions" and attending international trainings: "I have never seen an employee with a disability. Are you trying to say that a person living with disability is not capable of working with MSF?" This may not reflect an unqualified reality but captures the perception of exclusion and lip service. Employees in multiple countries expressed frustration at inaction from the executive despite associative engagement. One summed up:

> "We discussed that aspect in particular at the international level of MSF, we even voted on motions stating that MSF has to include people living with handicaps. But when is that going to be applied? That's the problem of that DEI."

Arguments that the institution was avoiding structural or more complex issues often underpinned claims that there was no appetite for change. For example, Congolese employees described how English language requirements remained a barrier in OCA. In describing their attempt to apply for a senior position, one employee explained:

> "Weirdly, in the written test, there were questions in English and questions in French. So, for us who are weak in English, the questions in English had to be left out, and we did not even make it on the list of people who were getting an interview. When I spoke to a colleague who had the chance to get an interview, he told me the interview was entirely in English. So, I told him it was going to be tough, if that is how DEI is implemented. Because these obstacles are set up by the same people at the headquarters who are pretending to be implementing this DEI in the missions. They are the ones setting up these obstacles. What kind of DEI is it if you are still blocking out people because of language? What type of DEI is that?"

There was a sense that change needed to begin higher up. "I am telling you that the headquarters are a part of the problem when it comes to the DEI because they do not want to change. They want the change, but they do not want to change themselves," a locally recruited employee concluded.

Supporting staff with issues related to sexual orientation and gender identity was another area raised. Recognition that in some countries where humanitarian organisations operate, homosexuality is either taboo or criminalised, has contributed to something of a 'don't-ask-don't-tell' culture in the sector. Within OCA, a study found that lesbian and gay staff members managed information about their sexual orientation differently in headquarters and on assignments, and that organisational support for staff navigating such choices was limited (Rengers et al, 2019). One interviewee said that "sometimes we find a more conservative approach in headquarters, more than in the field," based on the "patronising" idea that "we have to protect them [programme sites] from something that apparently is too crazy as an idea that there can be LGBTQ people in the field, or beneficiaries, or the local population." In their view, the claim that it was necessary to "prioritise" certain issues over others was a cover for an unwillingness to tackle a subject that, as already described above, raises issues of ethnocentrism and can have implications for acceptance and access – even though it is also important for the inclusion of different groups within communities. They concluded: "I don't feel that it is authentic. Or you take diversity or you don't take it, but don't pick and choose."

Finally, interviewees raised the exclusion of locally recruited staff from senior positions in their country of origin (see Chapter 5). Institutional responses to this issue illustrate the challenges of undertaking reforms that will have direct operational consequences across such a large and diverse movement. Although there have been some changes, in the past approaches have focused on diversifying access to international contracts. Mobility offers opportunities for development and ultimately progression through the organisation, and the rising proportion of internationally mobile staff from the Global South was repeatedly cited during interviews as a sign of increasing inclusion. However, while greater access to mobility may improve the outlook for individual employees, it does not address systemic issues at the collective level for locally recruited staff, nor does it move locally recruited staff into positions of power and seniority within MSF. Indeed, the limits of expatriation as a form of career progression were already recognised at the time of La Mancha, with a review noting that "expatriation has been, for many national staff, the only way of participating to MSF's decision-making" even though "expatriation of national staff does not contribute *stricto sensu* to the access of national staff to positions of responsibilities with MSF" (Dollé, 2006, p. 68). As Chapters 3 and 4 described, MSF's form of emergency intervention is built upon a two-tier system in which foreign decision-makers intervene quickly and pick the people they consider best to do the work they have set out to do. As a result, tackling these issues means questioning what one interviewee summarised as an operational model and culture based on "making decisions on behalf of people, about their own lives." Many staff expressed doubt about the willingness and ability to question the model.

Interestingly, the sheer volume of initiatives has not convinced sceptical staff members that leaders of the institution are committed to change, even less that they are able to achieve it. At the time this study was conducted, there were numerous large institutional efforts active: the 'MSF We Want to Be' conversation, for example, intended to enable collective reflection on how the movement should evolve; a 'Rewards Review' examining remuneration; a review of representation in the International General Assembly; and an entire funding scheme known as the Transformative Investment Capacity (TIC), which funds projects across the movement to "bring forward new ideas that can change how we work to better meet the evolving needs of our patients."[13] Yet there are also criticisms of these processes and impatience with their pace and, at least for some employees, a sense that ambition was lacking. One interviewee argued:

> "The two horrifyingly bad metaphors that are used regularly are: 'MSF is an oil tanker not a boat and turning takes time,' and, 'don't throw the baby out with the bath water.' Those are, sort of, in my mind, emblematic of the stagnation, of the justification of the position as it is."

13 https://msf-transformation.org/

Some of these concerns are held by people in leadership positions. Senior managers in OCA as well as in other parts of MSF criticised how DEI had been ringfenced as an 'HR issue,' avoiding a more fundamental self-questioning about the organisation's ways of working. Yet there were concerns from others that DEI was increasingly becoming a comfortable frame for the organisation specifically because it was not equipped, as one former employee argued, to "really address those fundamental criticisms." They said:

> "It can very easily just be reduced to: 'We need to diversify the workforce' and 'we need to make sure that people don't experience discrimination in the workplace.' All of which are absolutely important things, but they don't actually necessarily require that you disrupt systems of power and influence."

One experienced MSFer said that "let's do DEI" had become the response to two problems of MSF: "discrimination, racism, gender inequality and so on in the organisation," and "how MSF as an organisation acts upon people it serves," and concluded: "this is not going to be solved by diversity and inclusion."

The institutionalisation of DEI efforts has been criticised for its lack of radical ambitions and its failings to shift power substantially within the organisation (see also Hirsch, 2021a). Without those shifts, movement-wide DEI efforts risk becoming little more than window-dressing: a way of affirming an organisation's willingness to tackle inequalities without redistributing power and responsibility. Given MSF's structural divide between headquarters and 'the field', institutional narratives about DEI and in particular their focus on cultural norms seem to increasingly be drawing attention away from MSF's centres of power. MSF is not the only organisation facing such critiques, nor is it the only movement in which considerable investments in DEI coexist peacefully with a deep-seated desire to maintain the status quo – to the detriment of the global majority.

Staff throughout OCA therefore questioned the sincerity of the stated commitment to addressing injustices perpetrated within and by MSF. Depending on the speaker's position, this could reflect their perceptions of attitudes in headquarters generally or their impressions of senior management, or both. Many people who had been involved in grassroots efforts within OCA described a feeling of being held at a distance or kept out of discussions since the reinforcement of formal DEI structures. A former board member pointed to the lack of attention to the impact of activities, leading to the conclusion that activities were "just to show that we reacted." These perspectives echo Sara Ahmed's argument that institutional DEI commitments are not designed to address deep-seated inequalities, and do not commit the institution to doing anything. Instead, making commitments or naming the problem comes to stand in for action: "as a result, naming can be a way of not bringing something into effect" (Ahmed, 2012, p. 117). At the same time, the existence of these institutional mechanisms insures the organisation against accusations of inaction, and allows them to ignore complaints brought forward through other pathways. An Operations colleague said:

> "There are countless examples like this one, where we have expressed an intention but we cannot seem to cut the Gordian knot of our own rules and regulations. As a consequence, little of substance appears to be happening while I know for a fact that there is genuine intention […]. But the inability to cut through the bullshit means not enough is moving, not enough is being felt by staff in field positions and […] disbelief at the intentions is starting to emerge. Because of course people doubt – how hard can it be to just allow somebody to just do a job they are qualified for in their own country? And apparently it's really hard."

In sum, frustration and mistrust reflect a view that DEI risks oiling the system, rather than changing it – and a view that these are two different things. "I don't think we need a more palatable version of the status quo," one interviewee said, arguing that DEI was "being co-opted and instrumentalised to serve the exact opposite of its announced purpose." This affects the dynamics within which leadership must act. One member of the Operations Department said: "I agree with the problem, I disagree in how we address it" and argued that Operations had actually "done more things to remove some of these barriers" than official DEI initiatives. Another person said that they felt "sceptical" because "I don't see much action. I see a lot of doc[ument]s, but what does it mean?" The dominance of this discourse is a source of concern to some who have taken part in or witnessed efforts to introduce change:

> "I think it would be really unfair for some people to say, 'Okay, nothing is happening.' And that's what I hear now, a lot. And I'm tired of that discourse that nothing is changing, nothing is happening, it's the same status quo […] it's not true."

In the end, "people get disenfranchised," a programme colleague noted, and withdraw their participation from surveys, consultations, and research.

Nonetheless, notwithstanding critiques of insufficient actions at both OCA and intersectional or international level, it is not clear that a more imposing approach by senior leaders would be acceptable to staff. As the examples above and in the previous chapter show, there are widely ranging views about the types of leadership action that are acceptable and about the legitimacy of current officeholders. 'Debate' and participation are valued – even if they are not inclusive or equitable – in part because of MSF's associative make-up. One-size-fits-all approaches hold little appeal and opposition to anything that presents as 'bureaucratic' can also be strong. One of the results of all this is that staff take action of their own.

8.5 Action-oriented

As outlined in Chapter 3, individual initiative is an important part of MSF's identity, and this places value on a history of charismatic leaders who have challenged the organisation – and the humanitarian sector – to do ever better. People speak of MSF as 'personality-driven' or 'person-driven.' This appreciation of individuals who drive change is an important exception to critiques of leadership, though people need not be in positions of formal power to be perceived as leaders in this sense. The emphasis on individual initiative underpins the idea that "you need people who've got the conviction and passion to just really keep pushing on a topic." Interviewees described an organisational culture that is strong on reaction or improvisation, but weak on approaching structural issues. In this action-oriented organisational culture, people develop their own strategies and tactics for driving forward the issues that they see as important.

The power of initiative is reflected in some of MSF's formal structures and spaces as well as how staff approach their work. MSF's associative structures are intended to encourage this way of thinking and provide a forum for members' initiatives and agendas (see Chapters 3 and 5). The power of initiative has also been reinforced institutionally through mechanisms like the Transformative Investment Capacity scheme. Outside these institutionally sanctioned formats, too, ideas lead to new actions. Interviewees described a culture of developing workarounds, helping people working 'towards' their goals. One person commented: "When you hit roadblocks and obstacles, the easiest strategy – and maybe not only in MSF, because we see it in the sector – is to make and dig your own silo." Another member of staff involved in collaborations across the movement explained how they looked for "people of goodwill, people who want to do things, people that are interested, people who understand the issue."

However, the flourishing of ideas and actions appear to be also adding to a feeling of being overwhelmed and a sense of a lack of discipline. Day-to-day, the institution generates a large workload for its personnel. OCA programme staff described an "unrealistic" succession of agendas that inflate their workload:

> "Things are very *ad hoc* and very piecemeal and quite unstructured. [...] At one point it's patient-centred care, at another point it's employee engagement, at another point it's the climate, and so things are trendy and then, for that trend and that hype, we do a lot of talk [...] but when it comes to […] structured implementation, we lack that a lot."

Another said that "OCA is very good organisationally at putting ourselves in an in-between position that dooms us to fail." They described a pattern as follows: "We pick a priority, we agree it's a priority, and it requires support to put in place." Confronted with the costs of doing this comprehensively – hiring new implementers and trainers, updating all training courses, continuing training and socialisation process for years, and so on – the choice is made to instead hire a small number of advisors. The idea is that "people in projects can reach out to them through their line manager, through their Head of Mission or LogCo, their MedCo" – note the involvement of the filtering positions (see Chapter 6) – but "nobody calls, nobody goes to seek out that assistance because they're too busy, because they're slapped in the face every day with work [...] And so they cannot prioritise that priority because when everything's an emergency nothing's an emergency." The entire model of decision making, which concentrates power acutely in some areas and requires others to exert influence, is implicated in this critique, as well as the way that resources are allocated.

Parallel commentaries were made at movement level. With the emphasis on problem-solving, one person who had been involved in multiple high-level initiatives said: "it all gets started and loads of people working on loads of different stuff and then it quite often stalls because there's not enough political will to push it forward because there's too much happening." Such accounts dovetail with a recent movement-wide analysis that was critical of "the duplication of functions and projects, the permanent expansion of existing units, and the permanent addition of new initiatives without any counter-balancing closures" at headquarters level, noting that on the one hand, "it is hard to believe that they all systematically deliver their promises and must be maintained forever" and on the other "very few projects we manage reach their goals and eventually close" (Levery, 2019, p. 5).

These dynamics are visible in how staff members spoke about workplace injustices. An employee in one of OCA's partner sections commented that "there are a lot of measures" but "I don't know if you can call it a strategy" (a similar analysis is given in Schenkenberg van Mierop and Harvey-Dehaye, 2020). In recognition of the difficulty of addressing structural issues, several interviewees referred to the possibility of "quick fixes", "quick wins" or "low-hanging fruit" in relation to inequalities within the movement. This appeared to be another reflection of emergency culture. While they did not always believe that these opportunities had been taken – indeed, they were frequently critical of what they saw as failures to act on them – there was a sense that quick wins existed and could be contrasted with more challenging structural issues. In contrast with the issues described in the previous section, certain problems were considered to be in a "comfort zone" of being easily identifiable or approachable as technical or *ad hoc* adjustments, such as "revisiting our duty of care, our existing internal regulations and HR policies and procedures based off of how the context has shifted." In contrast, others criticised the "quick wins" mentality as a sign of a bureaucratic organisation that, instead of allowing DEI to meaningfully confront major issues, dragged it into "the big machine of MSF" and a "conservative approach." Yet others questioned whether "quick wins" exist at all.

Staff perceptions of blockages and an emphasis on the power of initiative encourage the proliferation of actions. In OCA, for example, the Kaleidoscope Network and the Rainbow Network were both formed by small groups of staff members based in the Amsterdam office. Staff members involved in these groups described feeling like it was necessary to "take matters into our own hands" as a response to perceptions of "absolutely nothing happening on the part of the [Management Team] whatsoever." They emphasised a desire for impact: "We don't want to be another guideline or paper or DEI discussion or committee, we want to provoke change in the organisation in a very practical way," with ambitions that go beyond their immediate area of work: "We wanted to be something that worked for the improvement of MSF, overall." These can contribute to positive steps, but also risk increasing the burden on individual staff in an already demanding workplace.

The creation of the Decolonise MSF group arguably also reflects the power of initiative in MSF, operating both within and outside the movement. Decolonise MSF, which exists as a WhatsApp group with some 1,300 members and on Facebook, offers something that institutional forums do not. One internationally mobile staff member described the importance of encountering Decolonise MSF after the destabilising impacts of what they described as "apartheid" structures in their first two assignments with MSF. Previously questioning whether they had been "too emotional," they described the feeling of relief when "I understood by reading the testimonies of others that I was not crazy. […] I finally understood that these things are repeating again and again with the same pattern." When asked what engagement with the group offered, another said:

> "I think I was feeling really frustrated and angry about a lot of the power structures that I was seeing in MSF and a lot of the internal racism and this colonialist divide between ex-pats and national staff […] I was looking for an outlet to share my frustrations and also hear from others to try to see if there were places that we could be useful to try to push for a little bit of change."

A former OCA board member summarised this as a "group of people that just don't feel seen, don't feel heard, don't feel included."

Yet, although its creation reflects disconnects between staff members and perceived institutional positions about necessary change, Decolonise MSF is not exempt from disconnects of its own. Decolonise MSF also faces challenges due to the range of different opinions it accommodates, from people "openly venting about MSF" to those "who are not necessarily there because they believe in the group, but they're there to watch what's happening." More broadly, there remains a lack of consensus about what 'decolonising' means, with growing concern in the humanitarian sector that it has become a metaphor, another "comfortable buzzword" for Northern actors and institutions (Tuck and Yang, 2012; Khan et al., 2021; James, 2022). As a result, in MSF, Decolonise MSF has sparked a conversation in the organisation about what structural change is possible, while still remaining 'MSF.' In short, what would 'decolonising' MSF look like in practice? Is 'decolonising' through reform possible, or would this require disbanding the organisation altogether? One person who had signed the 2020 open letter, for instance, now described the group as "not helpful", "populistic" and "just trying to pull down MSF." Another employee reacted to arguments within the group:

> "What you're describing isn't MSF. What you want is a new organisation. To enact the changes that you want would destroy MSF as it currently exists, which is fine. Then don't work for MSF, or work really hard to change it."

This situation can also create cognitive dissonance: one Decolonise MSF member said that, if the institution is opposed to radical change and even hostile to those who call for it, "you wonder if you are not a hypocrite for wanting to continue to work with MSF."

Conclusion

Throughout this study, power and inequality have been conceptualised differently in different places. This reflects both scale and diversity: with multiple generations and different political, social and professional cultures coexisting, MSF – like other humanitarian organisations – accommodates a wide range of views about its own role and purpose. Despite the imagined universality of the MSF movement, there are fundamental disconnects in how its concepts, ideas and policies are understood and experienced. Many staff members have their own interpretation of what these disconnects reveal about the institution or those at its helm.

While criticism dominated the views shared for this study, there were also some cautious, qualified observations that expressed hope for the prospects of improvement. A reflection from a former Head of Mission is worth quoting at length for how it captured the prevailing tone of self-criticism, directed towards the institution as well as the positionality of individuals, and for how it articulated the major change that the apparently small demand of being 'decent' requires. They said:

> "I think perhaps where OCA is in a positive sense is that improving our internal culture and being more decent isn't now seen as a tick-box activity. Decent, that makes it sound like something we should be doing, you know what I mean. And again, it's easy because I've always been the privileged person in the room that I can just say: 'Yes, sure we should just be doing it this way, come on guys, let's go.' [...] There is not a hope in hell that I would have reached where I am now in this organisation if I didn't come from the background that I do, if I didn't look the way I do, and if I hadn't had the opportunity, before MSF, right? With the opportunity of having a very comfortable childhood, good access to education, and not worrying about anything. And then add to that how I'm perceived and trusted as an authority, [without that] I wouldn't have ended up here. So, it's easy for me to say it's just about decency, it's clearly about much more than that, but I think at least where we are inside OCA is that increasingly people, and people who need to be party to changes, recognised that these are not tick-box activities, that these are actually integral to our ways of working and are directly aligned with our principles. It's just that we've always looked at those principles as being things we'd apply to other groups of people rather than to embody internally. I think we're getting through that."

If there is indeed a shift underway, or momentum building, efforts to foster it will need to confront not only the practical obstacles to structural change but also institutional and attitudinal ones. This includes the narratives according to which people understand MSF and the forces that shape its practices. These narratives play into internal power dynamics, favouring certain positions and discouraging others. They are constitutive of the environment within which MSF employees and leaders make choices and shape the relationships between different groups within the organisation.

The different diagnostic discourses outlined in this chapter may be persuasive to staff and others familiar with MSF, or they may meet with doubt. Some may align closely with individuals' experiences of working for MSF on particular activities or campaigns; others may appear more like received truths, myths, or generalisations. Some views may be held strongly in certain circles and not represented among others. They may or may not reflect official positions. But all are circulating amongst MSF and to at least some degree among OCA staff. They are important to recognise and heed, both as insights into the evolution of MSF to date and as influences upon its future.

Chapter 9. Conclusion

Throughout our conversations for this research, we heard repeated concerns about documents that lead nowhere in MSF. Several interviewees spoke of their experience of writing and sharing reports only for them to be ignored. For example, one employee early in their MSF career, deeply troubled by what they had witnessed on assignments, said: "I wrote a 20-page report with all the details of everything I observed, and I was expecting that in my debriefing we'd have a detailed discussion on this, and nobody even cared." Few among the group, they concluded, had even looked at it. Another employee with decades of experience in MSF, whose reports were addressed to the highest level of the movement's leadership, was equally deflated: "I had another shot at passing the same messages and it still goes nowhere. It goes nowhere."

We heard about agreements that do not change behaviours, studies that do not produce results, 'lessons' that are not 'learned', reports that 'sit on a shelf.' Indeed, these documents are part of the proliferation of initiatives aimed at some degree of 'improvement,' that do not lead to change. There were concerns that this research would join them.

Some interviewees linked this phenomenon to emergency culture, in which "people are not readers. If you bring a 50-pages document you have very, very few chances that anyone would read it." One even considered MSF to be an "anti-intellectual setting" in which there is "the thinkers and the doers duality, and you are MSF if you are the doer kind." Others suggested this was linked to limits in the ability or willingness to make use of analysis or critique. Criticism then becomes "a masking agent." One person said:

> "At the moment in MSF we are in a stage where we are good, that once we see a lesson-learned document, we rather praise ourselves to say, 'Hey, we are open enough to do research and identify our weaknesses,' and we accept our mistakes. The problem is it only stays or reaches that level."

Another felt the attitude was: "We have to listen to it; we don't have to do anything with it." Ultimately, these testimonies challenge whether the ways in which MSF cares about the realities of a majority of its employees is beyond what is stipulated by the contractual obligations in HR policies.

In this environment, some people seized the opportunity to speak up about their experiences. One locally recruited employee affirmed: “These are the concerns of many staff members here. Sadly, not everybody dares to say it.” Because of this, many locally recruited interviewees working in MSF projects actually wanted their views, and indeed their names, communicated as part of the study: “Tell them I said this. Write that, don’t worry. Be clear, do not hesitate, write my name, I don’t mind. I like change, and it matters to me that our headquarters OCA make changes.” For researchers who collect such testimonies, there is a question of responsibility. As one person who had conducted research in MSF said, after describing a defensive management reaction to the critical conclusions they developed in collaboration with a diverse group of staff: “I wasted these people’s time and it means so much to them to have their voices in that, and I wasted their time.”

This study has focused attention not simply on the challenges that OCA, MSF, and their staff face, but on the power dynamics that shape how they approach these challenges.

Approaching change

OCA employees shared great concern about how to make meaningful change that was not simply tokenism, or artificial. On the one hand, initiatives that focus on attitudes, discrimination and bias, were considered artificial, because they did not make the necessary structural changes. Here again a tension between thinking and action emerged: “Sometimes you get tired, so many guidelines, so many papers and so many analyses. I say, ‘Guys, great, but can we move on in the practicalities?’” A different person asked: “even if you are debating things, how much does it really change?” Taking the example of recent DEI and anti-racism debates in OCA, they described the fundamental structural inequities that remained in place: “We are just good at talking, talking, talking about it without any proper action.” This was also seen as a top-down dynamic: “We saw a lot of changes at HQ level, but where it actually happens, all the work with the patients and beneficiaries, people barely even know about these kinds of topics that got debated.”

On the other hand, there was concern about how even reform efforts aimed at more structural change still did not address underlying power hierarchies. For instance, former locally hired staff in coordination posts for the first time described how even though they had the same “responsibilities” they “still don’t have the same level of trust” as international colleagues. Instead, this nationalisation was described as “just for appearances.” More broadly, there were concerns that the current debate was too inward looking or narrow, missing the opportunity to question the paternalistic interventionism of MSF: “Many of us say that we don’t have a voice. Just imagine the ones who we engage, serve, treat. If we say we don’t have voice, what do they have? They’re the last in the rank. They’re voiceless.”

Clearly, informal and formal inequalities are interconnected and interact in complex ways; they cannot be addressed separately. For instance, efforts to combat racism also need to be accompanied by structural change that enables more people of colour to occupy positions of influence and shift the organisational culture from one centred around whiteness to one representative of the diverse range of staff who make up MSF. At the same time, as the experience of locally recruited coordinators shows, merely changing who occupies different posts does not solve inequalities between different staff when the attitudes and prejudices that underpinned and justified their prior exclusion in unequal structures remain. Instead, this research illustrates how informal power dynamics justify formal structures of inequality, and how an organisation still structured by such stark structural power inequalities reproduces racist and discriminatory tropes and imaginaries which continue to exclude certain people.

Overall, many people in OCA expressed a desire for discussions around inequality, change and reform to be explicitly reoriented towards fundamental self-questioning of the organisation's work, and the inherent hierarchies and exercise of power this involved. In effect, they were frustrated at the idea of a zero-sum game: how DEI had become pitted against operations, when discussions about power hierarchy were inseparable from MSF's operational work. As one interviewee summarised in relation to existing debates around anti-racism and DEI:

> "The topics are seen as too associated with HR. I struggle, even in a space with activists like Decolonise MSF, I struggle a lot on bringing it back to the operations and problematising ourselves […] I think it's because it's so deeply uncomfortable, even for people who are allies on the topic, to really recognise the harm we may be doing, and letting go of the successes and joys we felt in our time, even if there were good things. It's hard for everybody, and that's even among people already more bent towards the cause."

One employee said that "patients, communities, our staff" in countries of operation are "really doing all the difficult work. These people are there – if they weren't, MSF wouldn't exist […] and we don't listen to them most of the time." To meaningfully change MSF's work, this interviewee suggested that the shift needed to be epistemic as well as structural. This would require not just diversifying who carries out MSF's work, but also giving people the power to shape and conceptualise what it is fundamentally about. How inequalities in MSF are conceptualised and spoken about is as important as whether they are a topic of debate. A lot of personal pain can hide behind terms such as 'power hierarchies' or 'structural inequalities.' It is up to those in power to be vulnerable enough to recognise this and act on it. Another employee put this in terms of "who formulates the narrative," arguing that if you "claim to want to be diverse, then you have to be open to the idea that expressions will come in many different ways, a lot of it not acceptable to you, but you have to sit and listen." When discussing patients, communities, and staff across the world, the previous colleague concluded:

> "The way they see the world, the vision of the world, is not the same, and it shouldn't be. And we are not really integrating this element in our daily basis activities. This is DEI to me. Not having a big mission with people from 30 countries. That can be great, and for sure you'll have more interesting and fruitful discussions, and more creative solutions in that specific mission. But when you have locally hired staff with an amount of information and richness that are not enjoyed and integrated, you are missing a lot. So, DEI is not necessarily about the principles, it's a way of how to respect people, of how to really share power with them."

What happens now, and how reform efforts move forward, remains to be seen.

Love and dismay

What appears more certain is that people in the 'MSF family' will continue to try. Throughout the study, people we spoke to – whether they still worked with MSF, or not – expressed strong attachment to the institution. There were genuine stories of social mobility and lives changed, such as one locally recruited employee who had started as a daily worker and is now in one of the most senior programme positions, whose "love" of the organisation came not just from the work, but "because I was able to grow." "We never say, 'It's perfect'," another employee said. "Of course, there are things to do, but I think at the end of the day, we know that MSF is good."

Strikingly, affirmations of love and loyalty often came either before or after stark critiques of the organisation. An employee in Syria described how, in a context of personal loss, "MSF, for me, is very really family, and I do love them and I like to defend them," but experiences of facing criticism for speaking up made them "really feel regret that nobody is caring about your pain" and ask "why is the power in those people's hands?" Another interviewee captures the combination of faith and dismay evoked by many:

> "It's difficult because it's an organisation I love so much and I don't want to work for anyone else. At the same time, too, it could be so much better and – trying to reconcile the two because it's very difficult – how can I love something so much and be so passionate about it when it's also so broken? But it works somehow. There's a touch of magic somewhere that makes it all work."

At the end of the day, "the touch of magic" making it all work is people's willingness to continue working for MSF, but also their structural inability to leave. Employees' views of MSF weighed the institution against its own values as well as the world in which it seeks to intervene:

> "I think MSF is essentially a neo-colonialist organisation, probably, and that's really uncomfortable to hear and to think as a part of it. I still am part of MSF because I believe in universal free access to healthcare, which is an increasingly diminishing resource in the world, and MSF provides it in places where it really doesn't exist, so on the scales of my soul, I still balance working for MSF as better than not."

By tracing the power dynamics at work in OCA and more widely MSF, among staff and between staff and patients, this study has exposed some of the causes of dismay, hurt and frustration. It has shown how people drive forward the movement's medical humanitarian action, by acting on the powers the organisation has granted them, by mobilising influence within the organisation, and by working around the obstacles that organisational and operational contexts present. It offers a portrait of the organisation, providing an analytical resource for those seeking to bring about change in MSF, and showing why they continue to try.

Annex I. Suggested starting points for discussion

This research, *In Service of Emergency: Understanding Power and Inequality in MSF,* provides analysis to inform members of MSF as they examine and address the inequalities and power dynamics that affect their work. The study was not intended to develop recommendations. Nonetheless, we have provided questions that aim to trigger critical debate and reflection, based on some of the study's key findings.

Chapter 3: What is an 'emergency'? How does this shape affect MSF's systems and structures, and its everyday work? Is responding to an emergency more important than thinking about the structural inequalities MSF might be reproducing? Are these things in competition?

Chapter 4: What 'currencies of influence' have you observed in your time with MSF? Have they changed over time? What is their relationship with 'emergency'? How might this be linked to inequalities between MSF and its patients, and within the organisation?

Chapter 5: What is MSF identity? What are some of the markers of being MSF? Who can best embody these and how does this shape participation in the organisation? What are the roles of locally recruited staff in MSF's operational decision making and associative life?

Chapter 6: Do locally recruited staff manage internationally mobile staff in the contexts where you have worked? What are the advantages and disadvantages of powerful coordination roles? What are the limits of security provision and health care for different contract types? Where should such decisions be made and what might accountability look like?

Chapter 7: What are the key attributes through which people gain legitimacy in MSF? Do you think this is evolving? Do you agree or disagree with the argument that by investing in DEI we take resources away from the medical mission? In your experience, how important is the idea of volunteerism to MSF, and what are its impacts?

Chapter 8: Do attitudes to leadership shape what is it possible to do within MSF? Do you think MSF's principles and values are universal? If so, in what ways? What is the role of patients in decision making? What would you do to try to influence a change in how MSF works?

Prioritising where to take action

The research describes many inequalities and inequities, as well as problems such as discrimination and abuse of power. A discussion about what and how to prioritise could be valuable to inform decision making in MSF about systemic actions as well as *ad hoc* ones.

- What are the potential criteria for prioritising where to focus efforts to improve conditions and experiences? For example, should the focus be on issues that:
  - affect the largest number of people,
  - have the most severe impacts,
  - are connected to many dynamics, or
  - have the greatest chance of leading quickly to improvements?
  - What other considerations are there?

- Who needs to be involved in making decisions about priorities? How can the inequalities and inequities documented in the research be overcome so that previously marginalised voices are able to participate?
- Thinking about your own workplace or team, which of the issues raised in the research do you think should be prioritised? Why? Are there dynamics in your workplace that are not reflected in the research?

Enabling and protecting individuals

Individuals have played important roles in raising awareness, campaigning, and proposing responses. Some of this work has been done by people in formal positions but much has also been achieved by staff members acting on their own initiative. Exploring the potential and limits of individual agency and its relationship to the institution could be beneficial.

- What are the areas where there is scope for individuals to bring about improvements? Looking at how this plays out in specific places (not generalising), what is allowing or preventing this happening? How can the institution learn from these experiences?
- Are there roles or positions that should have less power? Are there roles or positions that should have more?
- What responsibilities does MSF have for enabling staff and association members who are active on issues related to internal power dynamics and inequalities? How can individuals with roles that require influencing others (e.g. DEI implementors, PCC ambassadors, ALFies) be supported in their roles? How can self-mobilising staff and allies be protected from burnout?

Annex II. Bibliography

The bibliography is divided into four categories:

1. MSF sources and publications, including institutional materials, such as policies and statements; MSF communications material, such as blogs; and research published by MSF.
2. Research or commentary produced by people who have worked for MSF or still do. This should not be taken to mean or imply that individual authors affiliated with MSF are speaking for the institution, but helps to identify their positionality.
3. Media coverage.
4. Secondary sources, including academic scholarship and grey literature, whether about the MSF movement or other areas.

Where possible, sources published by the MSF movement are credited to their individual authors. Note that this means that some authors figure in both the first and second category. Sources produced by parts of the MSF movement but not attributed to individual authors all indicate their movement affiliation, even where the original document does not do so (e.g., 'MSF OCA' or 'MSF International Board'). Where the document does not specify authorship, it is credited only to 'MSF'. All links were last verified in April 2023.

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